Ethics in Member Care

Towards an International Framework

Kelly O'Donnell

I will prescribe regimens for the good of my patients
according to my ability and my judgment and never do harm to anyone.
Hippocratic Oath, 4th century BC

Darts hit their mark when carefully thrown.
Words travel far when skilfully sown.
Sem Tob, 14th century AD

All human beings are born free and equal in dignity and rights…
and should act towards one another in a spirit of brotherhood.
Universal Declaration of Human Rights, 1948

This chapter[1] outlines important considerations for providing ethical "member care" to the diversity of mission/aid workers around the world. Responsible ethics in international settings must reflect principles that complement yet go beyond our usual professional codes. What are some of the main issues and what are some of the helpful guidelines that can be used by the different types of member care workers (MCWs), including mental health professionals and pastoral counselors? We'll explore some foundational values and premises along with three sets of guidelines. Together these materials point us towards an international framework for good member care practice in the mission/aid community.

Life is awesome—but as we all know it can also be hellish. Just think of some of the misery that confronts the world daily, the "problems without passports" that require the cooperative interventions of people in the faith-based, government, health care, and civil society sectors: natural disasters (earthquakes and tsunamis), environmental catastrophes (oil spills and pollution), poverty (one billion slum dwellers), HIV-AIDS (over 33 million infected), malaria (about 250 million cases and one million deaths per year) internecine war (with currently some 125,000 UN personnel serving in 15 peacekeeping operations), and the estimated 450 million people who currently struggle with mental, neurological, or substance use conditions.[2] For the mission/aid community[3], helping can often involve staying sane—and alive—in unstable, insane places. It is not that mission/aid work always deals with life-threatening experiences, of course. Rather it is just that helping to relieve the "maims and moans" of creation takes its toll. Mission/aid workers, like the people they are helping, have some special challenges. Consider some of these examples.

Challenges for Mission/Aid Workers

1. A single medical worker in Asia working with refugees. During times of stress this year I find myself struggling to maintain a balanced eating pattern. It seems we are always on call, and it is hard to turn away such needy people. There are days when I go to the refrigerator and look for things to eat and yet I am aware that I am not even hungry. This really bothers me because I hate to see myself falling into the trap of eating to cope with stress. I wish our base had a person with a pastor's heart who was willing to listen to our concerns and offer advice and encouragement.

2. An organizational leader in India coaching first-term staff. Culture shock is the biggest struggle as our new staff pursue learning a different language and culture. This usually is hard on their sense of identity and sifts through those who can stay on long-term from those who cannot. Loneliness and isolation are two words to describe the first year. Depression is frequently a part of the stress they feel as they try to cope with their new and demanding work.

3. A couple teaching in the Middle East. As Westerners, we must fight the fear of being unfairly labeled as politically subversive or as enemies of the established religion, and consequently be deported from the country. Paranoia is something that can keep one from sharing and helping. We often feel forced to lead divided and overly busy lives. Our "free time" is spent making visits, doing studies, and housing visitors. Faith compels us to be people-oriented and compassionate, willing to "waste time" on individuals. The problem is there isn't enough time!

4. A middle-aged administrator in Europe. What are the issues that led my wife and me to resign? First, I had labored here for over three years without having the slightest contact from other leaders from our organization in this country. No one asked how I was doing, what I was doing, or why. The isolation from full-time workers, from fellowship, and from avenues of dealing with the problems here, were the primary factors. Oddly, in discussing these issues with another leader, he seemed perplexed that they would even be issues. Such mentality prompted a letter to our international director in which I expressed my concern for more in-depth and comprehensive pastoral oversight of staff and leaders. Too little is understood and too much is presumed!

Member Care Background

Over the last 20 years, a special ministry within the Christian mission/aid community, really a movement, has developed around the world that is called *member care*. At the core of member care is a commitment to provide ongoing, supportive resources to further *develop* mission/aid personnel. Currently there are an estimated 417,000 full-time "foreign missionaries" and over 12 million national Christian workers from all denominations (Johnson, Barrett, and Crossing, 2012). Our member care catchment area is huge! But these figures do not even begin to reflect the number of Christians involved in the overlapping area of humanitarian aid, nor do they reflect the unknown number of "tentmakers" or Christians who intentionally work in different countries while also sharing their good works and faith. Sending organizations and churches, colleagues and friends, specialist providers, and also locals who are befriended are key sources of such care.

Historically, the member care ministry and movement did not develop easily. It was often through crises, mistakes, and failure that people began to realize that Christian workers needed quality support in order to help them in their challenging tasks. One of the first books written to help with this need was written by Marjorie Collins in 1974, providing many ideas for how churches and friends could better support mission personnel (*Who Cares About the Missionary?*). Previously in 1970 Joseph Stringham, a psychiatrist and missionary working in South Asia published two landmark articles in *Evangelical Missions Quarterly* on the mental health of missionaries. Stringham identified a number of external and internal challenges including culture shock, being disillusioned with others, children, medical care, etc. (external) and resentment, sexual issues, marital struggles, dishonesty, guilt, spirituality, trauma/deprivation in earlier life, motivation etc. (internal).

Mental health practitioners in particular who ventured into mission/aid were frequently faced with a belief that the desire for special/additional support might mean that Christian workers were being unspiritual or weak, and not trusting the Lord enough. As Tucker and Andrews point out in their article "Historical Notes on Missionary Care" (1992): "Mission societies held high the ideal of sacrifice. Strong faith in God, it was reasoned, was the prescription for a healthy mind and spirit…Self-reliance was the mark of a missionary—tempered only by dependence on God through prayer" (p. 24). But in retrospect, and at the

expense of over generalizing a bit, we (speaking inclusively) were overlooking our own *humanness*, sometimes trying to be something that we were not created or called to be. We in the mission/aid community began to better appreciate our Biblical need for one another—as seen in the dozens of "one another" verses in the New Testament. We began to understand that the issue was not so much our having a lack of faith, but rather our need to clearly see God's plan and His provision of care.

Connecting and Contributing:
Mental Health Professionals and Pastoral Counselors

There are many materials that can help orient and equip mental health professionals and pastoral counselors to member care. These examples below are on the Member Caravan website (Training for Member Care section): https://sites.google.com/site/membercaravan/training-for-mc

1. Field Counseling: Sifting the Wheat from the Chaff (Cerny and Smith, 2002) is one of 50 articles in *Doing Member Care Well: Perspectives and Practices from Around the World*. It includes five principles for ethical field care (reaching out, cross-cultural issues, dual relationships, responsibilities to counselees and organizations, use of email), a sample confidentiality statement, and eight short case vignettes with analyses.

2. Training and Using Member Care Workers (Gardner and Gardner, 1992) is part of the 25 chapter compendium, *Missionary Care*, and offers several suggestions for in-house and outside mental health professionals who provide services to mission agencies and mission settings.

3. What Mission CEOs Want from Mental Health Professionals (McKaughan, 2002) is in *Enhancing Missionary Vitality: Mental Health Professions Serving Global Mission* (56 articles). Two of the main suggestions from CEOs (based on a survey) were understandable language and thinking corporately.

4. Highlights from a One-Week Field Consult—This is a day by day brief description of a member care trip to work with mission staff in an organization/region. It involves a variety of services and learning too: leadership consultation, brief counseling, debriefing, conference speaking, and training.

The development of member care really has its origins in the Biblical admonitions to "love one another" (John 13:34), "bear one another's burdens" (Galatians 6:2), "be kind to one another" (Ephesians: 4:32), "teach and admonish one another" (Colossians 3: 16), "encourage one another day after day" (Hebrews 3:13) and scores of similar "one another" verses that fill the New Testament. Member care, in this sense, is nothing new. Christians and Christian workers, for better or for worse, have been trying to practice these relationship principles down through the centuries. Yet what is new are the more organized attempts all over the world to develop comprehensive, sustainable member care approaches to support cross-cultural Christian workers. These attempts have drawn on the contributions of practitioners from diverse health care fields like travel/tropical medicine, psychology/psychiatry, intercultural and transition studies, pastoral care and coaching, personnel and human resource development, and recovery and trauma care.

Member care began to be defined more formally in the early 1990s. It was and continues to be seen as the ongoing *investment of resources* by sending groups, service organizations, and workers themselves, for the *nurture and development* of personnel. It focuses on *every member* of the organization, including children and home office staff. It includes preventative, developmental, supportive, and restorative care. A core part of member care is the *mutual care* that workers provide each other. Workers receive it and they give it. Connecting with resources and people in *the local/host community* is also key. Member care seeks to implement an adequate *flow of care* from *recruitment through retirement*. The goal is to develop resilience, skills, and virtue, which are key to helping personnel stay *healthy and effective* in their work.

Member care thus involves both developing *inner resources* (e.g., perseverance, stress tolerance) and providing *external resources* (e.g., team building, logistical support, skill training).

The term *member care* was especially useful since it also connoted the mutual responsibility that people (members) in a group had to each other. So member care from the start was conceived as a "two-way street", as both senders and goers had responsibilities to each other. It also implied *belonging*: the sense of community between members who are part of a group. Finally, member care was a neutral term, which could be more readily used in settings where surveillance and security were an issue. The term has continued to take root over the last two decades internationally primarily within the Christian mission/aid community. Similar terms that have been used are: personnel development, human resource management, psychosocial support, staff care and development, member health and wellbeing, and people care.

Doing Ethics Well

Member care practitioners are part of quite a diverse group. They come from so many countries, training backgrounds, and organizations. We thus need to consider ethical care in light of our diversity. In this article we would like to offer three sets of guidelines that can help us chart a course towards an international framework for member care ethics (Gauthier & Pettifor, 2011; Sinclair, 2012). This framework includes core commitments for member care workers; a set of principles to help mission/aid organizations support/manage their staff; and a grid to review ethical rationalizations. The emphasis on a broad-based ethical framework is a more recent contribution to the development of the member care field. Colleagues are encouraged to utilize this framework along with the professional ethics code(s) to which they are committed. They are also encouraged to keep abreast with the major trends in global health, especially in the domain of global mental health (O'Donnell, 2011b).

Underlying this framework are the core values of *beneficence and nonmaleficence*, two sides of the same ethics "coin". These values impel us to intentionally seek *to do good* and *to do no harm*, respectively, within our spheres of practice and influence. They are embedded in the *Hippocratic Oath* from the 5th century BC and explicitly mentioned or reflected in many of the ethical codes in human health areas (e.g., American Psychological Association, *Ethical Principles of Psychologists, and Code of Conduct*, 2002, p. 3); Council of Collaboration (six associations), *Common Code of Ethics for Chaplains, Pastoral Counselors, Pastoral Educators and Students* (2004); International Union of Psychological Science and International Association of Applied Psychology, *Universal Declaration of Ethical Principles for Psychologists* (2008). For more information on the applications of the *Hippocratic Oath* to member care, see the weblog entries from June through September 2009 at: www.COREmembercare.blogsppot.com.

Those who want to provide quality care in mission/aid settings need to embrace and articulate these next five foundational premises. These premises build upon the *beneficence and nonmaleficence* values. They *positively influence* the ethical decisions necessary for good member care practice. They also are *protective factors* to safeguard the purposes and personnel of sending groups in mission/aid.

Five Premises for Ethical Member Care

- First, staff are *humans with intrinsic worth* and not just *resources with strategic worth*. We appreciate staff for who they are as well as for what they do.
- Second, ethical care is concerned with the *well-being of every one* involved in mission/aid. This includes the well-being of the organization, its purposes, and its personnel.
- Third, *sacrifice and suffering* are normal parts of mission/aid work. We acknowledge yet try to mitigate against the serious negative consequences that accompany work in risky places.
- Fourth, we encourage balancing the demands of professional work with the desires for personal growth. Personnel need to find a good work-life balance so they can both *run well and rest well*.

- Fifth, *how* we provide services to staff is as significant as the actual services themselves. We respect the dignity and rights of all people and thus provide quality care, *carefully*.

Consider the following three examples of some common ethical challenges in mission/aid. As you will see, applying these premises is not always a straightforward process. How would you apply these five premises in light of the commitment to do good and to do no harm?

Common Ethical Challenges

- *Competence*. An experienced consultant makes recommendations to a humanitarian organization based in Africa. The consultant is addressing the care of their emergency staff working in a mass disaster area, rampant with cholera and malaria. The consultant is vaguely familiar with that cultural context and the organization itself. To what extent does the consultant need to inform the agency about limitations in his/her background? When is it OK to "stretch" beyond one's areas of training and experience? What if no one else is readily available to offer advice? So is the consultant acting competently?
- *Confidentiality.* A compassionate leader informally exchanges a few emails with a man in their organization who has marital struggles. The man tells the leader that he and his wife have frequent fights that can be overheard by their Asian neighbors. He is also drinking a local alcoholic beverage most nights. Later, the leader prays with his own wife about the other couple's struggles. Is it OK for one's spouse to know such things? Is the disclosure of "significant problems" protected information? Would asking the leader to not share be "secretive"? So what type of confidentiality is appropriate?
- *Responsibility*. A reputable sending organization shortens a family's field preparation from three months to one month. The reason is so that the husband, a medical doctor, can cover a crucial and vacant position in a refugee clinic in the Middle East. To what extent does making such "adjustments" simply reflect the realities of mission/aid work? What if "lives", or a large funding grant, are at stake? So to what extent is the organization acting responsibly towards the family and towards the refugee patients?

Many other types of ethical issues get stirred up in mission/aid settings, not the least of which are jurisdiction issues and managing multiple roles and different types of relationships with sending groups/workers (Barber and Hall, 1996). Just a few of the many examples are listed below. It is important for sending groups and MCWs to anticipate and discuss such issues together. We thus need to be very conversant with the values, ethical principles, and guidelines that shape our decisions.

More Ethical Issues in Mission/Aid

- Assessing physical/mental disabilities during selection, including those of children
(e.g., whether hiring, locating, or promoting staff is based on such disabilities)
- Determining who has access to personnel files
(e.g., if team leaders have access to team members personnel files, especially "negative" information)
- Working in stressful settings with limited supervision, contingency plans, and personal debriefing
(e.g., whether senders can support staff adequately in isolated settings and/or with extreme stressors)
- Consulting with people with whom one has many types of social/work relationships
(e.g., whether to do conflict mediation for an interagency group that includes folks from your agency)
- Confronting the unhealthy and harmful practices of leaders and other staff
(e.g., how to protect staff that point out problems; whether certain lifestyle choices are private affairs)

Three Sets of Guidelines

Many types of professional ethical codes exist that can relate to the practice of member care. For some practitioners, these codes are essential and are a good "fit." But one size does not fit all! For example, a skilled Nigerian pastor providing trauma training/care in Sudan may not find a North American code for Counselors so helpful. Such ethical codes are primarily relevant for the disciplines and countries for which they were intended. Yet many member care workers (MCWs) enter the member care field via a combination of their life experiences and informal training, and are not part of a professional association with a written ethics code. So appealing to another country or discipline's ethical code can result in a rather cumbersome mismatch between the person and the code.[4]

We thus want to carefully identify *relevant ethical guidelines* that fit into as well as transcend our cultural and experiential backgrounds. In other words, MCWs and sending groups must develop an international framework which can further shape their ethical mentality and guide their member care practice. This framework would emphasize: *quality services* by MCWs and senders*; ongoing development* for senders and MCWs; *recognized standards* for those who are using/providing MCW services; and *protection* for service receivers via safeguards. We now consider three core guidelines that help form an international framework for ethical member care[5].

- Commitments for MCWs
- Principles for Senders
- Grid to Review Rationalizations.

1. Commitments for MCWs

The following guidelines include ten basic *commitments* for all types of MCWs. They focus on the personal characteristics, backgrounds, and relationships needed to practice member care ethically (qualities and qualifications). Like all three sets of guidelines, they are intended to be referred to regularly, discussed with colleagues, and applied in light of the variations in our backgrounds Sending groups that solicit/receive MCW services for their staff are responsible to carefully choose both internal and external MCWs. Understanding these ten commitments in combination with reviewing references and educational/experiential backgrounds, can thus help to evaluate prospective service providers.

Commitments for Member Care Workers

1. Ongoing training, personal growth, and self-care.
2. Ongoing accountability for my personal/work life, including consultation/supervision.
3. Recognizing my strengths/limits and representing my skills/ background accurately.
4. Understanding/respecting felt needs, culture, and diversity of those with whom I work.
5. Working with other colleagues, and making referrals when needed.
6. Preventing problems and offering supportive/restorative and at times pro bono services.
7. Having high standards in my services and embracing specific ethical guidelines.
8. Acknowledging different disciplinary/regulatory norms for different MCWs.
9. Abiding by any legal requirements for offering member care where I reside/practice.
10. Growing in my relationship to Christ, the Good Practitioner.

Application 1—Finding Your Ethical Niche. Some MCWs are specialists and have advanced degrees/certification in their respective disciplines. For example, for those whose main emphasis and professional identity is pastoral counseling, clinical psychology, or human resource management, the codes of professional associations to which they belong would be appropriate. Other MCWs have less formal or less systematic training routes (e.g., workshops, life experience.) Currently there is no generic accreditation or professional association for MCWs in this category. In view of *Commitment 7* in this first set of guidelines, they are strongly encouraged to practice member care in light of specific code of ethics that "fits" for them. It could be a code developed by a national or international organization/discipline, such as codes for Christian counselors, coaches, spiritual directors, or ombudsmen. They are also encouraged to have a written endorsement from their organization that attests to their competence and accountability. Note also that many field leaders and team leaders regularly function in member care roles—it is part of their job description in many cases. These leaders may not need a specific code per se but at the very least they need to be thoroughly informed by ethical guidelines such as those described in this article.

Application 2—Self-Care and Character: MCWs, like anyone else, can experience serious problems, including emotional, family, or moral struggles. In such cases, the quality of MCWs' services can decrease, and MCWs will need help, accountability, and often a break for restoration. If MCWs cannot manage their own life well, how will they manage the mission/aid "household" (I Tim.3:4-5)? Member care receivers expect Christian MCWs to model a healthy, godly lifestyle, and to maintain a close relationship with the Lord. *Commitments 1, 2,* and *10* are the most relevant for MCW character. These include personal growth, accountability, and relationship with Christ.

Application 3—Training and Competence: Christian workers in South Asia are being trained to provide pastoral care for staff in their organizations. Most do not have backgrounds in the health sciences. But they are mature people who have been chosen by their leaders to receive special training twice a year, in areas like basic counseling, crisis care, running a personnel office, and team building. They also have access to the trainers for case consultation via internet/telephone. These MCWs reflect a growing number of caregivers who are recognized within their organizations as being able to offer helpful services. Another example is the "peer debriefers" being trained in Africa as a first line of help when critical incidents occur. *Commitments* 1, 2, *3, 8,* and *9* are especially important for MCW competence. These include ongoing training, getting consultation/supervision, knowing strengths/limits, acknowledging different MCW norms, and abiding by legal requirements.

Application 4—Sacrifice and Compassion: MCWs often sacrificially give of themselves. They do so not to compensate for personal deficits but rather from a compassionate commitment to help others grow. Compassion has limits, and MCWs need to be aware of their boundaries and practice self-care. Nonetheless, there are times and even seasons when serving others is costly—and helping may be done out of a sense of duty and obedience; and it may temporarily "interrupt" our commitment to self-care (e.g., the tired disciples being asked to serve the crowds—Luke 9:10-17). *Commitments 1, 5,* and *10* are key for maintaining MCW compassion. These include self-care, respecting felt needs, and relationship with Christ.

2. Principles for Senders

This set of guidelines focus on the crucial role of sending groups to responsibly support and manage their staff well: international staff, local/national staff, home office staff, and family members of their staff. It also considers the big picture of member care from recruitment through retirement and the commitment to nurture both organizational health and staff health. We have taken these guidelines from the *Code of Good Practice in the Management and Support of Aid Personnel* (2003) developed by People In Aid in the United Kingdom. They include seven principles and several key indicators (specific criteria to demonstrate how the principles are practiced). Sending groups can use the *Code* to help them monitor how their member care (human resources) policies are integrated into their overall goals. These principles

are effective when they are understood and embraced at all levels of the sending group, and implemented by skilled managers with integrity. The complete *Code* and related documents are at: www.peopleinaid.org. See also Global Connection's (United Kingdom) *Guidelines for Good Practice for Mission Member Care* (2009), one of the most detailed codes for sending groups to date, organized into several core values with detailed guidelines for putting each value into practice.

Principles for Senders

Principle 1: Human Resources Strategy.
Human resources are an integral part of our strategic and operational plans.

- The organization allocates sufficient human and financial resources to achieve the objectives of the human resources strategy.

Principle 2: Staff Policies and Practices.
Our human resources policies aim to be effective, fair and transparent.

- Polices and practices that relate to staff employment are in writing, monitored, and reviewed. Staff are familiarized with policies and practices that affect them.

Principle 3: Managing People.
Good support, management and leadership of our staff is key to our effectiveness.

- Staff have clear work objectives and performance standards, know whom they report to and what management support they will receive. All staff are aware of grievance and disciplinary procedures.

Principle 4: Consultation and Communication.
Dialogue with staff on matters likely to affect their employment enhances the quality and effectiveness of our policies and practices.

- Staff are informed and adequately consulted when we develop or review human resources policies or practices that affect them.

Principle 5: Recruitment and Selection.
Our policies and practices aim to attract and select a diverse workforce with the skills and capabilities to fulfill our requirements.

- Written policies and procedures outline how staff are recruited and selected to positions in our organization. Our selection process is fair, transparent, and consistent.

Principle 6: Learning, Training and Development.
Learning, training and staff development are promoted throughout the organization.

- Adequate induction, and briefing specific to each role, is given to all staff. Written policies outline the training, development, and learning opportunities staff can expect from the organization.

Principle 7: Health, Safety and Security.
The security, good health, and safety of our staff are a prime responsibility of our organization.

- Written policies are available to staff on security, individual health, care and support, health and safety. Program plans include written assessment of security, travel and health risks specific to the country or region, reviewed at appropriate intervals.
- Before an international assignment, all staff receive health clearance. In addition, they and accompanying dependents receive verbal and written briefing on all risks relevant to the role to be undertaken, and the measures in place to mitigate those risks, including insurance… Briefings are updated when new equipment, procedures, or risks are identified. All staff have a debriefing or exit interview at the end of any contract or assignment. Health checks, personal counseling, and careers advice are available. Managers are trained to ensure these services are provided.

Application 1—Where There Are No (Well-Resourced) Senders: There are a couple important counterpoints for the guidelines suggested here. First, not all mission/aid workers actually have "senders." At least many may not have an ongoing long-term sender as they may work from contract to contract and from agency to agency. Others workers do things much more on their own without a sending group per se. Their charitable work and Christian witness are done as part of their lifestyle in a host culture. Many mission/aid workers surely wish that a sender would be able to support and manage them in ways that are recommended here!

Second, for some sending groups themselves, these guidelines may seem overly idealistic at best and inappropriately constrictive at worst. Senders coming from philosophically different, or less-experienced, or financially-limited settings may not be on the same page about what is "needed" to do mission/aid and member care well. For instance some senders may default to the practice of sending out "naked" mission workers who have no apparent resources other than to follow the Biblical injunction Christ gave his disciples to go without an extra coat, staff, or money. These folks embody that commitment, without an expectation of returning to their home country for furlough or retirement. This may seem extreme, but it does reflect the other end point of the sender's continuum for providing "comprehensive" member care. On a related note, in her concluding chapter in *Sharing the Front Line and Back Hills* (2002), Danieli describes how some potential contributors to her edited work dismissed her work as "preposterous or obscene". The reason was that she was focusing on aid workers themselves—the protectors and providers—rather than on what was perceived to be the far more needy victims who needed help (p. 388).

Application 2—Good vs Poor Practice: A sending church in Europe helps support 10 mission/aid workers. The workers are part of separate agencies and they work on four different continents. Their biggest issues are maintaining communication with these workers and feeling connected with each other. Most of the responsibilities for "managing and supporting staff" are assumed to lie with the sending agency rather than the church. During the past year one of the workers was severely injured in a car crash and needs months of intensive physiotherapy, while another suffers from recurrent malaria. What to do?

Good Practice: Each worker is assigned a volunteer advocate from church who stays in monthly contact with the worker. The mission coordinator reviews these seven good practice principles with the church pastors and elders. They agree to adopt these principles, and send copies of the *Code of Good Practice* to the volunteer advocates, the workers, and the sending agencies. Over the next two months the mission coordinator talks with each personnel director from the sending agencies. They review how best to support the respective workers, taking special note of *Principles 4*, *6*, and *7* (communication with staff, learning opportunities, and health/safety issues.)

Poor Practice*:* The sending church agrees to help send three more mission workers. The addition of three more photos looks pretty good on their world map in the entrance to the church. The mission coordinator gets a copy of the *Code of Good Practice*, reads it with appreciation, and dutifully files it…until a new crisis hits one of their 13 mission/aid workers. Rest in pieces.

3. Grid to Review Rationalizations

These recommended guidelines consist of 10 common rationalizations for our *faux pas* as practitioners. They are cover-ups. And cover ups, of course, can be just as bad or even worse than the ethical mistakes themselves. These rationalizations can be seen as sub-standards that we can unfortunately all-too-easily tolerate or even adopt. The prefix *sub* here refers to standards that are both inferior and wrong. Sending organizations and MCWs would benefit by adding to these 10 items in light of one's own "preferred" rationalizations. But beware: we can rationalize our rationalizations with "meta-rationalizations". One of the prime examples of a meta-rationalization is the self-serving belief that we do not in fact rationalize. Or a corollary meta-rationalization is to believe that even if we do rationalize, we do so for a very ethical or noble reason. We have drawn upon the work of Ken Pope and Melba Vasquez (1999) by adding to and adapting some of the rationalizations that they have identified in the practice of psychology.

Grid for Rationalizations

- It is ethical as long as you don't know a Bible verse, law, or ethical principle that prohibits it.
- It is ethical as long as your colleagues or service receivers do not complain about it; or as long as no one else knows or wants to know; or as long as you can convince others that it is OK.
- It is ethical as long as you or your telecommunications technology were having a "bad day", thus affecting your usual quality of work; or as long as the circumstances and decision were difficult; or as long as you are busy, rushed, or multi-tasking.
- It is ethical as long as you follow the majority of your ethical guidelines; or as long as you only intend to do it one time.
- It is ethical as long as there is no intent to do harm, you are being sincere, "your heart is in the right place", and you are trying to do the best that you can.
- It is ethical as long as you are a moral person; or a nice, competent, or respected person; or as long as you provide *free* services.
- It is ethical as long as you "take responsibility" for your decision/behavior; or as long as you were acting with "integrity"; or as long as it does not seem to negatively impact your behavior/emotions.
- It is ethical as long as the matter is not completely black and white; or as long as someone else is also "wrong or more wrong" than you are:; or as long as others do it; or as long as someone in authority over you reassures you or pressures you and asks you to do it.
- It is ethical as long as you believe/feel it is not unethical or as long as you think God is on your side.
- It is ethical as long as you are an important person or the most powerful person.

Application 1—Rationalization or Reflection: Using this grid is part of a larger process for both sending groups and MCWs to regularly look in the mirror of our hearts. We do this individually and with others in order to scrutinize both our motives and the ethical quality of our member care work. Our own capacity for self-deception and self-justifying revisions of our personal and work-related history give cause for much concern. In addition to reviewing the copious amount of Scriptures that expose our prevarication-prone human nature (e.g., Jeremiah 17:9), see the compelling work of Tavris and Aronson (2007) on how we distort reality: *Mistakes Were Made (But Not by Me): Why We Justify Foolish Beliefs, Bad Decisions, and Hurtful Acts*. So we have to trust ourselves surely, yet we also must have a healthy respect for the possibility of our own distortions.

Consider this situation. At an international health care conference, a group of mission leaders and MCWs discuss member care issues during a special interest group. The facilitator uses the 10 items in this grid as a springboard to discuss how quality services can be compromised. Many tricky examples are voiced: "I needed to do what I thought was best as there was not opportunity to consult a book or colleague;" "I do prayer ministry for depression and professional ethics are not relevant"; and "I am a good person and my good intentions guide how I run the personnel department." The participants then break into small groups to relate these 10 rationalizations with sayings from the book of Proverbs. They also identify a couple safeguards from the *Commitments for MCWs* and the *Principles for Senders* to help prevent them from lapsing into ethical sub-standards.

Final Thoughts

We have explored some of the ethical terrain in the diverse field of member care in mission/aid.[5] We suggested some important values and premises to help shape ethical practice. We offered three sets of guidelines that we believe helpfully point us towards an international framework for member care. These guidelines are seen as being complementary to one's own professional code of ethics.

Our quest for ethical member care has a destination. It ultimately leads us to the doorsteps of the world in need as we seek to positively impact the major challenges facing humanity (Grand Challenges 2011, Johnstone 2011). Our quality, ethical care can significantly bolster the wellbeing of the hundreds of thousands of workers within the mission/aid community. The work that we do in member care is thus a strategic support for those who in turn reach out in so many noble ways to help this struggling world.

The Case of Philip Faithful and Family

We conclude this chapter with a case study in two parts. It pulls together some of the member care issues and ethical challenges that we are likely to face in international mission/aid settings. This fictitious account includes at least 25 poor practices, including many unethical ones (part one), as well as good, ethical ones (part two). An analysis of a similar case (chapter 19 of *Missionary Care*, 1992) is available at Member Caravan's website: http://sites.google.com/site/membercaravan/test/mc-counting-the-cost-book-

Review one—good intentions. Read through this study and identify several of the ethical issues. Keep in mind these three broad areas in your analysis: the organization's policies and procedures for staff care; where and with whom the actual "problems" reside; and the involvement of well-meaning people in helping roles. All of these areas are intertwined with the cross-cultural context of this case[7]. How are the three sets of guidelines in this chapter (MCW commitments, Sender principles, Rationalization Grid) being utilized or not utilized?

Review two—good interventions. Describe what you would do to help in terms of these five areas for ethical care: organizational responsibility, confidentiality, MCW competence, testing, and personal values/legal standards. Based on the epilogue, list some of the main ways that the pastoral counselor, mental health professional, and senior leader intervened appropriately. Make a summary recommendation to this organization for improving its member care program. List some key ethical challenges for mental health professionals and pastoral counselors who working in international settings like this.

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The Faithful Family

Phillip, Anne (parents) Fatima, Jerome (children)

Part One. Phillip Faithful is a 28 year old staff member of a large Christian humanitarian organization in Southeast Asia. On the average he works ten hour days and is almost always available to help out when there is a need in the office. He is the type of person who exudes goodness and doesn't say no to those over him, sometimes at the expense of his own needs. He often uses part of his three weeks of annual vacation for helping others.

Phillip was raised in Singapore and went to a university in England for two years where he met his wife, Anne. He married at age 24 and has two healthy children, Fatima (age 3) and Jerome (age six months). Currently he and his family live in Jakarta, Indonesia and are involved in work locally and in Asia.

During the last three months Phillip, who is usually very friendly, has become increasingly irritable with his colleagues and somewhat withdrawn with his family. His supervisor noticed these changes and talked to Phillip's wife about what he viewed as "pride and independence" in Phillip. She confided in him that they both feel apathetic and that she has little energy to take care of her home and work responsibilities.

The supervisor shares some Scripture with her. He then encourages her to talk to Phillip about taking time off to "get back into work shape" and that he talk to someone about his problems. She follows his advice.

Phillip was too busy to take time off but he did agree to contact the Director of Training, Ms. North, for counseling. She is a North American woman who has taken some counseling courses at a Christian University and is recognized for her ability to listen and offer appropriate advice. She also provides counseling to Christians from some of the local churches to supplement her income.

Ms. North works on a fundraising committee in a local church with Phillip which meets once a month. Phillip approaches her after a meeting and schedules a time with her to talk and pray about his problems. She also begins to pray regularly for Phillip with the Pastoral Care Committee in the church.
Ms. North obtained Phillips personnel files from the temporary secretary in the Personnel Department to better acquaint herself with his background. Phillip had taken two personality tests as part of the screening process to be accepted on staff. He scored high on the "depression" scale, so she wondered if he had tendencies towards a serious emotional disorder.

Ms. North also decided to speak to Phillip's wife and supervisor to better understand his struggles. The supervisor recommended that Ms. North borrow a "temperament analysis" test and administer it to Phillip in order to further explore his personality. She administered the test along with an inventory to assess stress[8] and then spoke with the supervisor, suggesting that Phillip be put in a department with less paperwork and more people contact.

Phillip and Ms. North meet for four counseling sessions. They spend most of their time talking about the challenges of raising his two children, his past relationship with his father, and his apprehension to openly talk about his work frustrations with leaders. Ms. North spends time listening for what might be the "root" of his problems, and subsequently advises him to work fewer hours, spend more time with his family, and be more assertive with colleagues.

After the fourth session, Ms. North tells Phillip that she would like to recommend his seeing a visiting leader from a Christian charity from Europe. She feels this person can encourage him and possibly give him more insights into his current situation. Phillip gives her a small honorarium for her services, and a few days later approaches the visiting leader. The leader has never heard anything about Phillip.

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Part Two. One week later, with no changes in Phillip's situation, the supervisor updates a senior leader in the organization. The leader arranges a meeting the next day with the supervisor, Ms. North, and a certified pastoral counselor living in Jakarta. The counselor trained in Australia and receives regular referrals from several humanitarian organizations.

During the meeting everyone compares notes and agrees that Phillip has fallen through the member care cracks and that he needs professional help. Ms. North briefly shares how this has been difficult for her. The pastoral counselor points out that other family members will likely need support too and agrees to meet with Phillip and his wife Anne if they are willing. He points out that a physical exam, an assessment tool for depression symptoms, and a review of the overall work environment/relationships would be helpful. The counselor clarifies his fees for service (to be paid for by the organization) and confidentiality policy (stipulating that a general progress report can be given only with Philip and Anne's permission).

Later that day, the supervisor meets with both Philip and Anne to see how they are doing, informs them of the meeting earlier that day, and asks for their perspectives and what they think is best. The couple expresses their willingness to meet with the pastoral counselor, especially as they know of his reputation and are comfortable that he is not part of their organization.

Later that night, the organization leader talks informally with his sister-in-law about the situation (via internet webcam). She is a mental health professional (MHP) in the USA who is part of a member care network and consults regularly with member care situations internationally. The MHP is glad to give some general input with the caveat that there is only partial information available and that the local pastoral counselor should be the main person being consulted regarding member care for Philip and Anne. Because of their good relationship and similar backgrounds, the MHP is able to talk candidly with the leader, asking what he believes has been done well and not well so far. She then decides to focus the conversation on the bigger picture regarding the impact of the organization's ethos on work and member care and explores the overall human resource system (HR) that is in place.

Based on the MHP's suggestions, and prompted by the near-crisis with Philip, the leader is very interested in improving its HR and member care. They brainstorm together about ways to do so. In the process the leader confides with the MHP that Philip's situation bears some similarity to his own, with major work pressures and time commitments beginning to wear him out. The MHP suggests that the leader and his wife take an online work-life balance inventory and discuss it together as a couple, identifying both challenges and supports in their lives. The MHP also agrees to send an HR assessment resource to help the leader better understand the main components of HR and also gives a referral for a colleague who works in HR with international organizations. Their conversations ends with the leader recalling People In Aid's *Code of Good Practice* (2003) and committing to review it with fellow leaders.

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Kelly O'Donnell, PsyD is a consulting psychologist living in Europe and the CEO of Member Care Associates, Inc. His member care emphases include staff well-being, crisis care, ethics, team development, and practitioner affiliations. Global mental health is an overlapping focus via his work as the Coordinator of the Mental Health-Psychosocial Working Group for the Geneva-based NGO Forum for Health. Kelly holds graduate degrees in clinical/community psychology including a doctorate from Rosemead School of Psychology, Biola University, USA. His publications in the member care/mental health fields include more than fifty articles and four books including *Doing Member Care Well: Perspectives and Practices from Around the World* (2002*) and Global Member Care: The Pearls and Perils of Good Practice* (2011a) both published by William Carey Library. He works closely with his wife Michèle who is also a psychologist. MCAresources@gmail.org www.membercareassocaites.org

Notes

1. Many thanks to Dr. Steve Allison for his input and encouragement regarding this chapter. Much of the material is excerpted/adapted from *Global Member Care: The Pearls and Perils of Good Practice* (2011), William Carey Library. Used by permission. For more discussion of member care ethics see the four chapters in Part Three (Ethics and Human Rights in Member Care: Developing Guidelines in Mission/Aid). Some of the material is also available in a video/audio format, recorded from the 2009 Integration Symposium at Fuller School of Psychology, Pasadena, California: http://www.fuller.edu/academics/school-of-psychology/integration-symposium-2009.aspx

2. For a quick and poignant overview of some of the major challenges facing humanity, see: a) the multimedia material for the United Nations *Year in Review* for 2011, 2010, etc.: http://www.unmultimedia.org/tv/webcast/2011/12/un-year-in-review-2011.html; and b) the overview and updates for the *Millennium Development Goals:* http://www.un.org/millenniumgoals/

3. "Mission/aid" is a broad, inclusive term that represents the increasing focus and contributions of faith-based, Christian work around the world. By "mission" we refer to the efforts of both Christian workers serving in cross-cultural settings and national Christian workers located in their home/passport countries. By "aid" we refer to the extensive area of humanitarian assistance. This area, or sector, encompasses relief and development operations by civil society, NGOs, the United Nations, faith-based groups, etc. Mission and aid overlap with each other and using the term mission/aid reflects this practical reality.

4. For examples of various issues and ethical challenges in Christian mission in general: a) *Serving Jesus with Integrity:* and b) *Ethics and Accountability in Christian Mission* (2010), Dwight Baker and Douglas Hayward (Eds.), William Carey Library; and *Christian Mission: A Case Study Approach* (1995), Alan Neely, Orbis Books. For additional material on training for international ethics and cultural competence, see the article "Internationalizing the professional ethics curriculum" (Leach & Gauthier, 2012) and the book *Cultural Competence Training in a Global Society* (Dana & Allen, 2008), both part of Springer's extensive series on International and Cultural Psychology.

5. We refer to the three sets of guidelines as reflecting an *international* framework for ethical member care. The *MCW Commitments* and *Sender Principles* have been developed and reviewed by colleagues from many different countries over the past 10 years, including colleagues from the Global South(s) and Global North(s). The *Rationalization Grid* is broadly relevant in that its foundational perspective—the inherent capacity of humans for prevarication/self-deception—is seen clearly throughout Scripture, mental health literature, and history. Another international framework relevant for mission/aid is the World Association of Non-Governmental Organization's *Code of Ethics and Conduct for NGOs* (2004).

6. For additional materials regarding member care in mission/aid as well as ideas for involvement: a) *CORE Member Care* blogsite: www.COREmembercare.blogspot.com (e.g., the entries on global integration of mental health-member care, 13 July 2011-15 December 2011; and culture and diversity in member care-international health, 15 February-12 May 2010); b) the *Member Caravan* web site: http://sites.google.com/site/membercaravan/ (e.g., Resource Updates, MC Library); and c) the power point, *God in the Global Office* (2009): http://www.slideshare.net/MCAresources/god-in-the-global-office

7. For more perspective on cultural issues relevant for helping professionals: a) Twelve Critical Issues for Mental Health Professionals Working with Ethno-Culturally Diverse Populations (October 2011), Anthony Marsella, *Psychology International 22*(3), 7-10: http://www.apa.org/international/pi/2011/10/index.aspx; b) *Mental Health in A Changing World: The Impact of Culture and Diversity* (World Mental Health Day, 10 October 2001), World Federation for Mental Health: http://www.wfmh.org/PDF/Englishversion2007.pdf; and c) *Handbook of Multicultural Counseling Competencies* (2010) edited by Jenifer Erickson et. al., John Wiley & Sons.

8. Examples of other self-assessment tools for stress management and work-life-balance are listed on the Reality DOSE website (from Member Care Associates, Headington Institute, International Federation of the Red Cross, etc.): https://sites.google.com/site/mcaresources/giantsfoxeswolvesandflies