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Review Article

Physiotherapy Section

Connecting the Threads: A Descriptive Review of Social, Cultural and Spiritual Influences on Physiotherapy Practice

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ABSTRACT

In the 21st century, there have been significant indigenous advancements in the field of physiotherapy. However, there still exist certain sociocultural and spiritual beliefs among practitioners. Through meticulous examination, evaluation, diagnosis, prognosis, and physical intervention, physiotherapists utilise mechanical movements and force to treat impairments and help improve function, mobility, and quality of life. The cultural framework plays a crucial role in how individuals experience health, illness, and disability. Simultaneously, sociocultural factors are pivotal in the physical function, health, and illness of individuals. This paper explores the social, cultural and spiritual influences on physiotherapy across different societal and professional contexts. While there have been several recent studies providing snapshots of advancements in technologies in the healthcare system, there are not as many focusing on these three aspects in the clinical practice of physiotherapists. Due to the different eras in the history of physiotherapy, the present article demonstrates how physiotherapists are influenced by social, cultural, and spiritual domains. It is challenging to generalise the results in every situation and geographical area. Therefore, physiotherapists should be proactive in addressing these healthy beliefs at the grassroots level within the healthcare society. To create a personalised treatment plan, goal-setting, and care plan for the patient, the physiotherapist finds great value in understanding the patient's sociocultural and spiritual history.

Keywords: Cultural norms, Health, Social determinant, Sociocultural, Spirituality

INTRODUCTION

A person's health is their greatest asset throughout their entire life. One can survive without having more money, but they cannot survive without being well [1]. Optimal health is essential for full enjoyment of life. Personal circumstances of a person have a significantly greater impact on their health and well-being than do social determinants of health. People's perceptions of their health and health problems, when and from whom they seek medical assistance, and how they respond to suggestions for a change in lifestyle, medical intervention, and adherence to physiotherapy are all influenced by cultural health beliefs. The discussion of values and beliefs within coping mechanisms and support structures is made possible by the study of spiritual history, which also discloses both successful and unsuccessful spiritual coping strategies and offers chances for compassionate care [2]. The focus of the present study is on how patient care practices and the profession of physiotherapy are influenced by sociocultural and spiritual elements. Additionally, it affects how the patient is evaluated and how to create a treatment plan that will boost the patient's prognosis along these factors. Therefore, the present study can be regarded as a valuable contribution to clinical practice that can close the knowledge gap between the practice of physiotherapy considering sociocultural and spiritual aspects of society.

Social Influences in Physiotherapy

Health and social determinant: According to the founding document of the World Health Organisation (WHO), "Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." An important implication of this definition is that mental health is more than just the absence of mental disorders or disabilities [3]. The concept of health has several dimensions. Numerous factors, including the social context of health, have an impact on an individual's perception of their health and well-being. The social determinants of health include people's interactions with the healthcare system as well as the conditions under which they are born, grow up, live, and work. "Health inequities," the unfair and avoidable variations in health status seen within and across countries, are caused by social determinants of health. Within nations, an individual's health is poorer the lower their socio-economic status [4]. There is a "social gradient" in health that runs from top to bottom along the socio-economic spectrum. Therefore, it relates to how a person's general health and capacity to get healthcare may be impacted by their social and economic situation. If the aetiology of illness is focused on the cause of the illness, the social determinants of health are usually referred to as "the cause of the cause," or the underlying societal components that contribute to health. The issues surrounding these [Table/Fig-1] were discussed by the Pan American Health Organisation (PAHO), which includes social gradient, social exclusion, working conditions, assessment of food and early life factors [5]. These are the fundamental requirements for optimal physical and social health, which a physical therapist's subjective assessment cannot eliminate.

According to WHO and United Nations International Children's Emergency Fund (UNICEF), the primary healthcare model is based on procedures that are useful, reliable from a scientific standpoint,

Determinants of health	Definition
Social gradient	It alludes to several socio-economic classes in a society (lower, medium, and upper class individuals). People with low socio-economic level are experiencing poor health conditions.
Social exclusion	It results from a person's loss of ties to their local community. Less social support, less personal connections, and smaller social networks are traits.
Working condition	The disparities in the health status of socio-economic classes are related to the social spectrum's diversity in exposure to hazardous working circumstances.
Assess of food	For people to be healthy and happy, they must have access to decent food and clean water.
Early life factors	The environment and conditions a child is exposed to from birth through early childhood have an impact on their future development.

[Table/Fig-1]: Determinants of health discussed by PAHO [5].

and acceptable to society [6]. "Home physiotherapy" is an innovative idea in physical therapy delivery, falling under primary healthcare services. It is a primary healthcare service delivered at home with the goal of identifying, evaluating, supporting, and continuing to fulfill the health requirements of people and their families [7]. Enabling more continuity of care, this boosts the autonomy of the person and their family. The goals of the "home physiotherapy" centre focused on three areas [8]:

a. Ensuring access to quality physical therapy services;
b. Encouraging participation from the family;
c. Counselling other experts who provide home care.

Social Support and Health

The term "social support" refers to aid and assistance that is given and received through social ties and interactions [9]. The therapist tries to determine what sort of assistance the users of the social network are able and willing to provide. Therapists can learn a lot about a patient's social network and resources by just talking to them. A therapist is required to be knowledgeable about "employer's policies" and protocols that outline how to report, record, and respond to situations of suspected maltreatment (such as victims of physical assault, sexual assault, domestic abuse, or elder abuse or neglect). It is important for therapists to identify when patients are harmed by certain social interactions.

Families, close friends, or carers of the patient report significant levels of subjective burden, mood disorders, as well as changes in their roles in work, play, and social interactions [10]. The needs of the patient's family members for adaptation should also be continuously evaluated by therapists in order to support the patient's long-term quality of life. The family's priorities and contributions to the patient's treatment and adaptation can be tapped into by therapists using a family-centered approach. This line of reasoning states that therapists should "follow the family's lead rather than impose professional decisions" [11]. Finding out why is something that therapists should do when their work no longer feels like a privilege (e.g., for instance, a heavy caseload, a private life that is both distracting and burdensome, burnout, or unethical employer requirements that undermine integrity). In order to prevent their personal demands from interfering with their social relationships with patients, effective therapists take measures to handle the tensions brought on by their patients' overwhelming circumstances [12].

Gender Influences in Physiotherapy

Regarding how physiotherapists adapt their professional roles to fit with current gender norms, gender matters in the job duties of the physiotherapist [13]. Gendered social practices known as "production relations" are responsible for the division of labour and tasks within a profession [14]. This indicates that the power and meanings associated with the division of labour between groups and within a group are structured from a gender perspective.

Due to gender segregation, there are more women than men employed in these fields, and they are more likely to face threats and acts of violence from colleagues, bosses, clients, and patients, compromising professional ethics. There are statistical comparisons between men and women who take sick leaves, with more women than men taking time-off for musculoskeletal and mental health issues [15]. Employers' choices regarding recruitment are influenced by this kind of behaviour.

Due to their interest in sports and physical activity, males were more likely than women to choose a physiotherapy education. When questioned about their ideal future employment, men were also seven times more likely than women students to say they thought of running their own private clinic [16]. There are signs that physiotherapy lecturers could be biased against one gender over another when it comes to professional contributions made by students. The future integration of gender information will be difficult [17]. Notwithstanding these gender-centric conventions, the authors ought to take into account the therapist's potential based on their expertise, advanced training, and commitment to patient care. This is how we might inspire physiotherapy students to think critically about their learning and to consider how we could one day expand the function of physiotherapists beyond the confines of traditional gender roles. In this approach, higher education curricula may influence future physiotherapists' clinical practices and professional positions [18].

Cultural Influences in Physiotherapy

Culture is referred to as a set of acquired and shared norms for recognising, interpreting, and interacting with people and their surroundings that determine values, beliefs, and actions. Culture is not inherited biologically or influenced by geography or race. A person's ethnicity is a collection of customs and traditions linked to their ancestry. Ethnicity does not predict cultural identity on its own [19]. Although it has an impact on the political, social, and economic sectors, it offers little to aid a therapist in comprehending the patient's unique situation.

For example, the rehabilitation difficulties of an Indian with right hemiplegia who refuses to feed herself using her left hand because in her culture, the left hand is always reserved for personal hygiene duties. Cultural norms are adaptable, task- and environment-specific, graded, and frequently self-selected, even if they must be learned. Cultural heritage and identity have an impact on how therapists interpret social interactions, Activities of Daily Living (ADL), and performance on standardised tests. As a further illustration, Muslims who suffer from Osteoarthritis (OA) in their knees may find it difficult to pray the namaz, which could exacerbate their knee discomfort. Therapists take into account the cultural impacts on communication based on social hierarchy, turn-taking during discussions, styles of address (using first or last names), usage of gestures, and sense of personal space [20].

Clinicians must avoid categorising or stereotyping patients based on their racial or geographic origins because of the dynamic influence of culture on the human experience. Instead, therapists make an effort to acknowledge and then put aside their own cultural history and prejudices in order to respect and embrace the culturally specific traditions, values, and beliefs of each client [21]. Cultural assessment is an important factor for physical therapists to make a plan of care and exercise protocol.

The treatment of disabled people is influenced by cultural norms. If someone is ill, the rules frequently change. For instance, the Chinese in Taiwan are more likely to excuse the sick from their duties than the Chinese in the United States [22]. People with extreme mental retardation might be almost completely exempted from rules-following in some civilisations, yet they might be burned alive as children in other societies (like the Northern Salteaux Indians') [23]. Some civilisations don't take care of their sick members. For instance, anyone too unwell to travel was left to die in the Siriond society of Bolivia's tropical forests, where it is unacceptable for married women to be ill [24].

A person's reaction to their disability may be influenced by the visibility or invisibility of their impairment due to social interactions. For instance, invisible disabilities like pain can be challenging since other people sometimes expect the person with the disability to perform in impossibly difficult ways [25]. One woman with rheumatoid arthritis claimed that wearing her hand splints made going grocery shopping simpler for her since it made her disability more obvious and encouraged others to carry her packages for her without her having to ask [26]. These details might help therapists better understand how they can modify their services to the needs of their clients. These sources shed light on how people, who have a debilitating condition, find, develop, and use their resources

and strengths to adapt to the obstacles of their settings. The therapist's influence on this process can be significant. According to Robinson, the function of the physician should shift from controller to coordinator and that of the therapist from medical agent to an autonomous contractor (able to handle the long-term complicated interactions among impairment, disability, and handicap) [27]. The patient's role would shift from that of a passive participant with predetermined goals to that of an active definer of rehabilitation goals. The community would serve as the new location for service delivery instead of the hospital.

Spiritual Influences in Physiotherapy

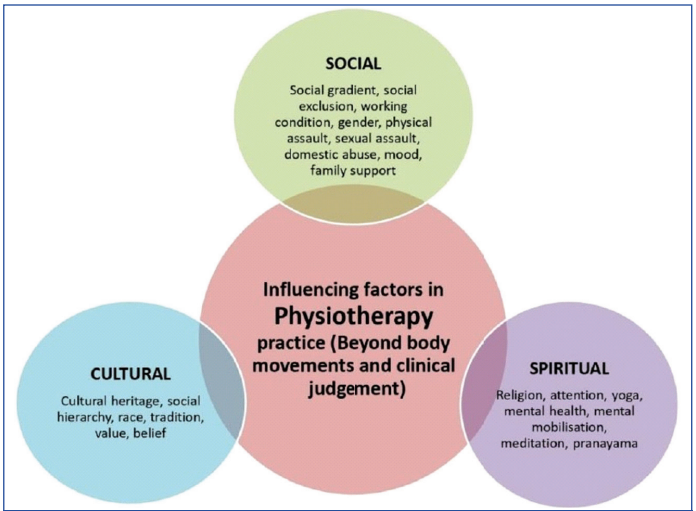
The ideas and behaviours about the world and one's role in it that give a person a transcending purpose in life are referred to as spirituality [28]. These convictions may take the form of a religious faith or be aimed at family, nature, or community. It displays a person's overarching meaning system, which affects how they spend their time, what they decide to do, and how they perceive their life's purpose. So, a person's coping and job performance are heavily influenced by their spirituality.

When a therapist incorporates spirituality into their practice, they do so by attending to the client's religious needs, fostering the patient's feeling of self-worth, and addressing or facing the patient's suffering [29]. For instance, a patient who is hemiplegic and a devotee of Hinduism may be advised to clap (Hari naam jaap) in prayer to Lord Krishna. This will encourage the patient to exert greater effort when moving their upper extremities. These relationships with clients serve as development opportunities for the therapist as well. Physical therapists must carefully evaluate patients' coping mechanisms, spiritual perspectives, and philosophical frameworks. The therapist invests in building therapeutic rapport to investigate the patient's beliefs and meaning systems; otherwise, patients may consider inquiries about their spirituality, for example, as being intrusive or obtrusive or insulting [30]. The degree to which the patient and the therapist are at ease with one another and the subject matter will influence how intimately these intensely personal and potentially sensitive matters may be discussed. Obtaining the patient's explanation for the disease or impairment (If the person believes that the development of their sickness or limitation is God's retribution for a past transgression or mistakes, they may not be motivated to invest in rehabilitation attempts) is crucial. Asking patients about their purpose and previous situations where their coping mechanisms were put to the test may help you better understand the role that spirituality plays in their lives [31].

In terms of reducing oxidative stress and releasing tension, which, in turn, leads to increased relaxation and attention, yoga asana has the strongest spiritual influence in physiotherapy. Yoga practices have been reported to be helpful in the treatment of Obsessive-Compulsive Disorder (OCD), major depressive disorders, phobias, dyslexia, bereavement insomnias, and other sleep problems, Post-traumatic Stress Disorder (PTSD), fear, managing anger, and antisocial behaviours [32]. The author hypothesises that yoga practitioners will use the same psychological and spiritual resources as physiotherapists during their practice to improve a patient's return to function. According to the author, yoga is a sort of "mental mobilisation," as practitioners engage in poses that promote improved self-efficacy, self-development, or optimistic states of mind [33]. To mobilise the joints and normalise blood pressure and Central Nervous System (CNS) processes, the author suggests practicing meditation in addition to facilitating breathing patterns. One way to incorporate these approaches is through yoga [34].

Longer-tenured physiotherapists were marginally more likely to concur that spiritual well-being is a crucial element of good health and to say that spirituality is a vital aspect of life that aids them in fulfilling their professional obligations. Physiotherapists believe that spirituality is a crucial component of healthcare and that they should play a role in providing some forms of spiritual treatment. Patients' spirituality may have an impact on therapy, and therapists should encourage patients to voice their spiritual needs and concerns [35]. This is a significant conclusion because it shows that, despite the physiotherapists' self-described religiosity, they believe that spirituality and spiritual well-being are crucial aspects of health and recovery.

The present study [Table/Fig-2] closes the information gap between the practice of physiotherapy and sociocultural and spiritual aspects of society, which can be considered a beneficial contribution to therapeutic practice.



[Table/Fig-2]: Influencing factors in physiotherapy practice (beyond body movements and clinical judgement).

CONCLUSION(S)

Health and socio-economic position are interrelated. For patients who are housebound and in remote places, home physical treatment needs to be increased. Additionally, the patient may benefit from family members being involved in the rehabilitation process. Human resources should not discriminate against therapist candidates based on their gender, ethnicity, culture, or caste. These issues have an impact on recruiting and professional growth in the practice of physiotherapy. For a physiotherapist to create a treatment regimen and exercise protocol, sociocultural evaluation is another crucial consideration. The therapist needs to be well-versed in the customs of many cultures. Instead of the hospital, the community should now be the site of service delivery. Yoga poses and pranayama can be used by the physiotherapist to treat mental health issues.

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REFERENCES

[1] Benzeval M, Bond L, Campbell M, Egan M, Lorenc T, Petticrew M, et al. How does money influence health? Project Report. Joseph Rowntree Foundation, York. 2014;01-70.
[2] Canda ER, Furman LD, Canda HJ. Spiritual diversity in social work practice: The heart of helping. 3rd ed. Oxford University Press, USA; 2019.
[3] World Health Organization. About World Health Organization. Constitution. Available from: https://www.who.int/about/accountability/governance/constitution. Accessed: 20 January 2024.
[4] Feinstein JS. The relationship between socioeconomic status and health: A review of the literature. Milbank Q. 1993;71(2):279-322.
[5] Galvão LA, Finkelman J, Henao S. Environmental and social determinants of health. PAHO; 2016.
[6] Perry B, Gesler W. Physical access to primary health care in Andean Bolivia. Soc Sci Med. 2000;50(9):1177-88.

[7] World Health Organization. The growing need for home health care for the elderly: Home health care for the elderly as an integral part of primary health care services. 2015. Available from: https://applications.emro.who.int/dsaf/EMROPUB_2015_EN_1901.pdf?ua=1.
[8] Hale L. Using goal attainment scaling in physiotherapeutic home-based stroke rehabilitation. Advances in Physiotherapy. 2010;12(3):142-49.
[9] Heaney CA, Israel BA. Social networks and social support in health education. Health Behavior and Health Education (Glanz K, Lewis FM, Rimer BK, eds). San Francisco: Jossey-Bass. 1997:179-205.
[10] Frosch S, Gruber A, Jones C, Myers S, Noel E, Westerlund A, et al. The long term effects of traumatic brain injury on the roles of caregivers. Brain Inj. 1997;11(12):891-906.
[11] Brown SM, Humphry R, Taylor E. A model of the nature of family-therapist relationships: Implications for education. Am J Occup Ther. 1997;51(7):597-603.
[12] Stevenson AD, Phillips CB, Anderson KJ. Resilience among doctors who work in challenging areas: A qualitative study. British Journal of General Practice. 2011;61(588):e404-10.
[13] Stenberg G, Fjellman-Wiklund A, Strömbäck M, Eskilsson T, From C, Enberg B, et al. Gender matters in physiotherapy. Physiother Theory Pract. 2022;38(13):2316-29.
[14] Connell R. Gender, health and theory: Conceptualizing the issue, in local and world perspective. Soc Sci Med. 2012;74(11):1675-83.
[15] Mather L, Ropponen A, Mittendorfer-Rutz E, Narusyte J, Svedberg P. Health, work and demographic factors associated with a lower risk of work disability and unemployment in employees with lower back, neck and shoulder pain. BMC Musculoskeletal Disorders. 2019;20(1):622.
[16] Öhman A, Hägg K, Dahlgren L. A stimulating, practice-based job facing increased stress–clinical supervisors' perceptions of professional role, physiotherapy education and the status of the profession. Advances in Physiotherapy. 2005;7(3):114-22.
[17] Edgar S. Identifying the influence of gender on motivation and engagement levels in student physiotherapists. Med Teach. 2015;37(4):348-53.
[18] Onyeso OK, Umunnah JO, Ezema CI, Anyachukwu CC, Nwankwo MJ, Odole AC, et al. Profile of practitioners, and factors influencing home care physiotherapy model of practice in Nigeria. Home Health Care Serv Q. 2020;39(3):168-83.
[19] Breland HL, Ellis C Jr. Is reporting race and ethnicity essential to occupational therapy evidence? Am J Occup Ther. 2012;66(1):115-19.
[20] Hearnden M. Coping with differences in culture and communication in health care. Nurs Stand. 2008;23(11):49-57.
[21] Burgess D, van Ryn M, Dovidio J, Saha S. Reducing racial bias among health care providers: Lessons from social-cognitive psychology. J Gen Intern Med. 2007;22(6):882-87.
[22] Hui C, Law KS, Chen ZX. A structural equation model of the effects of negative affectivity, leader-member exchange, and perceived job mobility on in-role and extra-role performance: A Chinese case. Organizational Behavior and Human Decision Processes. 1999;77(1):03-21.
[23] Hallowell AI. The role of conjuring in Saulteaux society. University of Pennsylvania Press; 2017.
[24] Heath DB. Changes in drinking patterns in Bolivian cultures: A cautionary tale about historical approaches. Addiction Research. 1995;2(3):307-18.
[25] Lingsom S. Invisible impairments: Dilemmas of concealment and disclosure. Scandinavian Journal of Disability Research. 2008;10(1):02-16.
[26] Sadura-Sieklucka T, Sokołowska B, Prusinowska A, Trzaska A, Księżopolska-Orłowska K. Benefits of wrist splinting in patients with rheumatoid arthritis. Reumatologia. 2018;56(6):362-67.
[27] Robinson I. The rehabilitation of patients with long-term physical impairments: The social context of professional roles. Clinical Rehabilitation. 1988;2(4):339-47.
[28] Coyle J. Spirituality and health: Towards a framework for exploring the relationship between spirituality and health. J Adv Nurs. 2002;37(6):589-97.
[29] Egan M, Swedersky J. Spirituality as experienced by occupational therapists in practice. Am J Occup Ther. 2003;57(5):525-33.
[30] Price B. Developing patient rapport, trust and therapeutic relationships. Nurs Stand. 2017;31(50):52-63.
[31] Puchalski CM. The role of spirituality in health care. Proc (Bayl Univ Med Cent). 2001;14(4):352-57.
[32] Kirkwood G, Rampes H, Tuffrey V, Richardson J, Pilkington K. Yoga for anxiety: A systematic review of the research evidence. Br J Sports Med. 2005;39(12):884-91.
[33] Posadzki P, Parekh S. Yoga and physiotherapy: A speculative review and conceptual synthesis. Chin J Integr Med. 2009;15(1):66-72.
[34] Shetty P, Reddy B KK, Lakshmeesha DR, Shetty SP, Kumar GS, Bradley R. Effects of Sheetali and Sheetkari Pranayamas on blood pressure and autonomic function in hypertensive patients. Integr Med (Encinitas). 2017;16(5):32-37.
[35] Oakley E, Katz G, Sauer K, Dent B, Millar AL. Physical therapists' perception of spirituality and patient care: Beliefs, practices, and perceived barriers. Journal of Physical Therapy Education. 2010;24(2):45-52.

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