

# Prerequisites for provision of spiritual care in the neonatal intensive care unit in Iran: a qualitative study

**Haideh Heidari**

Shahrekord University of Medical Sciences

**Nasrin Mehrnoush**

Ardabil University of Medical Sciences

**Mansoureh Karimollahi** (✉ [karimollahi@gmail.com](mailto:karimollahi@gmail.com))

Ardabil University of Medical Sciences

---

## Research Article

**Keywords:** Spiritual care, Neonatal intensive care unit, Health Care Team

**Posted Date:** August 18th, 2020

**DOI:** <https://doi.org/10.21203/rs.3.rs-58551/v1>

**License:**  This work is licensed under a Creative Commons Attribution 4.0 International License.

[Read Full License](#)

---

# Abstract

**Background:** Spiritual care in line with the holistic and comprehensive care is the important need for families with children who are hospitalized in an intensive care unit.

**Objectives:** This study aimed to explore perceptions of health care providers' regarding the spiritual care of parents with a newborn in the neonatal intensive care unit in Iran.

**Materials/Patients and Methods:** This study was conducted using qualitative content analysis which includes open coding, creating classification, and abstraction. Eight nurses and one doctor were chosen to be interviewed by a purposeful sampling method.

**Results:** Based on data analysis three categories of nurses' support need for spiritual care and the necessity of changes in structural conditions were identified.

**Conclusions:** Hospital administrators must adopt measures to change the neonatal intensive care unit circumstances. Also, it is mandated that nurse managers plan training about the importance of providing spiritual care to patients and families.

## Background

Annually 12.9 million preterm infants born in the world, 11 million (85%) are in Asia and Africa. These preterm infants need the neonatal intensive care unit (NICU) to live and to develop their organs. Most premature babies weighing very small at birth (less than 1500 grams) and gestational age less than 28 weeks were admitted in the neonatal intensive care unit (1), therefore a significant number of parents require early intervention in forms of professional health care for their newborns (2).

Evidence shows that parents of infants hospitalized in intensive care units do not know acceptance and readiness for unpredicted ethical decisions. Most parents in these units prefer to have the least responsibility for treatment decisions because they believe that doctors know the best action for their low birth weight and premature newborn (3).

Increased tension in the family can affect the ability of families to fulfill their role. Stress and how to fight it is family-oriented. When families are under stress they may experience varying degrees of threats. Parents who have a child in pain and suffering feel failed and blame and feel more stressed. They should receive the necessary training and see their baby's behaviors and learn infant care skills to experience less stress (4). At this time spiritual care for families is necessary to be done by a nurse or a priest. Spiritual care including attention, verbal and non-verbal communication, active listening, touching the patient and answering questions of the patient and family members, praying with the patient and for the patient, perform rituals, referral to a clergyman or priest, giving time for the patient, being with the patient in the experience of pain, distress or other problems and needs and giving meaning and value to life is

needed (5, 6, 7, 8). Personnel should consider the whole family for providing care because the child's hospitalization is a critical situation and the spiritual needs of the whole family should be considered (9).

Unfortunately, appropriate care and spiritual support of newborns are not performed in the neonatal intensive care unit, and the primary concern of nurses is providing physical care.

On the other hand, lack of attention to parental emotional and mental distress leads to their loss of interest in neonatal care at the time of discharge and increases the neonates' and parents' vulnerability (10). Accordingly, due to the stressful and critical state of the mother and her uncertainties about the future, sometimes her self-confidence is decreased, her faith is compromised, and her interpersonal communication is interrupted; moreover, the adjustment mechanisms become insufficient which may induce a sense of loneliness in the mother. In one word, the individual suffers from a spiritual crisis (11).

*Objective:* So this study aimed to better understanding spiritual care issues within neonatal intensive care units from the perspectives of healthcare providers.

## **Materials / Patients And Methods**

This qualitative study was performed using a qualitative content analysis method which is appropriate when available theories or research on a phenomenon is limited (12). The content analysis process includes open coding, classification, and abstraction (13). Eight nurses and one doctor were chosen as participants using a purposeful sampling method based on including criteria of being health care provider, willingness to participate in research, and working in neonatal intensive care units. The research setting was neonatal intensive care units in hospitals affiliated to the Ardabil University of Medical Sciences.

Face to face semi-structured interviews was conducted in the staff room for 15 to 25 minutes. At first a general question of "What do you think about the concept of spiritual care in neonatal intensive care unit?" was asked; and to seek further information, interviews were continued by questions like "Why should this be so?", "What do you mean about that?" or phrases such as "please explain this relationship further". All interviews were transcribed verbatim, words of the text which contain the key concepts were highlighted and the codes were extracted. After extracting the concepts and codes of sentences and paragraphs, we grouped them in the categories according to similarities and differences, and merged the categories based on their relationship between them and were reduced to fewer main themes.

Researchers also tried not to involve their presumptions as possible in the data analysis.

*Quality assurance:* The trustworthiness of the study was upheld through including a sufficient number of subjects, fulfilling the scientific procedure effectively, and achieving saturation. Additionally, sound recordings were utilized to gather information, and taped interviews were transcribed to avoid missing any data. Some members were requested to affirm a brief portrayal of each interview. Content coding and

analysis were performed by the two analysts independently to guarantee consistent patterns and getting comparable results. Besides, we attempted to fortify the study by utilizing peer-checking.

Ethical consideration: Ethical approval was taken from the Ardabil University of Medical Sciences. In addition to providing information about the objectives of the research to the participants, they were assured that their information will remain confidential. Also, they were assured that this information is confidential and they would regret from the study whenever they want.

## Results

The demographic characteristics of participants are shown in Table 1.

Based on data analysis three categories of *nurses' support* with two subcategories of *allowing for mothers to have contact with baby, and praying near the baby*; *the need for spiritual care* with two subcategories of *to reduce mothers' anxiety, and training nurses*; and *necessity of changes in structural conditions* with two sub-categories of *providing appropriate space for the mother to be present near the baby, and providing enough space for religious practices* were identified (Table 2).

### *Nurses' support*

This category with two sub-categories of allowing mothers to have contact with the baby and praying near the baby was found. Almost all participants stated that for the provision of spiritual care, nurses' support is needed. They described this support as allowing them to be and have contact with the baby and praying near their baby. A participant said in this regard: Nurse should help parents, support them. The newborn in this unit is very critical, when the mother comes and touches the baby and feed him/her, is different from a baby whose mother is not with him/her. I have experienced it. It is very effective and we should not prevent this and help them (parents) ... "[n3].

Another participant stated:

"... I remember that our monitors represented numbers, but a touch of a baby by mother or even a verbal communication affected the numbers, and baby's conditions were got better ..." [n5].

### **Need for spiritual care**

According to the data, the need for spiritual care with two subcategories of reducing mother's anxiety and education of nurses was found. Most nurses said that spiritual care reduces parental anxiety and nurses should be trained in this regard. As, a participant said: nurse should help by talking to the parents, let them have body contact and be alone with their babies, they need to pray, their tension be reduced by praying, reading Quran or putting it near their child, so they became calm.... "[n4].

Another participant said:

Personnel should be trained not to cut the emotional connection between patients and other family members. This is a spiritual need. If the family bands were disconnected because of the baby's hospitalization, they would be disappointed. ... By using family-centered care, the family status becomes clear that underlies spiritual care. This is a new subject for us and our staff necessarily should have training. There is a need to train nurses regarding good communication with families. This should be followed strictly... "[d1].

## The necessity of changing structural conditions

This category with two sub-categories of *providing appropriate space for the mother and providing enough space for religious practices* was another finding of this study. All participants expressed, for spiritual care, there is a need for structural changes to provide the necessary and sufficient spaces for the mother presence and doing religious practices, a participant said in this regard:

"Unfortunately, due to space constraints, spiritual care is not feasible. There should be curtains and chairs so that the whole family to be able to stay here, but there is not enough space; actually, it is not possible, the most thing we do is to allow the mother and the first-degree family members visit the baby, space is extremely low... "[d1].

Another participant stated:

Because of crowded patients there is not the place here parents be present near their babies, so, if we can provide the right place for their presence and do the spiritual rituals, pray to God and be alone with the baby it would be helpful, we need the proper space ... [n6].

## Discussion

This study provides insight into understanding and addressing issues related to spiritual care from the viewpoints of healthcare providers working at neonatal intensive care units. The findings of the study of Chism & Magnan in 2009 showed that spiritual care depends on the views of nurses about spiritual care (14), also Dhamani et al in 2011 reported that nurses need to have knowledge and readiness to provide spiritual care and support clients in need (15).

Dunn et al. contend that there ought to be expanded accentuation on training that advances the nurses' spirituality, both in pre-enrollment and proceeding with instruction programs (16).

Other studies have shown how instructive sessions may help pediatric nurses give spiritual care (17). A systematic review to set up parents' needs in neonatal intensive care unit has demonstrated that they need helpful information, assuring them that their newborn is being cared, and get in touch with their newborn, to be accepted by the nurses and to have a healing rapport with them, and unique care (18). Also, enthusiastic support, and inviting situation, parent strengthening, and instruction, and shared care were useful. Research shows that when the mothers were included in care, they became active. Also,

when parents integrate into the unit, they feel more secure, have control over the circumstances, were included in creating relationships, were more convinced, and felt more associated with their newborn. The mothers explained the need to have closeness and proximity and belonging to their infant. When these needs were met, the mothers became more responsible, confident, and familiar with their fragile infant (19).

Healthcare providers have identified the importance of spirituality, but it was not true about the components of comprehensive care. Our results reverberate and add clinical stories to Heyland et al multicenter quantitative investigations of palliative care patients and their family which distinguished that spiritual is an immense and neglected need in palliative care patients and their families (20).

This study recognized various difficulties linked to spiritual issues in a neonatal intensive care unit. While the health care team perceived that spiritual issues are inside the scope of practice of interdisciplinary team members, they recognized healthcare providers themselves as an inhibitor. As has been stated in various studies (21), Health care providers identified that still there is a profound theory-practice gap, because translating these capabilities into clinical practice in a delicate way is a considerable obstacle. Educational and training inadequacy is cited as a reason in most of the studies on this gap (22, 23), and suggest that healthcare faculties and continuing education programs should include training on effective spiritual care into their curriculum. Caldeira and Hall stated that Parents ask for prayer and request that religious sacrament or put some symbolic religious objects in the incubator, so meeting religious needs is a dimension of spiritual care (24).

Another study found that 60% to 80% of parents likewise felt frightful or anxious, had challenges in coping with their child's pain or symptoms, looked for medical information about their child's illness, addressed why they and their kid were experiencing this situation, asked about the meaning behind suffering, and felt guilty. Also, it claimed that empathetic listening, praying with children and families, touch or other forms of silent communication, and performing religious customs or ceremonies are very effective methods of giving spiritual care (25).

Regarding the change of structural conditions participants, declared the highly technical environment of the NICUs is very frustrating and a private place is crucial for mothers to be calm. Heermann [et.al](#) and Jackson [et.al](#) stated mothers require a private and individual place and in ICU, moments of family members come together in a private place with no interruption (26, 27). Hall's study (2009) showed that not being in a private place with the newborn led to mothers felt that the infant is belonging to the hospital (28).

## Limitations

This study has several limitations, including a small sample size that limits the generalizability of findings. So, future research with a larger sample is recommended to confirm our findings.

Second, a potential sample bias may have been introduced, because a disproportionate number of a spiritually-minded and motivated participant may be volunteered for the interviews that are not the presenter of the general healthcare team members.

## Conclusion

In this study, we explored the significance of spiritual care within a neonatal intensive care unit, from healthcare providers' perspectives. Findings show that spiritual issues are a significant component, which when addressed, may enhance the parent's well-being and satisfaction. Participants emphasized the need to address spiritual care and changing structural conditions and training nurses are the key components of spiritual care in the neonatal intensive care unit. So officials and hospital administrators must do necessary measures to change units' environments. Also, nurse managers should plan for training personnel about providing spiritual care for patients and families.

## Declarations

Competing interests: The authors declare no competing interests. All the participants were verbally informed and signed informed consent.

## References

1. Martin CR, Brown YF, Ehrenkranz RA, O'Shea TM, Allred EN, Belfort MB, et al. Nutritional practices and growth velocity in the first month of life in extremely premature infants. *Pediatrics* 2009; 124(2):649-57.
2. Jones L, Woodhouse D, Rowe J. Effective nurse parent communication: A study of parents' perceptions in the NICU environment. *Patient education and counseling* 2007; 69(1):206-12.
3. Howland LC. Preterm birth: implications for family stress and coping. *Newborn and Infant Nursing Reviews* 2007; 7(1):14-9.
4. Reid S, Bredemeyer S, van den Berg C, Cresp T, Martin T, Miara N, et al. Palliative care in the neonatal nursery. *Neonatal, Pediatric & Child Health Nursing* 2011; 14: 2-8
5. Taylor C, Lillis C, LeMone P, Lynn P. *Fundamentals of Nursing: The Art and Science*. Williams & Wilkins, Philadelphia, Pa, USA, 6th Ed, 2008.
6. McSherry W. *Making Sense of Spirituality in Nursing Practice: an interactive approach*: WB Saunders Co; 2000.
7. Mauk KL, Schmidt NA. *Spiritual care in nursing practice*: Wolters Kluwer Health; 2004.
8. Schroeder J. Ethical issues for parents of extremely premature infants. *Journal of pediatrics and child health* 2008; 44(5):302-4.

9. O'Brien ME. A nurse's handbook of spiritual care: standing on holy ground: Jones & Bartlett Learning; 2004.
10. Franck LS, Cox S, Allen A, Winter I. Measuring neonatal intensive care unit-related parental stress. *J Adv Nurs* 2004; 49(6):608-615.
11. Seyyedfatemi N, Rezaie M, Givari A, Hosseini F. Prayer and spiritual well-being in cancer patients. *Payesh* 2007; 5(4):295-304. [Persian]
12. Elo S & Kyngas H. The qualitative content analysis process. *J Adv Nurs* 2008; 62(1):107–115.
13. Graneheim UH & Lundman B. Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness. *Nurse Educ Today* 2004; 24(2):105–112
14. Chism LA & Magnan MA. The relationship of nursing students' spiritual care perspectives to their expressions of spiritual empathy. *J Nur Educ* 2009; 48(11):597-605
15. Dhamani K A, Paul P & Olson J K. Tanzanian nurses understanding and practice of spiritual care. *ISRN NURS* 2011; 2011:1-7.
16. Dunn LL, Handley MC & Dunkin JW. The provision of spiritual care by registered nurses on a maternal-infant unit. *Journal of Holistic Nursing* 2009; 27:1–28.
17. O'Shea ER, Wallace M, Quinn Griffen M. & Fitzpatrick JJ. The effect of an educational session on pediatric nurses' perspectives toward providing spiritual care. *Journal of Pediatric Nursing* 2011; 26: 34–43.
18. Cleveland LM. Parenting in the neonatal intensive care unit. *Journal of Obstetric, Gynecologic & Neonatal Nursing* 2008; 37:666–691.
19. Obeidat, HM. Elaine A. Bond, E A. & Callister LC. The parental experience of having an infant in the newborn intensive care unit. *The Journal of Perinatal Education*; 18(3): 23–29. DOI: 10.1624/105812409X461199
20. Heyland DK, Cook DJ, Rocker GM, et al. Defining priorities for improving end-of-life care in Canada. *Can Med Assoc J* 2010; 182: E747–E52.
21. Astrow AB, Wexler A, Texeira K, et al. Is failure to meet spiritual needs associated with cancer patients' perceptions of quality of care and their satisfaction with care? *J Clin Oncol* 2007; 25:5753–7.
22. Mansfield CJ, Mitchell J, King DE. The doctor as God's mechanic? Beliefs in the Southeastern United States. *Soc Sci Med* 2002; 54:399–409.
23. Rasinski KA, Kalad YG, Yoon JD, et al. An assessment of US physicians' training in religion, spirituality, and medicine. *Med Teach* 2011; 33:944–5.

24. Caldeira S. & Hall J. Spiritual leadership and spiritual care in neonatology. *Journal of Nursing Management* 2012; 20:1069–1075
25. Feudtner Ch, Haney J, Dimmers M. Spiritual Care Needs of Hospitalized Children and Their Families: A National Survey of Pastoral Care Providers' Perceptions. *PEDIATRICS* 2003; 111(1): 67-72
26. Heermann JA, Wilson ME, Wilhelm PA. Mothers in the NICU: Outsider to partner. *Pediatric Nursing* 2005; 31(3):176-81.
27. Jackson K, Ternestedt B M & Schollin J. From alienation to familiarity: Experiences of mothers and fathers of preterm infants. *J Advan Nurs* 2003; 43(2): 120-9.
28. Hall E & Brinchmann BS. Mothers of preterm infants experience of space, tone and transfer in the neonatal care unit. *J Neonatal Nursing* 2009; 15: 129- 36.

## Tables

Table 1. Demographic characteristics of participants

No	Age	Experience (years)	Education	Position
1	28	3	Bachelor	Staff Nurse
2	28	3	Bachelor	Staff Nurse
3	27	4	Bachelor	Staff Nurse
4	29	3	Bachelor	Staff Nurse
5	40	17	Bachelor	Head Nurse
6	37	14	Bachelor	Staff Nurse
7	34	11	MS student	Staff Nurse
8	34	9	MS student	Staff Nurse
9	46	17	Neonatologist	Dean of ward

Table 2. The main concepts of health care providers' viewpoint regarding spiritual care

Themes	Sub-themes
<b>Nurses' support</b>	<i>Allowing mothers to have contact with baby</i> <i>Doing religious rituals near the baby</i>
<b>Need for spiritual care</b>	<i>Reducing anxiety of the mother</i> <i>Training nurses</i>
<b>The necessity of changes in structural conditions</b>	<i>Providing appropriate space for the mother</i> <i>Providing enough space for religious practices</i>