

**Supplementary Material: Caregiver Questionnaire - Palliative caregivers' spirituality, views about spiritual care, and associations with spiritual well-being: a mixed methods study.**

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## Section A Demographics

To help us understand your background and how you would describe yourself in a spiritual sense, please complete:

1. What is your sex (please tick)? ☐ Male ☐ Female
2. What is your age? \_\_\_\_\_
3. What is the postcode of your primary residence? \_\_\_\_\_
4. What is your relationship status (please tick)?  
☐ Married / de facto ☐ Divorced  
☐ Widowed ☐ Other (please specify) \_\_\_\_\_  
☐ Single
5. What is your country of birth? ☐ Australia ☐ Other (please specify) \_\_\_\_\_
6. What language do you speak at home? ☐ English ☐ Other (please specify) \_\_\_\_\_
7. What is the highest level of education you have completed? (please tick one)  
☐ Primary School ☐ Postgraduate tertiary  
☐ Secondary School ☐ Other (please specify) \_\_\_\_\_  
☐ TAFE (Tertiary and Further Education)  
☐ Undergraduate tertiary
8. Which of the following best describes your current occupational status?  
☐ Unable to gain employment due to being a caregiver of someone with an illness or disability ☐ Employed full-time  
☐ Unable to gain employment due to illness or disability ☐ Not employed but looking for a job  
☐ Full-time student  
☐ Part-time student  
☐ Other (Please specify) \_\_\_\_\_  
☐ Retired ☐ Employed part-time or casually  
☐ Full-time domestic duties
9. What is the main diagnosis of the person you care for?
10. How long has this person been living with their main diagnosis?  
☐ less than 6 months ☐ 1 year to 5 years  
☐ 6 months to one year ☐ More than 5 years
11. What is your relationship to the person you are caring for? \_\_\_\_\_
12. What is their sex (please tick)? ☐ Male ☐ Female
13. What is their age? \_\_\_\_\_

## **Section B Facit-12**

Please circle one number per line to indicate your response as it applies to the **past 7 days**.

	<b>Not at all</b>	<b>A little bit</b>	<b>Some -what</b>	<b>Quite a bit</b>	<b>Very much</b>
I feel peaceful	0	1	2	3	4
I have a reason for living	0	1	2	3	4
My life has been productive	0	1	2	3	4
I have trouble feeling peace of mind	0	1	2	3	4
I feel a sense of purpose in my life	0	1	2	3	4
I am able to reach down deep into myself for comfort	0	1	2	3	4
I feel a sense of harmony within myself	0	1	2	3	4
My life lacks meaning and purpose	0	1	2	3	4
I find comfort in my faith or spiritual beliefs	0	1	2	3	4
I find strength in my faith or spiritual beliefs	0	1	2	3	4
The illness in the person I care for has strengthened my faith or spiritual beliefs	0	1	2	3	4
I know that, whatever happens with the illness in the person I care for, things will be okay	0	1	2	3	4

## Section C Spirituality and Religiosity and supports

1. How important is spirituality to you? (please circle)

Very important

Not important

Somewhat important

2. Please explain spirituality's meaning and role in your life, if any \_\_\_\_\_  
\_\_\_\_\_

### To help us understand your religiousness

3. How important is religion (or your faith or belief system) to you? (please circle)

Very important

Not important

Somewhat important

4. What is your religion (if any)? (please tick that which most applies)

- ☐ Buddhism      ☐ Christianity      ☐ Hinduism  
☐ Islam      ☐ Judaism      ☐ Judaism  
☐ Other religion or faith or belief system. Please specify \_\_\_\_\_  
☐ No religious affiliation or faith or belief system

5. Please describe religion's (or your faith's or belief system's) meaning and role in your life, if applicable to you:  
\_\_\_\_\_  
\_\_\_\_\_

6a. How often did you attend religious services before the main diagnosis of the person you care for? (please tick)

- |   |   |
|---|---|
| <input type="checkbox"/> Never                | <input type="checkbox"/> Once or twice a month  |
| <input type="checkbox"/> Once or twice a year | <input type="checkbox"/> Once a week            |
| <input type="checkbox"/> Every month or so    | <input type="checkbox"/> More than once a week. |

6b. How often do you attend religious services now? (please tick)

- |   |   |
|---|---|
| <input type="checkbox"/> Never                | <input type="checkbox"/> Once or twice a month  |
| <input type="checkbox"/> Once or twice a year | <input type="checkbox"/> Once a week            |
| <input type="checkbox"/> Every month or so    | <input type="checkbox"/> More than once a week. |

6c. If there is a change in how often you attend religious services since the main diagnosis of the person you care for, please describe the factors that influence this.  
\_\_\_\_\_  
\_\_\_\_\_

7a. How often do you spend time in private prayer now? (please tick)

- |   |  |
|---|--|
| <input type="checkbox"/> Never                | <input type="checkbox"/> Once or twice a month |
| <input type="checkbox"/> Once or twice a year | <input type="checkbox"/> Once a week           |
| <input type="checkbox"/> Every month or so    | <input type="checkbox"/> More than once a week |

7b. How often did you spend time in private prayer before the main diagnosis of the person you care for? (please tick)

- |   |  |
|---|--|
| <input type="checkbox"/> Never                | <input type="checkbox"/> Once or twice a month |
| <input type="checkbox"/> Once or twice a year | <input type="checkbox"/> Once a week           |
| <input type="checkbox"/> Every month or so    | <input type="checkbox"/> More than once a week |

8a. How often do you spend time in private meditation now? (please tick)

- |   |  |
|---|--|
| <input type="checkbox"/> Never                | <input type="checkbox"/> Once or twice a month |
| <input type="checkbox"/> Once or twice a year | <input type="checkbox"/> Once a week           |
| <input type="checkbox"/> Every month or so    | <input type="checkbox"/> More than once a week |

8b. How often did you spend time in private meditation before the main diagnosis of the person you care for? (please tick)

- |   |   |
|---|---|
| <input type="checkbox"/> Never                | <input type="checkbox"/> Once or twice a month  |
| <input type="checkbox"/> Once or twice a year | <input type="checkbox"/> Once a week            |
| <input type="checkbox"/> Every month or so    | <input type="checkbox"/> More than once a week. |

9a. How often do you spend time in private reading of sacred texts such as the Bible, Tanach, Mishnah, Talmud, Midrash, Sutras, Vedas, Quran and Hadith now? (please tick)

- |   |  |
|---|--|
| <input type="checkbox"/> Never                | <input type="checkbox"/> Once or twice a month |
| <input type="checkbox"/> Once or twice a year | <input type="checkbox"/> Once a week           |
| <input type="checkbox"/> Every month or so    | <input type="checkbox"/> More than once a week |

9b. How often did you spend time in private reading of sacred texts before the main diagnosis of the person you care for? (please tick)

- |   |   |
|---|---|
| <input type="checkbox"/> Never                | <input type="checkbox"/> Once or twice a month  |
| <input type="checkbox"/> Once or twice a year | <input type="checkbox"/> Once a week            |
| <input type="checkbox"/> Every month or so    | <input type="checkbox"/> More than once a week. |

10a. How often do you spend time in any other significant religious activity (or spiritual reflection) now? (Please tick if applicable)

Please state what you do if applicable: \_\_\_\_\_

- |   |   |
|---|---|
| <input type="checkbox"/> Never                | <input type="checkbox"/> Once or twice a month  |
| <input type="checkbox"/> Once or twice a year | <input type="checkbox"/> Once a week            |
| <input type="checkbox"/> Every month or so    | <input type="checkbox"/> More than once a week. |

10b. How often did you spend time in this religious activity (or spiritual reflection) before the main diagnosis of the person you care for? Please tick if applicable

- |   |   |
|---|---|
| <input type="checkbox"/> Never                | <input type="checkbox"/> Once or twice a month  |
| <input type="checkbox"/> Once or twice a year | <input type="checkbox"/> Once a week            |
| <input type="checkbox"/> Every month or so    | <input type="checkbox"/> More than once a week. |

11. If there is a change in the amount of time you spend in any of your religious activities (or spiritual reflection) since the main diagnosis of the person you care for, please describe the factors that influence this.

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12. To what extent are your religious/spiritual needs being supported by your religious and/or faith community away from Cabrini Health? (e.g., clergy, members of your congregation)

- |   |   |
|---|---|
| <input type="checkbox"/> Not at all           | <input type="checkbox"/> To a large extent                                      |
| <input type="checkbox"/> To a small extent    | <input type="checkbox"/> Completely supported                                   |
| <input type="checkbox"/> To a moderate extent | <input type="checkbox"/> Not applicable – do not have religious/spiritual needs |

**Section D Role of hospitals/the organization to meet spiritual and religious requirements**

1a. Do you consider that Australian hospitals need to support the spiritual requirements and well-being of the caregivers of patients with serious illnesses? (Please circle)

Strongly  
disagree

Disagree

Neither agree  
nor disagree

Agree

Strongly  
agree

1b. Please describe the factors that influence your response to 1a:

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2. To what extent are your spiritual requirements being supported by Cabrini Health? (Please tick)

☐ Not at all

☐ To a small extent

☐ To a moderate extent

☐ To a large extent

☐ Completely supported

☐ Not applicable - do not have spiritual requirements

3. To what extent are your religious requirements being supported by Cabrini Health? (Please tick)

☐ Not at all

☐ To a small extent

☐ To a moderate extent

☐ To a large extent

☐ Completely supported

☐ Not applicable - do not have religious requirements

4. (*If appropriate*) How else can Cabrini Health help you with spiritual or religious requirements? (e.g., sacraments, prayers, availability of sacred texts, music, connection with a representative from my faith, quiet contemplative spaces, respect for my religious dietary needs, etc).

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5a. Have you been offered pastoral care services within Cabrini Health? (Please tick)

☐ No

☐ Yes

5b. Have you requested pastoral care services within Cabrini Health? (Please tick)

☐ No

☐ Yes

5c. Have you received pastoral care services within Cabrini Health? (Please tick)

☐ No

☐ Yes,

5d. If yes, please state approximate number of times and describe the nature of these visits:

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5e. If you did receive visits from pastoral care services, how much comfort would you say this provided for you? (Please tick as many that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> Made me uncomfortable          | <input type="checkbox"/> Provided me a lot of comfort |
| <input type="checkbox"/> Made me somewhat uncomfortable | <input type="checkbox"/> Made me feel calmer          |
| <input type="checkbox"/> Provided no comfort            | <input type="checkbox"/> Made me feel better          |
| <input type="checkbox"/> Provided some comfort          | <input type="checkbox"/> Not applicable               |

6. Please add any additional comments you may have about Cabrini Health supporting your own, the patient you care for, your family's, or others' spiritual or religious lives (if any).

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**Section E Spiritual concerns [Note. Results from the spiritual concerns questions are to be validated and reported elsewhere]**

1. Some people carry spiritual or religious worries or concerns that may be difficult to describe. In order to improve services for caregivers of seriously ill patients at Cabrini Health we would like to know their importance for you. Are there any issues from this list that are of concern to you? If so, please tick all items that are applicable to you.

<b>Tick if a concern</b>	<b>Your concern</b>
<input type="checkbox"/>	Spiritual or religious doubts
<input type="checkbox"/>	Loss of faith
<input type="checkbox"/>	Loss of hope
<input type="checkbox"/>	Uncertainty about an afterlife
<input type="checkbox"/>	Losing control
<input type="checkbox"/>	Loss of meaning in life
<input type="checkbox"/>	Strain in my relationship with God or the transcendent
<input type="checkbox"/>	Regret about past behaviours
<input type="checkbox"/>	Prayers being unheard
<input type="checkbox"/>	Fear of the dying process
<input type="checkbox"/>	Guilt over past behaviours
<input type="checkbox"/>	Anger at God
<input type="checkbox"/>	Fear of punishment by God
<input type="checkbox"/>	Fear of death
<input type="checkbox"/>	Fear of hell
<input type="checkbox"/>	Forgiveness of others
<input type="checkbox"/>	Self-forgiveness
<b>If any others, please specify below:</b>	

2a. Are you currently receiving help from Cabrini Health for any concerns ticked in your answer to Question 28a above? (Please circle) Yes No Not applicable

2b. If yes, please describe this help:

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3. Would you like to receive help from Cabrini Health for any concerns ticked in your answer to Question 28a above? (Please circle) Yes No Not applicable