Spirituality, Religion, and Pediatrics: Intersecting Worlds of Healing

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Abstract. Religious practices such as prayer represent the most prevalent complementary and alternative therapies in the United States. However, biomedicine has sometimes viewed faith and related religious worldviews as relevant only when they obstruct implementation of scientifically sound biomedical care. Recent efforts to arrive at a new synthesis raise challenges for pediatricians. This article reviews theories of child faith development, and models of child spirituality from different disciplinary perspectives. It provides sources illustrating how spirituality and religion may inform children’s lives; play a part in children’s moral formation, socialization, and induction into a sacred worldview; and provide the child with inner resources. It also suggests some of the positive and negative effects of spiritual and religious engagement. Second, this article examines aspects of spirituality and religion that parents may bring to bear in relation to their children’s health. Third, this article addresses the spiritual and/or religious identity of the provider. These topics are discussed in the context of cultural competence and the related importance of religious diversity. The authors suggest 1) some approaches for appropriate inclusion of spirituality in clinical practice, 2) challenges for medical education, and 3) areas requiring further research. Pediatrics 2000;104:899–908; pediatrics, spirituality, religion, complementary therapies, cultural competence.

Religious practices such as prayer represent the most prevalent complementary and alternative therapies in the United States.1 Eighty-two percent of Americans believe in the healing power of personal prayer, 73% believe that praying for someone else can help cure their illness, and 77% believe that God sometimes intervenes to cure people who have a serious illness.2 A number of studies suggest that spiritual/religious beliefs and practices may contribute to decreased stress and increased sense of well-being,3 decreased depressive symptoms,4 decreased substance abuse,5 faster recovery from hip replacement,6 improved recovery from myocardial infarction,7 and enhanced immune system functioning.8 A recent meta-analysis of 29 earlier studies involving nearly 126 000 patients argued that the odds of survival were significantly greater for people who scored higher on measures of religious involvement than for people who scored lower, even after controlling for a variety of social and health-related variables,9 although the design and interpretation of these findings have been questioned.10

Since the time of Sir Isaac Newton (1642–1727), scientists in Europe and the United States have accepted the reality of a material universe controlled by fixed physical laws. This perspective considers faith and related religious worldviews as standing apart from scientific-based biomedical understandings. Indeed, it is common for clinicians to come into contact with this tension through direct challenges to clinical benefit by Christian Scientists, Jehovah’s Witnesses, and faith healers.

This separation may also be expressed by the physician’s feeling comfortable introducing discussions of spirituality and religion primarily in the face of life-threatening illness, dying, and death. However, pediatric practice may need to recognize that religion and spirituality are not confined to issues pertaining to death, but rather may play an important role in determining the way(s) families live, and therefore, have a broader impact on child health.

Recent efforts are underway to arrive at a new synthesis between medicine, religion, and spirituality, extending notions of healing to include concern for the body, mind, and spirit. In addition to the growing popularity of nontraditional, New Age workshops and programs on spirituality and healing, mainline religious traditions have also expanded healing services.11 The topics of spirituality and religion have also appeared in leading medical journals12,13 and major medical conferences. More than 30 medical schools have introduced courses in the academic study of the relationship between spirituality and medicine.14 For the past 2 years, the American Association of Medical Colleges has cosponsored annual conferences with the Maryland-based National Institute of Healthcare Research regarding spirituality in medical school curricula, which have drawn represen-
tatives from more than 40 to 50 medical schools each year.

Despite this integrative activity, the importance of these efforts for pediatric practice has received little attention. This article addresses the implications of the new synthesis of spirituality, religion, and medicine for pediatric practice. It reviews the literature on the relationship of spirituality, religion, and family and community well-being, and examines implications for clinical practice, training, medical education, and research in the United States.

**RELIgIOUS TRADITIONS, SPIRITUALITY, AND FAMILIES**

**Overview**

Polls hoping to gauge the importance of religion and spirituality in American life tend to define religion in relation to 1) institutional factors such as membership, synagogue, or church attendance, religious preference, and denominational affiliation; 2) belief in God, miracles, life after death, the Bible; and 3) practices such as prayer and Bible reading. However, these criteria are not shared by all religious traditions. They also may not adequately reflect the intersecting relationship between religion and spirituality. One noted pollster argued that it is a mistake to conclude that everyone in American culture means the same thing when using the words spiritual or spirituality: “Americans’ preferences . . . reveal a mixed bag of traditional and experimental, mainstream and fringe, Christ-centered and syncretistic . . . At the very time it grows in popularity, spirituality has become more and more an elusive term.”

The increasingly pluralistic religious landscape of the United States further contributes to this diversity of meanings. Therefore, although it is useful to recognize that people may draw distinctions between spirituality and religion, in connection with children we suggest that these 2 concepts are best understood as highly related, with blurred boundaries in everyday life.

It is important to assess the influence of spirituality and religion on the primary determinants of child health and clinical practice, namely the child, the parents, and the clinician. Each brings a different perspective on the role of spiritual/religious factors.

**Children, Spirituality, and Health**

Children in particular do not make sharp distinctions between spirituality and religion. Moreover, even very young children have clear ideas about divine realities, faith and prayer, although these ideas may prove fluid. Religious traditions can play multiple roles in the lives of children, such as providing structures for moral development, and for the socialization of the child into different ideals of personhood and behavior. They also may frame the child’s understanding of social relations and the natural world, as well as linking the observed phenomena of daily life to a broader sacred world. In addition, they may influence a child’s ideas about sickness, suffering, coping, and healing, issues of direct relevance to pediatric practice, and child well-being.

The best-known literature on children’s spirituality is the faith-development theory of James Fowler. Fowler proposes that the development of children’s faith occurs in stages related to Jean Piaget’s theory of cognitive development, Lawrence Kohlberg’s theory of moral development, and Erik Erikson’s theory of psychosocial development. Children, within this framework, are seen as becoming capable of increasingly abstract and multiperspectival religious thinking as they grow older. Other theorists draw on psychoanalytic models or on object-relations theory to explore the development of children’s images of God. Some studies have focused on specific aspects of children’s spirituality, such as imagination, spiritual needs, or the experience of gifted children. Some descriptive studies have focused on the spiritual experience of children from specific religious backgrounds. One study that examined the relationship between health, religion, and spirituality for children demonstrated that spiritual and religious practices are prevalent and often perceived by children as helpful. For example, in a study of patients with cystic fibrosis, of the 70% who sought nonmedical therapy, 60% used religious treatments such as prayer, pilgrimage, and the possession of religious objects. Of those participating in group prayer, the most common religious therapy, 65% reported frequent use and 92% reported perceived benefits.

For the most part, questionnaires that have been used to assess children’s spirituality and/or religion have been adapted from protocols designed for adults. In addition, these questionnaires have not reflected models responsive to the remarkable religious diversity that exists in America today. Nor have they drawn on cross-cultural theories of child development. Only a few such integrative approaches exist. Examples include 1 study of African-American children and 1 study of Indian Hindu adolescents.

A child’s sense of spirituality and/or engagement in a religious community may provide a structure for positive coping strategies. For example, different traditions offer different interpretations of suffering and illness, as well as related means for feeling supported in the midst of difficult experiences. Such resources may provide a child with the sense of having added assistance in coping with difficult circumstances, including illness. Instances in which spirituality and coping may intersect for children include nighttime fear, psychiatric problems, suffering, hospitalization, disability, cancer, and terminal illness. Children also find meaning in spirituality when facing substance abuse or acquired immunodeficiency syndrome in other family members, as well as the critical illness of a sibling, or the death of a family member. Although little of the resilience literature directly examines the
role of spirituality, that which does suggests that spirituality and involvement in a faith community can serve as protective factors.

Spirituality and religious involvement can also help children withstand the emotional assaults of sexual abuse, racism, cultural destruction, and the traumas generated by refugee experience and life in the disenfranchised urban neighborhoods. Such experiences may represent spiritual crises in the lives of children. Spirituality in these cases may contribute to a stronger sense of cultural identity.

Religious engagement can contribute to children’s pursuit of health-promoting and preventive health behaviors. A study of 5000 high school seniors related religiosity to health-promoting behavior. Religiosity can also be linked to better adolescent decision-making and well-being, less violence, and fewer high health risk and problem behaviors. Low religiosity also tends to be related to higher rates of smoking, drinking, drug use, and adolescent pregnancy. Male teens with close ties to churches are less likely to show sexual aggression. Church attendance may also contribute to lower levels of distress and worry, better adjustment, higher life satisfaction, lower risk delinquency and drug/alcohol abuse, increased academic and social competence, and lower suicidal ideation. Religious communities may also provide social support.

Spirituality and religion may not always prove to be beneficial to children. One potential negative effect for a child related to involvement in a religious/spiritual tradition is the risk of damage to self-esteem if the tradition emphasizes guilt. However, some authors argue that there is also a healthy guilt response, and that the two are different. Another potential negative effect is the promotion of religiously sanctioned prejudice, hatred, and violence, including homophobia. Children may be susceptible to abuse resulting from parental religious beliefs about discipline and corporal punishment, or from some religious therapies. Adolescents who come out as gay or lesbian may encounter their religious communities’ censure, and/or violence from peers who have been taught that homosexuality is a sin. Adolescents may also suffer psychological and emotional harm resulting from involvement in a group that proves to be a cult. Parents and community therefore play an important role in influencing how children experience the spiritual and religious influences in their lives.

Spirituality, Parents, and Other Family Caregivers

Spiritual and religious worldviews can shape parents’ approaches to all aspects of having and raising children, including family planning, pregnancy, childbirth, postpartum experience, the feeding and care of an infant, and images of fatherhood and motherhood. Caregivers may also use religious and spiritual worldviews to make sense of, and find meaning in, their children’s experience of illness, particularly in cases of chronic or life-threatening illness, or cases of disability, where parents may see themselves as being tested or even punished. The family’s understanding of why their child has become ill may draw on religious roots. If the child is a member of a refugee family, parents may locate the child’s illness experience within the spiritual crisis of other losses.

Religious and spiritual resources may affect how parents respond to their child’s illness, disability, or mental illness. What parents value religiously may also play a part in their decisions related to life support for their children. Parents may define major losses as part of a greater picture or divine plan. The karmic traditions (e.g., Hindu or Buddhist) may interpret such losses in relation to earlier lives. If parents/caregivers are part of a religious or spiritual community, this may also provide important support. However, if a tradition encourages resignation to divine will or authority, it may be construed as supporting negative religious coping. This passive adaptation to a stressor perceived as uncontrollable can delay a family’s response to illness, negatively affecting the family’s sense of mastery and competence.

Parents may engage in religious therapies, either as complements or alternatives to biomedical therapies. Such healing techniques are common in nearly every spiritual/religious tradition. Religious therapies can include prayer, anointing, laying on of hands, and other versions of faith healing, visits to the sick, pilgrimage, petitions and related vows to saints, exorcism, retrieval of a lost soul, animal sacrifice, the undoing of a curse, or amulets, icons, and other religious objects. In the pursuit of healing for their child, parents or caretakers may also seek out healers from their own religious context. Parents’ use of religious therapies may reflect the conviction that biomedical interventions can only address limited aspects of the person, or may otherwise prove futile. When a racial-ethnic and/or cultural group has had a troubled history with biomedicine, pursuit of religious therapies may express mistrust and even fear of physicians.

The pursuit of some religious therapies may function as barriers to biomedical care. For example, some parents in the United States believe that prayer and other spiritual practices can substitute for medical treatment of ill or injured children. These parents may decide for related reasons not to adhere to biomedical therapies, worrying that resort to biomedicine will indicate a lack of faith. Parents may be enjoined by their religious tradition from having their children undergo medical procedures like immunizations and treatments involving blood products.

Spirituality and Pediatrician Identity

In every clinical encounter, a child’s and family’s spirituality and religious life will interact with that of the clinician. The clinician may or may not identify with a particular spiritual and/or religious tradition, and may therefore exhibit different degrees
of receptivity to spiritual dimensions of care. Not only will these attitudes shape how one thinks about sickness, suffering, health and healing and, ultimately, death; they also affect how the pediatrician experiences the spirituality and/or religiosity of the child and the family.

Each religious tradition has its own images and ideals of the doctor, in which the individual engaged in healing is defined as enacting some of the highest ideals of the tradition itself. This is the case, for example, in Jewish traditions, in which Moses Maimonides, one of the leading teachers and interpreters of Jewish religious life, was a famous physician, as was Avicenna (ibn Sina) a great religious scholar in the Muslim tradition. Christian traditions have, from the beginning, envisioned Jesus as a healer. Christian, Muslim, Hindu, Buddhist, and shamanic traditions all see the project of healing as intersecting with one’s spiritual and religious identity. The same holds true for doctors who identify themselves as holistic, and not connected with a particular tradition.

Culture and Community

The diversity of religious practices in the United States is remarkable, and is likely growing. In addition, each religious tradition and its related understandings of spirituality will be heavily influenced by culture. Even the same traditions take on different forms in different cultural groups. Although significant similarities exist among Italian, Irish, Chicano, Haitian, and Vietnamese versions of Roman Catholicism, for example, there are also important differences. Likewise, African-American, Bosnian, Somali, and Pakistani versions of Islam demonstrate analogous similarities and differences. Differences can even exist within families, depending on the degree of acculturation, participation in a given tradition, or the possible conversion of some members to another religion. Such intra-family differences may surface when important clinical decisions related to a child are being considered.

Every medical encounter involves the meeting of multiple cultures. By culture we mean the conscious and unconscious structures of communal life that frame perceptions, guide decisions, and inform actions. It is the web of meaning in which each person lives. In this web, the religious, the medical, and the cultural may not be viewed as separate. As Navajo surgeon Lori Arviso Alvord writes of the traditional approach to healing in her own culture, “In this belief system, religion and medicine are one and the same.” Understanding cultural variations of spiritual and religious systems in relation to child health, therefore, constitutes a critical component of culturally competent care.

Medical anthropology has demonstrated that biomedicine is also a cultural system in its own right, with its own deeply held belief structures, and faith in specific methods and forms of knowledge. Pediatricians bring this cultural orientation into the clinical encounter along with their own personal orientation. When pediatricians are not familiar with families’ culturally-based religious orientations and therapies, and do not know how these relate to families’ broader worldviews, they may instruct parents to accept biomedically-indicated procedures at odds with the family’s own values and moral worlds, and then not understand why parents do not adhere to prescribed therapies. Clinical dilemmas may result from such misunderstandings as to what constitutes good care, the patient’s best interest, and competent decision-making. One of the best known examples is described in Ann Fadiman’s extended case study The Spirit Catches You, and You Fall Down, in which a Hmong family’s understanding of their child’s epilepsy was related to the religiously-related explanation of soul loss. Repeated misunderstandings between the family and the child’s biomedical caregivers resulted in a painful and persistent impasse.

IMPLICATIONS FOR CLINICAL PRACTICE

The American Academy of Pediatrics has recognized that religious traditions and spirituality can affect clinical interactions and has outlined several basic guidelines for practitioners. It has called for all those entrusted with the care of children to: 1) show sensitivity to and flexibility toward the religious beliefs and practices of families; 2) support legislation ensuring that all parents who deny their children medical care likely to prevent death or substantial harm or suffering be held legally accountable; 3) support the repeal of religious exemption laws; and 4) work with other child advocacy organizations and agencies and religious institutions to develop coordinated and concerted public and professional action to educate state officials, health care professionals, and the public about parents’ legal obligations to obtain necessary care for their children. Pediatricians cannot avoid discussions of religious and spiritual issues when they perceive these as adversely affecting child health. The constitutional guarantees of freedom of religion do not permit children to be harmed through religious practices, nor do they allow this freedom to serve as a valid legal defense when an individual harms or neglects a child.

These issues notwithstanding, clinicians may find the carefully undertaken discussion of spiritual and religious issues of major benefit in building constructive relationships with patients and their families, particularly when the relationship develops over time. Many adult patients want to discuss religious and spiritual issues with their doctor. In a study of hospital inpatients, 70% felt physicians should consider patients’ spiritual needs, 37% wanted their physicians to discuss religious beliefs with them more often, and 48% wanted their physicians to pray with them. However, 68% reported that their physicians had never discussed religious beliefs with them. The authors have observed that parents may want to discuss spiritual and religious matters with their child’s doctor, may also want physicians to discuss
these topics with their child. and/or may want the physician to discuss prayer with their child and/or pray, often in relation to life-stage events or to chronic or more severe illness.

However, anecdotal data from the authors’ experience also suggests that pediatricians may feel uncomfortable addressing the spiritual and religious dimensions of a case either with a child or with the parents or caretakers, concerned that to do so may open a Pandora’s box. Without appropriate training in these areas, such issues may seem too complicated to incorporate into one’s own practice. Some pediatricians may fear that attention to religious/spiritual issues will load them with an increased emotional burden, or that inclusion of religious views could bias their scientific judgment. For many, the constraints of managed care already make it so difficult to get through everything else one must do to provide good care, that the very idea of factoring in yet another set of questions becomes overwhelming. Each of these is a reasonable concern.

It has also been the authors’ experience that, in addition to physician attitudes against inclusion, in some cases both parents and children may have their own reasons for wanting to exclude religious/spiritual dimensions from the therapeutic encounter. Ethical issues are involved: inclusion can lead to families and/or patients feeling that something is being imposed on them. Some families may experience it as a threat to their privacy, and may feel a heightened sense of vulnerability. The specific context is important, because there may be no ongoing relationship between the clinician, the child, and the family. Also, tensions can arise when there are real differences in religious/spiritual views between the physician and the parents and/or caregivers. Physicians should not take it on themselves to prescribe spiritual or religious practices, because of the authority that families and patients assign to what a doctor says, and the related risk of abusing power.

Nevertheless, pediatricians can follow general guidelines for appropriate integration of spiritual and religious resources into their practice (Table 1). These guidelines have been developed and used by the authors. Although they have not been scientifically evaluated, they have proved helpful in practice. One can begin by assuming that children and families may have spiritual and religious concerns, and by becoming familiar with the religious and spiritual worldviews of the cultural groups one most frequently treats. Clearly a pediatrician cannot learn everything about each of these traditions or their cultural variations. But one can learn broad characteristics of particular traditions as a working hypothesis. In practice, however, and to avoid stereotyping, he or she must then ask family members about their own beliefs, interpretations, experiences, and expectations in relation to the child’s health. Additional resources are also available for assessing the spiritual needs of children. Some make explicit their orientation within a specific tradition. Others offer more general approaches to working with sick children, terminally ill children and their parents, and to addressing child bereavement. By gradually learning these kinds of approaches, one can better recognize and respond to key spiritual issues as understood by patients and families, and determine how to make appropriate referrals to family-preferred spiritual care providers. Such referrals might include rabbis, ministers, priests, imams, monks, nuns, shamans, and other spiritual care providers and traditional healers. Families, colleagues, and hospital chaplains are good sources for names, as are the Yellow Pages. The Internet can provide broader information about the different religious and spiritual traditions.

The authors have also developed a set of 7 questions for a cross-cultural discussion of religious and spiritual traditions in clinical encounters (Table 2). Again, although these questions have not been scientifically evaluated, the authors have found them useful. The questions represent an integrated approach with which to explore a family and/or patient’s religious and spiritual views in relation to a child’s illness, health, and healing. This approach is broad enough that one can adapt the questions not only to different religious and spiritual traditions, but also to biomedicine itself. The questions can be raised in the order most suited to the particular context, and can be modified for different age groups. Nor do they need to be asked all in the same interview, but can serve as a strategy to gather information over time. Together the questions provide useful information to help the pediatrician locate elements critical to clinical decision-making. This approach does not undermine the importance of the biomedical model, but can serve as a reminder that patients and families often define their reality differently from the pediatrician, and may turn to a variety of traditions or authoritative sources.

Often what children and families want is support as they struggle to make meaning out of what is happening to them. The most basic invitation of all is to say, “Tell me about it.” When the pediatrician remains open to understanding these issues, patients and families are likely to feel more empowered and satisfied with their care. The inclusion of religious/spiritual discussion can thereby contrib-

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**TABLE 1.** General Guidelines for Integrating Spiritual and Religious Resources Into Pediatric Practice

- Anticipate the presence of religious and spiritual concerns in pediatric care.
- Develop self-awareness of your own spiritual history and perspectives.
- Become broadly familiar with the religious worldviews of the cultural groups in your patient population.
- Allow families and children to be your teachers about the specifics.
- Build strategic interviewing skills and ask questions over time.
- Develop a relationship with available chaplaincy services.
- Build a network of local consultants.
- Refer to family-preferred spiritual care providers.
- Listen for understanding rather than for agreement or disagreement.
TABLE 2. Seven Questions for Learning About Connections
Families and Children Make Among Spirituality, Religion, Sick-
ness, and Healing

1. How is Ultimate Health understood? (This question involves learning about how the ultimate purpose and possibility of human life is envisioned by the child and the family. It includes understandings of Ultimate Healing, such as salvation or enlightenment. It may also include what a child and/or family think happens after death, because in some traditions, Ultimate Healing doesn’t happen until then).

2. How are affliction and suffering explained? (This question addresses how the child and the family explain why affliction and suffering happen in more general terms. The child and family may have >1 explanation).

3. What are the different parts of a person? (Different spiritual/religious traditions think of a person as being made up of different parts, such as body, mind, spirit, soul, or souls, vital forces, etc. Each tradition conceptualizes a human being differently. To know the parts is to know what can get sick, from the perspective of the child and the family. It also helps one understand a family’s strong feelings with regard to some biomedical therapies).

4. How is the child’s illness/sickness/disease understood and explained? (It is important to learn how family members describe and explain what has gone wrong for their child, and what the child thinks has happened. Causes in some spiritual/religious traditions may be seen as multiple, and may include variables like troubled relationships, divine will, punishment, or testing, the angry dead, demons, soul loss, or karmic influences).

5. What intervention and/or care is seen as necessary? (One can explore what the child and family see as necessary interventions for different conditions. Depending on how a family explains the child’s condition, these interventions may include not only biomedical therapies but other approaches to healing such as a wide range of religious therapies. Frequently, families pursue >1 approach, although they may not discuss the nonbiomedical strategies they are using. The core issue is what a child and family think needs to be done for healing to happen).

6. Who is seen as qualified to address the different parts that need healing? (This question involves learning that different types of practitioner may be recognized as capable of treating different aspects of the illness. Pediatricians may be seen as the best qualified caregivers for certain dimensions and not for others. Families may seek help for their children from different kinds of practitioners, ranging from physicians to priests, acupuncturists, and shamans).

7. What do the child and family mean by efficacy, or healing? (This question addresses what the child and family mean by efficacy. It is important to learn why the child and family think their specific actions have worked, according to their understanding of efficacy. The key issue is what a child and a family mean by healing. The term may also have multiple meanings for them).

Medically, the authors suggest several additional approaches to constructively integrating spirituality and religious issues into medical education. Of particular utility are good teaching cases that reflect the complex issues involved in wise decision-making when the cultural world of biomedicine meets the religious worldviews of patients and families. These cases can reflect the growing religious and cultural complexity of the United States, and ensure that spiritual/religious issues not be presented as nothing more than obstacles to adherence.

During clinical rotations, such teaching cases could become a standard part of the pediatric rotation, with students being encouraged to reflect on how the issues raised in the case studies may have a bearing in the cases they see. In collaboration with chaplains and/or the community advisors, students could also learn to include appropriate questions on spirituality in their interactions with parents and children, discovering whether and in what ways spiritual and religious dimensions inform how the family and child understand a given case. Learning to take this kind of history could also be incorporated into resident training, with the clearly stated expectation that it be routinely practiced, so that students will see it in practice. Related continuing medical education courses could also be offered for physicians, and should be designed to help them better understand the particular cultural populations they most regularly serve.

Research

Based on their review of the literature, the authors suggest that the following research areas could prove fruitful. Given the diversity and importance of spiritual beliefs, it would be extremely constructive to examine how children develop faith and religious worldviews from a cross-cultural perspective and how these views influence views of health and health care. Valid and reliable measures of diverse religious and spiritual beliefs, practices, and processes for children and their families must also be developed. These measures may need to be tradition-specific to avoid the bias that can result from assessing one form of spirituality or religion according to the criteria of another.

Religious and spiritual clinical interviewing tools appropriate for the pediatric therapeutic interaction in the culturally diverse population of the United States also need to be developed and evaluated. Longitudinal studies should assess the impact of religious and spiritual beliefs, practices, and processes on both process and outcome measures. Process measures could include medical decision-making, adherence to medical regimens, coping, and formation of resilience. Outcome measures could include psychological health, physical health, spiritual health, quality of life, satisfaction with biomedical care, frequency of health risk and health-promoting behaviors, and measures of social functioning and competency.

In line with emerging models of integrative medicine, there is a need for developing and evaluating new and existing health care delivery models that
integrate spiritual and religious resources with biomedical and public health resources. These could range from increased collaboration among health care providers, chaplains, and spiritual health caregivers from the different traditions represented locally, to increased partnering between biomedical and faith communities in promoting health prevention and deterring health risk behaviors in children and adolescents.

Guidelines further defining ethical boundaries and responsibilities of health care providers should be developed in relation to conflicts arising between biomedical and currently less familiar religious and spiritual beliefs, practices, and processes. It would also be useful to design and evaluate programs that assess health care provider self-awareness of personal religious and spiritual beliefs and their impact on health care delivery, coping, sense of self-efficacy, and relationship with patients.

The National Institutes of Health National Center for Complementary and Alternative Medicine has called for research on traditional healing systems, some of which include systems within religious frameworks (eg, Indian Ayurveda, Native American practices), particularly as these relate to the health of women and children. Defining and characterizing the religious therapies being used by different local cultural groups may be the first step toward qualifying for this call. This approach could lead to developing and evaluating comprehensive, culturally sensitive, and diverse religious- and spiritually-based clinical interventions, and to the assessment of the impact of these interventions in prospective, double-blind, randomized, and controlled trials. The National Institutes of Health National Center for Complementary and Alternative Medicine has also issued a call for research in frontier medicine, defined as including therapeutic prayer and spiritual healing. There is also a need to analyze how specific sociocultural variables such as racism, class difference, economic barriers to medical care, and gender differences influence how and why people engage in religious therapies.

CONCLUSION

Spirituality and religion can serve as key organizing principles in the lives of children and their families, particularly in relation to children’s illness, health, and healing. The topics of spirituality and religion have slowly gained currency in relation to biomedical practice, but many pediatricians have not felt comfortable addressing these matters. Few feel prepared to do so, which increases the chances of potential misunderstanding, and obstacles to coordinated care. The changing religious and cultural landscape of the United States makes it imperative that pediatricians understand the role of diverse spiritual and religious issues in the context of pediatric practice. Through enhanced skills in clinical practice, developing health policy and curricula, and pursuing a research agenda to support the inclusion of spirituality and religion in relation to pediatrics, it will be possible to link the best scientific practice with attention to the spiritual and religious needs of children and families as an integral part of good pediatric care.

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