

TRYING TO CATCH A COULD AND PIN IT DOWN: REFRAMING PEDIATRIC
SPIRITUAL ASSESSMENT IN A CLINICAL SETTING

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TABLE OF CONTENTS

Abstract	5
Case example: “Nikki,” 5yo female.....	6
Introduction	10
The Setting.....	12
Chapter 1—The Domains of Language in the Clinical Setting	19
Language Domains.....	19
The language domain of science.....	21
The language domain of ethics.....	22
The language domain of art.....	23
The language domain of politics.....	24
The language domain of philosophy.....	24
The language domain of religion.....	25
The spiritual language domain.....	29
‘Spirituality’.....	34
Conclusion.....	36
Chapter 2—Relational Consciousness, Existential Limits, the Creative Process and the Child’s Voice in Pediatric Spiritual Care	39
Case example: “Joyce,” 11yo female.....	40
Relational Consciousness.....	42
<i>Diagram: Relational Consciousness</i>	47
Existential Limits.....	51
The existential limit of death.....	53
Case example: “Allen,” 6yo male.....	56
The existential limit of aloneness.....	57
The existential limit of meaninglessness.....	63
Case example: “Franny,” 12yo female.....	64

The existential limit of freedom.....	7
Case example: “Moira” and “Jan,” 4yo female and sibling.....	6
<i>Diagram: Existential Limits</i>	73
Existential Limits and the Creative Process.....	73
<i>Diagram: the Creative Process</i>	78
Conclusion: The Field and the Fences, a Synthesizing Metaphor.....	80
<i>Diagram: Relational Consciousness within the Existential Limits</i>	82
Chapter 3 —Cognitive and Spiritual Development and Kinds of Knowing—Meeting Children Where They Are.....	83
Case example (submitted): “Janna’s Doll,” 5yo female.....	83
Ages, stages and kinds of understanding.....	84
Piaget and Stage Theory.....	87
Stages of Religiosity.....	90
Religious and Spiritual Development.....	91
The Pros and Cons of Stage Theory.....	92
Recapitulation Theory, Kieran Egan and the Movement from ‘Knowledge’ to ‘Kinds of Understanding’.....	96
Berryman on “The Five Stages of Egan’s Educational Scheme”.....	100
Case example: “Marco,” 11yo male.....	109
Conclusion.....	118
Chapter 4 —From Theory to Praxis in Supporting the Spirituality of Children in Clinical Settings.....	119
Spiritual Screening, Spiritual Histories and Spiritual Assessment Tools.....	122
S.P.I.R.I.T., The “Third Thing,” and the “Middle Realm”—Creating Space for Spiritual/Relational Building, Connecting and Expression.....	134
S.P.I.R.I.T. and the container: S/R Building.....	136
The ‘third thing’ and the “middle realm”: S/R Connecting.....	139

S/R Expression.....	148
Case Example: “Moira re-visited,” 4yo female.....	148
Chapter 5—S/R Building, Connecting and Expression in a Pediatric Behavioral Health Unit.....	152
S/R Expressions in “Purpose and Meaning” group—ages 12 and under.....	155
<i>11yo female</i>	160
<i>8yo male</i>	163
<i>10yo male</i>	165
<i>12yo male</i>	167
<i>11yo male</i>	169
<i>11yo female</i>	172
<i>9yo male</i>	174
<i>10yo male</i>	176
<i>9yo female</i>	181
<i>10yo male</i>	182
<i>10yo male</i>	185
<i>11yo female</i>	187
Conclusion.....	190
Appendix 1: Physician/Chaplain Dialogue.....	192
Appendix 2: Holy Listening Stones template, Rev. Dr. Leanne Hadley.....	197
Appendix 3: Spiritual Relational Model of Pediatric Spiritual Care.....	198
Bibliography.....	199

Abstract

This project aims to address the inherent challenges of pediatric spiritual care in clinical settings, explore current theoretical models that can be developed into a simple and cohesive way of addressing the spiritual needs of children as expressed in their own ‘language,’ and propose a different framework of what “assessment, intervention and outcome” looks like within the discipline of spiritual care. As a kind of ‘middle path’ between the purely reductionist model of spiritual assessment (spiritual assessment tool to collect data, utilization of spiritual interventions, measure outcome of the intervention) on the one hand and the position that what chaplains do simply can’t be described in words or measured at all on the other, I will propose spiritual/relational “expressions”, rather than clinical outcomes¹ when it comes to measuring the efficacy of pediatric spiritual care in clinical settings. In this way, I hope to bridge the language domains between the disciplines of spiritual and reductionist-informed medical care, allowing each to inform and compliment the other without subsuming one into the other and thereby compromising the integrity of both. My thesis, then, is this: When children are able to express themselves in terms of relational consciousness or existential limits, they are engaging in an expressive act of spiritual awareness and meaning-making and this is a necessary part of any healing journey. Spiritual/Relational Expressions (S/R Expressions) ARE the outcomes of spiritual care interventions with children. Foundational theories and case examples will be offered in support of this thesis.

¹ ‘Clinical outcomes’ here referring to measurable biological or behavioral data based on the assessment-intervention-outcome model utilized by physicians and clinically-oriented mental health providers.

Author's note: all information related to patients, stories, anecdotes, art and verbal responses throughout this work have been de-identified so that no personal information is contained herein. Names and other descriptors used in this work are not the real names or descriptors of the patients involved in order to protect their anonymity and privacy

“Nikki”

The chaplain working at a large, freestanding pediatric hospital was paged by a nurse to speak with a mom regarding the new diagnosis of an inoperable brain tumor found in her 5-year-old daughter, Nikki. This was, she was told, a terminal diagnosis. The chaplain met with the mom who was busy and frantic, making phone calls and reaching out to her friends and family for support, sharing this difficult news. She told the chaplain that her biggest fear in the moment was telling her daughter what was happening. The Chaplain agreed to meet with Nikki privately in her hospital room, while her mom continued to make phone calls outside the room. The purpose of the Chaplain's visit with Nikki was to explore what mattered to her most in that moment, and to discover what it was that she needed in terms of spiritual support, however that might look.

The Chaplain entered Nikki's room and noticed her pink princess blanket, several stuffed animals and some craft materials brought to her by the Child Life Specialist, a clinical provider who focuses on the developmental needs of children in the hospital. The Chaplain immediately crouched down to eye-level with Nikki and introduced himself. He carried with him a small gold box, but he said nothing about it—it was just there, waiting for Nikki's curiosity to invite exploration about what might be inside, or to ignore it completely. Either way, there was no expectation. After talking to Nikki, explaining what a chaplain is (“kind of like a pastor at church, but in the hospital—mostly I listen to stories, and tell stories”), noticing her blanket, asking about the names of her stuffed animals and letting her direct the conversation, Nikki saw the box and began to wonder. “What's in the box?” she asked the Chaplain. “Well, it's a story,” the chaplain replied, “and you never know what you'll find inside. Should we see?” Nikki said yes.

The Chaplain carefully opened the box and wondered about each item that was taken out and placed on her bed—a green square of felt, a smaller blue one, several small black ones, lots of long, skinny brown ones. As the wondering about what all these things might be began to settle, several sheep and a figure the Chaplain called “The Good Shepherd” were introduced. Now, both gazed at a green pasture, with sheep gathered safely in a sheepfold, a pool of still, clear water, and places of danger. This is the setting for the story. Later there came an “Ordinary Shepherd” and a “wolf” figure—all parts of the story. The Chaplain told Nikki the Godly Play[®] story, “The Parable of the Good

Shepherd.”² The story includes a Good Shepherd who knows the names of the sheep and who protects them from danger, unlike the Ordinary Shepherd who doesn’t know their names and runs away from danger. The Good Shepherd ensures that all of the sheep, even one that gets lost in the story, are returned safely to the sheepfold.

After the story was told, the chaplain and Nikki wondered about the story together, according to the Godly Play methodology³. “I wonder what the names of the sheep could be?,” “I wonder if you’ve ever been in a place like this?,” “I wonder who the Good Shepherd might really be?,” “I wonder where this whole place might really be?” These questions are open-ended and have no “right” answers. The meaning is for Nikki to make, not for the Chaplain to tell. Nikki didn’t have anything to say in terms of verbalizing her wondering, but she was clearly wondering about the story, focused on the materials carefully laid out before her on the bed. The Chaplain then wondered, “I wonder if you would like to tell the story?”

Nikki manipulated the materials in a way that allowed the following interaction with the Chaplain.

Nikki: “There’s a key that we have to find but its in the bottom of the lake” [pointing to the blue felt that was the “still, clear water” in the Chaplain’s telling of the story.]

Chaplain: “I wonder how we can get it? Can we swim? Can we use a fishing pole?”

Nikki: “Nope. We can’t swim and we don’t have a fishing pole. And oh, no! There it goes, washing right over the edge of the bed!” [Nikki made it look like the water rushed over the edge of the story materials, over the edge of the bed, taking the key with it]

Chaplain: “I wonder what happens next?”

Nikki: “there’s a huge tree and there’s another key, way up at the top.” [Nikki motioned that the tree was high above her left shoulder, a reference to the initial wondering about what the big green felt piece could be before the story began.]

Chaplain: “I wonder how we can get it?”

Nikki: “We can’t get it. We can’t climb that high. We need a woman.” [Nikki picks up the Good Shepherd figure, which has a non-specific gender representation, carries a sheep and has long hair.] “And we need a man.” [she grabs the Ordinary Shepherd figure, which does look more like a traditional masculine representation.] “Together, they can go up and get the key.” [Nikki held both figures in one hand and they climb up the “tree” and get the “key.”]

² This is one story or lesson that is contained within “The Complete Guide to Godly Play” by Jerome Berryman. For this story, see Jerome W Berryman, *The Complete Guide to Godly Play Volume 3* (Denver: 2008), 77-86.

³ The Rev. Dr. Jerome Berryman, along with his wife Thea, developed Godly Play® at Texas Children’s hospital in Houston, Tx.

Chaplain: “We need a woman and a man together to climb the tree and get the key. And now they’ve got it!”

Nikki: “yes, they’ve got it.”

Chaplain: “I wonder what they do with the key now that they have it?”

Nikki: “I don’t know. Do you know where my mom is?”

Chaplain: “I don’t know either. Would you like me to go and find your mom?”

Nikki: shakes her head yes, settling into bed, indicating she is finished wondering for now.

The Chaplain and Nikki carefully put the materials back into the box, and the chaplain leaves Nikki’s room to locate her mom. Mom is still on the phone, making calls to friends and family. She is tearful. When she sees the Chaplain, she ends her phone call and asks how it went. The Chaplain explained that he and Nikki had shared a story together and described the story a bit. The Chaplain then recounted in detail the dialogue and interaction they had when Nikki told the story. Mom responded to the Chaplain, saying, “Oh God. Her father and I separated 6 months ago. He moved to Oklahoma and is a working up there. She hasn’t seen him since he left.”

INTRODUCTION

Pastoral or Spiritual Care has been a discipline of care provision in children’s hospitals and clinical settings for many decades (Hilsman, 2017, 9). As it has developed as a clinical discipline and become an integral part of the Interdisciplinary Team (IDT) in most hospitals, chaplains, or spiritual care providers, work alongside physicians, nurses, psychologists, social workers, therapists, child life specialists, and others.

While every discipline consists of unique and complimentary skill sets, each has developed (and continues to develop) what “best practice” looks like in their particular clinical setting. What is “best practice” in nursing would be very different in terms of what “best practice” is in social work, for example, because of the obvious differences in the kinds of care they provide, their educational backgrounds, and the unique skills each

utilizes to provide patients and families the resources needed relative to their roles in the IDT.

The “best practice” of any clinical discipline is to assess a need or issue in a patient, provide an intervention to address the assessed need, and measure, if measurable, the outcome of the intervention in order to determine its efficacy. Outcome data is ascertained by whether the patient is clinically improving or declining through measurable evidence. This evidence-based, outcomes-oriented model of care is a vital part of providing standardized, measurable techniques for helping people find positive clinical improvement. The data collected and outcomes achieved play a large role in care plans, quality and safety, insurance coverage, patient satisfaction, and government reimbursement, among other factors. It makes sense that as a patient, or the parent of a patient, one would choose the hospital that has the most up-to-date data, the best providers, and the most cutting-edge therapies for this or that kind of illness. The best way to determine which hospital or provider to choose is rooted in measured clinical outcomes.

Understandably, nearly every discipline has developed a way of researching and measuring the efficacy of assessment-intervention-outcomes models of care. Pastoral or Spiritual Care is no exception. “Pastoral Care researchers Fitchett, VandeCreek, Handzo, Gleason and many others began to collect data about [spiritual] assessment, intervention and outcomes” (Hilsman, 2017, 12). Physicians like Harold Koenig, MD and Christina Puchalski, MD (and many others) have developed spiritual assessment tools and made careers of researching and writing about the importance that spiritual care plays in the clinical outcomes that contribute to the healing of the whole person. Large grants through

organizations like the Templeton Foundation, Lily and others have made possible the teaching and training of chaplains in research-oriented career tracks. The spiritual care discipline continues to develop as a clinical discipline alongside others in the IDT, and increased interest, research and writing has made it now, perhaps more than ever, an accepted and expected part of healthcare provision in the United States, as well as many other western and non-western countries.

There are, of course, challenges faced in trying to apply a clinical-reductionist⁴ model to a discipline that often deals primarily with the ineffable, the mysterious, the hard-to-put-into-words. For example, the challenges of a spiritual assessment alone can be daunting. Yes, we can ask patients a series of questions that gives them the ability to talk about whether they belong to a specific faith-group, or about how often they attend religious services. They may answer questions about how they see God in the midst of their illness, or if ‘God’, as a concept, is something they identify with or find helpful. These are helpful aspects of a person’s spiritual disposition to know—perhaps the intervention in response to these assessments would be to contact the hospital chaplain for a visit, contact local faith leaders to provide sacraments or rituals specific to their tradition, or to be sure to let other providers know that ‘prayer’ and other religious kinds of practices are specifically NOT helpful to this patient. But it becomes clear pretty

⁴ In this work, ‘clinical reductionism’ or ‘reductionism’ is the scientific model whereby all physical, mental, emotional and spiritual states in a human person are reduced to biological (in the case of the states of the body) or behavioral (in the case of states of the mind) description. I will argue that, while this is an important and fundamental methodological approach to much of clinical care, it is not always appropriate in the realm of spiritual care. The assessment-intervention-outcome model of clinical treatment is based on clinical reductionist methodology and is both efficacious and fundamental to treating the diseases of the body and, quite often, the mind. However, utilizing this model in spiritual care seems to me to be putting the wrong em-**pha**-sis on the wrong syl-**la**-ble. The state of the Spirit or Soul is quite a different kind of state and must be related to differently.

quickly, that even here, the language gets a bit murky. How is ‘religion’ used over and against ‘spirituality?’ Is measuring a person’s ‘religiosity’ the same as assessing their ‘spirituality?’ If a person has no specific religious tradition, or even faith language, does this mean that ‘spirituality’ is not something to be considered as part of the patient’s care plan? Once a spiritual assessment is made, how is it recorded in the medical record, how is the intervention determined and how is the outcome measured? And most relevant to this project, how does this work with, say, a 5-year-old child? Mercer notes, that when it comes to ‘spirituality’ and ‘religion,’ “these concepts are difficult to operationalize as research domains, particularly in contexts that tend to place higher value on quantitative measurements of investigation” (Mercer, 2006, 501).

“As spiritual health is a broad concept that covers a vast array of perceptions and experiences, it is extremely difficult to measure and assess” (Michaelson, et al., 2016). Many researchers continue to wrestle with some of these challenges. However, the vast majority of research being done on spirituality in the clinical setting is done with adult patients and rarely with children. Adults can think abstractly, answer spiritual assessment tools in a Likert-Scale format and tell you, in some regard, whether the prayer or the sacrament or the conversation they had with a chaplain or their local faith leader was helpful in terms of their coping with their illness. But how does this model work with children? Few researchers have worked directly with the spirituality of children, and when one finds work that mention pediatrics and spirituality, often the age sample is really more in the adolescent/young adult grouping—ages and stages that can think in abstract terms, command a sizeable vocabulary and are able to process experiences through reflection, verbalization, abstraction and dialogue. Little is being done to enact

this same focus on spirituality with young and school-age children in terms of clinical assessment, intervention and outcomes.⁵

This project aims to address the inherent challenges of pediatric spiritual care in clinical settings, explore current theoretical models that can be developed into a simple and cohesive way of addressing the spiritual needs of children as expressed in their own ‘language,’ and propose a different framework of what “assessment, intervention and outcome” looks like within the discipline of spiritual care. As a kind of ‘middle path’ between the purely reductionist model of spiritual assessment (spiritual assessment tool to collect data, utilization of spiritual interventions, measure outcome of the intervention) on the one hand and the position that what chaplains do simply can’t be described in words or measured at all on the other, I will propose spiritual/relational “outcomes”, rather than clinical outcomes⁶ when it comes to measuring the efficacy of pediatric spiritual care in clinical settings. In this way, I hope to bridge the language domains between the disciplines of spiritual and reductionist-informed medical care, allowing each to inform and compliment the other without subsuming one into the other and thereby compromising the integrity of both. More on language domains in the first chapter.

THE SETTING

⁵ Though there is more being done in terms of spirituality and religious education in the pedagogical disciplines, very few situate themselves firmly in the clinical environment. The *International Journal of Children’s Spirituality* is a good example of the important work being done on the subject, and the very few children’s spirituality researchers working in the clinical setting. The majority of work being done in this publication is more embedded in the field of pedagogy and education.

⁶ ‘Clinical outcomes’ here referring to measurable biological or behavioral data based on the assessment-intervention-outcome model utilized by physicians and clinically-oriented mental health providers.

Imagine being on an Intensive Care Unit, outside a child's hospital room. There are attending physicians from several disciplines (perhaps oncologists and intensivists), fellows and residents, nurse-practitioners, social workers and psychologists and the chaplain. This IDT team is discussing the current assessments of the patient's bloodwork, blood pressure, various levels of proteins and cell growth, awareness and consciousness in terms of wakefulness and alertness, orientation to self, others, location and circumstance. Team members discuss and assess the numbers, put together an informed plan for interventions to move any of those numbers in the direction that indicates healthy physical and/or mental function, and create a plan going forward with goals for where those numbers need to be in an hour, a day, a week. Mental states like anxiety or depression are discussed, therapies and medication prescribed, results measured. Imagine this is happening outside the room of "Nikki" introduced at the beginning of this work, and now imagine how the interaction that took place between the chaplain, Nikki and Nikki's mom could be described in the assessment-intervention-outcome model. Is what the chaplain did an assessment? Partly. Was it an intervention? Yes, in some ways. Was there a measurable outcome? It depends on what and how we "measure." Is the information provided by Nikki to the chaplain helpful in terms of what is most important to her in creating a plan-of-care that includes both the medical and psycho-social aspects of her healing? Absolutely. In fact, it is an integral part of her story—both the story she has lived and the story she is living in and hoping for through the symbols of the narrative she used to express herself. Without the narrative, imagination, wonder and symbols presented to her, she may never have been able to tell someone that this was what matters most to her in the moment. And without the relationship that was built

between her and the chaplain, rather quickly in this case (sometimes, it takes a long time...), there would have been no “container”⁷ in which the narrative could have been told.

This is a daily occurrence in pediatric hospitals across the country. Being part of an interdisciplinary team where most disciplines operate on the model of evidence-based, outcome-oriented assessment and intervention, based on empirical study and quantitative data, chaplaincy in general, and pediatric chaplaincy specifically, has struggled with how to situate itself within this clinical-scientific model while maintaining its identity as a discipline that works with both skillful assessment and observation, as well as interventions that constellate more the mysterious than the material. The avenue chosen has been research—if we can use research to develop evidence-based, outcome-oriented interventions, it is reasoned, we will be modeling the chaplaincy discipline upon the same scaffolding as the disciplines we work alongside. This is an obvious approach and makes perfect sense. Then again, there are fundamental problems with this approach, as well as many practical challenges. Research is of key importance, as is working to translate the work of spiritual care into the medical model without compromising the integrity of the spiritual care provided, and especially of the relationships necessary for supporting the spirituality of children in clinical settings. Below is a list of the challenges I see, and those which I wish to address in this project.

⁷ By ‘container,’ here, I refer to the physical, emotional and spiritual “space” created between the chaplain and the child. Similar to the notion of ‘Temenos,’ which, in Jungian terms, refers to a safe and protected space in which to heal (Sharp 1991, 133). This theme of the ‘container’ and ‘Temenos’ will be discussed further in chapter 4 through the lens of Rebecca Nye’s notion of S.P.I.R.I.T as a way of supporting the spirituality of children (Nye 2009, 41).

The challenges here are:

- ‘Spirituality,’ as such, is ill defined and even translating that concept into a medical model is difficult due to the differences in language domains held between the language of science and the language of theology/religion/spirituality. The notion of ‘children’s spirituality’ is an even harder cloud to catch and pin down.
- Current efforts to couch the chaplain’s discipline in scientific discourse by creating an objective, quantitative measure for the efficacy of spiritual intervention based on an objective assessment of the patient’s spiritual needs tends to reduce spirituality to ‘religiosity’ and risks the danger of becoming a superficial checklist rather than a careful, attuned encounter with the sacred, however the sacred is experienced and expressed by that child. The model simply relies on data and descriptions that are too objective to have any real meaning in regard to the spiritual and existential experiences of children that defy description, particularly within the necessarily limited language domain of science.
- Compromising the integrity of the discipline in order to fit into the model of other disciplines does neither discipline any good and even less for the patient
- Almost ALL research that has led to the development of Spiritual Assessment Tools has been done with adults, who are able to answer survey questions, think abstractly and, at least on a basic level, articulate with words how they view faith, religion and spirituality in relation to their illness
- There are very few research studies looking at the spirituality of young children (I’m interested in the ‘latency’ period, ages 12 and below) where the methodology

in adult “spiritual assessment tools” won’t work for obvious reasons, though few would argue that children aren’t as inherently spiritual as any adult

- SO—the gap lies in that there are virtually no specifically pediatric spiritual assessment tools, making it very difficult to fit pediatric spiritual care research into a clinical model of care that starts with ‘assessment.’ My hunch is that this is partly because they have a limited vocabulary and so are less likely to couch the deep existential and spiritual experiences they have into abstracted quantifiable language. I think this may also point to a shortcoming of adult assessment models, which may too readily reduce the same deep experiences into language without really getting to the deeper, phenomenologically informed, symbolic expressions of the sacred.

Given these challenges and the goals of this dissertation, I will work from theory to praxis, making my way through these challenges and hopefully coming out on the other end with a description of how chaplains can engage children in such a way that they are able to express themselves spiritually and existentially, finding hope, meaning and purpose, and communicating to those family members, friends and clinicians caring for them what it is that matters to them most. It is not only my contention, but that of many others as well, that encountering and expressing the spiritual and existential in this way, leads to healing alongside other medical therapies.⁸ My thesis, then, is this: When children are able to express themselves in

⁸ Here it is important that I distinguish ‘healing’ from ‘curing.’ Healing is a state of wholeness, re-connection, resilience, peace and meaning. Curing is the reversal or cessation of a physical or mental process/illness in order to return to the healthy state before that process/illness occurred. One can experience a cure without healing, and one can experience healing without curing. The medical model is

terms of relational consciousness or existential limits, they are engaging in an expressive act of spiritual awareness and meaning-making and this is a necessary part of any healing journey. Spiritual/Relational Expressions (S/R Expressions) ARE the outcomes of spiritual care interventions with children.

Chapter 1 will focus on the various language domains extant in the clinical setting, exploring how they relate to one another across and between the various clinical disciplines caring for children and their families. ‘Spirituality’ will be described and situated within a framework of spiritual and existential expressions available to all persons, and specifically to children. This framework includes, but is not limited to, the verbal expressions of children as they give ‘voice’ to their experiences of the sacred (as well as its limits). Finally, this framework will be connected to its *telos*, the language of narrative, symbol, hope, meaning and purpose, and the part this *telos* plays in a hospitalized child’s healing. This chapter will focus on the fundamental questions of “what?” and “why?” with regard to spiritual care for hospitalized children.

Chapter 2 will explore in depth the concept(s) of “Relational Consciousness,”(Hay and Nye, 2006, 109) and existential limits (Yalom, 1980; Berryman, 1991) and how putting them together provides the chaplain with a framework of exploring the spiritual and existential expressions of children without being bound by the limitations of a child’s vocabulary and way of understanding the

most closely oriented toward curing, though there are some who speak of healing as a more inclusive way of receiving care or being cared for. Healing can be, but is not always, inclusive of curing. One can be healed and still die, and after death, many of those who have survived their loved one will speak of that person’s finally being healed.

world. A critique of relational consciousness will be discussed and justification for why the framework chosen in this work seems best will be offered (i.e., why this framework best upholds the integrity of the spiritual language domain, the bridge to the clinical/medical language domains, and, most importantly, the integrity of the language of the child, in both verbal and non-verbal forms of its expression).

Chapter 3 will first address the most common theories in use to describe spiritual and cognitive development in pediatric spiritual care. As an alternative to the cognitive/developmental stage theories, I will explore the recapitulation-based educational theory of Kieran Egan as a more appropriate way of engaging children in spiritual support through mutuality, authenticity and spiritual/relational connecting by way of engaging in the “kinds of knowing” that children use to find meaning. Much of the explication of Egan’s theory will be through the notes and insights of Rev. Dr. Jerome Berryman and will then be applied to the clinical setting.

Chapter 4 will move from theory to praxis in supporting the spirituality of children in a clinical setting. Various adult-oriented spiritual screening and assessment tools will be discussed and critiqued in terms of their relevance in pediatric spiritual care. An alternative approach to the assessment—intervention—outcome model of clinical care will be proposed as more appropriate for the spiritual care of children: the Spiritual/Relational Building—Spiritual/Relational Connecting—Spiritual/Relational Expression model of pediatric spiritual care. This model will be explored using the praxis methods of Rebecca Nye, Jerome Berryman and Leanne Hadley.

Chapter 5 will conclude the project by looking at specific case examples taken from the spiritual support provided to pediatric patients, age 12 and under, in an inpatient psychiatry unit. A description of the spiritual care provided will be offered and various Spiritual/Relational Expressions (S/R Expression) in the form of responses to wonder, artistic expression, play and narrative will be presented. Each presentation of a child's S/R Expression will be followed by a proposed chart note template incorporating the articulation of the S/R Expression using the theoretical frameworks explored and proposed in previous chapters.

Chapter 1—The Domains of Language in the Clinical Setting

*“Of all that God has shown me
I can speak just the smallest word,
Not more than a honey bee
Takes on her foot
From an overflowing jar.”
--Mechthild of Magdeburg⁹*

⁹ Quoted in *The Enlightened Heart*, edited by Stephen Mitchell, 1989, 66.

Language Domains

We have all had experiences that defy description. As with poetry, it is often the case that the only way to use words to describe an experience or insight that defies description is to allow the words we use to point beyond themselves. At that point we are left, each of us, to enter into that place beyond description within our own minds, hearts and bodies. We can acknowledge to another that we are there, experiencing joy or peace, fear or hope, ecstasy or despair, but only most effectively with a silent look, a nod¹⁰, perhaps the repetition of the few poetic words that got us there, or to compare the experience to something observed in nature or in another story we may have heard, whether scripture, myth, parable or fairy tale.

Poetry is the kind of language that young children often use when they speak. They may not often recite Blake or Shakespeare, but they will describe their experiences and desires, hopes and worries with the limited vocabulary they have available to them, which means that the words they use, like in poetry, carry much more freight. For children, words are only part of their expression—they also use their bodies, toys, stories and symbols through play, imagination, wonder and creativity. A doll may be another version of themselves going through chemotherapy, a gesture with hands and arms may be a feeling that happens in a CT scanner, or a story image may be about the relational dynamics of their home environment. All these ways of expression constitute a type of

¹⁰ See Miller, 2015, 79.

language domain, a domain to which the listening adults must be attuned in order to honor and receive the child's expressions.

Like with any language domain, this takes practice. Language domains, or as the Rev. Dr. Jerome Berryman describes them, "Communication domains," are the ways "...we coordinate our actions when we are attempting to be specific and intentional about our language. For example, when you go to an attorney or physician, you need to translate your everyday language into language of the legal or medical system" (Berryman, 2013, p.76). Similarly, when we provide spiritual care at a child's bedside or with a group of pediatric patients, we must look for ways to allow both the language that we communicate, and the language that we hear, to be situated within the language of spirituality. Sometimes, especially with children, this language goes beyond conversational discourse and begins to include imagination, wonder, pictures, ritual, music, and many other forms of expression that can be both verbal and non-verbal.

Before delving more fully into the language domain of spirituality, however, it will be helpful to situate it within the other language domains that exist in the clinical environment—specifically, in a children's hospital. By exploring how the language domain of spirituality differs from many other language domains that are extant in the clinical setting, we may be able to consider, then, how the notions of assessment-intervention-outcome may also differ when it comes to providing care to a child in the hospital.

First, I'd like to consider some more general language domains as described in Berryman's article, "The Chaplain's Strange Language" (Berryman, 2013, pp. 75-102). In this article, he describes several language domains, including science, ethics, art,

politics, philosophy and religion. Exploring these as a starting point, I will also add the language domain of spirituality and then explore how we might bridge the language domains of science and spirituality, leaving each fully intact and in relationship with one another in such a way that both the goals of healing and curing work concordantly in the care of a hospitalized child.

The Language Domain of Science

Science, for example, “coordinates the actions of people who use terms in precise ways to identify particular entities...,” and “puts such terms to work by combining them in agreed upon ways to make explanatory sentences. Models are constructed from experiments that explain how events in the experiment take place” and “[e]vents in the world are inferred from such experiments and assigned a probability” (Berryman, 2013, 77).

To put this in context, let’s consider how this works in a simplified clinical circumstance. Jane, an 8-year old girl, has a body temperature above the normal range. The term ‘febrile’ is employed to describe this circumstance (‘febrile’ is a clinical term used to either denote or pertain to a ‘fever’). Based on experiments done in the past that have produced enough quantifiable evidence to reliably predict how to safely bring down a child’s temperature back into the normal range, the “evidence-based practice” of prescribing and administering, say, acetaminophen, is employed and the outcome is measured to determine the effectiveness. If the result of reducing the child’s temperature is achieved, the child’s body is now considered to be ‘afebrile,’ in which case the body temperature has been returned to the normal range as a result of the introduction of the medication into the child’s body. So, then, we have an assessment (the child is febrile),

and intervention (medication is prescribed and administered), and an outcome (the child becomes afebrile). This very simple example is the result of evidence-based, outcomes-oriented medicine and is communicated most effectively in the language domain of science.

The Language Domain of Ethics

Berryman explains, “While science gives us the reality of the experiment, ethics gives us the reality of human values. The subjective aspect of value is joined with the objective aspect in the world to provide a well-developed statement of reasoning” (Berryman, 2013, pp. 77-78). Ethics uses language to describe how what we agree we should or ought to do in relation to common societal (or theological, philosophical, etc...) values and are translated into action in a specific circumstance. Not all ethical systems are in agreement, but the language of ethics do agree, for the most part, on the terms they use to debate the concepts they may not agree on. To use our previous example, the ‘values’ of our western society says that when a child is suffering from a physical ailment, and the knowledge and resources exist to relieve suffering from that ailment, then we ‘ought’ or ‘should’ take the appropriate measures to act in such a way that we relieve that suffering. So, science tells us *what* to do to reduce a temperature when we encounter a febrile child at the hospital (prescribe medication and then measure the temperature again to determine if the desired outcome was achieved), and ethics tells us *why we should* do that in the first place (our agreed upon societal values are that when encountering the suffering of a child, we should act in a way that safely and reliably provides relief to that suffering).

Already, we can see that two distinct language domains can be bridged without compromising the integrity of the other. Fundamental to medicine is the well-known portion of the Hippocratic oath taken by physicians to “do no harm.” In this simple phrase, the action taken, the scientific “doing” is connected to the values that action is measured by, the ethics of not harming. It is my hope that we will be able to find a similar bridge between the language domains of science and spirituality as we move a bit further along in this discussion.

The Language Domain of Art

Art is a kind of language domain that “recreates life in another medium to express and identify the creator’s relation to life” (Berryman, 2013, 78) in a unique and phenomenological way—that is, the way in which a child’s consciousness experiences and interprets that phenomena which is encountered in life. If the child who suffered from a fever, was treated with medicine and then felt better drew a picture of her experience in the hospital--of arriving feeling sick, being in a strange room and a strange bed for a day or two and then feeling better and getting to go home--her picture may not even utilize words at all, but nevertheless would express and depict her experience of what happened in a particular kind of language domain. The child’s artistic expression would neither lack validity or truth, but is moving further into the more subjective of language domains, the place where what is measurable and quantifiable begins to be filtered through the un-measurable, the hard to describe but impossible to deny aspects of a child’s experience of observable and unobservable events. Prose, music or poetry could also be utilized, where stories, sounds and words can be used to point beyond themselves in order to more fully encapsulate the experience and expression of a given circumstance.

Children often mediate both clinical and spiritual experiences, as well as others, through the language domain of art.

The Language Domain of Politics

The language domain of politics “coordinates our actions through law and power. Legal structures provide the linguistic structures by which we must live, and power backs up these structures to force this reality on us whether we like it or not” (Berryman, 2013, p. 78). Most of the time, young children do not directly experience the language domain of politics in a hospital, though their experience is sometimes affected by the way in which political language interacts with and shapes their medical care in both helpful ways and arguably harmful ones. The political language domain interacts most often with the language domains of science and ethics in regard to the kinds of treatment, allocation of resources, funding, provider hierarchy, etc... While this is a very rich topic and a relevant domain of language in a hospital setting, adults generally use this language domain with one another and rarely with children.¹¹

The Language Domain of Philosophy

This language domain provides analysis of all of the other language domains, including its own. “We have a philosophy of science, ethics, art, politics, [and religion] for example. This thinking about a particular way of thinking is often joined with a

¹¹ It is, of course, a reality that while adults in the hospital rarely use political language with children, the structures placed upon pediatric care providers through politics and political language does affect them in direct and indirect ways. A child who needs a transplant of some kind, and who has access to resources to pay for that transplant, will have a very different experience than a child who, for whatever reason, may not have access to the same kind of care. The experiences of these two hypothetical children, shaped by the politics and political language of any given society, will be vastly different, and so will their spiritual and existential expressions about those experiences.

history of the way that kind of thinking has been carried on over the centuries” (Berryman, 2013, 7p. 8). It is an important language domain because it allows us, no matter how objective or subjective the language domain we are discussing, to do so in a somewhat reflective, self-removed and thoughtful manner. This very discussion is taking place within the language domain of philosophy and many language domains can be bridged through the perspectives gained from analyzing other language domains by utilizing this one. As we continue to discuss the spirituality of children, their needs, and the bridging of language domains between the scientific and the spiritual, we will be utilizing the philosophical language domain.

The Language Domain of Religion

The article in which Berryman discusses these language domains is entitled, “The Chaplain’s Strange Language” and it is in the religious language domain that the title of the article makes its case. The language domains discussed above consider the way in which we use agreed upon language domains to analyze how we explore limits to our knowledge, discuss how pushing the boundaries of these limitations can bring new knowledge and how to use that new knowledge to act in such a way that we bring about change in the situations and circumstances we find ourselves in. For example, in the scientific language domain, utilizing the language of experimentation, observation and evidence, we are able to develop new medications and interventions to treat certain medical conditions, thus moving beyond what was known about a given treatment for disease and enacting new knowledge to develop new medicines and new treatments that improve upon what was previously known in terms of curative outcomes. The religious language domain explores the limits and boundaries beyond which we cannot fully

know—the limits of our being and knowing. The religious language domain provides not only “a way to speak about what is literally unspeakable, but it also is a way to place all the other communication domains into perspective by referring them to these limits” (Berryman, 2013, p. 78). The language domain of science speaks about how we effect circumstances in the world by pushing the limits of what has been discovered into discovering what hasn’t through the scientific method. The religious language domain, by contrast, speaks of those limits that “by definition [are] beyond the power of speech to capture directly as if [they] were something in the world.” (Berryman, 2013, p. 79).

To talk about that which is impossible to fully capture through the above language domains requires a different kind of language, a “strange language” in contrast to the scientific—in religious traditions this is most commonly done through sacred stories, rituals, practices, symbols, parables, music and art. Religious language is employed in order that what lies beyond the limits of our being and knowing can “be put to work in pediatrics with children and families, as well as the health care team” in such a way that what carries meaning for all involved in the care of a child in the clinical setting has the proper perspective beyond that which an assessment-intervention-outcome model of description is capable of describing. (Berryman, 2013, 79).

A common example of this in the clinical context may be the belief that a trauma or illness befalling a child may carry some larger purpose, either for the child, the family or both, that relates to the larger meaning of life beyond the boundaries of physical existence—the idea that somehow, we know not how, God has a purpose for what is happening. Exploring that purpose, discovering that meaning, is how this child and family will engage with the clinical providers in terms of goals of care, whether those

goals move toward curative possibilities, permanent physical limitations or end-of-life realities. The well-known Old Testament story of Job may be employed by a family in trying to make sense of a particular tragedy or tragedies that befall their family, thus utilizing sacred story to find meaning in a situation that makes no other kind of sense.

It may help here to simplify the distinction between the scientific and religious ways of employing language by looking at the question, “Why?” When a child develops cancer, for example, she and her family may ask that question repeatedly. A physician may provide an answer by explaining the pathology of the disease, the behavior of cells and how that cellular behavior effects specific organs and how those effects interact with the physiology of the body as a whole and what can be expected to happen given what is known about that type of disease. This is the way in which the scientific language domain is employed to respond to such a question. But there is another kind of “why?” This other kind of “why?” is a question of meaning, not of pathology. “Why me?” “Why my child?” “Why now?” From the religious language domain, the answers will depend completely on the religious language (inclusive of word, symbol, ritual, etc...) embedded in the religious tradition the family is familiar with. For some, we may hear a parable, a scripture verse, a theology associated with a religious symbol (a Christian cross, for example, or the Buddhist image of a cherry blossom or lotus), and for others we may hear familiar phrases like, “God doesn’t give you more than you can handle,” or “God always has a reason.” None of these responses to the religious “why” really provide an answer in the same way a disease pathology does. In fact, the religious “why” really has no answer that makes sense within the limits of our being and knowing in the world. But the response to “why” in the religious language domain does provide a framework of

meaning, whether we personally agree with them or not,¹² that allows the child or family to sit in the paradox of needing an answer to the unanswerable and needing to feel anchored to something in this life while staying in relationship to what lies beyond this life. The religious language domain “does not approach the empirical ground for its coordination of human activity directly [like the scientific language domain does] but indirectly through sacred story, ritual, and parables” as they are found in their respective religious traditions. (Berryman, 2013, p. 79)

This is an important point: both the scientific or clinical language domain and the religious language domain can be employed at the same time, in the same room, with the same patient and family. Imagine a doctor and a chaplain sitting in a room talking to the family of a child just diagnosed with Leukemia and trying to respond to the question, “why?” The doctor will necessarily answer according to the knowledge they have of the disease process and pathology. The chaplain will answer the same question very differently, in a “strange language,” that seeks to guide the family to find the answer that best allows them to hold that paradox of knowing and not knowing within a framework of meaning that resonates with their beliefs. To try to answer the question “why?” in *either* a scientific manner *or* a religious (I would argue, ‘spiritual’) manner alone does not

¹² Each person—child, family member, clinician, chaplain, etc...--is rooted in their own understanding and experience. Many children and families will make meaning of illness that are in line with, uncomfortable for, or even antithetical to, our own way of finding meaning in the question, “why?” It is, however, incumbent upon all who bear witness to the way in which a child and family make meaning in answering this question to reflect and affirm the meaning the family is making for themselves, regardless of our own personal religious beliefs. Often, the answer to the religious “why?” will change, transform and evolve over the course of a disease process, or it will remain unchanged and anchor the child and family in their approach to answering the unanswerable. The job of the chaplain and other clinical providers is to help them negotiate the inherent ambiguity of the question in a way that support the child and family’s religious or spiritual needs. It is also important that the chaplain supports the clinicians in the same way—knowing that the beliefs of the clinicians may be quite different than those of the child and family that they are caring for.

fully address the enormity of the question. Both ways of approaching the question are necessary at any given time, depending on which language domain the child or family are employing in their asking it. The point here is that to subsume one language domain into the other compromises the integrity of both of those language domains and does not provide a container for the family to sit in the paradox that they are assuredly experiencing, but have no way of expressing without utilizing both domains of expression.

The Spiritual Language Domain

The Spiritual language domain is very similar to the religious language domain in its approach to the question, “why?” I suggest that *both* the scientific/clinical language domain, rooted in the “assessment-intervention-outcome” model of describing pediatric patient care *and* the spiritual language domain are necessary in order to provide holistic and healing care to hospitalized children and their families. I also suggest that when it comes to the spiritual language domain, and the pediatric spiritual care it describes, the “assessment-intervention-outcome” model as it is understood in the clinical/scientific language domain is not an appropriate framework of communication, but can still work in an adapted form, using the language domain of spirituality. A model more focused on the building, connecting and expressing of spirituality and relationality seems better suited to discuss the sacred relationships that children’s spirituality expresses as well as the relationships necessary to exist between the child and the spiritual care provider in order for this expression to occur. More of this will be explored in-depth in subsequent chapters. For now, I would like to keep this distinction in mind, while continuing to

explore what I see as a need to add the ‘Spiritual’ language domain, as distinct from the ‘Religious,’ in Berryman’s description of “the Chaplain’s Strange Language.”

In some views, the spiritual and the religious should not necessarily be separated. Indeed, “Spirituality and Religion are, after all, rather large elements in human life, elements that constitute the very world views through which persons organize and interpret their experiences and attempt to live out their deep yearnings and desires” (Mercer, 2006, 501). Nevertheless, in the US, Europe and western culture (though not exclusively), the phrase, “I’m spiritual but not religious” is becoming more and more resonant. Regardless of what Mercer describes as the “highly contested and complex terrain” that this distinction entails, it “can be particularly helpful in health care settings where spiritual and religious caregivers as well as other clinicians need to attentively and sensitively work across differences in belief systems” (Mercer, 2006, 501). I am aware that this is, in some sense, the philosophical language domain at work in making this distinction and is more for the benefit of the adults having the conversation. But this is necessary because the providers at the bedside are “meta-communicating” to one another across all of these language domains, and it is necessary to make the distinctions that will allow those language domains to be bridged, even if “adults may ‘over-value’ the distinction...in ways not relevant to the experiences of children” (Mercer, 2006, 501).

In a clinical setting, the spiritual language domain, like the religious, is about finding hope and meaning making in the midst of illness and in the face of the limits of being and knowing as described above.¹³ Where the difference may lie, if we allow for

¹³ These limits to being and knowing, or “existential limits” are based on the work of existential psychotherapist, Irvin D. Yalom and will be discussed in depth in Chapter 2. The limits to being and knowing as developed by Yalom are: death, freedom, aloneness and meaninglessness (Yalom, 1980).

the distinction between the two, is that the religious expressions of spirituality, through the language of a specific religious tradition, comes out of a particular set of stories, symbols, practices and rituals associated with the tradition in which they find identity and value—a shared narrative, symbology, and a core set of beliefs as they relate to God, the Transcendent or to whatever is “bigger than me” and gives shape to our meaning, purpose and values (Crompton, 1998). Of course, some may have been raised in, or exposed to, or interested in several of these traditions and may have access to a variety of religious stories, symbols, practices and rituals while identifying with various aspects of this or that religious tradition. The distinction between the religious language system and the spiritual language system, I propose, is in the fact that spiritual experiences can occur with *or without* exposure to a particular religious tradition. The difference, then, is in spiritual expression—where a child raised in a particular religious tradition may express a spiritual experience or existential limit within the container of the tradition in which they have been raised, a child with no religious identity or instruction may have a similar spiritual experience, but the expression of that experience will not necessarily have access to the elements of a particular tradition to call upon, with its symbols, narratives, practices and the like. The “non-religious” child will nonetheless express herself spiritually by using those aspects of being and knowing that she does have access to by virtue of living in the world, while experiencing a relational connection to the limits that are beyond her knowledge of being in the world. The language with which a child expresses her spirituality, while approaching, for example, the “why?” in a similar way as the religious language domain, will not have what we normally consider “religious” content, though it be no less spiritual. “Nikki,” whose story we heard in the introduction

to this paper, if having heard the story of Hagar and Ishmael, common to Judaism, Christianity and Islam, may relate her experience of being in a strange place with her mom, separated from her father and uncertain about what will happen, to the story of Hagar and Ishmael in the desert where God hears the cry of Hagar for her thirsty and starving child and provides a spring of water that allows them to find sustenance. Nikki used the elements of a different story (the Parable of the Good Shepherd) to *create her own story* about a man and a woman who had to be together to get the key out of the tree¹⁴. While this may not necessarily be a ‘religious’ story, it remains the case that there was an expression of spirituality as it connects to her experience of the existential limit of aloneness as well as her relationship with her mother and seeing her mother alone and worried. Through the creative process of engaging narrative and employing imagination, symbol and play, she describes her relationship to her parents and how their being together in her life can accomplish things that seemingly can’t be accomplished when they are not (together, they can get the “key”; alone, they cannot). Nikki’s expression of meaning utilizes the spiritual language domain, framed in “Relational Consciousness”¹⁵, and while this gets to the same kind of knowing that the religious language system does,

¹⁴ It is important here to note that Nikki’s spiritual expression is not diagnostic—there is no DSM V reference here for the spiritual care provider. As I have said, the chaplain (myself in this case) is not diagnostically assessing, but rather, providing a “space” for expressing spiritually significant relationships and felt existential limits by the child. It is in the expression of the child herself, and in the relationship that facilitates that expression, that is what contributes to meaning-making and, thus, healing in the spiritual sense. For Nikki, whatever the “key” might be (she may not consciously know), it is the relationship that she has to her parents that connects her to that transcendent, hard to describe but ultimately important symbol unique to 5-year old Nikki and her experience.

¹⁵ Why describing her relationship to her parents and the meaning she makes with it constitutes a spiritual expression will be discussed later in this chapter as we describe ‘spirituality’ below, as well as in Chapter 2 when discussing Hay and Nye’s framework of ‘Relational Consciousness’ in more depth. Briefly, Relational Consciousness in Hay and Nye’s framework is the capacity for, and expression of, spirituality through relationships with the self/Self (self-reflective/self-aware), others (family, friends, community, humanity), nature/Creation, and God/the Transcendent.

it does not necessitate a religious vocabulary or even a formal understanding of what ‘religion’ is whether in belief, community or practice.

This can also be helpful considering that the milieu of the clinical setting, with not only a diversity of clinical disciplines, but also a diversity of beliefs, practices and religious and/or spiritual identities exists within the team of adults caring for each child. By utilizing a spiritual language system that encapsulates spiritual expression that is inclusive of, but not limited to, religious expression, then communicating the spiritual needs or priorities of a child to the team is freed from any unintended or misunderstood connotations that one religious understanding may have in regard to a religious tradition that is unfamiliar. Speaking about Nikki’s awareness of the existential limit of being alone (for both her and her mom), and the meaning-making that she engaged in while imagining “the man and the woman” together and how that makes the world in which she lives open to different possibilities (it’s the only way to get the “key”) is communicating something—what matters most to Nikki is going through her journey with, presumably, both parents present in her life. This is, I will argue, an expression of Nikki’s spirituality, but without the religious language we might normally expect from a child who has a religious tradition to draw from.

How, then, is Nikki’s portrayal of the man and woman getting the key together an expression of spirituality? We must first discuss what is meant by the term ‘spirituality’ and then consider the way in which we hear the expressions of children when utilizing the spiritual lens.

‘Spirituality’

‘Spirituality’ is a notoriously difficult term to define by itself, let alone finding clarity in what we mean when we talk about ‘Children’s Spirituality.’ I will consider several definitions of ‘spirituality’ from across disciplines and will then offer a working understanding (as opposed to a definition) of ‘spirituality’ as it will be used throughout this work.

“Spirituality is an inner sense of relationship to a higher power that is loving and guiding. The word we give to this higher power might be God, nature, spirit, the universe, the creator, or other words that represent a divine presence. But the important point is that spirituality encompasses our relationship and dialogue with this higher presence.” (Miller, 2015, 25) (*Lisa Miller, PhD, psychologist, describing the term “as it exists as a crucial dimension of spirituality in science.”*)

“[T]he anthropologists, psychologists, sociologists or other scientists who might study this human phenomenon will define it from their specific interests. Knowing full well that the following definition is also so influenced, I understand religion as *the human quest for the transcendent in which one’s relationship with an ultimate ground of being is brought to consciousness and somehow given expression.*” (Groome, 1980, 22) Thomas Groome, professor of Theology and Religious Education. (*While this is Dr. Groome’s definition of ‘religion,’ embedded is the notion of “relationship,” “consciousness” and “expression” in regard to the “transcendent.” These elements, I would argue, are integral to a core understanding of ‘spirituality.’*)

“I define the spiritual as the dimension of life that reflects the need to find meaning in existence and in which we respond to the sacred. In this work I don’t make distinctions between the term *spiritual* and the related terms: *spirituality, religion, religiosity, pastoral, faith, or belief.* In fact, I use them interchangeably at times.” (Fitchett, 1993, p. 16) (*George Fitchett, DMin, PhD. Dr. Fitchett is a leading researcher in Pastoral Care and Chaplaincy in healthcare. This definition is a good example of how muddy the waters can be in discussing ‘spirituality.’ What is helpful here is that he notes that finding meaning as it relates to the existential through a responsive relationship to the sacred is part of the definition.*)

“Spirituality in its broadest meaning is what gives people ultimate meaning and purpose. For some that is seen in a religious or cultural context, for others it maybe [sic] in family, nature, the arts or philosophy. We all have something deep within ourselves, that sense of ultimate value and the ongoing search for meaning. What is this life all about, and what really matters? What is the meaning we derive from our profession as

healers? What are we called to?” (Puchalski & Guenther, 2012, p. 255)
Christina Puchalski, MD, MS has been the Director of the George Washington Institute for Spirituality and Health and Professor at the George Washington University School of Medicine and Health Sciences. *(The emphasis here on “meaning and purpose” and the variety of contexts in which that might be found here is important. Also important is the notion that ‘spirituality’ is common and innate to each of us.)*

Many more definitions could be offered, each with varying degrees of similarity or difference. While defining ‘spirituality’ conclusively is nearly impossible (like “catching a cloud and pinning it down”), what can be done is to talk about the aspects that seem common to the experience and expression of spirituality in children and adults, in its capacity and its ability to connect a person to meaning and purpose through relationships. As such, not only will my understanding of ‘spirituality’ derive primarily from the qualitative study done by David Hay and Rebecca Nye in 1998, but it will also anchor the framework in which I believe we can recognize the spiritual expressions of children in a clinical setting and thereby discover and support relationships with that which is most important to a child at a given time.

Nye describes spirituality by way of its key features:

Children’s spirituality is an *initially natural capacity* for awareness of the sacred quality to life experiences. This awareness can be *conscious* or *unconscious*, and sometimes fluctuates between both, but in both cases can affect actions, feelings and thoughts. In childhood, spirituality is especially about being attracted towards ‘being in relation,’ *responding to a call to relate* to more than ‘just me’—i.e. to others, to God, to creation or to a deeper inner sense of Self. This encounter with transcendence can happen in specific experiences or moments, as well as through imaginative or reflective activity (thoughts and meaning making). (Nye, 2009, 6)

In a nutshell, what Nye is describing is “Relational Consciousness”—the way in which a child’s spirituality is expressed through relationship with self, others, nature/Creation and God/the Transcendent. “[R]elational consciousness [is] a good working definition when

we keep in mind that the four dimensions of relationships named by Hay [and Nye](God/Mystery/Transcendence, others, world, and self) point us to spirituality as concerned with the deepest levels of human experiencing, the places of ultimacy, value, and deepest meaning in and for our lives.” (Mercer, 2006, p. 503) As mentioned above, this way of describing children’s spirituality comes from an evidence-based, qualitative study done in 1998 by Rebecca Nye and David Hay as reported in their revised book, *The Spirit of the Child (2006)*. The framework they developed to describe expressions of children’s spirituality they called “Relational Consciousness.”

In the next chapter, I will briefly describe its general acceptance in the field, and will go more deeply into Relational Consciousness and the accompanying existential framework taken from Yalom (1980) and Berryman (1991) as a way of situating the spiritual expressions of children into the provision of pediatric spiritual care later in this work.

Conclusion

In this chapter, I have explored the various language domains that exist in the clinical setting and have suggested that both the spiritual *and* scientific language domains, and the kinds of pediatric care they describe, are necessary in order to provide healing care for hospitalized children. I have suggested that the necessary model of communicating scientific/clinical interventions and outcomes in the strictly scientific language domain are not appropriate for spiritual care with children, hinting that “spiritual/relational outcomes” described within the spiritual language domain may be more efficacious in communicating spiritual care “interventions” to the IDT. I, and others in the field, have proposed that the framework of “relational consciousness” as developed

by Hay and Nye is an accepted and effective framework through which to identify the spiritual expressions of children, and that these expressions may not come only from verbal expressions, but through other mediums such as narrative play, art, imagination, music, poetry or even silence. I have suggested that it is through these spiritual expressions that children are able to communicate, in their own unique language, what matters most to them and what it is that they need most, which, in its expression in the language domain of the spiritual, is an element of healing.

In chapter 2, I will explore more fully the framework of “relational consciousness” as well as introducing Yalom’s framework of existential limits, Berryman’s incorporation of these limits into his theory of supporting children’s spirituality, and the way in which both of these frameworks combined can provide the chaplain or spiritual care provider with a way of receiving the spiritual expressions of children in a way that contributes to a child’s healing, as well as a way of communicating to the care team what matters most to the child for whom they provide care.

I will then explore the difference between commonly used tools such as “spiritual assessments” and “spiritual screenings” as they are employed in both pediatric and adult clinical settings, discuss the differences between assessments and screenings, and explore why current models seem to fall short of really engaging children (especially children 12 and under) in a way that allows for spiritual expression and healing. I will then discuss alternate approaches offered by others in terms of assessing children’s spirituality in the clinical setting and communicating those assessments to the IDT. I will offer a critique of these approaches and find synthesis with them as well, hoping to establish a clear and relevant framework in regard to approaching the spiritual support of children, both in

practice and in communicating that support to the care team. Finally, I will summarize the theory of approach to supporting children's spirituality in the clinical setting as I see it and suggest a model for communicating this model to the IDT in both charting and verbal communication with IDT colleagues in developing a plan of care.

Chapter 2—Relational Consciousness, Existential Limits, the Creative Process and the Child's Voice in Pediatric Spiritual Care

Many scholars in the field of children's spirituality have taken Hay and Nye's relational consciousness as the conceptual basis for studying the spiritual expressions of children (Michaelson, et al, 2016; Bakker, et al, 2018; Mercer, 2006; Campbell & Minor, 2018; Campbell & Nash, 2018; Campbell and Minor, 2016). In a 2018 article, "The Spirituality of Children with Chronic Conditions: A Qualitative Meta-Synthesis," (Bakkar, et al.) the authors note:

"The many results found regarding the relational aspects of spirituality seems to confirm the theory of Hay and Nye (2006) which describes spirituality in children as a 'relational consciousness.' It also supports the claim that the spirituality of children is complex and varied (Drutchas & Anandarajah, 2014), adding complexity when the healthcare context comes into play."

It is with this in mind that I have chosen this framework as a way to talk about children's spirituality without specifically defining it. More useful is the way in which we talk about the characteristics of children's spirituality, the way in which children's spirituality is expressed and the ability of relational consciousness to allow the spiritual care provider to hone in on what matters most to a child and where that child finds deep spiritual meaning through personal expressions of existential limits and the relationships in their lives that are most spiritually connecting.

For Nikki (see p. 6), then, her spiritual expression lies in the relationship she describes between the figures she uses in the story she created, the "key," or symbol of meaning she employs in that story, and the way in which "we" can get the key in relationship to the "man and woman," placing herself within a relationship to those she needs to get the "key." While Nikki's expressions do not necessarily contain any specific religious content (though we don't know what the "key" is to her), the story she

told was an expression of relationships that can be placed within the framework of relational consciousness and is, therefore, a spiritual expression about the meaning Nikki is making through symbols that carry more freight than mere words can. Importantly, Nikki is given the medium of narrative, play, wonder, imagination and creativity (all aspects of expression within the spiritual language domain) in order to facilitate this spiritual expression, rather than relying on the kinds of vocabulary and cognitive development exclusive to adults, to which Nikki has only limited access at 5 years-old.

“Joyce”

Just adjacent to the Pastoral Care office in a large Children’s hospital is the Family Room where chaplains offer space to the families of patients who might need it. The reasons families need this space varies—their child/grandchild/sibling, etc... may be having a long surgery and they need a place to wait that offers some privacy and can accommodate several visitors. It may be that an out-of-town family is having to remain at the hospital for an unexpectedly long time while their child is being treated and needs a place to stay for the night. Or it may be that the patient for whom they are here is in the Pediatric Intensive Care Unit (PICU) where there are restrictions as to the number and ages of those who can visit in the patient’s room.

“Joyce,” and eleven-year old sister to a PICU patient was in the family room next to the Chaplains’ office. She was there with several family members, including numerous cousins. The day before, Joyce’s father and two brothers were in a car accident that ended the lives of two of her family members. One brother, “Alex,” survived the accident and he was now in the PICU fighting for his life.

Joyce’s 19-year old cousin, “Jill,” was in the Family Room with several younger cousins, a few aunts and uncles and Joyce. Jill asked the chaplain about the Godly Play® Chapel across from the Family Room, wondering if she and the children she was with could use it. The chaplain invited them in.

“This is the kind of room you really need to be ready to enter,” the chaplain said to the group of 5 family members (ages 7-19), including Joyce. “It’s full of stories, and if you feel ready, they might open up for you and help you find what you need. Are you ready to go in?” Each family member, in turn, expressed that they were ready in their own way.

The chaplain and the family members sat in a circle and the chaplain showed them a story on a shelf in one corner of the room. The chaplain told the children the Godly Play®

story of “Creation,” which focuses on all of the gifts we have received from God since “all the way back to the beginning, and even a little before the beginning.” (Berryman, 2005, 41-48) Each “day” of Creation is described according to the Old Testament story, common to Judaism, Christianity and Islam, and is accompanied by a picture that describes the gift that each day brings. The gifts are: light on the first day, water on the second, dry land and green and growing things on the third, the sun, moon and stars—our way of keeping time—on the fourth, all of the creatures that fly and all of the creatures that swim on the fifth, all of the creatures that move about the earth—even creatures like you and me—on the sixth, and the gift of rest on the seventh day so that we can reflect on and enjoy all of the other gifts of Creation. The story is told slowly and carefully according to the script of the Godly Play® volume that contains it. After the story is finished, the chaplain begins to wonder with the circle according to Berryman’s methodology. Everyone is assured that there are no right or wrong answers when it comes to wondering about the story.

“I wonder what day in this story you like the best?” “I wonder what day you think is the most important,” the chaplain asks, “which may or may not be the same as the part you like the best?” “I wonder if there is a day you would want to take out so we have all the days we need?”

Each wondering question is asked and then lots of space and silence is left for the wondering, both silent and aloud, to take place. Joyce’s cousins all wondered aloud with each question, but Joyce remained silent, though engaged.

The chaplain then asked the last question, “I wonder which day you see yourself in, or which one of the days is especially about you?”

Joyce spoke first, pointing at the sixth day, where all the creatures that move upon the earth were created, and places her hand on the two human figures on the associated depiction.

“I’m in this day,” Joyce says. “it’s like being in that room with all of my family.” The chaplain repeats Joyce’s phrases back to her, without reframing them or exploring them—simply reflecting her words back so she knows she is being heard. “You are in the sixth day, because that’s where all of your family is—like in the room across the hall.”

“Yes,” Joyce says. “My family used to be eight, but now we’re only six. My dad and brother died.”

The Chaplain repeats Joyce’s words, and she nods an affirmation. There is a bit of silence in the room and when it is clear nobody else in the circle has more to say about the story, the chaplain invites them each to utilize the art materials in the room to create a response to the story however they like—there is no right or wrong way to do this kind of “work.”

After the art responses (each child chose to keep their work to show to their family), the chaplain and family leave the Godly Play chapel and the family returns to the Family Room. The 19-year old cousin, Jill, pulls the chaplain aside and is tearful.

“I can’t believe she knows,” Jill says.

“What is it you didn’t think she knew?” the chaplain asks carefully.

“Well, we all know what happened to her dad and brothers, but we haven’t been talking about it because we don’t want to upset her. But when she said that her dad and one brother died—that’s the first time she’s said anything about it since the accident.”

Relational Consciousness

Relational Consciousness as developed by Hay and Nye came from the need for a framework that allowed those involved in researching children’s spirituality to distinguish ‘spirituality’ from ‘religion’ in such a way that both the children and the researchers were freed from the limitations of exclusively religious language when focusing on children’s expressions that seemed to be of a spiritual nature, but had no formal religious content. As Daniel G. Scott, professor in the School of Child and Youth Care at the University of Victoria explains:

In the absence of a ready non-religious vocabulary for expressing spiritual experiences, both researchers’ questions and children’s responses are shaped by the language that is available to express the ideas being explored. This language is based on the religious language of the dominant culture in which a child lives, regardless of children’s identification as religious or non-religious. Such use of language could be seen as an indication that religious language is adequate, or even necessary, or, as Hay is suggesting, that there is a deficit and a need to explore spiritual experience through metaphors and language that might liberate the expression of the spiritual from religious language. Children are thus caught in a theoretical and cultural deficit demonstrated by the absence of alternate language forms. They do not have access to a vocabulary or concepts that would allow them to speak openly of their experiences if they are not locating them in religious contexts. (2003, 119-120)

Quoting Hay and Nye in 1998:

Knowledge *about* religion and the ability to use religious language is not the whole story when we are thinking about spirituality. It is important not

to get caught into the assumption that spirituality can only be recognized in the use of a specialized religious language. I have spoken about the difficulty with almost all research on children's spiritual life, up to the very recent past, in that it has been focused on God-talk rather than spirituality. I have also presented a notion of spirituality as something biologically built into the human species, an holistic awareness of reality which is potentially to be found in every human being (p. 57) (Scott, 2003, 119)

The point here is that the religious language of the dominant culture, and so of the adults doing the research, was all that was at hand when exploring the deep spiritual experiences that children often encounter and try to make meaning of. This meant that, while the content of children's experiences may have been quite available to them from a phenomenological point of view, they had no way of expressing those experiences outside the dominant language of religion and culture, even if the religion and culture was not their own, at least in a way that could be heard by the researchers as spiritual expressions. Further, I would argue, the language of 'adult' also was a hindrance insofar as the only way to receive the spiritual expressions of children on the part of the researchers was through the 'adult' understanding of how spirituality is expressed (i.e., through "God-talk."). The need to find some other way to listen to and recognize children's spiritual expressions without either the confines of the dominant religio-cultural vocabulary system on the one hand, or a reductionist, adult-laden positivism on the other, was identified.

In order to hone in on how individual children expressed themselves spiritually, Nye, using a grounded theory approach, interviewed 38 children under the age of 10 and gathered over 1000 pages of data (Hay & Nye, 2006). While there was the necessary cross-sectional examination of data and a general framework was developed out of this qualitative study, Nye points out something important: "Even in these rather constrained

research conditions, the expression of spirituality had a markedly individual character that seemed to reflect the unique disposition of each child. In fact, the primary influences on a child's spirituality appeared to flow from his or her personality" (Hay & Nye, 2006, 94). This is an important consideration in the clinical setting—the primary question of providing spiritual support for hospitalized children is, “what does *this* child need? What matters to *this* child?” The framework that relational consciousness provides gives the spiritual care provider a guide for listening to what constitutes spiritual expression through relationships, but what each child “means” is unique to their own personalities, histories and experiences. And that meaning may or may not be consciously available to them at the time of the spiritual expression. It is my contention, however, that whether the child has immediate access to what the spiritual expression means to them or not, *the expression itself is a means to healing through the meaning-making it opens up for that particular child.*¹⁶

Relational consciousness, then, in its simplest terms, is “a research-based way of defining children's spirituality...especially found in the child's emerging *awareness of themselves in relation to others, the world, and God* [my italics]” (Nye, 2009, p. 80). This awareness comes from “three sensitivities: awareness-sensing, mystery-sensing and

¹⁶ For example, what exactly was Nikki's “key?” Or what does it mean to Joyce to say for the first time, “my dad and brother died?” By bringing both symbol and circumstance to awareness, respectively, each child has access to an acknowledged need or a safe expression of realization that they hadn't necessarily had access to before. This access was provided by the chaplain by offering a context or container in which to express themselves and their awareness. In each of these cases, it was a Godly Play “intervention” that provided the container for their spiritual symbols and expressions—in one case involving how life goes forward through desired relationships, in the other, in acknowledging relationships with those whose lives have ended. In both cases, each child used aspects of relational consciousness to move closer toward one or more of the existential limits: aloneness, death, freedom and the need to make meaning (see discussion below).

value-sensing, to describe their view of a child's spiritual capabilities" (Scott, 2003, p. 120). These senses are derived from the researchers' observances of children being, in the case of awareness-sensing, "present in the here-and-now with an ability to be attuned through a heightened sense of awareness to an experience" and "both grounded in the body and simultaneously transcendent of the ordinary;" in the case of mystery-sensing, the capacity of children to experience life as "not already explained but...experienced as fresh and 'therefore mysterious;'" and in value-sensing as "based on children's capacity to experience a wide range of emotions and feelings from terror to delight, from despair to hope...[claiming] that part of their ability to delight and despair is based on a sense of ultimate goodness." (Scott, 2003, 121-124)

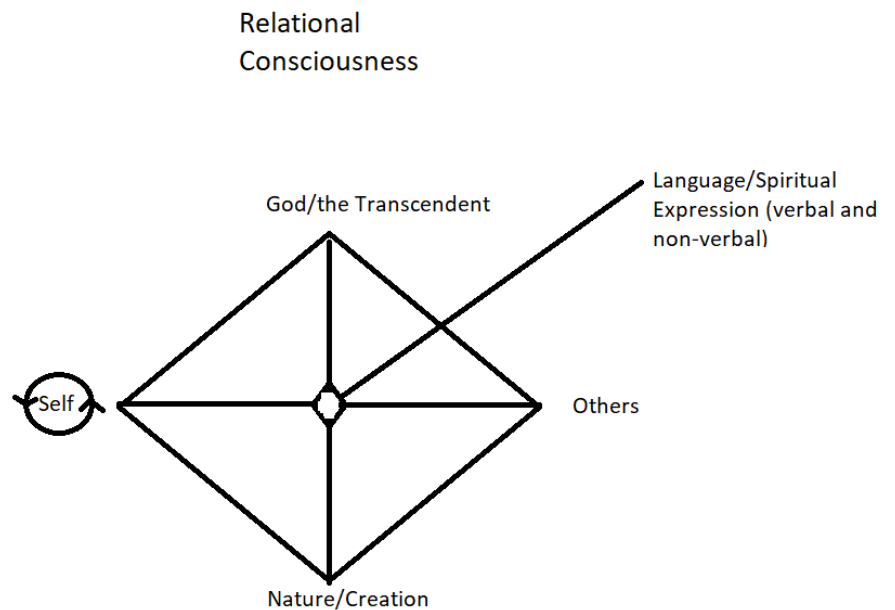
It is through these senses of awareness, mystery and value that children are capable of experiencing the spiritual aspects inherent in their lives. Children then express those spiritual experiences through the context of relationships that exist both inter- and intra-personally between themselves, others, nature/Creation and the Transcendent/God. "Children also experience moments of meaning-sensing which can include the transcendent moments of unity or oneness that take them out of or beyond the limits of their context, which may provide them with a sense of meaning that has a life-long sustaining potential." (Scott, 2003, 124).

Consider which aspects of awareness-, mystery- or value-sensing might be present in order that 11-year old Joyce can simultaneously feel connected to all of "Creation" and the humans depicted on a card representing the "sixth day", embedded in a sacred story, while also verbalizing to her cousins, for the first time out loud, that her father and brother have died. Consider Joyce's meaning-making and the feelings of

connection she has to the humans depicted in the story as “gifts” from God, while also being in relationship to two family members who have literally just died. Joyce still seems to feel connected to those departed loved ones as an ongoing part of the collective human family despite their no longer being immediately available to her in the way she’s always known. She is grieving the loss of a father and brother, while worried about another brother in the PICU. Trying to process family and relationships, grief and loss, hope and meaning—this is a difficult task for any person of any age, let alone an 11-year old girl. But with a story, a gesture and a few words, Joyce seemed able to consciously relate (*vis-à-vis* relational consciousness) to her own self-reflection about what ‘family’ is and where she experiences herself within it, to her relationship with others in her family (both alive and dead), to her sense of belonging within all that is (humans as part of a larger creation or nature as depicted in the narrative), and how that connects with her realization to what’s happening beyond her control (the Transcendent) but yet somehow still present in the figures she is touching and feeling connected to (the human figures depicted on the card and how she is connected to them).

This natural capacity exists within all children (and adults!) and the ability to utilize this framework helps to expand how children’s spiritual expressions can be received, nurtured and incorporated into the stories of hope and healing that are necessary for hospitalized persons and their family members, regardless of their age, but especially in children.

The figure below illustrates the elements of relational consciousness¹⁷:



While many have accepted the relational consciousness framework as an accurate lens through which to view the spiritual expressions of children, it is not without its critics. In his book, *Assessing and Communicating the Spiritual Needs of Children in Hospital*, Alister Bull notes that “Hay and Nye (1998) describe a ‘relational

¹⁷ In this figure, we see the four aspects of relational consciousness through which spirituality is expressed. The ‘self’, with arrows surrounding it, is indicative of the child’s own self-awareness, able to reflect intra-personally on her own sense of being and identity within the framework. ‘Others’ include family and friends, school, church and community groups, people-groups related to ethnicity, nationality and demography, and the whole of humanity as a species. ‘Nature/Creation’ incorporates the environment which surrounds the child, most fully manifest in the patterns of nature, seasons and places the child has encountered in memory, story or depiction. It may also include the places a child finds familiar like a bedroom, grandparents’ house, church or other type of “environment.” ‘God/Transcendent’ relates to that which is “bigger than me,” that is, what is known and felt through experience, but which is difficult to describe or even put into words, but that nevertheless is a real aspect of the mystery-sense of children described by Hay and Nye. Each of these four aspects of relational consciousness are in constant flow—none exists in isolation from the next, though spiritual expression may incorporate one, another or all simultaneously. The spiritual/relational expression comes about through the lens of language where all four intersect, though the ‘language’ may not always be verbal—it may also be through art, imagination, wonder, creativity, etc...

consciousness' which rests more on intrinsic qualities within the child. The difficulty with this perspective is that if a child does not display such a quality, there is a danger that the child is viewed as being incomplete or, as they conclude, having suppressed any sense of spirituality." (2017, 103) In the same paragraph, however, he then goes on to argue that "[m]eaning is constructed on the basis of visible mutual interaction with the patient and not from what is presumed to reside within them; if this does not happen, a healthcare professional is not taking into consideration their impact on a person's context."

I agree, that with any engagement with a child, the lack of specific "display" of a particular kind of quality might lead to providers thinking there is something lacking—a deficit or need that might be assumed necessary, but overlooked if not "displayed" in the way the provider might expect it to be. For example, a normally extroverted and socially interactive child who has suffered a setback during inpatient treatment might become more isolated and less interactive, choosing to stay in her room rather than engage with other providers or inpatients on the floor. Some may consider this lack of "display" of the patient's baseline personality to mean that there is a deficit, or something wrong, or even a "suppression" of the child's expected personality as observed by providers who are "assessing" the child observationally. However, my contention is that whatever the setback may be, this change in the child's behavior may indeed be about an expression of spirituality through some needed self-reflection, and a way of relating to others in a different way for now. Sometimes, the construction of meaning takes place in silence and contemplation, and not in verbal expression. We all have bad days, even children, and sometimes we just need to be alone. If a child sees that this is an accepted form of finding

meaning and this is affirmed to the child on the part of the chaplain, the child will trust the relationship with the chaplain more, and will more likely be able to engage in more interactive spiritual and existential meaning-making when she is ready to do so.

Bull's move away from focusing on the innate spiritual awareness and patient-centered expression of spirituality and meaning as described by relational consciousness to meaning being constructed on the basis of "visible mutual interaction" with the chaplain does not seem to resolve this issue. My understanding of Bull's argument is that simply observing a child and not seeing a "display" of spirituality is a flawed attempt to discover a child's spiritual expression because it lacks an engaged relationship between the chaplain and the child. It describes a removed observer just watching and waiting and then, when not seeing an expected expression of spirituality, there is a presumed lack, or a diagnosed deficit, of the child's spiritual capacity. Along with Bull, I agree this is a flawed approach. However, requiring a "visible mutual interaction" seems to me to be much the same thing, but is more focused on the facilitation by the chaplain and trusts less on the innate capacity of the child. If a child chooses not to engage, if there is no "visible" interaction, does this mean the child is not constructing meaning for herself? I would argue that if Joyce, for example, did not feel able to speak up in the Godly Play® chapel about the death of her father and brother, she would nevertheless have been constructing the same spiritual/relational meaning but may not have felt safe enough to "display" it visibly or otherwise in that moment. When she was ready, however, the images and experience of the story would be there for her and help her express the spirituality and meaning that was incubating within her after having been in that circle. I would hold that her own innate capacity to construct meaning for herself, as described in

relational consciousness, nevertheless maintains. Relational consciousness is a lens by which to view children's spiritual expressions, not an approach to engage it. I think here, Bull is confusing the theory with the praxis.

By requiring a "visible mutual interaction," my fear is that Bull's focus is more on what the chaplain can show others is happening in a child's spiritual expression through a chaplain's "intervention," rather than trusting that the child has an innate capacity, but is not ready to "display" the kinds of interaction Bull's model requires. Sometimes, it takes a long time to build the spiritual and relational trust necessary for a child to feel safe enough to connect and express themselves spiritually and existentially.

Bull focuses on a model of "connectedness," which he describes as "the visible and verbal statements of what is made visible and verbal between two individuals" (2017, 111). While I agree that "connection" is key to supporting the spiritual/relational expressions of children in the mission to help them find spiritual and existential meaning in the midst of illness, grief or difficulty, I believe that limiting those expressions to what is "visible and verbal" as evidence of connectedness is doing the same thing that he critiques relational consciousness researchers of doing. Rather, I would argue that through the lens of relational consciousness, the inability, or even unwillingness of a child to express spirituality or meaning visibly or verbally *is itself an expression of spirituality and meaning*, and the chaplain must have the skill and intuition to validate and affirm that expression as such. Bull is working hard to employ the assessment-intervention-outcome model in supporting children's spirituality. My argument is that his approach falls short because by using a scientific model of communication to facilitate meaning through spiritual and existential expression, he is trying to elicit the expression

of the spiritual language domain within the language domain of science. He is assessing and diagnosing a child's spirituality, based on a deficit/needs based model that requires observable, verbal expression, and overlooks the innate spiritual capacity of children to find meaning within themselves, mediated through relationships that honor all expressions of spirituality and meaning making, even when not verbal or visible. Some things you just can't see or say, but it doesn't mean they aren't already there.

Existential Limits

Often, spiritual awareness and expression points us toward one or more of the limits to our being and knowing. Sometimes, what becomes most spiritually relevant, and often anxiety producing, comes from bumping up against the limits of our own humanity—those limits beyond which we can have no direct experience within the inter- and intra-personal awareness of relationships that exist for us as described by relational consciousness. These limits to our being and knowing, these existential limits, are also important elements of children's spiritual expressions; we need to be aware of them when providing spiritual care, particularly in a hospital setting where these limits are often far more tangible and on the surface than in a child's normal, day-to-day life.

It is important here to note that the primary way of dealing with existential limits is to face them, to become aware of them and to find ways of expressing them whether in art, creative act, silence or word. All of the ways of expression of one's existential limits are done within the framework of relational consciousness—that is, they are made known

and dealt with in relationship with one's own self-awareness to begin with, but need also to be seen firmly within a relationship to others, to nature and to the Transcendent.

Existential limits cannot be alleviated or denied, but it is by coming to terms with them that we are able to employ our spirituality to find hope beyond these limits and to find meaning in the midst of them. "Existential issues are issues that do not yield to therapy. Awareness of such issues is not a symptom of pathology. It is a symptom that one is a human being. Pathology begins when so much energy is used to deny existential limits that energy is no longer available for growth" (Berryman, 1991, 57).

The existential limits as Yalom describes them are: Death, Aloneness, Freedom and Meaninglessness (Yalom, 1980; Berryman, 1991). I will talk about each one in turn, and then illustrate how these existential limits, along with relational consciousness, provide a framework from which we can identify spiritual expressions in children through the relationships that matter most to a child at a given time, and the limits to being and knowing that surround those relationships.¹⁸

It is also important here to note that none of these existential threats are experienced in isolation of the other three—they each contain within them aspect of all the others. While there are four sides to the square that comprise the existential limits, the square, which symbolizes the very limits to our being and knowing, is indeed one. So that when one is bumping up against the existential limit of death, for example, aloneness and freedom and the need for meaning is also closely related. However, these existential limits are often experienced more prominently in one or the other at any given time and

¹⁸ In a lecture given by Berryman at the General Theological Seminary in 2010, he reminds us that, as we recall from memory these four existential limits, we often forget one. "The one you forget is usually the one you're working on."

circumstance, particularly in a hospital where they are much closer to the surface of awareness.

The Existential Limit of Death

Death is an aspect of life that constantly surrounds us. This is a fact of which we are constantly (consciously and unconsciously) aware. In Western culture however, we generally avoid thinking, or at least talking, about it. When a child is in the hospital, the existential limit of death is much more in the forefront, especially if the reason for hospitalization is literally life-threatening.

Death is an existential limit for the simple reason that we simply don't know what happens on the other side of death. When a child comes close to this existential limit, anxiety can arise and questions become poignant—questions like, “What will it be like?”, “Will it hurt?”, “What happens to me after I die?”, “Will I see other family members who have died?”, “Will I still be able to see my family members who remain alive?”, “Can I talk to other people who have died and can they hear me?”, “What will happen to my body after I die?”, and many others according to each individual child. For most (though not all) children, these are questions that rarely if ever get asked of the adults in their lives for the simple fact that adults are not always comfortable talking about death with one another, let alone with their children. In asking these questions, children are often responded to with, “we don't need to talk about that—you have a long life ahead of you,” or “let's talk about something else.” I can remember as a child asking my mother about death as she put her laundry away in the closet. I may have been 4 or 5. I remember standing on her bed telling her I didn't want to die and asking her if I was going to die and asking her if it was ok if I didn't die, much in the same way a child might ask about

skipping a bath for a night. To my mother's credit, she didn't try to deflect the conversation or deny my questions had any merit in their asking. Her only response was, "We'll see", a phrase I often use with my own child when I don't have an answer (or the energy to answer) but don't want to deny the possibility. What this does do, however, is communicate to the child that this is not a topic of conversation the adult wants to have, and I don't know that I ever brought up death again with my mom, at least as it related to my own death, until I became an adult.

Children, especially young children, rarely get to explore the fact of death with adults. Death is considered to be too abstract a concept for them, or too morbid to consider or too far off to worry about. In the hospital, it's often the case that if we start talking about death, it means we are admitting that death is a real possibility, a place where parents are naturally (and understandably) anxious to avoid. The fact that children are fascinated with death, nonetheless, is evident when they are given an opportunity to explore it. In the Godly Play® story "The Great Family" (Berryman, 2005, 57-64), the characters of Abraham and Sarah both die and (in some versions of telling the story), are buried in the sand as part of the acknowledgment of their death. There have been countless times when, after having told this story, the children who decide to make the desert box their work¹⁹ will bury and re-bury the characters of Abraham and Sarah, as well as many other characters they may choose for the wooden figures used in the story to represent. It is not long before children of 5 or 6 will begin naming figures after pets or

¹⁹ The "desert box" is a material used in the telling of Godly Play® lessons that take place in the Old Testament and occur in the desert, in this case, Hebron. It is a box constructed of wood and plexi-glass that can be rolled on caster wheels to different places within the Godly Play® room. It contains sand to represent the desert. It is called the "desert box" so that the children know that it is uniquely tied to the stories that occur in the desert (itself an archetypal image), rather than just the sand of which the desert is, in part, composed of.

their own family members who have died, and then go on to bury them over and over. Giving them the ability to interact with this existential limit by literally allowing them to “bury” their dead and wonder what that means can go a long way in terms of normalizing death in a concrete and meaningful way.

The point here is that Death is an existential limit that children are aware of, rarely are given the opportunity to explore, but are quite clearly engaged with when given the opportunity. When in the hospital and confronted with either the death of a loved one in their family, or even the possibility of their own death, this existential limit can occupy a significant amount of spiritual “space” within the child. Providing an opportunity to engage, explore and express themselves about how they are bumping up against this existential limit can help them begin the process of meaning-making, re-frame what hope might be through a future story, and clear up some of that “space” so that they can begin working on other existential limits or important relationships within relational consciousness that may also need tending to.

It is, unfortunately, not at all a rare occurrence that the IDT team caring for a child are aware that a child will not survive their hospital admission. Often the team has this discussion with parents, who are then forced to consider what this means in terms of the direction of care, expected medical outcomes, and the comfort of their child throughout the dying process. It is also true that quite often, the family asks the IDT team not to disclose to their child the fact that she is dying. This is an example of how the existential limit of death is as uncomfortable for adults as it is for children, and often more so, particularly when it comes to the death of one’s own child.

“Allen”

“Allen,” a six-year old child who had undergone a bone marrow transplant on the unit I serve on as a chaplain explored his immanent death with many of his caregivers throughout his long admission in the hospital, both on the oncology unit and in the PICU. His parents, however, took the more difficult, but spiritually healing approach to bumping up against this existential limit in relationship with Allen. When it became clear that Allen would not survive his disease process, his parents, along with the IDT, had frank conversations with him about the fact that he would die. Rather than this being something he was not able to understand or cope with, Allen then began to explore other aspects of his life, whether watching traffic from the 12th floor window with his mom and noting “I bet none of them really know where they’re going,” or playing video games with his Child Life Specialist and communicating his trust in her simply by laying his head on her shoulder. He was also able to ask for things he knew he wanted to experience before his death, some of which included his grieving the kinds of relationships he observed adults having with one another, but which he knew he would never experience because of his young age. Allen, then, by being allowed to engage with the fact that he was dying, was then able to explore other areas of relational consciousness (relationships with his family and caregivers—“others” within the RC framework) and other existential limits (in particular, the “meaning” of his own life versus the lives of people on the freeway, far from the hospital, and what “where they’re going” might really mean for not only them, but for himself). Allen was even able to access his faith tradition and talk to his mom about how he would communicate with her after his death, an experience his mom verifies took place just the day after Allen’s physical life ended in the hospital.

I participated in Allen’s funeral, sharing the stories and the spirituality that both Allen and his parents clung to throughout their admission, treatment and the process of dying. It was clear that the wisdom, insight and clarity that Allen had, at 6 years old, was needing to be shared for his own healing journey. It was also clear that sharing his spiritual gifts and insights with others at his funeral was also part of theirs.

The Existential Limit of Aloneness

Another of the existential threats or limits is the limit of aloneness. Each of us must experience our own birth, and our own death, ultimately by ourselves.

Paradoxically, none of us can live in complete isolation—we are dependent upon the

relationships we have with others to survive. Neither our cells or organs, our congregations or hospitals, nor our nations or even our planet can survive without all else that exists within its given context (and ultimately, it is all one cosmic context). Children are aware of their dependence on others, even as infants and prior to their ability to articulate that awareness. Initially human infants experience the world as “me and not-me.” All is one and all is me, undifferentiated, until we begin to experience relationship with a “not-me.” The experience of our biological, emotional and spiritual needs is, phenomenologically, experienced within ourselves alone, but the satisfaction of those needs can only be met in relationship to others, who also share their own individual experiences. A child cries out of hunger, and a parent responds with nourishment, for example. The individual and respective needs for nourishment, on the one hand, and to nurture, on the other, are both met in the unity of relationship. The existential limit of aloneness becomes pronounced when we experience our individual needs, but either cannot find, or cannot imagine finding, anyone to satisfy that need through honest relationship.

Even our own experience of the other existential limits (i.e., “am I going to die?”, “what does this mean for my life?”, “what if I make the wrong decision?”) can push us toward the existential limit of aloneness when there is either nobody to explore these limits with, or no one is willing to consider these possibly life-altering circumstances in light of the religious or spiritual framework that we find ourselves connected to. We all know how it feels to feel alone, and when we encounter this feeling at the edge of existence, we feel all the more how existentially limiting this feeling can be.

When it comes to a child's experience of bumping up against this existential limit, aloneness can be pronounced in the hospital setting. Children undergoing chemotherapy, for example, may experience the comforting presence of their family and their providers, but they know ultimately that it is they alone who are experiencing their own disease process within their bodies, they alone who are feeling the stick of the needle accessing their port, and they alone who must find the necessary meaning they need in order to engender hope into the story of their diagnosis and within the context of the life they live. Children who are sick often seek out those who will care for them, only to find that others may want to distract or detract from the fact that the child is suffering existentially from the despair of having to undergo treatment for disease. Children may have meaningful experiences that they alone are privy to, and though they try to share this experience, may not be able to find adults who can simply be with them in that aloneness, without that experience being "swallowed up by some larger system or person" (Berryman, 2017, 100). Adults often unintentionally isolate a child's experience with good intention, but also (often unconsciously) avoid the very same existential limit of aloneness at work in themselves.

As a chaplain supporting one mother and son, for example, I was celebrating a patient's discharge with the child, while the nurse and mom went over discharge instructions for continuing care for the child outside the hospital. The 8-year-old boy said out loud, and without prompt (other than knowing I was his chaplain), "Sometimes I see God in the shower." Mom, somewhat uncomfortably, heard her child's exclamation and, breaking with the conversation with the nurse, turned and said, "Please don't say stuff like that," effectively shutting down the child's attempt to express an aspect of his

intimate experience of God and the sacred, his relational consciousness of the Transcendent. For the child, what he was trying to express from his own inner experience was not able to be received by the adults in the room, and so he was left to experience whatever sacred moments he wanted to give voice to, and receive affirmation for, alone and without acknowledgment—neither the nurse or myself as the chaplain intervened on the child’s behalf—something I regret with each remembering of this story.

As with the existential limit of death, aloneness is a limit that is uncomfortable for adults to speak about—the idea that what we experience in ourselves in our inner-most worlds cannot and should not be shared with others, because often that expression reminds others of their own subjectivity and of the fact that they often experience things that just cannot be made to make sense to anyone else—we are often alone in our own experiences and the meaning and consequence they hold for us. This relegates the child’s need to process those experiences to inner contemplation alone, effectively “swallowing up” the need to share subjective experience by a larger familial, systemic or cultural more that says “that’s private and should be kept to oneself.” Again, individual spiritual needs can only be met in relationship with others (Miller, 2015, 40-43).

Imagine this child, years later, after having a relapse of leukemia sitting in a hospital bed, surrounded by family, and having an inner experience of the fear of death, or an experience of a relative long departed communicating with them, or even what they experience as a comforting visitation from God or a vision of themselves far into the future, healthy and disease-free. Having learned earlier in childhood that these things are not appropriate to share with others, this experience must be kept to oneself, despite its importance in terms of what it might mean to the child in terms of healing through

meaning-making, hope and future story. Keeping this to himself leads that child into the limit of aloneness and a lack of ability to connect this experience with others through imaginative expression. This hampers the healing process of discovering meaning from that experience in his current context and moves the child further toward the existential limit of aloneness—only they alone experienced this and there is nobody with whom they can share that experience.

This is, of course, only one example of how a child might experience the existential limit of aloneness. It happens in other ways, too. Families often, after learning of a new diagnosis, will not want to communicate this fact to the child in order to “protect” them from what causes the adults themselves deep existential anxiety (i.e., the possibility of their child’s death).²⁰ In these cases, children may often notice their parents becoming tearful, or speaking in low voices, or having conversations outside of the child’s hospital room. The child, almost always intuiting that *something* is wrong, will take the cue that this is not something they are free to discuss with the adults in their lives. This further isolates the child because now, though they know something is up, and they know the adults know what it is, they alone are without the full picture and are excluded (again, with the best intention from the adults) from processing this existential limit with others. This further exacerbates the existential threat since whatever is going

²⁰ It is important here to note that, while the value of communicating truthfully with children the facts about their disease is predominant in our culture, this is often a very Western cultural value. Other cultures may see the role of not disclosing distressing medical news to family members, children and adult patients alike, as the role of the family—to protect the patient from distress.

on, there is nobody to talk about it with without the risk of upsetting the adults on whom the child depends.²¹

From the point of view of a pediatric chaplain, support of this child spiritually means providing them with a way to come up against the reality of this existential limit and helping them give voice to it, reflecting it back to them in a way that is supportive and affirming. Acknowledgment of the existential limit opens the creative process²² within the child, allowing that child to begin to search for ways to make meaning and find purpose alongside of (rather than in spite of) the awareness of the limit being experienced in the foreground.

I was once paged to a room to support the parents of a six-year-old child who was scheduled to have brain surgery the following day. Both of the child's parents were tearful and asking for prayer. I sat at the end of the bed, with the six-year-old girl facing me and her parents on either side of us. After mom asked for a prayer, I asked what the family would like to pray for and each parent tearfully expressed their petitions. When I asked the young girl what she would like to pray for, she responded, "I don't know why their crying—I'm the one who has to have surgery." She was able to express her awareness of her own experience of the existential limit of aloneness, while also in relationship to others—her parents and the chaplain. By incorporating this awareness into

²¹ For more on the "double bind," see Berryman, 2013, 111.

²² For more on the creative process within Berryman's theory and in terms of supporting the spirituality of children, see below.

a communal prayer²³, this limit was neither denied nor banished, but rather acknowledged as a difficult part of her sacred journey. She was able to experience existential aloneness, while also acknowledging that she was not alone in terms of the supportive relationships that she needed and found in her parents' love and in their spiritual practices (in this case, prayer). She was able to both bump up against the limit of aloneness AND have her spiritual needs met through her relationship with her parents and the spiritual care provider at her bedside.

Children are quite aware of this existential limit, and it is often in acknowledging this experience of being alone that children are free to make meaning. Recall Nikki and her search for the key in the introduction. She was not able to find the key on her own, but with her parents and she together, they were able to find what she was searching for, though whatever need the key represented seemed to be for her alone.

The Existential Limit of Meaninglessness

Jerome Berryman notes that when he was Chaplain at Texas Medical Center in Houston, many of the children with whom he worked who had attempted suicide had something in common—they had not heard their own stories and the stories of their family. Part of the treatment plan, then, was to facilitate, whenever possible, patients and

²³ The exact prayer I said was not recorded verbatim, but it was close to the following: "Gracious and loving God, we come to you and ask you to send your Holy Spirit upon your beloved daughter "Lacie." We ask that you bless the doctors, nurses and all who care for her, especially in surgery tomorrow, and that you work through their hands, their minds and their hearts, and guide their care for Lacie with wisdom and love. We ask that you bless her parents who worry for her because they love her—let them know you are with Lacie, within her, and that you surround her with your Love. Let them be comforted in knowing you walk with her throughout this journey. *Bless Lacie that she knows your peace and knows that even though she alone will be having this surgery, that You are there and that she will see her parents faces before and after, and that the people who care for her will keep her safe.* We ask that you bring her healing and wholeness in body, mind, heart and soul, and that You walk with her always, holding her in Your Light and Love. All this we ask in faith. Amen."

families telling and listening to stories about their families, their ancestors, their birthdays, their treasures. There is something vitally important to knowing the story of our birth, how we were named, where we came from and the stories that shaped the lives and beliefs of those who shape our own lives and beliefs. Narrative, symbol and ritual are each inherent to the human experience and impetus to make meaning. Where we lack narrative, symbol, meaning and purpose, we are up against the existential threat of meaninglessness—the idea that perhaps our lives mean nothing, that our relationships mean nothing, that whatever we are diagnosed with means nothing, that we are connected to nothing, that there is nothing we can do. Children suffering from life-limiting or even terminal diseases, as well as those who aren't, need to be able to wonder about what their lives mean and find ways to incorporate meaning into their lives in order to bear their suffering, create future story and situate themselves within a framework of hope and purpose. Viktor Frankl famously said that “the greatest difficulty of human life is not suffering, but suffering without meaning.”

Meaning in this framework is a meaning of a specific kind. There are all kinds of meaning, so its important to distinguish what I “mean” when I speak of “meaning” in the spiritual and existential sense.²⁴ Informed by both Berryman and Yalom, I use the term “meaning” in the ultimate, or as Yalom would say, the “cosmic” sense (Yalom, 1980,

²⁴ See appendix 1 for a lightly edited email exchange between this author and an emergency department physician regarding the role the chaplain plays in supporting patients and families with this existential limit. This discussion is not only relevant to the type of “meaning” I refer to in this dissertation, but is also an example of two persons, each from different language domains, working to bridge those domains (in this case the scientific on the one hand and the spiritual/existential on the other) through open dialogue and discourse. Note that neither the clinical nor the spiritual language domains are subsumed into the other. Rather, they work side-be-side to compliment each other in terms of their understanding of how each role functions to offer all of the different kinds of healing that are needed in the clinical pediatric setting.

423). The big “Why,” i.e., the “Why is this happening?” constitutes the kind of meaning I’m taking aim at. “Why?” is an important gateway into how we distinguish one kind of meaning from another.

“Franny”

A 12-year-old female who we’ll call “Franny” had attempted suicide and was admitted to the inpatient psychiatric unit with a diagnosis of a major depressive disorder (MDD). As part of the group processing component of inpatient treatment, Franny was part of a weekly “Purpose and Meaning” group facilitated by the chaplain. In this group, the chaplain presented the Godly Play® story “The Parable of the Good Shepherd” to Franny and three other children aged between 5 and 12. In particular, Franny used elements of the story to engage in her own sense of meaning-making by utilizing the symbols presented in the story to represent her own meaning and her own purpose, taken from her own personal narrative. Her art response to the story showed a figure stuck in the “dangerous places” depicted in the story with a “wolf” close by. There is a picture of a stick figure, denoted as “God” in the picture, and a path leading from the figure in the dangerous place to God and from the God figure toward the “safe place” or “sheepfold” also depicted in the story and which she denotes, both, as “His path.” Beyond the safe place, the destination far from the dangerous places, are several circles denoted in the picture as “family saved.” This 12-year-old writes, as a description of the picture, “I’m lost, seeking my way out. The better I get the closer I am to get out my pain [sic]. God calling me towards him [sic]. I’m closer and closer to his path.”²⁵

Yalom notes that “‘Meaning’ and ‘Purpose’ have different connotations.

‘Meaning’ refers to sense, or coherence. It is a general term for what is intended to be expressed by something. A search for meaning implies a search for coherence. ‘Purpose’ refers to intention, aim, function. When we inquire about the purpose of something, we are asking about its role or function.” (1980, p. 423) We can see that Franny is acting on her intention (“I’m lost, seeking my way out”), which is the purpose she has found in her admission to the hospital—to seek her way out of the dangerous place. Note also that there is coherence, as Yalom says, or meaning—she is using her own faith language to

describe a “path” that, if she finds it with the help of God, will both lessen her pain and bring her closer to not only God’s path, as she describes in words, but also to her family, as she depicts pictorially. She is relationally conscious of God, the Transcendent, who for her is the center of the meaning she is making of her life narrative, of the others in her life, particularly her family to whom she seeks to be with and be like, and she is reflecting on her own experience of being admitted to the hospital, and feeling separated from her family—aleness is another existential limit she is aware of and has depicted in her art response. Through the “cosmic meaning” she has made, her struggles, admission and treatment have been given a symbolic and narrative coherence, mediated by the parable told by the chaplain. This parable gave her a system of symbols that she was able to use in order to create the coherence needed to make sense of her situation and to articulate and depict a purpose for herself—the function that comes out of the meaning she has made is to seek her way out of being lost. By calling on her own understanding of her faith tradition, and her understanding of herself, her family, and her external circumstances, 12-year-old Franny was able to create both meaning and purpose for herself within those familiar frames. Of note, Purpose and Meaning group is 45 mins from start to finish, so the incredible work Franny did that is being discussed came to her quickly and creatively. It was already there inside her, but she needed a way to find expression within a spiritually and emotionally safe container—to bring some coherence to her story by utilizing her faith language and primary relationships. I will reference many more examples of art responses from the Purpose and Meaning group below and show how the overlapping models of Relational Consciousness and Existential Limits

can provide a framework for facilitating and communicating Spiritual/Relational Expressions later in this work.

Yalom notes that “The human being seems to require meaning. To live without meaning, goals, values, or ideals seems to provoke...considerable distress. In severe form it may lead to the decision to end one’s life” (1980, 422). This cosmic meaning “implies some design existing outside of and superior to the person and invariably refers to some magical or spiritual ordering of the universe” (423). Franny was able to incorporate this “cosmic meaning” into a personal framework that allowed her to express her situation, spiritually and existentially, in such a way that she could use her own language, her own imagination, her own creativity and her own way of being. *The Spiritual/Relational Expression that Franny produced IS the outcome of the chaplain’s spiritual care—prior to this expression Franny may not have had this coherence, this narrative or this sense of connection and purpose. After the chaplain’s spiritual care, she has a framework of meaning and a pathway of hope for her own future and in relationship with God and with her family.*

The Existential Limit of Freedom

We have discussed three of the four existential limits as developed by Yalom and incorporated into a method of spiritual guidance for children by Berryman. So far, we have looked at death, aloneness and the need for meaning. The fourth existential limit is that of freedom, which, intuitively, does not seem so much like a limit or a threat. However, looking at this limit in the clinical context will reveal how quickly freedom

becomes existentially limiting and even threatening for the children, their families and the providers, all.

The long and short of it is that we are free to make decisions, to act with resolve. It is also true that every decision we make excludes every other possibility of choice that we could have made. Short of seeing into the future, there is no way to truly know what will happen as a consequence of any one decision, and if another decision had instead been made, whether that decision would have led to a more favorable outcome. This frames every decision made within the context of an existential limit—the very freedom we have to choose among all the possible decisions before us, which feels like autonomy or control, is coupled with the responsibility we bear for the decision we choose, of which the ultimate outcome is unknown and beyond our control.

For physicians, mid-level practitioners, bedside nurses, and other clinicians, the decisions they make regarding the treatment of a child in the hospital are evidence-based and outcome-oriented. Science has shown through observation that treating a particular condition with a particular treatment regime will produce a particular desired outcome—generally aimed at the best possible restoration of biological function in the patient. In the Pediatric Intensive Care Unit (PICU), the Experimental Treatment Program (ETP), or other service lines that must use cutting edge medicine or treatment regimes that have less robust outcome data surrounding them, the existential limit of freedom is very much present. Physicians must make decisions for treatment that may ultimately rule out other types of treatments—either of which may or may not lead to the desired outcome. Many physicians treating children who are in need of chemotherapy and who develop an infection, for example, come up against this limit of freedom. Choosing to withhold

chemotherapy because of the immuno-compromised state it renders in the patient could help boost the child's immune system to fight the infection along with antibiotics and other medicines. But if the child goes too long without chemotherapy, the Leukemia may return and threaten the child's life. Continuing with chemo may do the work of helping the child achieve remission, but an infection could as easily threaten the life of the child despite the absence of Leukemia. PICU physicians and pediatric oncologist wrestle with these decisions every day and, as each child and circumstance are different, so each outcome is as well—outcomes unknown until after a treatment decision is made and carried out.

Parents are often placed in this position as well. When more than one treatment option exists, either of which seem to be a best possible choice according to the treating physician, parents are often given two scenarios and must consent to go forward with one or the other. The existential limit of freedom is most pronounced when another existential limit, that of death, is on the other side of the decision on how to proceed with treatment. Parents and physicians often need to consider how much medical intervention will be helpful to the child, and how much might be more detrimental than helpful, like in the case of radical interventions that a child may not be able to recover from or mechanical support (such as a ventilator) that may lead to dependence on machines with no possibility of recovery or life without them once introduced. The shape of the child's future existence literally hangs in the balance of the decision made.

For children in the hospital, their freedom is more limited than that of their parents or the other adults involved in their care—that is, they have less choices because

many of their choices are necessarily made for them. They are, nevertheless, confronted with this existential limit and also need ways of expressing it.

“Moira” and “Jan”

“Moira” is the four-year-old sister of an 18-month old patient, “Jan,” who was being sent home on hospice after having spent most of her life in the hospital, enduring long treatments, some experimental, and all ultimately unsuccessful in the curative sense. Jan was going to be baptized, along with her twin brother, and Moira, in the hospital per their parents’ request, as a way to bring a ritual threshold for leaving the hospital and a way to bring spiritual comfort going forward. Serving as this family’s chaplain, I entered the room prepared to baptize all three of the children. As it turned out, the plans of the adults in the room were already explained but not well understood by Moira, nor were they acceptable to her. As I entered the room, I got down on the floor, in the middle of the circle of adults that surrounded the children and spoke with Moira at eye-level about what baptism was and what it meant in their faith tradition, about what we would use (showing her the water and the shells we would use to perform the sacrament), and inviting her to be a part of it. The moment I mentioned her being baptized along with her sister and brother, Moira became tearful, shaking her head no and hiding behind her parents. Many of the adults in the room responded in ways that all adults seem conditioned to do—to coax the child into agreement with the planned proceedings—to convince her that it would be alright and that it would be a very special thing for her to be baptized with her sister and brother. But for Moira, her being baptized seemed a threat to her for her own reasons. As the adults tried to comfort her and coax her into participation, she became more tearful and more hidden.

“Moira,” I said, remaining on the floor at eye-level, “you don’t have to be baptized today if you don’t want to. I wonder if you might like to help me baptize your sister and brother, though?” Moira came quickly out from behind her parents ready to help. Together, we baptized her siblings. Afterward, when I offered to baptize her if she wished, her tears quickly returned, her head shook no and I assured her that saying “no” was a perfectly good choice to make for herself. We celebrated that her sister and brother were part of God’s circle, and that she helped them in that celebration. We also celebrated that she was part of God’s circle, too, and that she could decide if she wanted to be baptized at another time. We did a final blessing for Jan, and during the prayer, four-year-old Moira silently held a small wooden cross that we had blessed with the holy water used in the sacrament gently against her sister. Only those who had their eyes open saw this—she said nothing about it, but simply blessed her sister silently and in her own way, along with the adults who had placed their hands upon the child.

Moira was placed up against the existential limit of freedom because she was asked to make a choice, and was in a double bind—either she could choose to comply

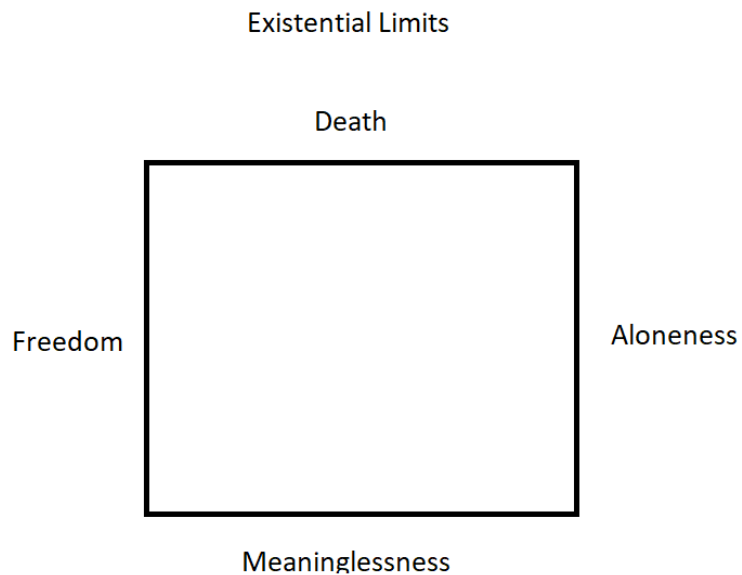
with the wishes of the most important adults in her life to make them happy, or she could choose not to participate in what made her tearfully uncomfortable. Either she could set aside her own fears and discomfort to please the adults in a way that was inauthentic to her own voice and whatever meaning she was making of the situation, or she could uphold her own voice and honor her fears and the meaning of the baptism that she held and risk disappointment from the adults, including her parents. Existentially, she was being asked to choose between whatever the threat she was being asked to engage in that lead her to tears and hiding (baptism with her siblings), or risk being alienated by the adults who not only gave her life, but sustained it as well, by not choosing to participate in the way that was planned for her.

Several weeks before this event, Moira, her mom and her chaplain (me) met in the Godly Play® chapel at our hospital to help Moira make meaning of her sister's hospitalization and illness, having only one parent at a time at home while the other was at the hospital (for nearly a year), and being a big sister to a sibling she saw rarely, and whom she could plainly see was very sick. The Parable of the Good Shepherd© was told to Moira using the Godly Play® methodology. In her art response, she depicted herself and her parents in a safe place in the story, and her twin siblings in what she called "the scary place," noting that she and her parents "were out searching for the babies." After taking a version of the story home with her, she retold the story to her grandmother many times, and her grandmother would wonder with her about the story each time. At one of the tellings, which her grandma recorded, Moira placed a sheep that she identified with herself in the "scary place." When her grandmother wondered about why she was in the "scary place," she responded, "because I go to scary places a lot."

While Moira is four and cannot tell us exactly what the scary place is for her, it seems evident that she placed her sister and brother there in her art response (what I will call her Spiritual/Relational Expression), while she remained with her parents in safety and imagined searching for her siblings. She told her grandmother in her own creative way that she goes to the scary place a lot. In the hospital room (the scary place, perhaps?) at the time of the baptism, she was being asked by the adults to be part of something that she and her siblings would participate in, but which her parents would not, at least not in the same way. This made me wonder about her Good Shepherd response, where she placed herself and her parents in one place, “searching for the babies” who were in the “scary place.” Now, we were asking her to join her siblings, apart from the safety of her parents, in that very place. I wondered if it was too much for her to be identified with what her sister was going through in that scary place, and spiritually or symbolically separated from her parents with whom she found safety in her art response. While it is not possible for any provider to know the exact meaning of the existential limit Moira was facing in this freedom to choose, it was clear that it felt threatening from her tears and her hiding. The response of the chaplain and her family was ultimately not to negate this threat or force a choice, but to find a creative way to help Moira process this existential limit in a way that was authentic to her in her own way. This gave her the opportunity to consciously relate with the others in the room and in relationship to God, by way of symbol and sacrament, that required no words of her. She baptized and blessed her siblings in her own way, using her own understanding of what was happening, and

her own way of making meaning of her place within the circumstances that surrounded her, supported by the adults that love her.²⁶

A subsequent phone call between this chaplain and Moira and her family took place just a week later. Moira and her family were with her sister at home, who had died peacefully in her mother's arms. I offered a blessing and commendation over speaker phone, per the family's request. Moira asked her parents who that was on the phone, and they explained that it was the chaplain from the hospital. Over the speaker phone, I asked her if she remembered that we baptized her siblings together. She responded, "yes. And I didn't have to." "That's right, you didn't have to," I responded.



Existential Limits and the Creative Process

²⁶ Anticipating our discussion of pediatric spiritual assessment tools in the chapter below, I wonder how we might take Moira's vignette and apply the assessment-intervention-outcome model. Is there a way to "measure" in a quantitative way what happened here?

Existential Limits are not pathologized issues that must be overcome—they are part of the inherent condition of being human. When we come up against an existential limit, we may avoid it or ignore it, which will ultimately lead to an unresolved anxiety that may remain from childhood through adult life. On the other hand, when we are able to face the existential limit of death, aloneness, the need to make meaning or of freedom and responsibility in such a way that we are able to acknowledge it, observe it and engage it, we are able to find new insight into ourselves as humans and in our relationships to others, to the world and to God, the Transcendent. In order to do this, there must be a creative process that provides for us a middle way through the paradox of where we find ourselves when coming up against a particular limit. This act of creativity, most often manifest in narrative, symbol, ritual, imagination, art and wonder, then creates a new way of relating to the limits of being and knowing within the nexus of relationships described as “relational consciousness.” It is by giving children the ability to engage in a creative process using these means that we are able to help children wrestle with the existential limits they are facing in a clinical setting. By giving them the ability to create a new way of engaging these limits, children like Moira are able to re-orient themselves in an act of creative meaning-making that helps them give voice to their spiritual and existential concerns without either forcing them to adopt an adult’s version of how they “should” experience them, or ignoring the concerns, leaving them to re-visit these unresolved experiences in a way that prevents them from creating a new way of being in the world alongside them.

Put simply, if we ignore or are forcefully traumatized in relation to an existential limit, it holds power over us and we get “stuck” in the way we relate to it. To have

forcefully baptized Moira may have had lasting negative effects on her relationship to religion and spirituality into adulthood. If, however, we can find a way to face the existential limit in a creative and supported way, we can get “unstuck” in our relationship to it. There is never a time when all four limits or threats aren’t present, but using a creative process to come closer to the limit and to be in relationship with it allows us to move past the potential trauma of it and bring that encounter into a larger narrative of meaning and purpose, giving us hope and a way through the next inevitable encounter.

When we get “stuck” against an existential limit, it often seems as if there is no good choice or way through. Consider the well-known phenomenon and phrase that describes being like “a deer in the headlights.” Things can seem so frightening that we are rendered “frozen” before the oncoming threat or limit and we simply don’t move. From the standpoint of existential limits, though we move physically and continue on with our lives temporally, we can find ourselves “stuck” again and again whenever that particular limit comes to consciousness or circumstance in our everyday experience. In this regard, while other aspects of spiritual, emotional and cognitive development may continue, the “stuck” part of our development may remain frozen in time, like a “deer in the headlights.”

Berryman (1991) refers to the work of Donald W. Winnicott as he explores notions of play and the creative process as ways to move beyond the spiritual and developmental “stuckness” that may happen when existential limits are ignored, avoided or traumatizing. As human beings, we need to be able to experience the limits of our humanity in relational ways in order to continue to develop new ways of relating to them. For example, when a child experiences the divorce of their parents, the limits of

aloneness or the need to make meaning may come to the surface. If the child isn't given the ability to explore these limits, to talk about the divorce and what it feels like, what it might mean not only in terms of their own lives but also in terms of how they experience the world, the child may become "stuck" in whatever impressions of the world, as it relates to herself, remains. This could be that marriage doesn't mean anything or that parents may just decide to leave, or commonly, that the child herself has some part to play in the divorce. Being "stuck" here can lead to deep traumas that can translate into the child's spiritual life as well as her emotional and psychological well-being. If, however, the child is given the opportunity, or opportunities, to engage this limit, to hear the story of the divorce and the child's place within it, new insight may emerge that allows the child to understand and relate to the divorce (or diagnosis, or death, or failure, etc...) differently. It isn't enough to simply explain the facts of the circumstance—the child needs to be able to use her own experiences, her own place within relational consciousness and her own creativity to find this new way of seeing the world—of becoming "unstuck" in regard to the existential limits the circumstance raises. If the child can engage the existential limits that she is bumping up against, and be given both a safe container to explore it, as well as to express (verbally or otherwise) her experience of this limit, she may then be able to relate to it in a new way, to become "unstuck" for having been able to do her work in relationship to the limit or limits her circumstances have brought into her experience.

Remember 5-year-old Nikki and her mother (see p. 1). For her mom, death was the existential limit she was most concerned about for Nikki, and for herself at the prospect of losing her child. For Nikki, however, it wasn't so much death, but a need to

make meaning about her parents' relationship and how she fit in. In using parable, wonder, imagination and play, Nikki was able to play with the limits of being and knowing and create a transcendent purpose using the relationships she did know. The creative process was key to Nikki finding a way to use the existential limits she faced to re-frame what she needed within herself and from those she loved (her parents). It was also "key" in helping her mom know what really mattered to her, rather than assuming what mattered most to her was what mattered to mom. And in terms of expressing the things that matter most, in "the chaplain's strange language," as Berryman aptly names it, we are in the realm of the language domain that communicates the spirituality of children.

This spiritual and/or existential "stuckness" I have referred to is, for Berryman and others, a kind of way of seeing the world—a way of mapping experiences into mental schemes about how the world is and how we relate to it. As I have said, if an experience of an existential limit becomes traumatizing, ignored or avoided, then the child experiencing it remains "stuck" in a way that impedes further development and may never move beyond it, or even be aware of it—it becomes an unacknowledged developmental need. Berryman notes of Winnicott,

Winnicott respected anyone he was involved with, children or adults. He worked to help patients discover early developmental needs that had been unacknowledged. The most important moments occurred when the client was surprised. These were moments, he thought, when the patient was released from compliance to the needs of someone else and discovered his or her own needs...[and the] laughter or smile of recognition that goes with such a surprise. (9)

This moment of surprise, of wonder, is keenly important because it represents a creative opening that allows the person to consider a new way of being in relationship to their

situation as they understand it. If we are able to acknowledge and face the existence of the existential limit we are up against and find a way to wonder—the initial step of the creative process as described by Berryman—we may find new and surprising ways to relate to the limit within the nexus of relational consciousness, in a way that is most important to our own experiences of ourselves in and beyond the world in which we live. In other words, if we can courageously wonder about where we are “stuck” spiritually and existentially, we may be surprised by what emerges in terms of our own personal insight.

Berryman notes:

Wonder opens the process, which leads to scanning for a new coherence to replace the broken or shattered one. Scanning continues until energy shifts again and the insight emerges. *It might take minutes or years to appear,*²⁷ but scanning moves forward relentlessly to renew the lost equilibrium of one’s world. When the longed-for insight breaks into consciousness, the scanning comes to an end...Once the insight becomes conscious, even in fragmentary form, the energy shifts again to the development of the insight.

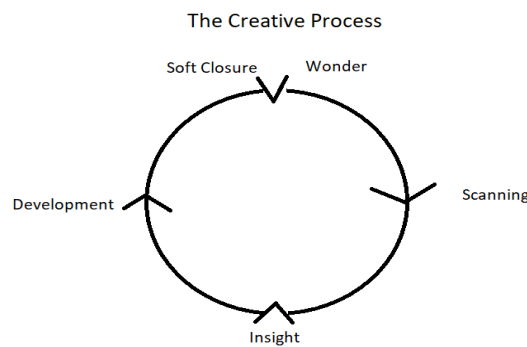
Development is the fourth step [the first three being wonder, scanning and insight]. We work out the details of the new idea and how it might be applied, even if the “new idea” is a new self or personal vision of the world. This step develops insight into an appropriate form for one’s field of interest, using the field’s method and language—such as engineering, poetry, music, law, theology or medicine. We might also put the insight into the language of everyday, which involves bits and pieces of many

²⁷ I italicize this phrase because it speaks particularly to the difficulty in the usual notion of “outcomes” in the medical model of “assessment-intervention-outcome” discussed earlier in this work as it relates to the spiritual care of children. It may be that new insight, meaning and purpose is found in the creative process just then, at the time of the “intervention,” or it may be well beyond a chaplain’s intervention that what was needed becomes spiritually accessible to the child. In either case, the point is that if the child is able to give some kind of expression, verbal or otherwise, to their own spiritual experience through relational consciousness and within the existential limits, I argue, this is an outcome that facilitates the spiritual healing process that did not exist before the chaplain’s intervention. It is in this way that I argue that the child’s spiritual/relational expression IS the outcome in this particular model.

formal languages, our region’s way of speaking, and our family’s unique way of expressing itself.

The fifth step is a soft closure, which allows the “solution” to be integrated with the self, one’s field, or a newly discovered field in a useful way that can be communicated. The integration of the soft closure continues until anomalies appear and we begin to wonder about the inconsistencies.

The closure needs to be “soft” so the process can open easily when it needs revision. The creator helps the process move forward by steering between chaos and rigidity without losing touch with either openness (that can decay into chaos) or structure (that can harden into rigidity) to maintain the movement of the process to the soft closure [my italics]. (2017, 121-122)



For Berryman, then, the creative process is how a child uses the awareness of their limits to relate to the world in a new way—to grow and develop in a spiritually and existentially informed way of relating to the world. Sometimes the creative process leads to new understanding, like in scientific research and the development of new medicines, new therapies and new possibilities for treating disease. Sometimes, the creative process leads to new ways of seeing oneself, or humanity, or the natural world, or even the

ultimate purpose, however conceived. Sometimes the former may very much lead to the latter, like when discovering the Earth is not the center of the universe. And sometimes, the latter can lead to the former, such as when a survivor of pediatric cancer decides that her experience in childhood was meant to help her realize her mission to become a pediatric oncologist and help others.

It is imperative that in a clinical setting where the dominant language domain of science—the domain of the measurable and the quantifiable—necessarily exists in order to communicate how to keep a child’s body alive and healthy, that the language domain of spirituality is also employed in a child’s healing journey, whether that healing leads to cure or not. By giving children the ability to express their experiences of the existential limits and use these expressions to frame their relationships to themselves, others, the world around them and God—through Relational Consciousness—we allow them to move along the path, not only of curative or palliative outcomes, but to a meaningful frame of coherence that gives them purpose, meaning and hope, all necessary for living a life in healthy relationship to what is known and the mystery beyond knowing.

Conclusion--The Field and the Fences—a Synthesizing Metaphor

By way of a metaphor, consider walking along the edge of a great field. The field is bounded on four sides by barbed wire. All that is known inside the field are the people, places, ideas, stories, experiences and phenomena that one has grown up with throughout a lifetime. The barbed wire marks the edges of where one has ever been or known. Beyond the barbed wire, one cannot go—it is beyond being and knowing. It is easy to spend most of one’s lifetime within the field so that the barbed wire fences that border the field on all four sides cannot even be seen—the field is vast and full. However, when one

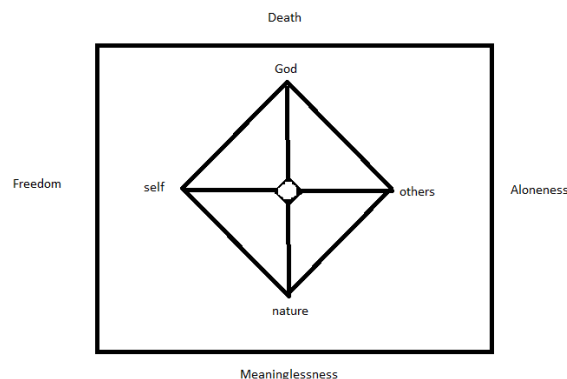
finds oneself near one of the edges either by will, curiosity or circumstance, the boundary of one's own being and knowing, one can feel the limitations of not knowing what's on the other side. And those limitations can feel threatening.

Imagine now walking along the fence line and getting so close that your shirt gets caught on one of the barbs. You are snagged, stuck, unable to continue walking, try as you might to put one foot in front of the other. You don't want to look back toward the existential limit because it's threatening—it gives a feeling of dis-ease. Not looking back, however, means not noticing what it is that impedes your progress in walking back into the field you are familiar with. The only way to get “unstuck” is to face that limit, acknowledge that it's there, and work your shirt free of the barb upon which it has been stuck. It may take courage just to turn and face the barbed wire. It may take time to imagine and wonder and finally work out how to get your shirt free. If you are able, you can finally move freely again within the field of all that can be known. And you bring something new with you—the knowledge and acknowledgement of a barbed wire fence line that you didn't know about before, or at least, you'd never encountered. You become aware of certain boundaries or limits that not only exist but that you can get stuck on. You got stuck, you faced the fence, and you got unstuck. You now experience all that exists in the field within the fence differently—it takes on new meaning knowing it has edges and limits. Your story has changed, your sense of self and of others has changed, and your sense of what can be known and what cannot be known—of the Transcendent—all this has been changed.

The field is relational consciousness (Hay and Nye). The fence, the existential limits (Yalom). The spiritual intervention is to help children find a way that feels safe

enough to turn toward the fence and work out getting their shirt unstuck. Helping the child find the courage to turn means validating and affirming them where they are and how they understand their dilemma—this requires engaging them according to Egan’s “kinds of understanding,” which will be discussed below. The work the children do of getting unstuck is the creative process (Berryman). The outcome is what new kinds of meaning, purpose and hope they bring back into their lives for having been able to see beyond their circumstance of “stuckness” and re-frame it in a new way that transcends the old way of being and knowing and relating to the world. The expression of this new meaning is sometimes possible with words, and sometimes not. Sometimes it takes symbol, ritual, art, music—even metaphor—to try to put it all into a way of meaningful expression. And what is meaningful to the child may not be meaningful to anyone else who hears it with ears that listen for logical and measurable explanation. But the very expression from the child—in whatever form it might take—this is the spirituality of the child—the cloud we try to catch and pin down.

Relational Consciousness within the Existential Limits



Chapter 3: Spiritual Development and Kinds of Knowing—Meeting Children

Where They Are

*Janna's Doll*²⁸

Last year, a newly diagnosed leukaemia [sic] patient, five-year-old Janna, was admitted. Her opinions and language skills are both above those of your average five-year-old. The clinic uses dolls that are bald. Upon being presented with them, most of our little girls, already bald from their chemo treatments, are immediately in love, exclaiming over the doll's being 'just like me!' So, one day when Janna was in for treatment, I found her playing with a bald Barbie. Since many of our patients want to talk about their bald dolls, my conversation began with 'What happened to your doll's hair?' No answer. I must have been off my game that day, because I didn't pick up that Janna didn't deem the question worthy of a response. So, with different words, I asked again essentially the same question. To which, with a sigh and an eye roll, Janna replied, 'She doesn't have cancer, she's just a doll.' Oh. Alrighty then! Ouch. A minute later the physician came in; while examining Janna, he too asked if the doll was bald due to chemo. A pause, then before Janna could repeat the exasperated answer she'd given me, her mom said, 'No, but if she did need chemo, her shirt is perfect for easy access to a port!' With a tone that indicated how unbelievably lame grown-ups are, Janna responded, 'She don't got a port; she only got boobs.'

This story is a playful example of what happens when we enter the world of a child with expectations about what is most important to the child at

²⁸ The practice example presented here, entitled "Janna's Doll," along with the brief commentary that follows is taken from a chapter entitled 'Approaches and Skills for Working with Children and Young People,' co-authored by the Rev. Dr. Sally Nash and this author. The example was submitted by Chaplain Marty Koontz, East Tennessee Children's Hospital. (Campbell and Nash, 2018)

that time. Here we see the chaplain assuming that the child is identifying with the doll (as does the doctor), and when it is clear that she is not, mom jumps in to save the day with a ‘no, but...’ to keep things on course. Janna, the patient of five years old, is clear with everyone that whatever game the adults in the room seem to want her to be playing is very much their own—she is playing a different game altogether! What we learn from this light-hearted account is that, sometimes, we as adults can use play to assume a child is making meaning that they aren’t necessarily making (or that they are making the same kind of meaning that we are). Other times, adults seem to use play to keep things light and approachable and accessible when what is happening might be better contained in the more serious side of play. Certainly, we know from child development theory that young children think in the concrete, and sometimes they are thought to lack the imaginative flexibility of mind to think more abstractly, but perhaps we might be called to be more open to other possibilities. The story ends with the child correcting the adults’ concrete assumptions, but what if that was just the beginning of the story? What if, at that point, the adults were able to stop, breathe, and get ready by being fully present to what Janna was creating in that moment? What could we wonder about with Janna, about who this doll is that she holds in her hands? What kind of meaning was she making at that moment and what would happen if we let her do the meaning-making, rather than the adults in the room? If we really engaged in play, what mysterious creation might come from a question like ‘I wonder about the doll that you’re holding?’ rather than focusing on the doll’s hair and moving the meaning-making in a specific direction?

Ages, stages and “kinds of understanding” (Egan, 1997, p. 24)

It is important for pediatric chaplains and spiritual care providers to be able to engage children authentically, allowing the children to show them the way toward their own ways of finding meaning and hope. Children are only able to exhibit spiritual/relational outcomes via spiritual and existential expressions when they are given a safe place to engage in the creative process as described in the previous chapter. Before this is possible, the chaplain must be able to engage the child where she is, building rapport and trust, not only from the standpoint of her diagnosis, course of treatment, spiritual/faith background and family makeup, but firstly by being able to relate to the

child in a way that the child feels heard, engaged and understood. This requires the chaplain to have an understanding of cognitive and spiritual development, so that the chaplain can observe the kind of knowing or understanding that a child is engaged in at the time of the visit, engage that kind of knowing within the chaplain herself, and “come along side” the child through that particular way of knowing so that the child’s expressions “make sense” to the chaplain and other adults in the room within the framework of understanding that the child is exhibiting. This “coming alongside,” or entering into the way the child understands the world, is key to allowing children to express themselves fully, without feeling evaluated, critiqued or assessed by the chaplain.

²⁹ One way to do this is to engage the child in play, or a shared activity, reassuring the child that there are no “right” or “wrong” ways to engage the chaplain in the shared activity—a counterintuitive notion in western pedagogy, where having the right answer (or an answer at all) is always right. “Such reassurances may be required so that children can feel they are in control of their story.” (Bull, 2017, p. 51) It is ironic, then, that the most effective way to assess a child’s current spiritual and existential place at a given time is to avoid the temptation, and perhaps even the intention, of abstracting and

²⁹ This is important, because to formally “assess” a child’s spirituality is to make the child herself into an abstraction, a kind of non-entity. Assessing liver function is one thing. A physician and a child can talk at a developmentally appropriate level about how well or not well a child’s liver might be working. Assessing a child spiritually, however, is to discuss with that child aspects of their deepest knowing and understanding, and to make this into an abstraction is to deny the child’s very identity. If a child expresses a deeply spiritual or existential aspect of their reality, only to be assessed with an aim at resolution or correction, the child may experience alienation from their authentic voice in the presence of the adult and is not likely to expose such a vulnerable place within themselves again. In this way, when “spiritual assessment” is used to make abstract something the child feels deeply within themselves, the person making the assessment is using a power-over approach that limits the ability of the child to trust that what she expresses will be heard, honored and respected for what it is. Rather, it becomes one more item on the “problem list” that so often appears in electronic medical records for individual patients, requiring a medical intervention with specific measurable outcomes as goals of care. Sometimes, existential aloneness (for example) just needs to be shared, not fixed.

assessing them. Consider the above practice example where the assessment has already been made (identification with the doll surrounding the effects of chemotherapy), when the child had not yet explained where she was in terms of her relationship with the doll, the center of the shared activity taking place between Janna, the chaplain, physician and mother. By presuming what kind of meaning Janna was making, in part, by evaluating her developmental stage (“her opinions and language skills are both above those of your average five-year-old”) and the likely meaning-making she engaged in based on what “most of our little girls” find meaningful when presented with the doll, the adults in the room miss an opportunity to come alongside Janna in the way that is most authentic to her. Cognitive/developmental stage theories can be incredibly helpful, as can generalized notions of what most children struggle with in a given context, but “[w]hen it comes to children, we are not in relationship with theories; we are in relationship with other people.” (Campbell and Nash, 2018, p. 88)

In this chapter I will discuss briefly cognitive development and stage theory (Piaget), religious development stage theories (Fowler and Dell), a spiritual developmental stage theory (Tacey), and the positive and negative aspects of these kinds of theories in terms of meeting children where they are. I will look more closely at the way in which professor and educator Kieran Egan utilizes recapitulation theory to more relationally engage children from the point of view of their own understanding by looking at the kinds of understanding they are engaged in, rather than abstracting children’s behaviors and expressions into formalized stages. Finally, I will explore how Egan’s theory provides chaplains with a better, more authentic way of engaging children in the clinical setting in order for the children themselves to feel safe enough, and

understood enough, to go to the deep spiritual places within and find ways of expressing themselves spiritually and existentially. Because this process of the chaplain's development of an authentic relationship with the child (spiritual/relational building and spiritual/relational connecting) is necessary in order for spiritual and existential expressions to take place, I will describe those spiritual and existential expressions as "spiritual/relational expressions," in an attempt to strengthen the bridge between the clinical and spiritual language domains, noting that the spiritual/relational expressions ARE the outcomes in pediatric spiritual care. In this way I hope to move closer to the "assessment-intervention-outcome" model prominent in clinical practice, re-framing it in terms of spiritual care, without subsuming it into the strict reductionist model of medical care which, by necessity, incorporates this model to optimize evidence and inform medical outcomes. I propose that for spiritual care, a more appropriate way of describing this model might be something like, "spirituality/relationship building (S/R building)--spiritual/relational connecting (S/R connecting)--spiritual/relational expression (S/R expression)."

Piaget and Stage Theory

Jean Piaget was a Swiss psychologist best known for his work on the cognitive development of children. His work with children led him to develop a theory about the way in which children develop distinct cognitive abilities over the course of maturation. "To Piaget, cognitive development was a progressive reorganization of mental processes as a result of biological maturation and environmental experience." (McLeod, 2018) As children's innate cognitive abilities matured, in relationship to their environment, they moved through "stages" of cognitive development that allowed them to experience the

world, think about those experiences in predictable ways, and develop schemes about themselves and the world in which they live and interact. This approach was very much about describing the process of building knowledge—knowledge about how the world works and how the child can interact productively with the world based on this knowledge, rooted in empiricism and logic as these capacities develop in children over time.

Piaget described four distinct stages with approximations of the age ranges in which these stages occur over the course of normal development. These stages are:

1. The sensorimotor stage which occurs from birth to about age 2
2. The preoperational stage—age 2 to about age 7
3. The concrete operational stage from age 7 to 11
4. The formal operational stage from around age 11 and into adolescence and adulthood

“Each child goes through the stages in the same order, and child development is determined by biological maturation and interaction with the environment.” (McLeod, 2018)

In the sensorimotor stage, children develop the scheme of object permanence—the knowledge that objects still exist even when they cannot be seen. This is a familiar stage to parents who have ever played peek-a-boo with their infant, noting the surprise and delight as faces disappear behind hands and then reappear back in full view. Balls that roll under couches that once seemed to disappear from existence are now known to the child to be under the couch even if not seen, and children can use that knowledge to

verify its presence by crawling beneath the couch to verify its existence and retrieve it.

Like all of the preceding stages, children are creating mental schemes that allow them to more fully act in relationship to their environment. This, for Piaget, is the development of cognitive abilities that progress fairly predictably during cognitive development.

In the preoperational stage, children begin to think symbolically so that a word or object can stand for something other than what it is. A table leg, for example, is not really a “leg,” and chairs that have legs, arms and backs are understood to represent parts of a piece of furniture, rather than a person. In this stage, children are still egocentric so that their views of the world are mainly of things that are either “me” or something else. The representations of arms legs and backs in describing the chair is, for the child, about *my* arms, *my* legs and *my* back in terms of relating the symbols to the world they experience. Taking the viewpoint of another person is difficult in this stage.

The concrete operational stage describes a child’s ability to work out logical schemes in their head, without needing to manipulate the environment to do so. The ball that rolls under the couch, for example, is known to be there without having to see and verify it. A child who observes a ball roll under a couch can walk away and engage in another activity without verifying the ball is there, returning to the couch at another time with certainty that the ball remains there, though out of sight.

Finally, the formal operational stage finds people with the cognitive ability to think abstractly about concepts and to develop hypotheses around these concepts that are able to be logically tested.

Piaget's theory led to the development of student-centered, discovery learning, generated vast amounts of research in education and beyond, and changed the way educators approached pedagogy, particularly in Western culture and classrooms. Criticisms focused on the fact that, though Piaget described these stages as universal, many didn't ever develop into formal operations as the theory described,³⁰ and the universality of his descriptions seemed to lack an accounting for social and cultural factors that existed beyond the strict cognitive/environmental interactions that were his focus.

Fowler and Dell on Stages of Religiosity

Alexander von Gottard notes that “[t]here seems to be more evidence for stages of religiosity than for spirituality” (2017, p. 124). This makes sense when considering the difficulty in defining ‘spirituality’ at all as discussed at the beginning of this work. James Fowler, who famously developed a theory on stages of faith development,³¹ wrote an article with M.L. Dell describing a stage theory regarding religiosity that was to apply not only to Christian faith development, but to all religions. Here, seven stages were described, as summarized by von Gottard (2017, 124-125):

1. Primal Faith (infancy to two years of age)
In early childhood, the emotional attachment between the infant and his or her caregiver forms the basis of future relationships. In this preverbal stage of development, a trusting and caring relationship enables the child to find psychological coherence and reliability through bodily contact, playful interactions and mutual affective attunement.
2. Intuitive-projective faith (toddlerhood and early childhood)

³⁰ “For example, Keating (1979) reported that 40-60% of college students fail at formal operation tasks, and Dasen (1994) states that only one-third of adults ever reach the formal operational stage.” (Mcleod, 2018)

³¹ See *Stages of Faith: The Psychology of Human Development and the Quest for Meaning* (1981)

In this stage, exploration, language and cognitive operations are expanding rapidly. Children form inner images to cope with the insecurities of life. First cognitive attempts at dealing with death are typical at this age. Phantasy [sic] and make-believe are more important than fact. As Fowler and Dell point out, in this stage powerful religious symbols and images can be associated either with positive aspects of love and interconnectedness, or, to the contrary, with negative aspects of guilt and terror.

3. Mythical-literal faith (middle childhood and beyond)
In this stage, children construct and interpret the mysteries of life in a literal, narrative way, with clear moral interpretations. The child believes that goodness will be rewarded, while evil will be punished. When disappointed, children can give up their belief in God built along these simple lines of moral retribution.
4. Synthetic-conventional faith (adolescence and beyond)
The concepts of God are formed by personal ideas and critical questioning. God is described in personal terms of love, understanding, loyalty and support. In addition, peer influences on religiosity increase. Adolescents are dependent on the evaluations and ideas of others.
5. Individuative-reflective faith
Following the synthetic-conventional stage, values, beliefs and commitments are reflected critically and re-examined. Struggling with self-identity and traditional beliefs leads to an individuative appraisal of God and faith.
6. Conjunctive faith
In this stage, different truths can be approached from multiple perspectives, tensions and paradoxes can be tolerated and other beliefs can be accepted.
7. Universalizing faith
In this stage, concerns about creation and [the] wholeness of humanity beyond [their] own self-limits are typical. A person is grounded and participates in a relationship to God outside of narrow self-limits. In a way, this is the most spiritual of the stages of religiosity.

It is clear that this stage theory owes much to those developed in the field of cognitive psychology and can be incredibly helpful in terms of describing the spiritual expressions of children within a formalized theoretical framework. Reading through these stages, perhaps the reader can even relate to one or more in herself, or as seems evident in the children in her life. Stage theories like this are compelling because of the staged, operational structure that can be applied to observed phenomenon and expressions in the

children being cared for, and they can communicate to others what has been observed. When a child speaks, for example, of losing their faith in God as a result of what feels like a punishment in the form of a cancer diagnosis, one may describe the child's religious expression as falling in the third stage of the mythic-literal.

Religious and Spiritual Development

David Tacey, who has written extensively on Jungian thought, spirituality and culture developed a five-fold path of spiritual development, which begins with the inherited religious beliefs of one's birth family and moves quickly to adolescence and adult spirituality. Again, von Gottard (2017, p. 128) summarizes:

1. The first stage is that of natal faith, being introduced to the religious traditions of one's family
2. The second stage of adolescent separation begins with critical questioning.
3. The third stage, called secular identification, is marked by the loss of natal faith, the renunciation of institutional affiliations and the orientation towards secular values.
4. The fourth stage, secular disillusionment, follows with a feeling that something is missing in the secular world, which seems unfulfilling.
5. The fifth stage then [sic] is one of developing one's own secular spirituality, free from religious influence and part of the resurgence of spiritual feeling in society. This stage is termed adult secular spirituality.

It can be seen that here, the stage theory moves away from specific age categories and closer to a more culturally influenced and socially oriented progression of development, aligning more closely with what I believe represents a flowing, organic process of relating to religion and spirituality in human persons. However, Tacey moves quickly from childhood to adolescence and adulthood, and while it is a helpful view telescopically, it does not necessarily help with the more granular aspects of supporting

young and school-aged children in such a way that the stages can be effectively communicated within what I am now calling the S/R building—S/R connecting—S/R expression model.

Nevertheless, I find the reluctance to ascribe specific age ranges helpful, and I think it serves as a good pivot-point to offer critiques of the above stage theories and the proposal of a theory of development that I believe, in conjunction with the lenses of relational consciousness, existential limits and the creative process, move us closer to helping chaplains and spiritual caregivers find their way to coming alongside children according to each child's way of understanding.

The Pros and Cons of Stage theories

As mentioned above, stage theories can be incredibly helpful in terms of generalizable frameworks that help chaplains and other care providers think about where children are in terms of their capacity to understand the facts and circumstances that surround them in a clinical setting. From the cognitive/developmental standpoint, we can speak to the child more concretely or abstractly depending on the stage the child is regarded to be in based on careful observation. We can also, in regard to stages of faith/religiosity and the sequences in which they occur, take advantage of the ways in which “[t]he sequence of these constructs develops in a consistent way from person to person, so one can make educated guesses about which particular faith stage another person might be using.” (Berryman, 1991, p. 102) It is important to note here, that at best, we are making an “educated guess” about where that person, that child, might be developmentally.

Berryman employs the metaphor of using these stages as a way of tuning in to the “right meaning ‘channel’” in order to “improve communication” and “reduce frustration” between the child and the chaplain or provider. He continues, “[w]hen we begin to use religious [or spiritual] language, however, something curious happens. People seem to be able to participate in the same parable, sacred story, [or ritual/symbolic act] regardless of the Fowler stage they happen to be in. This language domain seems to involve a kind of language that is open to all stages. The trouble begins when people begin to talk *about* what the language is saying. That is when the cross-stage static can jam the communication.” (1991, p. 102) Janna might offer a wonderful example—the adults were engaging her according to a stage that thinks concretely and is primarily self-oriented (Piaget’s pre-operational), but Janna herself was somewhere else. Not only was she somewhere that the adults couldn’t quite understand, but she herself was unable to articulate it, and in fact ignored the initial questioning and assumptions. Perhaps she was needing to normalize her own image within the image of a future self, as a grownup with “boobs,” who has neither cancer nor a port, like the grownups who surround her. Perhaps it was something else—it may be impossible to know. It is clear, however, that once the adults continued to talk about it, and Janna was finally cajoled into doing so herself, the communication got jammed. An alternate approach to ascribing wholesale a theoretical stage upon the child before us is to wonder and imagine with them, to walk with them in the spiritual language of silence, wonder, play, imagination and symbol.

Boyatzis agrees and explains that he “...believe[s] one major reason for our current difficulty in defining children’s spirituality is the long-standing dominance of cognitive-developmental models of growth that posited an invariant arch toward logical,

rational thought and away from other modes of thought. The post-Enlightenment Piagetian emphasis on rational thought brought a dismissive attitude toward other forms of knowing.” (Boyatzis, 2008, p 5). Citing Westerhoff (2000), Boyatzis notes that he argued that “two modes of consciousness are possible...One is intellectual...The other is intuitional...experiential, and is characterized by nonverbal, creative, nonlinear, relational activities. The development and integration of both modes of consciousness is essential to the spiritual life” (p. 70).

As a kind of remedy to becoming too invested in stage theories, Berryman reminds us that when we are talking *about* what religious or spiritual language is saying, that is something very different from what it’s like to be *in* that language domain (1991). He notes, “the participant is not standing outside of himself or herself as an observer...Religious language acts as a door into the pure coordination of actions among God, self, others and the creation. Being in religious language connects the imagination process to the coordination of actions. This being in the language is used in the first three steps of the creative process. As soon as one begins to articulate the new insight, Fowler’s stages come into play. One becomes an observer and begins to speak *about* religion.” (p. 103) For Berryman, the stages are helpful background in order to “tune in” to the language a particular child is using in the religious/spiritual language domain. But the expression of this language is not the same as the stage that tries to describe the “channel” that is broadcasting it. In other words, and to extend this metaphor of channels, not every song that plays on 95.3 FM is the same—some are much better and much deeper than others. The fact that they play on the same channel does not mean that they say the same thing, or even communicate in the same way.

Boyatzis employs a more radical critique:

The paradigm of cognitive-developmentalism and its focus on age-related cognitive processing has dominated the study of children's religious and spiritual development and still underlies many scholars' thinking (Spilka, Hood, Hunsberger, & Gorsuch, 2003). I assert that this cognitive-developmental hegemony has impeded our understanding of religious and spiritual development (see Boyatzis, 2005). As developmental psychology has substantially outgrown stage theory (see Overton, 1998), the study of children's spiritual and religious development should as well. An "obsession with stages" impedes our understanding of both the gradualness and the "complexity and uniqueness of individual religious development" (Spilka et al., 2003, p. 85).

Another problem with cognitive-developmental stage theory is that its narrow focus on the "typical kid at a given age" fails to account for the substantial variability between and within individuals at any given age. Individuals—children and adolescents—enjoy sudden spiritual gains and spurts (due to dramatic experiences or revolutionary insights)³² as well as regressions (due to trauma or despair); for many people, including children and teens, there are long seasons of stillness. Different individuals experience a different mix of these different experiences—growth, loss, stasis—at different times, in different ways, due to different causes, and with different consequences. An egregious flaw of stage theories is their failure to account for these varieties of religious and spiritual experiences within and between individuals at any age (Boyatzis, 2008)

The focus on the acquisition of knowledge *about* the world (e.g., Piaget) or *about* religious/spiritual experiences (e.g., Fowler) limit both the acknowledgment of, and communication of, deep, intimate and inexpressible experiences of spirituality within relational consciousness. Some things can't be put into words, which necessarily abstracts from the depth of the insight mediated by symbol or story, image or feeling, imagination or hope or even despair. Some spiritual and existential experiences, particularly in the lives of children who lack the vocabulary that adults rely on in the scientific language domain of assessment-intervention-outcome, require a different kind of expression altogether. The acquisition of knowledge that anchors developmental stage

³² See the above chapter on the creative process.

theories is not sufficient as we look at supporting children's spirituality. Spiritual development comes not from the acquisition of knowledge alone, but through transcendent and meaningful relationships to the self, others, creation and God/the Transcendent (Boyatzis, 2008), as well as providing opportunities to engage the existential limits that children face so tangibly in the clinical setting.

This is a key point: if the theory and language of cognitive and developmental stage theory satisfies the assessment-intervention-outcome model of the scientific language domain (one assesses the developmental stage of a child—intervenes according to stage theory to produce a desired outcome—the level of adherence or acquisition of knowledge of the desired outcome is measured) is not sufficient to engage children spiritually and existentially in our care for them, what is an alternative approach?

Recapitulation Theory, Kieran Egan and the movement from 'knowledge' to 'kinds of understanding'

“If there be an order in which the human race has mastered its various kinds of knowledge, there will arise in every child an aptitude to acquire these kinds of knowledge in the same order... Education is a repetition of civilization in little. “

— *Herbert Spencer (1861). Education. p. 5. (quoted in Egan, 1997, p. 27)*

Recapitulation theory, as articulated succinctly in the quote above by 19th century English philosopher Herbert Spencer, postulates that as the human species has developed—from pre-evolved beings, embryonic in the evolutionary process, to conscious but pre-verbal beings, to pre-literate beings of speech and story and artistic expression, to finally beings able to communicate through the written word, so too does intellectual development progress in each individual human person to the present day. Children are conceived and develop as embryos, are born and enter the world of

conscious interaction with the world but unable to use the language of speech to communicate these interactions, learn to speak and play and imagine and create through the language of images and art, become literate and able to express complex schemes and ideas about themselves and the world in the abstraction of the written word, and are finally able to reflexively engage in each of these ways of engaging and communicating in the world as needed. This notion, that the way in which human beings develop as individuals emulates the way that the species developed as a whole, provides the underlying theoretical framework for Kieran Egan in his book, *The Educated Mind* (1997).

Egan also uses the theory developed by Russian psychologist Lev Vygotsky (1896-1934), and his notion of “mediational means”—that is, “shapers of the kind of sense we make of the world.” (p. 5) “Vygotsky argued that intellectual development cannot adequately be understood in epistemological terms that focus on the kinds and quantities of knowledge accumulated or in psychological terms that focus on some supposed inner and spontaneous developmental process. Rather, he understood intellectual development in terms of the intellectual tools, like language, that we accumulate as we grow up in a society and that mediate the kind of understanding we can form or construct.” (Egan, 1997, p. 5) In other words, intellectual development does not happen in a vacuum—it is shaped by the society and culture—the people that surround us—and the means of expressing those relationships through forms of expression, that is, language. It is helpful here for me to point out that by “language,” I understand Egan to mean any kind of expression of experience, whether they include verbal or written words,

art, body movement and posture or any other way one communicates their inner states (including the spiritual and existential) to the outer world.

Egan tries “to separate out a set of general and distinctive kinds of understanding and characterize each of them in detail” in five stages—the Somatic kind of understanding, the Mythic, the Romantic, Philosophic and Ironic. (1997, p. 4) Egan continues, “education can best be conceived as the individual’s acquiring each of these kinds of understanding as fully as possible in the sequence in which each developed historically.”(p. 4) It is this recapitulative aspect, combined with Vygotsky’s intellectual tools (for Egan, language), that forms the basis of his educational theory. It is this theory, as adapted by Berryman in the field of religious education, that I am using as a basis for describing the spiritual/relational building that takes place, when used appropriately, between the chaplain or provider and a child in a clinical setting like a hospital.

Guided by an unpublished summary of Egan’s work that Berryman created in 2011 for a graduate seminar on the spiritual guidance of children at the General Theological Seminary of New York, I will outline each of these kinds of understanding, and discuss their application to the kinds of understanding spiritual care providers must be able to access in themselves in order to create spaces and relationships with children that foster the child’s expression of spirituality within the frameworks of relational consciousness and existential limits.

This approach can be distinguished from the stage theory approach in the following important way: stage theory involves observing and assessing from the outside—it assesses kinds of knowledge observed in children in a way that can only be abstract and empirical. That is, it belongs in the scientific language domain and, as said

above, is in line with the assessment-intervention-outcome model that is necessarily the standard of evidence-based, outcomes-oriented medical care. Egan’s approach, when employed clinically, requires that the chaplain or care provider not only observes or assesses the kind of understanding (rather than ‘knowledge’) taking place in the child with whom they are journeying, but must also access that kind of understanding *within themselves* in order to meet the child where she or he is. This moves beyond the strict observational assessment employed in the language domain of science *about* the child and, rather, engages an aspect of the self within the chaplain in order to enter into an authentic relationship *with* the child.³³ In this way, the chaplain *enters in* to the kind of understanding exhibited by the child so that there is mutuality, relationship and expression that moves more firmly into the realm of relational consciousness, the lens through which spirituality is expressed. Here, then, a different kind of language domain is required—the language domain of spirituality.

To be clear, I’m proposing that a focus on knowledge (which we will see later is the main focus of most current “spiritual assessment tools” used in current clinical care) is akin to the kind of assessment-intervention-outcome information attained and communicated in the scientific language domain. ‘Kinds of understanding’ as Egan articulates it is more closely aligned to the “S/R building-S/R connecting-S/R expression” model that I wish to develop, with an orientation to the spiritual language domain that Berryman proposes.

Berryman on “The Five Stages of Egan’s Educational Scheme” (Berryman, 2011)

³³ See the discussion on Nye’s S.P.I.R.I.T approach below on [p. 131](#)

Berryman calls these different ‘kinds of understanding’ stages, but makes an important clarification: “These stages involve both a kind of knowing and the related deployment of cultural tools for knowing in particular ways. The stages are not an on/off switching, but any later stage involves all the earlier stages and the full use of any later stage depends on the enrichment of the previous stages.” (Berryman, 2011, p. 2) This is a helpful description in terms of distinguishing Egan’s theory from a Piaget or Fowler scheme where stages are distinct and progressive, and allows for the ability of the theory to account for the natural movement between kinds of knowing taking place within and between individuals that Boyatzis holds most stage theories lack. The kinds of knowing Egan describes are more fluid and the person supporting a child can access each of these kinds of knowing in themselves, in order to meet the child where they are in that particular kind of knowing.

Berryman (2011) summarizes Egan’s kinds of knowing in the following way:

1. *Somatic Knowing (pre-birth to about 2 ½ years and the onset of language)*

The infant discovers that his or her own body can carry out intentions and at the same time discovers how the world around responds to this action. The kinds of body-knowing that take place includes actions in space, the passage of time, the links of causality, effort and response, the rhythms of hunger and satiety, pleasure and pain, rhythm (ear), patterns (eye), and other matters carried in one’s body. The future of all further understanding is grounded in this body-knowing and continues to guide and constrain children as they mature into adulthood.

Somatic learning is “central,” which is the metaphor Egan uses that refers to extending zones of development outward from a central core rather than in a straight line like Piaget’s stages of cognitive development. This view of development is mixed with a larger view of “stages,” much more like Vygotsky’s scaffolding and zones of proximal development, than Piaget’s use of a biological metaphor and the hierarchical development of thinking with a logico-mathematical focus. (2011, p3)

Somatic Knowing, then, is body knowing—the way in which we come to understand the world through our bodies. This kind of knowing is important for many reasons, not the least of which is that it is from this first way of interacting with the world that a child’s spiritual knowing radiates (along with all other kinds of knowing.) Thinking back to the diagram of relational consciousness, this is the first of the self reflecting on the self—in the way Winnicott might describe as me and not-me. It is the kind of knowing that is pre-linguistic, as the infant has no way of expressing herself with formalized language. Nevertheless, this kind of knowing and expression without language persists throughout a human life. Berryman notes again, “Human beings are present before language in a way that other animals are not and language grows with continuity from pre-linguistic knowing that is embodied.” (2011, p 4)

I have noted that in supporting children’s spirituality in the clinical setting, through the lens of relational consciousness, that the expressions of spirituality are rooted in “language” that is sometimes verbal and sometimes non-verbal. Even as adults with sophisticated vocabularies, some spiritual expressions just can’t be put into words, though we know an experience to be authentic. We feel it in our bodies. All the more important is that young children also feel with their bodies and if given the opportunity, *can* express themselves spiritually, though without the language that most spiritual assessment tools used in the clinical setting require. Knowing that all of what is gained through “Somatic understanding” carries on toward the next way of knowing the world, we will see some of the ways our body knowing develops alongside the development of language. This next kind of knowing Egan calls “Mythic Knowing.”

2. *Mythic Knowing (2 ½ years to about 8 years)*

“Mythic Knowing” is the point at which oral language develops and vocabulary grows.

It’s focus is pre-literate and involves great attention to knowing the world through several characteristic traits. Again, Egan’s theory is summarized by Berryman as he explicates those characteristics:

- “Binary Structuring”
 - Fundamental binary oppositions such as male/female, black/white, natural/cultural, good/bad, Yin/Yang are cultural universals although the actual oppositions may vary in dominance from culture to culture. This is the result of the effort to organize the world with language by noting at first contrasts (A and not-A) as well as similarity.
 - Children think of hot as hotter than I am or cold as colder than I am. Even before we can learn to ride a bicycle, skate, read or write, we can distinguish love and hate, fear and security, good and bad, etc...by this binary process.
- “Fantasy”
 - This involves the dislocation from everyday rules. One might think that familiarity and immediacy would appeal to children but why then does Peter Rabbit attract them? He is part of the natural world but wears clothes and talks. The wood is safe but the cultivated garden is not... [This] may simply be a mediating category between binary opposites such as home/away, life/death that is worked out in fantasy play with words.
- “Abstract Thinking”
 - In oral cultures, practical skills are passed on not by abstractions but by apprenticeship. Children have ready access to abstractions even though they cannot explain them consciously. Peter Rabbit’s narrative is structured by abstract binary concepts of security/danger, wildness/cultivation, life/death, nature/culture, obedience/disobedience and the abstract motives of hopes and fears are familiar to children and are evoked by the story.”
- “Metaphor”
 - This is a fundamental kind of understanding and is used and understood by children. Preschool children are better at metaphor creation and understanding than children in grammar school and can exceed college age people.

The metaphorical use and literal use of language are related. Notice how metaphors used to try to put something new into language can decay and become “normal” in usage, such as a chair’s “back,” “arms” and “seat.” Metaphor becomes literal by constant usage and language is strewn with such dead metaphors.

Ordinary words carry only what we know while metaphor, when alive, can help us find something new.³⁴ As one learns to write, especially at the beginning, language is objectified and moves toward logic and away from metaphor.

- “Rhythm and Narrative”
 - In oral cultures one knows only what one can remember, so prose is exploited to add to the stock of one’s memory by music or speaking with rhythm and rhyme.³⁵
- “Images”
 - Words can evoke images. We sometimes close our eyes to see mental images of the mind. An image brings reality to what is not present. Images also bring emotion to the meaning of the words.
- “Stories and their Meaning”
 - Stories give shape to the flow of experience. They begin and end, while life moves on like a river. Stories provide myths their power for shaping experience to make it intelligible. (2011, p 4-6)

The majority of the children I am advocating for in this work (12 and under) incorporate this kind of understanding in their spiritual and existential expressions—the “Mythic” understanding which incorporates all of the “Somatic” understanding and anticipates the next kind of understanding, the “Romantic,” which is where literacy begins to shape that understanding of the world.

³⁴ Children, by virtue of the fact that they have a limited vocabulary and are learning new words to communicate direct experiences, speak in a kind of poetry. They have fewer words at their disposal, and so the words they use carry more freight. These words, like in poetry, point beyond themselves—toward something they have experienced and are struggling to communicate. An example that comes to mind for me is a story about my son when he was 4 years old. We were driving to day care one day and it was a foggy morning with the sun just filtering through so that the air around us looked cloudy and yellowish and crisp. It was chilly, but I had the windows down—it was just the beginning of spring and this seemed a luxury—and an adventure—for my 4 year old. He exclaimed from the backseat, “Daddy! I can feel the outside of the car!!” as he discovered that his arm was now long enough for his hand to reach the external part of the car door, through the open window, while we were driving. It was a dirty car at the time, covered in dust and the grime of the road, wet with dew and saturation that such a humid and foggy morning brings. “I wonder what it feels like?” I asked him. He responded, after careful consideration and choosing just the right word, “It feels like... LEMONADE!!”

³⁵ Consider a book that is read to a child each night. Even when very young, though they cannot read, children will notice the moment a parent “skips” a few pages or lines in an effort to get on with the going-to-sleep process. These very young children will stop the reader and direct them right back to where the narrative anomaly occurred, often word-for-word and line-for-line.

In supporting children’s spirituality in the clinical setting, it is important for the chaplain/spiritual care provider to be able to access within themselves this kind of understanding so that the spiritual and existential expressions of the child can be “understood” by the adult facilitating the interaction. Young children express themselves spiritually through their “capacities for forming binary oppositions and mediating them, for abstract thinking and metaphor, rhythm and narrative, images, stories and affective meaning, humor, and no doubt a number of other capacities language development implies.” (Egan, 1997, p. 69) If the Chaplain providing a strict assessment of the child’s spirituality can’t do so through the lens of the language the child herself is using, the assessment is really more about the Chaplain, or even the “spiritual assessment tool” than it is about the child. That is, the Chaplain will take the language of children’s spirituality and try to fit it into the scientific language domain, thereby compromising the integrity of both. Again, there is a difference between talking “about” the child’s spirituality and being “in” it with them.

Five-year-old Nikki’s key³⁶ falls squarely into this kind of knowing the world—she used lots of binary oppositions to mediate the meaning she was making (lost/found, alone/together, able/not able), used it within the narrative of the story and created (literally—it was not part of the Godly Play® story shared with her) a “key” metaphor for what she was needing spiritually and existentially. But this key was not a concrete particular. She was not saying that she was actually looking for a key. She was speaking poetically in a way that, while truly giving expression to a spiritual need (seen through the lenses of relational consciousness and existential limits), an assessment—

³⁶ See “Nikki’s” story preceding the introduction of the work.

intervention—outcome model of spiritual assessment within the language domain of science (what Egan calls Logico-mathematical forms of thinking) simply wouldn't be able to accommodate. Rather, the chaplain needs to be listening and speaking and wondering poetically, in order to come alongside the child in her own spiritual expressions. Egan notes, "This poetic world—emotional, imaginative, metaphoric—is the foundation of our cultural life, as a species and individually...[This is true of] our own childhood understanding; its poetic nature has made it difficult to understand by those who approach it looking only for the origins of rational or logico-mathematical thinking." (1997, p. 69) If the chaplain would have been searching for an actual key, or tried to get Nikki to explain what the key meant in a rational and logical way, the point would clearly have been missed and the spiritual expression would have risked being stifled. This is an excellent illustration of the need to engage children within the kind of knowing they are displaying in an interaction, and Egan's theory is one that supports the authenticity of the relational aspect of child and chaplain that is key to supporting children's spirituality beyond the normative scientific model prevalent in clinical settings.

3. *Romantic Knowing (around 8 years to about 15 years)*

Again, Berryman summarizes:

Romantic knowing deploys the tools that explore limits of reality and people and events transcending the ordinary. There is an attraction to things, people, ideas, and qualities of character that push back against the constraints of everyday life. This kind of knowing is also attracted to "humanized knowledge," events that are the product of human emotions and intentions. There is also an interest in detailed knowledge about a limited subject, which motivates making collections of seashells, dolls, sports memorabilia, etc. Narrative structuring, affective meaning and images continue to be important. The richer the child's mythic thinking the more developed that romantic knowing can become.

The Characteristics are:

- “Reason, Reality and Writing”
 - The limits of reality, the extremes of experience, and the context of our everyday lives come into view for children this age...The context provides the setting for the details to be framed by. The movement from the whole to the particulars and from the particulars to the whole provide an interplay that leads to the best exploring, but the children and adults at this stage mostly enjoy the extremes by which reality is limited.
 - This interest is what leads to collecting so that one can know that there is something one really knows. This provides security. On the other hand, there is the interest in the outer limits and the exotic as the context for the details.
- “Transcendence within Reality”
 - The romantic figure of interest to this kind of knowing is the hero. The hero transcends the normal constraint that hem in most people...Part of the attraction of heroes to children during this period is the security of knowing that there are people like this to look up to and stirring the imagination to emulate them. The tension in any story about heroes is whether they can transcend ordinary existence or not.
 - One of the greatest expansions of abilities for transcendence is the spiritual. This is true whether the story is about the mystical ability to forget the self or to make the journey out of Eden.
- “Humanized Knowledge”
 - This way of understanding the world notices individuals and the emotions that stimulate them to act in a romantic way. Everything we know was discovered, invented, or authored by someone. It is this part of the story rather than the dry recitation of what was discovered that is of interest to children this age.
- “Romantic Rationality”
 - This kind of knowing is post-oral culture but pre-science. It is rational, but its mixture of the above characteristics—extremes of experience, transcendence above the normal constraints, and humanized knowledge are the primary features of this kind of knowing expressed in the narrative of the hero. (2011, p 6-7)

Incorporating the binary, abstract, fantasy and metaphorical thinking dominant in mythic knowing, romantic knowers now begin to contextualize imagination, narrative and self-perception into the realities of what can be known. The perceptions of limits are culturally established as rules of reality, as well as the rules of expressing this reality in

the written word, so romantic knowers begin to not only stretch wide the possibilities within those limits, but also dig deep to stretch the limits of knowing very particular things. Heroes of chivalry and myth, superheroes, idolized sports figures, idolized family members and even religious figures begin to provide motifs of possibilities for children to look up to and strive toward.

These limits within reality may often take the form of the existential limits Yalom describes. Children at this age generally know that all living things must die, for example, but what of those who have transcended death (either through recounted near-death experiences or through religious and spiritual narratives)? Romantic knowers begin making connections between their own sense of the limits that constrain them and the possibilities that others have shown can transcend those limits, “but for real, not pretend.” Knowing stories of the heroes who have experienced transcendence within reality, and knowing those heroes have thoughts and feelings just like the child who idolizes them, means the child may also relate to those experiences, and perhaps follow in the footsteps of the hero who has gone before. This gives them not only a sense of hope in the story of another, but in their own story as well. It also gives them a context within which to try things out, test their knowledge and really focus on what might be possible through story, imagination, play, wonder and artistic expression.

Children may seem “obsessed” with Pokemon cards, or a book series, or facts about sports teams that, on the surface, may just seem like a passing fancy. A chaplain who is able to connect to this kind of knowing in themselves, however, may begin to explore these particular interests, wonder about where they fit in within the context of the child’s life, and, in the clinical setting, perhaps the child’s diagnosis and how that has

affected the narrative of what the child hopes for in the future. The interests displayed in romantic knowing are invitations for the S/R connecting aspect of supporting a child's spirituality and should not be overlooked or dismissed.

Many spiritual caregivers, whether in the clinical setting or in a congregation may consider a child constantly talking about superheroes or sports stars to be missing the point and will often try to re-direct the child back to something religious, or to "God talk" as Nye describes it. But even in mainline Christianity, Jesus is often portrayed as a kind of "super hero" that transcended death and brought a new reality to the world. Children in the romantic kind of knowing easily feel this kind of romantic notion, but often apply this to what they are interested in, rather than what the adults tell them they should be interested in. In nurturing children's spirituality, it's not so much about the knowledge they can display, it's about the kind of knowing they are engaged in, and how they incorporate that kind of knowing into their own sense of self and the relationship they have to the world and all of the circumstances they experience in that world.

Marco

Marco was an 11-year-old boy who was obsessed with zombies. He was also receiving a bone-marrow transplant after his Leukemia treatment ended in relapse. I would visit with him and look at the numerous zombie pictures he drew—books of them—and watch him play video games where killing zombies was the name of the game. I was always tempted to try to re-direct him away from something that seemed so violent to me, but I forced myself to stay with him and really try to be curious about these zombies. I would tell him Godly Play® stories and his art responses always included zombies. These zombies were broken, bandaged and bloody, not very smart, pretty scary and had certain strengths and weaknesses. I learned a lot about zombies because Marco knew all there was to know about them.

One day, I brought a story to him called 'The Parable of the Mustard Seed.'³⁷ In the story, a person plants a tiny mustard seed into the ground and it grows to become so big that the birds of the air come and make their nests in it. Marco and I took turns placing

³⁷ See Berryman, 2008, p. 115.

the small bird and nest figures onto the felt material that represented the “tree” that grew from such a tiny seed.

As we wondered about the story, I noticed that he had placed one bird on the ground, away from the other birds, but near the figure of the person that planted the seed. “I wonder about this bird,” I said. “I wonder why that bird is down there, away from the other ones.” Marco described the bird in a similar way that he had described zombies. “This bird is broken and bandaged and doesn’t know how to get up in the tree like the other birds.” “I wonder how that bird is feeling,” I said. Marco then described how the bird was sick, but that the “person,” the figure in the story representing the person who planted the mustard seed, was there to help this bird so it could get better and fly up into the tree. “I wonder who that person could be,” I said. Marco looked at me and responded, “The doctor?” I repeated, “This could be the doctor,” neither correcting nor offering an alternative. “Or my mom,” Marco said. “This person could be your mom, too,” I repeated. “Maybe its God,” Marco explored. “Maybe the person is God, too,” I repeated. “Could be.” Soon, the bird made its heroic journey into the tree with the other birds through Marco’s hand and the story was ended.

Marco found a lot of safety in his zombie knowledge—it was something he really knew. The chaplain could have re-directed him, corrected him or even disparaged zombies at any time, but instead entered into the world of zombies with Marco in order to strengthen the S/R connecting. In this way, the “entering in” wasn’t about the zombies, per se, but about coming alongside Marco in his romantic knowing. This was the “intervention,” though at this point, the chaplain didn’t necessarily know what Marco’s spiritual needs were. But Marco eventually expressed his spirituality to the chaplain, making a hero with a bird of zombie-like description who was helped by a doctor, his mom, and God (Marco’s family was Catholic, though Marco didn’t say much about it during the visits). Marco was also able to contextualize the metaphor of the narrative into his own experience—so the bird’s mom was “my mom,” and he made the leap from the bird being a little figure on a felt underlay into his own journey through transplant and his hospital admission. He was relationally conscious of himself, others and the Transcendent in that moment, and he bumped against the existential limit of aloneness by

finding others who were there to help, as well as finding the meaning he needed from that story at that particular time.

4. *Philosophic Knowing (15 years into the early 20s)*

Berryman notes:

[In philosophic knowing, or Philosophic Understanding, as Egan terms it], knowing is attracted to the formation of general schemes and the development of a language of theoretic abstractions to support them... The lure of certainty and the search for authority and truth based on general schemes dominates. There is an interest in the dialectical play between the whole and the parts and an interest in anomalies that don't fit into one's preferred scheme for an open mind or anomalies are dismissed by a closed mind.

Plato and Aristotle were champions of a kind of thinking that excluded the arts because they wanted to directly experience nature so metaphor, intuition, poetry, and images were secondary and stood in the way of direct experience by reason and the reasoning from this direct perception of the forms of reality.

Schemes are neither facts nor generalizations based on facts. They are guesses, suggestions, or assertions about the nature of things. The generalizations are based on facts, but between the facts and the generalization there is an act of mind, of imagination, of faith that generates conceptions of things that are different in kind from the things themselves. The *scheme* is more than the sum of its parts.

The Characteristics are:

- “The Craving for Generality”
 - This accumulation of facts becomes known as an object at this stage, which is manipulated as if it were something less complex, like an ‘apple.’
 - The connections among things become more prominent than the things themselves.
 - This craving constructs theories, laws, ideologies and metaphysical schemes to tie together the facts available.
 - The dark side of this craving is that it leaves one vulnerable because of the range of possibility involved. Piaget described the most distinctive property of “formal operations,” as he called this period, as the “reversal of direction between reality and possibility, instead of

deriving a rudimentary theory from empirical data as done in concrete operations, formal thought begins with a theoretical synthesis implying that certain relations are necessary and thus proceeds in the opposite direction” (1958, 251). (quoted in Egan, 122)

- “From Transcendent Players to Social Agents”
 - The focus of intent and intellectual engagement during this period shifts from the hero to a self-understanding where one is part of a larger system... The hero may transcend the constraints of society, it appears from this standpoint, but the laws of nature or some other scheme of history or scientific principles, cannot be [transcended]. This “larger” truth is more abstract and stands “behind” what we do as individuals. We become aware of this content that is distant from the self but rules our lives. Knowledge now becomes a general scheme that defines our role in society and what supports or tears down that view.
- “The Lure of Certainty”
 - From [various religious traditions] (revelation), Plato (the Platonic Forms), Aristotle (abstractions built up from the particular), or the Enlightenment (the scientific method), we have inherited a sense that there is truth and that it can be known. There is a sense that it can be found, like a treasure buried in a field, rather than that we create or change it in the period that comes after this one (a feature of Ironical Knowing), or that it is lived in the life of the hero, which is a feature of the period that comes before the philosophic knowing (the romantic period).
 - The lure of certainty can be destructive as well as creatively drawing one into the search for an adequate theory and the detailed knowledge needed to support it. When a scheme is “found” that is beyond one and is seemingly objective, it can lead to arrogance. There is nothing quite so scary as a “true believer” in such a theory. Everything begins to be trimmed to fit into the world scheme of such a person and he or she is not aware that the theory has closed the mind and made it rigid. New knowledge gets stored in some box in the scheme’s hierarchy to be dismissed if in conflict or treasured if in agreement... The threat of anomalies sometimes causes one to retreat further into the security of a more intense belief in his or her system.
- “General Schemes and Anomalies”
 - When one’s intellectual security or sense of identity is tied up with a general scheme, used to make sense of the world, then the validity and adequacy of the scheme becomes vitally important. This can lead in two directions. It can

cause one to dismiss facts that don't fit or it can make one more curious about such anomalies, which can stimulate a search for what is more valid and certain.

- When one has only a little knowledge it is easier to have faith in one's preferred scheme, because the interplay between the general scheme and particular knowledge collapses. On the other hand, flexible minds adjust to anomalies and when they make the preferred scheme untenable, one moves on to a scheme which has more validity. A content rich curriculum is, therefore, very helpful to prevent unfounded, over-confidence. (2011, p 8-10)

I have chosen to quote this section of Berryman's summary of Egan almost in whole for several reasons. In the first place, it is in the domain of philosophical understanding that this entire work is written—I am myself taking the scheme I have inherited about clinical practice in spiritual care (the “assessment—intervention—outcome” model), the assumptions that outcomes must be observable, evident and measurable when it comes to spiritually supporting children, and, noting the anomalies, I am trying to be curious and wonder if there might be a different scheme, more adapted to the needs of the children we support, but for whom the generally accepted scheme does not seem to accurately reflect their spiritual and existential needs and concerns. Rather than try to fit the spiritual expressions of children into the existing scheme, or simply ignore this issue altogether because of its difficulty (“how do you catch a cloud and pin it down?”), I am proposing the combining of several schemes (relational consciousness, existential limits, Egan's theory of ‘kinds of understanding’), to create one that is more useful to the chaplain in its engagement, more useful to the

IDT team in communication, and more authentic to the spiritual and existential experience of the children we support.

Secondly, this kind of knowing or understanding is generally where adults land, and often, where they stay (see the notes on the “Lure of Certainty” above). There is no absolute age threshold as to when a developing human begins to engage philosophic knowing (beyond the generality noted of age 15 and into the 20s). Rather than age as the determining factor of who is considered a “child” and who is not, at least in this context, I propose it is the kind of knowing a person is engaged in as the determining factor. There are many times when an 18-year-old patient is engaged in romantic knowing, but rarely does one find a 4-year-old engaging in philosophic knowing. If, however, the spiritual assessment (and the assessor) used in clinical settings is only “tuned in” to philosophic knowing and expressions, then the scheme is limited, as are the spiritual assessment tools that are built around that scheme.

This is not the kind of understanding the children I am focusing on are engaged with, which is why I have limited the case examples throughout this work to children age 12 and younger. Much of the research literature done on religion and healthcare, spiritual assessments, and evidence based spiritual care practices that include “children” do so with the understanding that by “children,” anyone under the age of 18 is inclusive. However, in Egan’s scheme, some “children” (specifically those who are literate and philosophic thinkers), speak more like adults, so that answering a Likert Scale questionnaire on the role religion, spirituality or faith plays in one’s diagnosis and treatment is really not

inclusive of “children,” but of young persons who think, read and communicate in the same way adults do. I’m using this kind of knowing to underscore its insufficiency as a relational tool to support the spiritual guidance of children, and proposing a new, though not novel, way of using several schemes to approach younger children differently in terms of spiritual support.

Thirdly, it is clear in our Clinical Pastoral Education (CPE) program in the hospital where I serve as an adjunct facilitator of the “Children’s Spirituality” seminar in the program’s curriculum, that many, if not most who come to the program are also generously bequeathed with the inheritance of the Pastoral Care theologies and theories that the seminary, cognate CPE programs, or other training has bestowed, necessarily steeped in philosophic understanding. As we train to help these chaplains learn how to engage young children in spiritual care, it doesn’t take long for CPE Residents to realize that these methodologies are woefully unhelpful in their engagement. The reason, we explain, is that approaching a child who is engaged in a mythic understanding of the world, themselves and their relationships in it with a philosophic understanding and all of its assumptions, negates the individual child herself and assumes to bring her expressions into our own schema of spiritual care, rather than allowing our spiritual care to meet the child where she is. Again, we are in relationship with children, not with theories.

It is therefore incumbent upon the chaplain to relate to children but coming alongside them—not becoming a child or absconding responsibility—but engaging the kind of knowing the child is engaged in by accessing that kind of

knowing in the chaplain herself. This requires a flexibility of mind and spirit within the chaplain to be able to access and utilize the appropriate kind of knowing for the patient or patients she is caring for at any given time. This leads us to Egan's final kind of understanding, "Ironic Understanding," or, Ironic knowing (1997, p 137).

5. *Ironic Knowing (after early 20s)*

- During this period, one becomes fascinated by language itself, its limitations and possibilities. This attracts one to the way of knowing that is reflexive and can deal with all the previous ways of knowing. It also looks at different systems as options to choose among, depending on their usefulness and appropriate application for the job to be done. The dark side of this ironic ability is that sometimes everything seems to fall apart and the proliferation of perspectives creates anxiety. The fluent ironist, however, can slip from perspective to perspective with enjoyment and creative satisfaction.
- The ironic knowing of this stage cannot be reduced to the interests of postmodernism, because that kind of irony is not understood as one of the many ways of approaching how to understand the world. Its narrative is privileged and it is considered the only way of knowing. Ironically, the craving for certainty, even in uncertainty, is at work.
- Multiple perspectives provide multiple meanings. Since the days people began to wonder if the gods or God was watching over them, alternative perspectives have crowded the mind. The ironist is aware of more perspectives than most.
- Irony's fundamental paradox in modern times is not about gods or God. It is to hold at the same time a view of life as an art versus life known by the scientific spirit and reason. Schlegel (1772-1829), who was in the literary circle including Schleiermacher, called this "transcendental buffoonery" (quoted in Egan, p 147)
- The irony that Egan is talking about...involves the awareness that our minds and the use of language is more open. We all have other games to play besides trying to represent reality. Less energy is spent on trying to dissolve other kinds of knowing but is spent on trying to use the kinds of knowing we have access to appropriately.
- [Ironic Understanding] remains open to the possibility that none of the ways of knowing have been exhausted. It keeps its focus on the realm between the idea and reality where rational choice lives, and remains open and flexible rather than hardening into a disabling, rigid skepticism.

- The sophisticated ironist lives in a multivocal world, where for the task at hand some tools are more helpful than others. (Berryman, 2011, p 10-11)

The most important aspects of ironic knowing as they contribute to my proposed approach to supporting children's spirituality are twofold. Firstly, it is the paradox of being a spiritual care provider in modern healthcare where, as Berryman phrases it above, we must "hold at the same time a view of life as an art versus life known by the scientific spirit and reason." That is, the child battling heart disease, for example, admitted to the hospital for months (or even longer), enduring daily encounters with invasive therapies, experiencing the interruption of social development that her classmates continue to undergo in school, who is tangibly wrestling with the existential limits and spiritual relations with the world and all that is in and beyond it—this child needs both the science of medicine and the art of spirituality to work in tandem in a move toward healing (in whatever sense healing comes to take place). To work only in the spiritual domain would not help the child's body pump blood or re-activate her kidneys. To remain exclusively in the scientific domain would not address the spiritual and existential realities and limits that cause a child's need for meaning, or to process her hope or despair. Both domains are necessary, and they are necessary by way of facilitating the child's expression of understanding, hope and meaning-making in the midst of medical treatment.

In the context of this work, Ironic understanding comes on the part of the chaplain. The pre-literate ways of knowing (somatic, mythic and romantic) are where the chaplain will find most young children. The philosophic way of knowing is more for the chaplain to talk *about* how to support children generally, and to communicate to other care providers about the child's spiritual and existential needs. The ironic kind of

knowing is where the chaplain (and any care provider, really!) must be flexible enough to engage in themselves and employ with others depending on whether it's the art of living a meaningful life, or the science of sustaining it, that is in question at any given moment.

Berryman notes, "The mentor [i.e., "chaplain"] needs to be flexible in their own knowing and the emotional tug of all of the five states, and also [have] the nimbleness to help children remain open to both the stages they have passed through to those that are yet to be encountered." (2011, 11)

As adults, we often forget that children are whole persons with unique perspectives, voices, beliefs, fears and spiritual needs. It is easy for those of us who fluently speak "adult," vis-à-vis the philosophic understanding of adulthood, to bypass the spiritual expressions of children as undeveloped, immature, non-sensical, cute, playful, or lacking understanding. Much of the way in which children express themselves may be any or all of these, but lacking understanding is not one of them. The pictures a child draws when confronted with an existential limit and a narrative to connect to may not make sense to our own philosophical way of seeing it—that is, it may not fit into the scheme we think it should, but we have only to engage in the kind of understanding the child is engaged in to get closer to validating "their" expressions in a way that "we" can support, affirm and invite meaning into. Egan's framework provides us a way of doing so. "[I]nstead of identifying ourselves in terms of some excluded groups [i.e., children] who are unlike "us" [i.e., adults], and who consequently can be treated with less sympathy, less sensitivity, less humanity, we will seek to include wider and wider groups within the category of "us." (Egan, 1997, p 171) It is not that the children we don't listen to in current schemes of spiritual assessment are intentionally de-humanized, but it is the

case that when children are either dismissed for their lack of linguistic and precise logical expression, or are rendered to be simply a “stage” within a stage theory, we do unknowingly de-humanize them by not meeting them where they are, as individuals with the same inherent spiritual and existential needs and concerns that we as adults have.

Conclusion

Egan concludes, “Our initial understanding, according to this theory so far, is Somatic; then we develop language and a socialized identity, then writing and print, then abstract, theoretic forms of expressing general truths, and then a reflexivity that brings with it pervasive doubts about the representations of the world that can be articulated in language. But irony is a general strategy for putting into language meanings that the literal forms of language cannot contain; along with this, Ironic understanding involves abstract, theoretic capacities, plus capacities stimulated by literacy, plus the winged words of orality, and also our bodily foundation in the natural world.” (1997, p 171)

Language is limited when it is only seen as verbal, logical and concise. The language of children comes through play, imagination, metaphor, wonder, art, movement and any number of non-verbal expressions. As chaplains and spiritual care providers, we must strive to find ways to engage children on their level, as much as possible, to give voice to their spiritual and existential needs by virtue of giving them a safe container in which to express those needs. By doing so, we give those needs expression through imagery and narrative, symbol and meaning within the child’s own understanding. These spiritual expressions contribute toward a child’s healing and so, are a necessary part of a child’s clinical journey.

***Chapter 4--From Theory to Praxis in Supporting the Spirituality of Children in
Clinical Settings***

*“Give me a lever and a place to stand and I
shall move the Earth”—Archimedes*

Archimedes, famed Greek scientist, engineer and inventor used the above quote to encapsulate the very essence of the physical sciences. One needs a firm foundation upon which to stand and a mechanism for the work to be done. In a very apropos way, famous activist, theologian, contemplative, spiritual leader, Franciscan priest and best-selling author, Richard Rohr, has also used this quote to speak of the necessity of contemplation

as a foundational aspect of the activism and justice work he engages in.³⁸ This notion born of ancient science and bridged to engaged spiritual practice serves as a lovey symbol for the work I'm attempting to do—to bridge the language domains of science and spirituality in the clinical setting where children are those being cared for. My hope is to uphold the necessity and validity of both, without subsuming one language domain into the other, but rather, giving them a way to talk to one another in the same way physicians, providers and chaplains talk every day in the formulation of care plans for their patients.

So far, I have attempted to flesh out the three main theories (relational consciousness, existential limits, “kinds of understanding”), and the process description (the creative process) that are informing my approach to supporting the spirituality of children in a clinical setting. I have also used several examples of a kind of activity that allows for a spiritual/relational connection with a child (Godly Play®) and the kinds of spiritual and existential expressions that can come from such an activity. Finally, I have proposed what I think is a viable description of an alternative to the traditional assessment—intervention—outcome model of clinical care when caring for the spirituality of children, the S/R Building—S/R Connecting—S/R Expressing model of pediatric spiritual care. I have summarized how each of these theories work together in a metaphor of my own invention (see p. 80). I will now recap what I propose to be a way of describing this approach to caring for a child's spirituality, and will then move on to the final chapter to clinical case descriptions and attempt to show how the model I propose applies to the spiritual expressions of children in an inpatient psychiatric unit. Part of this

³⁸ See Richard Rohr's *A Lever and a Place to Stand*, Paulist Press (2011).

discussion in chapter 4 will be to work out how to create the space needed for this kind of interaction with a child or a group of children.

Before offering the case examples and praxis of this work in chapter 5, I will first review some of the most common spiritual screening and spiritual assessment tools in clinical use today and argue that while they are helpful in adult spiritual care, they are quite limited in their application to children who experience their spirituality, and express it, quite differently than these tools generally accommodate for.

I will briefly discuss the components of the type of chaplain's visit with a child that I propose, using Nye's notion of the "pieces" of the process that is supportive of children's spirituality, Winnicott's "third thing" that anchors the interaction, and Berryman's "Middle Realm" in which the child (or children) and the spiritual care provider are able to find a safe "container" (temenos) in which to explore relational consciousness and the existential limits.

Spiritual Screening, Spiritual Histories and Spiritual Assessment Tools

In order to determine the likely benefits to exploring the spiritual needs of patients, healthcare professionals of all types of disciplines can engage patients in conversations about their spirituality, religiosity or faith beliefs in order to include these aspects of a patient's life in their care. Often, the terms 'spiritual screening,' 'spiritual history,' and 'spiritual assessment' are used interchangeably, but there are important differences to note.

Patricia E Murphy, PhD, BCC (Board Certified Chaplain) presented to the National Association of Catholic Chaplains Annual Conference in 2017, and provides a helpful distinction:

“*Spiritual Screening*: a few questions to elicit basic preferences and any obvious distress that warrants follow up (minimal expertise & time required)

- Often completed at admission
- Triage level care” (Murphy, 2017)

These are very basic screening questions that frontline staff often ask patients at the time of admission that are some variance of, “Is faith, religion or spirituality important to you in coping with your illness?” “How much comfort do you find in your current faith/religion/spirituality?” “Do you identify with a particular faith tradition?” and “Would you like a visit from a chaplain?”

One example of a screening tool was developed by George Fitchett and James Risk in 2009 and was used in a pilot study where it was administered by non-chaplain healthcare staff to determine its effectiveness. (Fitchett, 2009) If the patient answers in such a way that a chaplain referral is warranted, the referral is made and the chaplain follows up with the patient for a spiritual care visit.³⁹

Three benefits of spiritual screening that Fitchett and Risk describe include, “first, using a screening protocol [delivered at admission by non-chaplain medical staff to

³⁹ Spiritual screenings, histories and assessments vary widely and are often specific to the particular institution in which they are used. Since one purpose of this work to evaluate the effectiveness of these tools with young children, rather than to evaluate the efficacy of specific tools, I will offer only general examples of each type, focusing more on assessment tools and their relevance to the pediatric population I am focused on.

determine appropriate chaplain referrals] can improve stewardship of the professional chaplain's time...[s]econd, a screening protocol such as this one can be very useful in documenting the need for spiritual care.” “Third, there is strong pressure to provide evidence about the benefits of spiritual care. Because it may be difficult to measure the impact of spiritual care among all patients, chaplains should begin with studies that examine the impact of spiritual care among patients identified as experiencing religious or spiritual struggle...providing spiritual care to patients experiencing religious/spiritual struggle may make a measurable difference in their quality of life, emotional adjustment to illness, and possibly their recovery and survival.” (2009, 9- 10)

All of these are very good reasons to initiate using a spiritual screening tool—offering spiritual support to those who display the highest evidence of need, providing a way to document that need in the EMR, and to be able to explore the benefits of the spiritual care they receive. It must be noted here that this spiritual screening, while helpful for adult patients and possibly adolescent patients, the language employed and the method of determining the existence of spiritual struggle does not specifically take aim at pediatric patients and relies on the parent or guardians of those children to make the determination on their behalf. On the one hand, this could be an important tool to determining the spiritual struggle of parents and family members of pediatric patients, which is very real and requires as much spiritual support as the patient herself. On the other hand, identifying spiritual struggle in children, particularly young children in the latency period, is extremely difficult to do in a question and answer format such as the spiritual screening provides. In addition, parents may not be able to accurately answer for the children themselves, and children are not given the ability to engage these spiritual

issues in their own way of knowing and expression. From a practical standpoint, this would take far too long during an admissions screening, does not allow for the necessary relationship building and connecting that facilitates a child’s spiritual expression—it would require much more time than a spiritual screening allows. For this reason, Fitchett and Risk recommend focusing research on those patient populations that can be measured within this framework. In the mean-time, chaplains must continue to strive to support children spiritually, and this requires a different approach, and perhaps a different paradigm of what assessment-intervention-outcome looks like.

“***Spiritual History***: Collecting the basic spiritual and religious story (medium expertise and time required)

- Can be completed by MD, RN or other healthcare professional
- Common history tools include FICA, HOPE and SPIRIT” (Murphy, 2009)

Spiritual history tools have been developed by several physicians and researchers, most famously, Christina Puchalski, MD (FICA), Todd Maugans, MD (SPIRIT) and Drs. Gowri Anandaraja and Ellen Hight (HOPE). These tools are commonly available on the internet, but I will show each as an example as they have been published in Harold Koenig, MD’s concise and helpful book, *Spirituality in Patient Care: Why, How, When and What?* (2002). These tools are often used by physicians to determine the importance of spiritual and cultural values in a patient’s plan of care and medical decision making.

FICA

F—Faith: What is your faith tradition ?

I—important: How important is your faith to you?

C—Church: What is your church or community of faith?

A—Apply: How do your religious and spiritual beliefs apply to your health?

A—Address: How might we address your spiritual needs?

SPIRIT

S—Spiritual belief system: What is your formal religious affiliation? Name or describe your spiritual belief system.

P—Personal spirituality: Describe the beliefs and practices of your spiritual belief system that you personally accept. Describe the beliefs and practices you do not accept. Do you accept or believe...[specific tenant or practice?] What does your spirituality/religion mean to you? What is the importance of your spirituality/religion in your daily life?

I—Integration within a spiritual community: Do you belong to any spiritual or religious group or community? What is your position or role? What importance does this group have to you? Is it a source of support? In what ways? Does or could this group provide help in dealing with health issues?

R—Ritualized practices and restrictions: Are there specific practices that you carry out as part of your religion/spirituality (e.g., prayer or meditation)? Are there certain lifestyle activities or practices that your religion/spirituality encourages or forbids? Do you comply? Are there specific elements of medical care that you forbid on the basis of religious/spiritual grounds?

I—Implications for medical care: What aspects of your religion/spirituality would you like me to keep in mind as I care for you? Would you like to discuss religious or spiritual implications of health care? What knowledge or understanding would strengthen our relationship as physician and patient? Are there any barriers to our relationship based on religious or spiritual issues?

T—Terminal events planning: As we plan for your care near the end of life, how does your faith impact on your decisions? Are there particular aspects of care that you wish to forgo or have withheld because of your faith?

HOPE

H—sources of Hope meaning, comfort, strength, peace, love, and connection. What are your sources of hope, strength, comfort, and peace? What do you do during difficult times? What sustains you and keeps you going?

O—Organized religion. Are you a part of a religious or spiritual community? Does it help you? How?

P—Personal spirituality and practices. Do you have any personal spiritual beliefs that are independent of organized religion? What aspects of your spirituality or spiritual practices do you find most helpful to you personally?

E—Effects on medical care and end-of-life issues. Has being sick affected your ability to do things that usually help you spiritually? As a doctor, is there anything that I can do to help you access the resources that usually help you? Are there any specific practices or restrictions I should know about in providing your medical care? (Koenig, 2009)

It should be quite evident to the reader at this point that these can be very helpful tools for engaging adult patients about what matters most to them, where they find hope, purpose and meaning, and how these aspects of their spiritual lives may contribute to their overall plan of care over the course of medical treatment. It might be true that these kinds of questions could be relevant to literate teens and young adults who can speak “adult” and think in Egan’s philosophic understanding. What seems very evident to me is that these tools, and others not included here, as incredibly helpful as they are, do not at all engage a 5- or 6-year-old on an appropriate level, nor were they designed to. However, if we hold as a fundamental tenant that children are as inherently spiritual as adults are (remember Dr. Nye’s definition of spirituality—that it includes an *initially natural capacity* for awareness of the sacred quality to life experiences...), then we need some other way to help children express what gives them purpose, hope and meaning as well.

It is true that some aspects of the questions that are contained within these spiritual histories could be helpful with children. Finding out, for example, the strength of the relationships a child might have in a congregational group could help in determining the connection to “others” or to the “Transcendent” within the relational consciousness model, but the child would need to feel comfortable enough to speak to those relationships in ways that can be accommodated by the tool being used and by the medical professional taking that history. In practice, when spiritual histories are taken in pediatric settings, they are generally, as with screening tools, more focused on the parents or guardians, rather than the children themselves.

“*Spiritual Assessment*: detailed process of listening to, interpreting and evaluating spiritual needs and resources (significant expertise & often more time required)

- Completed by a professional chaplain” (Murphy, 2017)

Even in the adult world of healthcare, the water gets a bit murky here. There are many, many spiritual assessment tools to be found in the literature, and many variances of each tool depending on the place and person employing them. Choosing among the many published tools is difficult enough for several reasons (explained below). Pediatric spiritual assessment is often talked about in the literature, but there are very few (if any) published spiritual assessment tools that focus specifically on children. Part of the challenge is related to what I have been focusing on in this work—children understand the world differently, express themselves differently and relate differently than adults do,

making the data-driven, philosophic understanding-oriented method of research and validation unable to accommodate children's spiritual/relational expressions. Even today, as research into this field is growing and the evidence-based efficacy of spiritual care in healthcare is expanding by leaps and bounds, it is difficult to find research articles that provide a concise, easy to follow, relationally appropriate model for assessing a child's spirituality in the clinical setting.

Spiritual assessment, "unlike spiritual screening or spiritual history tools, are the technical name given to '...an in-depth, on-going process of evaluating the spiritual needs and resources of persons for whom...' chaplains care (Fitchett, 2012, p. 300)" (quoted in Grossoehme & Fitchett, 2013, p. 293). The notion that these assessments are much more involved and should be done by professional, board certified chaplains is highlighted, noting that "...assessments are not a set of standard questions to develop cross-sectional data, but instead are interpretive frameworks for listening longitudinally to a person's story" and is based on "actively listening to, and reflecting, the spiritual meaning of events." (Grossoehme & Fitchett, 2013, p. 293) Additionally, "spiritual screening tools...were developed to be used by clinicians who are not chaplains, and to determine whether or not a more in-depth spiritual assessment is indicated." (ibid, p. 293)

While it is admitted that in order to determine whether a spiritual assessment, or more in-depth interaction with a chaplain should be made through spiritual screening: "All patients should receive a simple and time-efficient spiritual screening at the point of entry into the health care system and appropriate referrals as needed" (Puchalski et al., 2009, p. 893), it seems evident that by "all," in practice, ends up being all who are able to speak adult in the manner of Egan's philosophic knowing or in the scientific language domain.

For example, it is noted that the “evidence describing the harmful effects of spiritual struggle continues to grow” and that “this evidence comes from studies of adult patients with serious illness or chronic illness...as well as children and adolescents...and from studies of parents and other caregivers.” (Grossoehme & Fitchett, 2013, p. 294) However, the studies cited only involve adolescents rather than children.

Sandra B Sexson, MD, from the psychiatric perspective, notes that while religion and spirituality research and assessment continues to be recognized as a growing and necessary field in child and adolescent psychiatry, “[a]ssessment in child and adolescent psychiatry involves a complex process that involves a developmental and ‘milieu’ perspective.” (2004 p. 35) From the standpoint of my own framework, the “developmental” approach, at least in the pediatric spiritual domain, is best accommodated by Egan, and the “milieu” approach by allowing spiritual and existential expressions within the framework of relational consciousness and the existential limits. Again, this requires S/R Building, S/R Connecting and S/R Expressing within a safe, intentionally constructed “container” between the child, the chaplain and all that each brings to that encounter.

There is one relatively recently validated spiritual assessment tool, the Spiritual Distress Assessment Tool (SDAT) specifically created for the elderly (Monod, et. al, 2012). While this tool is focused specifically on spiritual distress in the elderly nearing end-of-life and not necessarily relevant for young children, it “demonstrates that a quantifiable approach to assessing unmet spiritual needs is possible.” (Fitchett et al, 2019, p. 1) This is important because, as noted above, “most published models for spiritual assessment were designed to be used in multiple clinical contexts—what we call the

‘one-size-fits-all’ approach...Research now permits the development of more efficient and research-informed condition-specific models for spiritual assessment.” (Fitchett et al, 2019, p. 2) I would note that pediatrics is, thus far, one of the least researched “condition-specific” areas of spiritual care, which contributes to the dearth of outcomes-oriented, evidence-based assessment tools for young children.

The notion that the intervention-assessment-outcome model doesn’t quite seem to fit in describing what happens in the spiritual support of hospitalized children is not new:

While the terms ‘assessment’ and ‘intervention’ fit well within a hospital environment, and other staff readily comprehend them, they do not fully represent the process that takes place in spiritual care as they are usually seen as separate processes. What is more accurate is that when members of staff offer a child or young person an episode of spiritual care based on their knowledge and understanding of that child or young person, the episode of care provides an opportunity for the child to express spirituality. One of the most significant observations[...] was that assessment and intervention are integrated and that often the activity we were using as part of what we originally called the assessment was actually an intervention. (Nash, Darby & Nash, 2015, p. 27)

Nash et al chose the term “episode” to describe the engagement of spiritual support with a child, rather than “intervention,” because it does not require a differentiation between the ‘assessment’ and the ‘intervention,’ which are often one in the same. I propose that while it is important to use relevant taxonomy in interacting with other disciplines in health care (the scientific language domain), we must also develop a framework of clinical documentation that accurately describes what spiritual care engages in with children that maintains the integrity of a spiritually-focused language domain that informs spiritual care.

Fitchett et al notes that, even in the adult world, “chaplains prefer a ‘conversational approach’ to spiritual assessment and have been uncomfortable with models that ‘attempt

to measure or quantify spirituality, religiosity, or spiritual injury.” (2019, p. 2)

Admittedly, I find myself in this frame of mind, particularly when it comes to children.

Fitchett et al continues, “Because it is essential that chaplains develop the ability to describe the effects (outcomes) of their care, models for spiritual assessment must have a quantitative component, which could be combined with narrative summaries.” (2019, p. 2) I see this as the possible bridge between the assessment-intervention-outcome model and what I am proposing here, the S/R building—S/R connecting—S/R expression model. *The keystone to this bridge, I believe, at least in pediatric spiritual care, is the re-framing of what “outcome” means in pediatric spiritual support, i.e., the S/R expression itself IS the outcome.* I believe that the model I will propose below is both narrative rich, accommodating narrative that is not always verbal or written, while also providing data-points within the frame of relational consciousness and existential limits⁴⁰ that could be part of future research studies with children.⁴¹

Fitchett et al recently developed a “Quantifiable Assessment of Spiritual Concerns of Patients Receiving Palliative Care Near the End of Life” that has been called the PC-7.

Key concerns related to religious/spiritual struggle included the “need for meaning in the

⁴⁰ See diagram above on p. 77

⁴¹ I want to note here that the discussions surrounding pediatric spiritual assessments that have occurred on the Pediatric Chaplains Network listserv, a platform of conversation and discussion in theory and practice for chaplains engaged in supporting the spirituality of children, have provided robust material and instructive professional scrutiny when it comes to informing this present work. I cannot offer enough gratitude to all who have sent me the pediatric assessment models that they use in their own practices (which vary from the models listed above, to models created for use in specific spiritual care departments, to noting that there aren’t any models that seem both sufficient and usable with children). One excellent example of a model created by a pediatric chaplain is the Que PASA model, created by Mark J Knoper, PhD, BCC. Mark’s presentation, “*Que PASA: Innovation in Spiritual Assessment*” at the Association of Professional Chaplains annual conference, June 4-7, 2015 in Louisville, Kentucky has been very helpful for me in determining what does seem to work, and where I feel we may need to innovate even more specifically into the pediatric realm of the spiritual language domain.

face of suffering; need for integrity, a legacy; concerns about relationships; concerns or fear about dying or death; issues related to treatment decision making; R/S struggle; and other concerns. An approach to scoring the patients' degree of unmet spiritual concerns was adapted from the literature. Assessing cases from the chaplains' practice led to high levels of agreement (reliability)." (2019, p. 1) The sample for the study and the tool's development included "men and women, middle age and older, white and African American, and most reporting a Christian religious affiliation," which is acknowledged as a limitation of the study by the authors: "theistic assumptions in the indicators for R/S struggle may limit the validity of the these for nontheistic patients." (2019, p. 5) This is a ground-breaking study toward a quantifiable spiritual assessment and could serve as a model, with proper adaptation, for developing some similar type tool in supporting the spirituality of children. One adaptation, of course, would need to include engaging children in ways that the model can accommodate for the kinds of understanding (ala Egan) that each patient is engaged in and allowing for their expressions to find a way into themes more relevant to their own spiritual concerns.

One brief note about what I see as the difference between what we have encountered as the concept of "spiritual struggle" above and how I would differentiate shifting the focus from this toward "spiritual expression," both of which may contribute to healing through the creative process as described in this work by Berryman. Spiritual struggle is defined as "maladaptive spiritual thoughts about disease, illness or some other stressful event" (Grossoehme & Fitchett, 2013, p. 281) and leads to poorer outcomes in those patients who experience them. Spiritual struggle is the trigger, if detected during screening, for a more in-depth engagement of spiritual support. It is a very real concern

for those engaged in the healing professions and must not be underestimated. The main assessment—intervention—outcome model for medical care is focused on assessing what isn't working, intervening to try and re-establish optimal function, and measure the outcome to determine the efficacy of the intervention and guide the future course of treatment. In the model Fitchett et al (2019) describes, the same scheme is extant—focusing on where aspects of spirituality in patients is causing struggle, intervening in an attempt to relieve or resolve this struggle, and measuring the patient's (generally) self-reported outcome, either explicitly or by reliability. While I completely support the efficacy and necessity of this approach, I would also note that there are times when spiritual struggle or existential limits are sometimes neither known to a patient, nor observed by the screener. In fact, I would argue that even in adults, it is often the case that the spiritual expressions that come out of the intervention with a chaplain or spiritual care specialist during an assessment (note here that the 'intervention' and 'assessment' are often collapsed or simultaneous) give birth to an expression or frame of meaning that, while not addressing a particular aspect of spiritual struggle (that may or may not be consciously present), a spiritual or existential expression may *add to* the patient's ability to find meaning and frame hope in ways that they did not know were available to them, and in ways the chaplain could never have anticipated. This is to say, that sometimes, spiritual care isn't about filling in the deficits of a person's spirituality (struggle), but rather allowing them to build on the spiritual strengths of what they already have but had not yet uncovered (resilience). It is often the case that the reality of spiritual strengths that lie in patients aren't even available to them *until the spiritual expression occurs*, and its ultimate affect may be instantaneous, or take hours or years to be felt. I make this

distinction not to deny the efficacy of spiritual struggle- related research toward chaplain interventions and measurable outcomes, but simply to point out that for everyone, and children especially, some of the most impactful spiritual experiences are almost impossible to put into an expression of words, though they may make all the difference when it comes to hope, meaning and the path to healing and wholeness if given voice in other spiritually and relationally engaged ways.

S.P.I.R.I.T.⁴², The “Third Thing” and the Middle Realm—Creating Space for Spiritual/Relational Building, Connecting and Expression

I have proposed in the course of this work that in supporting children’s spirituality, the strict assessment—intervention—outcome model of the scientific language domain, which necessarily dominates the professional disciplines focused on supporting patients in healthcare, seems unable to accommodate what spiritual care providers experience and observe when supporting these youngest patients. I have suggested that because this model is informed by the scientific language domain, the descriptions that come from this kind of model do not sufficiently accommodate the more relational, “hard to describe” aspects of the spiritual and existential expressions of children. I have also proposed, as an alternative to the assessment—intervention—outcome model, a path toward describing the way in which the spiritual language domain informs a pediatric approach to spiritual caregiving: Spirituality/Relationship Building (S/R Building)—Spiritual/Relational Connecting (S/R Connecting)—Spiritual/Relational

⁴² This is not to be confused with the SPIRIT acronym described above as a spiritual history-taking tool.

Expression (S/R Expression), emphasizing that the S/R Expression IS the outcome of pediatric spiritual support. I have proposed this model as something that I think might better communicate with accuracy what it is that pediatric chaplains actually do in their practice with children, which is both in feel and practice, different, in varying degrees, from the chaplain's support of adolescent and adult patients and family members, that is, those who are fluent in the philosophic understanding that Egan describes. My hope is, that as I move through the praxis portion of this work, the S/R Building—S/R Connecting—S/R Expression model will help describe what I'm aiming for and eventually inform future research in this area.

Before looking at specific cases of pediatric spiritual expressions, I want to talk about the components of creating the space for these relational activities to occur (S/R Building). Various chaplains across the US, UK, Australia and beyond have contributed ideas and professional practices in published works, as well as in conversation with one another and with other disciplines within the health care field (see Nash, Darby & Nash, 2015; Nash, Bartel & Nash, 2018; Bull 2017 and many others). In one way or another, the practices described in these works are similar to, and deeply inform, what I am proposing. My hope is that this present work can offer a simple, accurate and useful model of describing the chaplain's work in pediatrics in a concise and usable way. I will set forth on describing the building blocks used to create the safe "container" that allows for S/R Building, proceed to different practices that facilitate S/R Connecting, and describe by way of case presentations the contents of S/R Expression through art, narrative and play responses that I have collected in the course of my work with children.

S.P.I.R.I.T. and the "container"—S/R Building

Dr. Rebecca Nye describes the importance of honoring specific criteria that must be in place to “do justice to the challenge of spirituality,” noting that “we have to attend to more than simply what is said, to more than words. We need a guide to seeing, feeling and evaluating our practices and settings for their spiritual quality.” (Nye, 2009, p. 41) She offers a set of six criteria, using the acronym S.P.I.R.I.T. The Rev. Dr. Cheryl Minor and I have utilized this criteria in our own work together and we have adapted Nye’s guidance specifically for the inpatient pediatric setting for patients in the behavioral health unit. The challenge to create a safe space for children whom the chaplain has never met, for the period of 45 minutes, requires flexibility, intuition and careful and intentional presence. In this case, S/R Building must happen quickly. In other cases where the chaplain is able to make several consecutive visits to a long-term or chronic patient, the S/R Building may happen over a period of time, and is always ongoing⁴³. Below, in part, is how S.P.I.R.I.T. works in this environment, where facilitation of a “Purpose and Meaning” group is part of the treatment regime for these patients. The main activity utilized in these groups is, among others, the Godly Play® methodology, which will be discussed in further depth in the section below, “The Third Thing.”

Hay and Nye (2006) proposed some guidelines for adults to follow in an effort to promote spiritual well-being by nurturing relational consciousness in children which Nye (2009) further developed into six principles or conditions that support children’s spirituality: *space, process, imagination, relationship, intimacy and trust (SPIRIT)*. Minor (2012) did an extensive analysis of the Godly Play® method to show how it delivers these six conditions [though these conditions are not contingent of the method used, but rather the criteria of how any method aimed at supporting the spirituality of children should be evaluated].

1. ***Space***. Nye suggested that the *space* (the physical, emotional and auditory space) in which the nurture of relational consciousness takes

⁴³ Regarding the ongoing assessment, see Nash, Darby & Nash, 2015, chapter 5.

place is important for communicating a sense of value for spirituality, for the children in the space and for the relationships they are building with the adult guide, their peers and with God [/the Transcendent.] In a psychiatric setting, this must be done quickly and skillfully through rearranging the space, short introductions from patients and any adults in the room and creating an equity of power within the room (which is often either a classroom or a family room on the unit) that affirms the importance of each voice present and immediately sets boundaries that exclude judgment or criticism.

2. **Process.** In order for relational consciousness to flourish, Nye suggested there must be a focus on *process* as opposed to product. This is done by maintaining the usual flow of what is required for group processing in the unit, and by affirming and reaffirming that there are no 'right or wrong answers' to patient responses to a Godly Play® story, essentially removing any threat of assessment related to the patient's response or 'product.'
3. **Imagination.** In order for relational consciousness to flourish, Nye proposed that children need to be encouraged to use their imaginative faculties. After open wondering and dialogue, the opportunity for patients to engage in various artistic responses, done in silence, allows for both verbal processing in conversation and imaginative exploration in response to the same material and lesson. This also creates safety for patients who are not comfortable talking in group to find other ways to express themselves through less verbal and perhaps more imaginative means.
4. **Relationship.** Relational consciousness as defined by Hay and Nye (2006) is rooted in relationships, so it follows that attending to relationships must be an explicit part of its nurture. This is also challenging in such a short and variable group, so the skill with which the chaplain creates immediate relationships within the group is essential.
5. **Intimacy.** Nye proposed that in order to experience and express relational consciousness, *intimacy* is required. While measured within safe limits and therapeutic boundaries, this is accomplished through each member sharing an image that describes current feelings, including the chaplain and milieu therapist in the room. Thus, vulnerability is modelled by adults in the room and it is understood that what is said in group is done so with equity of sharing and personal investment from each person present.
6. **Trust.** *Trust* is defined in this context by Nye as less about the kind of trust needed for intimacy and more about the trust the adult leader has for the children and for spirituality in general. It is vital that the chaplain trusts the process of Godly Play® [or the intervention being used, as well as the group process itself] in what can be an intimidating clinical setting fraught with variables and disruptions. When engaged with trust and authenticity, it is rare that this intervention [S/R

Building and S/R Connecting] fails to uncover deep expressions of spirituality [S/R Connecting], as understood through relational consciousness, among group members. (Minor and Campbell, 2016)

These six criteria are essential for S/R Building, in order that S/R Connecting can lead to S/R Expressions through the lenses of relational consciousness and the existential limits, whether in a facilitated group process or one-on-one at the bedside, in chapel services or in consult rooms.

Nash, Darby and Nash (2015) conclude that “Creating positive spaces for spiritual care involves awareness of self and other as and the physical and emotional space between. Core good practice elements include:

- Being non-judgmental, listening, accepting, affirming and being attentive.
- Beginning and ending a session well offers an appropriate holding space.
- Gaining and ongoing voluntary informed consent.
- Using activities to help build rapport and open the way to deeper conversations.
- Chapels or other religious rooms can provide an appropriate space for religious and spiritual care, particularly at times of transition, but for more neutral spaces can also become the forum in which the sacred is noticed or shared.”(p 78)

On the issue of consent in the third bullet-point, I take this to mean two things.

Firstly, of course, consent of the patients’ parents or legal guardians is absolutely a necessity for engaging children in spiritual care, particularly in facilitated groups. The groups described in this work are all consented to by parents for the child’s participation.

Second, and equally important, is the consent of the child. Part of the safe “container” includes letting the child know that, in a one-on-one situation, the child has a choice to participate and is always respected when non-participation is the child’s preference. In a group, where the child’s care plan involves participation with peers (like in the behavioral health unit where group processing is part of the therapeutic milieu), that child may

choose the level of respectful, present participation. Verbal responses and active group participation is not forced in this setting.⁴⁴ Forcing a child to do anything, whether a story, activity or a sacrament (remember Moira and the baptism of her siblings), can be more traumatic and cause an erosion of trust that may ultimately make S/R Building impossible.

The “Third Thing” and the “Middle Realm”—S/R Connecting

There is an implicit power dynamic that exists between a hospitalized child and any adult that walks into their room. In a group setting there is a circle of children and the “facilitator” has a hospital staff badge from whom the children are expected to take direction. Part of the praxis of S/R Building, which is implicit in Nye’s S.P.I.R.I.T. description, is creating an equity of power in the circle of children, or between the child and the chaplain, so that the child is neither trying to please, comply with, or feel threatened by the chaplain’s larger status, hospital badge and affiliation with other healthcare workers. One fundamental tenant of spiritual care when introducing oneself to any child in the hospital is, whenever possible, to get at or below eye-level so that the power-over dynamic is immediately reduced. Another helpful way to begin to create S/R Connecting by means of S/R Building is to ask the child about familiar things in the room, note colors or characters or family members, and ask the child to teach you, show

⁴⁴ In fact, by not requiring a child to respond verbally in group, it is often the case that after the silent period for “art response” to a story or activity, the child has created something deeply meaningful and spiritually significant. I believe that by not requiring verbal answers, the child is able to trust and more fully find her way toward an expression of spirituality. This is a helpful example of the various ways in which S/R Building, Connecting and Expressing work together, but often not in a linear, algorithmic way.

you or introduce you to whatever seems to capture the child's interest. This will set the child or group of children at ease and make way for S/R Connecting.

As I have said many times throughout this work, asking direct and directive questions of a small child, like we find in the spiritual assessment and screening tools listed above, is simply not engaging children in either the kind of understanding that they are ensconced in, nor does it open the relationship to the spiritual language domain. Rather, a "third thing" is helpful to introduce in order for there to be something shared, mutual and open. In play therapy, for example, or in sand tray therapy as well, the objects of play provide a safe place for children to project big emotions onto in a way that is not so confrontational that they must own those emotions themselves and risk either approval or correction by the adult. Children are able to either objectify those objects, which become safe tools for children to use to express their own spiritual and existential awareness, or to allow those objects to carry the appropriate symbol that facilitates their S/R Expression by way of those symbols. The S/R Connecting described here involves engaging the objects of play, narrative or symbol (or game, or video, etc...any appropriate shared activity), by placing something between the child and the chaplain, or the group of children, and allowing that shared object of engagement to be the "third thing" that can be explored. As the chaplain actively listens, reflects back and affirms the child or children's voice(s), S/R Connecting begins to take place, paving the way for the deeper work of S/R Expression.

There are many examples of what this "third thing" can be. Bull (2017) focuses primarily on play, card depictions and storytelling, while Nash, et al (2015) list several

“activities”⁴⁵ that are meant to facilitate an “interpretive spiritual encounter” (2015, p. 29-42) allowing the chaplain to provide an initial and ongoing means to engage, in my proposed terminology, S/R Connecting. S/R Connecting, often occurring by means of this “third thing,” is a connection to the spiritual and existential issues at work within the child, supported, affirmed and validated by the chaplain, in such a way that S/R Expression of these issues can take place by virtue of the creative process. The name, “third thing,” refers to the mediating element, activity or “thing” that connects both the child/children and the chaplain to a common field of shared spiritual experience. It is important to remember here that the “connecting” necessarily entails mutuality—the chaplain cannot be a deliverer of an activity and simply stand back and observe the child.

...[T]heologically, there is an exchange that takes place between the adult spiritual caregiver and the child—what Berryman calls a ‘mutual blessing’ (2013, p.1) Such relationships requires presence—presence not only to children in a physical space, but also to children in their ways of being and knowing and loving, as well as to the children within ourselves who are still growing spiritually. The experience, then, of being with ourselves, of being with children and of being present to all the mysterious ways in which our presence affects the presence of others (and vice versa) cannot be found in theory alone. It can only be found by showing up! (Campbell & Nash, 2016, 89)

S/R Connecting requires the relationality that Nye describes in S.P.I.R.I.T., and resonates back to the notion that if the chaplain offers an activity to the child that is *about* the spiritual/existential aspects of that child’s life, the child is an abstraction and there is a product (versus process) that is being observed by way of the child’s response to the activity. This abstract reflecting on what happened during the S/R Connecting may be

⁴⁵ In this work, I will focus primarily on the use of Berryman’s Godly Play® and the Rev. Dr. Leanne Hadley’s Holy Listening Stones (see Hadley, 2007) Other activities might include beads and bracelets, Beads of Courage, clay or art supplies, books/bibliotherapy, sacred scripture stories, ritual, Blob pictures, music or others, depending on the kind of knowing the child is engaged in and their level of interest in a particular activity (see Nash et al, 2015, p. 36-37)

done after the S/R Expression has taken place so that the chaplain is more informed about how the child's spirituality is expressed, post-episode. But in the moment of sharing a "third thing," the chaplain must also connect to their own spiritual/existential experiences, thereby making the S/R Connecting a mutual one. This provides equity within the power dynamic as much as this is possible. It also requires the chaplain to utilize the Ironic Understanding Egan describes to access within themselves the kind of knowing the child in front of them is engaged in. This is, in my estimation, an essential aspect of truly facilitating the S/R Expressions of children by way of S/R Connecting. Children rarely remember what a chaplain might say to them, but they remember what it felt like to engage with the chaplain, and this feeling, this "limbic resonance⁴⁶," requires the chaplain to be *with* the child in their spiritual/existential exploration.

Campbell and Nash explain:

If you want to work with children [i.e., provide S/R Connection], you need to spend time around them. Neuroscience uses the term 'limbic resonance' (Lewis, Amini and Lannon 2000). Research suggests that our brains are affected by, and affect, the brains of those around us. This is all going on in the background, and we are interacting, often without any awareness of it, with one another's 'vibes.' Much of the popular conversations surrounding limbic resonance focuses on romantic love and institutional leadership, but it all starts in childhood. The effect of a parent's silent gaze into the eyes of an infant, the simple joy of being with a child engaged in a common activity, sitting with another person in the midst of crisis without trying to fix things—all of this can have scientifically measurable effects on the brains of those who are sharing physical space together. We engage in 'a symphony of mutual exchange and internal adaptation whereby two mammals become attuned to each other's inner states,' meaning our brains can literally 'learn' to be in a kind of 'harmony' with children when we

⁴⁶ On more recent notions of the neuroscientific concept of "limbic resonance," see Miller (2015), p 103-104: "we can with some scientific certainty talk about mirror neurons and limbic resonance, the brain's specialized capacity for processing emotional cues, and the inner states of those around us. In addition to whatever neurological explanation may eventually evolve, the loving responses that infants [and children] arouse in us can be understood in spiritual terms. That is, the power of an infant to orient us to love is a reflection of the innate, biologically based spiritual faculty we have discussed..."

are around them in an open and authentic manner (Lewis et al. 2000, p. 16). As spiritual carers of children in a clinical setting, embracing both the observable and explainable as well as the mysterious and ineffable, and the tension that sometimes appears to exist between the two, is tantamount to our being fully present with children. After all, sometimes we can see the sacred, and sometimes we can only feel it, but, either way, we know its there in the midst of a shared experience. (2016, 89)

For a familiar cultural example of a “third thing,” one need look no further than Daniel Striped Tiger of Mr. Rogers fame. In the documentary film, *Wont You Be My Neighbor?* (Neville, 2018), two scenes provide illustrations of what happens when there is a shared, mediating object (or story, activity, etc...) between two people exploring deep spiritual and existential experiences. In one, Fred Rogers, an ordained Presbyterian minister, discusses death with a young boy, who is open, emotional and expressive about his experiences. He does not speak directly to Mr. Rogers, but, rather, to the puppet, Daniel Striped Tiger who sits on Mr. Rogers hand. The viewer can literally see the S/R Connecting taking place between the two. The discussion is brief and intimate but touches on the existential limit of death and ends with the young boy hugging the puppet, exhibiting feelings of connection and smiling for having the conversation. In the second scene, Mr. Rogers pulls out the puppet for an adult interviewer and one can literally see the “third thing” create a connection between the two, leaving the interviewer delighted and seemingly bewildered.

As previously mentioned, there are many “things” that can be a “third thing,” including activities, story, play, puppets—anything that can mediate the connecting between the child/children and the chaplain to a common field of shared spiritual experience. What is most important about what is used is not so much the “thing” itself (though, some are certainly more prone to connecting than others), but the space or

“container” it happens in (S/R Building), the intention of the chaplain toward the child’s autonomy, mutuality, authenticity and respect, and the ability of the chaplain to *enter in alongside the child* (S/R Connecting) into that place that allows for S/R Expression to occur. In addition, it is essential that the object, activity or whatever is used for the “third thing” must be treated with the utmost reverence, wonder, curiosity and respect. If a child is to begin to project their own spiritual and existential experiences onto whatever is shared between she and the chaplain, the objects must feel safe enough, and sacred enough, to be able to contain this experience. “As children sense this respect they learn about the middle realm and how to treat the...objects. There is something more they learn, however, that is also very important and is also something to be shown and not just talked about. The children intuit that they too are respected and will be cared for in this place.” (Berryman, 2013, p. 96) A more detailed description of what this looks like using the Godly Play® methodology, as well as Holy Listening Stones as developed by Hadley, will be explored below.

The “Middle Realm” is a very difficult thing to talk about, because it truly describes an experience more so than it does a place, a thing, or even a feeling. It is, in some sense, what happens when the spiritual threshold is created by the chaplain for the child to cross over into, the “container” informed by S.P.I.R.I.T. is created, and the “third thing” is introduced and S/R Building has begun. Berryman calls this place, following several poets and scholars, the “still point,” “transitional space,” the “center-point,” or the “middle realm.”(2013, p. 86) It is something that can be felt if entered into playfully, reverently, wholly and authentically. It is a “place” we have all felt from infancy through adulthood, though its hard to remember and even harder to talk about. Berryman quotes

T.S. Eliot as a way to come close to it, borrowing from “Burnt Norton” in Eliot’s *Four Quartets*:

At the still point of the turning world. Neither flesh
nor fleshless;
Neither from nor towards; at the still point, there the dance is,
But neither arrest nor movement. And do not call it fixity,
Where past and future are gathered. Neither movement
from nor towards,
Neither ascent nor decline. Except for the point, the
still point,
There would be no dance, and there is only the dance.
I can only say, there we have been: but I cannot say where.
And I cannot say, how long, for that is to place it in time. (2013, p. 86-87)

This middle realm is a place outside of time, a *kairos* related to the states that occur in play, or flow (Csikszentmihalyi, 1990), referred to CPE students in our program as “the spell” that occurs when “inside” a Godly Play® training session. Something liminal and mysterious occurs where the child/children and the chaplain enter mutually into this space and connect spiritually and relationally to relational consciousness together.

“The middle realm...is the space in the midst of the four cardinal points on our relational compass—the relationship with self, with others, with nature, and with God. It is where we go to regain our balance. It is where existentialist philosophers, such as Gabriel Marcel, have said the mystery of being dwells and our authenticity resides.” (Berryman, 2013, p. 92) Quoting theologian John Macquarrie (1919-2007), Berryman

notes that “[t]he wholeness of our relationship with God, self, others, and nature can be fractured by words, but it can also be rediscovered and held together by words,” which is to say, it cannot be held in the scientific language domain and remain whole, but it *can* be expressed within the spiritual language domain and through this expression, give meaning and hope in the midst of spiritual and existential limits as they are experienced by children (and adults). (2013, p. 92)

The shift from the scientific language domain on the part of the chaplain, from the assessment—intervention—outcome model of spiritual care to the spiritual language domain of R/S Building, R/S Connecting and R/S Expression can be felt by the children we work with. When chaplains are able to enter into this middle realm, into R/S Connecting with a child, “[c]hildren know about this shift in communication...Children know that death is personal and that they are a case of one. They are not distracted by statistics. This is why it is good to meet children as a storyteller rather than an expert about religion [or disease, or diagnosis, or “what it means”]. The parable of the Good Shepherd [a Godly Play® story] is told, not explained. It is placed between you and the child so the two of you can enter the middle realm in the story to be with God and mutually bless each other as meaning is created.” (Berryman, 2013, 112)

This is how the middle realm is entered into and where S/R Connecting takes place. Mutually, in a connecting way. The chaplain must absolutely be aware of her own existential limits before being able to really support a child’s spirituality. The chaplain cannot separate themselves completely from their own experiences as children, like we might more successfully do when caring for philosophic thinking adults who are receiving an assessment or intervention, as commonly understood. Even pediatric

chaplains want for children to be happy, healthy and well-adjusted, but in the clinical setting, as stated above, the existential limits are surface and tangible. Children on the oncology ward who are not told they have cancer still know, though the adults may not want it to be the case. Nevertheless,

The repression of our existential limits is a major reason why adults maintain the fiction that children are always happy. Adults hope this is so, but that is cheap hope. It masks adult limits we share with children, and it hides from the responsibility to listen respectfully when children try to tell us about their ultimate concerns. This neglect traps children in a double bind. They must either please the adults and repress their anxiety or express their anxiety and risk having adults ignore, dismiss, and shame them. This is why children usually remain silent about their ultimate concerns, which ironically seems to confirm that they are always happy. (Berryman, 2013, 111)

When Child Life colleagues talk to children in the hospital about medical procedures, life limitations or even the process of dying, Child Life Specialists know by training how to help them cope by addressing the unknown. When a child, however, begins asking existential questions about the unknowable, *there is a shift that moves from normalization and coping to meaning-making and hoping*. A child wondering if she will die, and what it means to die and what she might hope for after death—this is of the spiritual language domain and it is in the middle realm that this conversation best takes place—through the creative process, by means of S/R Connecting, often mediated through a “third thing” and the mutuality experienced between the child and the chaplain in the middle realm.

S/R Expressing

If all of the factors described above are aligned, (not perfectly aligned, for there is no room for perfection in working with children), and the chaplain has skillfully created space for S/R Building, utilized an authentic way to connect to a child and enter mutually

into the spiritual and existential domains of spiritual language (S/R Connecting), children will by and large find a way to express themselves spiritually, existentially and relationally (S/R Expressing). The ability to create this kind of space requires all the dexterity, self-awareness, playfulness, mindfulness and presence of an improv performer who can read the room just right, and give themselves fully to the Spirit of whatever comes next (Campbell & Nash, 2016, p. 92-93; Madson, 2005; Riley, 2019).

The S/R Expression is, itself, the outcome of pediatric spiritual care. The relationship may continue, and new S/R Building, Connecting and Expression may come again, perhaps changed by or re-directed by the original facilitation of S/R Expression itself. However, the S/R Expression of young children should not be interpreted or given meaning by the chaplain or other healthcare providers, but rather acknowledged and utilized as a way to continue to build the child's comfort in relational consciousness expression and awareness of existential limits.

*Moira: re-visited*⁴⁷

Five weeks after her sister Jan died, 4yo Moira and her mom returned to the hospital for a visit to the Godly Play® chapel. Moira's mom wanted to give her some space to process her sister's death and some of what she had subsequently experienced. We began our S/R Building by choosing Holy Listening Stones⁴⁸ and she chose several stones to express how she felt before we began the story. One stone chosen by Moira looked like a symbol

⁴⁷ See "Moira and Jan" p. 60 and the discussion that follows.

⁴⁸ The creator of Holy Listening Stones, Rev. Dr. Leanne Hadley, describes them as "a tool to help children put their feelings, insights and thoughts into words. They also help adults to remember to listen to what children express." The stones consist of 28 symbols—some pictorial and some more abstract—all of which can mean whatever they seem to symbolize to the child at any time. There is no specific or "correct" meaning. Hadley writes, "The symbols on the stones were deliberately chosen to have several meanings and leave the interpretation of the meaning up to each child. For example, the stone that looks like the "tree" might be a symbol of new growth or strength. Or it can also be interpreted as a tree that is missing roots and ready to fall over. Or it can be seen as a bomb exploding. There is no correct meaning. Whatever the child shares is correct." These designs for the symbols used on the stones are offered free of charge and can be found at www.leanne-hadley.com/training-materials

of a broken heart. Another was a more abstract symbol. Her mom chose symbols as well, as did I as the chaplain. We were in the process of S/R Building, after coming into this sacred space, getting ready by sitting in a circle, and building trust by expressing ourselves honestly without any interpretation.

I asked, Moira, “I wonder what your stones might be saying about how you feel inside?” The S/R Connecting had already taken place between us, and Moira’s S/R Expressions began. She looked at the broken heart symbol she chose and said, “I picked this one because it makes me think about Jan.” Mom explained the stones she had chosen, and so did I. Moira looked at the more abstract stone she chose and we wondered what it might say about how she feels. She sat in silence and had a hard time finding her words. “What does that one mean to you,” her mom asked. “I don’t know, mommy, some things you just can’t say.” Moira knew the feelings she felt inside and the limits of her language, without feeling pressured to put them into words.

We then entered the middle realm by mutually engaging in the Godly Play® story, “Creation.”⁴⁹ The S/R Connecting continued, as did Moira’s S/R Expression. We wondered about what days of Creation we liked best, which ones were the most important, what we might take out of the story and where we might find ourselves in the story. Moira liked the day with water the best and “swam” around on her belly a bit. Then she began telling a story where the “monsters and bad people” stayed on the black felt underlay of the story materials, and the “good people” like her family were on the card representing the biblical account of the sixth day of creation where “all the creatures that move upon the Earth,” including humans, came to become gifts of God’s Creation. We wondered a bit more and did an art response, where Moira again engaged in her mythic knowing, showing lots of binary places that were one thing, and weren’t another, using stickers of religious symbols on her construction paper of yellow, explaining a bit about her work while her mom and I simply affirmed it.

Finally, she was ready to check-out and prepare to leave, so we went through the Listening Stones again as a way of closing the “container” we had created together. She again chose the “broken heart” stone and said, “I picked this because I’m still thinking about Jan.” She then chose the symbol that looked like a heart without a broken line down the middle. “I picked this one because I feel better, too,” she said. Her mom and I reflected her words back to her, affirming their truth, and they left not long afterward.

A few weeks later, I received an email from Moira’s mom, talking about the ongoing spiritual and existential work her 4 year old daughter continued to do since the session. Moira said to her mom on the way home from our previous session together, after having chosen the “water” (third) day of creation as her favorite in the Godly Play session, “Mommy can you guess what picture I loved the most?” After several guesses, Moira noted that the “white picture” (the day of rest where we can think about all of the other gifts that God had given us) was now her favorite, because she could “sit in that picture” and think about all the others and think about Jan. She then had a few more ponderings that I offer as an example of the kind spiritual and existential wondering that grew from

⁴⁹ See Berryman, 2010, p. 41.

her original S/R Expression as contained in the sacred narrative offered through the Godly Play® methodology:

She told her mom that she wanted to ask me, “How come people come to life without other people bringing them to life?” When her mom told her a simple version of the story of Adam and Eve, her mom noted that Moira hesitantly accepted the explanation, though it seemed silly that they didn’t have a mommy or a daddy. Moira also asked, “Where is Heaven?” “When did God create Heaven?” and “Why wasn’t there a picture of Heaven in the [Godly Play® Creation] story?”

Finally, her mom noted in her email to me, “She [Moira] has also mentioned several times that she wants her and her brother [Jan’s surviving twin] to both die so they can be with Jan. She says it nonchalantly, and the hospice child life specialist assured me that it’s completely normal for her age/development level, but I wonder if you could help me with ways to talk about the glories of Heaven that Jan experiences but why it’s important for Moira to stay here now. It’s hard to explain when Moira hears people at church and her aunt and uncle talk about “yearning for Heaven”, “yet we are discouraging her from going there.”

These are questions from the spiritual language domain that theologians, philosophers and spiritual seekers have wrestled with for millennium. They are also the questions a four year-old girl continues to wrestle with, S/R Expressions that continue months after her sister died, months after the initial interaction with the chaplain. Because her parents are dedicated to continuing the process of S/R Building, Connecting and Expressing at home, as modeled to them by this chaplain in the hospital and in subsequent sessions, Moira continues to do this sacred work.

Conclusion

When we consider how important our early childhood experiences are, and the imprints that existential limits unreckoned with can leave on our lives into adulthood, the spiritual care of this pediatric patient sibling is an excellent example of how “outcomes,” what I call S/R Expressions, can continue to grow and provide sources of hope and meaning-making to the youngest of those we care for, but for whom the strict

assessment—intervention—outcome model seems unable to accommodate—that is, unable to “catch the cloud and pin it down.”

Chapter 5—S/R Building, Connecting and Expressing in a Pediatric Behavioral Health Unit

Most of the case examples I have presented thus far are with patients or families where the spiritual support was offered one-on-one at the bedside, in the Godly Play® chapel at the hospital, by phone or in settings where the chaplain was able to meet the child wherever convenient for the family at the time over the course of an inpatient admission or, in Moira's case, after the death of her sister, Jan.

By contrast, the examples to follow took place in an inpatient psychiatry unit where patients spend their days and nights, adhering to a structured schedule (morning time, meals, school, one-on-one meetings with their attending psychiatrist and psychologists or licensed professional counselors, recreational therapists, music therapists, process groups, family therapy, family visitation, and routine bedtimes). This is a different milieu for these patients, as they are required to participate in groups, therapy and the practice of coping skills. Most are admitted for behavioral health issues that include suicidal and/or homicidal ideation, suicide attempts, self-harm, oppositional defiance disorders, major depressive disorders, dissociative disorders and others. Patients often remain for days or weeks until stable enough to be safe at home or transferred to an available long-term treatment facility. Many transition to "partials," where patients may come to the unit for treatment for part or all of a day, and then go home at night. The chaplain generally does not have the opportunity to work with outpatients receiving therapy outside the behavioral health unit due to scheduling and resources.

As mentioned previously, each patient is consented by their parents at intake to participate in "Purpose and Meaning" group, facilitated by the chaplain twice a week. One day a week is for latency-age children (generally 6-12 years of age), and on another day, the adolescent/teen group (13-17). The case examples below are for children ages 12

and under. I have intentionally chosen to exclude adolescent/teen case examples for reasons discussed throughout this work—namely, I wanted to focus on children who are more fully engaged in Egan’s somatic, mythic and romantic kinds of understanding, and for whom schematic, abstract and philosophic kinds of understanding are less pronounced, that is, for whom the assessment—intervention—outcome oriented clinical practice has a harder time accommodating for in its description of spiritually supportive clinical engagement. The practice of the spiritual support of children in the spiritual language domain, and the way of communicating this support, requires a different way of not only describing what happens in spiritual care encounters, but how what happens is recorded in the Electronic Medical Record (EMR). It is for this reason, I have argued, that we need a different kind of model for supporting the spirituality of children, and a different way of communicating this support to other disciplines on the care team. I have argued that rather than subsume the spiritual language domain into the scientific, we should seek to bridge the two language domains so that they can communicate with one another in providing holistic care to children, without compromising the integrity of either the scientific or the spiritual language domains by trying to speak fully in one or the other domain and thereby compromising the integrity of both. In this way, I have proposed replacing the assessment—intervention—outcome oriented model of clinical care to the Spiritual/Relational Building—Spiritual/Relational Connecting—Spiritual/Relational Expression model (S/R Building—S/R Connecting—S/R Expression) as a way of describing clinical spiritual engagement with children. I have argued that S/R Expression IS the outcome, though it may not be measurable in the same way “outcomes” are measured in a cognitive, behavioral or physiological way.

These case examples are helpful because art responses are part of the Purpose and Meaning group (though, while patients are required to attend this group, for the most part, the chaplain does not require specific kinds of participation within the group, so long as the patient is present, respectful of others and able to safely remain in the circle without disruption of other children's group process). They provide, therefore, S/R Expressions, created by children who have participated in spiritual support with a chaplain in the manner described throughout this work and summarized below. My hope is that it is helpful to include these S/R Expressions in this work so that the reader is able to see the S/R Expression for themselves and consider the way in which I propose these expression, these "outcomes," are understood and communicated to other members of the care team. The goal is to incorporate aspects of the spiritual and existential components of a patient's experience into their overall care without being limited by a strictly scientific understanding of what these expressions point back to, that is, to avoid reducing them strictly to the scientific notions of physiological, cognitive or behavioral observations and explanations.

In this chapter, then, I will summarize the key components of the applicable theories I have explored above, describe the method or praxis of facilitating such a group, and attempt to overlay the model I propose onto what actually happens in spiritually supporting children in this environment. I want to be careful here not to talk so much *about* the process that I neglect the necessary aspects of being *in* the process with the patients, that is, the influence of the "middle realm" as Berryman and others have described above. I leave it, then, to the reader, to remember that these descriptions are an attempt to bridge this tension—to describe what happens without abstracting the children

into “objects of study,” while also allowing the S/R Expressions of children to speak for themselves. I will not be interpreting their S/R Expressions or exploring how they might support this or that DSM-V diagnosis—this is not the role, training, or expertise of the chaplain. Rather, I will allow the S/R Expression of these children to stand on their own, and will propose a way to record them through the lenses of relational consciousness, existential limits and the S/R Building—Connecting—Expressing model in a chart note template by way of each example that follows below the S/R Expression. When possible, I may provide some background on the patient, but have disguised names and any other potentially identifying information in order to protect the anonymity of these patients. I have excluded any S/R Expressions that contain personally identifiable information from the case examples I will provide.

In some cases, where no specific art response was part of the S/R Expression, I will simply present the narrative of the S/R Expression and apply the charting template after each example.

Spiritual/Relational Expressions in Purpose and Meaning Group—ages 12 and under

Before we explore the S/R Expressions of children in the inpatient behavioral health unit, it would be helpful to give a brief overview of Godly Play® as it was conceived of by its creators, Jerome and Thea Berryman, and of how it has been adapted into the clinical setting. Much of this work has been done already in the 2016 article, “The Parable of the Sower: a case study examining the use of the Godly Play® method as a spiritual intervention on a psychiatric unit of a major children’s hospital” by this author and the Rev. Dr. Cheryl V Minor, so I will incorporate much of the background description of this methodology here.

The Godly Play® method is an approach to children’s spiritual formation [that is] used throughout the world. In congregations, Godly Play® is typically offered once a week for one hour, usually on Sunday mornings. However, [it] has also been adapted for use in...day schools, in synagogues, in hospital and nursing homes.

Godly Play® grew out of the Montessori movement, so each story or lesson has a two-or three-dimensional material to go along with it. These artefacts make the story visible to the listeners. The stories are written by the Rev. Dr. Jerome Berryman and are published in *The Complete Guide to Godly Play®*, volumes 1-8. [] The language of the majority of stories as published makes them accessible to persons of all faiths and denominations, regardless of their level of involvement or history in any one tradition. This is particularly important in a clinical setting with children of varying backgrounds.

After hearing a story, the children are asked a series of [wondering] questions designed to help them wonder about it in an open and supportive environment. The [chaplain] asks, for example, “I wonder what part of this story is the most important?” or “I wonder what part of this story felt like it was about you?” In both the congregational and clinical setting, the children offer ideas and the adult guide supports each answer, no matter what he or she thinks personally, with affirmation, reflective listening and acknowledgment. All ideas are welcome.

In the inpatient psychiatry unit..., the wondering comes to a close and the children are free to choose from a variety of coloured [sic] paper and crayons or markers and invited to respond to the story with art. Patients are encouraged to use pictures, art, poetry or journaling to respond to the story and wondering that just occurred. It is emphasized that there isn’t a right or wrong way to respond, but that whatever stirs inside each patient is just what is needed. After 10 mins or so, the circle puts away materials and each is encouraged to share a bit of their response in group processing time and focus on where they find themselves in that response. The emphasis on allowing each child to make their own personal meaning from the story is a fundamental tenet of the Godly Play® methodology.

After the children share their work, there is a brief time for group processing and a closing.

[...]

[Rebecca] Nye (2009) writes extensively about children’s spirituality and often uses Godly Play® as an example of how best to support children on their spiritual journey. Nye’s research study of spirituality in children’s lives revealed what she has described as a ‘remarkable capacity for *relational consciousness*, an evolved human capacity for an awareness of connections with self, others, the world, and a transcendent power (Hay and Nye 2006). Nye suggests that relational consciousness is what allows

individuals of all ages to reflect on their spiritual experiences, develop identity and a feeling of worth and find meaning and purpose in life, which lead to spiritual and emotional well-being (Minor and Grant, 2014).

[...]

There is...a growing body of evidence that Godly Play® helps nurture the spirituality of children and their spiritual well-being (Helm, Berg, and Scranton, 2007; Minor and Grant, 2014; Stonehouse 2001; Worsley, 2004)

Farrell et al. (2009) conducted an experimental study at Wolfson Children's Hospital in Jacksonville, Florida to investigate the impact of the Godly Play® method on the psychological and spiritual well-being of chronically ill children aged 6-15 years. Their findings indicated that the children who received the pastoral care in the form of the Godly Play® method had significantly higher scores on the McBride Spirituality Assessment than those in the control group (Farrell et al. 2009)⁵⁰

[...]

Existential limits...become conscious within the expression of relational consciousness/spirituality. These limits mark the unknowable, that is, what is beyond a person's experience and knowledge. Awareness of these existential limits and spiritual expression within these limits provides frameworks of purpose and meaning to patients who engage in spiritual expression and finding purpose and meaning lead to spiritual and emotional well-being. It is also important to stress the fact that the unique use of sacred narrative and specific language through the Godly Play® methodology provides group members the ability to carry this existential awareness and spiritual expression with them beyond the group process so that they can access them whenever they need to during the course of their admission and well after discharge. This can be compared to the way a movie, myth, novel or other narrative form remains in one's memory and serves as a framework as personal experiences bring one back to the storyline and shape understanding of our own meaning in relation to the interaction between the experience and the story.

[...]

This adaptation of the Godly Play® method for use on the psychiatric unit at the hospital is not a treatment plan, as such. However, as the patients learn to use the images and language from the stories presented to make their own meaning—meaning connected to their life and circumstances—it can hopefully be employed by the patient in their work with their doctors and counsellors Perhaps more importantly, it is clear...that Godly

⁵⁰ While there are many limitations to this study, in part due to the assessment-intervention-outcome model of assessing the spirituality of children by focusing on psychometric outcomes, it is, nevertheless, one of the few rare examples of looking at "spiritual assessment" with children specifically. (See Farrell et al., 2009)

Play® can be a powerful tool to support and promote the spirituality and spiritual well-being of children in the psychiatric unit of the hospital, children struggling to move out of the dark place they may find themselves in toward [a place] of healing and wholeness. (Campbell & Minor, 2016)

With this understanding of Godly Play® and the way in which its methodology is employed in the inpatient psychiatric setting, we can now look at the S/R Expressions of children aged 12 years and younger. In each of these examples, I was the chaplain facilitating the Purpose and Meaning group. The chart note template will follow each example and will describe the method of S/R Building (creating the container), S/R Connecting (the “third thing” used to connect with the child/children in the circle) and the wondering and reflecting that came from this connection and any available comments made by the children as they reflected on the S/R Expressions presented in their verbal and art responses.

While these examples of S/R Expressions are from the inpatient psych unit, the charting template can work just as well in bedside visits with children one-on-one, visits with patients and families or patient siblings where recording the spiritual encounter is appropriate for a patient’s electronic medical record.

As a reminder to the reader, the S/R Expressions ARE the outcome of the spiritual care encounter. The expression of spirituality through the lenses of relational consciousness and the existential limit(s) provides them with an external symbolic expression that can be engaged and explored and then internalized in a way that facilitates their own meaning-making, engenders hope and provides an inner working model for them to stand on as they face the uncertainty that is inherent with any hospital admission. These S/R Expressions are facilitated by a sacred narrative (e.g., Godly Play

®), and/or through intentional symbolic engagement (e.g., Holy Listening Stones) so that children are able to engage what is most important to them at the time.

11yo female



Spiritual/Relational Building: Introduction by Chaplain to group, Purpose and Meaning. Introduction by each group member, including: name, age, “why you’re here”

(diagnosis), and a feelings check-in. Invitation to share without judgement, encouraging respect and safety, assurance of no “right” or “wrong” in sharing/expressing. Expression of welcome by the Chaplain to each group member by name.

Spiritual/Relational Connecting: utilizing Holy Listening Stones⁵¹ for feelings check-in and Godly Play® story, “The Parable of the Sower.”

Spiritual/Relational Expression: above art response and reflective wondering.

Chart Note narrative:

Group began with introductions and feelings check-in. “Patient” checked in feeling “sad and angry.” Using Listening Stones as the symbols that best describe those feelings, “Patient” chose:

- A “broken heart” symbol, saying: “I’m sad and my heart is broken.”
- A “circle with a dot in the center,” saying: “I’m like a target and all the arrows shooting at it are negative thoughts and I’m in the middle.”
- A “spiral” symbol, saying: “I’m confused and scared and overwhelmed, like a spiral or a tornado.”
- A “frustrated face” symbol, saying: “I don’t like myself, weird...”
- An “arrow pointing to a perpendicular line” symbol, saying: “I know the arrow should be going up, like achieving something, but, and I know its bad, my arrow is going down because I’m not going anywhere.”

Chaplain told the Godly Play Story “The Parable of the Sower” and facilitated wondering and exploration of purpose, hope and meaning-making for group members. “Patient” reflected on the narrative and symbols in the story in the following way:

- “Patient” related to the story saying, “the birds are before I came to the hospital, then I came here and I was in the rocks—I tried to grow but my roots couldn’t break through. Then I was in the thorns and my roots grew but I couldn’t grow because the thorns were above me. Then I got meds and was good soil for growing and I was happy. Then, I went home and the meds went away and my [parent] and [step-parent] weren’t supportive and now I’m back in the rocks. The sun will scorch me—how will I grow?”
- ART RESPONSE (see above): “Patient” drew a picture and described it, saying: “I’m in the rocks. I can’t dig down, like a tunnel to escape because the rocks are too hard. I can’t go up, because the thorns are all around and in the way. So, I’m stuck in the middle—depressed, sad, nowhere to go and nothing to do inside. It’s gloomy and rainy outside and I’m just stuck here.”
- Chaplain reflected back “Patient’s” art response reflection and wondered, “I wonder what the person in this picture might be hoping for?” “Patient” responded, “A ladder so I can climb out!” Chaplain wondered what a ladder might really be for this patient; patient did not respond verbally.

⁵¹ For a visual template of each Holy Listening Stone, see appendix 2

Chaplain offered validation of feelings, affirmation of expressions of hope, purpose and meaning and affirmation of self-reflection. Chaplain will continue to follow as needed. Please page for additional spiritual support for this patient.

Relational Consciousness expressions: self-reflective, others, environment (nature imagery)

Existential Limits expressed: death, aloneness, need for meaning

Spiritual/Cultural Information: patient identifies as Hindu

8yo Male



Spiritual/Relational Building: Introduction by Chaplain to group, Purpose and Meaning. Introduction by each group member, including: name, age, “why you’re here” (diagnosis), and a feelings check-in. Invitation to share without judgement, encouraging respect and safety, assurance of no “right” or “wrong” in sharing/expressing. Expression of welcome by the Chaplain to each group member by name.

Spiritual/Relational Connecting: High/Low part of day for feelings check-in and Godly Play® story, “The Parable of the Good Shepherd.”

Spiritual/Relational Expression: above art response and reflective wondering.

Chart Note Narrative:

Group began with introductions and feelings check-in. “Patient” checked in saying the High for the previous day was [family] “visitation” and the Low for the previous day was [family] “visitation.”

Chaplain told the Godly Play Story “The Parable of the Good Shepherd” and facilitated wondering and exploration of purpose, hope and meaning-making for group members. “Patient” reflected on the narrative and symbols in the story in the following way:

- “The part I like best is its safe in the sheepfold and protecting the sheep.”
- “I live on a farm”
- “My cat got eaten by a coyote.”
- ART RESPONSE [see above]: “I’m in safe with the sheep. The darkness is all around—the purple and orange. I’m helping the sheep with the broken leg and the one with the broken leg is the brown one [which got ‘lost’ in the dangerous place in the telling of the parable].”

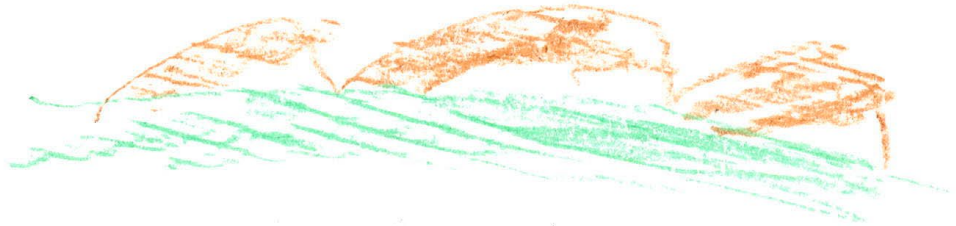
Chaplain offered validation of feelings, affirmation of expressions of hope, purpose and meaning and affirmation of self-reflection. Chaplain will continue to follow as needed. Please page for additional spiritual support for this patient.

Relational Consciousness expressions: self-reflective, others, environment (familiar home and nature imagery)

Existential Limits expressed: death, freedom, the need for meaning

Spiritual/Cultural Information: none

10 yo male



*** This is a difficult picture to see because of the colors the child chose, but I have chosen to include it because of the content this 10 year old boy described. The picture represents the “good soil” (top of the page) portrayed in the Parable of the Sower, with what the patient described as “gates of heaven” (bottom of the page) below in bright yellow. The “gates of heaven” are not in the text of that parable—the patient here used images from the sacred narrative to incorporate his own faith language and understanding of hope and meaning for himself.***

Spiritual/Relational Building: Introduction by Chaplain to group, Purpose and Meaning. Introduction by each group member, including: name, age, “why you’re here” (diagnosis), and a feelings check-in. Invitation to share without judgement, encouraging respect and safety, assurance of no “right” or “wrong” in sharing/expressing. Expression of welcome by the Chaplain to each group member by name.

Spiritual/Relational Connecting: “Choose a color that best represents how you feel right now” for feelings check-in and Godly Play® story, “The Parable of the Sower.”

Spiritual/Relational Expression: above art response and reflective wondering.

Chart Note Narrative:

Group began with introductions and feelings check-in. “Patient” checked in saying he feels “medicated” and chose not to associate that feeling with any particular color.

Chaplain told the Godly Play Story “The Parable of the Sower” and facilitated wondering and exploration of purpose, hope and meaning-making for group members. “Patient” reflected on the narrative and symbols in the story in the following way:

- Patient noted the gold box that contained the Parable of the Sower and noted, “That could be a box full of magic. It could be about Jesus. Or it could be about Lucifer.”
- Patient commented, “The beautiful, rich soil could be like heaven where people and angels are delightfully healed.”
- Patient remembered the introduction of the story spoken by the chaplain, “In the beginning, you said this parable might be about a place of healing and health.”
- ART RESPONSE [see above]: Patient commented on the story as integrated into his art response, saying “The rich soil = the gates of heaven.”
- Chaplain wondered with the patient, “I wonder where you see hope in this story?” Patient responded, “I hope to be at the gates of heaven. I still have another 90 years. I plan to live until I’m 100.”

Chaplain offered validation of feelings, reflection of faith-expressions, affirmation of expressions of hope, purpose and meaning and affirmation of self-reflection. Chaplain will continue to follow as needed. Please page for additional spiritual support for this patient.

Relational Consciousness expressions: self-reflective, Transcendent

Existential Limits expressed: death, the need for meaning

Spiritual/Cultural Information: Patient identifies as Christian

12 yo male

**



***This is a good example of a patient who incorporated images from one spiritual support encounter from the previous week into his reflection on the current story. The week before, in the same Purpose and Meaning group, this patient's group was presented with the Parable of the Good Shepherd. This week the Parable of the Mustard Seed was

presented. In the chart note below, one can see how images from both of these sacred narratives were incorporated into his own experiences and his personal relationships within relational consciousness***

Spiritual/Relational Building: Introduction by Chaplain to group, Purpose and Meaning. Introduction by each group member, including: name, age, “why you’re here” (diagnosis), and a feelings check-in. Invitation to share without judgement, encouraging respect and safety, assurance of no “right” or “wrong” in sharing/expressing. Expression of welcome by the Chaplain to each group member by name.

Spiritual/Relational Connecting: “Choose a color that best represents how you feel right now” for feelings check-in and Godly Play® story, “The Parable of the Mustard Seed.”

Spiritual/Relational Expression: above art response and reflective wondering.

Chart Note Narrative:

Group began with introductions and feelings check-in. “Patient” chose not to do a feelings check-in. Patient familiar with this group from participation the previous week.

Chaplain told the Godly Play Story “The Parable of the Mustard Seed” and facilitated wondering and exploration of purpose, hope and meaning-making for group members. “Patient” reflected on the narrative and symbols in the story in the following way:

- ART RESPONSE [see above]: “I’m the shepherd planting the tree so it grows and all the birds and their families come to live there.”
- “My grandpa is like the Good Shepherd [the story told the previous week]. He takes care of animals so they don’t have to sleep outside in the rain or get hungry.”
- “I’m important to my grandpa.”

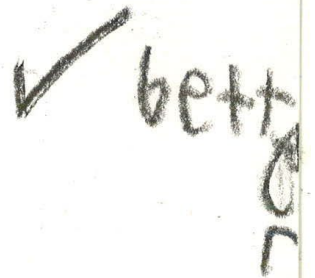
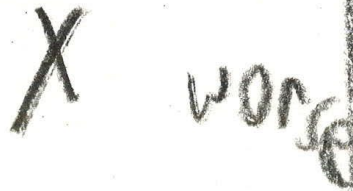
Chaplain offered validation of feelings, affirmation of expressions of hope, purpose and meaning and affirmation of self-reflection. Chaplain will continue to follow as needed. Please page for additional spiritual support for this patient.

Relational Consciousness expressions: self-reflective, others, environment (nature imagery)

Existential Limits expressed: the need for meaning

Spiritual/Cultural Information: None indicated

11 yo male



Spiritual/Relational Building: Introduction by Chaplain to group, Purpose and Meaning. Introduction by each group member, including: name, age, “why you’re here” (diagnosis), and a feelings check-in. Invitation to share without judgement, encouraging respect and safety, assurance of no “right” or “wrong” in sharing/expressing. Expression of welcome by the Chaplain to each group member by name.

Spiritual/Relational Connecting: Holy Listening Stones for feelings check-in and Godly Play® story, “The Parable of the Sower.”

Spiritual/Relational Expression: above art response and reflective wondering.

Chart Note Narrative:

Group began with introductions and feelings check-in. “Patient” used three separate Listening Stones to describe his current feelings in the following way:

- “I feel like an emotional mask.”
- “I feel sad because of my dad.”
- “A lot of actions have happened throughout my life, like, I have a lot of questions about those actions, and I’m nervous.”

Chaplain told the Godly Play Story “The Parable of the Sower” and facilitated wondering and exploration of purpose, hope and meaning-making for group members. “Patient” reflected on the narrative and symbols in the story in the following way:

- “Patient” wondered, using his own faith language, if the “person” mentioned in the story was “Jesus.” The chaplain reflected back, “I wonder if the Sower could be Jesus?”
- “Patient” began making personal meaning from the images, saying, “The rocks are because I had a hard time as a kid; it’s the beginning and it was bad.”
- “The thorns are when things got worse; it’s the middle and is worse.”
- “The good soil is that, as I got a little older, things got better, then went down. The bad stuff didn’t go away, but it got better; it’s the end and its better.”
- “I think the thorns are growing in sand—sand makes me think of dark places and the plants can get their roots more easily down deep if its sand.”
- “The Sower’s name is ‘Olive,’ and experimental farmer trying to find where things grow best.”
- ART RESPONSE [see above]: Patient made a picture that showed each type of ground as described in the story and labeled them (the rocks as “bad,” the thorns as “worse,” and the soil with flowers growing as “better”), and had a corresponding frame above each that portrayed his experience of his relationship with his dad, saying, “it was bad when I was young because of my dad; it got worse because he got meaner and did meaner things to me; it got better now because my dad isn’t in control of me anymore. The sadness is still there but I can see things better—now I’m learning to feel more than just sadness. I can feel happy, too.”

Chaplain offered validation of feelings, affirmation of expressions of hope and faith language, expression purpose and meaning and affirmation of self-reflection. Patient checked out of group choosing to use the Holy Listening Stones, saying:

- “I still feel sad, but now am kind of happy, too, because I can see things getting better” [adding an additional Listening Stone to symbolize this].
- Patient then chose a blank stone without a symbol on it, saying “sometimes I have a feeling...how do I explain this? I have a feeling that feels like nothing. It’s not an in-between feeling because it isn’t like one or the other. It’s just nothing.”
- Chaplain reflected back patient’s feelings check-out and thanked him for sharing his story. Patient responded, “thanks for bringing one to share with me, too. I’m discharging tomorrow!”

Chaplain will continue to follow as needed. Please page for additional spiritual support for this patient.

Relational Consciousness expressions: self-reflective, others, environment (nature imagery), Transcendent

Existential Limits expressed: aloneness, freedom, the need for meaning

Spiritual/Cultural Information: Patient states, “a mix between Christianity and Muslim.”

11 yo female

Patient chose to keep her art response so it was not collected (same group as child described immediately below)

Spiritual/Relational Building: Introduction by Chaplain to group, Purpose and Meaning. Introduction by each group member, including: name, age, “why you’re here” (diagnosis), and a feelings check-in. Invitation to share without judgement, encouraging respect and safety, assurance of no “right” or “wrong” in sharing/expressing. Expression of welcome by the Chaplain to each group member by name.

Spiritual/Relational Connecting: “Choose an animal that best represents how you feel right now” for feelings check-in, Godly Play® story, “The Parable of the Sower,” and Holy Listening Stones for feelings check-out.

Spiritual/Relational Expression: Art response (described below), symbolic expression and reflective wondering.

Chart Note Narrative:

Group began with introductions and feelings check-in. “Patient” expressed feeling “sad and angry” and chose “a cat” to represent that feeling, “because a cat is always angry unless you’re paying attention to it.”

After introductions, Chaplain told the Godly Play Story “The Parable of the Sower” and facilitated wondering and exploration of purpose, hope and meaning-making for group members. “Patient” reflected on the narrative and symbols in the story in the following way:

- “The Sower is angry or sad or content when the birds eat the seeds he planted. The birds are angry, sad and content, too.”
- “The Sower could be God trying to make the Earth a better place [by planting seeds].”
- “The Sower could be my mom, too. She tried to plant a garden in the good earth. When I get out of here, I’m going to plant plants in a good place and take care of them and help them grow.”
- ART RESPONSE: [Patient drew a Sower planting seeds near a tree and remarked]: “I’m the Sower, telling all the people about the place of healing and wholeness [from the Chaplain’s story introduction]. I’m planting seeds and will care for them until they grow.”
- “That’s like me—I am helpful and I like to put stuff in a good spot...when they grow, if they’re like tomatoes, I’ll make sure they’re ready to pick and then I’ll pick them and cook with them.”

Feelings checkout: Using Listening Stones, patient chose 5 symbols (specific symbols not recorded) and related to each of the following respectively:

- “When I’m angry,” [shows symbol] “I’m loud” [shows symbol] “and I start stomping” [shows symbol] “and crying” [shows symbol]. “I’m also tired right now” [shows symbol].

Chaplain offered validation of feelings, affirmation of expressions of faith, hope, purpose and meaning and affirmation of self-reflection. Chaplain affirmed patient's faith language and self-awareness. Chaplain will continue to follow as needed. Please page for additional spiritual support for this patient.

Relational Consciousness expressions: self-reflective, others, environment (nature imagery), Transcendent

Existential Limits expressed: the need for meaning

Spiritual/Cultural Information: None indicated

9 yo male

Patient chose to keep his art response, so it was not collected (same group as child immediately above)

Spiritual/Relational Building: Introduction by Chaplain to group, Purpose and Meaning. Introduction by each group member, including: name, age, “why you’re here” (diagnosis), and a feelings check-in. Invitation to share without judgement, encouraging respect and safety, assurance of no “right” or “wrong” in sharing/expressing. Expression of welcome by the Chaplain to each group member by name.

Spiritual/Relational Connecting: “Choose an animal that best represents how you feel right now” for feelings check-in, Godly Play® story, “The Parable of the Sower,” and Holy Listening Stones for feelings check-out.

Spiritual/Relational Expression: Art response (described below), and reflective wondering.

Chart Note Narrative:

Group began with introductions and feelings check-in. “Patient” expressed feeling “good” and chose “a dog” to represent that feeling.

After introductions, Chaplain told the Godly Play Story “The Parable of the Sower” and facilitated wondering and exploration of purpose, hope and meaning-making for group members. “Patient” reflected on the narrative and symbols in the story in the following way:

- “I like the story.”
- “I like that the birds landed and ate the seeds.”
- “I moved the Sower closer to the birds so they could eat the seeds. The Sower feels angry when the birds eat the seeds, but the birds are happy because they want something to eat.”
- ART RESPONSE: [patient drew a picture of a figure planting seeds] “I’m the Sower and I’m planting the seeds in a good place. I have a lot of seeds in my bag. I’m planting them in good earth so they can grow and I’ll take good care of them.”

Feelings checkout: Using Listening Stones, patient chose 4 symbols and related to each of the following respectively:

- [“sun” symbol]: “When I look at the sun, I think of God.”
- [“spiral” symbol]: “I feel good when I lick a lollipop.”
- [“connected curved lines” symbol]: “when I get mad, I close my eyes.”
- [“multi-directional arrows” symbol]: “when I get serious mad, I try to kill myself.”

Chaplain offered validation of feelings, affirmation of expressions of hope, purpose and meaning and affirmation of self-reflection. Chaplain affirmed patient’s faith language and self-awareness. Chaplain will continue to follow as needed. Please page for additional spiritual support for this patient.

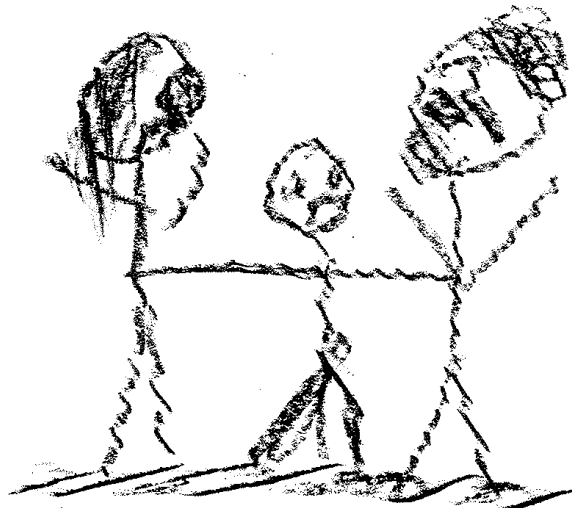
Relational Consciousness expressions: self-reflective, others, environment (nature imagery), Transcendent

Existential Limits expressed: death, freedom, aloneness, the need for meaning

Spiritual/Cultural Information: None indicated

10 yo male

3



1



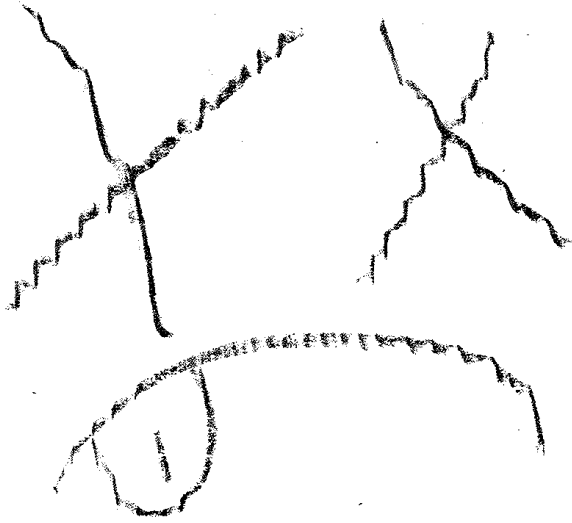
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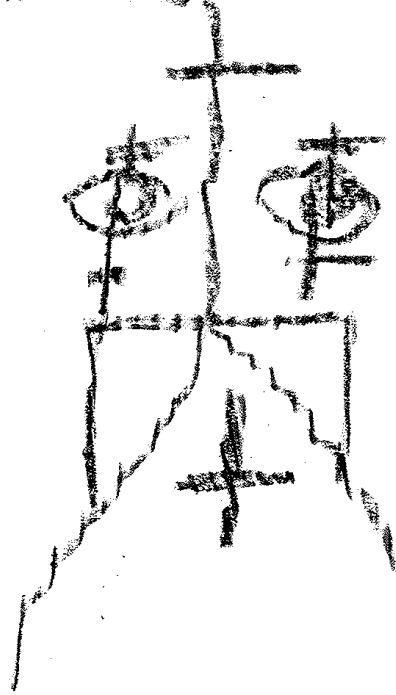
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Spiritual/Relational Building: Introduction by Chaplain to group, Purpose and Meaning. Introduction by each group member, including: name, age, “why you’re here” (diagnosis), and a feelings check-in. Invitation to share without judgement, encouraging respect and safety, assurance of no “right” or “wrong” in sharing/expressing. Expression of welcome by the Chaplain to each group member by name.

Spiritual/Relational Connecting: Holy Listening Stones for feelings check-in, Godly Play® story, “The Parable of the Sower,” and Holy Listening Stones for feelings check-out.

Spiritual/Relational Expression: Art response, symbolic expression and reflective wondering.

Chart Note Narrative:

Group began with introductions and feelings check-in. “Patient” expressed feeling “In between calm and excited” and “satisfied is the feeling I never show because I’m never satisfied” and chose a Listening Stone to represent those feelings.

After introductions, Chaplain told the Godly Play Story “The Parable of the Sower” and facilitated wondering and exploration of purpose, hope and meaning-making for group members. “Patient” reflected on the narrative and symbols in the story in the following way:

- [referring to the various kinds of ground the seeds fall on in the story]: “Its like our lifespan—you are born, then you go to school because your mom makes you and you get bullied, then you get a girlfriend and things seem better and then you get settled and then you die.”
- “The rocks could be people who are hungry, the thorns could be child abuse and the good ground could be women’s issues.”
- “The Sower could be, like, your source of life—your mom or even your foster mom, because they make you go to school and you get bullied. But then other grounds could be your own choices—you get to choose.”
- “I was in the good ground when I got to a school where I didn’t get bullied.”
- ART RESPONSE #1 [see above—first picture]: Patient drew two pictures. First picture (single sided): “This is my response to my parents fighting. 1: to run away, which is the one I chose.” Patient then tells a story about packing up, going to the woods and meeting a homeless person and trying to live on his own. “2: Drown them out. That’s me with headphones on, but they were too loud. 3: breaking them up. That’s me trying to get between them when they’re fighting. 4: killing myself” [patient points to a figure holding a gun to his own head in his art response].
- ART RESPONSE #2 [see above—second and third pictures]: The second picture relates to a friend he described who was “abandoned” by his parents who “just packed up the house and left with a Uhaul behind the car and the house was empty when my friend got home.” Patient reports that this child was “very religious” and the patient felt as though, in order to fit into his friend’s life, he had to choose either “religious life” or “no life.” Patient said, “I didn’t want either of those, so I ran away” [depicted on the third page].

Feelings checkout: Patient checked out feeling “great.”

Chaplain offered validation of feelings, affirmation of expressions of hope, purpose and meaning and affirmation of self-reflection. Chaplain affirmed patient’s faith language and self-awareness. Chaplain will continue to follow as needed. Please page for additional spiritual support for this patient.

Relational Consciousness expressions: self-reflective, others, environment (nature imagery), Transcendent

Existential Limits expressed: death, freedom, aloneness, the need for meaning

Spiritual/Cultural Information: None indicated

9 yo female

This patient chose to do her entire Purpose and Meaning group with Holy Listening Stones. My intention was to use the Holy Listening Stones as a feelings check-in and then present a Godly Play® story. Because she was so immediately drawn to the Holy Listening Stones, I amended my original intention and let the patient decide how best to explore her own spirituality within the container of the group. She was the only patient in the group that day, so the session was 1:1. This patient decided to construct several mini-stories with each stone as recorded below.

Spiritual/Relational Building: Introduction by Chaplain to group, Purpose and Meaning. Introduction by each group member, including: name, age, “why you’re here” (diagnosis), and a feelings check-in. Invitation to share without judgement, encouraging respect and safety, assurance of no “right” or “wrong” in sharing/expressing. Expression of welcome by the Chaplain to each group member by name.

Spiritual/Relational Connecting: Holy Listening Stones for feelings check-in, exploration of purpose and meaning and feelings check-out.

Spiritual/Relational Expression: Sacred narrative construction, symbolic expression and reflective wondering.

Chart Note Narrative:

Group began with introductions and feelings check-in. “Patient” was the only patient in Latency group today. Patient expressed feeling “happy and energetic.” Chaplain engaged patient with Holy Listening Stones and facilitated wondering and exploration of purpose and meaning.

Patient decided that the best way to explore her own purpose and meaning was to create sacred narratives about each Holy Listening Stone that she chose. Patient spoke as a narrator for each symbol. She reflected on the meaning and narrative associated with each chosen symbol in the following way:

- [Symbol one]: “Center of the World. This is God. He gives life to everything. He is the story writer of all. When people walk, swim or run, they all have life from God. The end. I was the storyteller.”
- [Symbol two]: “Luck-like a four leaf clover brings life to flowers. Find me in a patch of clover—maybe you will and maybe you won’t. If you do, I’ll grant any wish you want. If you could make a wish, what would it be? I would wish for me to get well. No, I would wish for my grandma to get well.” [Patient then reported to the Chaplain that her grandma is sick and goes to church every day and prays for patient. Patient reports that she is now praying for her grandma.]

- [Symbol three]: “Gotta catch ‘em all! In life we go. Wishes get granted but if we catch ‘em all, we surely will be happy. I would want to grant a wish for me to get better, for life to be good and for all to be well. I’ll know all is well when I draw a great picture that wins an art show for the second time.”
- [Symbol four]: “The perfect story—creating my own symbol, the fingerprint. The fingerprint is my touch and all that I can feel. Angels singing, God blessing, kids praying and my grandma getting well. And my dog.”
- [Symbol five]: “I matter most to my dog. He’s always been there for me.”
- [Symbol six]: “The sunshine symbol basically means to me, Halleluia! That I’m shining down, over the world, I want to be on top of the world. That’s where nothing can bring you down.”
- [Symbol seven]: “When I grow up, I want to spend all day with my dog—maybe be a dog sitter or a veterinarian.”

Feelings checkout: Patient checked out feeling “happy and energetic.”

Chaplain offered validation of feelings, affirmation of expressions of hope, purpose and meaning and affirmation of self-reflection. Chaplain affirmed patient’s faith language and self-awareness. Chaplain will continue to follow as needed. Please page for additional spiritual support for this patient.

Relational Consciousness expressions: self-reflective, others, environment (nature imagery), Transcendent

Existential Limits expressed: death, freedom, aloneness, the need for meaning

Spiritual/Cultural Information: Patient identifies as “not a Christian.” Patient utilizes faith language and references to the Transcendent (e.g., “blessing,” “God,” “He,” and “prayer”) and she reports her grandma is a daily church goer.

10 yo male



this patient identified a particular lake within the state of Idaho that has been obscured in his art response to protect anonymity

Spiritual/Relational Building: Introduction by Chaplain to group, Purpose and Meaning. Introduction by each group member, including: name, age, “why you’re here” (diagnosis), and a feelings check-in. Invitation to share without judgement, encouraging respect and safety, assurance of no “right” or “wrong” in sharing/expressing. Expression of welcome by the Chaplain to each group member by name.

Spiritual/Relational Connecting: Feelings check-in naming a color that best represents current feelings, Godly Play® story, “The Parable of the Good Shepherd.”

Spiritual/Relational Expression: Art response, faith expression and reflective wondering.

Chart Note example:

Group began with introductions and feelings check-in. “Patient” expressed feeling “happy” and chose the color “pink” to represent that feeling.

After introductions, Chaplain told the Godly Play Story “The Parable of the Sower” and facilitated wondering and exploration of purpose, hope and meaning-making for group members. “Patient” reflected on the narrative and symbols in the story in the following way:

- [using his own faith language]: “The Good Shepherd is God or Jesus.”
- “I felt lost in church once. I was found in church, too.”
- “The Ordinary Shepherd is just a human.”
- “The wolf is the devil.”
- “I’m water in the story—I can’t explain it. I can taste its cool smoothness...”
- ART RESPONSE [see above]: “I drew a place in Idaho called ... Lake. It’s a place I went with my family. It’s so peaceful there...”

Chaplain offered validation of feelings, affirmation of expressions of hope, purpose and meaning, and affirmation of self-reflection. Chaplain affirmed patient’s faith language and self-awareness. Chaplain will continue to follow as needed. Please page for additional spiritual support for this patient.

Relational Consciousness expressions: self-reflective, others, environment (personal memory and nature imagery), Transcendent

Existential Limits expressed: aloneness, the need for meaning

Spiritual/Cultural Information: Patient identifies as Methodist (Christian)

this Purpose and Meaning group had only one patient, who the chaplain had never met, so this was a 1:1 session. This patient did not produce an art response but decided instead to re-tell the story presented during the S/R Connecting back to the Chaplain. While I have held details of patient diagnosis and background back in these descriptions, allowing the S/R Expressions to speak for themselves, it feels salient to offer a few general details that do not compromise this patient's identity, but give insight into the symbolic and narrative nature through which this patient expresses his spirituality through relational consciousness and existential limits. This patient lost his mother at age 4 due to issues with drug abuse. His father at the time of this spiritual care encounter was unable to see the patient due to restrictions from Child Protective Services as a result of physical and emotional abuse, pending successful treatment in rehab. This patient was raised primarily by his grandparents.

Spiritual/Relational Building: Introduction by Chaplain to patient, Purpose and Meaning. Introduction by patient, including: name, age, "why you're here" (diagnosis), and a feelings check-in. Invitation to share without judgement, encouraging respect and safety, assurance of no "right" or "wrong" in sharing/expressing. Expression of welcome by the Chaplain to patient by name.

Spiritual/Relational Connecting: Feelings check-in using Holy Listening Stones, Godly Play® story, "The Parable of the Mustard Seed."

Spiritual/Relational Expression: Symbolic expression, sacred narrative integration and reflective wondering.

Chart Note Narrative:

Group began with introductions and feelings check-in. "Patient" expressed feeling "Pokemon, happy because of Pokemon and what happy looks like outside" and chose several Holy Listening Stones to represent that feeling.

After introductions, Chaplain told the Godly Play® Story "The Parable of the Mustard Seed" and facilitated wondering and exploration of purpose, hope and meaning-making for patient. "Patient" reflected on the narrative and symbols in the story in the following way:

- Patient helped this chaplain place bird and nest materials on the branches of the "giant" tree that grew from the "tiniest" mustard seed. Chaplain and patient began wondering about each bird. Patient told two separate stories about two different birds.
- Bird one: Patient told about a bird and his brother who were just eggs in a nest. The mother bird went out to get them food but just couldn't find her way back. While she was gone, the eggs hatched and another bird came to be their mom and help them get the food that they needed. This second bird went out one day, and she died, and the two brother birds were all grown up.
- Bird two: Patient told the story of a bird who was attacked by a fox and had a hurt wing. A lion arrived and chased the fox away. The lion put the bird up in the tree and the bird did its best to build a nest, even though it was hurt and had never

built a nest before. Then a bear came and attacked the lion, who “had to go away for a while” and “be with the pack” so he could get better. Meanwhile, the bear tried to knock the bird out of the tree, shaking it, but the bird stayed safely in the nest. The bear finally went away, and the lion got better. The bird found a tree near the “lion pack” and built its nest there. Patient liked that “the animals were there to help each other and that they had safe places to stay.”

- While putting the Godly Play® materials away, patient noted, “I forgot the other part of the second story.” Chaplain invited patient to tell this forgotten part and patient began choosing several Holy Listening Stones as symbols to represent the feelings in his story: “Well, the lion that saved the bird got attacked by a pack of wolves. The bird went down to try to help, but they were wolves and the lion, well...you know. The other birds saw this and they attacked the wolves to try to help their friend and the wolves ran away, and the bird was sad, because his friend the lion had...I don’t like to say it...he died. But he was also happy because it was night, and he looked up in the sky, and he saw that his friend the lion was the brightest star in the sky. And he knew that even though his friend had died, he was still with him. And the birds and animals were determined to help each other.”

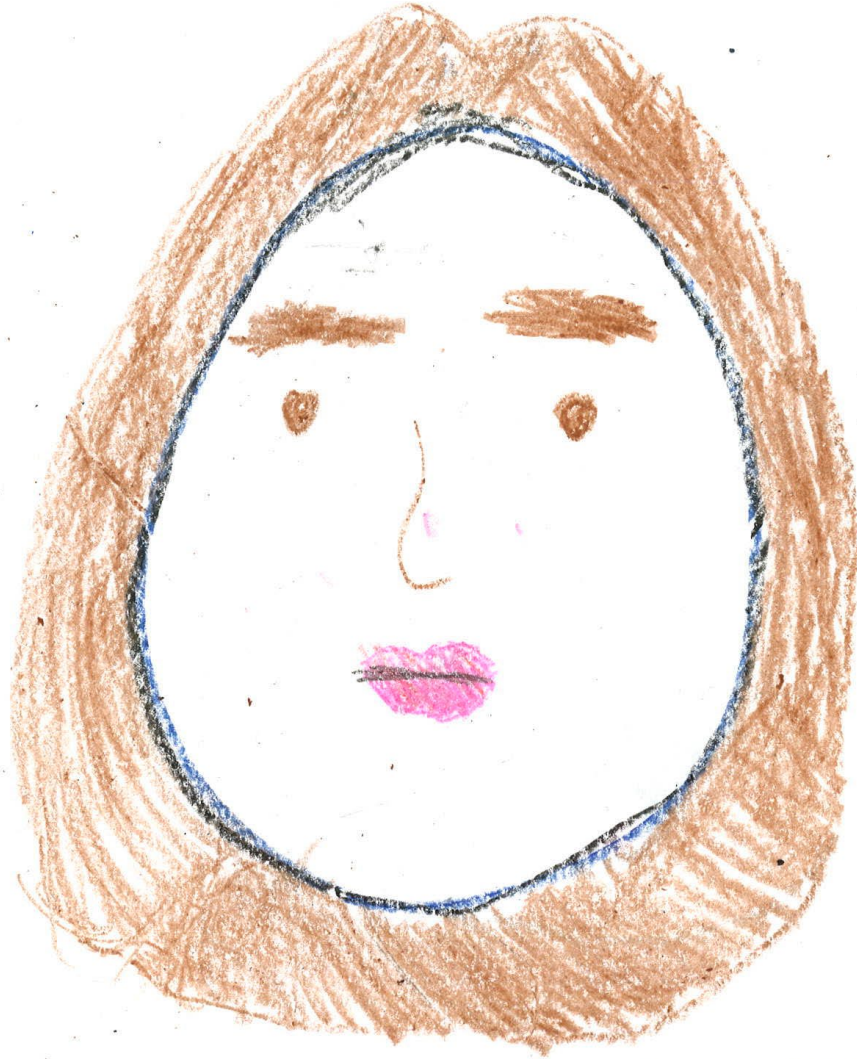
Chaplain offered validation of feelings, affirmation of expressions of hope, purpose and meaning, and affirmation of self-reflection. Chaplain affirmed patient’s narrative and use of symbols for S/R Expression. Patient checked out of group feeling “good.” Chaplain will continue to follow as needed. Please page for additional spiritual support for this patient.

Relational Consciousness expressions: self-reflective, others, environment (nature imagery), Transcendent

Existential Limits expressed: Death, aloneness, the need for meaning

Spiritual/Cultural Information: Christian

11 yo female



PIMPLES
Ugly Hair
Big Eyebrows

Acceptance



Spiritual/Relational Building: Introduction by Chaplain to group, Purpose and Meaning. Introduction by each group member, including: name, age, “why you’re here” (diagnosis), and a feelings check-in. Invitation to share without judgement, encouraging respect and safety, assurance of no “right” or “wrong” in sharing/expressing. Expression of welcome by the Chaplain to each group member by name.

Spiritual/Relational Connecting: “Naming an animal that best describes how you feel right now” for feelings check-in, Godly Play® story, “The Parable of the Sower,” and feelings check-out.

Spiritual/Relational Expression: Art response, symbolic expression and reflective wondering.

Chart Note Narrative:

Group began with introductions and feelings check-in. “Patient” expressed feeling “calm, happy, adorable and hyper” and described “a purple panda” as the animal that best represents those feelings.

After introductions, Chaplain told the Godly Play Story “The Parable of the Sower” and facilitated wondering and exploration of purpose, hope and meaning-making for group members. “Patient” reflected on the narrative and symbols in the story in the following way:

- When asked by the Chaplain as part of the Godly Play® methodology, “I wonder what part of the story you would take out so it was the story you needed it to be?” patient responded: “I would take out the dying parts of the story.”
- [after hearing another group member wonder about the images in the story]: “Though, if you take out the dying parts, then you take out parts of your own story, like your hair color or eye color.”
- “I think the moral of the story is to accept the parts you don’t like about yourself and then eventually something good will grow from that.”
- ART RESPONSE [see above]: Patient drew a self-portrait on one side of a piece of paper with the words, “pimples, ugly hair, big eyebrows.” On the other side of the paper is a self-portrait with a smile and the word “Acceptance” at the top. Patient explained, “accepting the parts you don’t like about yourself can lead to happiness.”

Feelings checkout: Patient checked out feeling “the same—like a purple panda.”

Chaplain offered validation of feelings, affirmation of expressions of hope, purpose and meaning and affirmation of self-reflection. Chaplain will continue to follow as needed. Please page for additional spiritual support for this patient.

Relational Consciousness expressions: self-reflective

Existential Limits expressed: death, the need for meaning

Spiritual/Cultural Information: Patient identifies as a member of the Christian Church

Conclusion

As noted at the beginning of this chapter, my intent is to let these Spiritual/Religious Expressions of children stand on their own as examples of the kinds of hope, purpose and meaning children find within themselves when provided with an intentional, spiritually supportive encounter. By creating a safe container through S/R Building and engaging with a “third thing” in order to facilitate S/R Connecting, children are able to express themselves spiritually and existentially without necessarily having those words or concepts available to them. Their expressions can be seen through the lenses of relational consciousness and existential limits, which can then be recorded as aspects of their S/R Expressions. I have attempted to use the charting templates created below each example to show how these theoretical frameworks can contribute to not only supporting children spiritually in a clinical setting, but also to communicate this important aspect of pediatric patient care to other members of the IDT within the EMR.

Because the assessment-intervention-outcome model is appropriate for the cognitive and physiological approach to pediatric clinical care, other members of the clinical care team can incorporate the content of these chart notes into the larger sphere of treatment, noting how children may be symbolically expressing pertinent life events, circumstances or frames of understanding as they relate to the child’s diagnosis and treatment. This is an example of how those clinicians operating in the scientific language domain can incorporate the child’s own kind of understanding into the larger milieu of care. It is important to note, however, that it is not the role of the chaplain to either diagnose the child through S/R Expressions, nor to translate those S/R Expressions into scientific or medical language. My hope is that by advocating for an approach to utilizing

the S/R Building-S/R Connecting -S/R Expression model of pediatric spiritual care within the spiritual language domain, clinicians can bridge the insight provided by the children themselves, facilitated by the pediatric chaplain, into the assessment-intervention-outcome model that necessarily informs medical and cognitive/behavioral clinical care. From the psychosocial perspective, my hope is that the “normalization and coping” emphasis of developmental/cognitive approaches to helping children within the scientific language domain will work in tandem with the “meaning-making and hoping” approach to caring for children within the spiritual domain.

More importantly, however, is the contribution of this approach to spiritually supporting children as it pertains to the child’s healing within themselves—spiritually, existentially and emotionally—and the way in which this healing in the spiritual and existential realm by way of S/R Expression contributes to the overall healing and well-being of the whole child—inclusive of mental, physical, emotional, relational and spiritual healing.

Appendix 1

The following is an edited email discussion had between this chaplain and a pediatric emergency physician in discussion about this project. I offer it here, with the physician's permission, as an example of the kinds of discussions that can help bridge the language domains of science and spirituality.

Physician: As someone with zero exposure to this body of work, I find Relational Consciousness interesting and find myself struggling to differentiate this framework and the interactions one has with children within it from work Child Life specialists might do using play. To me, they seem very similar. The primary difference, I see, so far, is that in exploring spirituality within a Relational Consciousness framework, you use historically religious stories, while Child Life might not (yet, they might explore the same difficult topics, e.g., death). I'm not suggesting any changes, just noting what I'm thinking, as I read your draft.

Chaplain: Thanks so much. This is really helpful! I will work to try make an explicit connection/distinction in the dissertation about the work we do as chaplains and the kind of work Child Life does (not to mention Social Work, Play Therapy, Music Therapy and Psychology). I have noticed that while psychosocial support folks often work in silos in the adult world, in pediatrics our roles often overlap because of the limitations inherent in communicating with children. With parents, our roles still overlap, but are more differentiated as they would be in the adult world. This actually makes sense in terms of the overall sense of the dissertation—that what is easily differentiated, quantified and measured in the adult setting gets complicated, less-defined and harder to describe when it comes to children and their ways of making meaning and finding ways to cope.

The distinction I usually make between what the Chaplain does versus a Child Life Specialist is: Child Life focuses on *normalization and coping* while the Chaplain focuses on *meaning-making and hoping*. Of course, there is overlap here as well, but it is a helpful distinction in terms of the primary focus of our disciplines.

I'm grateful to get your feedback from your own unique standpoint as one who is concerned not only with the science and practice of medicine, but also the measurement of patient experiences of the care they receive. It's challenging me to really wrestle with the way all this stuff interacts when trying to care for children who can't express on a Likert scale (for example) what their experiences have been like, but who clearly have their own experiences.

Physician: "The distinction I usually make between what the Chaplain does versus a Child Life Specialist is: Child Life focuses on *normalization and coping* while the

Chaplain focuses on *meaning-making and hoping*. Of course, there is overlap here as well, but it is a helpful distinction in terms of the primary focus of our disciplines.”

I’m going to ask you to think more through this or at least explain it more to me. Lots of people exist to help make meaning of things (e.g., philosophers). Can a Chaplain be a “Chaplain” in your model if they do not focus on and/or overtly discuss God? This, to me, seems to be what is unique to a Chaplain or any religious figure. Maybe I need to understand more the difference between a religious figure and a spiritual leader?

Chaplain: Thank you, again! As I think this through, please let me know if this is resonating. I really do appreciate you’re pushing me to be more clear and if I can make it so, it will only serve to make the discussion better.

The “meaning” I’m addressing (hopefully) is the more personal, spiritual, existential and phenomenological meaning than perhaps a philosopher might seek to flesh out, which I think of as more objective, schematic, sometimes observable and apparent to all (though its true that many of the greatest theologians are also philosophers and vice-versa). Both kinds of meaning are present at any one time (probably even more “kinds” of meaning), so perhaps I need to be really clear about what kind of meaning I am exploring.

The kind of meaning, and of hope, that I’m claiming the chaplain specializes in is different insofar as this is the kind of meaning that comes from, and creates, the narratives that people cling to (often religious narratives—scriptural, apocryphal or otherwise) and that connect them to the deepest experiences and beliefs they have for themselves in relation to others and to the Sacred/Transcendent/God/Universe/Whatever Connects Us All. These deep beliefs carry values about not only “what something means,” but even “what something means in light of my beliefs about God, the Sacred, the Transcendent.” In Oncology, for example, a poor prognosis means, in one respect, that the family can expect to see, experience and observe the following x/y/z physiological processes as a result of the disease and its treatment, which will ultimately end in the body ceasing to function. But on another level, what it “means” may be very different in terms of considering the purpose/meaning of one’s life, the purpose/meaning of the disease, the purpose/meaning of what happens after death. Hopes for “cure” during a difficult treatment often shift to hopes for “healing” after death, and then the post-mortem type of “healing” takes on a very different meaning than what we normally think of—it’s the kind of healing that can only be considered in light of a spiritual reality that the patient and/or family finds a home in. In many cases, the “healing” folks speak of is specific to an afterlife, even when a religious tradition is not part of the family’s story. Often, it is through this kind of meaning-making that patients and families base medical decisions on, find peace with in the midst of their illness, or stand on for inspiration, hope and resolve. This kind of meaning-making becomes part of the person’s spiritual narrative, which may or may not include a traditional understanding of God in the religious sense. Several pediatric oncology patients have become RNs or MDs because of what they felt was God’s hand in nudging them in that direction through their cancer diagnosis and remission. That’s the kind of meaning I’m trying to get at.

I do think that the chaplain's focus on meaning-making and hope is focused uniquely on the religious/spiritual values of the child and family (which are sometimes similar and sometimes very different). I also think there is an important distinction to make between the religious figure and the spiritual leader. Chaplains are, to my mind, often the former but most certainly the latter. There are so many different belief systems, religious affiliations and religio-cultural identities in the hospital that chaplains need to be adept enough to be able to honor and affirm each of these, but also be present to those who may lack this kind of grounding belief or identity in a way that still allows them to find the kind of spiritual meaning that helps create hope even when they lack the language or tradition to do so. Chaplains often become the person families with no religious affiliation seek out during a hospitalization because we listen to, reflect and ritualize their story in ways very different from our psycho-social counterparts. I've done lots of Atheist funerals over the years for patients and families because, despite their lack of religion (unless one argues that Atheism IS a religion of a certain kind), they still seek the kind of meaning and hope that spirituality brings. So, sometimes, it's specifically about the chaplain NOT talking about God that gives the family a reason to trust the chaplain to honor their ultimate concerns, however they conceive them to be. And of course, if a family DOES talk about God, the chaplain is wading in familiar waters, though still able to swim out a little deeper toward unfamiliar shores.

Most of my Child Life colleagues would say, I think (it's a risk and I mean not to speak for them), that they focus on cognitive and developmental needs of children and, through this focus, employ concrete explanations, orientations and distractions through normalizing what happens in the hospital in order to help children cope with what may or may not occur to their bodies over the course of their treatment. They often help them normalize and cope with what relationships might look like in terms of adapting to a new chronic condition or appearance or treatment regime. And they do so much more! All of this is 100% necessary as is, I would argue, the opportunity to make and find spiritual/religious meaning and hope. As one spiritual writer describes it, helping families to find meaning and purpose is like helping them find a "Lever and A Place to Stand." The normalization and coping offers a "how" in regard to a patient/family response to a particular diagnosis and treatment. The meaning-making and hoping, in the sense I'm trying to argue for, offers the "why." In this way, I think Chaplains, Child Life, Play Therapy, etc... offer complimentary, but distinct focuses of care when it comes to pediatric patients.

Finally, a really great example of how Chaplains and other psycho-social disciplines (in this case, Psychology) interact. For an adolescent oncology patient, the Psychologist wrote, "Prayer appears to be an important cognitive tool for biobehavioral self-regulation of pain and anxiety." Of the same patient, the chaplain writes, "NAME utilizes prayer as a primary source of hope and meaning-making, focusing on his experience of the love of God, and the support of his family, to give him peace in the midst of his hospitalization." I think the psychologist described this patient's practice of prayer in a normalization/coping sense, while the chaplain described it in the way the patient finds "meaning and hope." Both are true, and I believe both necessary. From the standpoint of

relational consciousness, I would say that the patient identified his relationship with the Transcendent (God) and his Family (Others) as primary to his spirituality and spiritual expression, while using these relationships to explore the existential limits of Death and the need for Meaning through those relationships.

I know this was a lot to read—thanks for getting through it all. Does this seem like something I might need to include in the dissertation, and does it help clarify what I mean in a way that seems coherent and answers your questions?

Talking about this stuff really is like “trying to catch a cloud and pin it down...”

Physician: Wow! Thank you for your reply. This is fascinating stuff and I’m enjoying reading it and learning from you. I’m an outsider, so for me, much of this is new. It seems like you meet people where they are and facilitate their understanding of the situation within the framework that they believe to help provide healing and hope. Perhaps this is too simplistic an explanation. I’d be interested if it resonates with you. The tools you use have a basis in religion, but I suspect, the more well rounded and diverse a chaplain is, the more effective they will be with this type of work.

Chaplain: “It seems like you meet people where they are and facilitate their understanding of the situation within the framework that they believe to help provide healing and hope.”

Yes! I hope you don’t mind my quoting you on this. It’s a simple, succinct distillation of all the ingredients of what we do. It resonates. And, indeed, the tools we use are grounded in religious tradition. Then we train and educate to expand our ability to help folks identify their own grounding, be it religious, humanist or otherwise, so that they can find the hope and meaning that brings healing to their hearts and souls.

Thanks so much for pushing my thinking. Having the opportunity to articulate it to a colleague and mentor outside of my discipline is beyond helpful.

Physician: You can definitely quote me. Thanks. Glad I got it.

I think this has the potential to be broadly read from the perspective of how people, not just chaplains, can interact with others, including children, and play a role in helping provide healing and hope. To be that broad, the language would have to be a bit different. Of course, it could be more narrowly focused towards chaplains.

What you are really talking about is how you speak with people to help them find peace and wellbeing, or healing, with a situation using the framework they believe in. This doesn't have to involve death. It could be anything (e.g., divorce) and it doesn't have to be big (e.g., a child not behaving). You listen, reflect, accept, and guide, based upon your knowledge of religion and their spiritual beliefs.

Having such long and involved discussion between a physician and a chaplain is, in my experience, not commonplace in most busy pediatric hospitals. To be quite honest, it can also be a bit intimidating from the perspective of the chaplain, who (in my case), is trying to speak from a language domain that is not prominent in the clinical environment, and that is less understood than most, even from within the discipline itself. What is most important here is that the spiritual-scientific language domains are in dialogue between two practitioners who are both engaged in the holistic care of children. This is an example of the bridge between these two language domains and how ongoing discussions may further solidify the need for both language domains to work side-by-side in the healing of children, without subsuming one language domain (i.e., the spiritual) so fully into the other (i.e., the scientific) that the integrity of either or both language domains is lost.

Appendix 2

Holy Listening Stones

Rev. Dr. Leanne Hadley

Below is the template of Holy Listening Stones discussed in this work and used in several of the case examples. These can be found on Dr. Hadley's website: <https://www.leanne-hadley.com/holy-listening>



Spiritual Listening Stones:

A trans-cultural tool to empower children to discover their inner-resiliency & healing when facing stress, crisis, trauma or grief.

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Appendix 3

Spiritual/Relational Model of Pediatric Spiritual Care

S/R Model of Pediatric Spiritual Care



S/R Building (≠ assessment)

- Creating a safe, autonomy-based container through spiritually intentional relationship and rapport--*relationally oriented*

S/R Connecting (≠ intervention)

- Creating a spiritually intentional connection through the use of mutual understanding (Egan), a connecting activity (third thing), and engaging the creative process--*mutuality oriented*

S/R Expression (= outcome)

- The expression of spirituality and/or existential meaning through the language of the child (verbal, artistic, contemplative or otherwise) as seen through the lenses of relational consciousness and existential limits in order to establish hope and/or meaning with the child--*healing oriented*

Clinical Model of Pediatric Medical Care



Assessment

- Observing and gathering baseline information to establish deficits--*observation/measure oriented*

Intervention

- applying specific evidence-based practices to address deficits --*provider oriented*

Outcome

- the curative effects of the intervention and measure of the efficacy to which the intervention addressed deficits and restored to optimal function (physical, behavioral, cognitive)--*cure oriented*

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