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Spiritual needs of mothers with sick new born or premature infants—A cross sectional survey among German mothers

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ABSTRACT

Background: Spirituality is part of the basic needs of all humans, yet often undervalued by health professionals. Less is known about the spiritual needs of mothers of preterm or sick new born children.
Aim: Identify unmet psychosocial and spiritual needs of these mothers, and to relate these needs to their perceived stress and impairments of life concerns.
Methods: Anonymous cross-sectional survey with standardized instruments (e.g., Spiritual Needs Questionnaire) among 125 mothers of two paediatric departments in Germany.
Findings: Mothers felt supported by their partner and hospital staff, and hospital staff assured 82% of them that they must not worry about their child's prognosis. They nevertheless did have specific unmet spiritual needs. *Religious Needs* and *Existentialistic Needs* scored lowest, while *Giving/Generativity Needs* were of moderate and *Inner Peace Needs* of strongest relevance. With respect to the expected diagnosis and prognosis of their child, there were no significant differences for their secular spiritual needs scores, but significant differences for *Religious Needs* which scored highest in mothers with children having an unclear prognosis ($F = 8.6$; $p = .004$). Particularly *Inner Peace Needs* correlated with their stress perception ($r = .34$), impairments of life concerns ($r = .25$) and grief ($r = .23$).
Discussion: Mothers of sick born/premature children felt supported by the hospital team and their partner, but nevertheless experienced stress and daily life impairments, and particularly have unmet *Inner Peace Needs*.
Conclusions: Addressing mothers' specific needs may help support them in their struggle with their difficult situation avoiding fears and insecurity and thus facilitating positive bonding to their child.

Statement of significance

Problem or issue

Aim of this study was to clarify which spiritual needs mothers with sick new-born or preterm infants do have, and how these are related to their child's prognosis.

What is already known

Mothers' insecurity about their child's prognosis is a challenging and stressful burden. This difficult psycho-emotional situation may affect the bonding to their child. While mothers' faith and spirituality have been identified as a relevant source also during pregnancy and childbirth, it is unclear which specific spiritual needs they may.

What this paper adds

Despite support from hospital team and their partner, mothers of sick newborn/premature children had specific unmet spiritual needs, particularly *Inner Peace* needs. These

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Inner Peace needs were related to their perception of stress, impairments of life concerns and with the perception of grief. *Religious* needs were strongest in mothers of children with unclear/poor prognosis.

1. Introduction

Spirituality is part of the basic needs of all humans, yet is often unvalued in health care settings. While the importance of a person's spirituality is considered part of midwifery's holistic approach to caregiving (Australian Nursing and Midwifery Accreditation Council, 2014),[1] in our experiences health professionals often do not give patients' spiritual support much credit in their daily work routine as they see it as beyond their professional duty. Meanwhile there is an increasing body of evidence that even in secular societies, patients with chronic diseases may have specific spiritual needs.[2–6] We likewise have knowledge about spiritual needs of elderly living in retirement homes and dying in hospice;[7–9] however, less is known about the spiritual needs of relatively young persons, particularly mothers of preterm or sick newborn children.[10,11] These mothers surely had the expectation to take home a healthy child and to be a happy family; but now they are confronted with the unexpected situation that their child has to be treated in the hospital. Some are unclear about the prognosis, some do know that the prognosis is rather bad, and others know that their child's symptoms are less relevant and treatment only temporary—and yet they are separated as a family, with one caregiver in hospital and the other possibly at home. Although direct skin-to-skin contact is essential for child and mother,[12,13] during this phase mothers may nevertheless feel highly insecure resulting in distancing behaviour of 'wait-and-watch' what the health professionals do with and for their child. This helplessness and insecurity is a challenging and stressful burden for the mothers,[14] which may persist for several years and may affect the bonding to the child.[15,16]

Yet, mothes' psycho-emotional situation is not the primary focus of the hospital team, albeit most do try to include them (particularly) in the caring process. There is evidence that it is important to support the processes of stable mother-child bonding, also to avoid depressive states of the mothers,[17] but in clinical reality mothers may nevertheless feel often helpless and insecure. Mothers of preterm infants are more anxious, experience grief and depressive states and other indicators of posttraumatic stress disorder symptoms compared to mothers with 'normal' children.[15,18–20] These experiences may impair the bonding of the child, resulting in insecure binding pattern.[19] For others it is therefore essential to receive adequate support by the hospital team, partner and family, and to find own strategies to cope with the situation. One of these resources is a person's faith or spirituality.

The multifaceted construct 'spirituality' was identified as a relevant resource to cope with stressful situations.[21] The relevance of mothers' faith and spirituality during pregnancy, childbirth and neonatal care was highlighted by several authors, such as Corrine et al.,[22] Jesse et al.,[23] Caldeira and Hall,[24] and Crowther and Hall.[25] Recently it was found that giving birth for the first time, and in particular birth with complications, provokes many existential and spiritual needs and considerations.[26–28] The Danish researchers assessed prayer and meditation as indicators of mothers' spirituality 6–18 months after birth of their child, and did not find differences between mothers with preterm or full term children with respect to the "affirmative responses to prayer or meditation" (p. 1).[28] In contrast to these studies on mothers' practices and behaviors, qualitative work of Moloney & Gair investigated the influence of midwives' empathy and spiritual care on mothers' feelings and perceptions.[29] They found that this support may enhance mothers' "birth experience" and thus "providing a solid foundation for confident mothering" (p. 323), while a lack of this support was related by the mothers themselves to "birth trauma and difficulty bonding with their babies" (p. 323).[29] While there is also a study dealing with the emotional and spiritual concerns of parents whose children died at a paediatric intensive care unit,[30] to our knowledge there are, however, no empirical studies about specific spiritual needs of mothers with sick new-borns. To fill this gap of knowledge, we performed a survey among mothers with sick new born or premature infants and focussed on their unmet spiritual needs.

According to a conceptual framework for research and clinical practice, spiritual needs can be categorized as 'Connection', 'Peace', 'Meaning/Purpose', and 'Transcendence' and attributed to the underlying categories of 'social', 'emotional', 'existential', and 'religious'.[31] With respect to Alderfer's Existence-Relatedness-Growth (ERG) model,[32] 'Peace' needs can be related to the Existence domain, 'Meaning/Purpose' needs to the Growth domain, and both 'Connection' and 'Transcendence' needs to the Relatedness domain of the ERG model.[33] Such 'needs' can be seen as the difference between a person's *expectation* of what should or could be and their *perception* of the current situation, which is the lack of the expected or needed.

We therefore intended to identify and quantify unmet spiritual needs of these mothers, and to relate these needs to their perceived stress and impairments of life concerns. Specifically, we intended to analyse (1) which spiritual needs were relevant to them; (2) whether these needs were related to their perceived burden due to the health situation of their child; and (3) whether information and support provided by the hospital team and/or partner and friends has an influence on the intensity of spiritual needs. The related research questions (# 2 and 3) can be seen in the context of a Demand-Resource model. Therefore we measured indicators of mothers' stressors and demands (e.g., child's health situation/prognosis, stress perception, daily life impairments, feeling under pressure, escape from the situation, and negative mood states) and putative resources (i.e. self-efficacy expectation, information and social support, spiritual wellbeing), while mothers' mood states and their life satisfaction were included as 'ambivalent' additional variables. We assume (1) that the prognosis/health situation of the child (and also related variables such as mothers' stress perception, their intention to escape from the situation, etc.) may have an influence on the intensity of their spiritual needs, and 2) that resources such as information/social support and self-efficacy expectation may have a negative (buffering) effect on mothers' spiritual needs.

2. Materials and methods

2.1. Participants and ethics

All participants were informed about the purpose of the study (approved by the IRB of the Witten/Herdecke University; #17/2012; date of approval April 4, 2012) by one of the medical doctors in the respective clinics, were guaranteed confidentiality and anonymity (i.e., no identifying details were collected, neither names, initials or addresses, and no further details on the medical course of their child were reported, except the general diagnosis and expected hospital stay). Further, they were assured that they could decide against participation at any point in the process. After signing the informed consent document, persons interested in participating were asked to fill the German language questionnaire. Mothers' returned the questionnaires in an envelope either to the registry, head nurse, physician or via post, respectively.