How do children express their spiritual needs?

Abstract
Like adults, children draw on previous experiences of life including religious and spiritual beliefs to make sense of life events and to cope with crises. They will have a range of preconceived ideas, fears, concerns and fantasies which are usually linked to their stage of cognitive development and prior experiences. This article provides examples of expressions of spiritual beliefs across childhood, related to a discussion of the meaning of spirituality in the context of holistic care. Spiritual needs should be incorporated into daily practice of nursing, beginning with assessment, so that normal home routines are maintained and the family’s beliefs respected. However this requires nurses to understand ways that children may express their spirituality.

To fully meet the health needs of each child, healthcare professionals need to consider the cultural background, religious beliefs, ethnicity and health beliefs of the child and his or her family. One aspect that appears to be challenging for nurses is understanding and responding to the child’s spiritual needs (Dell’Orfano 2002, Elkins and Cavendish 2004, Feudtner et al 2003). Defining spirituality is not easy; in health care it has been described in terms of:

- Existentialism, the need to find meaning and purpose in life (Frankl 1987)
- A source of connectedness or interconnectedness within oneself, with other people, and the universe (Reed 1992)
- A universal phenomena in all people, primarily coming into focus during time of crisis (Murray and Zentner 1989)
- Different meanings to different people depending on their world view or philosophy of life (Martsolf and Mickley 1998).

These descriptions demonstrate how culture, religion and spirituality are intertwined and are therefore all relevant to the child and his or her family. How the child may express his or her spiritual beliefs will undoubtedly be influenced by, and may parallel the child’s cognitive development (Elkins and Cavendish 2004, Ratcliffe 1995).

In an earlier article the authors reported a concept analysis relating to spirituality and child development (Smith and McSherry 2004). The aim of this article is to describe the possible expressions of spiritual beliefs across childhood, beginning with a discussion of the meaning of spirituality in relation to holistic care. Contemporary opinions relating to spirituality are debated and examples provided of children’s expressions of inner beliefs that may be suggestive of spirituality and/or spiritual development, according to the age of the child. Conclusions are made on ways the assessment of spiritual needs may be incorporated into everyday practice.

The need for holism
Current healthcare policy and codes of conduct emphasise the need to have an holistic approach to care, with the needs of the child and family central to care delivery (Department of Health 2004a, 2004b, NMC 2004). This represents a shift from a biomedical approach to care to a more individualised approach (Gerrish 2000). An holistic approach to care recognises the complexity of the individual and acknowledges that many people draw on a range of beliefs, including cultural, religious and spiritual, during periods of stress and illness to make sense of the situation (Dell’Orfano 2002, Elkins and Luc Tuman

Key words
- Children: development
- Spiritual care
- Holistic care

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Cavendish (2004). Culture, religion and spiritual beliefs are powerful dimensions that can shape human experiences (Rehm 2000). If nurses are to provide comfort, strength and hope to the child and his or her family, they need to provide opportunities to meet their religious and spiritual needs (Anderson and Steen 1995, Elkins and Cavendish 2004, Kenny 1999).

Spirituality
The concept of spirituality has received growing attention in children's nursing but much of this interest reflects adult-based sources (Kenny and Ashley 2005). Irrespective of the source, a great deal can be learned from contemporary writings on spirituality in healthcare practice, which could be applied to children's nursing. This does not negate the need to develop an empirical base relating to spirituality in children's nursing but enables children's nurses to build on existing knowledge.

There is no consensus on what constitutes spirituality (Narayanasamy 2001) although Cobb's (2001) description of spirituality as a catch-all phrase for things associated with the non-material or metaphysical realms still has currency. Despite much debate the concept remains subjective, confusing and polarised. McSherry and Cash (2004) argue that spirituality can be viewed as a continuum; on one side it is viewed in a religious framework, on the other it applies to all people irrespective of a faith or belief in a God or other deity. This continuum supports the argument that spirituality is a universal phenomenon applying to all, believers and unbelievers alike (Burnard 1988, Cavendish 1997).

Children's beliefs
Ehmeier et al (1991) suggest that spirituality may play an important part in a child's daily life, which can intensify during times of crisis such as periods of ill health. Some children experience traumatic life-threatening events such as physical and emotional harm, illness and death. Like adults, the child will draw on previous experiences including religious and spiritual beliefs in an attempt to make sense of and cope with these crises (Pfund 2000). In addition, the child will have a range of preconceived ideas, fears, concerns and fantasies which are usually linked to the stage of cognitive development and prior experiences. It seems logical that a child's expression of inner beliefs will depend on their stage of development; it seems appropriate to attempt to understand children's spirituality using a developmental approach (Kenny 1999, Kenny and Ashley 2005, Smith and McSherry 2004).

Table 1 provides examples from the literature that may represent a child's expression of a spiritual belief or spiritual development across the age span. The examples are linked to the key stages of child development as outlined in Erikson's (1963) stages of psychosocial development and Piaget's (1952) stages of cognitive development. Using age-related stages implies that an individual's spirituality may change according to their position on the lifespan continuum (Carson 1989). However, many child development theories have used Western and Judeo-Christian traditions and are based on adult interpretations, and therefore may not truly reflect the child's perspective or be transferable or have significance for all cultural, ethnic or religious groups.

For some age groups, the way a child expresses him or herself may be literal, for example the three-year-old believing people who die go to prison. Children can have powerful insights in relation to spirituality; there appears to be a connection between Mary, other people, and the universe at large. For some children, typified by Jessica, illness is connected to punishment. The nurse can help foster the development of spiritual awareness and allow the child to express his or her views but should also ensure the child understands the illness and its cause.

Meeting the child's spiritual needs
Nursing practice is usually based on a model of care and delivered through the process of assessment, planning, implementation and evaluation. The well-established "Partnership Model" (Casey 1988) stresses that to achieve his or her full potential, the child's physical, emotional, cognitive and spiritual needs must be met. Adopting a nursing model that recognises the importance of meeting the spiritual needs of the child is the beginning of developing a holistic approach to care.

Elkins and Cavendish (2004) provide a useful summary of several assessment tools, which can be adopted to undertake a formal assessment of the spiritual needs of the child and family. The tools focus on areas such as religious practices, sources of strengths and hopes, and the relationship between spiritual and health beliefs. The use of specific assessments tools raises several issues; first, tools are often used as a checklist with little application to practice (Elkins and Cavendish 2004), second, nurses may not feel comfortable undertaking a spiritual assessment (McSherry and Ross 2002, Stoll 1979), third, spirituality is subjective and personal in nature (McSherry et al 2004, Narayanasamy 2001), and finally, in the current clinical climate, undertaking additional assessments may be unrealistic given the demands already placed on nurses. Consequently, the assessment of spiritual needs, the starting point of the nursing process, is often reduced to banal statements such as recording the child's religion (Anderson and Steen 1995).
Improving practice
Omitting spiritual assessment may deny a child the opportunity to maintain normal home routines and does not foster respect for the family’s beliefs. Spiritual distress will not be recognised and there will be difficulties in planning individual care in response to a child’s distress. The assessment of spiritual concerns should include the child and family’s concept of faith, sources of strengths and hopes, lifestyles and practices, the importance of

Table 1

<table>
<thead>
<tr>
<th>Age</th>
<th>Examples of children’s expressions of inner thoughts that may have a spiritual dimension</th>
<th>Key developmental stages (Erikson 1963, Piaget 1959)</th>
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<td>First year of life</td>
<td>It is difficult to identify the infant’s spiritual needs because of their limited ability to communicate on a linguistic level. However, positive experiences of love and affection, and a stimulating environment may foster aspects of spirituality such as hope and security in an infant (Bradford 1995).</td>
<td>A sense of trust can develop during infancy in response to feeling comfort and having basic needs met. A tentative link has been made between the support parents provide an infant and an ability to foster spiritual wellbeing.</td>
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<td>Late infancy and toddlerhood</td>
<td>A three-year-old was describing what happens when a person dies: ‘People who die go to prison’. This little boy was an avid watcher of the A-team, where lots of ‘bad guys’ were blown up as a matter of routine, and somehow end up in prison’ (Pfund 2000). The little boy’s brother was terminally ill.</td>
<td>This is a time when young children are fascinated with magic and mystery and may express themselves in elaborate thoughts. Children at this age may take meanings very literally. In this three-year-old’s example there appears to be a link between illness and death, with punishment and wrongdoing.</td>
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<td>Pre-school years</td>
<td>Jason, a four-year-old was in hospital: ‘Jason slept very little the night of his hospital admission. The nurse brought in his breakfast tray and set it on the bed-side table in front of him. Before anyone realised what was happening Jason pushed the tray of food off his table and onto the floor’ (Steen and Anderson 1995).</td>
<td>At this age the child experiences a challenging, widening social world where active, purposeful behaviour is needed to cope with these challenges. There may be link between Jason’s spiritual distress, fears and anxiety, which are being exhibited through disruptive behaviour.</td>
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<td>Junior school years</td>
<td>Jessica, a seven-year-old, told her nurse that: ‘She got cancer because she hit her brother. When the nurse explored this with her, Jessica stated that God was mad at her for being mean to her brother’ (Anderson and Steen 1995).</td>
<td>At this age the child develops a sense of responsibility. Jessica may be associating her illness with being irresponsible and the consequence is illness.</td>
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<td>Middle school years</td>
<td>Mary, a nine-year-old demonstrated mastery of knowledge: ‘I saw a neighbour, and he’d been in an accident, and he told my dad that he’d just as soon die later because of all the pain he has... the funny thing – our neighbour, he smiles, despite his troubles. He’s glad he can see the sun come up in the morning, my mom says. Today I saw the sun coming up, and I was glad, and I thought, I should be double glad, because I can see it, and I love the way the whole sky becomes lit up, presto, and I don’t have any pain’ (Coles 1990).</td>
<td>At this age the child develops initiative, bringing them into contact with a wealth of new experiences. This natural need for knowledge can be fostered and developed. Mary appears to be able to reflect on this knowledge and applies it to herself when considering her neighbour. In many ways this is powerful representation of self-awareness.</td>
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<td>Adolescence</td>
<td>John, a hospitalised 18-year-old, was dying of leukemia: ‘The first day that John’s nurse cared for him, she noticed how depressed and hopeless he seemed. During a quiet moment one afternoon, she asked John if he would like her to rub his back. John readily accepted and stated that she was the first person who had touched him since he had been in the hospital. John had been on the unit for one month and felt totally isolated from people. Through touch, the nurse reached out and comforted John’ (Anderson and Steen 1995).</td>
<td>Adolescents are faced with many new roles – romantic, vocational – which they need to explore in a healthy manner and should be neither pushed nor restricted. John appeared to have a need for contact with people. However this had not been recognised by the nursing staff.</td>
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spirtuality to the child and family, and beliefs relating to the role of spirituality in regaining health (Anderson and Steen 1995, Elkins and Cavendish 2004). The assessment can only be achieved if practitioners have an understanding of the complexities of spirituality, feel comfortable undertaking a spiritual assessment and are willing to listen and interpret the child and family's views (Elkins and Cavendish 2004). One of the difficulties in undertaking a spiritual assessment is a lack of examples of children's expressions of inner beliefs that may be suggestive of spiritual needs.

Developing a broader approach to understanding and meeting the spiritual needs of the child and family could be achieved by:

- Developing an understanding of the multifaceted nature of spirituality, through training and education (Seden 1998)
- Nurses being aware of their own beliefs and values (Elkins and Cavendish 2004)
- Ensuring a child-centred approach to care that enables children to express their beliefs (Seden 1998)
- Minimising separation or disruption to the child and family during periods of illness (Elkins and Cavendish 2004)
- Understanding that spirituality may or may not be expressed in religious beliefs (Seden 1998)
- Ensuring, where appropriate, that opportunities are available for spiritual or religious routines to be practised (Elkins and Cavendish 2004, Seden 1998).

Conclusion

There is a growing literature base suggesting spirituality and spiritual care are central to the delivery of holistic health care. However, it is doubtful that healthcare professionals consider the spiritual needs of children, the meaning of spirituality to children, its changing appreciation as the child develops and the effect of not considering this aspect of a child's needs. In general children have much more limited experiences compared with adults and their developmental stage may have a direct effect on the interpretation of their experiences. An understanding of the ways a child may express spiritual awareness gives the nurse the ability to recognise and therefore react to a child in distress. There is a pressing need for research to be conducted that captures the meaning of spirituality and spiritual care from the child's perspective, so that these are reflected in practice and education.

References


