

Rituals in General Spiritual Care

*Nicolette Hijweege, Jos Pieper, Wim Smeets, Hans Hamers
& Jacqueline van Meurs*

1. Introduction

One of the characteristics of the return of religion to the public sphere is the freedom people have to construct their own spirituality, making use of various traditions. The term 'spirituality' denotes all human experiences relating to an ultimate reality, otherwise the personal orientation of life – and therefore is broader than institutional 'religiosity'. The tension between a classic denominational/institutional religious identity and the 'postmodern' eclectic/multifarious and 'unaffiliated' religious identity is one of the most striking features of the contemporary religious landscape, causing religious identity to be contested at various levels. On macro level, it means that the return of religion to the public sphere does not entail a revival of traditional church-based religiosity, but that instead, the churches are forced onto the defensive by the new religiosity. At meso level, it means that the established order in public and private institutions, which mandates a role for religious ministers, is undermined by the arrival on the scene of new, more 'generalist' professionals. One such professional is the general spiritual carer trained at the University of Utrecht and a few other universities. Finally, at micro level, it means that personal religious identity has become more fluid, and this brings its own dynamics with it in religious communication. In rituals the tension between a denominational and an unaffiliated religious identity is visible by the way a concrete ritual relates to individual life, to the identity of a group and to a meaning system. For that reason we will specifically focus on rituals.

Spiritual carers working in public organizations in the field of health care, the law or defense find themselves particularly confronted with changes in the religious landscape. Nor do these changes in religiosity apply only to their clients; the spiritual carers themselves are affected too. The emergence of the general spiritual carer who is not a minister within one clearly defined denomination is in fact an embodiment of the return of religion in forms that do not fit within a traditional religious framework. However, the concept of a general spiritual carer is disputed both by the traditional churches and by a group of professionals among spiritual carers who believe that they need a basis in a church to safeguard their official status. That official status is primarily expressed in a mandate to conduct theologically sound rituals. It is perhaps in relation to the conduct of rituals that the most serious doubt is cast on the religious identity of the general spiritual carer. It evokes the discussion on the relationship between legitimacy and effectiveness of rituals.

In our contribution to this discussion we tackle the issue in three stages. In the first stage, we outline the overall context of the changes in the religious landscape, at the same time showing how contemporary health care is characterized by its market-driven character and an increasing emphasis on extramural health care provision. In the second stage, we examine the ritual dimension of religion and the meaning that rituals can have for people in the context of health care. In the third and final stage, we reflect on the scope for ritual in general spiritual care in the light of a study of outpatient spiritual care.

2. The new religiosity and developments in health care

While going about my work at the hospital I meet Mrs. Kali, who is expecting her second baby, in the internal medicine department. At first, Mrs. Kali had put the tiredness she has been suffering from in recent months down to her pregnancy. But when it did not get any better after the fourth month, blood tests were done and eventually she was diagnosed with leukemia. She is now six and a half months pregnant and she and her partner face big decisions about whether to start treatment and about the future of the pregnancy. Neither Mr. nor Mrs. Kali was brought up as a churchgoer. What matters to them in life – friendship, their love of nature and music – has so far mainly found expression through participation in sporting activities and activities undertaken with friends. But it comes out in my discussions with them that this way of giving meaning to life is not much use to them in the present situation. Visits are rapidly too tiring and amid such an upheaval, music is not the right way to find some peace with each other and in themselves. They also need to support their four-year-old son, who is longing for a brother or sister. But how? In my third meeting with them, the discussion shifts from illness and the decisions they face to the subject of nature, nature conservation and the natural cycles of birth and death. Many images are evoked: spring mornings which quiver with new life but which also make you reach for your scarf and gloves. This particular image helps them make contact with the growing baby. A longing and an urge to reach out to it, accompanied by a wish to cradle and protect it. Involuntarily, they both put their hands on her abdomen for the first time since the diagnosis... Contact is made...

Spiritual carers in health care institutions guide people whose prospects are bleak and who are struggling with issues of spirituality and meaning in life. Their engagement with these processes is based on their religious convictions. This is a domain in which a great disparity has come to light over the last few decades. During this period, churches and other religious institutions have lost a lot of ground when it comes to the connection and commitment people feel they have to these institutions. Meanwhile other spiritual paths, some of them with a very long history, have emerged from the shadow cast by the dominant religious institutions and have created their own spiritual market with a wide range of forms and practices. This market operates quite plausibly alongside both the dominant religious institutions and conventional health care institu-

tions. In the past decade, analytical studies of the changes in religious life have been supplemented by empirical studies.¹ These studies reveal how the religious landscape includes the following types: on the one hand, there is the traditional religious activity, with about 25% of the Dutch population describing themselves as Christians and 3% as Muslims; then there is a new category of people (26%) that describe themselves as spiritual but ‘unaffiliated’; a third category are inclined towards a liberal humanism (28%); and lastly, there is a group that do not align themselves with anything (18%). These are the categories and figures given by Kronjee and Lampert.²

Further sociological analysis of the ‘unaffiliated’ category proves rather complex. After all, the term ‘unaffiliated’ expresses one of the most salient characteristics of the trend: individualism. Although people’s self-categorizations in terms of religion reflect falling levels of involvement in traditional religious institutions, spirituality is far from disappearing from the landscape. In the sociology of religion therefore, talk about secularization has been replaced by talk of desecularization or resacralization.³ The ways in which people connect to these new spiritual paths and practices differ from the former group membership of Christian institutions. Participation in practices is often motivated by a specific question or theme. Participation – and this counts for Christian institutions too – is no longer ‘for life’ but for a limited period. And central to this participation, in many cases, are self-realization and health.⁴

The changed religious landscape, along with the changed focus in religious involvement, has consequences for spiritual care as a profession in the health sector. We are going to take a closer look at two of these consequences. Firstly, the wide range of religious perspectives among the potential clientele demands a wide range of perspectives from the spiritual carer. And secondly, the diverse range of religious affiliations is also reflected within the profession itself, where the ordained spiritual carer who in some sense represents a particular religious community no longer has the stage to himself, but now shares it with the general spiritual carer.

¹ G. KRONJEE & M. LAMPERT: ‘Leefstijlen en zingeving’, in W. VAN DONK, A. JONKERS, G. KRONJEE & R. PLUM (red.): *Geloven in het publieke domein* (Amsterdam 2006) 171-208; J. BECKER & J. DE HART: *Godsdienstige veranderingen in Nederland. Verschuivingen in de binding met de kerk en de christelijke traditie* (Den Haag 2006); T. BERNTS: ‘Een religieuze atlas van Nederland’, in VAN DONK, JONKERS, KRONJEE & PLUM: *Geloven in het publieke domein* 89-138; T. BERNTS, G. DEKKER & J. DE HART: *God in Nederland 1996-2006* (Kampen 2007); E. SENGERS: *The Dutch and their Gods. Secularization and transformation in the Netherlands since 1950* (Hilversum 2005).

² KRONJEE & LAMPERT: ‘Leefstijlen en zingeving’.

³ A. VAN HARSKAMP: *Het nieuw-religieuze verlangen* (Kampen 2000).

⁴ M. MEESTERS: *Jonge denkers over grote religies. Nieuwe spiritualiteit* (Kampen 2008); F. JESPEERS (red.): *Nieuwe religiositeit in Nederland. Gevalstudies en beschouwingen over alternatieve religieuze activiteiten* (Budel 2009).

The potential clientele of the spiritual carer includes a wide range of religious preferences and behaviors – some more explicitly stated than others. It also includes people who find themselves in totally unfamiliar territory when confronted with the brokenness of life and the need to discuss the meaning of a possible choice in a contingent situation. They may speak a different religious language or they may only be able to deal with the situation through concrete action or by talking in psychological terms, for example. The great variety in religious activity and language means that the spiritual carer needs on the one hand to have a firm basis in his own religious tradition, as this may be called on directly, and on the other hand to be skilled and creative in tuning in to the religious background of the clients and their wishes in terms of activities or language. When it comes to ritual behavior, this can mean that the spiritual carer adapts – as in the above-mentioned case – to a meaning system of the client's, adopting its customary vocabulary and looking for appropriate and helpful symbols and, if wished for, rituals.⁵

The second point that arises here is that the variety of religious affiliations is starting to be reflected in the profession itself. Ordained ministers work side-by-side with unaffiliated general spiritual carers, whose training for the role is less rooted in a thorough theological grounding or specific religion. The training of the general spiritual carer has a strongly professional bias, so that the spiritual carer positions himself as one of the health carers in an institution. The spiritual carer's own religious position is subject to scrutiny and to a supervised learning process, with a view to ensuring professional interventions. Most general spiritual carers have some degree of affiliation and/or affinity with a specific religious or spiritual group. However, they cannot or do not wish always to represent this group. If we restrict ourselves to the theme of ritual acts, the position of the general spiritual carer demands actions and words that are carefully chosen and appropriate, both in professional and in religious terms. Clear communication, both about the content in question and about roles and responsibilities, is crucial to this.⁶

Working in health care institutions has been linked with religious values since time immemorial. These values are quite clearly reflected in contemporary policy papers and the formulations used in discussions of quality. However, the formulation of religious values such as compassion, loving-kindness and holistic 'healing' should be seen not just in the context of resacralization, but also above all in the light of market forces in the health sector and the wish to communicate an 'identity of one's own'.⁷ Market forces have brought about big

⁵ N. HIJWEEGE: "Wat betekent dat" en "Waar staat dat voor?". Over de samenwerking tussen geestelijk verzorger en psycholoog', in *Psyche en geloof* 21/3 (2011) 178-195.

⁶ N. HIJWEEGE & W. SMEETS: *Verandering van voorkomen. Het ambt van de geestelijke verzorger in discussie* (Utrecht 2010); W. SMEETS: *Vanuit en op basis van geloofs- en levensovertuiging. Algemene en ambtelijke geestelijke verzorging* (Utrecht 2010).

⁷ K. WAAIJMAN: 'Spiritualiteit in de zorg: in de interactie tussen zorgvrager en zorgverlener', in B. BOUWER (red.): *Spiritualiteit en zingeving in de gezondheidszorg* (Kampen

changes in the way health care is organized. Not only did it have to become more efficient, but it was differently funded and became more 'client-centered'. Client-centeredness may sound as if it might mean 'the customer is always right', but in practice it was chiefly a matter of how time and funding were managed. One effect was that increased efficiency, combined with budget cuts, shortened the average length of hospital admissions. In an approach validated by studies showing that a familiar environment can speed recovery, patients now spend as much of their convalescence as possible in a familiar environment, namely at home. Any further treatment or supervision is given in the form of home visits or at the outpatients department. District nursing services and other health care providers help to make this convalescence in a familiar environment possible. In other words, a considerable proportion of the care needed is now extramural. However, this is not necessarily the case for spiritual care. Spiritual care is part of the intramural care provided by the institution, but is not, in theory, available to the outpatient department, as it is not covered in this context by the basic health insurance package. Patients at home are assumed to be able to fall back on their own social networks or religious organizations for spiritual care. But given the falling level of membership of religious institutions, the casual nature of people's affiliations to contemporary spiritual practices and paths, and the increased individualism, it may be that people do not always find the spiritual care they need.

We have now outlined the general framework of our contribution. It is demarcated on the one hand by the increasing differentiation in the Dutch religious landscape caused by processes of individualization, desecularization and resacralization. One of the consequences of this for the field of spiritual care has been the arrival on the scene of the general spiritual carer who is not affiliated to a single well-defined religious tradition. At the same time, health care itself has become more differentiated as it has changed from largely hospital-based specialist treatment to a range of professional services providing first-line care, home-based care, outpatient care and finally, hospital admission. There is a challenge here for spiritual carers: to expand their field of work. One way is in conducting rituals with people suffering from health problems.

3. Rituals: characteristics, functions and effects in the changing religious and health sector contexts

The dynamics of religious individualization, desecularization and resacralization are visible not just at the levels of experience and emotions, of convictions, and of norms and values, but also in the typically religious area of ritual. What do

the tensions we have mentioned mean for ritual forms of communication? In the past, the churches and their ministers have had a monopoly on religious rituals. But have they adapted the forms of these rituals to the 'postmodern' religious identity? And how can new professionals, who embody this identity, communicate through ritual with people who may have traditional expectations of a ritual, or may turn out to have vaguer 'postmodern' ones? In order to be able to answer these questions we must first take a look at what rituals are, which role they can play in people's health and wellbeing, and what the implications of this may be for spiritual care.

3.1. The legitimacy and effectiveness of ritual

In her studies of rituals in individual pastoral care, Menken-Bekius made a distinction between the legitimacy of rituals and their effectiveness.⁸ By legitimacy she means a firm grounding in the central theological tenets of the denomination of the person conducting the ritual. Communion and baptism are considered to be the key rituals presided over by protestant spiritual carers. Effectiveness, on the other hand, denotes the way ritual sets something in motion and aims at certain objectives such as removing anxiety or insecurity or finding meaning. Legitimacy is examined in the context of a religious denomination and the debate conducted within it on its fundamental religious beliefs. Effectiveness is examined in relation to the insights provided by cultural anthropology, ritual studies, sociology of religion and psychology of religion on the way rituals work. The general spiritual carer does not have a sense of mission from a particular religious tradition, so the question of the legitimacy of ritual will not be our main focus here. Rather, the emphasis will lie on examining the effectiveness of rituals. And it is possible that the answers we find may serve to legitimize the use of the ritual. In other words, it seems useful to present some generally accepted knowledge about the way rituals work, something we will do by looking at the characteristics and functions of ritual. To be effective, a ritual should be conducted in line with these characteristics and functions.

3.2. Characteristics of rituals

Van der Hart sees rituals as stereotyped symbolic acts characterized by inflexibility, repetition, a prescribed form and altered consciousness.⁹ Rituals are divided into two main groups: rites of passage (*rites de passage*) and rites of intensification (*rites de confirmation*). Rites of passage mark social and cultural transitions, the most obvious of which are those linked with major transitions in life such as birth, marriage and death. But they also include rituals surrounding

⁸ C. MENKEN-BEKIUS: *Rituelen in het individuele pastoraat. Een praktisch-theologisch onderzoek* (Kampen 1998); IDEM: *Werken met rituelen in het pastoraat* (Kampen 2001).

⁹ O. VAN DER HART: *Overgang en bestendiging. Over het ontwerpen en voorschrijven van rituelen in psychotherapie* (Deventer 1978).

illness (for example, healing rituals), divorce, moving house, graduation and retirement). Rites of intensification are repeated regularly and aim at maintaining stability during one of life's phases.

The French ethnologist Arnold van Gennep described the characteristics of a rite of passage in his *Les Rites de Passage* of 1909, and provided the framework that has been used ever since then for studying the transformational power of ritual. Van Gennep looks at territorial and status-related transitions, and distinguishes three phases in them: separation, transition and incorporation or aggregation. In the separation, or 'pre-liminal' phase there is a severance of some kind, in which an old social position is left behind. In the transition phase, also known as the marginal or 'liminal' phase, the actual transition takes place. It is an ambiguous or paradoxical state, seen variously as somehow holy or as impure. In the final phase of incorporation (the 'post-liminal' phase), people participate anew in the life of the society, but now from a new social and cultural status. This framework was expanded by the anthropologist Wallace, who added a phase that precedes the ritual and one that follows it.¹⁰ In the pre-ritual phase, learning processes take place which familiarize the individual with how the existing culture sees the process and with the end result of the ritual. The phase which follows the ritual is all about the continued effect of amulets, charms, ornaments or other symbols handed out during the ritual. Turner focuses explicitly on the middle, or liminal phase, identifying three characteristics.¹¹ Firstly, it involves a confrontation with the cosmogony, the religious vision of the community (the 'communication of sacra'). Secondly, these 'sacra' can be playfully distorted and enlarged, leading to a reflection on the fundamental values of the social and cosmic order ('ludic deconstruction and recombination of sacra'). And lastly, the social inequality between the participants in the ritual is diminished, leading to a sense of equality and camaraderie/companionship, a kind of universal brotherhood that transcends everyday social boundaries (*communitas*).

3.3. The functions of ritual

Lukken distinguishes a wide range of dimensions of ritual, most of which can be seen as functions.¹² They are: negotiating with the past, disburdening and canalizing, a therapeutic function, an expressive function, an exorcising function and a social function. Pieper looks at it from the angle of individual wellbe-

¹⁰ E. CANDA: 'Therapeutic transformation in ritual, therapy, and human development', in *Journal of religion and health* 27 (1988) 205-220.

¹¹ V. TURNER: *The forest of symbols. Aspects of Ndembu ritual* (Ithaca 1967); IDEM: *The ritual process: structure and anti-structure* (London 1969).

¹² G. LUKKEN: *Rituelen in overvloed. Een kritische bezinning op de plaats en de gestalte van het christelijk ritueel in onze cultuur* (Baarn 1999).

ing and indicates two main functions:¹³ canalizing or evoking emotions and providing an interpretive framework. A ritual can provide an outlet for emotions that are hard to express. This happens along the fixed channels that a ritual provides, ensuring that the individual is not overwhelmed. At a wedding, these may be feelings of joy and celebration; at a baptism, feelings of wonder; and at a funeral, a sense of being lost for words when confronted with the question of the meaning of life. A ritual can also bring a person back in contact with suppressed emotions. For example, a visit to the pilgrimage site Lourdes can bring to the surface feelings about the loss of health, and can lead to an acceptance of this loss. So there can be a canalization of overwhelming emotion or a reawakening of suppressed emotion. The second function of ritual identified by Pieper is the provision of an interpretive framework (cognitive level). The situation people are in is interpreted and given direction. In some sense it is given meaning. At a funeral, for example, that meaning is found in the Christian belief in a life after death, implying a possible future reunion with the dead. Rites ease the transition to a new role by offering an explicatory framework, an ideology which explains how to behave in the new social position and which also legitimizes that position. In relation to initiation rites, Van der Hart points out that the ancient myths and key symbols (cosmology) are transmitted to the initiates.¹⁴ Further insight into the way ritual works cognitively is offered by the attribution theory, which suggests that people seek explanations and interpretations of exceptional and far-reaching life events. These explanations and interpretations may address the causes of life events ('causal attribution', which is done with hindsight) or their implications for the future ('attribution of meaning')¹⁵. Psychodynamic theories are more suited to explaining the affective impact of rituals. Jung, for example, points out that the symbols in ritual make it possible to make contact with the archetypes of the collective unconscious in a non-threatening manner. Ross and Ross assume that there are parallels between the liminal phase and the relationship between mother and child in the pre-oedipal phase.¹⁶ Turner stresses the experimental, creatively playful nature of liminality.¹⁷ This fits well with the emphasis of object relations theorists such as Winnicott (1971) and Pruyser on the use of (often religious) imagery as a

¹³ J. PIEPER: *God gezocht en gevonden? Een godsdienstpsychologisch onderzoek rond het kerkelijk huwelijk met pastoraaltheologische consequenties* (Nijmegen 1988); M. VAN UDEN & J. PIEPER: *Religie in de geestelijke gezondheidszorg* (Nijmegen 1996).

¹⁴ O. VAN DER HART: *Rituelen in de psychotherapie: overgang en bestendiging* (Deventer 1984; tweede en uitgebreide uitgave).

¹⁵ R. BULMAN & C. WORTMAN: 'Attributions of blame and coping in the "real world": severe accident victims react to their lot', in *Journal of personality and social psychology* 35 (1977) 351-363.

¹⁶ M.R. ROSS: 'Mothers, infants, and the psychoanalytic study of ritual', in *Signs: journal of woman in culture and society* 9 (1983) 26-39.

¹⁷ V. TURNER: 'Variations on a theme of liminality', in S. MOORE & B. MEYERHOF (eds.): *Secular ritual* (Assen/Amsterdam 1977).

psychic resource people have for preparing themselves for a confrontation with reality.¹⁸

3.4. Applications in spiritual care

Here we will address two theories about effective functioning of rituals that are especially relevant for spiritual care. The first is a theory about the creation of a farewell ritual in psychotherapy. This is a development that has also found its way into the domain of pastoral work and spiritual care. The second theory concerns Menken-Bekius's model in which the effectiveness of a ritual is taken to entail doing justice to three aspects: the individual, the group and the meaning system.

Van der Hart (1981) developed a ritual for processing loss in the context of long-term therapy.¹⁹ In a psychotherapeutic treatment, the processing of loss of life, health, relationships etc. can be helped towards closure by developing and carrying out a farewell ritual. This is done in consultation between the client and the therapist. Farewell rituals consist of several phases, which are reminiscent of Van Gennep's rites of passage. In the preparatory phase, explanations are offered of possible effects of rituals. Examples give the client a sense of standing in a certain tradition. The re-ordering phase is the phase in which the client carries out a number of concrete tasks which stimulate an internal process until a certain degree of closure is reached. The client can make objects that serve as symbols for the link he/she still feels with the past (drawings, paintings, statues or stories). The various activities in this stage can evoke strong feelings and emotions. The therapist guides the client in this exploratory creative process so that such feelings are brought to light within the safe framework of the ritual. Once this re-ordering phase has been completed, the concluding phase can begin: here the client conducts a farewell ritual, ceremonially distancing himself from the symbols created or collected. This farewell often takes the form of burning or burying the objects, or casting them into a river or sea. Distancing oneself from a precious object symbolizes the farewell from the person or thing that it stands for. The concluding phase is followed by a short purification ritual, in the form of a shower or bath, for example. The entire process is brought to an end with a reunion ritual, perhaps in the form of a meal with the main social relations in the new life phase (partner, friends, or family). Van der Hart points out that in such a ritual the unique situation of the client in question must be born in mind and catered for.

It is interesting that in her research among 280 pastors and spiritual carers (both Protestant and Catholic) in the province of Utrecht in the Netherlands, Menken-Bekius found that comparable rituals were being practiced in pastoral

¹⁸ D.W. WINNICOTT: *Playing and reality* (New York 1971) en P. PRUYSER: 'Vormen en functies van de verbeelding in religie', in IDEM (red.): *Geloof en verbeelding. Essays over levensbeschouwing en geestelijke gezondheid* (Baarn 1992) 101-120.

¹⁹ O. VAN DER HART: *Afscheidsrituelen in psychotherapie* (Baarn 1981).

and spiritual care.²⁰ Twenty percent of those questioned were making use of 'new rituals'. This category included farewell rituals following a course entirely or partially in line with Van der Hart's phases. Examples were: a special good-bye ritual, a visit to a symbolic place, burning a text, writing a letter to the deceased, a reunion ritual in a difficult relationship, and burying or burning a symbolic object. The spiritual carers who made use of these sorts of ritual were mainly chaplains working in institutional settings, while parish priests and ministers tended to keep to traditional Catholic and Protestant rituals.

The second example is the function triangle described by Menken-Bekius (1998) in her thesis.²¹ An effective ritual, she says, should make sure there is an appropriate balance between the individual, the group and the symbolic meaning system. At the individual pole, what is at stake is the ritual's impact on mental health. Rituals structure and give order to daily life and also to the major transitions in a person's life. At the group pole, there is the social function of a ritual, which usually has some meaning for the group and the community. Rituals strengthen group identities. The symbolic meaning system pole, finally, encompasses the ideology of the ritual: the totality of convictions, perspectives and dogmas in a particular tradition. Like this, the past is offered as an explicatory framework for the presenting existential or social problem. Although not every pole is of equal importance in every ritual, it is nevertheless important that they are all addressed at some level, for the ritual to be considered as fully functional. In her booklet *Werken met rituelen in het pastoraat (Working with rituals in pastoral care)*,²² Menken-Bekius analyses a series of rituals in pastoral practice from this angle or better triangle.

4. Rituals in general spiritual care in an outpatient context

In the first section of this paper, we described the changed context of society at large and the health sector in particular. In a nutshell, what is happening in the health sector is a process of transmuralization, putting pressure on the current provision of spiritual care intramurally. In society at large, the religious context has changed through processes of individualization, desecularization and resacralization, resulting in ever decreasing membership of religious communities and a tendency for people to construct their own spirituality combining elements from various religious traditions as well as contemporary spiritual trends. In section two, we addressed the meaning of the kinds of ritual that play an important role in spiritual care. We noted that rituals can be meaningful for people in crisis situations. But how can they be created in the new context in the society and in the health sector?

²⁰ MENKEN-BEKIUS: *Rituelen in het individuele pastoraat*.

²¹ MENKEN-BEKIUS: *Rituelen in het individuele pastoraat*.

²² MENKEN-BEKIUS: *Werken met rituelen in het pastoraat*.

This is one of the questions in a research project that is being carried out at the Radboud University Nijmegen Medical Centre (RUNMC) under the supervision of a research panel with members from various disciplines and universities.²³ In this section, we will start with a short outline of our frame of reference and research questions, and a short description of an initial pilot study. One of the cases in this pilot study helps us to reflect on the scope for ritual in general spiritual care in the light of the new society and health care context.

4.1. The research project and pilot study

Hitherto, spiritual care has only been provided and funded in hospitals, whereas health care is increasingly being delivered through the outpatients department, day care centers or general practitioners. The Spiritual Care department at RUNMC feels it should address this problem by starting to provide spiritual care for outpatients at the hospital, in the belief that this contributes to the quality of the care provided and to the quality of life of outpatients who are confronted by weighty issues.

Quality of care is coming in for quite some attention these days in the light of the social pressure to create a more efficient, effective and safe health service. In Nijmegen, particular attention is paid to the quality of care, and great efforts have been made to improve it following problems experienced in the heart surgery department. In RUNMC's vision on health care it is not just technical targets that count. In 2007 there was an initiative to give new expression to the hospital's Catholic identity in its patient care, which resulted in the concept of 'humane care' in which the patient was to be treated with attention, compassion and respect. This 'humanity' is seen as the 'soul of our care' and as a virtue that should be in evidence at every level from the individual to the institutional.²⁴ Seen like this, humane care adds value – human value – to the improvement of health care. Truly seeing patients as they are and making genuine contact with them is also more likely to bring out their spiritual needs and make these visible to staff. Guidelines on spirituality such as those developed by the Spiritual Care Department, with standards on spiritual needs and spiritual coping, can provide some help here. The aim is to increase alertness to patients with spiritual needs or for whom spirituality contributes to coping with health problems, as well as to increase the accuracy of referrals to spiritual care. This will equally apply to the outpatients department, in which spiritual care is virtually absent to date.

²³ The disciplines involved are spiritual carers, doctors, nurses, and psychologists. They are at work within the Radboud University Nijmegen, Utrecht University, Tilburg University and the Hague Parnassia Centre.

²⁴ M. PIJNENBURG: *Menslievendheid: ziel van onze zorg. Advies ALEA* (Nijmegen 2007); IDEM: *Sources of care. Catholic healthcare in modern culture. An ethical study* (= proefschrift Radboud Universiteit Nijmegen) (Nijmegen 2010).

The objective of providing good care has generated an increasing emphasis on measuring the quality of life.²⁵ The RUNMC is doing research on the quality of life in collaboration with the Faculty of Philosophy, Theology and Religious Studies. In this research, particular attention is paid to the relation between quality of life and spiritual wellbeing. As early as 1982, Paloutzian and Ellison pointed out that the contribution of spiritual quality of life is often excluded from measurements of overall quality of life.²⁶ They therefore developed a scale specifically for measuring this spiritual quality: the spiritual wellbeing scale. According to Schilderman and Van Laarhoven,²⁷ there is an explicitly ethical dimension to this, namely that people's own moral and religious convictions partly inform their ideas of a good quality of life. There seems to be a certain tension between the essentialism of religious traditions and the more existential orientation towards competencies when we talk about quality of life. Nevertheless, Schilderman and Van Laarhoven believe that the religious aspects of quality of life can easily be combined with the capability approach, and they apply it to spiritual care around death and bereavement. Van Laarhoven et al., have researched the links between images of God and coping strategies among palliative cancer patients.²⁸ The importance of their research lies in the way they relate changing ideas of God to the way in which patients relate to their illness. It emerges, for example, that a personal God goes together with religious coping strategies, whereas an impersonal God is more often combined with strategies such as gathering information, seeking moral support, and denial.

The focus on quality of care and quality of life provide the two perspectives for the research: the perspective of the health carer and that of the patient. This leads to two central research questions. Firstly, we aim to find out to what extent providing extramural spiritual care can contribute to the quality of care provision. Secondly, we want to investigate how far the provision of extramural spiritual care contributes to a patient's quality of life; in the provision of this spiritual care we focus on rituals: how they can be meaningful for patients and how they can be created in the new context in society and in health care.

We have opted to concentrate on patients who receive most of their health care from the RUNMC, with their main treatment being provided by one of RUNMC's specialist doctors. This treatment is provided through the outpatients department, and for this reason we have chosen to start by offering spiritual

²⁵ H. DERKX: 'Kwaliteit van leven (KvL): een nieuw begrip in de geneeskunde', in *Tijdschrift voor kindergeneeskunde* 71/3 (2003) 81-82.

²⁶ R. PALOUTZIAN & C.W. ELLISON: 'Loneliness, spiritual well-being and quality of life', in L. PEPLAU & D. PERLMAN (eds.): *Loneliness: a sourcebook of current theory, research, and therapy* (New York 1982) 224-237.

²⁷ H. SCHILDERMAN & H. VAN LAARHOVEN: 'Kwaliteit van leven in de zorg rond het levenseinde', in *Handelingen* 35/5 (2008) 52.

²⁸ H. VAN LAARHOVEN, J. SCHILDERMAN, K. VISSERS, C. VERHAGEN & J. PRINS: 'Images of God in relation to coping strategies of palliative cancer patients', in *Journal of pain and symptom management* 40/4 (2000) 495-501.

care to outpatients. We started the research with a pilot project at the outpatient's wing of the palliative care department. Patients who are terminally ill and need palliative home care are a category of patients for whom we expect life's big questions in relation to sickness and death to play a prominent role. Palliative care at the RUNMC is conducted by the Department of Anesthesiology, Pain and Palliative Medicine, where efforts are made to relieve the severe suffering of patients with a terminal illness of which they are expected to die. The Palliative Consult Team (PCT) sets itself the target of providing care for palliative patients based on a balanced and well-coordinated collaboration between all the disciplines involved. One of the members of this team is a spiritual carer from the Spiritual Care Department, in the role of 'spiritual care consultant'. The pilot research we carried out was embedded in the activities of this PCT.

The form of contact that took place in the pilot project can generally be characterized as counseling and ritual guiding. Counseling means that certain aspects of the patients' experience were systematically explored, chiefly in order to support them in the process of saying goodbye and facing death. In spite of the short time span between the first meeting and the patient's death, it was nevertheless possible on several occasions to explore in some depth the patient's (and sometimes also the partner's) spirituality. Ritual guiding means that rituals played a key role in the communication between the spiritual carer and the patient. During the meetings there were shared prayers, texts were read or an image was looked at. And there was the simple sharing of silence. All this served to create the peace and the space for the experience of sorrow, anger and gratitude. Sometimes other forms of ritual were conducted, such as the laying on of hands or the administering of communion. Partners and other close relatives were usually involved in this, and there was aftercare contact with various close relatives or friends.

4.2. Case study: rituals in outpatient general spiritual care

A spiritual carer who was involved in the pilot study describes her experience of the contact with one of her clients. In all 8 cases we discovered more or less the complexity of outpatient spiritual care in relationship to the changes in society and health care, and also the particular role of rituals in general spiritual care. This one case provides a clear sketch of almost all mentioned aspects.

Mrs. L is about 60 years old, a mother of grown-up children, and with several grandchildren. She and her husband both grew up in the Christian church. He was brought up as a Protestant but over the course of their marriage; the Catholic Church gained a central place in their family life. The children were baptized and took first communion, and so did some of the grandchildren. After the early death of two young people in the family, some members of the family turned their back on the church. Mr. and Mrs. L live in a village.

In July 2008, Mrs. L became seriously ill and was admitted to hospital for several months. She described this as 'a very difficult period full of uncertainties and full of

medical treatments'. During her long periods in hospital she had regular contact with a spiritual carer from the hospital, something she valued highly. In the summer of 2010, her illness flared up again and she was treated at the palliative care outpatients department at RUNMC. In the context of the pilot study, she was offered contact with a pastor/spiritual carer. She indicated that she would seek such support in her own parish. Two weeks later Mrs. L was told at the outpatients department that she was to be admitted to hospital for a few days. She let it be known through the doctor that she would like to be put in touch with a hospital spiritual carer. I visited her on her second day in hospital and found both Mr. and Mrs. L in the room. Mrs. L told me that she had been told the previous day that she probably had a very short time to live and that a number of things needed to be decided as a consequence. 'The doctors wanted to talk to my husband and me about whether or not to resuscitate me. I also have to think about whether I want to be put on a drip... I find all this so difficult! I have been told I am dying but I haven't been able to find the time to reflect on this. How can I leave that until I get home?'

Together we sought to create space for her to take in the message she had received: 'I am dying'. There was space for tears and for deep sighs; for at last really taking it in that Mrs. L was dying. The couple reached out to each other and we sat quietly together. Into this space came the nurse from the palliative care team. She and Mrs. L had known each other for some time. I asked Mrs. L whether she would like to share with the nurse the message that had just demanded to be heard. The nurse took up the thread and I gave her my chair by the bedside. Mrs. L said she was grateful for my intervention and asked me to come back the next day.

The next day I found Mrs. L in the company of her husband and a daughter. Mrs. L: 'I don't exactly know why I have asked you to come. I don't have a question...'. I referred to the previous day and suggested that shared silence might once again help us to find our way. After a long silence, Mrs. L talked about what death meant to her, and what life meant to her. And she asked me to guide her on her way towards death. 'And would you also be willing to conduct my funeral?' One of her daughters came in and together we explored what it meant to prepare and plan a funeral. Mrs. L told us: 'all the children and the grandchildren have a role to play too. Could that help them to process their grief? We are all dying a little bit...'

I found out to what extent the funeral could be planned and presided over by the family's own parish priest and/or the spiritual carer she had previously had contact with at home. Mrs. L indicated that she wanted a funeral that did justice to who she was, but more importantly which allowed space for those of her children who no longer go to church because of the blows life had dealt them. Mrs. L said she found it difficult to make the transition to home. There was talk of a transition ritual or the administration of the sacrament of the sick, with prayers for the family to receive the strength they needed for the road ahead of them.

When I returned the next day, it was busy in Mrs. L's room. The last medical treatment had been given; the last arrangements had been made with health care workers; and the next day Mrs. L would be going home to be able to die there. I shook hands with Mrs. L, her husband and a daughter who was present. Mrs. L expressed how important it had been to her that there had been attention for the things that really mattered to her.

A few days later, Mr. L got in touch with the Spiritual Care Department and told me that they had been in touch with the local spiritual carer, who led a previous

funeral in the family in a way that people liked. If Mrs. L wanted her funeral service to be held at the parish church, then this pastor was the obvious person to lead it. And so it was decided that she would help with planning the funeral and would conduct it.

Mr. and Mrs. L had another question for me. 'At the hospital we also talked about the sacrament of the sick. Would you be willing to come to us to administer this?' They explained how meaningful they found our contact, and the fact that I had managed, in the face of all the issues and activities thrown up by the clinical setting, to create space for something that had not been given any space up to then: the news that no further treatment was possible and that Mrs. L would die very soon. This had inspired confidence and led to her taking the first steps in the hospital towards a new horizon, planning a ritual in which all her nearest and dearest could participate: going further together down the road ahead of them.

The sacrament of the sick was administered less than a week later. Beforehand, via email, a little book was put together with the family. Mrs. L was lying in bed in a small room on the ground floor. All the children and their spouses and the grandchildren were present, the youngest children sitting on the bed. The spiritual carer from the home environment was there too, and it had been agreed that she would say a few prayers. Because not all of the children had been confirmed and not everyone present had any affiliation with a church, a small plate of pieces of 'ordinary' bread was set down.

Beside the bed, a little 'house altar' was set up for the occasion, bearing objects connected with significant moments in the lives of Mrs. L and her husband: a statue of Mary, a statue of the Buddha, photos of deceased family members and their wedding candle, which Mr. L lit. We read a poem by Elisabeth Kübler Ross which Mrs. L said expressed her feelings: 'If I had not loved so much, I would not be suffering so much now. But heaven knows: I wouldn't be without a fraction of that so precious love'.

Everyone laid hands on their mother/mother-in-law/grandmother, thus blessing her. We prayed, we were silent, and we broke bread together. There was weeping. Almost all the children and grandchildren took communion. Then, as if Biblical times had returned, Mrs. L 'blessed' her children, grandchildren, husband and children-in-law by speaking from her bed about the love she had felt and experienced. She spoke of her faith that that love would continue after her death as well. As a blessing for Mrs. L, all the children and grandchildren, all those present offered her a red rose and made their own gesture of affection: a kiss, a few words, a tear, a smile. Mr. L and the children stayed with Mrs. L while coffee was served in the living room. One of the grandchildren was playing fanatically with his Nintendo. 'Do you know that my grandma is the kindest grandma in the whole wide world?', he asked without looking up from his game. When I asked him whether he had told his grandma that, he said: 'I don't have to. She knows!' The oldest grandchild looked me in the eye and said: 'There are so many horrible people in the world and people who do bad things and aren't kind. And my grandma, who is so sweet, gets sick and dies. It isn't fair!'

Ten days later I heard from the doctor on the palliative care team from the hospital that Mrs. L was extremely ill. The spiritual carer from the home environment got in touch with me to say that it looked likely that the funeral would take place during her holiday, and the family asked whether I could conduct the funeral in that case. Mrs. L died a few days later.

The day before her holiday began, the spiritual carer from the parish got in touch again and explained that the family had chosen only music on CDs for the funeral. Most of the service had been filled with poems and other texts, together with a lot of music. The reading chosen was from the *Book of Proverbs* ('a strong woman...'). I contacted the family. The trust that had been built up at an earlier stage was confirmed, but so was the pain in relation to the church and the Christian faith. They made clear that the funeral should be conducted in line with their wishes. It was decided in consultation that I would preach, and that a link would be made with the parish community by hanging a memorial cross on the big cross at the back of the church on behalf of the parish. In the communion rite the 'old words' would be heard and the text of the absolution would be heard in its entirety. These fixed liturgical elements lent a certain order to the service, or so it was experienced on the day of the funeral. During the sermon, the question was posed: 'But where is the Lord in the life of this strong woman?' And so the question posed by the grandson during the sacrament of the sick was heard.

The local church volunteers and the church warden who help at the service said they were glad to be able to help with this service for Mrs. L and her family. They were open-minded about the way it was done, and the consultation process went well. The service was described both by family and church volunteers as 'impressive' and 'meaningful' – a view shared by Christians and non-Christians and by regular and occasional churchgoers alike. All the children and grandchildren were able to contribute, but there was also a place for age-old gestures, rites and words. The presence of a doctor from the hospital was experienced as very comforting. The next day there was contact with the family by telephone and it was agreed to meet again in a few weeks. The two spiritual carers, from the parish and the hospital, also rounded off our contact with a meeting.

4.3. Reflections and discussion

If we examine this case in the light of the foregoing notions, several striking points emerge. We will conclude our paper by taking a look at the following topics: the 'do-it-yourself spirituality' of our clients; the spiritual position of the spiritual carer; the legitimacy and effectiveness of rituals; the process of developing rituals; the distribution of attention during rituals over the individual, the group and the religion; the quality of care and the quality of life.

Let us start by considering what we have called the clients' do-it-yourself approach to spirituality. This is something that comes out very clearly in the case we have taken. On the house altar set up for the sacrament of the sick stands a wedding candle and a crucifix, both belonging to the Roman Catholic tradition. There is also some Lourdes water – not so much because Mrs. L is a devotee of the Virgin Mary, but because it connects her with the friend who brought it back for her. And in the midst of these Catholic symbols stands – like an old companion – a Buddha statue. This is there because Mrs. L meditates and finds it very helpful to do so, she has told the spiritual carer. Shrines are an interesting phenomenon for research on how people put together their own spirituality

from different sources.²⁹ The funeral of the client was a mix of traditional elements from the rite of interment and modern spiritual sources in the forms of poetry and music. This example illustrates the desecularization and resacralization discussed at the beginning of this article.

Then there is the spiritual position of the spiritual carer. Some of our minister or priest colleagues would balk at the positioning of the cross and the Buddha side by side. Not this spiritual carer, whose own spiritual journey involved a literal journey to the East, where she found both a broader perspective and fresh inspiration for her Christian background. There are numerous examples of Christians who took this path and have written about it: Karlfried Graf von Dürckheim, Thomas Merton, Han Fortmann, Jeroen Witkam and Hessel Postuma, to name but a few. Buddhism is particularly popular in the west, largely due to the added depth people find through meditation. Mindfulness is promulgated in the health service, in the Netherlands by the Catholic RUNMC, among others. Among the students following the training program for general spiritual carers, there are some for whom their encounter with Buddhism has enriched their Christian faith, and others for whom it has led to a real conversion, which they seek to express in the professional context by establishing a Buddhist chapter of the professional association. A spiritual carer is – in the words of Quartier – a ritual counselor, choosing an appropriate ritual for particular patients and their environment. The spiritual carer draws on the information the patient supplies and her or his knowledge of worldview-related traditions. Sometimes the spiritual carer is able to preside a ritual from a specific tradition, in other occasions one has to look for another carer from a specific tradition. That depends on the ritual and the correspondence between the worldview of the patient and the carer.³⁰

We spoke above of the relation between the legitimacy and the effectiveness of rituals, and it was suggested that the arrival on the scene of the general spiritual carer might increase the emphasis on effectiveness. That appears to be true in this case, in which neither the client nor those around her were the slightest bit concerned about the legitimacy of the person conducting the ritual. Quite the contrary, in fact: the patient was anxious to avoid the spiritual carer taking up a too narrowly ecclesiastical and doctrinaire stance that could alienate her children and grandchildren from the whole event. This came out very clearly both during the sacrament of the sick and during the planning of the funeral. And in the responses after the funeral, not just the family but all those present and the church volunteers involved were full of praise for the form chosen.

²⁹ TH. QUARTIER: *Veranderende rituelen rondom de dood* (= symposiumbijdrage) (Nijmegen 2009); J. WOJTKOWIAK & H.J.M. VENBRUX: 'Gedenkplekken in huis. Hoe het 'postsels' zich manifesteert rondom huisaltaren in Nederland', in C. HALLEN, M. PRINS & M. VAN UDEN (red.): *Religie doen. Religieus handelen in tijden van individualisering* (Tilburg 2009) 82-96.

³⁰ TH. QUARTIER: 'Deathbed rituals. Roles of spiritual caregivers in Dutch hospitals', in *Mortality* 15/2 (2010) 107-121.

The form of ritual chosen was oriented towards helping the patient to prepare for the end of her life and helping those around her to deal with their loss. In other words, the effective contribution of the ritual to individual, psychological and spiritual processes was central. This brings us to the next point: the process of developing these rituals.

Van der Hart makes a distinction between the various phases in a farewell ritual. In this case, we saw these phases spread throughout the entire process of counseling and guiding the patient and those around her. From the moment that it became clear that her death was approaching, an important focus of discussions was how to approach the end of one's life and to say goodbye. This included the preparation phase and the re-ordering phase, in which the possible content of the ritual was discussed and an emotional conversation took place about issues from the past and present that were still worrying the patient in some way. The completion phase then took place in the home environment in the form of the sacrament of the sick and the funeral. An interesting theme for further reflection is in what sense one can speak of a purification ritual taking place in the sacrament of the sick: what is the meaning of the repeated use of water in this ritual? And to what extent does burial or cremation – which always had a hygienic function – signify a form of purification for the participants? The administration of the sacrament of the sick and a funeral is very often followed by a gathering in the form of coffee or a shared meal.

In these rituals there was an attempt to share the attention equally over the individual, the group and the symbolic meaning system, in Menken-Bekius's terms. For the patient, the sacrament of the sick clearly had a beneficial effect on her mental wellbeing, which was perhaps most evident in the way in which she gave her family her blessing for the future, and the way she took the process of parting into her own hands. In the funeral, on the other hand, the social function was more prominent in the way in which everyone was able to express their relationship with the deceased in their own way, and the way these diverse elements were woven into one whole by the minister. The function of the meaning system was clearly addressed during the preparation of both rituals, by exploring together which traditional elements they included and which ones the patient and her loved ones wished to use. Both listening to time-honored texts and using contemporary texts, music and symbols are ways of giving meaning to life and of finding an identity: something Ricoeur calls the process of refiguration (cf. Dupont, 2010).³¹ This process combines the individual, the social and the symbolic meaning functions.

To what extent does this case constitute a contribution to the quality of care? In terms of the effects of ritual, one advantage of providing spiritual care via the outpatients department certainly seems to be the continuity of support that it makes possible. The continuity between the various phases of the ritual is

³¹ J. DUPONT: *Identiteit is kwaliteit. De identiteitstheorie van Paul Ricoeur als voorstudie voor een verbeldering van de identiteit van katholieke basisscholen in Nederland* (Budel 2010).

hampered if a series of different carers step into this role. Counseling processes are often disturbed when a new counselor comes in with different ideas and approaches. In the health care sector in general, a smooth handover is a key issue in efforts to improve the quality of care. In pastoral or spiritual care, such a handover is complicated by the relative lack of professional standards on which the professionals all agree. The gulf dividing intramural spiritual carers from extramural spiritual carers adds to the problems here. In the kind of delicate situation at stake in palliative care it is strongly recommended to work with a small team of counselors who coordinate the process in close collaboration. In order to address the quality problem, we at the RUNMC have started intervention and coaching on spirituality for spiritual carers and other professionals engaged in first and second line health care.

Lastly, there is the issue of the patient's quality of life. As Van Laarhoven and Schilderman pointed out, moral and religious themes deserve more attention than they get in this respect. By being offered outpatient spiritual care, this patient was given a space in which to raise issues she was at first unable or unwilling to express. From the account of the spiritual carer we gather that space and openness are extremely important. Many patients, whether in palliative care or not, find it difficult to express their spiritual experiences and to articulate their needs and expectations. This relates on the one hand to the taboo that often seems to be placed on religion and spirituality – and in this sense taboo means not just a negative ban but also a positive protective mechanism. And on the other hand, it has to do with the fact that the old formulations and images do not work for people any more, and yet they have not yet found a new language for expressing their spiritual experience.³² In the light of this, the approach of this pilot research is definitely a useful one: no excessive demands are made on people to formulate their spiritual needs and wishes in an autonomous and self-reflective manner; instead the outpatients department offers them a helping hand to find a way through it together, not just in terms of their physical, psychological and social welfare, but also at the spiritual level – which, according to the WHO (World Health Organization), is part and parcel of the health of a human being.

Nicolette M. Hijweege: lecturer in pastoral psychology and spiritual care at the Faculty of Humanities, Utrecht University.
E-mail: n.m.hijweege@uu.nl

Jos Z.T. Pieper: senior lecturer psychology of religion at the Faculty of Humanities, Utrecht University, and Tilburg School of Catholic Theology, Tilburg University.
E-mail: j.z.t.pieper@uu.nl

³² W. SMEETS & N.M. HIJWEEGE: 'Geestelijke verzorging als ondersteunende discipline in de oncologische zorg', in K. JORDENS & I. NEIJNENS: *Oncologie en geestelijke verzorging* (Apeldoorn 2010) 50-69.

Wim Smeets: lecturer in theology and spiritual care at the Faculty of Humanities, Utrecht University, and head of Spiritual Care Department Radboud University Nijmegen Medical Centre.

E-mail: w.smeets@uu.nl.

Hans Hamers: psychologist and spiritual carer at the Spiritual Care Department Radboud University Nijmegen Medical Centre.

E-mail: h.hamers@dgvp.umcn.nl.

Jacqueline van Meurs: spiritual carer at the Spiritual Care Department Radboud University Nijmegen Medical Centre.

E-mail: j.vanmeurs@dgvp.umcn.nl.