Re-evaluating a suicide pact. Embodied moral counselling in a Dutch case study of mental healthcare chaplaincy

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ABSTRACT

Case studies in the field of spiritual care provide us with important information in the search for good care practices. However, the research process in the Dutch mental health care research community shows that good reflection on practice is not self-evident. To investigate this gap between practice and reflection we introduce the concept of professional body of knowledge (PBOK) in this field. On the one hand, practitioners need to adopt an attitude of not-fully-knowing in order to be open to fruitful atonement in communication. On the other hand, they need methodological reflection to make the skills involved explicit so that they can improve the interactions next time. With the help of one singular case study about moral counselling in the context of a suicide agreement between two adolescents, we show the case study approach in the Netherlands as well as a first application of our working model on PBOK.

Introduction: The Dutch case study project

The state of the practice of chaplaincy as presented in this volume reveals a growing need for research in this field, preferably involving a range of methods. Case studies are a useful tool for obtaining good research data that adequately communicates the profession of chaplaincy. There are at least four reasons for this. First, there is an absence of good comparable examples of spiritual care interventions in the research literature. Second, and central to this paper, there is a need for more information about the specific relationships between the theories that spiritual caregivers apply and concrete practices. Third, interdisciplinary communication about good healthcare 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), Martin Walton and Jacques Körver initiated the Dutch case studies project (2017) in the Netherlands. They developed a structured research format to describe

case studies in the Dutch context that were rated as good examples by spiritual caregivers. A multidisciplinary group of Dutch researchers supported this initiative. The explicit focus is on spiritual care interventions: when discussing different cases, what kind of practices do spiritual caregivers agree upon as constituting good care? Six parallel research communities were composed, each consisting of 8–12 experienced spiritual caregivers and one researcher. Five of the groups were characterised by one the following fields: Psychiatry, elderly care, general hospital, defence and the judicial context. Spiritual counsellors from various fields took part in the remaining mixed group. A standardised procedure was developed for the research communities to work on these case studies (Cf. Walton & Körver 2017).

In this paper, we focus on the Dutch mental healthcare research community and we ask the following research question: what helps spiritual counsellors to reflect on their practices? First, we sketch a working model, based on observations made by the research community, to show what we mean by reflection on practice. Next, we present a case study and then apply the working model.

Spiritual caregivers' professional body of knowledge in mental healthcare

One of the main observations in the mental healthcare research community during the past two years (2017–2018) is the difficulty researchers experience in reflecting explicitly and adequately on the use of theoretical sources in relation to their own care interventions. This difficulty is in contrast with some of the initial group dynamics. When the group discussed a case at the start of the project, they were clearly tempted to critically assess the case study in terms of arguments containing core values and models that other research members felt attached to. *"If I was the spiritual caregiver in this case, I would have done things (completely) differently by addressing ...".* The presenters also displayed some hesitancy in introducing their cases, as though they found it difficult to believe that others would agree that their cases were examples of good spiritual care. In time, these interactions transformed into open and trusting discussions. However, they continued to find it a challenge to be clear and specific about the relationship between their own theoretical sources and practices. Other research communities in the Dutch case study project deal with similar processes. We recognise this reflective struggle of integrating practical care activities with theoretical knowledge in other settings as well. We can see this clearly when inexperienced students do their internships as part of the various Master's degree programs in spiritual care. The same is true for experienced spiritual caregivers in post-academic courses, although to a lesser extent, they also struggle to express their "professional body of knowledge" in concrete words and images. The idea that discourses of knowledge and practice are not easily bridged is certainly not new (Cf. supervision theory, such as the work of Louis van Kessel). In case study research in psychotherapy, for example, researchers seek ways to close the "science-practice gap" (Van Nieuwenhove & Notaerts 2019; Datillio et al. 2010) These authors stress the failure on the part of practitioners to keep up to date with what researchers are doing, and vice versa, which obstructs their learning from each other. Thus, we can conclude that although bridging the gap between theory and practice involves a need for explicit verbal representations of different professionals' bodies of knowledge, articulating this has proven 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 concept of "body of knowledge" (BOK) emphasises the lived body experience as being human, in contrast to a more separated concept of body and mind. In the cognitive approach, the term "professional body of knowledge" (PBOK) is used for more or less detailed professional standards that specific professions identify as distinctive (Morris et al. 2006). In the field of spiritual care, based on our case study group observations and the relevant theory, we propose a description containing elements that correspond to both definitions: 1) the human lived body experience, and 2) the more for-

mal professional knowledge. We would also add 3) the relational context as a building block because people communicate by combining intrapsychic processes with interpersonal ones and contextual influences (Remmerswaal 2013; Muthert 2019). We thereby build upon the following line of thought. The members of our case study research group appear rather eclectic in their use of meaningful combinations based on different theoretical frameworks. These theoretical frameworks are commonly recognised 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 professional standards. However, like other professions, the way in which chaplains practice these elements and connect the various theoretical elements calls for a more personal embodied (experiential) knowledge (Cf. Weerman & Abma 2018) and relational characterisation alongside spiritual skills. Chaplains combine their professional knowledge and experience with reflective spirituality and autobiographical knowledge and experiences. The research community agrees that good spiritual care needs embodied or lived theory in order to be implemented effectively.

Based on best practices in our specific research community, we therefore propose the following working model. The way in which spiritual caregivers embody certain combinations of theoretical concepts and frameworks, in interactive alignment with inter-relational processes and cultural factors together, shapes decision-making about meaningful intervention in a particular case. This process should not be equated with doing the job purely intuitively ("without knowledge"), although it could feel like "not knowing". This is because the embodied relation creates something new by actively combining the spiritual caregiver's PBOK in a specific spiritual care context with another person's (spiritual) embodiment. The "atonement" (Stanghellini 2004, 68vv) involved may feel more decisive than any theory. This working model could at least partly explain the challenge of putting theories into words. At the same time, our research group members insisted that the growing awareness ("knowing") of their own PBOKs and that of others was rather helpful and inspirational in their present work (Cf. the notion of "stimulated recall", Chittenden 2002). They mentioned it explicitly as one of the advantages of taking part in the case study project. One could therefore argue that it increased their intrinsic work motivation (Cf. Ryan & Deci 2017). The profession thus builds on two contrasting tracks. On the one hand, practitioners need to adopt an attitude of not-fully-knowing in order to be open to fruitful atonement. On the other hand, they need methodological reflection to make the skills involved explicit so that they can improve the interactions next time.

We cannot evaluate this working model thoroughly by means of a single case study. The first author will present a more thorough study of this PBOK elsewhere (in preparation). Below, we will 1) present a case study by adhering roughly to the case study format (Walton & Körver 2017), 2) show how the spiritual caregiver reflected on her PBOK with the help of other mental healthcare professionals and the research community, 3) conclude by evaluating how the three different PBOK elements in our working definition were involved (the human lived body experience, professional knowledge, the relational context). In the presentation of the case study, the letters a–i indicate the places where the research group felt in retrospect that different moral counselling interventions took place (see table 1).

1. A promise is a promise!? Moral counselling in the event of a life-threatening dilemma

(Cf. Van Hoof, Muthert et al. 2019)

The mental healthcare research community presents the following case study as a good example of moral counselling. In this case, the counsellor is a 54-year-old woman who has worked for seven years as a spiritual counsellor in the south of the Netherlands. Her core business involves ethical and philosophical reflection in both one-on-one contact and group meetings, and policy issues in the healthcare organisation. She is familiar with the hermeneutic philosophy of Gadamer's and Nagy's contextual therapy. After a moral deliberation meeting in a residential

care facility for adolescents, the spiritual counsellor has received a referral from the client's main therapist. The client is a 15-year-old girl named Esther. Esther is struggling with an agreement she made with a friend almost one year earlier: That if one of them committed suicide, the other one would do the same within a year. Almost a year has passed since her friend killed herself and Esther is experiencing immense pressure to keep her promise. The care team doesn't know how to break the chain of compulsive thinking about this agreement, which they link to her diagnosis of autism. Different kinds of cognitive interventions have been unsuccessful. 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 attends the meetings. Esther has regularly been in clinical care settings over the past few years. Her parents are divorced but she has a bond with each of them. She used to be very good at team sports. There is no prior information about her religious affiliation or beliefs.

The counselling consisted of four sessions. The focus of the first two sessions was on moral counselling. The third involved ritual counselling aimed at confirming the chosen pathway. The fourth and final session concluded matters and focused on the future.

Session 1

Esther, her therapist and the spiritual counsellor meet in the therapist's room. After a brief introduction, the counsellor says that she knows from the therapist 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 wiggles her legs awkwardly. Then she quietly says: "A promise is a promise. I think it's very important to keep my promises". She doesn't go into the nature of her promise. The spiritual counsellor responds by saying firmly that she thinks it's good when people adhere to their agreements. This response captures Esther's attention; she is clearly surprised, as is her therapist. The spiritual counsellor adds that life is much easier and more pleasant if people keep to their agreements. "If we hadn't done so, we couldn't have had this meeting today. But sometimes agreements must be reconsidered because, for all sorts of reasons, you can't or don't want to keep them." The spiritual counsellor deliberately doesn't directly address the problem of Esther's specific agreement or her persistent attitude. **(a)**

The spiritual counsellor then invites Esther to say something more about her promise. Esther recounts in a soft tone that she and her best friend made an agreement that if one of them committed suicide, the other one would do the same. The spiritual counsellor responds by saying that it must have been a very important friendship to agree to risk their lives together in this way. Esther starts crying and says she misses her friend. The counsellor invites her to talk about her friendship. **(b)** Esther says that they met about two years ago in a care institution and they clicked right from the start. They had a lot of fun together, which was a new experience. Before then, Esther had never had friendships. She was bullied at school and she didn't feel she belonged; she was lonely. Neither of them wanted to lose this experience of being together. The spiritual counsellor then asks what exactly prompted Esther to make the agreement. Esther says that she assumed that if they made the promise, it would protect them from suicide because the other's life was at stake. The spiritual counsellor says: "Your own life may sometimes make you feel that it is worth nothing, but you wanted to fight for the life of your friend!" Esther looks straight at the spiritual counsellor and says clearly: "Yes, that's it exactly." The caregiver continues: "And for you, the agreement wasn't 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 would like to stop. She wants to go back to her room. The spiritual counsellor comments that she can see that her last remark has touched Esther, that Esther misses her friend very much and that she recognises this as mourning. **(d)** Esther cries softly. She looks at the spiritual counsellor and repeats that she would like to stop. The counsellor confirms that it is indeed enough for today. Respecting Esther's limits is important for the

safety of their contact. After taking Esther back to the department, the therapist expresses satisfaction with the "depth of the conversation". She sees a new perspective and she feels that Esther might too.

Session 2

They meet again a week later. It is exactly three days before the anniversary of Esther's friend having taken her own life. After entering the room, Esther ducks down in a chair, her head on her chest. She talks even more softly than the first time. The spiritual counsellor asks Esther if she can say something about what is going on. She shrugs her shoulders and remains silent. After a while, the spiritual counsellor says that it must be a difficult week for her, with all the memories of what happened a year ago. Esther nods almost imperceptibly. The spiritual counsellor decides to structure the conversation. First, she briefly summarises 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 counsellor puts into words what this agreement means to Esther: "The agreement is made to protect you from committing suicide." She asks Esther whether this is true. Esther nods. She is not exactly sure about what the agreement meant for her friend. However, her friend had always said that if she ended up living on her own, she would commit suicide. Just before taking her life, she had indeed been given her own apartment. The last time they saw each other, the day before the suicide, Esther said to her: "Don't make me sing!" That was also part of the agreement. If her friend committed suicide, Esther would sing a song at her funeral. The spiritual counsellor translates Esther's "Don't make me sing" as a cry for help: "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 counsellor writes "I find life worth living" on the whiteboard. Then she asks why Esther thinks life is worth living. Esther says that she has hope for a better future, and that she doesn't want her family and her friends to feel the pain she felt when her friend died. The spiritual counsellor calls this love for and from those around her. She also asks Esther to reflect on the opposite: Why she would like to die. Esther says that she sees no point in living and she wants to die because of the agreement. The counsellor writes down both answers. **(f)** The spiritual counsellor then asks Esther which choice she would make right now, seeing both arguments side by side. Esther says that she would like to choose life and she cries. After a silence, the spiritual counsellor carefully summarises by saying that Esther has had a very difficult time in her past and that this particular friendship must have been a comfort. With her friend, her hope for a better future was able to grow. **(g)** Esther returns to the care unit. The spiritual counsellor promises to bring photos of the whiteboard later that day. **(h)**

In the afternoon, the atmosphere in the care unity where Esther stays is tense. The employees seem to be stressed. The spiritual counsellor sits quietly with Esther for a while. She seems more relaxed than this morning and is happy with the photos. She is pleased with the suggestion that they have an appointment on the anniversary of her friend's death.

The counsellor calls in on the therapist and shares her feedback on the atmosphere in the unit. The therapist mentions that the team is having a difficult time: there was another suicide recently. Seeking control, the team wants to make firm restrictive agreements with Esther to protect her (and the others involved) from another suicide. The spiritual counsellor argues that Esther, in addition to protection, needs to be given support and trust. **(i)** The therapist will discuss this in the team.

Session 3

When the spiritual counsellor picks Esther up, she shows her the memorial area she made, with a picture of Esther and her friend, a small book containing written memories, and tea lights. She takes these items to the counsellor's room. They first light a candle for her friend, followed by one for Esther, with the words "Let there be light and warmth for you". They then

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 says that Esther would continue living. Earlier, Esther hadn't interpreted that sentence in the way she does now. Finally, the counsellor lets her choose two ceramic hearts. Esther places an orange one for her friend and a blue one for herself next to the candles. She is invited to take the hearts with her; the candles will burn out in the room.

Session 4

Five days later, they meet for an evaluation. Esther will move to a specialised youth clinic at short notice. School and treatment will be combined. Esther says that she no longer wants to die because of her friend's suicide. At the same time, she is often sad and has difficulties with life. The spiritual counsellor refers to the whiteboard diagram and confirms that these feelings are there and won't magically disappear. She also emphasises Esther's hope for the future and the other connections that she cares about. Both feelings belong to life. But she may have struggled more with suffering than her peers. Finally, the counsellor expresses the hope that Esther will increasingly perceive opportunities for the future. She asks whether Esther will take up sports again. Esther's face lights up and she smiles.

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

Central to this case study was the question of whether Esther needed to keep her suicidal pact with her friend. Cognitive interventions did not appear to work. The spiritual counsellor opted for moral counselling – guiding and assisting clients who must make moral choices in difficult circumstances. The aim of this process is to be at peace with a choice or decision in the near future. Because the diagnosis of autism is not leading in moral counselling, the counsellor said that the client can experience more space to search for significance, meaning and reorientation. This thought is inspired by *Het geheim van het lege midden* (2003) [The secret of the empty middle space], by the systematic theologian Theo Witvliet. When asked by the researcher to elaborate on this theory before the first discussion in the research group, the counsellor highlighted the protective function of the biblical image ban. Such an "empty middle space" counteracts fixations in conceptual thinking that are too rigid. In translating this idea to her case study, she saw the cognitive perspective as being too dominant in treatment. There needs to be more space for the human struggle with life and death on an existential level.

In her first draft, the spiritual counsellor took her moral counselling approach more or less for granted. She distinguished four interventions. 1) First, she wanted to put Esther at ease and gain her trust. She therefore used self-disclosure: paraphrasing at the meaning level and allowing Esther's input on content and duration to lead the conversation. 2) Second, biographical values and meanings were examined. The spiritual counsellor used a value inquiry on the whiteboard, which promoted a fruitful distance between Esther and her concrete emotions and thoughts. The friend's perspective was also considered. 3) Third, the counsellor tried to support the team by adding her perspective to the team approach. 4) Finally, ritual guidance confirmed both the connection and the boundaries between Esther and her friend, thereby strengthening Esther's own identity.

Esther felt visibly better after the counselling. Her attitude, the way she made contact and the tone and content of her speech spoke for themselves. After evaluating the case study, Esther concluded: "I was finally able to mourn the loss of my friend." Her mother was grateful: because of the interventions, Esther was able to reconsider her agreement. One nurse used the word "magic" to describe what had happened. The team had given up on Esther changing her mind. However, she still had suicidal thoughts and existential questions. The spiritual counselling ended there because Esther moved to another institution. If Esther had chosen death over life, further guidance would have been necessary. To the counsellor's surprise, Esther viewed mourning as the most essential part of the contact, whereas she herself highlighted moral

counselling.

The therapist was not surprised about Esther's remarks on mourning in her evaluation of the written case study. That was the focus of all the therapeutic interventions, but Esther's suicide pact stood in the way. In the therapist's opinion, the counsellor's approach contributed to this. She could freely look at the client's suffering at that very moment (Muthert 2019). She could also pay attention to a specific part of the problem from different perspectives – the values involved in Esther's dilemma. Compared to the counsellor, the treatment team also had to keep an eye on many other interests, for example behaviour agreements, conflicts and department rules, future directions, contact with the parents, other patient's safety, etc. Finally, the counsellor was able to frame Esther's ideological values in a positive way.

The discussion in the research community was quite helpful in identifying more precisely what the counsellor raised in her moral counselling (Meetings I and II). First, the group invited the spiritual counsellor to be more explicit about her sources. During the discussion – based on the format-related questions and remarks (Walton & Körver 2017) – explicit theoretical sources cropped up quite naturally. Subsequently, the moral counselling actions that were identified were adequately defined (See Table 1).

3. A brief evaluation of the PBOK aspects of the case

To a certain degree, the spiritual counsellor was aware of her moral counselling abilities and knowledge in this case. It was also because of these skills that she was asked to intervene. At the same time, she did not follow a strict protocol, and she needed the interaction with her research community to identify more clearly the different moral counselling interventions involved, as well as her theoretical sources (PBOK). The research group recognised the case as an example of good spiritual care from the beginning. At the same time, the group needed the theoretical specifications to be articulated (BOK) to find out exactly what made this case worthwhile. This joint reflection (relational) led to a growing awareness of a shared idea about good spiritual care. The case study also shows the

Table 1. The different moral councelling interventions in Sessions 1 and 2 (Van Hoof, Muthert et al. 2019)

a	Creating space for the human value of adhering to an agreement and for the struggle or ambivalence involved.
b	The invitation to talk about friendship offers a different perspective on the relationship between the two girls than that of a problematic agreement.
c	The spiritual counsellor marks Esther's interpretation of the agreement as "being able to cope with life together" by/in friendship.
d	By acknowledging the loss of her friend, Esther can gradually acknowledge her own grief and loss.
e	By paraphrasing the statement "Don't make me sing!" on an existential level, Esther's deepest need is acknowledged.
f	What makes life worth living or not is clearly juxtaposed with values on the whiteboard (Cf. De Groot & Leget 2011).
g	A connection is made between the past and the future by how Esther values friendship.
h	With the concrete photos, Esther is given tangible control of her own valuing process as discussed together. This reinforces the fact that she knows that her choice has been seen and heard.
i	Linking core values from Esther's discussions with the spiritual counsellor (including safety and trust in Esther's own judgment and strength) to the department's daily routines where protection is central.

importance of direct relational aspects; the verbal and non-verbal responses of both Esther and the spiritual counsellor were decisive. It is not possible to derive from this an interview schedule that has general validity. With our working definition in mind, the spiritual counsellor "simply" worked out what to do next in atonement with her communication partner. Her (P)BOK was coloured by her knowledge of the importance of exploring values, meaning and moral decision-making. She truly embodied that kind of knowledge and theory. The concrete situation, however, led her to act in the way she did in interaction with Esther.

The concrete healthcare context seems to have been decisive as well, in addition to other contextual factors (such as her life story – her youth, parents' divorce, bullying, loneliness, a growing sense of friendship, the tremendous loss of a best friend). The department team was wrestling with the impact of a recent suicide and, therefore, tended to behave quite strictly and imposed rules. One could argue that alongside the wish to protect everyone from another suicide, a fixed idea of what was good for Esther in behavioural terms was articulated verbally and non-verbally. In short, they expected Esther to adhere to the department's rules. At the same time, they expected Esther to change her mind completely about her private agreement. One could very well argue that Esther literally needed to experience another, more open, context in order to look at her situation. The spiritual counsellor framed what happened as moral counselling, while Esther highlighted mourning. Both frameworks touched upon the existential level, where they do seem to have come together. This fruitful attuning produced something new: a new perspective on the immense existential questions of coping with freedom and death.

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

We can conclude by emphasising that the mental healthcare research group in the Dutch case study project was increasingly able to articulate their spiritual care practices. The following factors seem to play a role in this: 1) 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 has proven to be helpful in framing interventions and skills in the communication with colleagues and other mental health professionals.

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References

De Groot, J. & Leget, C. (2011). Moral Counselling: A Method in Development. *Journal of Pastoral Care & Counselling*, 65(1), 1–14. https://doi.org/10.1177/154230501106500102.

Chittenden, A. (2002). A pastoral care teacher's theory of action, interactive thinking and effective teaching practice. *Pastoral Care in Education, 20*(1), 3–10. doi: 10.1111/1468–0122.00214.

Datilio, F.M., Edwards, D.J.A., Fishman, D.B. (2010). Case studies within a mixed method paradigm: Towards a resolution of the alienation between researcher and practitioner in psychotherapy research. *Psychotherapy Theory, Research, Practice, Training* 47(4): 427–441.

Fitchett, G. (2011). Making our case(s). *Journal of Health Care Chaplaincy, 17*(1–2), 3–18. doi: 10.1080/08854726.2011.559829.

Fitchett, G. and Nolan, S. (eds.). (2015). *Spiritual Care in Practice. Case Studies in Healthcare Chaplaincy.* London & Philadelphia: Jessica Kingsley Publishers.

Marrone, R. (1990). *Body of Knowledge. An introduction to body/mind psychology.* Albany: State University of New York press.

Morris, P.W.G., Crawford, L., Hodgson, D., Shepherd, M.M., Thomas, J. (2006). Exploring the role of formal bodies of knowledge in defining a profession – the case of project management. *International Journal of Project Management* 24: 710–721.

Muthert, J.K. (submitted 2019). Bridging inner and outer worlds. A psychodynamic approach to meaningful mourning. Berger, P., Buitelaar, M., Knibbe, K. (Eds) *Religion as relation*. Sheffield: Equinox Publishing Ltd.

Remmerswaal, J. (2013). *Handboek groepsdynamica. Een inleiding op theorie en praktijk*. Amsterdam: Boom/Nelissen.

Ryan, R.M. & Deci, E.L. (2017). Self-determination theory: Basic psychological needs in motivation, development, and wellness. New York, NY, US: Guilford Press.

Stanghellini, G. (2004). *Disembodied spirits and deanimated*

bodies. The psychopathology of common sense. Oxford: Oxford University Press.

Van Hoof, M., Muthert, J.K., Körver, S., Walton, M. (2019). Afspraak is afspraak. Morele counselling bij een levensbedreigend dilemma. *Tijdschrift voor Geestelijke Verzorging* 22(94): 36–40.

Van Nieuwenhove, K. & Notaerts, L. (2019). Een weg uit de impasse van single case onderzoek. *Tijdschrift voor psychoanalyse* 25(1): 27–36.

Walton, M.N. & Körver, J. (2017). Dutch Case Studies Project in Chaplaincy Care: A description and theoretical explanation of the format en procedures. *Health and Social Care Chaplaincy,* 5(2), 257–280.

Weerman, A. & Abma, T. (2018). Social work students learning to use their experiential knowledge of recovery. An existential and emancipatory perspective, *Social Work Education,* DOI: 10.1080/02615479.2018.1538335.

Witvliet, T. (2003). *Het geheim van het lege midden. Over de identiteit van het westers christendom*. Zoetermeer: Uitgeverij Meinema.

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