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Integrating Spiritual Care Into Pediatric Healthcare: Insights from the Dutch Model

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Abstract
This article examines the integration of spiritual care into pediatric healthcare, with a focus on the Dutch model at Erasmus MC–Sophia Children's Hospital in Rotterdam, the Netherlands. The extent to which interdisciplinary spiritual care supports the psychological resilience and emotional well-being of children and their families is investigated. Given the hospital's patient demographics and staff composition, numerous insights are drawn from encounters with Muslim patients and spiritual caregivers. A qualitative, multi-source design is employed, combining a literature review, hospital observations, interviews with spiritual caregivers, and semistructured interviews with parents to illuminate family perspectives. Care practices, child-centered communication, and the institutional structures enabling service delivery are analyzed. The Dutch model represents a comprehensive, interdisciplinary approach in which spiritual care is legally recognized and professionally institutionalized. Services are tailored to children's developmental needs and are culturally responsive, extending support beyond religious practice to encompass existential and psychosocial dimensions. The presence of trained spiritual caregivers in clinical teams has been found to reduce anxiety, enhance coping mechanisms, and foster a sense of emotional security among both patients and family caregivers. The findings suggest that the integration of spiritual care into pediatric healthcare can significantly improve patient–family outcomes and promote holistic well-being. Transferable insights are offered by the Dutch example for countries seeking to formalize and expand spiritual care within healthcare systems. It is recommended that policy-level support, interdisciplinary collaboration, and professional training be prioritized in developing sustainable, child-centered spiritual care frameworks.

Keywords Spiritual care · Pediatric healthcare · Dutch healthcare model · Psychological resilience · Interdisciplinary approach

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Introduction

Spiritual care has been defined as a professional healthcare service intended to support individuals in navigating the psychological, spiritual, and existential challenges encountered during illness (Karagül, 2012). Over time, the scope of this service has extended beyond religious rituals to encompass a multidimensional support mechanism that contributes to the process of meaning-making for patients and their families. In this context, efforts have been directed not only toward physical recovery but also toward strengthening emotional and mental well-being.

In many Western countries, spiritual care has been institutionally integrated into healthcare systems for several decades. In the Netherlands, for instance, spiritual care has been established as an independent discipline within hospitals, with trained professionals recognized as part of multidisciplinary teams. Within this framework, systematic spiritual care services have also been developed specifically for pediatric patients, including those with chronic or terminal illnesses.

In other healthcare systems where spiritual care has not yet been formally institutionalized, various structural challenges continue to be observed. These include insufficiently developed service models and limited interprofessional coordination (Ağılkaya-Şahin, 2016). Although initial efforts have been undertaken in certain institutional contexts to incorporate spiritual support through religious counseling or chaplaincy services, a fully integrated and interdisciplinary approach remains an ongoing need.

It has been emphasized in the literature that spiritual care for pediatric patients requires a distinct and specialized approach compared to that for adults. Given the psychological trauma, fear of death, and risks of developmental disruption associated with prolonged hospitalization, spiritual care is reported to support children's coping and psychological resilience during treatment (Bakker et al., 2018; Sülü Uğurlu & Başbakkal, 2013). Moreover, it has been argued that children begin to form spiritual orientations from an early age and that appropriate spiritual support during this stage may significantly strengthen their emotional stability and resilience (Özdoğan, 2008).

The aim of this study is to analyze the Dutch model of spiritual care for pediatric patients and to extract transferable insights that may inform the development or enhancement of spiritual care frameworks in diverse healthcare systems. The theoretical underpinnings of the Dutch model, the structures designed for pediatric patients and their families, and the roles of healthcare professionals in these services are examined. Additionally, the study considers the broader global context in which spiritual care is increasingly recognized as a component of holistic pediatric healthcare, and it offers strategic recommendations to support the institutionalization of sustainable, culturally responsive spiritual care models across various health systems. While the primary aim of this study is to examine the structure and implementation of pediatric spiritual care within the Dutch interdisciplinary model, it also considers how such care influences the emotional resilience of children and their families. The study does not aim to generalize about Islamic spiritual care. Instead, it reflects the demographic composition of the observed patient population, in which a significant number of families identify as Muslim. This context-specific focus is designed to offer a grounded understanding of spiritual care practices shaped by cultural and religious diversity within clinical settings. This approach aligns with the recent national Dutch quality standard on meaning-making and spirituality in psychological healthcare (AKWA GGZ, 2023). This standard emphasizes the importance of integrating spiritual dimensions into routine care practices. Accordingly, this study explores spiritual care as a dual process

that engages both children and their caregivers. Drawing from the same qualitative dataset, the findings are presented as distinct analyses of children's and parents' experiences.

Methodology

A qualitative research design was employed to explore the structure and implementation of spiritual care services for pediatric patients. Data collection comprised a literature review, nonintrusive field observations, and semistructured interviews. Relevant scholarly and regional sources were systematically examined to establish the study's theoretical foundation, with particular attention to gaps in research on pediatric spiritual care (Creswell, 2013).

Observational data were gathered in hospital settings where spiritual care was actively practiced. These observations provided insight into the psychosocial conditions of pediatric patients and their families, the contextual challenges encountered during care, and the organizational environment in which services were delivered. The perceived effects of spiritual care on patient well-being and family coping were noted to contextualize subsequent analyses.

To obtain practice-based perspectives, semistructured interviews were conducted with spiritual care professionals and with parents of hospitalized children. The interview protocol focused on practitioners' roles in emotional support, approaches to spiritual engagement, and interdisciplinary collaboration. In total, three family units (parents/primary caregivers; $N=3$) and six certified spiritual caregivers (Dutch: *geestelijke verzorgers* [GV]) at Erasmus MC–Sophia Children's Hospital in Rotterdam, the Netherlands, were interviewed. Participants were recruited via purposive sampling on the basis of direct experience with pediatric, palliative, and intercultural care. All interviews were conducted in person and lasted 45–75 min. Interviewees represented diverse professional and religious backgrounds (including Christian, Islamic, and humanistic traditions), reflecting the hospital's pluralistic service structure. Parent interviews were conducted by the author.

Due to ethical and developmental considerations, direct interviews with pediatric patients were not conducted. Children's needs and responses were inferred from caregiver narratives and detailed field observations; while young children and adolescents were observed during spiritual care sessions, the primary data were obtained from adult care providers with extensive experience across developmental stages.

Interview data were transcribed verbatim, coded, and analyzed using thematic analysis within a grounded-theory orientation. Field observations were conducted across four weeks in 2015 during hospital visits, with attention to patient–caregiver interactions, team dynamics, and environmental factors. Observations remained non-intrusive and were used to triangulate and contextualize interview findings. All observations and interviews were conducted by the author. Throughout data collection, reflexive memoing documented researcher role, positionality, and potential biases; these memos informed coding decisions and theme consolidation to enhance analytic rigor.

Insights from early field observations informed refinements to the interview guide, and the literature review provided sensitizing concepts that shaped both observation foci and thematic coding, resulting in an iterative, triangulated design. The research design was guided by Creswell's (2013) framework for qualitative inquiry, incorporating elements from narrative, ethnographic, and case-study approaches to integrate theoretical and experiential perspectives.

Theoretical foundations of spiritual care

Recent meta-analytical findings confirm the therapeutic potential of spirituality-based approaches when integrated into standard mental health treatment, further legitimizing spiritual care as a clinically relevant domain (Bouwhuis-Van Keulen et al., 2023). Spiritual care is recognized as a professional service that addresses the spiritual, emotional, and existential needs of patients and their families. It goes beyond religious rituals and is grounded in interdisciplinary frameworks that combine psychological, social, and ethical dimensions (Karagül, 2012).

In the Dutch context, the core principles of spiritual care are formally defined in the *Professional Standard for Spiritual Caregivers* issued by the Dutch Association for Spiritual Care (Vereniging van Geestelijk VerZorgers [VGVZ], 2015). In this professional standard, spiritual care is defined as professional, ethically grounded support for meaning-making and existential concerns across worldviews, delivered in collaboration with clinical teams and responsive to developmental and cultural needs. This framework outlines ethical responsibilities, interdisciplinary collaboration, and institutional integration, forming the basis of spiritual care practice in healthcare. Recent Dutch studies offer further insights into pediatric spiritual care; Smit (2015) emphasizes a dialogical, presence-based approach in counseling, while Falkenburg (2021), based on qualitative research at Erasmus MC-Sophia, highlights the fragile and evolving spirituality of seriously ill children and their families. Furthermore, Schoot et al. (2024) developed and validated a Dutch competency scale (SCCQ NL), underscoring the need to assess professional capacity in spiritually sensitive care.

Three primary models of spiritual care are commonly identified in the literature. The proclamation and guidance model delivers spiritual advice in a directive, often nonadaptive way (Karagül, 2012). The therapeutic model incorporates psychotherapeutic techniques, supporting emotional processing and insight within the patient's belief system (Heitink, 1998). The consolation and exegesis model uses a client-centered approach focused on existential dialogue and empathetic reflection (Dijkstra, 2007).

Spiritual care for children presents distinct challenges, as it must consider not only medical needs but also emotional and developmental factors. Research indicates that such care helps alleviate anxiety, foster psychological resilience, and nurture a hopeful outlook during illness (K. M. Moore, 2015). It has also been linked to better psychological adaptation in long-term treatments.

In addition to its benefits for children, spiritual care supports families navigating uncertainty and emotional distress. Parental spirituality has been shown to influence children's emotional responses to illness, highlighting the importance of family-integrated care models (Koenig, 2013; Pompele et al., 2022).

The institutionalization of spiritual care varies across healthcare systems. In some countries, it is a legally recognized, interdisciplinary service delivered by trained spiritual caregivers embedded within clinical teams (Heitink, 1998). In contexts where structures are less developed, however, spiritual care often remains informal and limited to religious advice, underscoring the need for structured education, policy development, and interprofessional cooperation.

Spiritual care in pediatric settings is thus understood as a multidimensional intervention that not only supports the child's psychological well-being but also reinforces familial coping. The integration of developmental psychology, pastoral care, and

communication sciences is considered essential for effective implementation (Özdoğan, 2008; Rodriguez, 2025).

Spiritual communication with children and families

Effective communication is recognized as a core component of spiritual care, particularly in pediatric contexts. It enables practitioners to establish trust, provide emotional reassurance, and address the psychological needs of both children and their families (Bierkens, 1986; Doğan, 2009).

Spiritual care professionals are expected to apply active listening strategies that go beyond hearing to include empathetic presence and emotional engagement. Environmental conditions, such as noise and clinical atmosphere, have been shown to influence communication quality in hospital settings (Dijkstra, 2007; Gümrükçüoğlu, 2013). In pediatric care, developmentally appropriate feedback is essential to ensure children feel heard and secure (Dökmen, 2009).

Verbal communication must also be adapted to the cognitive level of the child. The use of concrete, simple language is recommended, especially when addressing abstract spiritual or religious concepts (Bilgin, 1995; Köylü, 2004). Constructive and gentle language has been found to contribute positively to children's psychological resilience (Doğan, 2009). The use of kind and constructive language is highlighted not only in psychological frameworks but also in spiritual texts such as the Qur'an, where the importance of gentle speech is associated with compassion and interpersonal harmony (Qur'an 2:83, 4:63).

Empathy plays a critical role in supporting pediatric patients. An empathetic approach helps reduce anxiety, fosters a sense of security, and enhances the efficacy of spiritual care interventions (Ganzevoort & Visser, 2012; Sabuncuoğlu & Gümüş, 2008). For children undergoing long hospitalizations, a framework rooted in patience, affection, and emotional sensitivity is especially important (İnal & Akgün, 2003).

Professionalism in spiritual care requires not only theological knowledge but also competence in psychology, ethics, and interpersonal communication (Hanrath, 2002; Seyyar, 2010; VGVZ, 2015). These competencies have been shown to significantly shape the quality and differentiation of care in mental health contexts as spiritually competent professionals tend to offer more comprehensive and personalized support (De Diego-Cordero et al., 2023). Spiritual care specialists are considered integral members of interdisciplinary teams and are expected to contribute to the overall quality of healthcare services (Peeters, 2006).

Importantly, emotional connection, including the expression of balanced affection, has been identified as a meaningful dimension of spiritual care for children. Practices such as attentive presence, empathetic dialogue, and compassionate interaction are regarded as essential to establishing effective support mechanisms.

The legal and institutional framework of spiritual care in the Netherlands

Spiritual care in the Netherlands is supported by a robust legal and institutional structure that ensures its integration into the national healthcare system. Article 6 of the Dutch Constitution guarantees freedom of religion and belief, which provides a foundational legal basis for the provision of spiritual care in public institutions. Additionally, the Dutch

Health Quality, Complaints, and Disputes Act (Wet kwaliteit, klachten en geschillen zorg, 2024) mandates that healthcare institutions must facilitate access to spiritual care as part of quality healthcare services. Within hospitals, spiritual care is recognized as an essential component of multidisciplinary treatment teams. Professionals in this field are employed as permanent staff and actively participate in policy discussions and treatment planning, particularly in pediatric and palliative care settings (Heitink, 1998). Their responsibilities extend beyond religious support to include psychosocial and existential guidance, enabling them to address the comprehensive needs of patients and their families.

The legal framework has also influenced training and certification standards. Spiritual care providers are required to complete advanced academic education in theology, ethics, psychology, or related disciplines, and often undertake clinical pastoral training. This formalization enhances the credibility and professional status of the field (Bal Koçak, 2015). Recent developments, such as the validation of a national competence measurement tool (SCCQ NL), further emphasize the need for standardization and continued professional development (Schoot et al., 2024).

In addition, Dutch healthcare institutions foster collaboration between spiritual caregivers and medical staff. The existence of a legally recognized and publicly funded framework ensures consistent access to spiritual support across hospitals. This model not only strengthens the psychological resilience of patients and families but also supports the emotional well-being of healthcare professionals (Peeters, 2006).

Overall, the Dutch example illustrates how legal recognition, standardized education, and institutional commitment are key to integrating spiritual care into health systems. It offers a valuable blueprint for countries aiming to move beyond traditional religious roles toward a more holistic, patient-centered model of care. The national legal-institutional framework outlined above serves as the reference point for the organizational account that follows. Section 4 shows how this framework is operationalized at Erasmus MC–Sophia, with points of convergence and context-specific adaptation to the general Dutch model noted for clarity.

Pediatric spiritual care at Erasmus MC-Sophia Hospital

In the Netherlands, spiritual care has been integrated into the healthcare system as a recognized profession supported by legal and institutional frameworks. At Erasmus MC-Sophia Children's Hospital, spiritual care is delivered by trained professionals known as spiritual caregivers (GV) who are embedded in multidisciplinary care teams (Heitink, 1998; VGVZ, 2015). These professionals provide individualized support to pediatric patients and their families, addressing spiritual, emotional, and psychosocial needs.

A key element of the hospital's approach is the emphasis on building trust with children through developmentally appropriate methods. Techniques such as play therapy, storytelling, and creative expression are commonly employed to help pediatric patients articulate their emotions and engage with spiritual themes in a safe and age-appropriate manner (Rullmann & Reinders, 2006). This strategy is supported by recent research highlighting the unique value of arts-based approaches in spiritual healthcare, especially in fostering meaning-making in pediatric settings (Laranjeira & Querido, 2023). Establishing trust is viewed not as a single event but as a gradual and ongoing process, with each interaction serving as an opportunity to reinforce the child's emotional resilience throughout the course of their illness.

Given the multicultural composition of Dutch society, Erasmus MC-Sophia provides spiritual care across various belief systems, including Islamic, Christian, Jewish, Hindu, and humanistic traditions (AKWA GGZ, 2023; VGVZ, 2015). Insights from early field observations informed subsequent refinements to the interview guide, while the literature review provided sensitizing concepts that shaped both observation foci and thematic coding, creating an iterative, triangulated design. Dedicated programs have been developed for Muslim patients and families, including the creation of prayer spaces and the use of culturally sensitive storytelling and art-based interventions.

Spiritual care services are offered not only to children but also to their families, especially during critical moments such as end-of-life care. In palliative settings, professionals provide both emotional and spiritual support to assist families in coping with grief and uncertainty (Peeters, 2006). The hospital also implements group sessions and one-on-one consultations for parents navigating complex emotional experiences.

By prioritizing empathy, trust, and culturally responsive care, Erasmus MC–Sophia exemplifies a holistic model of pediatric spiritual care. Collaboration with medical staff ensures that spiritual needs are addressed alongside clinical treatment, creating a supportive environment for children and their families (Bal Koçak, 2015; Mooij-Kemp, 2006). Spiritual caregivers at Erasmus MC–Sophia participate in interdisciplinary care teams (*kindercomfortteams*), joining weekly meetings with physicians, nurses, psychologists, and social workers. Their remit encompasses individual support for patients and families as well as ethical consultation and facilitation of team communication. In practice, this integrated approach involves regular comfort-team huddles, ad hoc ethical case discussions, and warm handovers between clinicians and spiritual caregivers. To support continuity, contributions are summarized in the electronic health record, and joint family meetings are convened at clinical inflection points (e.g., transitions to palliative trajectories) to align care plans.

The impact and effectiveness of spiritual care on children

Understanding the impact of spiritual care on children requires an initial clarification of the concept of childhood within legal and developmental frameworks. For the purposes of this study, childhood is defined as the period from birth to 18 years of age, in accordance with civil law (Doğan, 2009). Research suggests that spiritual development begins in early life, even during the prenatal period, as children are influenced by the spiritual environment in which they are immersed (Yüksel, 2013). Although infants may not directly participate in religious rituals, the sense of emotional and spiritual security experienced during this stage is believed to shape future belief systems.

It has been proposed that the trust a child develops in their parents may later translate into spiritual trust or belief in a higher power. A nurturing relationship grounded in love and respect is considered beneficial to the formation of moral and spiritual values (Kirkpatrick & Shaver, 1990). In Islamic thought, the proper and consistent transmission of religious values during early development is emphasized as a determinant of long-term moral orientation. Spiritual care therefore plays a significant role in helping children internalize religious and ethical values. Observational learning and imitation are central to how children acquire religious behavior in their early years, which later evolve into conscious belief and practice (Yavuz & Şirin, 2011). Consequently, it has been recommended that

spiritual care interventions be tailored to the child's age, cognitive abilities, and developmental stage (Selçuk, 1991).

Within the hospital environment, children often face psychological challenges arising from illness, including fear, sadness, and isolation. These difficulties tend to intensify during long-term treatment or chronic conditions (Hökelekli, 1991). Spiritual care in this context has been associated with the enhancement of emotional resilience, providing children with a sense of strength and continuity throughout the healing process. However, Miller and Kelley (2005) researchers have cautioned that rigid or dogmatic religious interpretations may lead to anxiety, fear, or psychological strain. Such approaches are considered potentially harmful and counterproductive to a child's spiritual development. Therefore, spiritual care services should be delivered in a manner that fosters psychological well-being while reinforcing emotional and moral growth.

To achieve these outcomes, spiritual care specialists are expected to develop age-appropriate communication strategies aligned with children's cognitive and emotional development. For instance, the use of prayer can be introduced as a comforting tool, explained in terms that are accessible and reassuring. Phrasing such as "Would you like to pray together?" or "You may say your own words to God" can facilitate active participation and emotional inclusion. Framing illness as a temporary difficulty and emphasizing hope has been shown to support coping and enhance meaning-making in pediatric patients. From a practical perspective, spiritual care practices in Dutch hospitals provide a compelling example of holistic child-centered approaches. During religious holidays or special occasions, hospital environments are adapted to incorporate symbolic and celebratory elements, including decorations, storybooks, and spiritual activities suited to children's developmental levels (Kuyk, 2006). These practices go beyond ritual to promote a sense of belonging and emotional continuity in clinical settings.

In addition to environmental design, the Dutch model highlights the intentional inclusion of core spiritual concepts such as patience, gratitude, and trust within care sessions. These values are conveyed using pedagogical techniques adapted to the child's level of understanding. Communication methods are customized during individual sessions to support the child's exploration of spiritual meaning and to encourage personal expression in a safe and supportive context (Türker-Şahin, 2011).

Taken together, these insights underline the importance of developmentally appropriate, emotionally sensitive, and pedagogically informed spiritual care as a vital component of pediatric health services. When effectively implemented, such care not only contributes to children's spiritual development but also enhances their overall capacity for psychological resilience during hospitalization and beyond.

Case illustrations of pediatric spiritual care at Erasmus MC-Sophia Hospital

At Erasmus MC-Sophia Children's Hospital, spiritual care services are provided as a multidimensional support mechanism for both pediatric patients and their families. These services are structured to meet spiritual, emotional, and psychosocial needs throughout the healthcare journey. The following three cases illustrate the implementation of spiritual care in real clinical contexts and highlight its role in enhancing coping capacities and relational dynamics during illness. The vignettes are composites derived from field observations and

spiritual caregivers' narratives; all personal identifiers are anonymized and minor details modified to protect privacy without altering the analytic meaning.

Case 1: A 2-year-old leukemia patient and her mother

This case focuses on the spiritual care process involving a 2-year-old girl diagnosed with leukemia and her mother. The psychological distress experienced by the mother, compounded by communication challenges with hospital staff, revealed a significant need for spiritual support. Through active listening, the spiritual care provider facilitated emotional expression and psychological relief (Bierkens, 1986). Additionally, the specialist contributed to resolving tensions between the family and medical personnel, functioning not only as a provider of religious care but also as a mediator offering psychosocial guidance (Puchalski et al., 2014). Spiritual care interventions, including guided prayer and presence-based accompaniment, helped reduce the caregiver's sense of isolation and enhanced her capacity to navigate the medical process. The mother, who came from a non-Dutch-speaking background, experienced heightened anxiety and disorientation during her child's chemotherapy. The caregiver applied narrative-based techniques and incorporated short prayers in the mother's native language, creating a culturally safe space for expression. These personalized efforts helped ease her distress, improved her trust in the clinical team, and fostered a greater sense of partnership in the child's care.

Case 2: Parents of a 24-week premature infant

The second case centers on a couple whose infant was born at 24 weeks gestation and faced a high risk of mortality. Both parents, who came from a migrant background and lacked extended family in the Netherlands, experienced intense emotional distress and social isolation. The spiritual caregiver maintained regular contact, offering culturally attuned religious reassurance and mediating communication with NICU staff. During a particularly critical phase, the caregiver's composed presence supported the parents in making emotionally complex decisions amid medical uncertainty. Coping practices such as prayer were adapted to the family's faith tradition, helping reduce anxiety and reinforce emotional stability (Ganzevoort & Visser, 2012; Peeters, 2006). Cultural and language challenges deepened their vulnerability, making the caregiver's role essential not only for spiritual grounding but also for psychosocial navigation. This case illustrates how tailored spiritual interventions can simultaneously foster resilience, trust, and informed engagement in high-stress pediatric care settings (Dijkstra, 2007).

Case 3: An 11-year-old with chronic respiratory illness

The third case involves an 11-year-old child hospitalized for an extended period due to chronic respiratory disease. Long-term hospitalization created challenges related to education, social isolation, and psychological endurance (Kuyk, 2006). The child, struggling with separation from peers and missing daily school activities, developed signs of emotional fatigue and withdrawal. To address these needs, the spiritual caregiver introduced therapeutic storytelling sessions, where the child could engage in symbolic play and narrate personal experiences through metaphors. Drawing activities were also facilitated to help externalize fears and hopes in a safe and creative space.

In addition to working with the child, the caregiver provided emotional counseling to the mother, who was showing signs of burnout due to prolonged stress and caregiving demands. The mother was supported through regular conversations focusing on emotional resilience, spiritual patience, and hope. The spiritual caregiver also liaised with the medical team to coordinate psychosocial support and helped the family access broader hospital resources, including peer support initiatives and family counseling programs. These interventions made the hospital environment more tolerable and supported the child's psychological adaptation. The collaboration between the spiritual care provider and the family played a central role in managing the child's illness process. The integration of personalized encouragement, moral support, and interdisciplinary coordination contributed to better coping, enhanced emotional resilience, and sustained family engagement in the treatment process (Bal Koçak, 2015; Sabuncuoğlu & Gümüş, 2008).

The three case illustrations also suggest nuanced differences between the spiritual needs of children and their parents. While children often required age-appropriate emotional expression and trust-building through play or storytelling, parents primarily sought guidance, meaning-making, and emotional stabilization under stress.

Insights from spiritual care specialists: core dynamics and challenges

As part of this study, semistructured interviews were conducted with certified spiritual caregivers (GVs) to examine the core components of practice, implementation processes, and associated challenges. Participants represented different faith traditions (e.g., Muslim, Christian, humanist) and role emphases (e.g., pediatric, palliative, intercultural) and brought varied field experience. The analysis focused on the values that guide their work, communicative approaches, ethical considerations, and strategies for addressing complex emotional needs. A central theme emerging from the interviews was the necessity of an individualized and empathy-based approach. Practitioners emphasized that spiritual care must be tailored to the client's emotional state, belief system, and personal history. Rather than offering prescriptive advice, specialists sought to create a supportive space that would enable patients and families to explore their own meaning-making processes. In this context, ethical sensitivity, cultural competence, and emotional neutrality were consistently cited as foundational principles.

Professionals also underscored the importance of maintaining respect for clients' beliefs without projecting personal ideologies. This aligns with previous findings emphasizing the need for ethical neutrality and cultural sensitivity in spiritual care (Bal Koçak, 2015; Ganzevoort & Visser, 2012). The role of spiritual care was framed not as religious instruction but as guidance through emotional and existential complexity. In multicultural settings, practitioners reported the need for inclusive, adaptable approaches that acknowledge diverse spiritual worldviews. Interviewees reported using a range of individualized support methods. These included life-story reflection, symbolic language, guided prayer, and silent presence. Many emphasized the value of nonverbal cues, including body language and tone, to foster a sense of trust and emotional safety. Strategies varied according to the needs of the individual, but all aimed at fostering connection and facilitating meaning.

Several challenges were identified in the delivery of spiritual care. First, clients experiencing trauma often encountered spiritual crises or belief conflicts. Practitioners described such cases as emotionally intense, requiring patience and careful listening. Rather than providing direct answers, they aimed to support the client in articulating their own insights.

Another common difficulty involved misconceptions about spiritual care. In some settings, these services were narrowly perceived as religious in nature, which discouraged potential beneficiaries. Practitioners responded by educating healthcare teams and families about the broader scope of spiritual care, emphasizing its psychological and emotional dimensions.

The emotional burden of continuously engaging with individuals in distress was also frequently mentioned. This concern echoes earlier studies highlighting the importance of professional supervision and institutional support structures to prevent burnout (Hanrath, 2002; Peeters, 2006). Specialists acknowledged the risk of burnout and highlighted the importance of supervision, peer support, and reflective practice. Institutional mechanisms for self-care and emotional protection were viewed as essential to professional sustainability. Effective communication was consistently identified as a cornerstone of practice, particularly in contexts requiring sensitive engagement with pediatric patients. This emphasis aligns with prior literature highlighting the role of structured and empathic communication in spiritual care (Dijkstra, 2007; Dökmen, 2009). Interviewees described their interactions as rooted in empathy, active listening, and emotional attunement. Open-ended questions such as "What is most meaningful to you right now?" and the use of silent presence were reported as key strategies for building trust. Nonverbal communication, including facial expression, posture, and vocal tone, was also cited as a means of conveying understanding and emotional safety. These subtle cues were considered particularly valuable in establishing rapport with pediatric patients and families experiencing acute stress. Overall, the interviews revealed that spiritual care is not merely a collection of techniques but rather a complex, ethically grounded, and emotionally responsive professional practice. It is based on individualized support, deep interpersonal connection, and the capacity of the practitioner to facilitate reflective processes without judgment. These findings offer valuable direction for enhancing training curricula, institutional policies, and interdisciplinary collaboration in spiritual care services.

Strategic considerations for integrating spiritual care in pediatric healthcare

The integration of spiritual care into pediatric healthcare systems requires careful attention to structural, professional, and cultural dimensions. Insights derived from the Dutch model highlight the importance of institutional recognition, interdisciplinary collaboration, and context-sensitive implementation strategies (Bal Koçak, 2015; Heitink, 1998). One of the critical factors contributing to the successful incorporation of spiritual care is its legal and professional acknowledgment. When spiritual care is recognized as a legitimate healthcare service and supported through regulatory frameworks, it becomes possible to embed it systematically into hospital operations. In such systems, spiritual care providers are formally employed, granted access to patients and families, and participate in multidisciplinary care teams. These structural elements ensure that spiritual needs are addressed alongside physical and psychological ones (Peeters, 2006).

Equally important is the preparation and training of spiritual care professionals. Effective service delivery depends on interdisciplinary competence, which includes knowledge of developmental psychology, ethics, communication, and pastoral or spiritual counseling. In the pediatric context, this interdisciplinary skill set is essential for understanding age-specific needs and for engaging children and families in meaningful, nondirective ways (Bal Koçak, 2015; Mooij-Kemp, 2006). Institutional collaboration is also a key driver of

successful implementation. Spiritual care should not operate in isolation but should be integrated with clinical, psychological, and social services. Interprofessional communication channels, shared decision-making processes, and routine consultation with spiritual care providers help to align spiritual support with the broader care goals of the medical team (Ganzevoort & Visser, 2012; Peeters, 2006).

Cultural adaptability further enhances the relevance and inclusiveness of spiritual care services. In increasingly pluralistic societies, spiritual care must accommodate diverse belief systems, values, and worldviews. This includes employing professionals from multiple traditions, offering inclusive rituals, and designing flexible support mechanisms that respect individual preferences without imposing doctrinal frameworks (Kuyk, 2006).

Another strategic consideration involves raising awareness of the scope and purpose of spiritual care among healthcare providers and patients. Misconceptions that spiritual care is limited to religious rites can undermine its potential. Educational efforts aimed at clarifying the holistic and supportive nature of spiritual care are essential for promoting access and acceptance within healthcare environments (Koenig, 2013; Rodriguez, 2025).

A further consideration, the sustainability of spiritual care, depends on institutional investment and evaluation. This includes allocating resources for professional development, creating supervision and support structures for caregivers, and conducting outcome-based research to assess the impact of spiritual care on patient and family well-being (Ganzevoort & Visser, 2012; Puchalski et al., 2014).

Collectively, these considerations underscore that spiritual care is most effective when implemented as a fully integrated, professionally grounded, and culturally sensitive component of pediatric healthcare. Models that combine regulatory support, interdisciplinary engagement, and inclusive practices offer scalable frameworks for healthcare systems seeking to strengthen the emotional and existential dimensions of patient care. At Erasmus MC-Sophia, interdisciplinary spiritual care is institutionalized through structured participation in care teams and shared decision-making. Spiritual caregivers are consulted during ethical dilemmas, end-of-life discussions, and care planning meetings. Their contributions are documented in the electronic patient record, enhancing continuity of care and ensuring spiritual needs are integrated into the broader healthcare trajectory.

The role of spiritual care in supporting the families of pediatric patients

Qualitative interviews were conducted to examine the impact of spiritual care services on the families of pediatric patients. Participants included parents of hospitalized children, relatives of patients in palliative care, and families with children in intensive care units. These interviews explored the psychosocial challenges experienced by family members, their perceived need for spiritual support, and the contributions of spiritual caregivers to their coping processes.

Across the interviews, parents and other close family members frequently described feelings of stress, helplessness, and emotional isolation during the illness trajectory of their children. Spiritual care was reported to play a meaningful role in addressing these psychological burdens. Participants emphasized that such care should not be limited to religious guidance but should adopt a holistic approach that includes spiritual, emotional, and social dimensions. Families who received support from spiritual caregivers noted reduced anxiety levels and greater emotional stability in coping with their child's illness (Okyay, 2008).

However, some families also reported difficulty accessing these services, highlighting the need for more consistent and structured availability in hospital settings.

A recurring theme was the communication gap between families and healthcare professionals. Physicians and nurses were often perceived as focusing primarily on clinical procedures, leaving emotional and spiritual needs insufficiently addressed. The involvement of spiritual caregivers was described as filling this gap by offering empathetic listening and psychosocial support. Their presence helped families feel less alone and contributed to the development of greater resilience. The hospital experience was widely described as traumatic for both children and their caregivers, reinforcing the importance of structured spiritual support mechanisms (Yavuz & Şirin, 2011).

Participants also indicated that spiritual care should extend beyond the hospital stay. In cases involving chronic illness, parents expressed the need for ongoing guidance through individual consultations, group therapy, and family-centered interventions (Bakker et al., 2018). This continuity of care was viewed as essential for managing long-term emotional stress and maintaining coping capacity throughout the illness process.

The significance of collaboration between spiritual caregivers and other healthcare professionals was also emphasized. It was noted that when physicians and nurses were knowledgeable about the role of spiritual care, they were more effective in guiding families toward appropriate resources. Interdisciplinary collaboration was viewed as contributing to more holistic and coordinated support systems (Puchalski et al., 2006).

Participants perceived spiritual care as particularly impactful in pediatric settings, where both children and their families face elevated emotional challenges. Children undergoing long-term treatment often described fear, loneliness, and uncertainty. In this context, families and caregivers linked spiritual care encounters with improved emotional adjustment and increased psychological resilience.

Parental coping was also reported to be supported through faith-based practices, which were frequently employed to maintain emotional strength. Families receiving structured spiritual counseling described more effective adaptation to the illness process, including lower stress and anxiety levels (Vithana & Asurakkody, 2025). Interviews with spiritual caregivers indicated that such support enhanced both children's motivation and parental resilience during hospitalization (Dijkstra, 2007; Koenig, 2013). Despite the reported benefits, limited awareness of spiritual care among healthcare staff was identified as a persistent barrier. Many professionals lacked adequate training in this area, which restricted effective collaboration with spiritual caregivers (Heitink, 1998; Karagül, 2012).

Discussion

The development of spiritual care has been historically shaped by religious traditions, particularly within Abrahamic frameworks, and has evolved significantly over time (Cobb et al., 2012). Within Christian contexts, spiritual guidance was traditionally provided by clergy, but with the professionalization of healthcare, these services have increasingly been delivered by academically trained specialists (Den Toom et al., 2023). In countries such as the Netherlands, the United States, and various European nations, spiritual care has become formalized through structured educational programs and institutional frameworks (Best et al., 2020). In the Dutch context, pediatric spiritual care is structured by legal provisions and institutional standards, ensuring access in inpatient settings (VGVZ, 2015). At Erasmus MC–Sophia, this is operationalized through a multifaith meditation/prayer center

and a multifaith chaplaincy team (Erasmus MC–Sophia, n.d.; Erasmus MC, n.d.). Interdisciplinary collaboration and clear referral pathways are emphasized as core to holistic and coordinated care (National Coalition for Hospice and Palliative Care, 2018).

The professionalization of spiritual care is viewed as essential for its effective integration into healthcare. Studies have underscored the importance of equipping spiritual caregivers with interdisciplinary training, including communication skills, ethical sensitivity, and developmental psychology (Bal Koçak, 2015; Puchalski et al., 2014). In pediatric contexts, these competencies are particularly critical as children's understanding of spirituality, illness, and death is deeply influenced by their cognitive development and emotional environment (Ferrell et al., 2016).

Building on these developmental insights, recent studies emphasize that spiritual support for children must address not only their beliefs but also their emotional and existential concerns. International research suggests that spiritual support for children must go beyond religious instruction to include meaning-making, emotional reassurance, and the facilitation of existential exploration (Cai et al., 2020; Cheng et al., 2024). The Children's Spiritual Lives scale developed by K. Moore et al. (2016) was cited as a valuable tool for assessing children's spiritual orientation and its relation to their well-being. Children facing serious illness have been observed to pose questions regarding mortality and the afterlife, and healthcare professionals, particularly nurses, play a central role in mediating these conversations (Ferrell et al., 2016; Llewellyn et al., 2013). Effective spiritual care requires providers to demonstrate empathy, presence, and the capacity to support individualized spiritual inquiry (Bal Koçak, 2015; Llewellyn et al., 2013).

The importance of integrating families into the spiritual care process is also well documented. Parents of pediatric patients often experience spiritual distress related to uncertainty, loss of control, and fear of death (Gullick et al., 2017). Active inclusion of families in spiritual care has been associated with improved psychological outcomes and increased resilience for both children and caregivers. Kelly et al. (2016) emphasize that assessing and addressing the spiritual needs of primary caregivers contributes to the overall therapeutic relationship and enhances the family's engagement with the care process.

In addition to individual and family-level interventions, the effective implementation of spiritual care also depends on its systemic integration within healthcare institutions. Research further indicates that spiritual care should be implemented through multidisciplinary collaboration. Studies in European healthcare settings, particularly in the Netherlands, have demonstrated that spiritual care is most effective when integrated into interdisciplinary treatment models and supported by institutional policies (Van de Geer et al., 2018). This integration fosters better coordination between medical staff, mental health professionals, and spiritual caregivers, ensuring that the holistic needs of patients and their families are met. When embedded in routine team workflows, spiritual care has functioned as a relational bridge between clinical information and lived experience, enabling more coherent goals-of-care discussions, fewer unresolved tensions, and steadier adherence to treatment plans. Taken together, these mechanisms underwrite gains in resilience for both children and family caregivers, particularly during prolonged hospitalization and at transition points such as escalation to intensive or palliative care.

While system-wide collaboration enhances the reach and structure of spiritual care, attention to developmental stages remains equally critical, particularly in pediatric settings. The developmental dimension of childhood spirituality has also been highlighted. Spiritual understanding in children is closely linked to their evolving perception of concepts such as trust, fear, and moral values. Studies have shown that children benefit most from spiritual care when services are tailored to their developmental stage and delivered in an

emotionally safe and age-appropriate manner (Elkins & Cavendish, 2004; Kirkpatrick & Shaver, 1990). Within this institutional configuration, measurable effects on both children and families have been observed at the levels of emotional regulation, meaning making, and participation in care. For children, developmentally appropriate encounters such as play, story, drawing, silence, and, where desired, ritual have been associated with reduced fear and uncertainty, clearer emotional expression, and a strengthened sense of safety in the clinical environment. For parents, greater calm, restored agency in complex decisions, and enhanced capacity to support the child have been reported, with downstream improvements in family communication and cohesion. Key themes such as love, patience, gratitude, and trust are considered essential in constructing supportive spiritual frameworks for children (Bal Koçak, 2015).

In addition to clinical practice, several studies emphasize the need for expanded educational programs, international knowledge exchange, and the adoption of best practices to advance the field (Cai et al., 2020). The inclusion of family support groups, bereavement counseling, and death education has been recommended as part of a comprehensive spiritual care approach. These strategies reflect a shift from exclusively religious interventions to more integrative and psychologically informed models (Hexem et al., 2011). In contrast, healthcare systems where spiritual care has been formally institutionalized, such as the Netherlands, offer more integrated and accessible services, anchored in professional standards and national quality guidance and embedded within multidisciplinary teams (AKWA GGZ, 2023; VGVZ, 2015). To advance spiritual care within pediatric healthcare, greater institutional commitment and policy-level support are required. Rather than viewing spiritual care as a supplementary or informal service, it must be recognized as a vital component of comprehensive, family-centered care. Establishing legal frameworks and interprofessional partnerships will be essential in ensuring the sustainability and scalability of such services across diverse healthcare systems. Institutionalizing spiritual care as a standards-based, team-embedded, and culturally sensitive service yields tangible gains in access, continuity, and interdisciplinary coordination within pediatric healthcare.

Lastly, while faith-based practices remain central to many families' coping strategies, a growing body of evidence supports the inclusion of humanistic and nonreligious approaches within spiritual care services. This pluralistic model is considered vital in addressing the diverse spiritual needs of patients in modern healthcare systems (Cai et al., 2020; Dijkstra, 2007; Koenig, 2013).

Conclusion

This study has explored the role and impact of spiritual care within pediatric healthcare, with particular emphasis on its structured application in hospital settings. Drawing from qualitative interviews, field observations, and case illustrations, the findings suggest that spiritual care plays a meaningful role in supporting the emotional and psychological well-being of pediatric patients, particularly those facing chronic illness, long-term hospitalization, or end-of-life conditions.

According to participants, spiritual care interventions contributed to reducing levels of fear, anxiety, and uncertainty in children. These interventions also supported emotional expression and enhanced psychological resilience during treatment. These benefits are closely associated with child-centered approaches that incorporate developmentally appropriate methods such as play therapy, storytelling, and creative expression. By facilitating

meaning-making and emotional support, spiritual care contributes to the holistic adaptation of pediatric patients to the hospital environment. The model implemented at Erasmus MC-Sophia Hospital exemplifies a structured and interdisciplinary approach to spiritual care in which professionals are integrated into healthcare teams and provide support not only to patients but also to their families. This integration enables a more responsive and emotionally sensitive care environment, reflecting the value of spiritual care as an essential component of pediatric health services.

The case illustrations further reveal that the spiritual needs of children and parents often differ. Children required trust-building, creative expression, and emotionally safe spaces, whereas parents frequently sought existential reflection, guidance in decision-making, and emotional stabilization. These findings reinforce the importance of extending spiritual care beyond the individual patient to the broader family system, particularly during emotionally intense moments in clinical care.

In light of these findings, healthcare systems aiming to strengthen holistic pediatric care are encouraged to consider the institutional integration of spiritual care services. Key strategies include developing training programs for professionals, fostering interdisciplinary collaboration, and establishing child- and family-centered spiritual support structures within hospital environments.

While this study presents practice-based insights into the impact of spiritual care, further empirical research is recommended to examine its long-term outcomes. Areas for future exploration include the effect of spiritual care on psychological resilience, family cohesion, and treatment adherence. A broader evaluation of spiritually integrated care models across different cultural and institutional settings will contribute to the evidence base for holistic pediatric healthcare.

Limitations and future research

This study is constrained by its single-site design and relatively small qualitative sample. For ethical and developmental reasons, no direct interviews were conducted with pediatric patients; children's perspectives were inferred from caregiver narratives and unobtrusive field observations. Access restrictions related to privacy and confidentiality prevented accompaniment of certain encounters at families' request; accordingly, case vignettes were constructed as composite and anonymized narratives to protect participants while retaining analytic meaning. These contextual features, together with the empirical reality that a substantial portion of the encounters during the study period involved Muslim families and Muslim spiritual caregivers, limit the generalizability of Muslim-specific examples beyond comparable settings. Future research should pursue multi-site longitudinal designs and employ standardized outcome measures to assess effects on coping, family communication, and care integration.

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Author Contributions The author conceptualized and designed the study; conducted the literature review, field observations, and interviews (including parent interviews); curated and analyzed the qualitative data; drafted the manuscript and prepared the responses to reviewers; revised and approved the final version; and is accountable for all aspects of the work.

Data Availability No datasets were generated or analyzed during the current study.

Declarations

Competing interests The author declare no competing interests.

References

Ağılkaya-Şahin, Z. (2016). Theoretical foundations of pastoral care in Christian tradition. *Spiritual Psychology and Counseling*, *1*(1), 68–77. https://doi.org/10.12738/spc.2016.1.0002

AKWA GGZ. (2023, May 16). *Nieuwe kwaliteitsstandaard zingeving in de psychische hulpverlening* [New quality standard for meaning in mental health care]. https://akwaggz.nl/nieuwe-kwaliteitsstandaard-zingeving-in-de-psychische-hulpverlening

Bakker, A. A. D., Van Leeuwen, R. R., & Roodbol, P. F. (2018). The spirituality of children with chronic conditions: A qualitative meta-synthesis. *Journal of Pediatric Nursing, 43*, e106–e113. https://doi.org/10.1016/j.pedn.2018.08.003

Bal Koçak, D. (2015). Çocuk hastalara ve yakınlarına uygulanan manevi bakım (Hollanda örneği) [Spiritual care applied to pediatric patients and their relatives: A Dutch example] [Unpublished master's thesis, Institute of Social Sciences, Ankara University]. Ankara, Turkey.

Best, M., Leget, C., Goodhead, A., & Paal, P. (2020). An EAPC white paper on multi-disciplinary education for spiritual care in palliative care. *BMC Palliative Care, 19*(1), Article 9. https://doi.org/10.1186/s12904-019-0508-4

Bierkens, P. B. (1986). *Woord en communicatie: Gespreksvoering in theorie en praktijk* [Word and communication: Conversation in theory and practice]. Dekker & Van de Vegt.

Bilgin, B. (1995). Çocuklarımızın duyguları ve duaları [Our children's feelings and prayers]. *Din Eğitimi Araştırmaları Dergisi*, (2), 69–78.

Bouwhuis-Van Keulen, A. J., Koelen, J., Eurelings-Bontekoe, L., Hoekstra-Oomen, C., & Glas, G. (2023). The evaluation of religious and spirituality-based therapy compared to standard treatment in mental health care: A multi-level meta-analysis of randomized controlled trials. *Psychotherapy Research, 34*(3), 339–352. https://doi.org/10.1080/10503307.2023.2241626

Cai, S., Guo, Q., Luo, Y., Zhou, Y., Abbas, A., Zhou, X., & Peng, X. (2020). Spiritual needs and communicating about death in nonreligious theistic families in pediatric palliative care: A qualitative study. *Palliative Medicine, 34*(2), 160–168. https://doi.org/10.1177/0269216319896747

Cheng, L., Cai, S., Zhou, X., & Zhai, X. (2024). In every detail: Spiritual care in pediatric palliative care perceived by healthcare providers. *Journal of Pain and Symptom Management, 67*(2), 167–172. https://doi.org/10.1016/j.jpainsymman.2023.11.005

Cobb, M., Puchalski, C. M., & Rumbold, B. (Eds.). (2012). *Oxford textbook of spirituality in healthcare*. Oxford University Press.

Creswell, J. W. (2013). *Qualitative inquiry and research design: Choosing among five approaches* (3rd ed.). SAGE.

De Diego-Cordero, R., López-Tarrida, Á. C., Linero-Narváez, C., & Galán González-Serna, J. M. (2023). "More spiritual health professionals provide different care": A qualitative study in the field of mental health. *Healthcare (Basel), 11*(3), Article 303. https://doi.org/10.3390/healthcare11030303

Den Toom, N., Kruizinga, R., Liefbroer, A. I., & Körver, J. (2023). The professionalization of chaplaincy in the Netherlands. *Journal of Health Care Chaplaincy, 29*(1), 14–29. https://doi.org/10.1080/08854726.2021.1996810

Dijkstra, J. (2007). *Gespreksvoering bij geestelijke verzorging: Een methodische ondersteuning om betekenisvolle gesprekken te voeren* [Conversation in spiritual care: A methodological support for conducting meaningful conversations]. Uitgeverij Boom.

Doğan, D. M. (2009). *Doğan Büyük Türkçe Sözlük* [Doğan comprehensive Turkish dictionary]. Vadi Yayınları.

Dökmen, Ü. (2009). *Sanatta ve günlük yaşamda iletişim çatışmaları ve empati* [Communication conflicts and empathy in art and daily life]. Remzi Kitabevi.

Elkins, M., & Cavendish, R. (2004). Developing a plan for pediatric spiritual care. *Holistic Nursing Practice, 18*(4), 179–184. https://doi.org/10.1097/00004650-200407000-00002

Erasmus MC–Sophia. (n.d.). Facilities & services (meditation/prayer center). https://www.erasmusmc.nl/en/patient-care/voorzieningen

Erasmus MC. (n.d.). *Islamitisch geestelijk verzorger* [Islamic chaplain] (staff profile). https://www.erasmusmc.nl/nl-nl/patientenzorg/zorgverleners/sahin-ozturk-samiye

Falkenburg, J. L. (2021). *Unveiling a fragile spirituality: Experiences of connectedness in pediatric palliative care* [Doctoral thesis, Vrije Universiteit Amsterdam]. https://research.vu.nl/en/publications/unveiling-a-fragile-spirituality-experiences-of-connectedness-in-

Ferrell, B., Wittenberg, E., Battista, V., & Walker, G. (2016). Nurses' experiences of spiritual communication with seriously ill children. *Journal of Palliative Medicine, 19*(11), 1166–1172. https://doi.org/10.1089/jpm.2016.0138

Ganzevoort, R., & Visser, J. (2012). Zorg voor het verhaal: Achtergrond, methode en inhoud van pastoraal begeleiding [Care for the story: Background, method and content of pastoral counseling]. Meinema, Zoetermeer.

Gullick, J., Krivograd, M., Taggart, S., Brazete, S., Panaretto, L., & Wu, J. (2017). A phenomenological construct of caring among spouses following acute coronary syndrome. *Medicine, Health Care and Philosophy, 20*(3), 393–404. https://doi.org/10.1007/s11019-017-9759-0

Gümrükçüoğlu, S. (2013). Din eğitiminde dil ve iletişim etkinliği olarak dinleme [Listening as a language and communication activity in religious education]. *Yalova Sosyal Bilimler Dergisi, 3*(5), 4–34.

Hanrath, A. C. H. (2002). *Bestaansgronden en verstandshorizon* [Foundations of existence and the horizon of understanding]. *Tijdschrift Voor Geestelijke Verzorging, 4*(23), 51–68.

Heitink, G. (1998). *Pastorale zorg: theologie, differentiatie, praktijk* [Pastoral care: Theology, differentiation, practice]. Kok.

Hexem, K. R., Mollen, C. J., Carroll, K., Lanctot, D. A., & Feudtner, C. (2011). How parents of children receiving pediatric palliative care use religion, spirituality, or life philosophy in tough times. *Journal of Palliative Medicine, 14*(1), 39–44. https://doi.org/10.1089/jpm.2010.0256

Hökelekli, H. (1991). Ölüm ve ölüm ötesi psikolojisi [The psychology of death and the afterlife]. *Uludağ Üniversitesi İlahiyat Fakültesi Dergisi, 3*(3), 151–165.

İnal, S., & Akgün, M. (2003). Hastanede yatan çocukta terapötik iletişim [Therapeutic communication in hospitalized children]. *Atatürk Üniversitesi Hemsirelik Yüksekokulu Dergisi, 6*(2), 67–76.

Karagül, A. (2012). Manevi bakım, anlamı, önemi, yöntemi ve eğitimi: Hollanda örneği [Spiritual care: Its meaning, importance, method, and education – The Dutch example]. *Dini Araştırmalar, 15*(40), 5–27.

Kelly, J. A., May, C. S., & Maurer, S. H. (2016). Assessment of the spiritual needs of primary caregivers of children with life-limiting illnesses is valuable yet inconsistently performed in the hospital. *Journal of Palliative Medicine, 19*(7), 763–769. https://doi.org/10.1089/jpm.2015.0509

Kirkpatrick, L. A., & Shaver, P. R. (1990). Attachment theory and religion: Childhood attachments, religious beliefs, and conversion. *Journal for the Scientific Study of Religion, 29*(3), 315–334. https://doi.org/10.2307/1386461

Koenig, H. G. (2013). *Spirituality in patient care: Why, how, when, and what*. Templeton Foundation Press.

Köylü, M. (2004). Çocukluk dönemi dini inanç gelişimi ve din eğitimi [Religious belief development and religious education in childhood]. *Ankara Üniversitesi İlahiyat Fakültesi Dergisi, 45*(2), 37–54. https://doi.org/10.1501/Ilhfak_0000000190

Kuyk, E. (2006). Geestelijk verzorgers in de jeugdzorg [Spiritual caregivers in youth care]. In J. Doolaard (Ed.), *Nieuw handboek geestelijke verzorging* (pp. 119–129). Kok.

Laranjeira, C., & Querido, A. (2023). An in-depth introduction to arts-based spiritual healthcare: Creatively seeking and expressing purpose and meaning. *Frontiers in Psychology, 14*, Article 1132584. https://doi.org/10.3389/fpsyg.2023.1132584

Llewellyn, H., Jones, L., Kelly, P., Barnes, J., O'Gorman, B., Craig, F., & Bluebond-Langner, M. (2013). Experiences of healthcare professionals in the community dealing with the spiritual needs of children and young people with life-threatening and life-limiting conditions and their families: Report of a workshop. *BMJ Supportive & Palliative Care, 3*(1), 1–7. https://doi.org/10.1136/bmjspcare-2012-000437

Miller, L., & Kelley, B. S. (2005). Relationships of religiosity and spirituality with mental health and psychopathology. In R. F. Paloutzian & C. L. Park (Eds.), *Handbook of the psychology of religion and spirituality* (pp. 460–478). Guilford Press.

Mooij-Kemp, D. E. (2006). *De opleiding en bevoegdheid van geestelijk verzorgers* [The education and competence of spiritual caregivers]. In J. J. A. Doolaard (Ed.), *Nieuw handboek geestelijke verzorging* (pp. 131–138). Kok.

Moore, K., Gomez-Garibello, C., Bosacki, S., & Talwar, V. (2016). Children's spiritual lives: The development of a children's spirituality measure. *Religions, 7*(8), Article 95. https://doi.org/10.3390/rel7080095

Moore, K. M. (2015). *The development of a children's spirituality measure and the exploration of the role of spirituality in the lives of childhood cancer survivors and a healthy comparison group* (Publication No. 28265993) [Doctoral dissertation, McGill University]. ProQuest Dissertations & Theses Global.

National Coalition for Hospice and Palliative Care. (2018). *Clinical Practice Guidelines for Quality Palliative Care* (4th ed.). https://www.nationalcoalitionhpc.org/clinical-practice-guidelines/

Okyay, N. (2008). *Hemşirelerin maneviyat ve manevi bakıma ilişkin düşüncelerinin belirlenmesi* [Nurses' views on spirituality and spiritual care]. *[Master's thesis, Cumhuriyet University]*. Cumhuriyet University.

Özdoğan, Ö. (2008). İnsana manevi-psikolojik yaklaşım [A spiritual-psychological approach to the human being]. *Ankara Üniversitesi Ilahiyat Fakültesi Dergisi, 49*(2), 77–102.

Peeters, J. L. J. (2006). Interdisciplinaire samenwerking [Interdisciplinary collaboration]. In J. J. A. Doolaard (Ed.), *Nieuw handboek geestelijke verzorging* (pp. 675–683). Kok.

Pompele, S., Ghetta, V., Veronese, S., Bucuță, M. D., & Testoni, I. (2022). Spirituality and children's coping with representation of death during the COVID-19 pandemic: Qualitative research with parents. *Pastoral Psychology, 71*(2), 257–273. https://doi.org/10.1007/s11089-021-00995-w

Puchalski, C. M., Lunsford, B., Harris, M. H., & Miller, R. T. (2006). Interdisciplinary spiritual care for seriously ill and dying patients: A collaborative model. *The Cancer Journal, 12*(5), 398–416. https://doi.org/10.1097/00130404-200609000-00009

Puchalski, C. M., Vitillo, R., Hull, S. K., & Reller, N. (2014). Improving the spiritual dimension of whole person care: Reaching national and international consensus. *Journal of Palliative Medicine, 17*(6), 642–656. https://doi.org/10.1089/jpm.2014.9427

Rodriguez, M. C. (2025). How can a spiritual pedagogy in religious education contribute to children's spiritual growth? *International Journal of Children's Spirituality*, 1–15. https://doi.org/10.1080/1364436X.2025.2450436

Rullmann, W., & Reinders, M. (2006). De kinderafdeling [The children's ward]. In J. J. A. Doolaard (Ed.), *Nieuw handboek geestelijke verzorging* (pp. 215–223). Kok.

Sabuncuoğlu, Z., & Gümüş, M. (2008). *Örgütlerle iletişim* [Communication with organizations]. Arıkan Yayınları.

Schoot, M., Bartels-Velthuis, A. A., Rodrigues Recchia, D., Frick, E., Büssing, A., & Hoenders, R. (2024). Translation and validation of the Dutch version of the Spiritual Care Competence Questionnaire (SCCQ-NL). *Religions, 15*(4), Article 496. https://doi.org/10.3390/rel15040496

Selçuk, M. (1991). *Çocuğun eğitiminde dini motifler* [Religious motifs in the education of the child]. Türkiye Diyanet Vakfı Yayınları.

Seyyar, A. (2010). *Tıbbi sosyal hizmetlerde manevi bakım* [Spiritual care in medical social services]. Rağbet Yayınları.

Smit, J. D. (2015). *Antwoord geven op het leven zelf: Een onderzoek naar de basismethodiek van de geestelijke verzorging* [Answering to life itself: A study on the basic methodology of spiritual care]. Eburon.

Sülü Uğurlu, E., & Başbakkal, Z. (2013). Spiritual care requirements of the mothers of the hospitalized children in intensive care units. *Turkish Journal of Intensive Care, 11*(1), 17–24. https://doi.org/10.4274/tybdd.43531

Türker-Şahin, A. (2011). *De dokter is God: Omgaan met het levenseinde in verschillende culturen* [The doctor is God: Dealing with the end of life in different cultures]. In I. de Beaufort, M. Hilhorst, S. Vandamme, S. Van de Vathorst, & M. Schermer (Eds.), *De Kwestie: Praktijkboek ethiek voor de gezondheidszorg*. Boom Lemma Uitgevers.

Van de Geer, J., Visser, A., Zock, H., Leget, C., Prins, J., & Vissers, K. (2018). Improving spiritual care in hospitals in the Netherlands: What do health care chaplains involved in an action-research study report? *Journal of Health Care Chaplaincy, 24*(4), 151–173. https://doi.org/10.1080/08854726.2017.1393039

Vereniging van Geestelijk VerZorgers. (2015). *Professional standard spiritual caregiver: Main text (v.03) with appendices*. https://vgvz.nl/wpcontent/uploads/2023/02/VGVZ_Professional_Standard_2015_Main_Text_EN_v03_WITH_APPENDICES.pdf

Vithana, K. V. G. S. G., & Asurakkody, T. A. (2025). Spiritual practices as coping with mothers of children with attention-deficit hyperactivity disorder: A qualitative explorative study. *Bmc Psychology, 13*, Article 3. https://doi.org/10.1186/s40359-024-02331-2

Wet kwaliteit, klachten en geschillen zorg. (2024). [Quality, Complaints and Disputes in Health Care Act]. *Wet-en regelgeving*. Overheid.nl. https://wetten.overheid.nl/BWBR0049963/2024-07-12/0#search_highlight0

Yavuz, K. E., & Şirin, N. (2011). *Yürekten anne baba olmak: Çocuklarınızla etkili iletişim için 5 altın adım* [Being a wholehearted parent: Five golden steps for effective communication with your children]. Timaş Yayınları.

Yüksel, A. Ş. (2013). Dini gelişim [Religious development]. In M. D. Karacoşkun (Ed.), *Din psikolojisi el kitabı [Handbook of the psychology of religion]* (pp. 112–126). Grafiker Yayınları.