Re-evaluating a suicide pact
Körver, Jacques; Muthert, Hanneke; van Hoof, Monique; Walton, Martin N.

Published in:
Tidsskrift for Praktisk Teologi

Document version:
Peer reviewed version

Publication date:
2019

Link to publication

Citation for published version (APA):
Valuing one’s holding to a suicide appointment. Embodied moral counseling in a Dutch case study of chaplaincy in Mental Health care

Hanneke Muthert, Monique van Hoof, Martin Walton, Jacques Körver

Introduction: The Dutch case study project

The state of the art in chaplaincy as has been presented in this volume shows an upcoming need for research in this particular field preferably carried out by using various methods. In building good research data for communicating the profession of chaplains/spiritual caregivers adequately, case study materials are worthwhile. The reasons are at least fourfold. First there is an absence of good comparable examples of spiritual care interventions in research literature. Second, and central in this paper, there is a need to learn more about the specific relationships between theories spiritual caregivers use and various concrete practices. Third interdisciplinary communication about good health care practices would benefit from clear examples and fourth, there is a need for good educational materials. Following the general outline and initiative of George Fitchett and Steve Nolan’s case studies design in the United States (2015; Fitchett 2011), in the Netherlands Martin Walton and Jacques Körver initiated the Dutch case studies project (2017). They developed a concrete structured research format to describe case studies in the Dutch context that spiritual caregivers themselves assess as good examples. A multidisciplinary group of Dutch researchers sustained this initiative. The focus is explicitly on the provided spiritual care interventions. What kind of practices do spiritual caregivers agree upon as good care when they discuss several cases? For this goal the procedure for the research communities to work on these case studies was standardized (cf Walton & Körver 2017). Six parallel research communities were composed, each consisting of 8-12 experienced spiritual caregivers and one research scholar. Five specific fields characterize these different groups: psychiatry, elderly care, general hospital, defense and the judicial context. In the other mixed group spiritual counselors of various fields participate.

In this paper, we focus on the Dutch research community Mental Health Care asking the following research question: what helps spiritual counselors to reflect scientifically on their practices? First, based on observations in the research community, we sketch a working model for what we mean by reflection on practice. Next, we present a concrete case study after which we apply this working model.

Spiritual caregivers’ professional body of knowledge in Mental Health Care

One of the main observations in the research community Mental Health Care during the past two years (2017-2018) is that it proves to be difficult for the researcher members involved to reflect explicitly and adequately on the use of theoretical sources in relation to their own care interventions. This difficulty contrasts in a way with some initial group dynamics. When the group discussed a case in the beginning of the project, the temptation was manifestly there to assess critically the presented case study by arguments that hold core values and models other research members felt attached to. ‘If I was the spiritual caregiver in this case, I would have done things (completely) different by addressing….’ The presenters themselves also showed some hesitance in introducing their cases. As if it was difficult to believe that others would agree upon the idea that their cases are examples of good spiritual care. In time these interactions transformed in open and trustful discussions. However, being clear and concrete about the relation
between one's own theoretical sources and practices is still challenging. Other research communities of the Dutch case study project deal with similar processes. We recognize this reflective struggle of integrating practical care activities with theoretical knowledge in other settings as well. We see this quite strongly when inexperienced students do their internships in the diverse master programs spiritual care at university. The same is true for experienced spiritual caregivers in post academic courses. Although to a lesser extent, they too struggle to pour their 'professional body of knowledge' into concrete words and images. The idea that discourses of knowledge and practice are not easily bridged is certainly not new (cf supervision theory, for example the work of Louis van Kessel). In the field of case study research in psychotherapy, for example, one searches for solutions for the so-called science practice gap (Van Nieuwenhove & Notaerts 2019; Datillo et all 2010) These authors stress the lack of keeping updated by sciences in practice and vice versa, which obstructs learning from each other. Thus we can conclude that to bridge the gap between theory and practice we are faced with the challenge that we need explicit verbal representations of different professionals' bodies of knowledge, but exactly this putting into words proves to be difficult. A first step is to explore the concept of 'professional body of knowledge' in the context of spiritual care.

In humanistic transpersonal psychology (Marrone 1990) the particular concept 'body of knowledge' (BOK) emphasizes the lived-body experience as human in contrast to a more split body and mind concept. From a cognitive approach the term 'professional body of knowledge' (PBOK) is used for more or less detailed professional standards that are recognized as distinctive by specific professions (Morris et all 2006). In the field of spiritual care, based on our specific case study group observations as well as relevant theory we would suggest a description with elements that correspond to both definitions: 1) the human lived-body experience and 2) the more formal professional knowledge. Additionally we will add 3) the relational context as a building block because persons communicate by combining intra psychic processes with interpersonal ones and contextual influences (Remmerswaal 2013; Muthert 2019). We thereby build upon the following line of thought. Our case study research group members seem to be rather eclectic in the use of meaningful compilations based on different theoretical frameworks. These theoretical frameworks as such are commonly recognized as belonging to certain Dutch educational programs and they can be related to the professional standard (VGVZ 2015) of spiritual care. One can certainly speak about PBOK as related to the professional standards. However like other professions, the way a chaplain practices those elements and connects the diverse theoretical elements, asks for a more personal embodied (experiential knowledge, cf. Weerman & Abma 2018) and relational characterization next to spiritual skills. Chaplains combine their professional knowledge and experience with reflective spirituality and autobiographical knowledge and experiences. The research community agrees that for the sake of effective implementation, good spiritual care needs embodied or lived theory.

Therefore, based on best practices in our specific research community we propose the following working model. The way spiritual caregivers embody certain combinations of theoretical concepts and frameworks in interactive alignment with inter-relational processes and cultural factors together, do shape the (mutual) decision-making of meaningful intervening in a certain case. This process should not be equated with doing the job purely intuitively ('without knowledge'). But at the same time one could imagine it feels like that (not-knowing). Precisely because this embodied relation creates something new by combining the spiritual caregiver's PBOK in a specific spiritual care...
context actively with another person’s particular (spiritual) embodiment. The attunement (Stanghellini 2004, 68v) involved may feel as more decisive than whatever theory. This working model can at least partly explain the challenge to put the used theories in words. At the same time, our research group members insist that growing awareness (‘knowing’) of one’s own and other PBOK’s is rather helpful and stimulating in their present work (Cf the idea of ‘stimulated recall’ by Chittenden 2002). They mention it explicitly as one of the advantages of participating in the case study project. One could therefore argue that the intrinsic work motivation increases (Cf. Ryan & Deci 2017). The profession thus builds on two tracks that contrast. On the one hand one needs an attitude of not-fully-knowing during practice to be able to open up for a fruitful attunement. On the other hand, methodological reflection is necessary to make the skills involved explicit to be able to improve interactions next time.

We cannot evaluate this working model comprehensively by means of one case study. The first author will present a more thorough study of this PBOK elsewhere (in preparation). What we will do is the following. 1) First we present a case study by roughly keeping to the format (Walton & Körver 2017). 2) Additionally we show how the spiritual caregiver reflected on her PBOK with the help of other Mental Health Care professionals and the research community. 3) We conclude by evaluating how the three different PBOK elements in our work definition were involved (the human lived-body experience; the professional knowledge; the relational context). Within the presentation of the case study, the letters a-i indicate the places where, according to the research group, different moral counseling interventions took place in retrospective (see table 1).

1. A promise is a promise!? Moral counseling in the event of a life-threatening dilemma (cf. Van Hoof, Muthert et al. 2019)

The Mental Health Care research community presents the following case study as a good example of moral counseling. In this case, the counselor is a 54-year-old woman who works for seven years now as a spiritual counselor in the south of the Netherlands. Ethical and philosophical reflection in face-to-face contacts as well as group meetings next to policy questions in the health care organization is core business. She is also quite familiar with the hermeneutic philosophy of Gadamer and Nagy’s contextual therapy. After a meeting of moral deliberation concerning a client in the Clinical Department for adolescents, the spiritual counselor receives a referral from the main therapist of a 15-year-old girl named Esther. The reason is Esther’s struggling with an agreement she made with a girlfriend, almost one year ago. If one of the two would commit suicide the other would follow within a year. Now that the year has almost passed since her girlfriend actually killed herself, Esther experiences great pressure to keep her promise. The care team doesn’t know how to break the chain of compulsive thinking in terms of this agreement, which they link at her diagnosis of autism. Different kinds of cognitive interventions are not yet successful. Because of the time pressure four meetings are scheduled at short notice. As the therapist is concerned with Esther’s feelings of safety and her vulnerability in making new contacts, the therapist also joins the meetings. Esther has been in clinical care settings regularly the last few years. Her parents are divorced but with both of them she is connected. She used to be very good at team sports. There is no information concerning religious affiliation or philosophy of life in advance.
The counseling consisted of four interviews. In the first two meetings, moral counseling is central. The third conversation concerned ritual counseling aimed at confirming the chosen pathway. The last conversation was conclusive and focused on the future.

Meeting I

Esther, her therapist and the spiritual counselor meet in the practitioner's room. After a brief introduction, the counselor mentions that she knows from the practitioner that Esther is struggling with something difficult, but that she would like to hear the story directly from her. Esther stares at the ground and wobbles uncomfortably with her legs. Then she softly says: 'A promise is a promise. I think it's very important that I keep my promises'. She does not go into the content of what she promised. The spiritual counselor reacts by saying firmly that she truly appreciates it when people stick to their appointments. This response catches the attention of Esther, who is clearly surprised just like her practitioner. The spiritual counselor adds that life is much easier and pleasant if people keep their appointments. 'If we had not done so, it would not have been possible to have this meeting today. But sometimes agreements have to be reconsidered because you cannot or do not want to keep them for all sorts of reasons.' The spiritual counselor deliberately does neither directly address the problem of Esther's specific agreement nor her persistent attitude. (a)

The spiritual counselor then invites Esther to tell something more about her promise. Esther recounts in a soft tone that she made the agreement with her best friend that if one of the two would commit suicide; the other person would do the same. The spiritual counselor responds that it must be a very important friendship if you agree to put your life at risk together. Esther starts crying and says she misses her girlfriend. The counselor invites her to tell about her friendship. (b) Esther narrates that they met about two years ago in a care institution and it clicked right away. They had a lot of fun and that was a new experience. Before that time Esther never had friendships, she was bullied at school and she did not feel part of it; she was lonely. Both did not want to loose this experience of being together. Now the spiritual counselor asks what exactly moved Esther to make this appointment. Esther says that she assumed that if they made that promise, it would protect them from suicide precisely because the other's life was at stake. The spiritual caregiver: 'your own life may sometimes give the feeling that it is worth nothing, but the life of your girlfriend, you want to fight for that!' Esther looks straight at the spiritual counselor and clearly says: 'yes, that's it.' 'And,' continues the caregiver, 'the agreement for you was not an agreement to want to die together, but an agreement to be able to cope with life together.' (c)

Esther is in tears again and says she prefers to stop. She wants to go back to the department. The spiritual counselor notes that she sees that her last remark touches Esther, that Esther will miss her girlfriend very much and that she recognizes that as mourning. (d) Esther cries softly. She looks at the spiritual counselor and repeats that she would like to go back to the department. The counselor confirms that it's indeed enough for today. Respecting Esther's limits is important for the safety of contact. After bringing Esther back to the department, the practitioner expresses satisfaction with 'the depth of the conversation.' She sees a new perspective and she has the feeling that Esther might also.

Meeting II
A week later, they meet again. It is exactly three days before it was a year ago that Esther's girlfriend stepped out of life. Upon entering, Esther ducks down in a chair, her head on her chest. She talks even softer than the first time. The spiritual counselor asks if she can tell something about what is going on. She shrugs her shoulders and remains silent. After a while, the spiritual counselor says that it would be a difficult week for her, with all the memories of what happened a year ago. Esther nods almost invisible. The spiritual counselor decides to structure the conversation. First, she briefly summarizes the first conversation. She writes on the whiteboard: 'A promise is a promise. If one person commits suicide, the other person does too'. Esther looks up. Underneath that sentence, the spiritual worker puts in words what this agreement means to Esther: 'the agreement is made to protect you to commit suicide'. She asks Esther whether this is true. Esther nods. She is not sure about what the appointment exactly meant for her girlfriend. However, her girlfriend always said that if she finally would live on her own, she would commit suicide. Just before she did, she indeed had been given her own apartment. The last time they saw each other, the day before the suicide, Esther said to her: 'Don't let me sing!' That was also part of the agreement. If it would happen, Esther would sing a song at her girlfriend's funeral. The spiritual counselor translates Esther's 'Don't let me sing' as an emergency cry: 'Don't let me down, I want to stay here, I find life worth living'. (e) Esther nods visibly, but her words are unintelligible.

Following this nod the spiritual counselor adds the sentence ‘... I find life worth living’ on the whiteboard. Then she asks why Esther thinks life is worth living. Esther indicates that she has hope for a better future. Moreover, she does not want her family and current friends to feel the pain she felt when her girlfriend died. The spiritual counselor calls this love for and from the environment. She also asks Esther to reflect on the opposite: why would she like to die. Esther indicates that she herself sees no use and reason why she should live. And she wants to die because of the agreement. Both answers are written down. (f) Subsequently, the spiritual counselor asks Esther which choice she would make right now, seeing both arguments next to each other. Esther says that she would like to choose for life and she cries. After a silence, the spiritual counselor carefully summarizes that Esther had had a very difficult time in her past and that this particular friendship must have been a relief. With her girlfriend her hope for a better future has grown. (g) Esther returns to the department. The spiritual counselor promises to bring photos from the whiteboard later that day (h).

In the afternoon the atmosphere in the department is tense. The employees seem to be stressed. The spiritual counselor sits quietly with Esther for a while. She seems more relaxed than this morning and is glad with the photos. She is pleased with the proposal of an appointment on the day that it is a year ago that her girlfriend passed away.

Dropping in by the practitioner, the counselor shares her feedback on the atmosphere in the department. The practitioner mentions that the team has a difficult time. Recently there was another suicide. In search for control, the team wants to make firm restrictive agreements with Esther to protect her (and the department) from another suicide. The spiritual counselor argues that Esther, in addition to protection needs holding: support and trust. (i) The practitioner will discuss this in the team.

Meeting III

When the counselor picks Ester up, she shows her the memorial area she made with a picture of the two of them, a little book with written memories and tea lights. She takes
these items to the room of the spiritual counselor. They first light a candle for her friend followed by one for Esther, with the words ‘Let there be light and warmth for you’. Thereafter they have a look at the memorial booklet. Esther recounts her friendship through photos. They continue by reading her friend’s farewell letter. In the letter her friend expresses that Esther would continue living. Esther had not before taken that sentence in the way she understands it now. In the end, the counselor lets her choose two ceramic hearts. Esther places an orange one for her friend and a blue one for herself next to the candles. At the end she is invited to take the hearts with her, the candles will burn out in the room of the spiritual counselor.

Meeting IV

Five days later, they meet for an evaluation. Esther will move to a specialized youth clinic on short notice. School and treatment will be combined. Esther states that she no longer wants to die because of the suicide of her girlfriend. At the same time, she is quite often sad. She also has difficulties with life. The spiritual counselor refers to the whiteboard map and confirms that these feelings are there and will not magically disappear. Next to that she underlines Esther’s hope for the future and the other connections she cares about. Both feelings belong to life. But she might have struggled more with suffering than her peers. Finally, the counselor expresses the hope that Esther will experience increasingly future directions. She also informs if Esther will take up sports again. Her face lights up and she smiled.

2) PBOK reflections of this spiritual counselor, other professionals and the research community

Central in this case study is the question if Esther needs to keep her suicidal appointment with her girlfriend. Cognitive interventions do not seem to work. The spiritual counselor chooses for moral counseling: the guidance and assistance of clients who have to make moral choices in difficult circumstances. This process is aimed at being at peace with a choice or decision in the near future. The diagnosis autism is not leading in moral counseling. The counselor states that therefore the client can experience more space to search for significance, meaning and reorientation. This thought is inspired by the book ‘The secret of the empty middle’ (2003) written by the systematic theologian Theo Witvliet. Asked by the research scholar to elaborate on this theory before the first discussion in the research group, she highlights the protective function of the biblical image ban. Such an ‘empty middle’ counteracts too rigid fixations in conceptual thinking. In translating this idea to her case study, she sees the cognitive perspective operating too dominantly in treatment. The human struggle with life and death on the existential level needs more space.

In her first draft, the spiritual counselor takes her moral counseling approach more or less for granted. She distinguishes four interventions. 1) First, she wants to put Ester at ease and gain her trust. Therefore she uses self-disclosure; paraphrasing at the meaning level and allows Esther’s input on content and duration to lead the conversation. 2) Second, biographical values and meanings are examined. The spiritual counselor uses a value inquiry on the whiteboard. This promotes a fruitful distance between Esther and her concrete emotions and thoughts. The girlfriend’s perspective is also taken into account. 3) Third, the counselor tries to sustain the team by adding her perspective to
the team approach. 4) Finally ritual guidance confirms the connection as well as the boundaries between Esther and her girlfriend. This strengthens Esther's own identity.

Esther visibly feels better after the counseling. Her attitude, the way she makes contact and the tone and content of her speech speak for themselves. After an evaluation of this case study, Esther concluded: 'I was finally able to mourn the loss of my friend.' Her mother is grateful. Due to the interventions, Esther was able to reconsider her appointment. One nurse uses the word ‘magic’ for what happened. The team had more or less given up on change. However, suicidal thoughts remain present. There are more existential questions left. Caused by Esther's move to another institution, spiritual counseling ended here. If Esther had chosen death above life, further guidance would have been necessary. To the surprise of the counselor, Esther sees mourning as the most essential element of the contact, where she herself highlights moral counseling.

The therapist is not surprised about remarks of Esther on mourning in her evaluation of the written case study. All therapeutic intentions were aimed at that, but Esther’s suicide agreement stood in the way. To her opinion, the counselor's approach did indeed contribute to that. She could freely look at the suffering of the client at that very moment (Muthert 2019). She was also able to pay attention from different perspectives to a specific part of the problem: the values involved in Esther's dilemma. - Compared to the counselor, the treatment team also had to keep an eye on many other interests, for example behavior agreements, conflicts and department rules, future directions, the contact with the parents, other patient's safety etcetera. - Finally, the counselor was able to frame Esther's ideological values in a positive way.

The discussion in the research community was quite helpful in distinguishing more precisely what the counselor brought up in her moral counseling (meeting I and II). First of all, the group invited the spiritual counselor to be more explicit on her sources. During the discussion - based on the format related questions and remarks (Walton & Körver 2017) - explicit theoretical sources popped up quite naturally. Subsequently the distinguished actions of the moral counseling involved were adequately defined, see table 1.

<< insert table 1 about here>>

3. A short evaluation of the PBOK aspects involved in the case

To a certain degree, the spiritual counselor is aware of her moral counseling qualities and knowledge in this case. Moreover, she is asked to intervene especially because of this particular skill. At the same time, she is not following a strict protocol. And she needs the interaction with her research community to discern more clearly the different moral counseling interventions involved as well as her theoretical sources (PBOK). The research group recognized the case as an example of good spiritual care from the beginning. At the same time the group itself needs theoretical specifications to be articulated (BOK) to find out what exactly makes this case worthwhile. This joint reflection (relational) leads to a growing awareness of a shared idea of good spiritual care. The case study also shows the importance of direct relational aspects; both Esther's and the spiritual counselor's (non) verbal reactions are decisive. It is not possible to distil a generally valid interview schedule. The spiritual counselor 'simply'
finds out what to do next in attunement with her communication partner. Her (P)BOK is colored by her knowledge of the importance of exploring values, meaning and moral decision-making. She truly embodies that kind of knowledge and theory. The concrete situation, however, lead her to act the way she does in interaction with Esther.

The actual concrete health care context seems to be decisive as well, apart from other contextual factors (like her life story about youth, divorce, bullying, loneliness, a growing sense of friendship, the tremendous loss of a best friend). The department team is wrestling with the impact of a recent suicide. As a consequence they tend to behave quite strictly and regulative. One could argue that alongside the wish to protect everyone from another suicide, a more or less fixed idea of what is good for Esther in behavioral terms is articulated (non) verbally. In short, they expect Esther to keep to the department rules. At the same time, they expect Esther to change her mind completely about her private agreement. One could very well argue that Esther literally needs another context to experience more openness to look at her situation. The spiritual counselor frames what happens as moral counseling. Esther highlights mourning. Both frameworks touch upon the existential level where they do seem to meet each other. By attuning quite fruitfully, something new emerges: a new perspective on the immense existential issues of coping with freedom and death.

This analysis is only a beginning. We expect however that the way we describe PBOK in the context of spiritual care seems to be fruitful for further elaboration. One question concerns the specific concepts we use. A comparison with, for example, supervision theory seems to be interesting, although the format of the case studies approach (Walton & Körver 2017) mentions explicitly that an atmosphere of supervision should be avoided.

We can conclude by underlining that the research group Mental Health Care of the Dutch case study project is increasingly able to articulate what they do. The following factors seem to play a role in this: 1) a close observation and identification of interventions; 2) theoretical articulation and explanation; and 3) relating these interventions and explanations to concrete effects. Embodied interaction seems essential. The experience of an increased awareness proves to be helpful in framing interventions and skills in the communication with colleagues and other mental health professionals.

References


<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>Creating space for the human value of making appointments as well as for the struggle or ambivalence involved</td>
</tr>
<tr>
<td>b</td>
<td>The invitation to talk about friendship offers a different perspective on the relationship between the two girls than that of a problematic appointment</td>
</tr>
<tr>
<td>c</td>
<td>The spiritual counselor marks Esther’s interpretation of the agreement as ‘being able to cope with life together’ by/in friendship</td>
</tr>
<tr>
<td>d</td>
<td>By acknowledging the loss of her girlfriend, Esther herself can gradually acknowledge her own grief and loss</td>
</tr>
<tr>
<td>e</td>
<td>By paraphrasing the statement: ‘Don’t let me sing!’ on an existential level, Esther is acknowledged in her deepest need</td>
</tr>
<tr>
<td>f</td>
<td>What makes life worth living or not is clearly juxtaposed with values on the whiteboard (cf De Groot &amp; Leget 2011)</td>
</tr>
<tr>
<td>g</td>
<td>A connection is made between the past and the future by means of how Esther values friendship</td>
</tr>
<tr>
<td>h</td>
<td>With the concrete photos, Esther is given tangible control of her own valuing process as discussed together. This reinforces that she knows herself seen and heard in her choice.</td>
</tr>
<tr>
<td>i</td>
<td>Linking core values from Esther’s discussions with the spiritual counselor - including safety and trust in Esther’s own judgment and strength - to the department’s daily routines where protection is central.</td>
</tr>
</tbody>
</table>