A Guest in Their World

By Karen F. Carr[i]

As a clinical psychologist working with missionaries, I have discovered that there are certain values and assumptions that can serve as either bridges or roadblocks in the relationship between mental health professionals and mission administrators. Therapists or mental health consultants who want to work overseas with missionaries may need a new and different paradigm from the one they were given in their training programs unless they have been a part of a program which is uniquely designed to equip mental health professionals for Christian service overseas. I, however, was trained in a secular clinical psychology program that was designed to prepare me for work in middle class America. In my program, I was taught to be an expert, but in this world, we must be servants and learners. I was taught to be non-directive and vague, but we must have something practical and tangible to offer. I was taught about confidentiality and advocacy, but not so much about their limits. I was taught about objectivity and not having dual relationships, but then again my internship was not in a remote city of Africa. I learned secular theories regarding psychopathology that did not acknowledge the role of the soul, and certainly not the healing power of the Lord. My missionary colleagues have taught me new lessons and I'd like to share a few with my colleagues.

It seems that the mission organizations have become much more open to the contribution and influence of mental health professionals, who are the focus of this article. Mental health professionals are needed and wanted in the missions community. Most often they are used at the screening phase, but more are also being invited to come to the field to provide workshops, crisis intervention, or short term counseling. These visits have the potential to encourage and build up (I Thessalonians 5:11). Sometimes, however, they result in a mission administrator developing a fairly negative view of mental health professionals in general. Some of the contributors to this negative view are the use of jargon, an absence of recognizable integration of faith and practice, a style of therapy that may not be contextually appropriate, and a misperception of the role and motives of mission administrators. The following case studies illustrate how some of these barriers may develop. *They are composites and all names are fictitious.*

Reference:

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Case study # 1

Dr. Tom Jenkins, a clinical psychologist, has a brother on the field and offers to provide a workshop and counseling for missionaries during the two weeks that he will be there visiting his brother. The director accepts his offer and asks him to send a brief résumé for field members to read before he arrives. In his resumé, Dr. Jenkins emphasizes his degree and explains that he uses a cognitive-behavioral theoretical approach. When he arrives on the field, he presents himself as an expert, describing his professional achievements his home country. While these credentials carry a certain weight and importance, they are not the leading quality that will bring trust or confidence from the missionary clientele. What may bring credibility on a standard resumé or for a professional conference, could raise more suspicion than acceptance in the missions world. While our degrees and areas of expertise and theoretical orientations are important to us (and maybe our colleagues), they will not generally impress one whose life experience may far exceed our own. Our credentials are relevant, but not as relevant as our cross-cultural understanding. Our language, whether written or verbal needs to make a cultural shift, from an emphasis on professional expertise and clinical knowledge, to an emphasis on teachability, cultural sensitivity, and biblical understanding which reflect a genuine care for missionaries. In short, we must enter their world.

While he is on the field, Dr. Jenkins does a stress management workshop in which he gives tips on lowering stress levels. He suggests separating work from home life and maintaining firm margins and boundaries. He does not realize that there are rarely clear distinctions between work and home life in the average missionary's life. Dr. Jenkins explains the current theories on stress management, but he does not offer a scriptural basis in his teaching, nor does he promote a discussion on how spiritual resources are effective in managing stress on the field. He says little about his relationship with the Lord or any previous cross-cultural experience. As he works individually with missionaries who have been through recent losses and trauma, he discusses the impact on their job performance and their families. He does not draw out the spiritual dimensions of their grief, nor does he appreciate the depth of their struggle to give themselves permission to grieve their own losses when their national colleagues have suffered far more in their eyes.

If we are to be helpful in the culture of missions, we must have a well-grounded, deep, abiding trust in the Lord that permeates every aspect of our professional selves and naturally builds bridges as we articulate our integration of faith and practice. This will manifest itself in a style that is genuinely humble and respectful while also being competent and capable.

Case study # 2

Dr. Eun Ae Lee, a professional counselor, has been asked to come to the field for several weeks following a traumatic situation. One of the field members was raped and has left the field, but a number of her colleagues on the field are struggling with what happened and have asked to speak to a counselor. When Dr. Lee arrives, she sets up a schedule that allows individuals to sign up to see her. Several of the women she sees reveal that they were sexually abused as children and this rape incident has stirred up troubling memories and feelings for them. Dr. Lee begins a process of uncovering, intensive therapy with these women, assuming that they will continue this work with a local therapist after she leaves. Several weeks after she leaves, the administration is distressed to discover that several women in the branch can no longer perform their job duties because their functional level has so declined. Additionally, there has been increased tension and stress in their families.

Dr. Lee made several assumptions that may not be true. One assumption is that a local therapist would be available – often, even if one is available, he or she may not speak the client's first language. Another assumption is that this kind of therapy work can be done on the field. I would propose that intensive therapy is not appropriate for the field given the stresses and demands of field living which require a great deal of energy. I believe that the most helpful form of therapy on the mission field is a brief, solution oriented mode, which is educational, goal oriented, and strength enhancing. Intensive work can be done in a less stressful, less demanding environment that may be available on a furlough or study leave.

Case study # 3

Nigel Smith, a qualified social worker, is asked to present at a field conference and decides to offer a workshop on grief and adjusting to loss. He makes himself available for several days after the workshop for any that want to come see him for a private counseling session. Mr. Smith emphasizes that these counseling sessions are completely confidential. Tom and Betty have been on the field for 20 years. They have never been to see a counselor before but both have been feeling fairly depressed and low energy and they liked this counselor's presentation style in the workshop. As they talk with Mr. Smith, they help him understand that their new administrator has been abusive and critical. It seems that the administration has unreasonable expectations of them and does not at all understand their situation. In fact, the administration has asked them to go home to get some things taken care of but they are convinced that this would only make things worse. They ask Mr. Smith to explain to the administration that they should stay on the field.

Although it seems obvious that Mr. Smith only has one side of the story and does not understand the system context of this situation, nevertheless he may be pulled to respond as an advocate for this couple. In fact, many counselors have fallen into this particular pitfall of advocating for the "client" missionary and becoming an adversary to the administrator. Our role, in contrast, should be to strengthen the entire system whenever possible. In this

particular example, the counselor has not spoken with the administration so he does not know the circumstances of the couple being asked to leave the field. Because he has stressed absolute confidentiality, he has ruled out the possibility of a consultative, collaborative relationship with administration. There may be possibilities he has not considered such as moral lapse, job performance problems, interpersonal conflicts, or low financial support and debt.

Whether or not a missionary stays on the field is a complicated decision that involves a number of factors including their mental health, support system, job performance, resources of the missions community, ethos of the organization, and the preferences of the family, home office, and supporting churches. We may have a contributing voice, but we do not have the right to be an authoritative or final voice in the decision. The administrator or field leader is the one who will remain on the field to care for and work with each of the missionaries there. We have the opportunity to coach and mentor administrators in the value of member care if we take a supportive rather than an adversarial role with them.

Case study #4

Dr. Jesse Pinto is a psychiatrist who has been interested in working with missions for many years. He has done some work with a mission agency which is based in his local area and he eagerly accepts an invitation to travel to Africa to provide debriefing for a team of missionaries who have just been evacuated out of their country of service to another country in Africa.

As a medical doctor, Dr. Pinto is aware of the medical precautions he must take – he gets his Yellow Fever shot and gets started on malarial prophylaxis. Dr. Pinto has been following the international news and has some basic understanding of what has been happening politically in the country these missionaries have just left. His understanding of African politics and geography is minimal, however. He does not speak any French, but will be traveling to a French speaking country.

A combination of sleep deprivation, severe climate difference, language barriers, and general adjustment to new stimuli lead Dr. Pinto to feel much more tired than he expects. He is unable to keep the pace he had hoped for. He is also surprised to learn when he arrives, that the missionary team is a multinational team with people from North America, the UK, Switzerland, Brazil, and Argentina. His materials are all in his first language with a lot of idioms and as he looks over his handouts, he realizes that many of his examples are specific to his culture.

When Dr. Pinto facilitates the group and individual debriefings, he notes that some people seem uncommunicative. Some give very poor eye contact, some seem sullen, some seem despondent, some seem angry. He interprets these behaviors within the context of what they would mean if someone were from his country. He does not appreciate or understand the cross-cultural interpersonal dynamics that he observes.

Dr. Pinto is especially uncomfortable when some of the members begin talking about the demonic aspects of what they have experienced. When some begin to talk about unexplained

illnesses, curses, and demonic possession, he wonders about their grasp on reality. He does not have a spiritual framework to understand the spiritual battles and demonic activities that are commonly experienced in Africa. The missionaries served by Dr. Pinto are grateful for his availability and technical skills. They are gracious in their response to him. Privately and among themselves, they know that he is very limited in his understanding of what they have experienced.

There are several ways Dr. Pinto could increase his cross-cultural sensitivity. Before leaving he could familiarize himself with the geography, politics, religion, and culture of the country he is going to through various news and written resources. He could also do some reading that would help him become more familiar with his own cultural values and how these are perceived by people of other cultures. He could find out in advance what nationalities he will be serving and attempt to access resources in their mother tongue or consult with other mental health professionals from their home countries who may assist him. Once arriving, he could spend some time with several missionaries, not directly involved in the crisis, to gain a better understanding of the unique stresses and issues faced in this area. Finally, he could broaden and deepen his understanding of spiritual warfare as it is manifested in different parts of the world.

Building relationships between counselors and mission personnel

Clearly, receiving training as a mental health professional does not automatically qualify or prepare one for working with missionaries overseas. In general, however, mental health professionals have made a commitment to certain ethical principles such as working only within their area of competence and expertise, working responsibly such that they do not harm their clients, and maintaining supervision and accountability as professionally needed.

There is also an increasing commitment to cross-cultural awareness and more training available in this area within many of the mental health professional organizations around the world. These commitments can aid us in overcoming roadblocks and building bridges.

Roadblocks:

- Expert mentality
- Use of technical jargon
- Non-directive, vague style
- Long term, intensive therapy model
- Unstructured loose use of time
- Adversarial approach with leadership
- Use of culturally biased materials
- Slow response to crisis situations
- Lack of accessibility
- Assumptions re: organizational needs
- Inexperienced in cross-cultural counseling
- Lack of follow-up

Bridges:

- Servant mentality
- Humble approach
- Integration of faith and practice
- Biblical basis of teaching
- Solution focused, brief therapy model
- Brief, relevant workshops/devotionals
- Knowledge of local resources
- Knowledge of field history
- Clear communication regarding confidentiality
- Trust & credibility built through visits
- Knowledge of demonic/spiritual warfare
- Prayer with/for leaders

Developing a better understanding of the administrative perspective

Mental health professionals who take time to cultivate relationships with mission leadership will ultimately provide a better service to the missionaries on the field. Just as some psychotherapy models in the past ignored and alienated the family members of identified patients, seeing them as the source of the problem rather than pivotal to healing, so have some mental health professionals treated the mission community. Our challenge is to maintain good boundaries and competent, ethical professionalism while also entering into relationships with missionaries and their leaders as genuine, vulnerable, co-laborers in Christ.

With this in mind, we have the serious task before us of chipping away at some of the negative reputations and perceptions that have developed in the minds of many mission administrators towards mental health practitioners. Some of these perceptions are the result of actual experiences and some based on bias or misperception. Regardless of the source, these are perceptions which can create barriers and which can perhaps be altered in the context of a genuine experience. Some examples of characteristics attributed to the “ineffective” mental health professional include: evasiveness; permissiveness; promoting weakness; touchy-feely approach; liberal theological views; and opening up cans of worms (stirring up old issues which are better left alone).

A model case study

Heidi Schaeffer, a master's level counselor, is asked by a mission administrator to come to the field to do a workshop on transitions and to be available for counseling afterwards. She spends time on e-mail and the phone with the administrator, clarifying the expectations, needs of the community, values of the community, and recent crisis events within the community. She understands that even a crisis event that only involves one person can affect the entire community because of the family nature of inter-dependence and support that is common in missionary groups. She probes further with this administrator to find out what his expectations are and who in the community might need additional attention. She clarifies before coming what will be kept confidential and what will be shared. Ms. Schaeffer talks openly with the administrator about the financial cost of her visit. They make an arrangement that covers the costs of her travel and provides for a modest honorarium. She works closely with the administrator to write a bulletin that will announce her coming and will explain her availability. Ms. Schaeffer has been to this field before and is known by many of the missionaries there. She has developed the reputation of someone who is humble, unassuming, and available. She understands now the kinds of things that contribute to ongoing grief and stress in missionaries' lives. These are things like conflicts with others, saying goodbye to kids who will return to the home country for college, worrying about elderly parents, and severe sickness that is recurrent and life threatening in their friends and family on the field. She is aware of these things and she prepares for her time on the field through prayer and the gathering of relevant resources.

When she meets with individuals and couples, she draws out their spiritual questions as well as their spiritual strengths and resources. Her work with them is brief and practical. She prays with them and commits to a follow-up plan with them. They know in advance what will and what will not be communicated to their administrators. Though she is a guest in their world, they treat her as one of their own.

Conclusion

Mental health and other health care specialists have a lot to contribute on the mission field. We can offer workshops, consultation, assessment, and counseling. We can provide crisis intervention and debriefing. Our presence has the potential to be as Aaron and Hur were to Moses when they offered a very tangible way of providing strength, endurance, and courage in the battle (Exodus 17:12). But, if we do not enter into their world with cultural sensitivity, we also have the potential to harm and do damage. Key to our effectiveness is working with mission leaders, and building relationships with them. Together we can better understand the member care needs of their people and provide the ongoing care that enhances a resilient and loving Christian community on the field. We have a lot to learn. And many from the missions community are willing and able to teach us and welcome us as guests in their world.

Questions for Discussion

(use this space to write your responses)

What values, assumptions, or behaviors might be roadblocks between mental health professionals or member care providers and missionaries?

How can mental health professionals and member care providers build bridges with missionaries and mission leaders?

For each of the case studies, talk about what you might do to improve the service being provided.