Mobile Crisis Response:
Responding in the Aftermath of Trauma

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Introduction

Trauma seems to have become a part of the fabric of ordinary life experience. There was a time when a person could not be diagnosed with Post Traumatic Stress Disorder unless they had experienced "an event that is outside the usual human experience and that would be markedly distressing to almost anyone." (APA, 1987). *The Diagnostic and Statistical Manual of Mental Disorders* (DSM IV) modified this language and now states that "the person has been exposed to a traumatic event." They go on to clarify what must have been experienced in that traumatic event – this includes directly experiencing, witnessing, or being confronted with an event that involves actual or threatened death or injury in addition to feelings of intense fear, helplessness, or horror (APA, 1994). The language about "outside the usual human experience" is gone.

If trauma has become such a usual experience for us as human beings, then we must adapt and learn how to prepare ourselves, how to cope, and how to help one another if we are to follow in the steps of Christ who suffered for us, leaving us an example, that we should follow in his steps. (I Peter 2:21).

Most missionaries we have met have suffered some kind of trauma in the course of their missionary career. In Bagley's study of 31 missionaries who were working on 4 different continents, 94 percent had experienced trauma at least once on the field and 78 percent had experienced multiple traumas. The most common types of trauma reported were combat/civil unrest, violent crime, natural disaster, and life endangerment. (Bagley, 2002).

The Mobile Member Care Team is a multi-disciplinary, inter-mission team providing crisis training and response to missionaries in West Africa. This team has been in Abidjan, Cote d'Ivoire for 17 months as of October 2001. (For more information on the structure and strategies of the MMCT, see Mobile Member Care Team – West Africa: Our journey, vision, and strategies (Jerome, 2001). In that time we have been involved in 98 clinical interventions, serving 280 missionaries from 24 mission organizations serving in 12 African countries. The most frequent types of trauma that we have responded to through debriefing and consultation are armed robbery, civil unrest, carjacking, and death of a colleague. The most common problems addressed by brief therapy services have been depression, marital conflict, job stress, child behavior problems, team conflict, anxiety, and post-traumatic stress symptoms.

Case Study: The Trauma

The situation and people described in this case study have been disguised to protect confidentiality.

MMCT received a call one day that a missionary woman with three small children had been robbed at gunpoint in her home while her husband was away. This family lived in a West African city where there had been increased civil unrest and numerous incidents of violent robberies targeting expatriates. The family did not employ a day guard and it was one of the children who opened the gate that inadvertently allowed three gunmen to enter the house. They terrorized the woman for about 30 minutes, threatening to kill her and the children while demanding money. One of the gunmen pointed his gun at her head and pulled the trigger, but it appeared the gun had jammed. She was treated roughly, pushed around and punched. The children were miraculously calm and quiet. After the robbers left, the woman cried to her neighbors for help. Some were very helpful coming to be with her and help her with the children while others kept their distance. The woman was pretty sure that some of her neighbors had heard the robbers and wondered why they had not done something to help her. Her husband was contacted and was able to be with her within an hour. Together they went to the police but they did not get much cooperation or sympathy from them.

The director of the mission and his wife came to be with the couple for support. The family indicated to the director and his wife that this incident was just about the last straw in a series of events and they just wanted to go home. They had an older child living at boarding school who had been worried about the news she had been hearing of civil unrest and they were unsure what they should tell her. They also wondered what they should communicate to their families in their home country.

The mission administration called MMCT to see if they could come to provide some assistance for this family. They also wanted help for others in the mission community who had been through some difficult situations in the past six months including death of a colleague, theft, and serious illness. The administration indicated that the risk of violence had increased in their area and they were wondering what they could do in response to this.

The Response: Initial Assessment

The information above, if gathered beforehand, gives some important clues as to the kind of response that will be needed. We know that there were young children involved who may or may not be able to verbalize what happened to them. We know that the woman has some ambivalent feelings towards her neighbors and may be experiencing feelings of anger or betrayal. The child who let the gunmen in may be feeling a certain level of guilt. The parents may be feeling guilty for not having implemented better security measures. There is another child who is in boarding school who is already feeling considerable anxiety and it is likely she will hear about this attack on her family eventually. It is likely that the family has had previous stressors, which are factoring into their view of this situation, but we do not know what those

stressors are. We have learned that there have been other incidents of violence in the missions community so that a variety of issues including grief, depression, burnout, anxiety, and post-traumatic stress disorder may be present in this community. Also we know that the administration would like some consultation regarding crisis contingency plans and we may be able to give them some input regarding member care during times of crisis.

Questions we might ask before responding would include:

- How long has this family been on the field?
- How have they coped with other difficult things?
- What kind of support system do they have?
- Who else is being affected by this event?
- As an administrator, what is your hope for what will ultimately happen with this family?
- What other needs do you have within your mission community?
- What member care resources do you already have?

The Response: Service Contract

The above questions are related to member care needs, however there are some other logistical details which need to be sorted out before making the decision about who will respond and how they will respond. For example, the issue of confidentiality should be clarified ahead of time. Is the administration expecting a report and what will this report include? It's also a good idea to find out who has the authority within this particular mission to request this help. In some organizations the field leadership has this authority and in others a decision needs to be approved by the home office. In terms of finances, who will be paying for this trip and what will be covered (i.e., travel, room and board, honorarium)? Finally, we want to make sure we have gathered relevant contact names, phone numbers, and e-mail addresses.

The Response: Preparation Before the Trip

The preparation for the mobile response includes developing a strategy for response, gathering relevant resources and materials, and preparing yourself physically and spiritually.

Developing the Strategy for Response

We need to decide who should go, how many should go, and how long they should stay. As we assess the skills that are needed in the above case study, it seems it would be good to have someone with crisis debriefing skills who can work with both children and adults. It would also be good to have someone who can serve as a consultant to administrators dealing with practical crisis contingency matters. Given the number of people who may need to be served in this scenario, we would ideally send two staff to stay for approximately one week.

Plans could be made ahead of time for the plan of action including times set aside for debriefing and assessment of the family, counseling for others who are expressing a need to

see a counselor, and consultation times with the administration. Plans might be made for a group meeting where we present practical materials or help lead the group in a discussion and prayer time. We could work with the administration ahead of time to write an e-mail or group announcement which will let members know who is coming and what they can provide while they are there. A system can be set up for individuals to anonymously sign up for appointment times ahead of time.

As we set up the time we will spend with the family, we also want to ask if someone could be available to assist with childcare so that we can have some uninterrupted time with the family. It's possible that the children will not tolerate being separated from their parents depending on the impact of the trauma for them so we will have to be flexible in this regard. If possible, we will make arrangements ahead of time to have meeting space that is quiet, comfortable, and free from distractions. It's also helpful if there is someone there who is designated to host and take care of practical needs such as housing, meals, and transportation. We do not want the burden of this to fall on the trauma victims. It's also good to know ahead of time what the e-mail and phone access will be while there.

Gathering Relevant Resources and Materials

As we anticipate the kinds of needs that will be present, we can plan to take certain assessment tools, handouts, books, and contact information that will be helpful to those we see. Handouts can be left behind for those who do not choose to see a counselor but who would benefit from written materials.

The assessment tools that we have found helpful to include in our crisis packet include:

- *Beck Depression Inventory* (Beck, 1972)
- *Post-Traumatic Stress Diagnostic Scale* (Foa, 1995)
- *CHOPS 100 Stress Inventory* (O'Donnell and Cerny, 1996)
- *Burnout Inventory* (Williams, 1998).

Some handouts in our crisis packet include debriefing handouts (found on our website at www.mmct.org), and the grief U curve (Greeson, et.al., 1990). See the reference list below for books and articles that can be helpful to take and/or leave behind. Other practical things to take include extra passport photos, information about counselors and centers available in the victim's home country, mobile phone, credit card, local currency or U.S. dollars, and appliances with the correct plugs and voltage.

Preparing Yourself Physically and Spiritually

For travel within West Africa, it's very important to stay up to date on all vaccinations. This would include yellow fever (mandatory), typhoid, meningococcal, Hepatitis B, and Hepatitis A. Malaria prophylaxis is also strongly advised. Given the intensity of this kind of intervention, the

responders should be well rested and healthy for this trip. This means having a balanced life with margin built in before the crisis call comes!

Spiritual preparation is essential for the effectiveness of this kind of trip. Being covered in prayer by supporters before, during, and after these trips is a key part of the strategy. Also, we will be most effective if we have developed our own theology of suffering and are at peace with the difficult questions of why God allows evil things to happen and why there is so much suffering and pain (Romans 5:1-5). This is not for the purpose of sharing it with the victims who will need to discover it for themselves, but rather so that we can abide with the trauma victims during their time of deep spiritual turmoil (2 Corinthians 1:3-11).

The Response: On site crisis intervention Staffing

In the case study described above, MMCT would ideally send two staff to respond to this situation but, realistically, we are often only able to send one. Other types of staff may be used as adjunct to MMCT including associate staff (mental health professionals who are available part time to assist MMCT) and peer responders (missionary peers who have been trained by MMCT in basic crisis assessment and response skills including debriefing).

Given the number of missionaries in West Africa (over 5000), the frequency of trauma, and the limited number of staff on MMCT, part of our strategy is to train missionaries to become peer responders. This goal is achieved through a screening process, an intensive training program, and follow-up consultation and supervision provided by MMCT staff. In this way, we can multiply the crisis response efforts being made throughout the region. Our belief is that missionaries have been providing crisis care to one another for years and this program is just a means to enhance their existing skills.

Timing

On site response should be as soon after the crisis event as possible, but must take into considerations factors such as availability of staff and needs of the victims. Adequate time must be given to prepare for the trip as described above. Logistical details may need to be completed before a psychological intervention can begin (i.e., legal requirements following a crime, funeral arrangements following a death, etc.). The total amount of time of the intervention will vary from situation to situation with a range of 3 to 10 days being the norm. Pacing is key in this kind of intensive response – it's a combination sprint and marathon and building in rest time for both the responders and the victims is important.

Goals of the Crisis Intervention

A detailed description of crisis intervention objectives and strategies can be found in Slaikeu's BASIC model (Slaikeu, 1990). In most crisis situations, our primary goals of the intervention will be to:

- Assess the impact of the crisis on the primary and secondary victims (including children)
- Debrief the trauma and provide supportive care which stabilizes the victims and defuses post-trauma symptoms
- Provide education which helps to normalize the post-trauma symptoms
- Identify and reinforce the coping mechanisms of the victims
- Mobilize support systems
- Develop a follow-up plan that maximizes successful adjustment and growth

Strategic Concepts for Crisis Intervention

It is important to develop rapport and effectively communicate with the victims and their support system. This rapport building includes the administration and necessitates clarity regarding the parameters of confidentiality at the very beginning. In most cases, it is helpful if we establish from the beginning that we will be giving administration a general report of how each victim is doing and any recommendations for follow-up. This can be done without the person feeling that their privacy has been violated; especially if we agree to show them anything we will send to the administration before sending it. Part of the rationale for this is that it is the administration that will often be providing the ongoing care after the crisis responders leave and they are the ones who can facilitate support and further care being provided as needed.

The crisis responder must listen carefully and patiently and draw out the trauma victims such that they are able to talk about all details of the trauma at their pace and in stages. We modify our debriefing or therapy approach according to where they are in the grief or post trauma process, sometimes being directive and sometimes non-directive. We may need to take initiative and be assertive when it comes to setting up the structures and times for meeting with members and yet low key and not intrusive as we listen to them. We look for opportunities to provide gentle education and normalizing of the post-trauma symptoms. For more specific techniques of crisis intervention see *Crisis Intervention: A Handbook for Practice and Research* (Slaikeu, 1990). For more details on specific areas to cover in an intensive crisis intervention see "Crisis Intervention for Missionaries" (Carr, 1997).

One type of intervention that can be effective in post-crisis situations is the Mitchell model of Critical Incident Stress Debriefing (CISD) (Mitchell & Everly, 1993). This seven step model provides structure for the crisis victims to talk about the facts, thoughts, emotions, and symptoms related to the crisis. It also includes a psychoeducational component. It is one part of a more comprehensive Critical Incident Stress Management approach (Everly & Mitchell, 1999). There has been considerable controversy concerning the efficacy of CISD in reducing posttraumatic symptoms. The research is contradictory in its conclusions although there seem to be consistent subjective reports from the recipients of CISD that it is helpful (Hytten & Hasle, 1989; Kenardy et.al., 1996; Robinson & Mitchell, 1993). A comprehensive review of the relevant literature noted that the bulk of CISD research has been methodologically flawed and thus there is no conclusive evidence either that CISD prevents PTSD or conversely that it leads to an exacerbation of symptoms (Trice, 2002). We must use caution in how the CISD model is

applied. CISD cannot take the place of trauma therapy, but it does provide normalizing of the symptoms and general education, and can decrease one's sense of isolation related to the event.

A key conceptual difference in mobile crisis response for missionaries is that it often does not fit the traditional therapy mode or rules. For example, we may be washing dishes together with the one we are providing supportive counseling to or we may spend eight hours in one day with one person. This requires flexibility as well as a strong sense of boundaries and self that allows for the phenomenon of dual (or multiple) relationships without compromising the integrity of the therapy relationship. When in a position of providing crisis response on the mission field, as missionaries ourselves, we find ourselves in the multiple roles of therapist, friend, dinner mate, fellow worshipper at church, etc. This can feel and is awkward, but it is a reality of life on the mission field.

A key strategic concept in this kind of crisis intervention is to identify those who will be the ongoing supporters and caregivers and to spend time with them in a way that heightens their understanding of what is helpful and what is not. When there have been child victims, it is helpful to spend time with the parents, teachers, dorm parents, and other significant adults. They can tell us about the child's pre-crisis functioning and we can give them handouts and coach them as to how to help the child walk through this crisis. Parents can be coached to try to re-establish a safe and structured routine for the children that will enhance their ability to cope. Additionally, to the extent that we help the adults to re-establish stability and peace, the children will be indirectly helped.

In this case study, the administration has asked for assistance in responding to a missions community that has dealt with a series of violent and traumatic events. Providing the administration with a listening ear and an opportunity to debrief can be very helpful. Often administrators on the field are carrying a number of burdens that they have not been able to share with others. Secondly, it's helpful to provide them with some practical, tangible resources related to risk assessment and contingency planning. MMCT has developed a workshop that trains mission administrators in the skills of assessing and giving member care to crisis victims under their care. Crisis Consultants International (https://cricon.org) provides training in risk assessment and crisis contingency planning as well as a video series available for purchase.

Attitudes for Crisis Responders

The key attitude for us as crisis responders is to enter the situation as a learner, not assuming that we are experts or that we have a full understanding of what has happened. We need to leave our egos at the door – not looking to be noticed, appreciated, valued, or esteemed; remembering that our presence there is not about us, it's about them. Related to this is that we can't judge the success of our interventions by how people respond to us in the moment.

Another important attitude or belief in crisis intervention with missionaries, is the belief that most people we are working with are normal, strong and resilient and have what they need to

work successfully through the traumatic aftermath. Many of us have been trained as mental health professionals to look for and find pathology as opposed to searching out and reinforcing the strengths and coping skills that are already there. Whenever possible, we need to avoid pathologizing and diagnosing the victims. At the same time, we can help them identify their liabilities as well as potential triggers of traumatic reactions so that they are better prepared for future stress or trauma situations.

Some attitudes that we look for in the missionaries we train as peer responders include: non-judgmental, humble, teachable, respectful, non-cynical, tolerant of ambiguity, and genuineness.

General Concepts for Leaving/Follow-up

Sometimes we compare the crisis intervention model of the MMCT to that of a MASH unit in the war. We're out there in the field and we work with people who have been wounded in the battle. Our job is to assess whether or not they can be helped on the field or if they need to go home away from the battle. If we can help them on the field, then we need to provide them with care that will equip them to return to the battle with the best functioning possible. We don't expect to see them again unless they are wounded again.

Generally, as we are leaving a scene, we ask the people we have helped to keep in touch and let us know how they are doing, but we do not foster a continued relationship of dependency or ongoing care. We will make referrals if ongoing care is needed. We do, however, try to work with their support system such that they understand and value the importance of follow-up and ongoing care. We try to help them understand that recovery can be a long and slow process and friends will be needed long after the intense memory of the trauma has passed.

Follow-up care is also important for the crisis responders. It's important to build in a plan for us to be debriefed when we return from the crisis scene. We also need some rest and recovery time. This should be scheduled in right from the very beginning. As Elijah experienced after his victory over the prophets of Baal, sometimes the hardest spiritual battle comes after the crisis is over (I Kings 18-19). In the let down and post-crisis fatigue, we are vulnerable to spiritual attack. If we are to persevere and thrive in this role of crisis responder, we need to be sure that our full armor is on and practice what we preach!

PostScript, August, 2019, Karen F. Carr

In 2000, MMCT developed a model of mobile member care with regional resident teams in Africa. For 17 years, our teams provided inter-mission training, crisis response, counseling, and mentoring of leaders and peer responders for hundreds of missionaries in Africa, Middle East, and Central Asia. Our strategy included asking organizations to "loan" their staff to MMCT teams. However, by 2016, many organizations had developed member care departments and staff positions making it difficult for us to maintain the regional team model. At the same time, Darlene Jerome and Karen F. Carr, MMCT international leaders, felt called to more deeply pursue their personal callings to provide direct member care rather than the administrative tasks necessary to maintain an organization. The MMCT Board and leadership felt that this was an opportunity to make a significant change that would adapt the resources and experiences we

had to the current trends and needs in missions member care. At the end of 2017, the Mobile Member Care Team closed down the organization. Former MMCT team members and peer crisis responders trained by MMCT continue to serve with a variety of organizations in member care capacities. The mmct.org site continues as a tool box for member care providers. The founders of MMCT, Karen F. Carr and Darlene Jerome, work as member care consultants with Barnabas International and continue to develop and provide crisis response training for missionaries. We pray that more organizations and providers will come together in collaborative, Christ centered efforts to provide the best possible training and care for God's global servants.

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