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Spiritual Needs Fulfillment in Physiotherapy Inpatients: A Cross-Sectional Descriptive Study

Marianus Oktavianus Wega[1], Gabriel Mane[2], Kristoforus Samson[3], Epifanius Yolandus[4]

[1-4]STIKes St. Elisabeth Keuskupan Maumere, Nusa Tenggara Timur, Indonesia

Corresponding author:
Name: Marianus Oktavianus Wega
E-mail: marthonwega@gmail.com

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Abstract

Background: Holistic physiotherapy care recognizes that recovery is influenced not only by physical interventions but also by psychosocial and spiritual factors. For hospitalized patients undergoing physiotherapy, unmet spiritual needs may reduce motivation, coping capacity, and engagement in rehabilitation.

Objective: To describe the level of spiritual needs fulfillment among physiotherapy inpatients and to examine its distribution across patient characteristics.

Methods: A cross-sectional descriptive study was conducted among 50 physiotherapy inpatients in the Flamboyan Ward of BLUD RSUD dr. T.C. Hillers Maumere. Participants were recruited using accidental sampling based on predefined inclusion criteria. Spiritual needs fulfillment was assessed using a structured questionnaire encompassing six dimensions: meaning and purpose of life, relationship with God, spiritual practices, religious obligations, interpersonal connections, and professional interaction with physiotherapists. Data were analyzed using univariate descriptive statistics and presented as frequencies and percentages.

Results: Most participants were aged over 60 years (48%) and had a primary education level (62%). Fulfillment of meaning and purpose of life and relationship with God was reported by all respondents (100%). High levels of fulfillment were also observed for spiritual practices (96%), religious obligations (94%), interpersonal connections (96%), and professional interaction (98%). The pattern of spiritual needs fulfillment was consistently high across all respondent characteristics.

Conclusion: Spiritual needs among physiotherapy inpatients were predominantly well fulfilled across all assessed dimensions. These findings highlight the importance of integrating spiritual awareness into routine physiotherapy practice to support holistic, patient-centered rehabilitation.

Keywords
Spirituality; Physical Therapy Modalities; Inpatients; Rehabilitation

Introduction

Spirituality is increasingly recognized as an integral component of holistic healthcare, encompassing patients' search for meaning, purpose, connection, and transcendence during illness and recovery.[1] In the context of physiotherapy, where rehabilitation often requires sustained motivation, coping, and active participation, spiritual well-being may play a crucial role in supporting psychological resilience and treatment adherence.[2] Holistic physiotherapy practice therefore extends beyond physical restoration to address the bio-psycho-social-spiritual dimensions of health, particularly among hospitalized patients experiencing functional limitations and dependency.[3]

Hospitalized physiotherapy patients frequently face conditions associated with long-term disability, such as stroke, degenerative neurological disorders, orthopedic injuries, and chronic musculoskeletal pain. These conditions not only impair physical function but also disrupt patients' sense of identity, autonomy, and meaning in life.[4] Patients with restricted mobility or prolonged hospitalization are more vulnerable to anxiety, emotional distress, and loss of hope, which may negatively affect engagement in rehabilitation programs and delay functional recovery.[5] Consequently, attention to spiritual needs may help patients maintain hope, interpret illness meaningfully, and sustain motivation throughout the rehabilitation process.[6]

From a professional standpoint, international physiotherapy guidelines emphasize that patient-centered care should respect individual values, beliefs, and spiritual concerns as part of ethical and holistic practice.[7] Physiotherapists interact intensively with inpatients through repeated therapeutic sessions, positioning them uniquely to recognize spiritual concerns through therapeutic communication, empathy, and professional interaction.[3] A supportive therapeutic alliance, characterized by trust and respect for patient beliefs, has been associated with improved adherence and rehabilitation outcomes in musculoskeletal and neurological physiotherapy settings.[8]

Epidemiologically, the burden of conditions requiring inpatient physiotherapy remains substantial. Stroke alone affects approximately 101 million people worldwide, with an estimated 12.2 million new cases annually, making it a leading cause of long-term disability globally.[9] In Indonesia, the prevalence of stroke among individuals aged ≥15 years is reported at 10.9 per 1,000 population, indicating a large population potentially requiring inpatient rehabilitation services.[10] Patients recovering from stroke and other disabling conditions often experience heightened spiritual concerns related to uncertainty, dependence, and altered life roles, underscoring the relevance of spiritual care in inpatient rehabilitation contexts.[6]

Despite growing recognition of spirituality in healthcare, empirical evidence describing spiritual needs fulfillment specifically among physiotherapy inpatients remains limited. Most existing studies have focused on spiritual care in palliative care, oncology, or general nursing populations, with relatively few investigations situated explicitly within physiotherapy or rehabilitation services.[11] Furthermore, available studies often examine spirituality as an abstract construct or correlate it with psychological outcomes, rather than systematically mapping the extent to which patients' spiritual needs are fulfilled during routine inpatient physiotherapy care. This

lack of context-specific evidence limits the ability of physiotherapists and institutions to integrate spiritual considerations into clinical practice in a structured and pragmatic manner.

To address this gap, structured frameworks for spiritual assessment have been proposed to guide health professionals in identifying and responding to patients' spiritual needs. Hodge's six-dimensional spiritual framework offers a comprehensive approach encompassing meaning and purpose of life, relationship with God, spiritual practices, religious obligations, interpersonal connections, and professional interaction.[12] This framework is particularly relevant to inpatient physiotherapy settings, where professional interaction and therapeutic relationships form a central component of care delivery. Mapping spiritual needs fulfillment using such a framework may provide actionable insights for enhancing holistic physiotherapy services without exceeding professional boundaries.[13]

Therefore, the objective of this study was to describe the level of spiritual needs fulfillment among physiotherapy inpatients in the Flamboyan Ward of BLUD RSUD dr. T.C. Hillers Maumere based on six spiritual dimensions, and to examine its distribution across patient characteristics. By providing a systematic overview of spiritual needs fulfillment in this setting, the findings are expected to inform the development of spiritually sensitive, patient-centered physiotherapy practices in hospital-based rehabilitation services.

Methods

This study employed a quantitative descriptive cross-sectional design to provide a systematic overview of spiritual needs fulfillment among physiotherapy inpatients. The study was conducted in the Flamboyan Ward of BLUD RSUD dr. T.C. Hillers Maumere, East Nusa Tenggara, Indonesia, between 3 and 9 July 2025. This ward provides inpatient physiotherapy services primarily for patients with neurological, orthopedic, and chronic musculoskeletal conditions requiring ongoing rehabilitation.

The study population comprised all patients receiving inpatient physiotherapy services in the Flamboyan Ward during the study period. A total of 50 respondents were included using accidental sampling, a non-probability sampling technique appropriate for descriptive hospital-based studies with limited recruitment windows. This approach allowed inclusion of eligible patients who were available and clinically stable during the data collection period while minimizing disruption to routine clinical care.

Inclusion criteria were: (1) adult patients receiving inpatient physiotherapy services, (2) conscious and able to communicate verbally, (3) clinically stable at the time of data collection, and (4) willing to participate by providing informed consent. Exclusion criteria included patients in emergency conditions, those with severe cognitive or communication impairments, and individuals who declined participation. Potential selection bias related to non-probability sampling was acknowledged and addressed through transparent reporting of eligibility criteria and study context.

The sample size was determined pragmatically based on the number of eligible inpatients during the study period. Although the Lemeshow formula is commonly used to estimate minimum sample sizes in descriptive studies, the present study prioritized feasibility and complete coverage of accessible patients within the ward over statistical power considerations, as no hypothesis testing or inferential analysis was conducted.

The primary outcome of this study was the fulfillment of spiritual needs, which was conceptualized as a multidimensional construct. In accordance with Hodge's spiritual assessment framework, spiritual needs fulfillment was evaluated across six interrelated dimensions: meaning and purpose of life, relationship with God, spiritual practices, religious obligations, interpersonal connections, and professional interaction with physiotherapists. These dimensions were assessed to capture both the intrapersonal and interpersonal aspects of spirituality within the clinical context. In addition, participant characteristics, including age, sex, education level, and occupation, were collected as descriptive variables to provide contextual information regarding the distribution of spiritual needs fulfillment across the study population.

Data were collected using a structured spirituality questionnaire consisting of 33 items, conceptually adapted from established spiritual care frameworks. The instrument was designed to capture practical expressions of spiritual needs fulfillment relevant to hospitalized patients. Prior to use, the questionnaire underwent content review by physiotherapy and nursing academics to ensure clarity, cultural relevance, and conceptual alignment with inpatient rehabilitation settings.

Each item was scored dichotomously ("fulfilled" = 1; "not fulfilled" = 0). Dimension scores were calculated as percentages of fulfilled items within each domain. For descriptive interpretation, higher percentages indicated greater fulfillment of spiritual needs. Given the descriptive aim of the study, no cut-off values were used to infer adequacy or deficiency; results were presented transparently as observed distributions.

Data collection was conducted by the primary researcher with assistance from trained staff. Eligible participants received a standardized explanation of the study objectives, procedures, potential risks, and benefits. Questionnaires were completed through self-administration or interviewer-assisted administration for patients with visual, literacy, or motor limitations. Completed questionnaires were checked for completeness and consistency prior to data entry.

Data were processed through sequential stages of editing, coding, entry, and cleaning. Statistical analysis was performed using SPSS software, focusing exclusively on univariate descriptive statistics. Results were presented as frequencies and percentages for respondent characteristics and each spiritual dimension. No inferential statistical tests were conducted, in line with the descriptive study design and objectives.

This study involved a non-invasive, questionnaire-based assessment and did not include any medical intervention or collection of biological samples. In accordance with institutional policy, formal ethical committee approval was not required for this type of minimal-risk observational study. Nevertheless, all research procedures were conducted in line with the ethical principles of the Declaration of Helsinki.

Participation was entirely voluntary. Prior to data collection, all participants received a clear explanation of the study objectives, procedures, potential risks, and benefits, and written informed consent was obtained. No personally identifiable information was collected. Anonymity and confidentiality were strictly maintained by using coded data and secure data storage accessible only to the research team.

Results

During the study period, all inpatients receiving physiotherapy services in the Flamboyan Ward were screened for eligibility. Patients who met the inclusion criteria and agreed to participate were consecutively included until the end of the data collection period. A total of 50 participants completed the questionnaire and were included in the final analysis. No incomplete questionnaires were identified. The baseline characteristics of the respondents are presented in Table 1. These data describe the demographic and socioeconomic profile of physiotherapy inpatients included in the study.

Table 1. Characteristics of Respondents (N = 50)

Variable	Category	n	%
Age (years)	Early adulthood (18–39)	8	16.0
	Middle adulthood (40–59)	18	36.0
	Late adulthood (≥60)	24	48.0
Sex	Male	25	50.0
	Female	25	50.0
Education level	Primary	31	62.0
	Secondary	11	22.0
	Higher	8	16.0
Occupation	Farmer	32	64.0
	Laborer/Skilled worker	5	10.0
	Teacher	7	14.0
	Student	2	4.0
	Retired	4	8.0

As shown in Table 1, nearly half of the respondents were aged ≥60 years (48%). The distribution of sex was balanced, with equal proportions of male and female participants (50% each). Most respondents had a primary education level (62%) and were employed as farmers (64%). The distribution of spiritual needs fulfillment across the six assessed dimensions is summarized in Table 2.

Table 2. Distribution of Spiritual Needs Fulfillment by Dimension (N = 50)

Spiritual Dimension	Fulfilled n (%)	Not Fulfilled n (%)
Meaning and purpose of life	50 (100.0)	0 (0.0)
Relationship with God	50 (100.0)	0 (0.0)
Spiritual practices	48 (96.0)	2 (4.0)
Religious obligations	47 (94.0)	3 (6.0)
Interpersonal connections	48 (96.0)	2 (4.0)
Professional interaction	49 (98.0)	1 (2.0)

As presented in Table 2, all respondents reported fulfillment of the dimensions related to meaning and purpose of life and relationship with God (100%). High levels of fulfillment were also observed for professional interaction (98%), spiritual practices (96%), interpersonal connections (96%), and religious obligations (94%).

Overall, the results indicate that spiritual needs fulfillment among physiotherapy inpatients was consistently high across all six assessed dimensions. The descriptive distribution suggests minimal variation in fulfillment levels, with more than 90% of respondents reporting fulfillment in each dimension.

Discussion

This study provides a structured overview of spiritual needs fulfillment among physiotherapy inpatients using a descriptive cross-sectional approach. The findings demonstrate that spiritual needs across six dimensions—meaning and purpose of life, relationship with God, spiritual practices, religious obligations, interpersonal connections, and professional interaction—were reported as highly fulfilled by the majority of participants. These results underscore the relevance of spirituality as an integral component of holistic physiotherapy care, particularly within inpatient rehabilitation settings.

The universally high fulfillment of meaning and purpose of life and relationship with God suggests that patients possessed strong internal spiritual resources during hospitalization. Previous studies have shown that maintaining meaning, hope, and spiritual connectedness can enhance psychological resilience, emotional stability, and coping in individuals facing disabling health conditions.[2] In rehabilitation contexts, such spiritual resources may help patients tolerate discomfort, sustain motivation, and persist with repetitive and physically demanding therapeutic exercises. Although this study did not assess functional or clinical outcomes, the consistently high fulfillment of these dimensions aligns with evidence indicating that spirituality supports adaptive coping during illness and recovery.[11]

High levels of fulfillment were also observed in spiritual practices and religious obligations, indicating that most patients were able to maintain personal religious routines despite hospitalization. This finding is consistent with literature suggesting that institutional environments that permit or facilitate religious practices may contribute to patients' emotional comfort and sense of continuity in daily life.[14] In inpatient rehabilitation, flexibility in therapy scheduling and sensitivity to religious practices may therefore support patient-centered care without compromising therapeutic goals.[15]

The interpersonal connection dimension was fulfilled by the majority of respondents, highlighting the role of social support from family members, caregivers, and the surrounding care environment. Social connectedness has been consistently associated with improved psychological well-being and adaptive health behaviors, including adherence to rehabilitation programs.[16] In physiotherapy practice, family involvement may reinforce therapeutic instructions, provide encouragement, and enhance continuity of exercises beyond supervised sessions.[17]

Notably, fulfillment of the professional interaction dimension was also very high. This finding emphasizes the importance of empathetic communication, respect for patient values, and supportive therapeutic relationships in physiotherapy services. The therapeutic alliance has been identified as a key factor influencing adherence, satisfaction, and outcomes in musculoskeletal and neurological rehabilitation.[18,19] Although physiotherapists are not spiritual counselors, professional behaviors such as active listening, empathy, and respect for beliefs may indirectly support patients' spiritual well-being while remaining within professional scope of practice.[3]

From a clinical perspective, these findings suggest that physiotherapists are well positioned to contribute to holistic care by acknowledging spiritual dimensions during routine interactions. Simple strategies—such as incorporating brief spiritual needs screening during initial assessment, aligning rehabilitation goals with what patients perceive as meaningful, and collaborating with family or spiritual care providers when appropriate—may enhance patient-centered rehabilitation without increasing clinical burden.[20]

Despite these insights, several limitations must be acknowledged. First, the descriptive cross-sectional design does not allow for causal inference or assessment of changes in spiritual needs over time. Second, the use of accidental sampling in a single ward may limit the generalizability of findings to other hospital settings or patient populations. Third, the questionnaire relied on self-reported data, which may be influenced by social desirability bias, particularly in the assessment of spirituality. Finally, the study did not include objective rehabilitation outcomes such as functional improvement, pain reduction, or therapy adherence; therefore, the relationship between spiritual needs fulfillment and physiotherapy outcomes cannot be empirically established.

Future research is recommended to employ analytical or longitudinal designs to explore associations between spiritual needs fulfillment and rehabilitation outcomes. Incorporating validated outcome measures and expanding sampling across multiple institutions would strengthen external validity and provide deeper insight into the role of spirituality in physiotherapy practice. Mixed-methods approaches may also enrich understanding by capturing patients' lived experiences of spirituality during rehabilitation.

Conclusion

This study provides a descriptive overview of spiritual needs fulfillment among physiotherapy inpatients in the Flamboyan Ward of BLUD RSUD dr. T.C. Hillers Maumere. The findings indicate that spiritual needs across six key dimensions—meaning and purpose of life, relationship with God, spiritual practices, religious obligations, interpersonal connections, and professional interaction—were largely fulfilled among the study participants. These results highlight spirituality as a relevant and observable component of holistic inpatient physiotherapy care.

From a clinical perspective, the consistently high fulfillment of spiritual dimensions suggests that patients undergoing inpatient rehabilitation possess substantial spiritual resources that may support coping, motivation, and engagement during the recovery process. Although this study did not assess clinical or functional outcomes, the presence of fulfilled spiritual needs may contribute to a more supportive therapeutic environment and strengthen the therapeutic alliance between patients and physiotherapists.

The findings underscore the importance of recognizing spirituality as part of patient-centered physiotherapy practice. Physiotherapists can integrate spiritual awareness into routine care through simple and feasible approaches, such as respectful communication, sensitivity to patients' beliefs and values, alignment of rehabilitation goals with what patients consider meaningful, and collaboration with family members or spiritual care providers when appropriate. These strategies do not require specialized spiritual counseling skills but rather emphasize empathy and ethical professionalism within the physiotherapy scope of practice.

Given the descriptive nature of this study, the results should be interpreted within the context of its methodological limitations. Nevertheless, this research contributes context-specific evidence on spiritual needs fulfillment in inpatient physiotherapy settings and may serve as a foundation for future studies. Further research using analytical or longitudinal designs is warranted to examine the relationship between spiritual needs fulfillment and rehabilitation outcomes, as well as to explore the implementation of spiritually sensitive physiotherapy interventions across diverse clinical settings.

Author Contribution

Marianus Oktavianus Wega: Conceptualization, Methodology, Investigation, Writing—original draft.
Gabriel Mane: Data curation, Investigation.
Kristoforus Samson: Formal analysis, Data validation.
Epifanius Yolandus: Writing—review & editing, Supervision.
All authors have read and approved the final version of the manuscript.

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Conflict of Interest Statement

The authors declare that they have no conflict of interest.

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Ethics Statement

This study involved a non-invasive, questionnaire-based assessment and posed minimal risk to participants. In accordance with institutional policy, formal ethical committee approval was not required for this type of descriptive observational study. All procedures were conducted in line with the ethical principles of the Declaration of Helsinki. Written informed consent was obtained from all participants prior to data collection, and anonymity and confidentiality were strictly maintained.

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