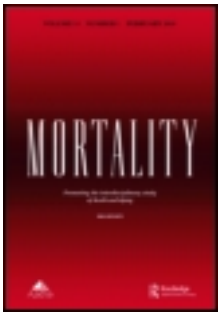

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Deathbed rituals: Roles of spiritual caregivers in Dutch hospitals

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ABSTRACT *This article deals with the possible roles of professionals in the process of ritual counselling of dying patients in hospital. The key question is: how can rituals performed for the dying in spiritual care meet the diverse needs of patients and what is the professional's role in this regard? The contexts explored are Dutch hospitals in which spiritual caregivers are often not religiously bound. The patients asking for ritual guidance are also in most of the cases religiously unaffiliated. What kinds of rituals can be performed then to enact the process of dying, and from what sources can those rituals be derived? What kind of professional skills are needed when professionals try to meet patients' needs? Those kinds of questions are dealt with from a theoretical and practical perspective. The research material presented has been gathered in projects with professionals, observations and educational programmes in the Netherlands.*

KEYWORDS: spiritual care; deathbed rituals; hospital; religion; dying

In modern hospitals, the ritual accompaniment of dying is no longer a foregone conclusion. As a result of social processes like secularisation and individualisation (Felling, Peters, & Scheepers, 2000), the hospital chaplain is not necessarily the person who is called to a dying patient's bedside. Besides, in modern nursing the word 'ritual' tends to have a negative connotation; it is associated with redundant routines in medical practice that should be discarded (Walsh & Ford, 2001). The symbolic dimension of counselling dying people is no longer in the limelight (Quartier & Venbrux, 2006). Nonetheless, recent years have seen fresh interest in symbols and rituals in counselling dying people. Already in the work of Kübler-Ross and others, the significance of symbolic means (the smallest units of ritual activity; Turner, 1973) to assist those leaving this world or parting from a loved one is focal (Kübler-Ross, 1975). Today many practices in care institutions can gain a ritual quality in that sense (Mohammed & Peter, 2009); this is most clearly observable in palliative care (Rumbold, 2002). But the task of ritual in counselling dying people extends beyond the excellent work already being done in many hospices.

To do justice to a dying person's life, death has to be a shared process (Nuland, 1994, p. 242) in which spiritual care rituals might be helpful. The question is *who*

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should provide the spiritual care. Here the role of professional caregivers is both important and unclear. To many present-day professionals an important concept is that of spiritual care in the sense of special attention to the existential needs of dying persons and their loved ones (Narayanasamy, 2001). It is a task for nurses, doctors, social workers, psychologists and chaplains (White, 2006). For the process of counselling those people, there are diverse sources on how to handle the process of dying.

This article focuses on the role of professionals in the ritualisation of dying by looking at spiritual care as practised in modern Dutch hospitals. To this end, I draw on material that I compiled at the *Centre for Thanatology* at Radboud University Nijmegen in the Netherlands. I also cite qualitative research data from workshops held with professional spiritual caregivers. I trust that the questions and viewpoints I describe are not only pertinent to the Dutch context, but might also be helpful to diverse groups of professionals in hospitals elsewhere.

The Dutch context

Dutch practice is an interesting case, in that most people in Dutch society no longer belong to a particular religious institution. In the 1970s, 75% of the Dutch claimed they belonged to a religious institution. This number decreased to 45% by 2005 (Becker & De Hart, 2006, p. 29). Furthermore, there is a large number of different religions present in Dutch society (e.g. Christianity, Islam, Hinduism, Buddhism) and many people who call themselves 'spiritual' claim to be religiously unaffiliated (25%) (Jespers, 2009). This shift from a Christian majority to a multi-religious population also includes unaffiliated and non-religious patients who can be confronted with religious or spiritual questions in hospital. The shift is reflected in patients and professionals and a new type of professional group whose primary task is spiritual care has emerged. Dutch care institutions are legally obliged to provide spiritual care for their patients. Where the majority of patients are no longer religiously affiliated, it is logical to have unaffiliated professionals with the necessary expertise, who can help people to find meaning in an existential crisis and guide them. Dutch courses in religious studies make it their business to train spiritual caregivers: to equip them with knowledge from different religious traditions or other sources relevant for sense-giving actions and inculcate skills in the principal areas of religious and spiritually guidance (Doolaard, 2006, pp. 23–120).

In spiritual care, rituals are a specific challenge, since they present a concentrated focus on what constitutes the core of a person's identity (Quartier, 2008, p. 61). Here people express the frame of reference in which they operate and what emotions they experience as a result of pivotal moments in their existence. Because of the different cultural frames of reference in modern society, the search for appropriate rituals can be a complex task for both patients and professionals. For example, when people in hospital have to confront their own death, it can be difficult to find a ritual repertoire that meets their needs. That is attributable, firstly, to the changing patient population, who often come from very different

worldview-related backgrounds. Apart from Christians, spiritual caregivers have to deal with patients from other religions or with no religion at all (Garces-Foley, 2006; Van Endt-Meijling, 2006). In addition there is a change among spiritual caregivers themselves (Smeets, 2007). How do they deal with their own world view-related background and how does it influence their ritual association with patients?

The key question in this article is: how can rituals in spiritual care performed for dying people meet their diverse needs and what is the professional's role in this regard? I take my point of departure from ritual studies and the first section examines changes in the ritual repertoire for dying and death in spiritual care. The second section identifies some basic aspects of ritual acts so as to clarify the phenomenon. Next I apply these aspects to concrete examples of rituals in spiritual care for dying and dead people and formulate some pertinent questions that patients ask in this regard. In the final section, I explore the ritual role of spiritual caregivers and outline a model of ritual activity with various steps.

1. Changes in spiritual care

Recently, I held a workshop with a team of spiritual caregivers at a large Dutch hospital. The intention was to help them reflect on their role and to support each other in their own confrontation with mortality (Shanker, 1991). Some of them have a confessional background, but they have just been joined by a new colleague who does not have any such affiliation. This triggered a debate in the hospital. Should patients be counselled in terms of the Christian tradition? Is that tradition the source of the rituals offered to patients in which the spiritual caregiver presides, or can other sources of rituals be used? What does that entail for the spiritual caregiver's role? When somebody dies many people question the meaning of life. These questions are at an anthropological level: Where am I going? What does mortality mean? How do I deal with it? Those close to the dying person also ask such questions.

There are no easy answers. Death causes a void, and it is hard to find an approach to that void (Quartier, 2007a). Can spiritual care help people to deal with such voids? One possibility is through ritual: rituals offer people the possibility to enter what can be called a 'comfort zone' in which the strong emotions that confront them with death can be dealt with. Psychologically speaking, the attachment people feel with their own life or the life of a person dying is threatened. In ritual, people have the opportunity to use a pattern of action that reorganises the attachment they feel (Parkes, 2009; Stroebe, 2008). Rituals offer patterns for a 'comfort zone' within which the attachment can be reorganised. Rituals often derive from a particular religious tradition, which lays down a particular behavioural pattern. Traditionally a ritual expert presides, presents patients with a ritual and plays a clear, active role within it: the expert performs the ritual and represents a particular worldview-related tradition (Menken-Bekius, 2001; Riesebrodt, 2007, p. 158). But nowadays there is an additional role, centring more on ritual counselling. The ritual counsellor is not a presider from a particular tradition, but a professional who helps

people find their individual style of ritual in the varied field of death rituals (Embsen & Overtoom, 2007; Quartier & Venbrux, 2006).

In the workshop, the team of spiritual caregivers examined the distinction between presider and counsellor. The first question concerned the spiritual caregiver's own background. For example: the Roman Catholic Church reserves the provision of the sacrament of extreme unction for priests but, given the present-day shortage of priests, what is the solution?

In addition, the ritual repertoire of particular religious traditions, such as extreme unction and other Christian rituals like blessings, are no longer satisfactory for many patients. Formerly the need was clear and the repertoire was largely fixed. If a Catholic was dying, one called the priest. It was clear what needed to be done, and by whom: the *presider*. Nowadays many patients still value this tradition, but it is no longer a self-evident choice. It can no longer be taken for granted that, say, nominal Catholic patients want the sacrament of extreme unction when they are gravely ill. And if they do, it cannot be taken for granted that they would like a priest, doctrinally the only person qualified to administer it, to conduct it. There is also a growing number of nonreligious patients. What would be an appropriate repertoire for them? Can a ritual *counsellor* be meaningful to them? If so, how can the ritual be accommodated?

In contemporary Dutch society, one observes a changing or declining ritual awareness among patients. This is because they form part of various social networks, in which ritual does not necessarily feature (Kastenbaum, 1996). Many patients that spiritual caregivers encounter in the aforementioned hospital feel no spontaneous need for a ritual farewell when they are dying. Nonetheless, the spiritual caregivers felt that a ritual helped them to express the unsayable and thus channel emotions that would otherwise not have been expressed (Driver, 1998).

This presents spiritual caregivers with new challenges that also concern their self-awareness. Recent research among spiritual caregivers in the Netherlands shows that they do not always take their own confessional background and mission as their point of departure in their work (Smeets, 2007). They also look for ways of ritualising that incorporated the patient's perspective. But how can a ritual counsellor present patients with a ritual repertoire? How does one relate patients' individual needs to the various religious traditions that permit collective rituals that can be shared with others?

2. Basic aspects of ritual

The team of spiritual caregivers in the workshop wanted to work out what ritual actions entailed in reality. After all, one can only consider contemporary challenges if one has a clear picture of what happens in the actual ritual performance. They presented a diverse range of views of ritual. What does it imply if different spiritual caregivers *do* different things with different patients? One can follow the 'liturgical order' (Rappaport, 1999) of a particular religious tradition or the hospital's own order, but what does that order entail in contemporary society? And what must spiritual caregivers with no traditional religious background do?

Another option is to create a ritual in collaboration with patients. One then 'ritualises' in the context of the dying person (Grimes, 1990). But what happens to the collective aspect of ritual; where does one find ritual actions? The team agreed that patients and their networks should form the basis of ritual. They are guided to discover and perform their own rituals. The rituals may differ and the role of the spiritual caregiver may vary from one ritual to the next. Sometimes the spiritual caregiver is a presider following a liturgical order, sometimes a counsellor helping people to devise their own rituals. Often caregivers play both roles. Some basic aspects of ritual can clarify the range of variations, constellations and roles in rituals associated with death and dying. In my view, all rituals in spiritual care have two basic aspects in common: *structure* and *meaning* (Quartier, 2007b).

Structure

The first key aspect of rituals is their structure. Here I distinguish between the structure that a ritual *has* and the structure it *brings about*. In the former, which I call the *internal* structure, rituals, whether traditional and fixed or individual and open, are always performed in a particular structure. A classical example is the rites of passage structure described by Arnold van Gennep. According to him every transitional rite, such as rites performed when a person dies, proceeds in three phases: parting, transformation and integration (Bell, 1997, p. 33; Van Gennep, 1999).

But the internal structure of present-day rituals is no longer fixed in all instances. People may feel a need for an ordered ritual at various points in the dying process, resulting in a variable structure. This raises questions about Van Gennep's rites of passage scheme (Sörries, 2005). For example, do modern people still part from their dead in fixed ways? Are there not diverse forms of transitional rituals in evidence? Some put more emphasis on personal farewells (parting), others on how to continue family life (integration). I have argued elsewhere that the internal structure varies, depending on the parties involved and the context (Quartier, 2009a).

Then there is the structure that the ritual effects, which I call its *external* structure. Ever since Emile Durkheim it has been emphasised that rituals promote social cohesion (Bell, 1997, p. 23; Durkheim, 1968), but what is the form of the community that the rituals structure? Is it a static community or a dynamic network? Victor Turner puts the accent on the dynamism of the network arising from a transitional rite. His concepts of *liminality* and *communitas* indicate that pivotal moments in human life entail an intermediate state (*liminality*). One is no longer a spouse, but is not yet a widow or widower, which then triggers a dynamic bond (*communitas*) with one's immediate environment (Quartier, 2007a, p. 97; Turner, 1969). That interaction is an example of external structure. Because of the various people around the deathbed, including the spiritual caregiver and other professionals, and the various constellations involved in the structure that the ritual effects, it is often variable, especially in our individualised culture. When somebody dies the internal and external structure of ritual gives people something

to hold onto and brings them closer to each other. In a modern context this allows for considerable variation.

Meaning

Apart from the structure that rituals possess and effect, they also have *meaning*. Here too one can distinguish between internal and external meaning. *Internal* meaning implies recognisability, *external* meaning refers to something that transcends the actual performance. With internal meaning, rituals can have inherent meaning naturally associated with certain objects and gestures. According to Edmund Leach a symbol is an element of ritual that 'condenses' meaning (Leach, 1979). A gesture or object is singled out in a manner that makes people recognise it. If not, the symbol has no referential power. In the case of deathbed rituals the question today is what internal meaning is recognisable to the dying person and her nearest and dearest, as well as to the spiritual caregiver and other professionals. Traditional religious objects and gestures are certainly potential vehicles of meaning, as are highly personal objects and gestures. When mass is distributed at a deathbed according to Roman Catholic tradition, modern participants may no longer respond with the traditional 'Amen' but may say with genuine feeling, 'Thank you very much'. In that case the symbol per se no longer has a standard internal meaning. By the same token personal objects belonging to the dying person may not necessarily be recognised by everybody. Internal meaning may vary, again depending on the actual circumstances of the dying person, the people around him and the spiritual caregiver.

In addition, the objects and gestures used have *external* meaning, that to which the ritual refers. This meaning extends beyond the concrete performance: it is 'transcendent' (Bell, 1997, p. 155; Quartier, 2007a, p. 31). The external meaning is particularly important for dealing with death, which is often experienced as a paradox not easily grasped without reference to some overarching meaning. The Dutch theologian Schillebeeckx calls it a 'contrast experience' that evokes transcendent questions (1989). But what referential power exists when people no longer have just one definitive system of meaning? What does the ritual refer to? A major source of meaning is religious traditions, but they are not the only source. In a secular era in which many people have no use for classical images of God and the hereafter, diverse sources (including secular ones) may be pertinent. Hence external meaning, too, is flexible. The four basic aspects of rituals are summarised in scheme 1.

Scheme 1. Basic aspects of rituals.

Structure	internal	ordered
	external	ordering
Meaning	internal	recognisable
	external	referential

What does it imply that all four aspects can be interpreted variously in the modern context? To my mind all four aspects of ritual function on a continuum between individual and collective interpretation. It depends on the persons participating in the actual ritual. Both their individual points of departure and the collective form of ritual behaviour influence all four aspects, with varying accents. The opposition between the two poles is an essential feature of rituals associated with death and dying in the modern context. To my mind this raises questions about Heelas and Woodhead's postulate of a 'spiritual revolution' (Heelas & Woodhead, 2005). According to them institutional forms of religion are disappearing, along with the concomitant forms of ritual activity. But are there really no collective religious rituals anymore? The basic aspects indeed suggest variable interpretation of ritual activities. But when somebody dies the rituals of churches and other religions may well be invoked. Research in the Netherlands has shown that Christian basic values still play an important role in Dutch hospitals, which also has implications for very basic symbols and habits (Smeets, 2007; Walter, 1997). It is important to openly observe concrete actions and analyse whether there are really no traditional elements or symbols present (Turner, 1973). Christianity might still play a role, implicitly, but not necessarily. It might also be a family tradition or some symbol that was meaningful to the deceased person. Sometimes the collective dimension is more pronounced, although the individual dimension should not be overlooked. Sometimes this aspect dominates, for instance personal symbols, but one should be alert to links with a broader system of meaning, in terms of which people may assign external meaning to recognisable objects (Quartier, 2005; Walter, 1996).

3. Structure and meaning in modern spiritual care

In the workshop, after exploring the basic aspects, the team immediately raised the question of their practical implications for ritual counselling of a dying person in hospital. Two practical examples were cited, which I include here. The first is extreme unction, a traditional Roman Catholic ritual in the context of illness and dying (Richter, 1973; Von Arx, 1979). This sacrament, which is very meaningful to Catholics, is administered by a priest. It is a collective ritual with a fixed liturgical order. Because many hospitals do not have the services of a priest, chaplains looked for alternative rituals in the Christian tradition. One example is the so called 'blessing of the sick'. This is not a sacrament in the classical sense, but simply a ritual in the Christian tradition for accompanying a dying person similar to the anointing of the sick. All members of the team were able to identify with this ritual, which they regularly conducted for patients; yet they all interpreted it differently.

There were also some questions. The first pertains to the patients and their close family and friends. Is the traditional Christian administration of extreme unction still appropriate for all patients? Some spiritual caregivers maintained that these rituals can be made accessible to individuals, for example by permitting them to participate. A symbol or text that is particularly meaningful

to the dying person, albeit not traditionally Christian, can also be included (cf. Quartier, 2009b).

Another question concerned the spiritual caregivers. How do they relate to a sacrament reserved for priests? How does a spiritual caregiver with no Christian background feel about the ritual? Spiritual caregivers vary greatly, and each has to work out her own position. It was agreed that a caregiver's role in the ritual would depend on their personal worldview.

A specific example was cited. One spiritual caregiver described how she counselled an elderly dying woman without any church affiliation. The woman found it hard to part from her daughter; both of them were stunned by the verdict that the patient was dying. Leafing through family photograph albums together unleashed a flood of emotion. The albums symbolised the past, what their life used to be (cf. Embsen & Overtoom, 2007). In times of crisis the family had always looked at old photographs. Looking at the photographs together enabled them to say goodbye and to ask questions about the meaning of life and death. The photographs triggered an exchange on worldviews that would not have happened otherwise. It opened them up to a broader system of meaning. Every time the daughter visited her mother the two of them looked at the photographs together, sometimes in the spiritual caregiver's presence. This led to questions about the mother's death. They expressed fear, grief but also hope. The spiritual caregiver said that she gradually started to join in the process by bringing along poems and meditative texts from various religious or spiritual sources that imparted peace to the activity and broadened the horizon. She herself found new meaning for the woman and her daughter. They re-invented the rites of passage (Grimes, 2000).

To my mind both examples, extreme unction and looking at those photographs, amount to rituals, only the relation between individuality and collectivity differs. Whereas extreme unction and other rituals in the Christian and other religious traditions are pre-eminenently collective, looking at photographs is primarily individual. Yet both rituals are on the continuum of individuality and collectivity (Venbrux, 2007). I explain this with reference to the four basic aspects of ritual identified in the previous section.

Structure

When it comes to the *internal structure* of rituals, extreme unction exemplifies an ordered activity. The various elements are performed in a given sequence. Nowadays there are variations in the structure of traditional Christian actions performed at a deathbed. The dying person's input and that of his immediate circle also play a role. The structure is adaptable in terms of who acts at which moment.

Many patients believe that the Roman Catholic ritual of extreme unction should only be administered when the person is actually dying. Others have a different view. They may even see it as a step towards recovery. In that case, the ritual does not mark the end of life but the start of living on after an illness, the original

meaning of the anointing of the sick, and that affects the structure of the rite. Everything depends on people's individual interpretation of the collective ritual.

In the case of the photograph albums no predetermined structure is discernible at first glance. From both the patient's and her daughter's point of view it appears to be a purely individual act. Yet in the course of their joint scrutiny of photographs a pattern emerges that permits discussion and questions. Looking at the photographs acquires an internal structure that enables mother and daughter to voice their grief, fear and hope. The spiritual caregiver, too, becomes involved through reading certain texts. Hence the study of photographs is not simply an individual activity but a way of relating to the past and taking leave. It frees all parties to face the future. It establishes a link with a larger whole, a collective aspect.

As for *external structure*, a Roman Catholic ritual such as extreme unction again has a fixed premise. Christians gather at a deathbed and are able to draw comfort from certain gestures and prayers. As a result, the ritual draws them together and joins them in communion (Chauvet, 2001). Today, often not only Christian but also non-Christian patients and relatives attend the Christian ritual. They may have close ties with the dying person, which the ritual then confirms. In that case the external structure contradicts the notion that people are primarily united by their faith. It could give rise to a different kind of communion, a different external structure that is still experienced as ordering the ritual.

Our example of looking at photograph albums presents a different picture: the external structure affected by the ritual consists in restoring the bond between mother and daughter. The mother's impending death had impaired that bond and a ritual brought it to life again. Although it started as an individual activity, it transcended the individual level. Even the spiritual caregiver became involved, and along with her a broader context that finds expression in texts. The ritual exceeds the limits of a purely private domain and opens the participants up to a broader collectivity than personal experience.

These two aspects challenge spiritual caregivers to find a feasible internal and external structure in the case of each patient. The uniformity that could be missing in either of the two examples implies that one has to start by determining which internal structure would be recognisable to the patient. Secondly, the spiritual caregiver must find what external structure the ritual could effect. Who are the people gathered round the deathbed and what could unite them? This invariably raises the issue of what role the spiritual caregiver could play. In regard to the internal structure affiliation with the structure of, for example, a Christian ritual and identification with it are relevant. Can they gain access to the internal structure? When it comes to the external structure, can they form part of the Christian community round the deathbed, and to what extent can they join an intimate community?

Meaning

When it comes to the *internal meaning* of a ritual, extreme unction and other religious rituals are highly recognisable to many people. But as in the case of

structure, it can be viewed from diverse perspectives. Do people recognise it as a ritual associated with grave illness or as a religious or spiritual interpretation of leavetaking? To some the ritual may be interpreted as a generally meaningful act not confined to the Christian tradition as such. Or they may not recognise it at all. That, too, depends on whether and how the collective ritual is interpreted.

While looking at photograph albums used to be highly recognisable to mother and daughter, it does not follow that it will still be so in the face of death. It has to acquire that recognisability, so that the ritual can become an internally meaningful activity embodying their parting, as well as permitting them to share questions, fears and hopes. If that happens, the individuality of looking at photographs together is transcended and makes way for a collective element in which a broader horizon of meaning opens up: the finitude of life confronting these two people, which they, together with the spiritual caregiver, seek to express in a recognisable act.

The *external meaning* of extreme unction and other deathbed rituals in the Christian tradition is God's support for the sick and the dying. Naturally there are different interpretations, but the act always indicates divine help and consolation. Nowadays one has to ask whether people in fact see the ritual as a reference to the Christian message of God's support of the sick and the dying. Could they not assign it a different referent, for instance the healing power of a loving gesture like extreme unction? Or could it not be a general spiritual hope deriving from the transcendence that pervades the ritual?

At first glance, looking at photograph albums has no external meaning in the minds of mother and daughter. They only discover it by degrees, together with the spiritual caregiver. At first the external meaning of their life together predominates and only later that of searching for an answer to the question of human mortality. Here the spiritual caregiver's texts play a major role. It is a joint ritualisation, which leads to the articulation of questions, fears and hopes.

The accent in structure and meaning varies in our two examples, but both challenge professionals to overcome the polarity between individuality and collectivity. Helping people to bridge this divide is the task of modern spiritual caregivers. An important requirement is to sensitively probe the beliefs and assumptions of the dying person and her loved ones. What possibilities are there for them to discover faith and hope, as Davies puts it (Davies, 2008, p. 17)? In respect of the four basic aspects of ritual this could entail guiding questions such as the following.

4. Possible roles for present-day spiritual caregivers

The examples discussed by the team of spiritual caregivers reveal a number of features. They thought that the foregoing four aspects of ritual are helpful to distinguishing rituals from each other and to find rituals to meet the needs of individual patients. They enable caregivers to see what repertoire the person is receptive to. Is she receptive to a collective ritual offered by a particular religious

Scheme 2. Guiding questions when looking for ritual activities.

Internal structure	How do the parties visualise the process of dying? What kind of ritual are they accustomed to?
External structure	Which persons join in the ritual? What are the roles of the dying person and the other people involved?
Internal meaning	What identifying traits do they recognise? Are there symbols or gestures that they hold dear?
External meaning	What references could offer comfort to the parties involved? What system of meaning/religion is important to them?

tradition? Or is the patient more amenable to an individual ritual deriving from his own life world? Do the various premises underlying the ritual overlap?

In the spiritual caregivers' experience the latter possibility, an overlap of tradition and personal life world as a source of ritual, was particularly common. Interestingly, in practice the two forms of ritual, predominantly individual and predominantly collective, tended to converge (Quartier, 2009b). Many spiritual caregivers try to interpret predominantly collective rituals together with their patients, and to add a collective dimension to predominantly individual rituals. In effect this constitutes a hermeneutic process in ritual practice in spiritual care: an interaction between tradition and situation (Zimmerman, 1999). The spiritual caregiver's task is to help people find structure and meaning in the contingent experience of dying. Ritual is an apt medium, since its concrete actions transcend the purely verbal message.

A persistent question in the previous section was what the various forms of ritual activity on the continuum between individuality and collectivity implied for the spiritual caregiver's role. The question concerns the caregiver's ritual identity. Spiritual caregivers may have different views of their own role in different rituals. To clarify the point I consider a few steps that every spiritual caregiver undertakes when counselling dying patients.

The first is to explore the basic aspects of ritual presented in the previous section. To this end the guiding questions offered in scheme 2 can be helpful. On the basis of the answers the spiritual caregiver then looks for an appropriate ritual for the particular patient, drawing on the information the patient supplies and his knowledge of worldview-related traditions, Christian or otherwise. Non-religious sources can also be tapped. In this the spiritual caregiver remains a ritual *counsellor,* helping patients to find a ritual that suits their reality in the process of dying. Depending on the joint choice of spiritual caregiver and patient, the former then decides on her own role.

In two examples from the previous section, if the spiritual caregiver and the patient conclude that a Christian deathbed ritual would suit all parties, the next question is whether it requires a *presider* who might necessarily be a minister, and whether the spiritual caregiver concerned can play this role. If the ritual is to be the sacrament of extreme unction, the presider would have to be a priest. In the case

Scheme 3. Steps relating to ritual activity.

Step 1	Explore basic aspects of ritual
Step 2	Define ritual activities
Step 3	Define ritual roles
Step 4	If necessary, call in a suitable presider
Step 5	Perform the ritual

of some other Christian rituals he has to identify with its structure and meaning to perform it. If a Christian or Muslim family elects to say prayers and perform other acts, a non-Christian or non-Muslim spiritual caregiver can still play a role; here a presider is probably unnecessary and the spiritual caregiver merely helps the family to perform a ritual from their own tradition. The extent to which the spiritual caregiver can and should play the role of counsellor as well as presider depends on the ritual and the degree of correspondence between the worldviews of the patient, her immediate circle and the spiritual caregiver.

The same applies to the example of looking at photograph albums. The spiritual caregiver as ritual counsellor can look for a ritual together with mother and daughter. In this case the role is mainly to counsel them, but she can also assume the role of a presider; when the conversation flags, when words must be found to articulate the ineffable. Then the spiritual caregiver speaks on behalf of those she is dealing with, in our example by way of poetry and meditative texts. To do so she taps certain sources at her professional disposal. Again the extent to which this is possible depends on the degree of correspondence between patients and caregiver.

If the spiritual caregiver concludes that the ritual requires a presider and she cannot play the role herself, her professional duty is to bring in a suitable presider. That may happen when the people involved explicitly request the sacrament of extreme unction and the caregiver is not a priest. Or the people may want a Christian ritual and the spiritual caregiver is not a Christian. Or they may be inspired by a spiritual movement with which a colleague is familiar while the spiritual caregiver is not. To arrive at a decision she has to consider her own ritual identity and worldview-related background carefully. I would argue that these steps have to be completed before deciding on the right deathbed ritual. The steps are summarised in scheme 3.

Conclusion

The basic question in this article is: how can rituals in spiritual care performed for dying people meet the diverse needs of patients and what is the professional's role in this regard? Naturally I could not answer the question fully, but the theoretical distinctions I made and the practical examples from the workshop with spiritual caregivers in the Netherlands show that the roles presider or counsellor need not conflict. Professionals performing rituals with patients are ritual counsellors, sometimes also, depending on their own identity, presiders. It is important to note that they might also need to respect the sometimes individual character of the way

people want to die. If somebody wants to die in a private setting, there might be no role for a professional. It is an ethical question of piety that people can also long for privacy (Wils, 2007). I think the basic aspects of ritual activity, the guiding questions that were formulated and the steps I distinguished provide a method that is widely applied in the practice of spiritual care. That was the impression I got in the workshop with a team of spiritual caregivers and in the educational program offered by the *Centre for Thanatology*.

I also think that a differentiated, professional approach is particularly important when conducting rituals, also in the case of spiritual care professionals with no explicitly religious background. Thus in instances where a colleague or ritual expert from a given tradition is needed to preside this should be planned systematically. Here it should be noted that a counselling process always has its own organic dynamics. As a rule the apparent contrast between patient and spiritual caregiver usually does not exist in such interaction. Nonetheless, reflection on roles is part of the discipline of spiritual care and is conducive to cooperation in a pluriform team of spiritual caregivers and other professionals, for instance in hospitals. Professionalisation in this area may well promote positive development of the renewed interest in the symbolic dimension of dying which can also be important for nurses, doctors, social workers, psychologists, etc. I trust the material I present here will trigger discussion of the specific challenge posed by ritual activity relating to death and dying in present-day health care.

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