Original Article

Spiritual Needs of Families With Bereavement and Loss of an Infant in the Neonatal Intensive Care Unit: A Qualitative Study

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Abstract

Context. The hospital is a place full of distress and questions about the meaning of life. The death of a child can cause a spiritual struggle and crisis. Therefore, it is necessary for health care providers in the neonatal intensive care unit (NICU) to assess the spiritual needs of families that have lost a child.

Objectives. The purpose of this study was to explore the spiritual needs of families in Iran at the end of their baby's life and through bereavement in the NICU.

Methods. This study was an exploratory qualitative study performed using purposeful sampling and semi-structured interviews with 24 participants. Inclusion criteria for families, nurses, and physicians included having experienced at least one newborn death in the last six months in the NICU. The research environment was the NICU in Isfahan, one of the largest cities in Iran.

Results. Data analysis revealed three main themes: spiritual belief in a supernatural power, the need for comfort of the soul, and human dignity for the newborn.

Conclusion. The results of this study created a new vision in addressing spiritual needs of Iranian families who experience the death of a newborn. J Pain Symptom Manage 2016;52:35–42. © *2016 American Academy of Hospice and Palliative Medicine. Published by Elsevier Inc. All rights reserved.*

Key Words

Spiritual needs, family, end of life, infant, Neonatal Intensive Care Unit, Iran

Introduction

The main goal of palliative care is providing the best support for increasing quality of life for patients and their families. In a palliative care approach, psychosocial and spiritual care are offered based on patient/family needs, beliefs, value systems, and culture.[1] Spirituality is defined in different ways at different points in our lives and has a unique meaning for each individual.[2] Spirituality is a characteristic and a domain that allows a human being to find his or her purpose and meaning in life.[3]

Parents usually find a spiritual meaning for their own lives that is focused on their children's lives.[4] Therefore, admission of neonates in the neonatal intensive care unit (NICU) can be a traumatic experience for parents.[5]

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The hospital is often a place full of distress and that raises questions about the meaning of life. The NICU in particular is a critical environment because it is a place where lives may end or change in important ways.[6] The number of cesarean sections, overall neonatal morbidity, and the percentage of premature deliveries also has increased in last 20 years.[7] Each year approximately four million neonates die of 130 million live births around the world;[8] three-quarters of neonatal deaths occur in the first seven days,[9] and the majority occurs in the NICU.[10] Most childhood deaths occur in the newborn period.[11] A child dying before a parent is an unusual and stressful process, contrary to the normal order of things.[12]

Parents who have lost an infant experience a tragic event.[5] The death of a child can cause a spiritual struggle and crisis while searching for meaning and purpose of life.[13] This can lead to even deeper spiritual distress if these needs are ignored for a long time;[2] therefore, it is necessary for health care providers in the NICU to assess the spiritual needs of families that have lost their child.[4] Spiritual distress can be identified as a questioning about lack of meaning in life in loss or grief.[14]

In the context of infant death, most parents rely on their faith and spirituality for finding answers and comfort.[4,11] Health care providers are ideally situated to detect spiritual distress and perhaps even to begin to address such needs and, therefore, should comprehend the concept of spirituality and religion from the perspective of families. Studies have shown that spiritual needs of parents caring for children at the end of life have unaddressed spiritual needs.[13,15] Spiritual care is an important factor in the support of families in the NICU.[4] Awareness about spiritual needs falls within the framework of spiritual care;[2] to organize spiritual care interventions in the NICU, it is necessary to first evaluate spiritual needs of families.

Different spiritual needs have been identified in several studies, needs that are dependent on cultural, historical and social backgrounds and specific religious beliefs.[2] In the cultural context of Iran, Islam is practiced by most Iranians. They typically believe that death is part of God's plan and that terminal illness is an opportunity for prayer. The basis of the social structure is family. Most family is nuclear and extended. The concept of family is more private than in many other cultures. A Muslim family may want to see their family and friends when a loved one is dying or is in a bad situation or crisis because their relatives may help provide support and a sense of peace.

In the study by Meert et al.,[12] spiritual needs are mentioned by parents in connection with their child and also truth, compassion, prayer, ritual, sacred texts, connection with others, and bereavement support.[12] Cobb et al.,[16] in a review article, mentioned that often the term "spirituality" is used with regard to religious and sometimes used in other articles to mean spirituality/religiosity. In this review article, a belief in God was reported in Hindu, Muslim, and Sikh, but there was no explanation about the content of this belief. The most important feature of spiritual needs in Islam is based on human nature and relationship with God, according to religious concepts. These factors must be taken into consideration in each community.

The purpose of this study was to explore the spiritual needs of Iranian families at the end of their baby's life and through bereavement, from families' and professional health care providers' perspectives in the NICU. The research question was "What are the families' spiritual needs at the neonate's end of life in the NICU from family and professional health care provider perspectives."

Methods

Study Design

In this study, the conventional approach of qualitative content analysis was used.[17] Qualitative research methods are appropriate for studying spiritual care and bereavement, where qualitative researchers interpret events in terms of participants' points of views.[13]

Setting

The research environment was the NICUs in five educational and noneducational medical centers in the city of Isfahan, Iran. Isfahan is a religious city, and most people in the area are Muslim and believe in Allah, a Doomsday, life after death, Ramadan, an imam or religious leader, and prayer five times a day facing Mecca. The term "religious" is more familiar than "spirituality" in Iranian daily lexicon.

Participants and Interview

In qualitative research, participants are considered as research samples.[17] Sampling was done with a purposeful sampling method and considering maximal variation. In this method, the researcher for diversity selects a small number of units or cases with maximum variation relevant to the research question.[18] In maximum variation, heterogeneity in cases is important.[19]

Inclusion criteria for families, nurses, and physicians were having experienced at least one newborn death in the last six months in the NICU. The study data were collected from June 2013 to March 2014 with face-to-face, semi-structured, in-depth interviews. All participants (family) were identified in the NICU and informed about the purpose of this study. The first author stayed in the NICU for the length of the study and communicated with families who had an infant at the end of life. The head nurses at each NICU helped identify families that met the inclusion criteria.

Families of infants who died in the NICU six months prior were identified by reviewing the family's name and contact information in admission/discharge logs. The first author contacted the deceased infant's family by telephone and explained the aim of study and asked them to participate in an interview regarding their needs at the time of their infants' death in the NICU and during bereavement. The medical professional participants from each hospital who met inclusion criteria were invited to take part in the research. Some of them did not have time for the interview and rejected our request.

After obtaining written and verbal informed consent, the interview dates were arranged in a convenient place. All participants were interviewed in a quiet, minimally distracting environment at the medical centers, except for two cases where individuals were interviewed at their homes at their request.

In this study, 24 participants (mother, father, grandmother, nurse, and doctor) who met the inclusion criteria were interviewed. Twenty-five interviews were conducted; 24 participants were interviewed one time and one mother was interviewed twice. The length of the interviews was from 45 to 75 minutes. All interviews were recorded.

Interviews with nurses and doctors began with a main question such as "Could you please tell me about your experience of the needs of families with infants hospitalized in the NICU and near death?," before addressing more specific questions regarding spiritual needs. Interviews with families also began with a main question such as "Could you please tell me about your wishes when your child was first admitted to the NICU?" and then further questions were asked regarding the spiritual needs of their families. Our study explores the families' needs during their newborn's hospitalization and end of life but focuses on spiritual needs. Our findings regarding other needs are reported elsewhere.

In this study, similar to the study by Hirai et al.,[20] we selected two types of participants: nonmedical participants and medical participants. The nonmedical participants were families with a newborn approaching or after end of life, and the medical participants were nurses and physician in the NICU. The data analysis was carried out for data combined from all the participants to achieve a more robust data set.

Data Analysis

The analysis was conducted by qualitative content analysis based on the method by Graneheim and Lundman.[21] In this method, the categories and their names were obtained from data.[22]

The first author conducted all the interviews. After each interview, two investigators listened to the interviews separately. All recordings were transcribed verbatim immediately after the interviews. Data were reviewed by primary researchers who had long-term engagement in this study. The results were reviewed to abstract the meaning of words and phrases and to allow the researchers to obtain a general sense of the data. Also, two first researchers (N.S. and M.H.) read and categorized the entire interview separately. Then codes, subthemes, and themes were compared between the two researchers to explore similarities and differences in the codes and themes. Data collection continued until no new data emerged. Saturation in data was gained after 25 interviews with 24 participants (15 interviews with 14 families and 10 interviews with staff members).

After we conducted 25 interview analyses, two additional interviews (one mother and one nurse) were conducted, but no new data were produced. After we conducted all the interviews, as an additional check (member check), two parents and four nurses reviewed codes, categories, and themes and confirmed that their views had been properly interpreted. Moreover, as a peer check, codes, categories, and themes were reviewed by eight other expert researchers (not members of the main research team) who were familiar with qualitative research methods, spirituality, and the NICU.

Data were managed without any software package; analysis was done manually. Conventional content analysis was conducted. In this method, categories and their names are obtained from the collected data. The method of analysis includes selecting the unit of analysis and identifying the important sentences and phrases as meaning units. Meaning units were reviewed several times, condensing sentences into condensed meaning units, and labeling condensed meaning units as codes. The same code was classified into subcategories, merging subcategories into categories and finally creating themes. Themes were determined by each researcher separately, and disagreements between researchers were discussed and negotiated. The themes of spiritual need were developed after negotiation between researchers.

To achieve rigor and trustworthiness of the data, participants were selected with maximum variation in age, education, and employment. Also, peer check and member check as mentioned earlier were done. To achieve transferability of the data, data, themes, and categories were reviewed and confirmed by two nurses and one mother who were not involved in this study but had experienced a similar situation as the research participants. To confirm the data, each interview was managed by two researchers. An external audit was conducted by a person with expertise in qualitative content analysis.

Ethics

This study was approved by the Ethics Committee of Isfahan University of Medical Sciences (no. 393003). Before every interview, a written informed consent

form was obtained from all participants. The participants were assured that they could withdraw from the study in each phase without any obligation or penalty. The participants' real names were secured and replaced by code numbers for confidentiality in all phases of the study, from data transcription and analysis to dissemination of findings. Psychosocial support of participants who might experience negative effects were taken into consideration, although none of the participants reported any negative effects from the study and did not apply for support.

Results

In the 25 in-depth interviews that were conducted, the research population included parents and grandparents (60%), nurses (36%), and physicians (4%). The average nursing working experience was 14 years, and all of them were women. Islam was the religious affiliation of all the participants. Prematurity was the major cause of death identified among the infants. Of all the neonatal mortality cases, 11 were singles (6 boys and 5 girls), two cases were twins (girls), and one case was triplets (two girls and a boy). All cases died in the NICU. Table 1 lists the demographic characteristics of participants and the deceased neonates.

The study was twofold; i.e., there were 15 interviews with family members and 10 interviews with professionals. The professionals' characteristics are listed in Table 2.

Spiritual needs were categorized into three categories: 1) belief in a supernatural power, 2) the need for comfort of the soul, and 3) human dignity for the newborn.

Belief in a Supernatural Power

Belief in a supernatural power was defined as religious belief in a supernatural power to heal and to revive and the will of God. Most participants believed that having faith in God is an important factor in the end-of-life and bereavement periods. Most participants specified that when their children are in the NICU at the end of life, their belief in God as a healing power can help them in coping with the situation. Most families with a child in the NICU reported an increase in religious thoughts and practice. They believed that birth and death are signs of God's power.

Table 1
Demographic Characteristics of Participants and Deceased Neonates

Participant's Code	Neonate Gender	Age at Death	Diagnosis
Mother #1	Girl	1 Day	Prematurity
Mother #2	Boy	4 Months	Prematurity
Mother #3	Boy	Dying	Cardiac congenital malformation
Mother #4	Boy	1 Day	Prematurity
Mother #5	Girl	28 Days	Prematurity
Mother #6	Girl	1 Day	Prematurity
Mother #7	2 Girls and 1 boy	1 Day	Prematurity
Mother #8	Boy	7 Days	Cardiac congenital malformation
Mother #9	Boy	Dying	Prematurity
Father #1	Boy	10 Days	Prematurity
Father #2	Twin girls	1 Day	Prematurity
Grandmother #1	Twin girls	1 Day	Prematurity
Grandmother #2	Girl	1 Day	Prematurity
Grandmother #3	Girl	1 Day	Prematurity

Table 2
Demographic Characteristics of Professional Health Care Participants

Participant's Code	Education Level	Position	Work Experience (Years)
Nurse #1	Bachelors in nursing	Nurse	6
Nurse #2	Bachelors in nursing	Head nurse	18
Nurse #3	Bachelors in nursing	Nurse	7
Nurse #4	Bachelors in nursing	Nurse	7
Nurse #5	Master in nursing	Nurse	6
Nurse #6	Bachelors in nursing	Nurse	7
Nurse #7	Bachelors in nursing	Nurse	30
Nurse #8	Bachelors in nursing	Head nurse	23
Nurse #9	Master in nursing	Tutor	23
Doctor #1	Neonatologist	Doctor	3

A number of families wanted to put the Holy Qur'an over their baby's head, and they believed that by doing this, the power of the Qur'an would protect their child. Parents read the Qur'an and prayed for their babies and believed that prayer can heal and result in a miracle for the baby. Moreover, a number of nurses pointed out a single case of a baby who was cured miraculously, as they perceived it, as a result of parents' prayers.

One nurse mentioned with regard to religious belief in a supernatural power to heal and revive:

> A mother who is not involved in religious matters, when she comes by her baby's side, she puts a Qur'an or a green cloth above her baby's head. Some nurses blamed her by asking her 'what are these things that you have brought?' Perhaps the spiritual care is respecting the parent's beliefs which parents adopt in these difficult situations. Her feeling is that if the Qur'an is near to her baby, she or he will stay safer and God would protect her or him, or if she put a little green cloth on her baby's incubator, she feels more comforted and assured. (PN5)

Most families believed that everything must be the request of God. Nurses also believed that the family's religious beliefs and thoughts should be respected. Another nurse said:

> In one of the cases, a mother had a very strong belief. She believed that if God wants to cure her baby he will cure the baby, though doctors

> constantly say that his baby not worth trying to save. Miraculously her baby was saved and lived to be discharged. (PN4)

Most families believed that the death of their baby is the will of God and expressed that God is the creator of life and death. They felt that the death of their baby is a test from God and they did not want to fail this test and wanted to obtain the approval of God. So they wait and trust in God's will. With this belief, none of the participants had any spiritual distress.

One of the participants (father of newborn twins) stated:

> …I want to please of God; we've finally convinced ourselves this way. My God, I accept whatever which satisfies you. We have surrendered to God's will. (PGF2)

Another participant in this regard noted:

> My belief made me patient; however, it was the will of God. The baby did not belong to me; my baby belongs to God. It was a blessing that God had given me and God had the authority about my baby's life. My baby was a gift from god and he wanted, I consider his power. (PM2)

One of the mothers stated:

> But all of these are related to God's will, whatever God has intended, will happen. A leaf from a tree does not fall without Allah's permission. When we consider this, we realize that God one day gives and one day takes back all things us including our baby. 6 months ago, God wanted this fetus [to] come in to existence but now God wants this baby away from me in this way and when I consider this, I should not destroy my life and I must say Oh Allah I am pleased with your satisfaction. (PM3)

As mentioned earlier, the first and most important identified spiritual needs were belief in a supernatural power or belief in God. For Iranian and Muslim patients, belief in God is very important. They want to be healed and revived by God. They read from the Qur'an for comfort and peace. They believe their children belong to God and believe in life after death, and hope to see their child in another world. They ask God to help them, which helps them to achieve calm and better accept loss. They accept the death of a newborn as the will of God.

The Need for Comfort of the Soul

One of the spiritual needs of the families was the need for relief and comfort of the soul. This category was defined as the need for hope, the need for peace, and the need for understanding and empathy. Most families wanted the medical team to give them hope about their baby's recovery and reported they were searching for even a hint of hope for their baby's recovery. They needed to talk with nurses, doctors, or a spiritual person to achieve a sense of calm and peace. Moreover, they thought that belief in life after death, spiritual talk, and rituals, prayers and hymns, and religious traditions are useful tools for achieving a sense of peace. Some parents believed that after their own death, they would see their baby again and they were comforted by such ideas. Some even expressed their hope for dying sooner to then meet their baby in the hereafter.

One of the nurses stated:

> She always hoped that we tell her that her son is recovering and needed such speak. When the telephone rang out she was hoping to hear happy news and not hearing that her baby was becoming too…(PN1)

One of the mothers, when asked about her need for peace, explained:

> We need someone to give us compassion and peace, become our rock and be able to help a little bit to ease our pain to prevent despair. We need to talk with someone to come out of this depressive situation in order to comfort to ourselves. (PM3)

Some of the parents believed that God has included some benefit for them in their newborn's death. This idea gave them peace. One of the mothers stated:

> But I said God is the greatest, I mean I was saying God has put some benefit for me in this. In my view my strong belief in God's will is very important. It feels very safe to say God intended and there is no other reason. It is narrated in Holy Scripture that the children who are in these situations, they will be able to meet their parents in another world and they are parent's provision for future in the other world. (PM8)

Most families have expressed their need to be understood and empathized with by the medical team, and also reported they were looking to communicate with families in a similar situation, so as to feel that they are not the only ones who have this problem. One of the participants stated:

> Well yeah, for instance they (nurses and physicians) did not answer me appropriately, I would like they speak with me more accurately, but they did not take the time to answer my questions, though I was in a bad emotional state, I expected they become more patient and nurses have more compassion with me. (PM5)

The same participant said:

> When the health care provider makes consultations and gathers mothers, this is the best method, in this

case moms feel that they are not alone and this event has not happened only to them and there are so many other people who have this problem. When they had come to take my baby away, at that moment I felt that I am not alone and this made me calmer and relax. (PM5)

In the participants' view, the need for hope, the need for peace, and the need for understanding and empathy were very important spiritual needs in neonatal end of life and bereavement. The health care professionals simply can meet these needs by expressing realistic information about the condition and prognosis of their newborn. Furthermore, the health care professionals should consider communication with families and listening to them with empathy as a spiritual need.

Preserving the Human Dignity of the Newborn

One of the spiritual needs of families was preserving the newborn's dignity. This category was defined as human dignity of the newborn before and after death.

Most participants stated that the child should be resuscitated in a proper setting. A dying baby should be faced toward Mecca and also should be respected just like a Muslim adult.

One of the nurses said:

We must consider this baby is a human and have a body and a soul. We must respect the newborn and their family in neonatal end of life. I did not want to take any blood sampling, because he was in end of life and I did not want [to] annoy him. I wanted to turn his incubator toward Mecca, but I did not can anywhere… (PN7)

Most participants called for a funeral and respect for the child's dead body, just like for an adult. They also wanted a burial and funeral ceremony for the babies and an attendance over their graves. By doing these things, they feel comforted and are better able to accept the death of their baby. One of the mothers explained:

I hugged and talked with my baby. You know, If this did not happen, it would be impossible having this calmness that I have now. I told him, I hope to see you here after. I told my baby all I wanted to tell him. (PM9)

Another mother noted:

Afterward, when I go to visit his grave, I talk to him. It brings me a sense of calmness. (PM2)

The parents needed respect and human dignity for their newborn. They wanted to have time to say goodbye. They wanted religious rituals for their newborn as for a Muslim adult. They read a passage from the holy Qur'ans to comfort themselves.

Discussion

The results of this study provided a new vision for the spiritual needs of families with extremely ill babies at the end of life and through bereavement. Detection and recognition of such needs is essential for proper delivery of spiritual care by health care providers.

Our study adds to what is known about Iranian parents' spiritual/religious needs during bereavement and loss of an infant in an NICU. These findings may be useful in changing NICU policy and facilitating better support for parents in the realm of spiritual belief in a supernatural power, comfort of the soul, and human dignity for their newborn. Health professionals can help parents with preserving the human dignity of the newborn before and after death and supporting them in seeking hope, peace and empathy in loss. Furthermore, nurses should pay attention to these spiritual needs in nursing assessments and in delivering spiritual care.

Spiritual needs identified in this study were 1) belief in a supernatural power, 2) the need for comfort of the soul, and 3) human dignity for the newborn. Belief in a supernatural power was the most important spiritual need identified for participating families. Most families considered their beliefs and associated religious rituals, such as prayer, donations, reciting the Qur'an, and appealing to imams, as a source of strength in the face of the critical situations that they were surrounded by. When participants were questioned about the relation of religion to spiritual needs, they mentioned that religious needs, from their perspective, were the same as spiritual needs. As Mueller et al.[23] stated, spirituality and religion are overlapping concepts.

The study by Robinson et al.[13] has shown that, when there is a medical crisis for which routine health care seems unlikely to be helpful, parents usually turn to prayer and worshiping God. NICU health care providers believed that the religious and spiritual concerns of the family are very important in newborn care and some of the nurses even prayed for their patients. Meert et al.[12] found that parents often felt they needed the prayers of others, such as family, friends, and employees. Some of them also believed that these connections provided by shared prayer are a type of spiritual support and they felt the whole world was praying for their children. In the research by Robinson et al.,[13] most parents believed that prayer and faith are the most important factors during their children's dying moments. In this study, God has been considered to be the supernatural power and a spiritual

need. In the review by Edward et al.,[2] the concept of spirituality was associated with God or a higher being.

Infant mortality causes deep suffering for parents,[4] and several studies have suggested that the worst experience possible for parents is the death of a child.[24] This experience may stay fresh even years after the death[25] and can cause a heavy burden for parents and communities. In this study, belief in God, acceptance of death as God's will, and surrendering to the will of God were the most important factors contributing to calmness and acceptance of death and prevention of spiritual distress for parents. Most parents believed that the birth and death of their children was a test by God and they tried to pass this test appropriately. In the study by Robinson et al.,[13] it was disclosed that religious faith is a significant contributing factor in dealing with the death of a child and a parent's coping during hospitalization and after the baby's death. In our research, submission to the will of God, patience and trust in him, and accepting the catastrophe as a divine test correlated with and thought to demonstrate a high degree of faith and religious belief facilitating adaptation to the child's death.

The need for comfort of the soul is another spiritual need of the families. Most families were searching for hope for healing and possible liberation from their difficult situation. Hope and confidence are both thought to be implicitly spiritual concepts.[13]

Rosenbaum et al.[4] and Robinson et al.[13] found that most families were hopeful about the future and tried to make sense, seeking new hope; some of them found hope and peace in the belief that they would meet their children in another world. Such hope is an experience that relates to the meaning of life that we all look for.

However, health care providers should be careful not to give false hope to families when death is inevitable, but rather they should help families to build a new sense of hope, from this perspective, hope is based on true information and its root is in reality and related to building meaning.[4] The results of our study are consistent with the previously mentioned studies.

In this study, most families identified their religion and spirituality as important factors for calmness. They believed that they will meet their children in the next world and that enduring the pain and sorrow will gain them eternal rewards. In the research of Brosig et al.,[10] families with newborns near death declared that belief in God had an important role in providing a sense of comfort and peace and that they also believed that a return to religion is an important factor in filling the empty feeling about life they were experiencing. The study by Robinson et al.[13] noted that after a child's death, parents were able to achieve peace and comfort through reliance on their faith. Similar to the earlier mentioned studies, in this research, reliance on religion and spirituality provided significant peace and psychological comfort for families. But there is a question regarding who most appropriately should provide this care. In Iran, in some hospitals, there is a religious leader (imam), who will help patients regarding religious issues, but in terms of spiritual care, there is still much work to be done.

Most mothers expressed their desire to communicate with other mothers who have lost their children, because they want to feel that they are not alone and there are others who have had similar experiences. The research by Brosig et al.[10] stated that communicating with families who have similar experiences and talking about their baby's death is quite helpful.

In the study by Meert et al.,[12] some of the parents looked for people with the same condition on the Internet to exchange ideas. This study is consistent with other research findings and suggests finding an appropriate setting for these families to meet and discuss their issues.

In this study, the human dignity of the baby was one of the spiritual needs of families. Families wanted their children, before or after death, to be treated like a human being and as a Muslim and for their human dignity to be respected. In Islam, the dying and dead person is accorded certain respect and dignity, and most families requested respect accordingly.

Similar to other studies, parents in the toughest conditions sought for their children the dignity and respect that they deserve as a human. Robinson et al.[13] noted that in the initial stages of a baby's hospitalization, parents may have hope for a miracle cure, but, when it becomes clear that the child will not survive, they expect a respectful and dignified death for their children. Therefore, the results of this study are consistent with other research.

Conclusion

During the period surrounding a baby's death in the NICU, families encounter critical spiritual needs. It is important that clinicians take care to identify these needs to ensure proper delivery of spiritual care. Most families believed that relying on faith and spirituality had been helpful in coping with their child's death. Therefore, health care professionals should be familiar with the concepts of spirituality, religion, and spiritual care. Implementation of spiritual care in the NICU could facilitate the process of bereavement for families.

This study reveals how Muslim persons in a particular cultural setting experience spiritual belief in a supernatural power or belief in God as spirituality and

spiritual needs. We suggest that communication with families who have lost their newborn in the NICU is a form of spiritual care that should be supported and facilitated. Health care providers should respect families' beliefs in religious rituals and preferences, such as prayer, reading of the Qur'an over the baby, and belief in miracles.

Limitations

This study was conducted in population of Isfahan, with regard to sensitivity of the topic of the study and the close relation between the concept of death with religion and culture. In this study, our participants were Muslim and we did not have any participants from any other religious backgrounds. Therefore, the results of this study may not reflect spiritual needs in other religious that are less common in Iran.

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