Trauma and Post-traumatic Stress Disorder Among Missionaries

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How to recognize, prevent, and treat it

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Over the past 10 years, I have spoken with many missionaries who have experienced various types of trauma, including robbery, assault, rape, suicide of a friend, murder of a friend, and living through natural disasters such as earthquakes. Many have experienced additional trauma such as evacuation, guerrilla warfare, loss of a child, and sexual abuse. These lists are by no means exhaustive. Some have come onto the field having experienced childhood trauma (e.g., sexual, physical, emotional abuse) which has never been resolved. They may function at high levels for years before the symptoms of unresolved trauma begin to come forth in a way that can no longer be ignored.

The tragedy is that many of their more severe symptoms and disorders are preventable and treatable, especially if they are recognized early on, but often the problem is not recognized until considerable damage has been done. This means that the healing and recovery will take much longer and the impact may be much greater (i.e., the missionary may have to leave the field and may not be able to return). If we can equip missionary administrators to recognize early symptoms so that they can make appropriate referrals and compassionate interventions, then we can go a long way in reducing the numbers of casualties on the mission field. As Miersma (1991) said in her paper comparing the Vietnam experience to that of missionaries, "If we are to reduce the stress impact of the loss of innocence and idealism for missionaries, more will need to be done at both prefield and field levels of

experience for missionaries."

Understandably, many missionary administrators feel that they are already overburdened with responsibilities. The prospect of being asked to recognize symptoms of stress and trauma in their missionaries may seem like an overwhelming and unreasonable expectation. However, if missionary administrators can become better equipped in recognition and referral skills, it will ultimately lead to less stress for them. Often, if only a very small percentage of one's staff is suffering or experiencing performance or personal problems, they may take up a large percentage of the administrator's time and energy. Several studies demonstrate that there is considerable benefit to the early recognition and treatment of post-trauma symptoms (Friedman, Framer, and Shearer, 1988; McCarthy, 1988; Mitchell and Everly, 1993). The hazards of late or no intervention include longer recovery times, which increase financial costs of treatment, sick leave, termination, disability, and workman's compensation.

In order to illustrate the syndrome of symptoms which are typical in response to trauma, I am going to use throughout this article a fictional example of a missionary whom I will call Jane. While Jane is not a real person, her story is an accurate composite of what many missionaries have experienced, regardless of age, gender, or the specifics of the trauma. In this example, the trauma is rape. However, the symptoms described are not unique to rape victims.

Jane is a 25-year-old single woman who enthusiastically and eagerly goes to the mission field. She develops a love for the people she works with and adapts well to the culture. She forms friendships on the field with her coworkers. The first five years of her term are fruitful and successful. One day she is driving to the village and her car is accosted by a band of robbers. She is robbed at gunpoint, raped, and left for dead by the side of the road. Her world has just transformed from a place of relative safety and security to a place of fear, nigphpares, and uncertainty.

When Jane first saw the men with the guns she felt her heart race and her hands became sweaty. She began breathing rapidly

and screamed for help, but her screams were quickly silenced with a blow to the face. Everything seemed to be happening in slow motion and she felt as if it couldn't possibly be real. As she was being raped, she felt herself go numb; almost as if she were watching the whole scene at a distance away from her body. She stopped resisting and felt completely powerless. Somewhere inside of her she knew she would be killed and she resigned herself to this fate.

Let's assume that Jane makes it back to the center. Let's look at her reactions in the first 24 hours following the crisis event. At first, Jane felt as if she were acting on automatic pilot. Her only thought was getting to a place of safety and she did not focus on anything else. Once she began to have contact with coworkers and medical personnel, she felt overwhelmed with the questions and exams. Details of the crisis were sketchy in her mind and she began to wonder if the rape had really happened at all, or if she had just imagined it. The obvious evidence of bruises on her face and arms reminded her that what had happened was real and not some nigphpare.

Jane's mind began swimming with her own questions and fears as friends approached her to ask how they could help. Who will find out about this? Will I be blamed? Where are those men now? What if they find me and kill me? Will people look at me differently? Jane didn't sleep well that night and she had no appetite. The sound of a car driving by brought back a vivid visual image of the men driving off in her car as she lay helpless in the road. She woke up in a sweat the next morning and felt very alone.

Jane's friends and coworkers weren't sure how to respond to her. They talked with each other more than to Jane and asked each other, "What should I say to her?," "What do I do if she falls apart?," "What if she doesn't know that I know?" Because they didn't know what to say or how to act, most of them avoided her. The center administrator wasn't certain how to respond either. He talked to Jane, but felt awkward. This was the first time anyone from the center had dealt with something like this. He wasn't sure whether to ask publicly for prayer or not. He knew that there weren't any English-speaking counselors available for

Jane on the field. He didn't know if he should send her back to the States where she could get some help, or keep her here where she seemed to have a good support system. So many questions and so few answers.

Understanding crisis, stress, trauma, and post-traumatic stress disorder

Crisis

A crisis is defined as "an emotionally significant event which acts as a turning point for better or worse in a person's life" (Mitchell and Resnick, 1981, p. 3). For some, a crisis results in deterioration in functioning; for others, it results in personal growth and character building. A crisis may be a role-changing event such as marriage or retirement, or it may be a something sudden such as an accident or death in the family.

Mitchell and Resnick describe four characteristics common to most crises. First, crises are sudden; they tend to take people by surprise. This is probably best illustrated by a car accident or a sudden death. In some cases an event, such as a prolonged illness, may extend over a long period of time and a person may experience fluctuations in their own ability to cope with the crisis.

A second characteristic of a crisis is that a person's normal coping mechanisms are not adequate and the person feels unprepared to handle the event. For a period of time, a person's sense of balance or equilibrium is disrupted and it takes higher levels of energy and effort to restore a sense of balance and/or control.

Third, Mitchell and Resnick state that the duration of the crisis is short term (24-36 hours) and in rare cases it is prolonged beyond six weeks. I would modify this somewhat and say that the most intense reaction to the crisis is short term. However, the effects of a crisis may be lifelong.

Finally, crises have the potential to lead to dangerous, self-destructive, or socially unacceptable behavior. For example, it is not uncommon for a person to attempt to deal with a crisis by using alcohol excessively, or by acting out sexually (both are

attempts to numb the pain). A person may also become reckless or suicidal in the midst of very intense emotions which seem unbearable.

An additional characteristic of crisis not mentioned by Mitchell and Resnick is the impact on one's perception of the world. Crises often make one's world look different and shatter assumptions about one's invulnerability and sense of safety (Kleber and Brom, 1992). For a Christian, an additional factor may be the disillusionment one experiences regarding God's apparent lack of intervention. It is very important to address and be sensitive to the ways that a person's view of God may be significantly changed whether positively or negatively.

Stress

Stress literally means force or pressure. It has been defined as "a response to a perceived threat, challenge, or change" (Mitchell and Bray, 1990, p. 4). Like crisis, stress is not a uniformly negative term. Small doses of stress are necessary for growth and motivation. Extreme levels can cause illness and death. In fact, approximately 80 percent of non-trauma related deaths are caused by illnesses or accidents which are stress-related (Mitchell and Bray, 1990, p. 4).

Trauma

Trauma is defined as "an injury to mind or body that requires structural repair" (Waites, 1993, p. 22). The term trauma clearly reflects that some damage has been done either physically or psychologically in response to some form of crisis or stress.

Post-traumatic stress disorder

Post-traumatic stress disorder (PTSD) has been known to professionals since the Civil War. The documented symptoms of soldiers from the Vietnam war led to PTSD being included as a diagnostic category in the third edition of the Diagnostic and Statistical Manual (DSM-III). Previously it had been called by different names such as traumatic neurosis, combat neurosis,

and combat fatigue (Meek, 1990).

Diagnostic criteria

1. The individual has experienced an event that is outside the range of usual human experience, one that would be markedly distressing to almost anyone, e.g., serious threat to one's life or physical integrity; serious threat or harm to one's children, spouse, or other close relatives or friends; sudden destruction of one's home or community; or seeing another person who has been, is being (or has recently been) seriously injured or killed as the result of an accident or physical violence.

2. The traumatic event is persistently reexperienced.

3. Persistent avoidance of stimuli associated with the trauma or numbing of general responsiveness (not present before the trauma).

4. Persistent symptoms of increased arousal (i.e., difficulty falling or staying asleep; irritability or outbursts of anger; difficulty concentrating; hyper-vigilance; exaggerated startle response; physiologic reactivity at exposure to events that symbolize or resemble an aspect of the traumatic event).

5. Duration of the disturbance of at least one month. The essential components of the primary symptoms of PTSD are: the existence of a traumatic stressor; reexperiencing the trauma; increased arousal; and avoidance behaviors. There are also a number of secondary symptoms which often are associated with PTSD. These include depressive symptoms (suicidal, sad, poor appetite); anxiety symptoms (hyper-vigilance, fear of death); impulsive behavior (substance abuse, change in lifestyle); and psychosomatic disease (muscle pain, ulcers, colitis) (Peterson, et. al., 1991).

Normal reactions to crisis

There is a normal or typical series of reactions that any person in a crisis will experience. It is important to understand these responses and to recognize that they are to be expected and they are temporary. The majority of people who go through a

crisis will experience a temporary state of disorganization and confusion, but will have the resources to reorganize and ultimately will return to their pre-crisis level of functioning. This process can happen in a more efficient and less painful way if the person is supported and helped through the process. Approximately 20 percent of those experiencing a crisis will develop more severe symptoms requiring psychological intervention (Mitchell and Resnick, 1981).

Immediately following a traumatic event, a person is in a very vulnerable state. Most research shows that it is the event itself more than a person's past experience that determines how severe one's reactions may be (Kleber and Brom, 1992).

In other words, witnessing a murder, being raped, or being taken hostage are traumatic events which will produce very similar symptoms in many different types of people, regardless of their past experiences. However, it is also true that a person's recovery from trauma may be complicated by their history and their individualized means of coping. For example, someone with a history of sexual abuse may have a more complicated recovery to rape than someone who had never been previously abused. A firefighter with two small children at home may be impacted in a more troubling way by witnessing two young children die in a fire than another firefighter who has no children.

Most people will experience intense levels of anxiety, denial, anger, remorse, and grief during various phases of any crisis (Mitchell and Resnick, 1981). Somatic reactions are also common and may include pain, muscle tension, gastrointestinal problems, and genitourinary problems. These feelings may be experienced simultaneously or independently. They may be experienced immediately following the crisis or years later.

Many people are affected and may need assistance with coping even if they were not directly involved in the crisis. For example, missionaries who have come home on furlough and hear that a fellow missionary back on the field has been killed may need assistance to cope with the impact of this trauma. This example also demonstrates the need for agencies to have a plan in place for responding to a crisis so that immediate and compassionate

interventions may be offered.

Prevention and treatment

One of the best models which is designed to prevent the development of PTSD is the critical incident stress debriefing model developed by Jeffrey Mitchell. It was designed for emergency services personnel who are exposed to traumatic events such as a child burning in a fire, or a person trapped and crushed in an automobile. In my experience, this model has a much broader applicability. In addition to using it with police officers and firefighters, I have used it with bank tellers who have been robbed at gunpoint, friends of a person whose son had just committed suicide, and family members who have had a loved one murdered.

24 to 72 hours ideal

A critical incident stress debriefing is a structured group meeting which is held 24 to 72 hours after the crisis. This is considered the ideal time. Any sooner would not give the person the opportunity to rest or attend to immediate needs. Additionally, in the first 24 hours, the person may still be shocked or dazed and the memory of the event is fuzzy and unclear. Within the 24- to 72-hour time period, the person is likely to be experiencing more vivid memories of the event and is at a prime time to vent feelings and work through some of the intensity of the trauma. After the 72-hour time period, the individual begins the sealing over process and it becomes more difficult to reopen the wound in order to clean it out. Although debriefings were designed to be done in groups, a modification may be used individually.

Debriefings should only be conducted with trained mental health professionals. Often in the course of a debriefing subtle symptoms of past unresolved issues or indicators of future problems arise, and these may not be recognized by a lay person. Debrief-ings are not therapy. However, they provide the opportunity for screening and assessment of therapy needs.

Stages of critical incident stress debriefings

A critical incident stress debriefing generally takes about two or

three hours and has six important components (Mitchell and Bray, 1990).

1. Introduction Phase. At this stage, the leader explains the purpose of the debriefing and explains the importance of confidentiality. Other rules of the meeting designed to foster feelings of safety and trust are explained. It is also important at this point to make sure that the right people are in the room. People who were not directly involved in the crisis should not be included. Many organizations have chosen to make debriefings mandatory for those who are involved in critical incidents. Therefore, some people may not want to be there and this will need to be addressed early on. An effective technique for people who do not want to be there is to tell them that they may not need to be there, but it is very likely that they can be helpful to someone else in the room.

2. Fact Phase. During this phase, each member of the group is asked to tell the facts of what happened and what their role was in the event. A rescue worker, for example, might say that her role was to provide mouth-to-mouth resuscitation to a five-year-old child.

3. Thought Phase. At this point each member is asked to tell the first thought they had once they stopped operating in an automatic mode. At this stage people might say, for example, that the first thought they remember thinking was, "I'm going to die. What will happen to my children?"

4. Reaction Phase. At this point the group is asked to talk at a more emotional level about what happened. People are often reluctant to talk about their feelings, so a useful question is, "What was the worst part of the event?" or "What sticks with you the most?" People will likely talk at this point about feelings of fear, guilt, numbing, or rage. They may also report particular sensory memories such as, "I remember the sound of the gun trigger pulling back," "I remember the smell of burnt flesh and the stench is still in my nostrils," "I remember the look in his eyes and when I close my eyes I can still see him looking at me."

5. Symptom Phase. During this stage, the leader asks each

member to describe any symptoms they experienced at three time periods (during the event, after the event, and currently). Members are asked to talk about any effects of the stress such as trouble sleeping, poor appetite, inability to return to work, etc. The leader should be normalizing these symptoms and helping group members to understand that they are universal and common in response to stress.

6. Teaching Phase. At this stage, the leader educates the group members regarding reactions to stress and techniques for stress reduction. Handouts are often used at this stage.

7. Reentry Phase. This is a time for the leader to summarize the meeting and to answer any questions. The leader should be available afterwards to talk to anyone who may need one-on-one time.

Crisis intervention

Following a traumatic event, a person who undergoes a debriefing and receives continual emotional support may not need any other form of intervention. Some will benefit from short- term crisis intervention, however, and others will need more intensive long-term intervention and medication in order to recover successfully. In order to determine the appropriate treatment disposition, a mission administrator should consult with a mental health professional in the very early stages of a traumatic event.

Ideally, the mental health professional would arrive on the scene within the 24- to 72-hour time period, provide a debriefing, and assess the need for further intervention. At a minimum the administrator should have had: (1) training to recognize the symptoms of stress related disorders; (2) a written plan and policy regarding response to a crisis event; and (3) a telephone consultation with a mental health professional immediately following the event.

The goals of short-term crisis intervention are to stabilize the individual and help to bring him or her back to a pre-crisis state of functioning. The mental health professional does this by having the person describe the event; assessing for stress-

related symptoms; assessing the person's resources and strengths; helping the person come up with a short-term plan which is designed to bring back stability, enhance support, and respond to immediate physical, medical, or emotional needs; helping the person to set short-term goals which are likely to be successfully completed; and providing the person with support, encouragement, and hope.

More intensive therapy may be needed if the person develops the symptoms of post-traumatic stress disorder, or related disorders such as major depression or generalized anxiety.

I would like to revisit the story of Jane one more time. The end of her story really depends on what type of intervention she receives. If Jane never receives any help, then the following scenario is most likely. Jane begins having regular nigphpares of the rape. She is fearful and becomes more and more distant from her friends. Worst of all, she is deeply resentful and angry and this begins to taint every relationship she has. She is angry with God for allowing the rape to happen. She is angry with herself for not resisting and fighting the rapists more. She is angry with the administrators who forced her to talk about the event in an open prayer meeting, which humiliated her. She is angry with everyone around her who acts as if she now has some contagious disease. After six months Jane begins taking over-the-counter sleeping pills, first to help her sleep and later to help her forget. She becomes less and less functional and ultimately decides to leave the mission field feeling bitter and disappointed.

Hope for the future

If Jane does receive a debriefing, and/or some form of crisis intervention, her outcome is likely to be very different. She still may experience symptoms of depression, anxiety, or anger for a short time, but she will understand that it is all a part of the process and she will have hope for a future which isn't as painful as the present. Ultimately, her chances of staying on the mission field, fostering healthy relationships, and coping adequately with future stressors will be greatly enhanced.

Summary and recommendations

Clearly, many missionaries on the field have experienced traumatic events. While some have received compassionate responses and appropriate intervention, many have had little or no response and have been left at high risk for the development of post-traumatic stress disorder or other stress-related illnesses. There are ways to prevent the development of these illnesses and there are ways to respond to them so that the symptoms do not become worse and are not prolonged.

There are three very important goals that each mission board should have in response to traumatic events:

1. Response and prevention. Any missionary who experiences any type of trauma should receive an immediate response which is designed to enhance his or her coping and to prevent the development of stress-related illnesses.

2. Early recognition. Each mission center should have the training and capability to recognize early signs of stress or mental illness so that early intervention can be provided.

3. Referral for treatment. Each mission center should have representatives who have received training that provides them with the capability to refer missionaries who are experiencing multiple and prolonged symptoms of stress-related disorders to a mental health professional.

Some specific recommendations

Mission administrators

1. Every mission administrator/supervisor should receive training in the recognition of mental illness so that he or she can make appropriate referrals and have increased understanding into the nature of mental illness.

2. Mission administrators/supervisors should know the missionaries well enough to know when the missionary is exhibiting significant changes in her or his behavior.

3. Administrators should develop good communication channels with available mental health professionals so that consultations

can be readily obtained.

4. Debriefings should be mandated following any traumatic event. Missionaries may not feel they need the debriefing, or they may feel that there is a stigma associated with attending one. A mandated directive from the administrator gives the missionary the opportunity to get help and bypasses initial resistances.

Mental health professionals

1. Mental health professionals who are involved in missions should be trained in critical incident stress debriefings.

2. Debriefing teams should be formed and should be sent to the field within 72 hours of a crisis incident.

3. Any person who receives immediate help with a crisis should also receive periodic follow-up visits.

Missionaries

1. Missionaries should be educated regarding normal responses to stress and crisis so that they can recognize their own symptoms and self-refer when needed.

2. Missionaries should hear from their administrators that it is safe to reveal emotional difficulties and that the response will be a confidential and compassionate one and not a punitive or judgmental one.

(To order reprints of this article, see p. 291).

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