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Addressing Children's Beliefs Through Fowler's Stages of Faith

Michelle E. Neuman RN, MA, MSN, PNP-BC*

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Knowledge of child development, including faith development, is important in providing holistic care to the child. Pediatric nurses and nurse practitioners may be inadequately prepared to meet the spiritual needs of children in developmentally appropriate ways. This article demonstrates why it is necessary to asses a child's or an adolescent's religious and spiritual beliefs and when and how a nurse intervenes. Modeled here is one way in which pediatric nurses can effectively combine their knowledge of child development and Fowler's theory of faith development to address the child and adolescent's spiritual needs.

NURSES SEEK TO care for and comfort the whole person. Nurses strive not to reduce their patients to an illness, but to see them as multifaceted human beings. Just as nurses assess patients for physical signs, so too they must question the child and parent about health behaviors that are not always observed, such as their sleep habits, self-concept, roles and relationships, and values and beliefs (Burns, Dunn, Brady, Barber-Starr, & Blosser, 2004). Although a child's values and beliefs are often overlooked, they indeed may be as important to one's recovery or acceptance of disease as alleviating physical discomforts. For example, one study of adolescents with end-stage renal disease found that "the majority of adolescents who reported a religious affiliation also reported that they seek spiritual support to assist them to cope with stressful situations" (Snethen, Broome, Kelber, & Warady, 2004, p. 46).

One key to understanding a child, to seeing a pediatric patient holistically, is to understand child development from cognitive, social, behavior, and faith perspectives. The purpose of this article is twofold. First, it demonstrates why it is necessary to assess a child's or an adolescent's religious and spiritual beliefs and when and how the pediatric nurse might begin this process. Second, this article focuses on applying knowledge of child development, especially James Fowler's Stages of Faith model, to pediatric nursing practice.

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* Corresponding author: Michelle E. Neuman, RN, MA, MSN, PNP-BC.
E-mail address: neumanml@email.uc.edu.

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Definition of Terms

Religion is generally used in the literature to denote formalized ritual worship of a god and its attendant belief patterns (Josephson & Dell, 2005; Mueller, Plevak, & Rummans, 2001). The term *spirituality* is more broadly defined as a connection with something transcendent and an individual's quest for meaning in life. It is often used for people who consider themselves "not religious," that is, people who do not formally ascribe to an established organized religion but have feelings and beliefs that fit a spiritual pattern (Josephson & Dell, 2005; Mueller et al., 2001). Faith as conceived by James Fowler is typically more broad than the preceding definitions of religion and spirituality, embodying both while also including the fervor of revolutionary liberation movements as well as the passions found in secular organizations (Fowler, 1981). Therefore, *faith* is the overarching, all-encompassing term, which includes within its bounds the definitions of religion and spirituality. All three terms (*religion*, *spirituality*, and *faith*) are used in this article.

Why Assess Faith—A Brief Review

Why should nurses, nurse practitioners, and physicians be involved in assessing a patient's spiritual and religious life? First and foremost, it is because a person's faith and values pervade all facets of his life. One researcher bluntly states

that since for many patients spirituality is an essential part of their being, it should not be ignored (Koenig, 2000). In terms of health care, religious beliefs influence various medical decisions, compliance with treatment, end-of-life care, coping methods, thoughts about suicide, physical health, and social support (Koenig, 2002), plus attitudes and restrictions on diet, exercise, tobacco and alcohol use, sleep patterns, and sexual practices (Koenig, 2003). Assessing a person's beliefs allows the nurse to understand and incorporate into interventions the patient's perception of the mind, body, and spirit connection (Maddox, 2001). It can be done seamlessly as part of the original intake history-collection process. There are several specific models for assessing a patient's faith needs, such as the BELIEF model (Belief system, Ethics or values, Lifestyle, Involvement in religious community, Education, and Future events) and the HOPE model (sources of Hope, Organized religion, Personal spiritual practices, and Effect of these behaviors on health care; Burns et al., 2004; Heilferty, 2004; Maddox, 2001). These models are acronyms designed to guide the assessment process. They provide a quick way to open conversations on beliefs and faith.

There is also growing empirical research showing that a person's religious and spiritual beliefs play a part not only in helping one cope with and recover from illness but also in preventing mental and physical illnesses (Josephson & Dell, 2005; Koenig, 2003; Mueller et al., 2001). Research also exists demonstrating that one half to three fourths of those surveyed want their physicians to address spiritual issues or at the very least be aware of their religious and spiritual beliefs when providing health care (Larimore, 2001; Maclean et al., 2003). Although some people may be opposed to such discussions with their primary care providers, there is no evidence suggesting these discussions are harmful to the patients, especially for the one desiring such interventions (Larimore, 2001).

That being said, not every patient will need or should have a spiritual history done. For example, a child who comes in just to have sutures for a superficial wound would not likely need a discussion of his or her religion and spiritual beliefs. On the other hand, children with whom the nurse will have a long-term relationship, such as those with chronic or terminal diseases or mental health issues, are good candidates for such a dialogue. According to Koenig (2004), the whole purpose of a faith assessment is to seek out how a patient and family cope with illness and to assess if they have strong religious or other beliefs that could impact their medical decisions. For example, patients or families might refuse certain beef- or pork-based medicines for religious reasons. Other religious groups, such as Christian Scientists, prefer prayer to standard medical treatments (Linnard-Palmer & Kools, 2004). Another facet to a discussion on coping is to discover what type of support system the child and family have. However, one must bear in mind that if a patient or family is uncomfortable or denies that religion and spiritual issues play a role in his life, then the spiritual history assessment must be discontinued (Koenig, 2004).

Children have a rich spiritual life, although less is known about children's beliefs than adult beliefs related to religion and spirituality because there have been few studies actually involving children (Davies, Brenner, Orloff, Sumner, & Worden, 2002). One study notes that because children have a rich spiritual life, including beliefs about faith, hope, fairness, blame, and the afterlife, it should be addressed. The researchers warn health care providers that it is especially important to address issues of faith where there is a culture clash between provider and patient because in instances where the family's needs are not met, they may turn away from standard medical care to faith healers (Stuber & Houskam, 2004).

Older children will be able to directly answer questions such as, "Does your religion play an important role in your life?" For younger children, it will be the family who will provide the religious and cultural context of the child's life. A child's family provides the child's earliest culture and religious practices. These traditions and beliefs can positively or negatively shape the way a child understands health, illness, and death. Children may use spirituality and religion not only to cope with physical illness but also to try to understand and cope with other difficult situations including physical and emotional abuse (Sexson, 2004). Sexson also points out the need to assess whether a child's religious or spiritual views fall in line with his or her family's, are different, or even are a source of conflict. Although one's family creates a context in and foundation on which to develop a belief system, know that each child, even an atheist, constructs a worldview, that is, a system of beliefs that deals with the fundamental questions of the meaning, purpose, behaviors, and origins of life (Josephson & Dell, 2005). Fowler (1981) emphasizes this point by noting that in the United States, nearly every child, even one from an atheist home, has a concept of God, religion, and/or spirituality because of the pervasiveness of religious and spiritual images in our culture.

An added dimension to the debate involving why, when, and how to assess faith in patients and families for pediatric nurses is the developmental age of the child. Children are known for their endless questions and curiosity. It is highly probable that a nurse will hear a child ask his or her parents or directly ask the nurse questions such as "Why did God punish me with this disease?" "Why me?" "Will it hurt?" or "Is it ok to be afraid?" These questions deserve a response, even if the response is, "Shall I call the chaplain?" An alternate response might involve using Fowler's Stages of Faith model to explore the child's level of understanding and serve as a sounding board for the child to air hopes and fears. This simple act of listening, of allowing these questions to be asked, may comfort the child and shows that the nurse responds to the whole patient.