Chapter 6

How religious communities can assist in addressing the needs of sick and hospitalised children

Annemarie E. Oberholzer

> The sky of childhood is so quickly clouded over by what adults see as trivia, that what lies deeper may never be noticed. They will get over it, we say, and regard as signs of immaturity the child's inability to react 'sensibly' to everyday problems and disappointments, as well perhaps as those profounder questionings that we are no better able to come to terms with than they are (more often we have just stopped trying). (Robinson, 1977:107)

Introduction

A visitor from the church came to see the six-year-old in the children's intensive care unit, and I gave them some space. It was an open-plan unit, and from where I was standing at the nurse's station, there was an unobstructed view of the scared little face of the child. The visitor was praying, but, as seen so many times in a paediatric unit, the wording of the prayer was aimed at the adults around the bed, causing nothing more than confusion and misconceptions in the mind of the child.

Down the corridor, a church had an outreach and volunteers were entertaining the children in the oncology ward. The same happened the previous day, when employees from a consulting company came to play with the children, and there was no way of telling the difference between the two events. The purpose of this chapter therefore is to equip theology students with practical strategies to become involved

in healthcare ministry and to effectively address the needs of sick and hospitalised children in religious communities.

Hence, the learning outcomes would be:

- Students will be able to understand the background and rationale for the adequate emotional and spiritual support of children in the South African healthcare context.
- Students will be able to advocate for a holistic approach to the care of sick and hospitalised children, taking into consideration their physical, intellectual, emotional, social, and spiritual needs.
- Students will be able to facilitate initiatives in religious communities so that they can become involved in addressing the spiritual needs of children in healthcare.

Background

In ancient times, spiritual and religious leaders were responsible for the health and well-being of the people. Since the early days of Christianity, Christians saw it as their calling to care for the sick, and after Christianity was legalised in 313 AD, Christians established the first hospitals in the Western world (Ferngren, 2009:86) – a tradition that has been carried over through the ages. However, as scientific knowledge increased, people became more confident in their abilities to cure illness, and less emphasis was placed on the spiritual, leading to negligence of the spiritual needs of all people in healthcare.

Our healthcare system is overwhelmed and tends to focus on saving lives and treating bodies – there is not much time, energy or resources left to address the emotional and spiritual needs of patients. Where children are concerned, the need for emotional and spiritual support becomes even more important, as any healthcare encounter holds the potential of overwhelming a child. Children seldom have the experience and knowledge to be able to understand the complexities of illness, pain, and suffering, as well as the healthcare

interventions intended to alleviate these. Misconceptions are rampant, adding more confusion to the mix.

In some countries, hospital chaplains are part of the healthcare system, but this is not the case in South Africa. De la Porte (2016:4) states that there is not even any 'statutory requirement or official system in place for accreditation and certification of spiritual and pastoral workers in healthcare'. Children receive even less support, and adequate emotional and spiritual support for children rarely happens in healthcare. And it is not just a local problem. Across the world and through the years, authors pointed out the lack of such support for children (Farrel et al., 2008:262; Feudtner et al., 2003:67 Nash, Darby & Nash 2015:13).

In a study to determine the different viewpoints on illness, pain, and suffering of the Christian churches in South Africa and the way these viewpoints are communicated to children, Oberholzer (2019:10) questions 'whether the church is in fact talking to children about this subject, or whether it is being left to the secular world and fantasy'.

This is an area where religious communities can and should be equipped to take on this responsibility.

Holistic care of sick and hospitalised children according to their needs

When supporting children in healthcare and during illness – whether minor ailments or chronic, and even life-threatening, conditions – it is important to focus on the child as a whole. In healthcare, a patient's admission always starts with a needs assessment, and this discussion will therefore centre around the needs of the child with regard to the physical, intellectual, emotional, social, and spiritual domains.

Children are often admitted to hospitals without parents, caregivers, or family members present and addressing the physical needs of a child can be a good starting point for religious communities to reach out and connect with a child.

Physical needs

This section discusses the various physical needs of sick and hospitalised children.

To be well nourished and protected from the elements

The high rates of poverty and unemployment in South Africa have a great impact on sick and hospitalised children. Not only are malnourished children, who must live in appalling conditions, more vulnerable and prone to getting ill, but when children are discharged from hospital or, for example, between cancer treatments, they need adequate food and protection to regain their strength. Religious communities can play a role in this regard and Beyers (2014:7) points out that our religion should motivate us to address poverty and restore human dignity, stating that 'religion not only becomes the moral consciousness reminding society of being generous to the poor but also seeing the poor as fellow human beings'. Ministering to sick and hospitalised children should therefore start with meeting their needs for food, clothing, and warm blankets.

To be touched, held and comforted

Clutter (2005:383) mentions that 'human touch can convey spiritual compassion in a way that words cannot'. In the earlier days, it was believed that a sterile environment where children were touched as little as possible, would prevent infections and contribute to children's speedy recovery. However, the death rate amongst children under the age of one remained high until Bakwin (1942) noted that when nurses were encouraged to pick up and cuddle these children, the mortality rate decreased significantly from more than 30% to less than 10%.

Unfortunately, the (real and legitimate) concern for inappropriate physical encounters with children led to the abstaining from any physical touch of children. However, children need reassuring physical touch to comfort them and help them to feel safe. Social touch (being touched effectively by someone else) is a vital aspect of childhood development and has been found to decrease stress, help children to feel

safe, and give them the courage to explore a new environment (Gliga et al., 2019). Even teenagers can benefit from being touched and Anderson and Steen (1995:15) mentioned that when someone offered to rub the back of a terminally ill 18-year-old, he commented that this 'was the first person who had touched him since he had been in the hospital'.

A little girl from a rural area in one of our neighbouring countries was once flown in – all by herself – to receive open heart surgery. With non-existing emotional support at the time, the experience was overwhelming for the five-year-old, and she withdrew in a dark cloud of depression, not talking and not reacting to anyone or anything. When I, at some point, approached her with a little bottle of body lotion and started to rub her arms and legs, her whole demeanour changed, and she suddenly started to talk and took notice of what was happening around her. This simple act of affective touch also started to influence her vital data and bodily functions and assisted her on her road to recovery.

Children should be empowered to have control and agency over their bodies. Always ask permission from the child and parents (if they are present) before touching that child and be mindful of cultural differences. Any touch that makes a child uncomfortable is regarded as inappropriate touch. While some might see it as affection to ruffle a child's hair, in another culture, it could be regarded as unacceptable and even rude to do this. If possible, it is safest to visit children in the hospital in pairs and to never close the door or bedside curtains when alone with a child.

To be able to play and be active

Play comes naturally to children, and they need to play as a way of coping, of expressing themselves, and of learning. In the healthcare setting, play also has added benefits as it allows children freedom of choice where they can manipulate objects and make their own choices in an environment where they usually don't have any say or control. If children play with a medical play set, they can become the doctor or nurse,

calling the shots (pun intended). Play is a great way to connect with children, and any visitor to a children's hospital ward should be equipped with some toys, books, and activities for the children. However, always ask about safety and infection precautions, and follow the guidelines of the hospital staff.

Clutter (2005:390) also refers to 'spiritual play' as a way of understanding the child and addressing the spiritual domain through the child's natural way of communication. This author further mentions the value of something like finger puppets, allowing children to communicate through the puppets. During a research study exploring the way that churches render spiritual support to children in hospitals, only one of the churches mentioned that they would give children a picture related to a Bible story to colour in (Oberholzer, 2018:234). According to Nash et al. (2015:22), it is important to include religious activities that can be meaningful to the sick child.

Through the Godly Play programme,[6] children can visualise the message of a Bible story and engage with the characters in a playful manner (Berryman 1991:xi). This approach is often used in hospitals in the US, and Farrel et al. (2008:261) explained that it had a 'significant effect on anxiety, depression, and spirituality' of chronically ill hospitalised children. It was also found useful to enable children with disabilities so that they can establish relationships and express spiritual concerns (Eddins et al., 2014:9).

To normalise the environment

Levine and Kline expressed the way children might react towards the hospital environment as follows:

6 Godly Play South Africa Facebook page: https://www.facebook.com/Godly-Play-South-Africa-437832309695128/. The Godly Play International Website: https://www.godlyplayfoundation.org/

> Without appropriate support, children do not have the inner resources to comprehend the blinding lights, physical restraints, surgical instruments, masked monsters speaking in garbled language, and drug-induced altered states of consciousness. Nor are they able to make sense of waking up alone in a recovery room to the eerie tomes of electronic equipment, the random visitations of strangers, and possibly moans of pain coming from a bed across the room. For infants and young children, events such as these can be as terrifying and traumatizing as being abducted and tortured by revolting alien giants. (Levine and Kline, 2007:184–185)

It is therefore vital to try and normalise the unfamiliar and scary healthcare environment for children as far as possible. Parents can be encouraged to bring the child's favourite toy and/or blanket from home, as this will help a child feel more at home in an unfamiliar environment. Bringing children some toys or a soft, colourful blanket that can stay with them, can also help – just remember to clear this with the staff.

A child's artwork can also help to brighten the walls around the bed. Pictures portraying the child's favourite Bible story, can remind him or her of the message and become an added source of comfort and support. We once had a volunteer who assisted some of the older children to paint a cross on a card with glo-in-the-dark paint. After lights out in the evening, the crosses became a visual reminder of the presence of God.

Music is another way of normalising the environment and supporting children in healthcare, especially if it is uplifting and familiar to the child. Children can even be included in making the music and singing along; however, it is important to first clarify this with the hospital staff and to keep sound levels at an acceptable level. Allen (2019:33–36) discusses the emotional impact of music, explaining that music holds religious or cultural meaning; it can assist with concentration; it is uplifting and has a strong emotional aspect that people find very rewarding; and it can

also improve emotional empathy. This author came to the following conclusion:

> If emotional experiences with music involve areas of the brain that are important for empathizing with other people, then perhaps the purpose of music is to arouse emotional responses that resonate with other minds. Music, then, is a social artefact for empathy (Allen, 2019:36).

Needs of the mind (intellect and emotion)

This section discusses various intellectual and emotional needs of sick and hospitalised children.

To understand what is happening

Children are often traumatised more by what they think is happening to them, than by what is actually happening. It is difficult for children to understand the abstract concepts of illness and pain, and in our healthcare system, they typically don't have any say in what is happening to them and their bodies. Children usually see any pain or suffering as punishment for something they did wrong, and the limited life experience of children could further lead to a variety of misconceptions in the hospital. Aside from the misconceptions that children may have, there is also a very real threat to their bodies when they are faced with intrusive and often painful medical procedures. It is a protective instinct to fear mutilation of the body, and when children are exposed to these procedures without adequate preparation and support, they could develop phobias that might have an impact on their lives for many years to come. When children are prepared for a healthcare experience such as an operation, they tend to react with trust and confidence, but if they don't understand what is happening, they react with fear (Lööf et al., 2019:1370).

Because of the magical thinking of children in the pre-school years, they have numerous fears that can be challenged in the hospital and that could lead to misconceptions. I once came across a boy who developed an abnormal fear that his ears would be cut off. Upon closer examination, we discovered

that someone once made a thoughtless remark, telling him that if he didn't want to listen, his ears could just as well be cut off. Unfortunately, this little boy had to be admitted to the hospital repeatedly for several operations to correct a defect that he was born with, and he was living in constant fear that the next time he went to the theatre, he would come out without his ears.

School-age children with their increased cognitive abilities are more aware of the extent of their treatment, and it is easier to explain medical diagnoses and treatment to them. However, they are still prone to misconceptions. I had to prepare an eight-year-old girl for an operation that involved a biopsy of a gland in her neck. She appeared terrified and when I started to talk to her, I realised that she thought the doctors were going to slash open her throat and leave it that way. I couldn't determine the exact cause of her misunderstanding, but comic books, television programmes and computer games could contribute to such detrimental thoughts. Siblings, classmates and even parents often made jokes and teasing remarks, creating unnecessary anxiety and fear.

Religious teachings could also contribute to misconceptions. When a doctor showed a little child an X-ray of her chest, explaining where her heart was, the last thing the doctor intended was to cause a spiritual crisis for the child. But that was exactly what happened when the child couldn't see Jesus inside her heart as she was taught in church.

Remember that children are not capable of abstract thought, and it is important to use pictures or other concrete examples when communicating with children or preparing them for healthcare experiences. Children will form images in their minds about what you tell them, so it is important to 'manipulate' these images through your words.

When interacting with children, always look for any odd behaviour or listen for any statements that don't make sense. Clarify this with the child by asking them what they think is going to happen and why, and if you detect any

misconceptions, don't overreact, but gently discuss it with the child.

To give expression of their emotions

Children can experience a range of negative emotions, including feelings of anger that can be directed towards the medical staff, parents or even God. They often hold themselves responsible for their illness and tend to regard the treatment as punishment for some wrongdoing. Even school-age children might blame the medical staff for their pain and suffering; however, they would seldom express any anger towards the adults as they could regard the open expression of anger as wrong and possibly leading to further pain and suffering.

Intense and overwhelming emotions could result in regression and developmental delays. Levine and Kline (2007:114) caution against suppressing emotions:

> The body simply cannot contain the energy and – like a rainstorm breaching the banks of a river, or a bathtub tap that's been turned on and left unattended – an emotional flood spills its contents outside the container of the body. Those unable to modulate affect, whether it's a two-year-old's tantrum or an adult's rage, a literally 'beside themselves' rather than 'inside themselves'.

Being active and able to run around can help children to give expression to their feelings, but that is not always possible in hospitals. Visitors can therefore help children in other creative ways, such as playing with playdough or drawing pictures. When asked to draw pictures of their doctors, a ten-year-old boy once drew a red devil-like figure, complete with horns and a tail, but also with a stethoscope around his neck. Although never acting out or voicing his feelings in any other way, this was his way of expressing the feelings of anger and resentment that he had towards his treating doctor.

Social needs

This section discusses the various social needs of sick and hospitalised children.

To receive support from family and friends

Darby et al. (2014:34) concluded that the presence of the family of children with cancer provides much-needed reassurance for the young patients. However, children would usually look at the reactions of the adults around them as part of their appraisal of a situation. If the adults are calm and coping, children tend to assess the situation as less threatening than they would if the adults are anxious and not coping. If a situation causes discomfort or anxiety for an adult, children tend to pick it up very quickly and would often try to comfort the adult through comforting gestures, being extra good or avoiding the topic. If they can get the adult to feel better about the situation, the child will feel better as well.

When children are diagnosed with an illness, whether it requires a short stay in hospital or whether it is chronic and/or life-threatening, it requires an adjustment from everyone in the household. Someone once said that you can't have a funeral for normal. The life that was regarded as normal no longer exists, and families find it difficult to juggle all the priorities in life together with the extra demands of having to take care of a sick child. It is therefore vital to support parents, caregivers, and significant others and to empower them so that they can support the child more efficiently, and religious communities can play a critical role in this regard. Unfortunately, support from religious communities often stops here, focusing on the adults without reaching out to the child as well.

For school-age children, their peers start to play an important role in their lives, and they tend to base their self-esteem on the way others react towards them. It could, therefore, be detrimental to the self-esteem and social interaction of these children if friends start to treat them differently or make remarks about physical changes such as scars, hair loss, amputations, skeletal abnormalities and/

or weight gain or loss. Because relationships with friends are important, long periods of hospitalisation and/or a change or restriction on the social life of these children could put pressure on social relationships and lead to social isolation. It is therefore important to provide school-age children, suffering from a chronic condition, with the necessary information and skills so that they can explain their illness to their peers.

Siblings play an important role in the lives of children and they tend to rely a lot on their siblings for companionship, emotional support and help with their daily activities. It follows that support from the family should also include support for the siblings of the sick child.

To experience love and companionship

If you want to form a trusting relationship with children, start by checking your motives. Children are very perceptive, and if you don't want to be with them, they are quick to pick it up. However, if you see children as valuable and significant, and if you know that they are precious in the eyes of God, you are already halfway to forming a meaningful relationship with a child. Children are quickly drawn to people through small acts of kindness. When young children with cancer were asked 'What gave you strength?', the support from others topped the list as children referred to someone sitting with them, holding their hand, or saying a prayer (Nash et al., 2015:149).

Chapman and Campbell (2012:23) explained that we can truly meet a child's need for love by addressing the five love languages of children: tender touch; supporting words; quality time; gifts; and acts of service. As we've addressed the need to be touched, held, and comforted above, let's look at the rest and how we can communicate love to sick and hospitalised children.

Supporting words

Words have so much power, and we should use them wisely. If we pity, overly reassure children, or diminish what they are

going through, it does not help at all. Children need to know that they are successful in what they are doing. Pointing out things that they did well while acknowledging the difficult situation they find themselves in can help them cope better in future. Giving children who can read a certificate of bravery can further drive home the fact that they did a great job of coping with a stressful situation.

Quality time

Taking the time to be with a child and to do something meaningful with him or her makes them feel special and loved. A five-year-old who was admitted to the hospital described her time in the hospital as follows: '[T]hey looked at my ears, they looked at my throat, they looked at my tummy, but they didn't look at *me*' (Jolly 1981:9). Spending quality time with a child starts by sitting down so that you can be at the same eye-level as the child to make eye contact, even if it means that you have to sit on the floor. Listen to children. You will be surprised at how much we can learn from them when we listen to what they have to say.

Gifts

Children love receiving gifts, and if the gift can carry a message, such as a booklet with a colourful Bible story, it can help them feel special and cared for. The child can even help to make the gift, such as the glo-in-the-dark crosses mentioned earlier.

Acts of service

Parents, families and even the staff tend to pity sick children and often do too much for these children. Children must be able to continue doing for themselves what they can so that they can be empowered, and their self-esteem boosted. However, sometimes children need help with a difficult task, such as with schoolwork, and assisting them can communicate love and support – but always ask first. It can also be meaningful for the sick child when the other children from the children's church or Sunday school class design and make get-well cards,

as it communicates to the child that others are willing to go the extra mile to encourage him.

Spiritual needs

Children intuitively know that they need spiritual support. When treated in the hospital for cancer, children in a research study were asked to rate 19 resources according to their importance for the child. First, they need their parents to be with them, and they need their siblings and friends. But before they want their pain assessed, being able to play or watch television, they expressed the need for religious engagement as a fourth priority (Oberholzer et al., 2011).

Children's spiritual perception of illness, pain and suffering can greatly impact their experience in hospital and during illness. Clutter (2005:368) mentions that children often have a distorted view of God that can negatively impact their road to recovery. Keep in mind that children might have encountered different viewpoints from teachers, other children at school, social media or from television programmes, and do not assume that a child will have the same beliefs as you. It can therefore be helpful to start a discussion by asking children about their spiritual experience and how they see God. Even if you know the child well, do not assume that you know how the child relates to God. Listen carefully to what a child is telling you, and never judge or make fun of the child's answers.

Clutter (2005:364) mentions a list of symptoms that could indicate spiritual distress in children. These are anger or resistant behaviour; resentment; exaggerated fear; self-blame; questions about meaning and purpose; crying; nightmares; asking numerous or repeated questions; and regressive behaviour.

However, children don't often express their spiritual distress in an observable way. One way of getting children to talk is by asking them to draw a picture of God and encourage them to tell you more about the picture. Robert et al. (2019:7) conducted a literature review and referenced thirty-nine

studies 'that used a wide range of scales and tools to assess facets of spirituality'. They also referred to a study by Sposito et al. (2015), who incorporated the child's handcrafted puppet through which the child could communicate.

The questions posed by Anderson and Steen (1995:5) cover three areas of spiritual concerns that children may have when in hospital and have been used widely in healthcare. If you want to use specific questions such as these, remember to keep the conversation light so that the child doesn't feel like he or she is being interrogated.

- **Concept of God** – asking questions such as: 'Have you thought about God during this time?'; 'What is God like?'; 'Do you believe God causes...?'; 'Do you have a favourite Bible story or character?; and 'What do you like about this story?'.
- **Sources of strength and hope** – asking about the emotions children might experience and the support they have such as: 'Who do you tell when you feel afraid (or sad, scared, alone, happy)?'; and 'What helps you feel better?'.
- **Faith practices** – asking about the practices and rituals that can help the child feel closer to God.

The following sections consider a few important spiritual needs a child may have.

To have a relationship with God

James W. Fowler (1940–2015) proposed a framework with stages for the development of faith to illustrate how we understand God and how a belief in God will impact our values and beliefs (Fowler, 1991:17–18; Fowler & Dell, 2006:34–45). This framework has been greatly influenced by the stages proposed by Jean Piaget for cognitive development. Note that these stages are focused on the development of faith, which is different from spirituality. We cannot grade into stages the intimate relationship with and experience of God that children can have. Cognitive development is irrelevant when

considering the spiritual experience that children can have with God, without having a theological understanding of Him.

However, children's ability to have any spiritual experiences is often questioned. During a debate on religious education in the 1960s in Great Britain, Ronald Goldman was influential in arguing that children are not yet ready for religious teaching. He also claims that it is only from the age of 12 that children have developed the 'ability to conceive God in symbolic, abstract and spiritualised ideas' (Goldman, 1964:239, 1965).

In a research study that was done in the 1970s (Robinson, 1977), people were asked to write about their personal experiences with regard to God or a power greater than themselves and the impact this had had on their lives. Several people spontaneously related to meaningful experiences they had in childhood. Although this was not a Christian study as such, what was noteworthy about these stories, was that several participants mentioned a significant difference between how they experienced God, and what they were taught in school and church. Children can have a profound experience of God, and we can learn so much by giving children the space to share their experiences with us, without judging them according to what we think is the 'right way' to relate to God.

Children don't have to understand everything about religion. However, their concept of God will influence their relationship with God, and because children often harbour misconceptions about God, it is important to guide their religious and spiritual experiences to ensure that they have a realistic view of God and their relationship with Him. The child's concept of God will also influence experiences of illness, pain and suffering, and misconceptions are common. The following is a quote from one of the participants in the research study mentioned earlier:

> I was influenced by religion to think of God as an awful parent, looking constantly to see what I was doing and condemning it anyway. 'The eyes of the Lord are in every place, beholding the evil and the good'. Since I expected

> constantly to be punished for my sins, I can't think how I ever got the idea that God had enough love in Him to help when I asked. As I usually had only God to talk to when troubled, I must have picked up an idea from somewhere that He would help me. Perhaps that idea is in all of us, without having to be implanted. (Robinson, 1977:100)

Because children are concrete thinkers, religious practices, rituals, and symbols can be meaningful to them and help them to connect with God. When asked what they did to feel closer to God, children with cancer mentioned the following: prayer/talking to God (64%); going to church (17%); other religious or spiritual acts (7%); reading Bible/devotions (7%). Five percent did nothing to feel closer to God (Kamper et al., 2010:304).

God created all people, including children, with the same spiritual needs and deep longing so that we can seek Him. Religious beliefs and rituals are meant to assist in connecting with God, but so often we tend to concentrate only on the rituals and the differences in our beliefs, that we lose focus of the bigger picture: the importance of connecting with a loving God.

To seek for meaning and purpose

In the beginning of his book, *Medicine and Health Care in Early Christianity*, Ferngren (2009) wrote: 'The purpose of medicine is to relieve suffering; of religion to explain suffering or to help us accept it'. Children also need to search for answers to certain life questions, such as the meaning of suffering when it seems as if nothing is going according to God's promises. Viktor Frankl (1984:98) well-known as a Holocaust survivor, cautioned that 'questions about the meaning of life can never be answered by sweeping statements,' and nowhere is it truer than when talking to children. Adults want to protect children from the harsh realities of life and often opt for quick and easy answers to set a child's mind at ease. However, children should be encouraged to reflect on the difficult issues in life. Eaude (2009:190) explains that 'in failing to help children recognise that some questions do not have easy or definite answers, we

may discourage them from continuing to ask such questions'. If we listen to children, we will not only learn a lot about them, but you might be surprised to realise how much you might learn from them.

Nash et al. (2015: 25) explained that it could be meaningful for children to reflect on any positive and enriching aspects of the illness experience without disregarding the negative, and to explore 'both the light and dark within the hospital experience'. Helping children to identify and strengthen sources of support would not only benefit them in their current situation but could also assist in building resilience and help them overcome other challenges in the future.

To address guilt and sanctification

Children tend to see any pain or suffering as punishment for something they did wrong. I always casually reminded children that the illness or operation they were facing was not because they did something wrong, and often, you could see the relief on their faces as they believed that they were to blame.

Sometimes, whether intentional or not, children's behaviour could cause something bad to happen. It is not likely that children will mention this to anyone without being prompted, and adults are often hesitant to bring up the subject because they don't want to implicate the child. However, if children can feel guilty when they didn't do anything wrong, they are likely clouded in guilt and shame and compelled to carry this load on their own. If it was an accident, it should be explained to the child and if needed, children should be carefully guided to ask for and receive forgiveness from others as well as from God and to forgive themselves, as forgiveness is an important aspect of coping in children. Clutter (2005:389) explains the importance of forgiveness for children's well-being and adds that it can be powerful for children to experience forgiveness.

As mentioned above, children could have feelings of anger and resentment towards the healthcare staff, but they

will usually be very hesitant to reveal these feelings for fear of more punishment. These feelings are usually because of misconceptions and should be carefully explored and the intentions of the healthcare staff should be explained.

If children know that they didn't do anything wrong and that the staff will help and take care of them, it could also enable them to experience the goodness of God and the love of others in a difficult situation.

To find comfort and hope in biblical truths

Children are inclined to gravitate towards hope, and Yust (2004:18) concludes that children tend to 'dwell in states of hopefulness and imaginative possibilities'. Clutter (2005:387) explains that hope can contribute to healing and general well-being and prevent feelings of despair. Koenig (2012:4) agrees, pointing out that several studies showed a positive relationship between health and the degree of hope.

Bible stories emphasising comfort and hope should therefore form part of the spiritual support of children in healthcare. A colour-in picture on a postcard or bookmark can serve to remind children of the biblical truth discussed. It could even be beneficial to develop a small pocket-size booklet with Bible lessons that can be distributed to children during hospital visits. In a research study on the spiritual needs of young people with cancer, Darby et al. (2014:35) concluded that religious faith resulted in 'hope, resilience and a sense of connection with others and community'.

Knoetze (2015:6) urges religious communities to help children understand that God is involved in their lives in the same way He was involved in the lives of the characters they read about in the Bible. This author further explains:

> The goal of spiritual transformation is not to 'solve' everything. Spiritual transformation is effective to the degree that African children and youth, through spiritual interactions with the living God of the Bible, are in a better position to manage their life situations

> through participating in the use of spiritual resources and opportunities (the Bible and faith community) to live their lives more effectively. (Knoetze, 2015:7)

Conclusion

Clutter (2005:352) compares the spiritual support of children in healthcare with politics and states that the best strategy is usually regarded as 'the less said the better'. However, this strategy is often chosen due to a lack of knowledge and feelings of incompetence from the adults surrounding sick and hospitalised children. Religious communities can and should play a bigger role in the spiritual support of children in healthcare, and more focus should be placed on educating and equipping people to take on the important task of effectively ministering to and supporting sick and hospitalised children.

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