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Comparative Analysis of Spiritual Care Delivery in Small and Large Groups Among Palliative Outpatients: An Intervention and Control Study at dr. Goeteng Tarunadibrata Regional General Hospital, Purbalingga, Indonesia

Aris Fitriyani[1], Budi Aji[2], Novan Ardy Wiyani[3], Supadi [4]
[1]Students of the Islamic Studies Doctoral Program UIN SAIZU Purwokerto
[2] Lecturer in the Department of Public Health, Faculty of Health Sciences, Jenderal Soedirman University Purwokerto
[3]Lecturer of the Islamic Studies Doctoral Program UIN SAIZU Purwokerto
[4]Lecturer of the Purwokerto Nursing Study Program, Semarang Health Polytechnic
Email address: arisfitriyani39@gmail.com

Abstract*—Background** *Spiritual care is an essential component of palliative care, playing a vital role in supporting the holistic needs of patients. However, the impact of group size on the effectiveness of spiritual care delivery has been underexplored, especially in Indonesia and particularly among outpatients in neurology clinics. This study aims to compare the effectiveness of spiritual care between small and large groups among palliative outpatients at RSUD dr. R. Goeteng Taroenadibrata Purbalingga. It is hoped that the findings will provide evidence that spiritual care services can be effectively delivered in various group sizes, thereby offering flexibility in service implementation and ultimately improving the quality of palliative patient care.* ***Research Objectives*: This study aimed to compare the effectiveness of spiritual care between small and large groups among palliative outpatients at RSUD dr. R. Goeteng Taroenadibrata Purbalingga.* ***Research Methods****: A quantitative controlled intervention study was conducted involving 60 patients in the small group and 128 patients in the large group, each subdivided into intervention and control groups. Data were analyzed using independent sample t-tests to assess differences in spiritual care effectiveness.* ***Results and discussion****: The mean spiritual care scores were 58.8 (intervention) and 58.4 (control) in the small group (p=0.580), and 62.2 and 62.5 respectively in the large group (p=0.550). The study findings reveal no significant difference in spiritual care effectiveness between intervention and control groups in both small and large groups. This indicates that spiritual care can be effectively delivered in groups of varying sizes without compromising outcomes. These results provide important insights for flexible implementation of spiritual care services in healthcare settings, especially in palliative patient management.* ***Conclusion****: Group size does not significantly impact spiritual care effectiveness in palliative patients. It is recommended that spiritual care services be flexibly tailored to group needs without strict adherence to group size.*

Keywords*— Spiritual Care, Palliative Outpatients, Group Size, Intervention Study.*

I. INTRODUCTION

Quality healthcare must holistically encompass physical, psychological, social, and spiritual aspects, especially for palliative patients experiencing multidimensional suffering. Numerous international studies have shown that spiritual care interventions positively contribute to patients' spiritual well-being and quality of life, reduce anxiety and depression, and increase patient satisfaction with care (Austin et al., 2025; Paal et al., 2015; Gijsberts et al., 2019). Meeting spiritual needs is a fundamental component of modern palliative care standards (World Health Organization, 2020).

Nurses' spiritual competence plays a vital role in delivering effective holistic care, including empathetic communication, meaning facilitation, and religious support aligned with patients' beliefs, resulting in more positive patient care experiences (Rizkina et al., 2024). In Indonesia, Sufi values such as patience and reliance on God help terminal patients face death with inner peace and increase patient satisfaction because they are valued as whole persons, not merely medical objects (Pertiwi et al., 2024).

Spiritual care is grounded in humanitarian values, professional ethics, and respect for patients' rights to have their spiritual needs recognized. Its delivery is a shared responsibility of the healthcare team, integrating the spiritual dimension with physical and psychosocial care (Winslow & Wehtje-Winslow, 2007). This approach safeguards patient dignity and alleviates spiritual loneliness during end-of-life processes (Liefbroer et al., 2019).

Effective spiritual communication through prayer, strengthening faith, and support from family and healthcare providers is essential to optimize fulfillment of meaningful life values for patients. This strengthens therapeutic relationships and potentially increases patient satisfaction significantly (Ul et al., 2025; Nagai-Jacobson & Burkhardt, 2001). Various global guidelines, such as the NHS Golden Jubilee, emphasize that fulfilling spiritual needs is a fundamental right of patients in palliative healthcare (NHS Golden Jubilee, 2023; Sulmasy, 2009; Puchalski et al., 2009).

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Palliative care seeks to improve the quality of life of patients and families facing life-limiting illness by addressing physical, psychosocial, and spiritual needs in an integrated manner (Kestenbaum, A., 2025). Spiritual care, as a core domain of palliative care, supports patients in finding meaning, hope, and inner peace amidst suffering and serious illness (Paal, 2020). For patients with neurological conditions, spiritual concerns often intertwine with fear of disability, loss of autonomy, and uncertainty about prognosis, making structured spiritual support particularly relevant in neurology settings (Gijsberts, 2019).

In recent years, empirical evidence has shown that spirituality and spiritual care are associated with better health outcomes, including improved quality of life, better psychological well-being, and more value-concordant medical decisions (Zhang, 2024) Systematic reviews also indicate that spiritual care interventions may reduce psychological distress and enhance overall life satisfaction in patients with serious chronic diseases. (Gijsberts, 2019). this growing body of evidence, spiritual care remains under-implemented and inconsistently structured in routine clinical practice, especially in low- and middle-income countries (Zhang, 2024).

Group-based approaches are one promising format for delivering spiritual care, as they may foster peer support, shared meaning-making, and a sense of community among patients with similar conditions (Dueweke, 2022). However, the question of optimal group size remains largely unanswered, even in the broader group psychotherapy literature (Liefbroer, 2025). Existing reviews on group size in therapeutic settings suggest that smaller groups may enhance cohesion and interaction, although findings across studies are mixed and context-dependent. Conal Twomey & Clodagh Dowling These inconsistencies highlight the need for context-specific research on group size in spiritual care delivery (Dueweke, 2022).

Neuropalliative care has emerged as a subspecialty focused on the complex needs of patients with serious neurological illness, including their spiritual and existential distress. (Gijsberts, 2019). Within this context, outpatient neurology clinics represent a critical yet understudied setting for structured spiritual care interventions, particularly in regions such as Southeast Asia. Indonesia, with its strong spiritual and religious traditions, offers a unique context to explore how spiritual care can be organized effectively for palliative outpatients in public hospitals (Kestenbaum, 2025) dr. Goeteng Tarunadibrata Regional General Hospital in Purbalingga, Indonesia, provides outpatient neurology services to a diverse population of palliative patients with varying cultural and spiritual backgrounds. However, standardized models for organizing spiritual care especially regarding group size and structure are not yet well established in this setting. This gap may limit the ability of healthcare teams to deliver consistent, patient-centered spiritual support as part of multidisciplinary palliative care (Paal, 2020).

From a service delivery perspective, understanding whether spiritual care is equally effective in small versus large groups is essential for planning feasible and scalable interventions in resource-constrained environments. If outcomes are comparable across different group sizes, hospitals may be able to optimize staff time and infrastructure while still maintaining high-quality spiritual support. Conversely, if one group size proves superior, service models can be adapted accordingly to maximize therapeutic benefit. The present study therefore focuses on comparing spiritual care delivery in small and large groups among palliative outpatients in a neurology clinic using an intervention–control design. By examining mean spiritual care scores across group sizes and conditions, this research aims to clarify whether group size meaningfully influences the effectiveness of spiritual care in this context. The results, showing no statistically significant differences between intervention and control groups in either small or large group formats, suggest that spiritual care can be flexibly implemented across group sizes without compromising patient-reported outcomes.

This study is expected to contribute to the international literature on spiritual care and group-based interventions in palliative settings, while providing practical guidance for hospitals in Indonesia and similar contexts. The findings may support the development of adaptable spiritual care models that integrate efficiently into outpatient neurology services and align with local cultural and spiritual values (Paal, 2020).

II. Purpose

This study aims to compare the effectiveness of spiritual care delivery in small and large groups among palliative outpatients at dr. Goeteng Tarunadibrata Regional General Hospital, Purbalingga. Additionally, it examines whether there is a statistically significant difference between intervention and control groups across both group sizes.

III. Method

This study employed a quantitative research design with an intervention-control approach conducted at dr. Goeteng Tarunadibrata Regional General Hospital, Purbalingga. The sample consisted of 188 palliative outpatients divided into two groups by size: a small group with 60 patients and a large group with 128 patients. Each group was further subdivided into intervention and control subgroups.

The spiritual care intervention was administered to the intervention groups during the study period, while the control groups received standard care without the specific spiritual care intervention. Data collection was conducted using a validated spiritual care measurement instrument, and statistical analysis was performed using independent sample t-tests to compare differences between intervention and control groups. Data were analyzed with a significance level of 0.05 using SPSS software.

IV. Result

The results of the study on the characteristics of respondents and the differences in spiritual care in small and large groups, both intervention and control, are presented in the following table below

Based on Table 1, it is known that when viewed in terms of age, most of the respondents in the small intervention group were aged > 50 years (73.3%), as well as in the control group,

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some respondents were aged > 50 years (73.3%). The gender characteristics show that most of the respondents in the small intervention group were female (56.7%), as well as in the control group, some respondents were female (56.7%). The educational characteristics show that some of the respondents in the small intervention group had a high school education background (33.3%), as well as in the control group, some respondents had a high school education background (43.3%)

TABLE I. Frequency Distribution of Respondent Characteristics of Intervention and Control Small Groups

Characteristics	Small Group			
	Intervention		Control	
	n	%	n	%
Age				
< 21 Year	1	3,3	-	-
21 - 30 Year	1	3,3	1	3,3
31 - 40 Year	2	6,7	2	6,7
41 - 50 Year	4	13,3	5	16,7
> 50 Year	22	73,3	22	73,3
Gender				
Man	13	43,3	13	43,3
Woman	17	56,7	17	56,7
Education				
Elementary School	5	16,7	4	13,3
Middle School	5	16,7	5	16,7
High School	10	33,3	13	43,3
Diploma	3	10,0	3	10,0
Bachelor's Degree	7	23,3	5	16,7

Source: Primary data 2025

TABLE II. Differences in Spiritual Care in Small Intervention and Control Groups

Spiritual Care	Mean	Mean Difference	t_{count}	P value
Spiritual Care Intervention	58,8	0,4	0,541	0,580
Spiritual Care Control	58,4			

Source: Primary data 2025

Based on Table 2, it is known that the average spiritual care value of the intervention group was 58.8, while the average spiritual care value of the control group was 58.4. This indicates that the difference in the average spiritual care value of the two groups was 0.4. Through the calculation of the independent sample t-test, the results of this study showed a significant value of the difference in spiritual care between the intervention and control groups of 0.580. This result indicates that the significance value is > α (0.05), so it can be interpreted that statistically there is no difference in the spiritual care value of the intervention and control groups.

Based on Table 3, it is known that when viewed in terms of age, most respondents in the large intervention group were aged > 50 years (81.3%), as well as in the control group, some respondents were aged > 50 years (79.73%). Gender characteristics show that most respondents in the large intervention group were male (51.6%), while in the control group, some respondents were female (59.4%). Educational characteristics show that most respondents in the large intervention group had an elementary school education background (39.1%), while in the control group, some respondents had a high school education background (40.6%).

TABLE III. Frequency Distribution of Respondent Characteristics of Large Intervention and Control Groups

Characteristics	Small Group			
	Intervention		Control	
	n	%	n	%
Age				
< 21 Year	1	1,6	2	3,1
21 - 30 Year	4	6,3	3	4,7
31 - 40 Year	4	6,3	5	7,8
41 - 50 Year	3	4,7	3	4,7
> 50 Year	52	81,3	51	79,7
Gender				
Man	33	51,6	26	40,6
Woman	31	48,4	38	59,4
Education				
Elementary School	25	39,1	16	25,0
Middle School	13	20,3	17	26,6
High School	17	26,6	26	40,6
Diploma	9	14,1		
Bachelor's Degree	7	23,3	5	7,8

Source: Primary data 2025

TABLE IV. Differences in Spiritual Care in Large Intervention and Control Groups

Spiritual Care	Mean	Mean Difference	t_{count}	P value
Spiritual Care Intervention	62,2	0,3	0,600	0,550
Spiritual Care Control	62,5			

Source: Primary data 2025

Based on Table 4, it is known that the average spiritual care value of the intervention group was 62.2, while the average spiritual care value of the control group was 62.5. This indicates that the difference in the average spiritual care value of the two groups was 0.3. Through the calculation of the independent sample t-test, the results of this study showed a significant value of the difference in spiritual care between the intervention and control groups of 0.550. This result indicates that the significance value is > α (0.05), so it can be interpreted that statistically there is no difference in the spiritual care value of the intervention and control groups.

V. DISCUSSION

Educational characteristics showed that most respondents in the small groups had a high school education (33.3% intervention and 43.3% control), whereas in the large groups, most respondents had an elementary school education (39.1%) in the intervention group and a high school education (40.6%) in the control group. Education level influences patients' understanding and acceptance of spiritual care interventions, consistent with findings that education and health literacy correlate with patients' comprehension of healthcare plans and information (van Rensburg et al., 2020; Szabó et al., 2021).

This study also found that the average spiritual care scores in the small groups did not significantly differ between the intervention group (58.8) and control group (58.4), with a p-value of 0.580. A similar pattern was observed in the large groups, with average scores of 62.2 in the intervention group and 62.5 in the control group, with a p-value of 0.550. These findings indicate that the effectiveness of spiritual care delivery is relatively similar between small and large groups. This aligns with literature stating that the quality of interaction and emotional support in spiritual care has a greater influence

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on intervention success than group size (Paal et al., 2020; Gijsberts et al., 2019).

These findings reinforce the assumption that spiritual care interventions yield similar outcomes to standard care among palliative patients in both small and large groups. This may relate to other factors in the delivery of spiritual care, such as the quality of communication, depth of emotional support, and sensitivity to patients' personal needs, which are more determinants of intervention success than group size alone (Paal et al., 2020; Gijsberts et al., 2019).

Flexibility in implementing spiritual care across various group sizes could be an important strategy in resource-limited healthcare facilities, especially public hospitals. This approach allows the adaptation of spiritual care services to real conditions without reducing effectiveness, while also facilitating staff and facility management (Austin et al., 2025). This study contributes important evidence that spiritual care can be flexibly applied in both small and large groups without compromising its effectiveness. This is highly relevant in public hospitals with limited resources, where efficient patient group management is a vital aspect of service improvement (Austin et al., 2025).

VI. Conclusion

The conclusion of this study is that the effectiveness of spiritual care delivery to palliative patients is not significantly influenced by group size, whether small or large. Although there are variations in demographic characteristics such as gender and education level, the difference in average spiritual care scores between intervention and control groups is not significant. This indicates that the quality of interaction and emotional support in providing spiritual care plays a more important role in the success of the intervention than the size of the patient group. A flexible approach to spiritual care can be applied across various group sizes without reducing its effectiveness.

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