



Affirming Childhood Spirituality of Hospitalized Immigrant Children

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On several occasions my fellow European hospital chaplains have invited me to visit African patients, more especially hospitalized children. The purpose of such invitations is to facilitate the patient's openness and comfortability since I am an African just as the patient is. While there maybe advantages in such practices, the African patient is robbed of a new European spiritual relational experience. Children are open to new experiences and new relationships even in a hospital care environment. Therefore denying them new cultural and relational experiences may inhibit both spiritual development and cultural skill building opportunities .

Pastoral care to children in hospitals may take two approaches. Spiritual care providers may employ predefined methods based on what they deem to be spiritually viable and appropriate for the hospitalized children or the other approach in which children are taken seriously as spiritual persons with valid problems and spiritual potentials. This first approach may find its basis in taking children as immature people who have to be grafted into adulthood by experienced people or as little innocents who have to be protected from the leaven of this sinful world. The pastoral care provider is concerned with protecting the vulnerability of the child in the whole process of care. In light of that goal, the pastoral care provider joins forces with *loving* parents and other care providers in shielding the child from experiencing the reality of suffering, illness and the isolation of hospitalization. Consequently, the reality of sickness is watered down with half-truths, pain is candy-coated and deep theological questions from the child that arise from hospitalization are often stifled. All these are done not for the wellbeing of the child, but for the sake of the adults relief from their stinging realities of the child's pain and suffering.

The second approach is composed of care providers who take children seriously as spiritual subjects who are able to relate to God in their own way. The responsibility of the pastoral care provider in this second category is to affirm and support the child in his or her problems and tap into childhood spiritual potentials to enhance spiritual growth.

It is from the second approach that I affirm 1.) the importance of listening to children's voices in care and 2.) the need for pastoral care providers to remain consciously in the periphery allowing the God-child relationship to take center stage. Additionally, I suggest taking the

hospital as an environment for spiritual growth (*atrium*) and the role of the pastoral care provider as an aide rather than a source in affirming childhood spirituality. The aim of this article is to present a model of pediatric best practices for spiritual care of hospitalized children who find themselves hospitalized as expatriate for different and varied reasons.

This article begins with theories on childhood faith development, models of children's spirituality, children's coping and their resilience. From a pastoral theological point of view, it then highlights sources that prove that childhood spirituality is a major resource in care of immigrant children who are undergoing isolation and pain due to illness and hospitalization. This theoretical component is followed by pastoral care best practice recommendations for such immigrant children. These practices are aimed at affirming children's unique, age appropriate spirituality in a multiculturally diverse hospital setting with respect to children's dignity, spontaneity and creativity. Lastly, it defines the best role of the pastoral care provider in the whole process of care. These themes are discussed in the context of pastoral theology from the Christian tradition drawing its inspiration from developmental psychology, sociology and pediatric care disciplines.

Vulnerability of an Immigrant Hospitalized Child

High income countries (HICs) have become targets of hope for a better life and hope which leads to immigration. Some examples of HICs include Australia, France, Germany, Italy, Netherlands, United States of America, Switzerland and United Kingdom¹ among others.

¹ UNICEF records a great percentage of immigration into these countries among others in Asia. Innocenti Insight, "Children in Immigrant Families in Eight Affluent Countries," *UNICEF* (2009): 2–3, www.unicef-irc.org/publications.

Hospitalized immigrant children who have travelled to HIC's with their parents from developing countries such as Africa, Central America, and Eastern Europe are the focus of this article.. This contribution will cover the spiritual needs and best practices for hospitalized children who find themselves surrounded by staff and volunteers who are predominantly foreign to their own cultural identity and/ or language.

Globalization has posed opportunities and challenges to communities that are willing to accommodate others such as immigrants. The phenomenon of migration in western countries has brought about shifts in society and a considerable strain on social amenities, especially health care delivery.² The question of migration in itself has been a social problem throughout history, as locals hold onto their resources more closely and deny outsiders even human basics. These actions by locals make immigrants more vulnerable.³ In its policy statement, the Committee on Community Health Services in America⁴ lists some of the problems that children share with their immigrant parents. This committee observes psychological problems such as depression, grief, and anxiety caused by relocation coupled with trauma if their place of origin was plagued with violence. Social problems such as difficulties in communication due to language difference, and separation from their traditional support group, alienate them further from the hosting nation. Helplessness due to poverty adds to this vulnerability in many cases.

² C Saulina, L Vall-Ilosera, and M Saez, "A qualitative Analysis of Immigrant Population Health Practices in the Girona Healthcare Region," *BMC Public Health* 10, no. 379 (June 2010): 2–11.

³ David H. Jensen, *Graced Vulnerability* (Cleveland. OH: The Pilgrim Press, 2005), 17.

⁴ Committee on Community Health Services, "Providing Care For Immigrant, Homeless, and Migrant Children," *Pediatrics* 115, no. 4 (April 1, 2005): 1095–1100.

There are many and various reasons why immigrant children may be hospitalized. The reasons can be positive or negative. Children are being hospitalized because of physical or psychological harm due to child trafficking, child prostitution, or from injuries from home violence. On a positive note, children may find themselves in hospitals away from their own home countries to access advanced care that they cannot get in their own countries of origin. Hospitalization and isolation from the child's usual environment become a spiritual stressor on the lives of the hospitalized children. This is evidenced in deep spiritual questions such children ask in care.

Spiritual stressors may be exacerbated by several physical factors. Children may stay a long time in foreign health facilities due to difficulties in diagnosis and treatment of diseases that would be easily recognized in their own home countries but are non-existent or rare in the new localities. This long hospitalization leads to distress in the child. Late medical attention due to negligence may lead to serious illness that shakes the child's spiritual wellbeing. This negligence often results from illegal immigrant parents who may delay taking their child to the hospital and go only as a last resort for fear of arrests and deportation, or due to shame and fear of prosecution if their child is a victim of home violence in which the parents themselves are involved. Other immigrant parents may neglect children's sickness because they are busy with two or more jobs they have taken up to make more money.

Therefore, the case of the hospitalized immigrant children is much more complex since it involves a multiplicity of factors before and during care. During the hospitalization itself, these children of foreign origin, whether documented or undocumented, find themselves isolated and

surrounded by local children and hospital staff who may be very different from themselves.

These new neighbors may have different ethnicity, culture, race and language from their own.⁵

The label ‘illegal immigrant’ can also be detrimental to children’s dignity in many parts of the world.⁶ The very use of the term ‘illegal immigrants’ in reference to people, especially children, who have entered a country without following procedures is found wanting.

Paspalanova argues that the use of the term ‘illegal immigrant’ merely labels subjects and criminalizes their presence in a foreign land⁷.

This label also creates resentment and rejection from locals⁸. In reference to children, the use of the label is against the rights of children and young people as the term is derogatory and prejudicial⁹ and given in a situation that they have no control over as they are minors and must accompany their parents. The right to access healthcare and equal treatment is uncontested in the west for immigrant children.¹⁰ Hospitalization of the child would therefore call for more protection from such a damaging label.

⁵ Marshall et al., “Ethical Issues in Immigrant Health Care and Clinical Research,” 203–226.

⁶ In places like United States of America this label ‘illegal immigrant’ is a politically incorrect term. After the arguments given below, I will refrain from using the label. The preferred term will be ‘undocumented persons’.

⁷ Mila Paspalanova, “Undocumented and legal Eastern European immigrants in Brussels” (dissertation, Leuven: K.U.Leuven. Faculteit Sociale Wetenschappen, 2006).

⁸ Maria Margaronis, “Europe’s Unwelcome Guests: Resentment Against Immigrants, Even Those Seeking Asylum is at the Boil,” *The Nation* 274, no. 20 (2002): 14–20.

⁹ “Convention on the Rights of the Child” (Office of the United Nations High Commissioner for Human Rights, 1990), Article 40:2, <http://www2.ohchr.org/english/law/crc.htm> (accessed November 17, 2012).

¹⁰ Mónica Ruiz-Casares et al., “Right and access to healthcare for undocumented children: Addressing the gap between international conventions and disparate implementations in North America and Europe,” *Social Science & Medicine* 70, no. 2 (January 2010): 329–336.

While we appreciate initiatives in which specialized infrastructures are put up for use by people that do not belong to the local populace and special care approaches employed at their service, with Jensen we fault care practices that look like welcoming others but in fact “... smothers the particularity of other names.”¹¹ A spontaneous reaction by a pastoral care provider faced with an immigrant hospitalized child may be to protect the child from further harm. This may include creating an environment that no longer exposes the child to further stressors, provision of material or spiritual resources that the pastoral care provider deems are useful to make the child comfortable and finding people who can communicate with the child in a language the child is comfortable with. These interventions can be of importance to the child, yet they are half of the required holistic pastoral care of the immigrant child. These protective practices and methods are only designed to shield the child. The undesired consequence is that it is a means of protecting the child that excludes that child from experiencing local cultural diversity. They keep the child’s old experience apart from the new, instead of initiating a dialogue between the two experiences. Presupposing the needs of the child may lead to prioritization of the pastoral care provider’s own aspirations and incorrect reading of the voice of the child in care. Jensen warns of projections due to preconceived ideas that are furnished by “... violence that characterized the (post)modern world. Attempting to hear them is fraught with peril: often we think we hear their voices when we really are hearing only ourselves and *our intentions* for the children.”¹²

¹¹ Jensen, *Graced Vulnerability*, 132.

¹² Jensen, *Graced Vulnerability*, xiii (author’s emphasis).

Under this protective pastoral approach the child remains in the comfort of the old experience while in reality, the child is exposed to the new experience of illness, hospitalization and isolation. The child is shielded from coming to terms with the new experience and the use of the capabilities that are innate in childhood development. It is not therefore the intention of this contribution to romanticize or denigrate these stressors. These crisis elements are transient; the child has to move on. I recognize the fact that the child is fully present as a subject who has potential to grow into the future using the present negative experience. From the child's worst-case scenario, we may build on the child's internal spiritual resources, affirm the child and offer an environment conducive to growth. This contribution neither exaggerates childhood capabilities of coping, in order to perpetuate violence on children nor discourages care providers from protecting vulnerable children. It is the moral duty of each person to fight injustices and protect the vulnerable and the powerless, especially children. Bunge draws various examples from scriptures and different Christian traditions that stood for the rights of children and call for the protection of children.¹³

From the above mentioned observations, we can learn that the vulnerability of immigrant hospitalized children is multi-layered and touches on almost all corners of the child's social, psychological, spiritual and physical wellbeing. There is therefore a need to review existing practices and initiate changes that accommodate this new challenge in the health sector. Loue acknowledges that in order to meet this challenge in its entirety, we need a multidisciplinary

¹³ Marcia J. Bunge, "Historical Perspectives on Children in the Church: Resources for Spiritual Formation and a theology of Childhood Today," in *Children's Spirituality: Christian Perspectives, Research and Applications*, ed. Donald Ratcliff (Eugene, OR: Cascade Books, 2004), 50.

approach¹⁴. Deeper understanding of language, cultural norms and beliefs of the immigrant are among the three fundamental areas needed in health work in resolving this challenge¹⁵. Four tools may aid a pastoral care giver in practice. The first is to put the child and God at the center of care. Secondly, the pastoral care provider is to remain vigilant to the grace of God which is active among the weak in the process. Thirdly, I suggest the affirmation of the childhood spiritual capabilities and lastly I call upon the pastoral care provider to be creative enough in transforming the pediatric ward in cooperation with other care providers and hospital designers into an avenue that leads the child back into society with hope and a renewed awareness.

Child Centered Pastoral Care for Hospitalized Immigrant Children

During critical times such as illness and isolation, the potential of children for reflecting on what is happening to them is of vital importance. Children look for reasons for their suffering. They utilize spiritual resources they have acquired to find meaning in the problems at hand¹⁶. This unalienable relationship between spirituality and reality in moments of crisis defines how children deal with illness. Research has shown how spirituality in children has been reflected in

¹⁴ Sana Loue, *Handbook of Immigrant Health*, Illustrated (New York & London: Plenum Press, 1998).

¹⁵ Patricia Marshall et al., "Ethical Issues in Immigrant Health Care and Clinical Research," in *Handbook of Immigrant Health*, ed. Sana Loue (New York & London: Plenum Press, 1998), 203–226.

¹⁶ Robert Coles, *The spiritual life of children*, A Peter Davison book (Boston, MA: Houghton Mifflin, 1990), 100.

how children cope with and process different kinds of diseases¹⁷. Coping in children will not be discussed thoroughly in this paper but its elements are clearly visible since they are linked to how children process stressors such as illness and hospitalization.

Taking children seriously as active spiritual subjects has also taken childhood studies by storm¹⁸. Scholars have explored the spiritual care needs of hospitalized children¹⁹. Immigrant and undocumented children have also been featured in a variety of studies²⁰. In line with this study,

¹⁷ Pendleton *et al.* illustrate coping in children with cystic fibrosis. Sara M. Pendleton *et al.*, “Religious/Spiritual Coping in Childhood Cystic Fibrosis: A Qualitative Study,” *Pediatrics* 109, no. 1 (January 1, 2002): 1–13. Spilka *et al.* demonstrate these childhood capabilities in children with cancer. Bernard Spilka, William J. Zwartjes, and Georgia M. Zwartjes, “The role of religion in coping with childhood cancer,” *Pastoral Psychology* 39, no. 5 (May 1, 1991): 295–304. In children having problems with mental health are studies by Wilson. William P. Wilson, “Religion and Psychoses,” in *Handbook of Religion and Mental Health*, ed. Harold G. Koenig (Orlando, FL: Elsevier, 1998), 161–174.

¹⁸ Don Browning and Bonnie Miller-McLemore, eds., *Children and childhood in American religions.*, vol. 233, VIII., The Rutgers series in childhood studies (New Brunswick, NJ: Rutgers University Press, 2009).; Jerome W. Berryman, *Children and the theologians : clearing the way for grace* (New York: Morehouse Pub., 2009). ; A. Dillen and D. Pollefeyt, *Children’s voices: children’s perspectives in ethics, theology and religious education*, Bibliotheca Ephemeridum theologicarum Lovaniensium (Leuven: Peeters, 2010). From children voices in schools, Thoillez takes a practical view and uses the voices of children to find out what makes them happy and live fulfilled lives. Bianca Thoilliez, “How to Grow up Happy: An Exploratory Study on the Meaning of Happiness from Children’s Voices,” *Child Indicators Research* 4, no. 2 (2011): 323–351.

¹⁹ Feudtner *et al.* calls for sensitivity by pediatric care providers to the spiritual needs of children and their parents. Chris Feudtner, Jeff Haney, and Martha A. Dimmers, “Spiritual Care Needs of Hospitalized Children and Their Families: A National Survey of Pastoral Care Providers’ Perceptions,” *Pediatrics* 111, no. 1 (January 1, 2003): e67–e72.

²⁰ Saulina *et al.* find out the importance of considering the beliefs and attitudes to sickness among hospitalized immigrants from Morocco and the Sub Sahara. Saulina, Vall-Ilosera, and Saez, “A qualitative Analysis of Immigrant Population Health Practices in the Girona Healthcare Region,” 2–11. Ruiz-Casarea *et al.* discuss how worrisome the differences in provision of healthcare the undocumented in Europe and North America due to strict measures taken in immigration policies, contrary to international human rights laws. Ruiz-Casares *et al.*, “Right and access to healthcare for undocumented children: Addressing the gap between international conventions and disparate implementations in North America and Europe.” And from ethical point of view see, Janine Young, Glenn Flores, and Stephen Berman, “Providing Life-Saving Health Care to Undocumented Children: Controversies and Ethical Issues,” *Pediatrics* 114, no. 5 (November 1, 2004): 1316–1320.

voices of refugee children with trauma have also been studied.²¹ Drawing conclusions from these studies pastoral theologians have made recommendations on how pediatricians can incorporate the spiritual values of children in their work²². Unfortunately, most of this material on hospitalized and/or immigrant children is on policies in medical care. They treat the hospitalized child as a victim who has to be cared for yet children or not mere receptors of pastoral care predetermined interventions. They have spiritual resources and capabilities to contribute positively to the process. I therefore recommend a child-centered approach that acknowledges the present negative experience of the child, the child's spiritual capabilities, and the responsibility of the pastoral care provider as a prudent guide to the child in care.

Graced Vulnerability

David Jensen, in his contribution towards a theology of childhood, comes up with the term “graced vulnerability,” as a theological explanation that calls for a deeper reflection on how God uses what seems weak to show his God-self in relation to humanity. He argues that “God chooses the difference of a human being for intimate relationship [since] divine life seeks otherness.”²³ Throughout his discussion he cites different biblical narratives that reveal God's power through what is considered demeaning to humans. He crowns his contribution with an

²¹ Atia Daud, Britt af Klinteberg, and Per-Anders Rydelius, “Resilience and vulnerability among refugee children of traumatized and non-traumatized parents,” *Child and Adolescent Psychiatry and Mental Health* 2, no. 1 (December 1, 2008): 1–11.

²² B Davies et al., “Addressing spirituality in pediatric hospice and palliative care.,” *Journal of palliative care* 18, no. 1 (2002): 59–67.

²³ Jensen, *Graced Vulnerability*, 20.

invitation for theologians to look at childhood, which is considered inferior, as a rich resource into God's ways of relating with humanity.

Focusing on hospitalized immigrant children, it is not only childhood that vilifies children. The present negative experience is itself vilifying as discussed above. Without any recourse to pre-empt the importance of the future, childhood spirituality places so much importance on the experience of the present. The present has to be lived to the full. Any attempt to rob children of their present moment and shift them as people of the future does not only violate their childhood experience but also "disrupt ... [their] spontaneity and surprise ..."²⁴. While we recognize attempts by a pastoral care provider to create a familiar atmosphere for the child by employing all the cultural and linguistic instruments as they enhance communication avenues between the pastoral care provider and the child, these attempts should not inhibit the child from coming to terms with the reality at hand. This approach is merely problem focused and leaves out the child as an important partner in care.

The Child is Vulnerable Yet Capable

On children's pastoral care, Dillen faults problem centered approaches that were predominant in the 1980's. She argues that mere concentration on problems faced by children undergoing stressors impedes "re-active and pro-active" potentials within the child's own positive aptitude which enable them to deal with the existing problems and other similar

²⁴ Ibid., 121.

problems in future²⁵. This contribution relies on taking children seriously as subjects with a potential to contribute positively to their growth. Children are subjects of their own experiences and no other person can claim to have a full knowledge of what they are going through or claim to have a language to express it. Studies have shown that,

... children understand their well-being as complex and multi-faceted, that ... [their] perspectives validate and confirm existing measures of well-being but also extend and challenge these understandings by giving new meaning to issues already in our focus and by drawing our attention to issues that are currently not receiving attention.²⁶

This awareness is a major building block in the healthy development of resilience as it fully takes into account the present crisis moment and opens to the future. This new understanding of children is not confined to individual aspects of problems at hand, but takes into account the multiplicity of factors that formulate the present problematic experience. This awareness inherent in children is a richer resource because it incorporates other elements that escape our attention but are important to the child. Shutting down children in a care setting impedes them from these capabilities. Deep inside them they wish to explore the meaning of their suffering. They wish to find out the place of God and spiritual reasons of their suffering. In taking children seriously, this quest can be read from children's voices.

In consideration of children as subjects, the children's openness to the presence of the divine is appreciated and the meaning they are trying to attach to their suffering is recognized.

²⁵ Annemie Dillen, "The resiliency of children and spirituality: a practical theological reflection," *International Journal of Children's Spirituality* 17, no. 1 (February 1, 2012): 61–75.

²⁶ Toby Fattore, Jan Mason, and Elizabeth Watson, "When Children are Asked about their Well-being: Towards a Framework for Guiding Policy," *Child Indicators Research* 2, no. 1 (2009): 58.

The material for spiritual care therefore is derived from the very child that will benefit and own it, not some outside influence onto the child that at times does not correspond well with what the child finds important. A conducive environment that can necessitate openness in children is therefore needed within the hospital itself.

The Hospital as an *Atrium*

Space and/or an environment that empowers a child in spiritual growth is vital in childhood spirituality. This would be an environment in which a child feels alive and at one with God the creator. Montessori, borrowing the term *atrium* from basilica infrastructures of her time, expresses how creating a place where the child ‘wonders’ with God on his or her situation is important in spiritual growth. The atrium is a space between the

classroom and the church [the past and the future] it is a place where the child learns the great realities of his life as a Christian ... [and] begins to live these realities in meditation and prayer.²⁷

Just like Montessori’s student, the immigrant hospitalized child is the main focus in the process. The hospital becomes the *atrium* since it is an environment in which “great realities of life” are reflected in the life of the child. It is also the *atrium* since the child will not stay forever, the child had a life before the hospitalization and will have to go on after discharge or death. The hospital should therefore offer an environment that engages the child with experience on his or her own

²⁷ As quoted in: Sofia Cavalletti, *The religious potential of the child: The Description of an Experience with Children from Ages Three to Six* (New York N.Y.: Paulist, 1983), 56.

terms, and aid the child to utilize his or her capabilities to reflect on spiritual issues important to his or her life.

Two resources that children utilize to express their reflection and *wondering* are art and play. In a creative way, children use imagery to express how they are engaging with reality. Architecturally, children's hospitals that aim at holistic child centered care are adapting to the need of putting care at the center of children's wards.²⁸ Traumatic experiences and pain find their expressions through the games children decide to play and the drawings they opt to draw.²⁹ Children's play and art take a theological turn when deep reflections of children's relation with God are brought into the scene. Pendleton *et al* have gathered a collection of children's drawings with clear images of God, angels and Jesus accompanying children suffering from cystic fibrosis in their illness. The drawings include those even of children whose parents were atheists.³⁰ The drawings reflect hope or belief that God is going to cure them, or Jesus is working some miracle or "*something*" in their life. The experience is not, therefore, something without a reason. It propels them to something more after their suffering. Even prospects of death are put in

²⁸ In Grampian Children's Hospital in Aberdeen in Scotland, children's wards are built in a circular manner. At the center of each circle is a play area, a school and an art facility. This becomes the heart of the children's ward. This area is easily accessible and available for use at all time.

²⁹ Hill *et al.* discuss war pictures of children who survives wars and massacres of their loved ones. Margret Hill et al., *Healing the Wounds of Trauma: How the Church Can Help* (Nairobi: Paulines Publications Africa, 2004), 46–47.

³⁰ Pendleton et al., "Religious/Spiritual Coping in Childhood Cystic Fibrosis: A Qualitative Study," 3–4.

perspective as a reunion with the divine if treatment fails, to borrow the word of Sara,³¹ “[when I am] not here anymore.”³²

These reflections from children will only be possible if the children’s ward is made conducive to the child’s relaxation. This entails creating an atmosphere where the child is helped to feel included in the care team as a contributor to the process of healing and health. Pediatric nurses and doctors are making strides in how to include children in carrying out diagnostics, and management of health procedures; or instance a child is asked to hold a stethoscope when measuring heart beat or watch the clock. Pediatric doctors take time to explain to children in simple terms with toy models what is happening in their bodies. Such little things get the children involved and included in care.³³

The Place of the Pastoral Care Provider

A realization of childhood potentialities in spirituality invites pastoral care providers to move to the sidelines as witness of the God-child relationship in a care setting. On the other hand considering the vulnerability of the child the pastoral care providers are called to serve as the child is experiencing a stressor that bring about fundamental spiritual questions in him or her.

³¹ Sara is a child whose verbatim was used in Pendleton *et al.* study and she uses the words “... not here anymore” to make reference to death.

³² Sara Pendleton *et al.*, “Spiritual Influences in Helping Children to Cope with Life Stressors,” in *Children’s Spirituality: Christian Perspectives, Research and Applications*, ed. Donald Ratcliff (Eugene, OR: Cascade Books, 2004), 359.

³³ Pediatric nurses and doctors are trained to engage children in various and many ways so as to get feedback from children on the care they are receiving and to make children more comfortable during care. Fiona Reid, “Experience of a Specialized Pediatric & Palliative Care Nurses in Inverness,” interview by Peter Kantembe, 2012.

Pastoral care providers are therefore called to be active observers who remain at the borders yet are guiding the child with prudence during this stressor. Yust captures this well:

Adults cannot presume to mediate children's spiritual experiences by inserting themselves between God and children as informers, but must wonder with children about the relationship between children's personal spiritual experiences and the tradition's understanding of who God is and how God is present to us in all aspects of our lives.³⁴

On the other hand we can read from Yust's contribution that the pastoral care provider is an expert. S/he is endowed with tradition and expertise to help the child to clarify the stressor experience. Based on this expertise, it is imperative for a spiritual care provider to use knowledge of the existential problems that are being faced by the child in the hospital since they directly relate to the disturbances in the child's spiritual dispositions. It is equally important for the (spiritual) care provider to have at hand the spiritual history of the child. This knowledge clarifies how the child is using religion or spirituality in coping, and gives familiarity to beliefs that are at play as the child processes the illness. These beliefs may have direct impact on health outcomes.³⁵

³⁴ Karen-Marie Yust, "Theology, Educational Theory, and Children's Faith Formation: Findings from the Faith Formation in Children's Ministries Project" (presented at the Christian Theological Seminary, Indianapolis, IN, 2002), 15, http://old.religiouseducation.net/member/02_papers/yust.pdf.

³⁵ Drawing from a wide range of authors on religious coping, Pendleton *et al* discuss in detail how religion in children has direct impact on coping. *Religious appraisals* lead maybe expressed as *benevolent* if the child believes God will reduce the stressor; *punishing God* if the child believes God is punishing him/her through the stressor; *demonic* if the child sees the stressor as malevolent deeds of the devil; and *pleading for direct intercession* when the child resolves to continually ask for divine intervention during the stressor. These appraisals lead the child to either adapt to the stressor, resignation or to live in hope, these attitudes are fundamental in the child's health. Pendleton et al., "Spiritual Influences in Helping Children to Cope with Life Stressors."

All this intervention by the pastoral care provider is done from the periphery, the experiential relationship between God and the child takes the center stage. Pembroke compares this prudence by the care provider to ‘tenderness’ as he states “A tender participation in the life of the other is at the heart of healing relationships. Tenderness is characterized by empathy, vulnerability, suffering with deep respect and strong affirmation.”³⁶ The pastoral care provider should decrease before the other, the child and God, who are active in this experience. Pembroke continues to explain that in such a relationship, the I – you dyadic relationship that reduces the client (the child) has no place if we are to recognize the strong bond between the child and God. The I – You – He/She relationship is viable, where the ‘I’ is a small yet observant agent who focuses on ‘You and He/She’ be it God or the child in this respect. If the child already enjoys this special relationship, what is the place of the pastoral care giver then? I have appreciated the fact that most children are aware of their situation and have capabilities to reflect on what is happening in their lives. We also observe that questions of suffering and the place of the divine in this suffering cloud the child’s minds. The child needs a vehicle to clarify and explain this according to the level of his or her understanding. The child is also aware that s/he is not alone. S/he appreciates and has trust in others. Through experiential human relationships, the child’s own trust in the divine is nuanced by others who form his or her worldview. The intervention of an experienced spiritual care provider in the child’s theological reflection gives the child’s spirituality and religiosity shape and form. The pastoral care provider is an expert equipped with necessary theology, tradition and expertise in communicating with the child.

³⁶ N. Pembroke, *Renewing Pastoral Practice: Trinitarian Perspectives on Pastoral Care and Counselling* (Burlington. VT: Ashgate Publishing Company, 2006), 66–67.

Büttner puts across three main thrusts of these interventions into children's spiritual lives and theological reflections. Tapping from theological and philosophical resources, the pastoral care giver helps the child to clarify: abstract ideas and religious paradoxes; images and realities; and arguments and facts. The intervention of the pastoral care giver offers a "knowledge matrix" in which confusions in the experience of God-Child relationship are clarified. Secondly, children are good at imitating. Imitation is vital in learning, be it by repeating actions like following a user's manual, committing to memory things, events or people's names, language and signals of communication or learning conventional ways of doing things in a society. It is within this cultural setting that a child orders the confused world around him or her. Therefore the pastoral care giver helps the child to access this rich 'cultural memory' as a tool for interpretation of his or her own world. Lastly, children are inquisitive, they are always probing into the new areas to broaden their understanding. For understanding to happen, new and strange reality has to find relations or be placed within existing knowledge schema. With the help of the pastoral care giver, children are helped not to follow slavishly religious dictates. With their capabilities to probe and ask questions they are guided into principles of how questions are argued and developed within a particular religion³⁷.

We have to make particular emphasis here on the second intervention, culture, since we are dealing with an immigrant child who has moved from one culture to a different culture.

³⁷ Gerhard Büttner, "The Role of Tradition in Theologizing with Children," in *Hovering Over the face of the deep: Philosophy, theology and children*, ed. Gertrud Yde Iversen, Gordon Mitchell, and Gaynor Pollard (Münster, New York, München, Berlin: Waxmann, 2009), 185–195.

Culture and Pastoral Care for Children

Culture is an important factor in pastoral care. It affirms a person as an individual within a supportive community with a tradition. Culture creates avenues of communication and irons out boundaries of respect.³⁸ Culture gives a person some identity and a sense of rootedness. Culture through language system provides a vehicle in which feelings, reflections and hopes are expressed. It is thanks to culture that God's initiatives in relating to humanity find their expression. On the other hand God's grace surpasses particular cultures or mere words that make up a language system. Children have also a potential to reflect outside predetermined cultural modes since they "are capable of boundless openness to the world and others ..."³⁹ This brings about a new challenge on the use of the immigrant child's culture in pastoral care. Omelan outlines problems Polish teenagers face when they come to central Europe. Some of the stressors they face are, language difficulties, cultural shock, rejections by locals who fear for jobs, less time with parents who are busy working for survival and rejection from their age group because Polish teenagers are considered primitive. In this research she found out that children and teenagers acculturated quicker than their parents. They were able to combine peacefully their Polish strong family bonds and central culture needs with the fast life of central Europe.⁴⁰

³⁸ Lartey examines the problems of pluralism in the modern multicultural society and sees the importance of particular cultures/traditions in pastoral care of individual cases. He advocates for mutual exchange of cultures in care and a movement from individualistic and mono-cultural attitudes that reduces the other in the practice of power in care. Emmanuel Y Lartey, *In Living Color: An Intercultural Approach to Pastoral Care and Counseling* (London & New York. NY: Jessica Kingsley Pub, 2003), 153 ff.

³⁹ Jensen, *Graced Vulnerability*, 7.

⁴⁰ Magdalena Omelan, "Acculturation process among Polish teenaged boys and their families" (Negotiated Extended Study, Aberdeen: University of Aberdeen, 2011).

The hospitalized immigrant child is a full person of the moment who has a whole life after this stressor of hospitalization and illness. The child has a past and a negative present experience but s/he has to make a life in a new world rather than be stuck in the past. Therefore the use of culture or tradition in pastoral care is not employed to protect the child from the new experience but is used to make sense of what the immigrant child is going through so that acculturation and new life is achieved.

Building on the potentials of the child to live fully in the moment and capabilities of acquiring informed knowledge of what is currently happening, we can bank on Vygotsky's theory of human development⁴¹. Vygotsky understood a child as subject who needs adult guidance and help. He rejects any attempts to explain human development as a linear step by step process. For him development is a dynamic transformation that is always active in a child and involves the inter-relation between the individual, the context and the society. He classifies modes of development in three spheres which he called 'zones': *zone of Actual Development*, a sphere where the child is able to reflect independently at present; *zone of Potential Development*, a sphere in which the child has potentials to reflect on an advanced level and *zone of Proximal Development*, a sphere where intervention is needed for the child to move from the zone of actual development to zone of potential development. We have appreciated that the child is fully spiritual and is aware of the divine actions as a subject. This state of awareness can be related to the zone of actual development. On the other hand the child's spiritual development is in a continuous flux due to new experiences that the child is exposed to, negative or positive. This

⁴¹ Lev Semenovich Vygotsky, *Mind in Society*, ed. Michael Cole et al. (Cambridge, MA, London: Cambridge University Press., 1978), 84–91.

defines the zone of proximal development. With the aid of a pastoral care provider, the child is helped to redefine the state of his or her spiritual beliefs (zone of actual development) in order to realize a state of new potential (zone of potential development). This is not a linear progression but a continuous dynamic process because the zone of potential development is ever challenged by new experiences that makes it always shift to zone of actual development⁴².

If the child is empowered by the expertise of the pastoral care giver, the negative experience of isolation and hospitalization become a stepping stone to the state of potential development. Bronfenbrenner observes that childhood potentials are not only affirmed during life experiences but also prepare the children for future endeavors.⁴³ Just as like children, we are always young in our spiritual development as God keeps on shifting the boundaries.

Conclusion

This article highlights the importance of childhood spiritual capabilities as an important resource in pastoral care for hospitalized immigrant children. In its child-centered approach it zeros in on taking the child seriously as an important contributor to the system of health or hospital care. Pastoral care for such children is complex and multifaceted. It is in the process of

⁴² James Riley Estep and Jr & Lillian Breckenridge, “The Ecology and Social Dynamics of Childhood Spirituality,” in *Children’s Spirituality: Christian Perspectives, Research and Applications*, ed. Donald Ratcliff (Eugene, OR: Cascade Books, 2004), 335–340.

⁴³ Bronfenbrenner defines ecology of human development as “... the scientific study of the progressive, mutual accommodation between an active, growing human being and the changing properties of the immediate settings in which the developing person lives, as this process is affected by relations between these settings, and by the larger context in which the settings are embedded.” U. Bronfenbrenner, *The Ecology of Human Development: Experiments by Nature and Design* (Cambridge, MA: Harvard University Press, 1979), 21. Bronfenbrenner therefore recognizes the presence of childhood potentialities of processing the immediate environment and the need for relationships to clarify the new experiences at hand. This is done in mutual trust and openness with the guide that accompanies the child.

affirming the child in care that the whole process of spiritual growth unfolds. The negative multi-layered hospital experiences; children's capabilities of spiritual awareness; children's creative expression; children's hope and intervention of a spiritual care provider who stays consciously at the helm while accompanying; make up the major pillars of this process of theological reflection. Neither indoctrination, nor treating the child as a mere passive receptor of spiritual care, has a place in spiritual growth. This has been a project of identifying best practices for multicultural pastoral care for hospitalized children. These include: respecting the child's age, national and cultural identity, spiritual contributions, and children's voice in the care process because s/he can speak; taking the hospital as an *atrium* of reflection because the child is aware of whatever is happening and; an avenue of hope because the child is in continuous process of relating to other new people, new experiences and new divine interventions entering into his or her life.

Bibliography

- Berryman, Jerome W. *Children and the theologians : clearing the way for grace*. New York: Morehouse Pub., 2009.
- Bronfenbrenner, U. *The Ecology of Human Development: Experiments by Nature and Design*. Cambridge, MA: Harvard University Press, 1979.
- Browning, Don, and Bonnie Miller-McLemore, eds. *Children and childhood in American religions*. Vol. 233. VIII. The Rutgers series in childhood studies. New Brunswick, NJ: Rutgers University Press, 2009.
- Bunge, Marcia J. "Historical Perspectives on Children in the Church: Resources for Spiritual Formation and a theology of Childhood Today." In *Children's Spirituality: Christian Perspectives, Research and Applications*, edited by Donald Ratcliff, 42–53. Eugene, OR: Cascade Books, 2004.
- Büttner, Gerhard. "The Role of Tradition in Theologizing with Children." In *Hovering Over the face of the deep: Philosophy, theology and children*, edited by Gertrud Yde Iversen, Gordon Mitchell, and Gaynor Pollard, 185–195. Münster, New York, München, Berlin: Waxmann, 2009.
- Cavalletti, Sofia. *The religious potential of the child: The Description of an Experience with Children from Ages Three to Six*. New York N.Y.: Paulist, 1983.
- Coles, Robert. *The spiritual life of children*. A Peter Davison book. Boston, MA: Boston (Mass.): Houghton Mifflin, 1990, 1990.
- Committee on Community Health Services. "Providing Care For Immigrant, Homeless, and Migrant Children." *Pediatrics* 115, no. 4 (April 1, 2005): 1095–1100.

“Convention on the Rights of the Child”. Office of the United Nations High Commissioner for Human Rights, 1990. <http://www2.ohchr.org/english/law/crc.htm> (accessed November 17, 2012).

Daud, Atia, Britt af Klinteberg, and Per-Anders Rydelius. “Resilience and vulnerability among refugee children of traumatized and non-traumatized parents.” *Child and Adolescent Psychiatry and Mental Health* 2, no. 1 (December 1, 2008): 1–11.

Davies, B, P Brenner, S Orloff, L Sumner, and W Worden. “Addressing spirituality in pediatric hospice and palliative care.” *Journal of palliative care* 18, no. 1 (2002): 59–67.

Dillen, A., and D. Pollefeyt. *Children’s voices: children’s perspectives in ethics, theology and religious education*. Bibliotheca Ephemeridum theologicarum Lovaniensium. Leuven: Peeters, 2010.

Dillen, Annemie. “The resiliency of children and spirituality: a practical theological reflection.” *International Journal of Children’s Spirituality* 17, no. 1 (February 1, 2012): 61–75.

Estep, James Riley, and Jr & Lillian Breckenridge. “The Ecology and Social Dynamics of Childhood Spirituality.” In *Children’s Spirituality: Christian Perspectives, Research and Applications*, edited by Donald Ratcliff, 324–385. Eugene. OR: Cascade Books, 2004.

Fattore, Toby, Jan Mason, and Elizabeth Watson. “When Children are Asked about their Well-being: Towards a Framework for Guiding Policy.” *Child Indicators Research* 2, no. 1 (2009): 57–77.

- Feudtner, Chris, Jeff Haney, and Martha A. Dimmers. "Spiritual Care Needs of Hospitalized Children and Their Families: A National Survey of Pastoral Care Providers' Perceptions." *Pediatrics* 111, no. 1 (January 1, 2003): e67 –e72.
- Hill, Margret, Harriet Hill, Richard Bagge, and Pat Miersma. *Healing the Wounds of Trauma: How the Church Can Help*. Nairobi: Paulines Publications Africa, 2004.
- Hutcheon, George Rev. Fr.). "Catholic Hospital Chaplaincy in Aberdeen- Scotland." Oral, July 1, 2012.
- Insight, Innocenti. "Children in Immigrant Families in Eight Affluent Countries." *UNICEF* (2009). www.unicef-irc.org/publications.
- Jensen, David H. *Graced Vulnerability*. Cleveland. OH: The Pilgrim Press, 2005.
- Lartey, Emmanuel Y. *In Living Color: An Intercultural Approach to Pastoral Care and Counseling*. London & New York. NY: Jessica Kingsley Pub, 2003.
- Loue, Sana. *Handbook of Immigrant Health*. Illustrated. New York & London: Plenum Press, 1998.
- Margaronis, Maria. "Europe's Unwelcome Guests: Resentment Against Immigrants, Even Those Seeking Asylum is at the Boil." *The Nation* 274, no. 20 (2002): 14–20.
- Marshall, Patricia, Barbara Koenig, Paul Grifhorst, and Mirjam van Ewijk. "Ethical Issues in Immigrant Health Care and Clinical Research." In *Handbook of Immigrant Health*, edited by Sana Loue, 203–226. New York & London: Plenum Press, 1998.
- Mawn, Barbara Ellen. "Children's Voices: Living With HIV." *Lippincott Williams & Wilkins* 36, no. 6 (December 2011): 368–372.

Omelan, Magdalena. “Acculturation process among Polish teenaged boys and their families”.

Negotiated Extended Study, Aberdeen: University of Aberdeen, 2011.

Paspalanova, Mila. “Undocumented and legal Eastern European immigrants in Brussels”.

Dissertation, Leuven: K.U.Leuven. Faculteit Sociale Wetenschappen, 2006.

Pembroke, N. *Renewing Pastoral Practice: Trinitarian Perspectives on Pastoral Care and Counselling*. Burlington, VT: Ashgate Publishing Company, 2006.

Pendleton, Sara, Ethan Benore, Katherine Jonas, Wendy Norwood, and Carol Herrmann.

“Spiritual Influences in Helping Children to Cope with Life Stressors.” In *Children’s Spirituality: Christian Perspectives, Research and Applications*, edited by Donald Ratcliff, 358–382. Eugene, OR: Cascade Books, 2004.

Pendleton, Sara M., Kristina S. Cavalli, Kenneth I. Pargament, and Samya Z. Nasr. “Religious/Spiritual Coping in Childhood Cystic Fibrosis: A Qualitative Study.” *Pediatrics* 109, no. 1 (January 1, 2002): 1–13.

Reid, Fiona. “Experience of a Specialised Pediatric & Palliative Care Nurses in Inverness.” Interview by Peter Kantembe, 2012.

Ruiz-Casares, Mónica, Cécile Rousseau, Ilse Derluyn, Charles Watters, and François Crépeau.

“Right and access to healthcare for undocumented children: Addressing the gap between international conventions and disparate implementations in North America and Europe.” *Social Science & Medicine* 70, no. 2 (January 2010): 329–336.

- Saulina, C, L Vall-Ilosera, and M Saez. "A qualitative Analysis of Immigrant Population Health Practices in the Girona Healthcare Region." *BMC Public Health* 10, no. 379 (June 2010): 2–11.
- Spilka, Bernard, William J. Zwartjes, and Georgia M. Zwartjes. "The role of religion in coping with childhood cancer." *Pastoral Psychology* 39, no. 5 (May 1, 1991): 295–304.
- Thoilliez, Bianca. "How to Grow up Happy: An Exploratory Study on the Meaning of Happiness from Children's Voices." *Child Indicators Research* 4, no. 2 (2011): 323–351.
- Vygotsky, Lev Semenovich. *Mind in Society*. Edited by Michael Cole, Vera John-Steiner, Sylvia Scribner, and Ellen Souberman. Cambridge. MA, London: Cambridge University Press., 1978.
- Wilson, William P. "Religion and Psychoses." In *Handbook of Religion and Mental Health*, edited by Harold G. Koenig, 161–174. Orlando. FL: Elsevier, 1998.
- Young, Janine, Glenn Flores, and Stephen Berman. "Providing Life-Saving Health Care to Undocumented Children: Controversies and Ethical Issues." *Pediatrics* 114, no. 5 (November 1, 2004): 1316–1320.
- Yust, Karen-Marie. "Theology, Educational Theory, and Children's Faith Formation: Findings from the Faith Formation in Children's Ministries Project" presented at the Christian Theological Seminary, Indianapolis. IN, 2002. http://old.religiouseducation.net/member/02_papers/yust.pdf.