Journal of Psychology and Christianity
2021, Vol. 40, No. 1, 29-39

ISSN 0733-4273

What Mental Health Professionals Can Learn from Missionary Member Care: Ways of Thinking, Doing, and Being

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The field of member care has contributed to the development of resources for missionary personnel and has assisted with the preparation and retention of cross-cultural workers. While member care historically drew from Western psychological models of care, member care models developed within the past 20 years have resulted in distinct ways of thinking, ways of doing, and ways of being that reflect the unique characteristics, cultures, and preferences embodied in missionary personnel. This article provides a summary of the development of missionary member care and explores future member care paradigms that professional mental health care practitioners might consider instructive.

Missionary member care has at its core the provision of support and service to missionary personnel. In essence, member care seeks to apply biblical principles of loving one another through providing international and interdisciplinary support for mission personnel and their work (O'Donnell, 2015). O'Donnell's (1997) seminal article provided the most often used definition of the term member care:

> [Member care is] the ongoing investment of resources by mission agencies, churches, and other mission organizations for the nurture and development of missionary personnel. It focuses on everyone in missions (missionaries, support staff, children and families) and does so over the course of the missionary life cycle, from recruitment through retirement. (p. 4)

During its early development from the 1950s-1980s, missionary member care was heavily influenced by Western mental health practices and models of care, largely because of the predominance of North American mental health professionals interested in missionary care (Powell & Wickstrom, 2002). But mission personnel on the field quickly learned that a more multi-disciplinary and contextualized approach than was common in Western psychology was needed given the distinctive cultural milieu and facets of life overseas (O'Donnell, 2002). These unique cross-cultural situations required new ways of thinking, new ways of doing, and new ways of being.

Member Care History

The practice of structured and targeted care systems for missionaries originated in the 1950s with the inception of Missionary Training International in 1953 and the Narramore Christian Foundation in 1958 (Koteskey, 2013). The 1960s brought a greater focus on supporting cross-cultural workers in overseas missionary service by providing preparation for language study, field orientation, and furloughs (Odman, 1964) and assisting sending agencies in identifying factors that contributed to an individual's fit for missionary service (Hubble, 1969). At this time, the term "member care" was not yet in use, although the concept of "missionary care" was beginning to take hold, and by the late 1980s the two terms would be synonymous (Koteskey, 2013). Of importance, many of the foundations of member care began within the field of psychology (O'Donnell, 2015) and drew on literature

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describing missionary characteristics (Webster, 1955; Sargent, 1960) and common emotional difficulties among mission personnel (Stringham, 1970; Williams, 1973). In addition, the field of missionary care pioneered some of the earliest efforts at integrating theology and psychology (Koteskey, 2013; Narramore, 1973), with efforts to ensure the emotional well-being of first-term missionaries (Piepgrass, 1972).

The member care movement expanded rapidly during the 1980s through the inception of Mental Health and Missions, an annual conference founded by John Powell and David Wickstrom, in collaboration with Missionary Training International (Gardner, 2002; O'Donnell, 1997, 2015). Subsequently, the 1990s introduced a growing body of literature on member care, a term that had been operationally defined by O'Donnell and O'Donnell (1992) in *Missionary Care: Counting the Cost for World Evangelization*. Later publications of O'Donnell's (2002) classic text on Doing *Member Care Well* and Powell and Bowers' (2002) volume on *Enhancing Missionary Vitality* introduced standards for care and best practices. Member care had developed a platform for voices from around the field, resulting in a global voice.

In reviewing the history of member care, it is important to recognize factors that account for underrepresentation in academic literature. Many member care experts are first and foremost on-field practitioners, providing care and actively working to serve their missions community and context. In some cases, the practitioner role and non-academic nature of member care work lend little time for empirical research and the types of scholarly publications that are commonly eschewed as authoritative among English-speaking academics. Thus, contributing voices outside the English-speaking, Western world are frequently overlooked in the peer-reviewed literature. Additionally, security concerns for members working in countries where missionaries are not welcomed may also contribute to the scarcity of academic literature within the field of member care.

Contributions to the Literature

Nonetheless, there is an ever-expanding body of literature on topics related to missionary member care. To date, the literature has primarily focused on the history and development of the field and has highlighted contributions to cross-cultural living and service (Crawford & Wang, 2016; Hall & Schram, 1999; Powell & Bowers, 2002). For example, guidelines for pre-field assessments for international workers, alternative treatment approaches, re-entry to the home country, and trauma and burnout are recurring themes in the member care literature. Much of the empirical literature stems from dissertations that focus on third culture kids (TCKs) and re-entry and missionary retention (Crawford, & Wang, 2016; Davis et al., 2010; Davis et al., 2013). Additionally, research continues to grow on what impacts "resilience" among missionary personnel (Schaefer & Schaefer, 2012; Thom et al., 2019; Davis et al., 2020). Yet there is scant literature exploring or evaluating member care models or current trends in member care, including what Crawford and Wang (2016) identified as gaps in the literature pertaining to clinical outcomes, longitudinal studies, the impact of technological advances and telehealth approaches, and studies to equip mental health professionals to work with diverse mission personnel.

One consistent theme in the field of member care regards the openness to embrace new paradigms and consider future directions (Crawford & Wang, 2016; O'Donnell, 1997; Powell & Bowers, 2002) largely because circumstances on the mission field require innovative approaches to care without the resources available in the professional mental health disciplines. Perhaps member care, with its nimble and pioneering approach to missionary care, can help inform and inspire professional mental health care directions. In particular, the member care movement embraces ways of thinking, ways of doing, and ways of being that may provide useful instruction to mental health professionals.

Learning from Missionary Member Care: Ways of Thinking, Doing, and Being

Ways of Thinking

Two decades ago, as the member care movement began to expand, Kelly O'Donnell and Dave Pollock proposed a new way of thinking about missionary member care by suggesting a Member Care Model for Best Practice (O'Donnell, 2002; see Figure 1). This model sought to address the multiple and overlapping contours of care needed when providing care to mis-

sionaries. The model suggests a flow of care that includes five permeable spheres visualized as concentric circles. In this model, the most central sphere of care is deemed *Master Care*, indicating that all care begins with one's relationship to Christ. The circles of care then proceed outward to include *Mutual Care/Self Care* (ways of caring for self and others); *Sender Care* (ways that mission agencies and churches care for their personnel from recruitment through retirement); *Specialist Care* (the explicit care of pastors, mental health professionals, physicians, etc.); and *Network Care* (connecting to others and consulting, strategizing, etc.). It is a holistic, flexible framework that O'Donnell suggested was "a grid to guide and a guide to goad" (O'Donnell, 2002, p. 16).

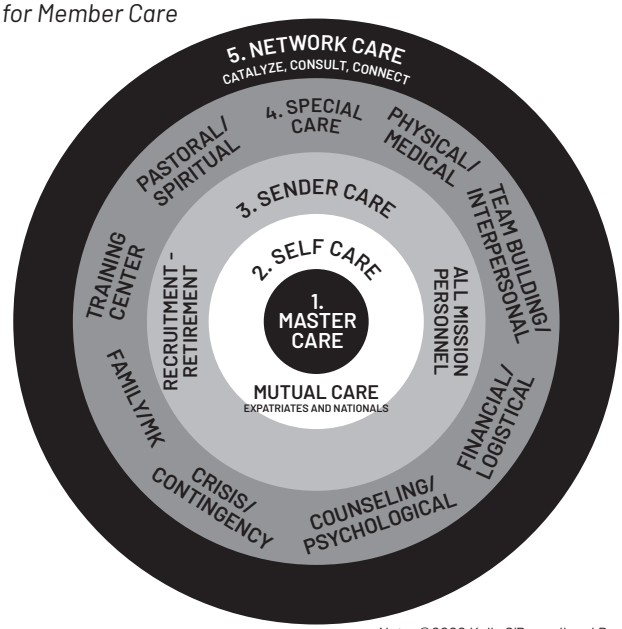
In essence, this member care model suggested that a permeable back-and-forth flow of care among missionaries, their team, their senders, specialist caregivers, and the broader network allows the best care for missionaries (Pollock, 2002). Without overlapping care from sending agencies and the greater network, care by provided by mental health professionals alone may not be adequate. This concept of inter-disciplinary care has long been embraced by the mental health profession as contributing to successful outcomes (Mulvale et al., 2008; Schultz et al., 2014; Stamm, 2003).

What may be novel thinking for mental health professionals, however, is the central importance of both *Mutual Care* and *Master Care* as starting points when addressing the care needs of individuals. Missionary member care begins with the care that community members provide for each other and with an understanding of the individual's relationship to Christ. The importance of both social support and spiritual support as key components of adjustment is supported in the professional mental health literature (Myers et al., 2011; Wolf et al., 2014). An intriguing paradigm conceptualization within member care, however, considers *Master Care* and *Mutual Care* as intrinsic and overlapping with *Specialist Care*. Many North American mental health care models begin with assessment and diagnosis by a specialist and then seek structures including community and spiritual resources as adjunctive care. Yet in many cultures, *Specialist Care* is considered a luxury, a Western ideal, or an unattainable resource (O'Donnell, 2011).

Given the centrality of *Master Care* and *Mutual Care* in this model, member care places a strong emphasis on training lay-level counselors

Figure 1

A Best Practice Model for Member Care



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through on-field workshops and seminars related to mental health care, spiritual formation and direction, peer-to-peer debriefing, and conflict resolution. For example, the Narramore Christian Foundation offers a bi-annual Counseling and Member Care Seminar in locations such as Thailand, Turkey, and Greece to train cross-cultural member care providers. Each two-week, intensive seminar is limited to 40 participants and provides practical training in basic counseling skills and understanding key psychological issues, such as anxiety and depression, suffering and trauma, shame, grief and loss, gender identity, conflict resolution, and sexuality. The training provides a foundation for cross-cultural member care workers to be equipped to provide care to others in situations where specialist mental health care may be limited, inaccessible, or undesirable.

Perhaps there is a place for Western mental health professionals to implement a care model that centralizes and even prioritizes the importance of *Master Care* and *Mutual Care* as the first means of caring for others. This idea gained relevance during the COVID-19 pandemic, when travel and resources became quickly limited and communities needed to find new ways to provide mental health support to those in their midst. While the mental health professions diligently adapted to modify service options for existing clients and to provide continuing education regarding telehealth to providers, the missionary member care movement advanced extraordinarily. For example, the Global Member Care Network (GMCN; Global Member Care Network, 2020), sponsored by the Mission Commission of the World Evangelical Alliance, had a well-functioning platform already in place when the pandemic of 2020 created a need for new ways of thinking about how to provide member care services. Within a few weeks of global shutdowns, GMCN offered support to member care providers through email correspondence, 10-minute YouTube videos, reflective worksheets, and access to a vibrant Facebook community (H. Hoffmann, personal communication, November 24, 2020). The advance of member care education that occurred due to the pandemic was described by Harry Hoffmann, who is coordinator of GMCN, as "a breakthrough," (personal communication, November 24, 2020). During the first few weeks of the pandemic, nearly 6,000 member care providers signed up for a free online course entitled "Member Care Foundations" (Hoffmann, 2020) and offered by GMCN, which provided immediate access to a confidential forum for consultation regarding missionary clients, powerful sharing of new ideas, and perhaps most importantly care and support for the member care providers in the community—*Mutual Care* at its best.

Of crucial importance, the member care model as posited by O'Donnell (2002) is culturally sensitive and applicable across diverse contexts, largely because the model creates a permeable back-and-forth flow that is broad enough to be used by both large and small organizations and widely applicable to member care contexts across diverse nationalities (O'Donnell, 2015). Within the past two decades since this model was first introduced to a mostly Caucasian, Western missionary member care community, member care has rapidly expanded to include a strongly contextualized focus that is attractive to diverse providers in North and South Asia, across Africa, and throughout Latin America (Schulz & Howley, 2013). A seminal text entitled *Doing Member Care Well: Perspectives and Practices from Around the World* (O'Donnell, 2002) dedicates nearly half of the text to counseling and member care perspectives penned by diverse authors and representing cultures worldwide.

To further illustrate member care's commitment to diversity, when GMCN offered a free course entitled Member Care Foundations at the outset of the 2020 pandemic, the participants included member care providers representing Rwandan, Ugandan, Indonesian, Chilean, and Colombian ethnicities, among others. The synergy that exploded as a result of prioritizing diverse and global perspectives on member care was described by participants as "powerful" and "simply outstanding" (H. Hoffmann, personal communication, November 24, 2020). May this serve as a potent prototype for mental health professionals and educators committed to including diverse voices in training the next generation of mental health care professionals. Perhaps educators might borrow from the member care way of thinking to offer free online courses that incorporate both professors and students who represent global perspectives on mental health care.

Ways of Doing

From the outset, missionary member care providers needed flexible ways of providing care to constituents, simply because Western models could not be easily applied to an overseas context or the needed resources were not readily available. A noted strength of cross-cultural workers, in general, is their ability to be flexible and creative when typical ways of doing are unavailable (Powell & Bowers, 2002; Schaefer & Schaefer, 2012). Thus, missionary member care incorporated creative approaches, such as integrated care and counseling teams who traveled to remote locations where cross-cultural missionaries live to provide services for several days or a week; regional care facilities that provide on-field psychiatric assessment, clinical mental health services, pastoral counseling, spiritual direction, and educational consultation from one location; and the implementation of internet-based virtual counseling, psychiatry, and debriefing long before the 2020 pandemic made telemental health a common practice (GodSpeed Resources Connection, 2020; Schwandt & Moriarty, 2008).

Short-term Member Care Approaches

An early method of providing member care involved caregivers who traveled to remote locations to provide short-term counseling, psychiatric assessment, prayer, spiritual guidance, team conflict resolution, educational consultation for children, and so on. While organizations such as Barnabas International, Narramore Christian Foundation, and Mobile Member Care Team began utilizing itinerant caregivers decades ago, the idea is now mainstream in providing care to cross-cultural missionaries. Long-term experience suggests that "the ministry of presence" (P. Bradford, personal communication, November 25, 2020) in which missionaries have an opportunity to build ongoing relationships in face-to-face interactions with care providers who travel at regular intervals provides the most helpful model. Carr (2002) noted that itinerant caregivers must be mindful to engage with cultural sensitivity and recognize the importance of working with mission administrators to plan the visit.

Counseling Centers

What began as itinerant travel to offer mental health services to missionaries burgeoned in 1990 to become a counseling center in Nairobi, Kenya (Brown & Brown, 2002). Tumaini Counseling Centre was the first multi-disciplinary counseling center that exclusively served Christian missionaries and remained the only on-field missionary care center for several decades. Currently, Tumaini offers services in four different languages. Their providers, which include psychologists, psychiatrists, professional counselors, social workers, education specialists, and a family physician, offer a robust set of services to missionary families who travel to the center (Tumaini Counseling Centres, 2020). The idea of offering care on-field to missionaries, rather than having them return to their home country, represented a paradigm shift in member care. Subsequently, multi-disciplinary counseling centers for cross-cultural workers have opened in Chiang Mai, Thailand (Cornerstone Counseling Foundation, 2020; The Well International, 2020); Antalya, Turkey (Olive Tree Counseling, 2020); and Málaga, Spain (SentWell, 2020), with other locations being planned (T. Hibma, personal communication, November 24, 2020). Hoffmann (personal communication, November 24, 2020) reported that there are approximately 30 member care center initiatives all over the world intending to open soon, offering a mix of therapeutic services and preventative trainings.

One of the unique offerings of these regional counseling centers is the provision of short-term intensive services. The authors, both of whom worked in member care roles cross-culturally for more than a decade, recall regular instances when clients would travel from a nearby country for one to three weeks to obtain various services, such as intensive individual or family counseling, psychiatric assessment, trauma care, educational assessment, spiritual and pastoral care, and so on. For practitioners trained in the West, this model has many drawbacks and may introduce ethical concerns to be addressed. However, in the past two decades as the member care movement has developed, much has been written to address ethics and standards of practice (Crawford & Wang, 2016; Hall & Sweatman, 2002; O'Donnell, 2006; Pow-

ell & Bowers, 2002). Carr (2002) suggested that mental health professionals who undertake working overseas with cross-cultural workers need to be mindful of obtaining supervision and working within an accountability structure that includes other professionals. Brown and Brown (2002) noted that complex situations, such as personality disorders, significant unresolved early trauma, or some eating disorders, are not able to be managed on the field and, instead, require the cross-culture worker to return to the home country for treatment.

The benefits of on-field counseling, however, seem to outweigh the risks when member care services are offered with attention to competence and ethical standards. Brown and Brown (2002) noted that on-field counseling is more cost-effective in regards to both time and finances, is less disruptive to the family unit, requires less time away from the primary mission assignment, and is a more attractive option to many cross-cultural workers. For example, when missionaries are able to receive on-field counseling, they avoid the travel expense of returning to their passport country, the disruption to their children's schooling, and the impact on their ministry team when they depart. Granted, some situations require missionaries to leave their ministry location and return home for long-term counseling; however, many common difficulties may be successfully managed with short-term, intensive counseling while remaining in the ministry location.

What is noteworthy is the surprising success of this short-term intensive model, where clients travel to the counseling center location for one to three weeks and engage in multiple sessions, returning every three to four months for regular, intensive work over a longer period of time. While the examples are anecdotal, since the field of member care lacks significant empirical research, it should be noted that newer cross-cultural workers beginning their tenure of service frequently inquire about the availability of member care and counseling services as they make decisions regarding field of service. Mission agency administrators have indicated that the on-field model provides fewer disruptions to the missionary's family, team, and overall work-life balance. Cross-cultural workers who have received on-field counseling propose that their family is stronger and more able to continue the work of their calling.

Creative Adaptations

Yet on-field member care is changing as the world adapts to a new normal. The Mobile Member Care Team that provided itinerant services to missionaries in West Africa disbanded in 2017 and, instead, maintains an active and robust website of resources known as the Mobile Member Care Toolbox (2020). The Tumaini Counseling Centres in Kenya and Uganda are reforming, as their staff has become more transitional and they have invited mental health professionals to join the Centres for shorter periods. Additionally, although missionary member care accepted and incorporated telehealth as a creative platform long before it was widely utilized by mental health professionals (Crawford & Wang, 2016; Reguiero et al., 2016; Rosik & Brown, 2002; Schwandt & Moriarty, 2008), the COVID-19 pandemic propelled member care providers to implement telehealth modalities for multi-day or week-long retreats that had not previously been conducted solely online. For example, Narramore Christian Foundation flexed to offer a one-week virtual retreat for children of missionaries who were returning to the U.S. to attend college (Narramore Christian Foundation, 2020). Missionary Training International also shifted its annual Mental Health and Missions conference to a shortened online format, rather than canceling or postponing the event (Missionary Training International, 2020). While it is unknown whether this trend toward online retreats will continue, what seems apparent is that core characteristics like flexibility, creativity, and the ability to adapt quickly to stressful changes—all of which are key traits of seasoned missionary personnel—enabled the field of member care to thrive during the COVID-19 pandemic. Websites that were already providing free resources, such as the one maintained by Member Care Associates (Member Care Associates, 2020), were poised and ready. One online member care organization, GodSpeed Resources Connection, quipped on its website, "Quarantined? We are built for this—literally!" (GodSpeed Resources Connection, 2020). There may be an embedded lesson for mental health professionals. Perhaps we would be wise to consider how creativity and greater openness

to change, within the bounds of competent and ethical practice, might allow for more adaptive and culturally responsive mental health care.

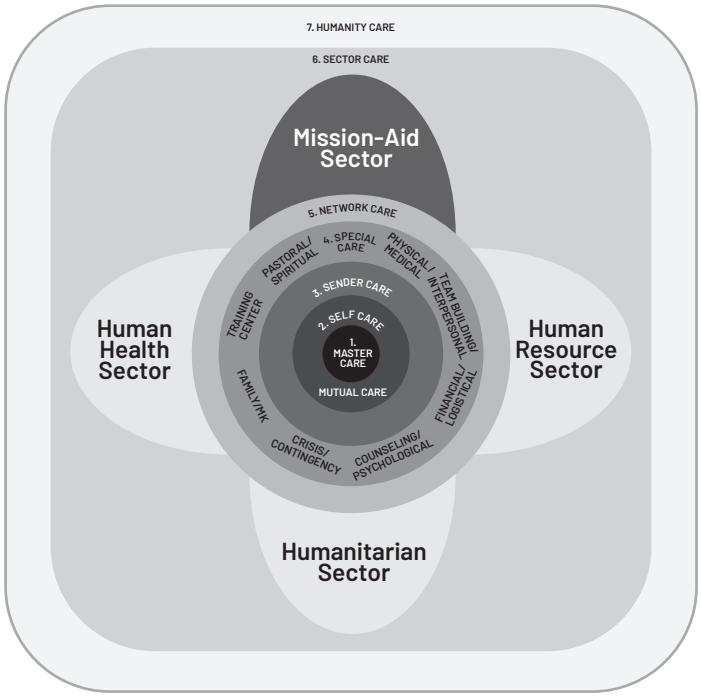
Ways of Being

A core way of being for member care involves embracing diversity in leadership and implementing contextualized, culture-specific perspectives on care. For example, the GMCN website (Global Member Care Network, 2020) highlights member care leaders and perspectives from countries such as India, Brazil, Indonesia, Korea, Malaysia, several African nations. and several European countries. Indeed, one might notice that care representatives from North America are in the minority in the GMCN. In essence, missionary member care adopts an attitude of learning from diverse approaches to member care. For example, Member Care Latin America is emerging with care centers in Colombia, Peru, and Ecuador. In Nigeria, a member care model adapted and contextualized to meet the needs of Nigerian missionaries is being implemented among over 800 Nigerian missionaries (H. Hoffmann, personal communication, November 24, 2020). In Málaga, Spain, a therapeutic retreat center is being developed to provide culturally appropriate member care resources for Ibero-American missionaries serving in North Africa and the Middle East (T. Hibma, personal communication, November 24, 2020). May this embracing of diversity at the highest levels of member care leadership provide a model for Christian mental health professionals in the West who wholeheartedly agree with the usefulness of diverse perspectives but often struggle to implement diversity in leadership.

As previously highlighted, another core way of being in the member care movement involves embracing creativity, flexibility, and openness to change. Perhaps it is this openness to change that has allowed member care to lead the way in truly embracing diverse perspectives in member care models and creating a diverse leadership within the global movement. Perhaps, too, it is the flexible thinking so indicative of mission personnel that allowed for the integration of psychology and theology in the practical, forward-thinking way that was evident in

Figure 2

Global Member Care Model Updated to Include the Missio Dei



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missionary member care from the 1950s, even before a strong integration perspective existed in Christian mental health practice.

The Way Forward

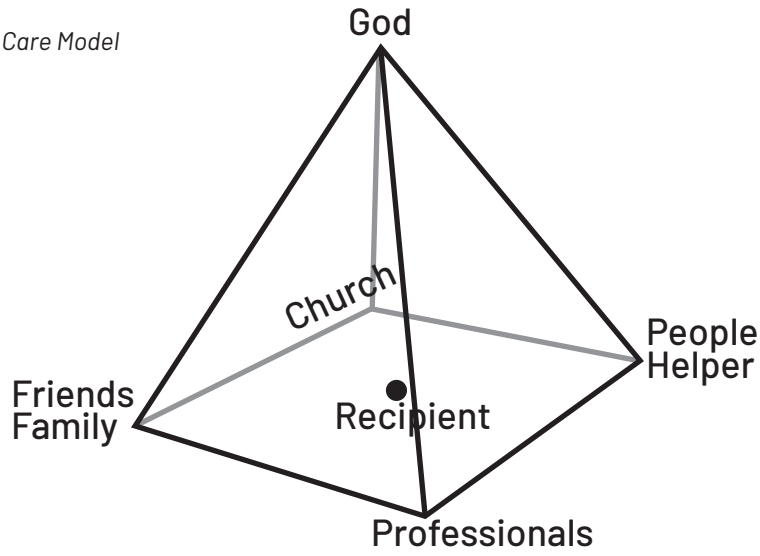
As we look to the future, we might surmise that the same creative, flexible thinking that allowed important paradigm shifts to occur in the way that member care is conceptualized might also serve to direct future endeavors. While gains have been made in contextualizing member care materials for diverse populations, more effort is needed to provide and disseminate those resources globally (P. Bradford, personal communication, November 25, 2020). One way this might occur is through the burgeoning availability of online Master Classes made available for little or no fee. Because of the remarkable success of the vast GMCN online network, perhaps smaller groups of contextualized trainings could be held online, targeting member care needs in a specific cultural population. Hoffmann, who coordinates GMCN, suggested that the future of member care training may lie in "content marketing" (Hoffmann, personal communication, November 24, 2020), which relies on offering valuable and relevant content to attract and train a clearly defined audience.

As times change and member care adapts to new global realities, new models of member care are being developed and applied globally. In 2016, O'Donnell and Lewis-O'Donnell updated the original Best Practices Model for Member Care (O'Donnell, 2002) to include multi-sector care for all humanity as part of the *missio Dei* (O'Donnell & Lewis-O'Donnell, 2016, p. 304; see Figure 2). This model expands the original vision of missionary member care beyond mission-aid workers to include sectors encompassing international business, human health, humanitarian, and human resources. As with the original model, the updated model continues to highlight holistic care and personal development for those working in demanding contexts (O'Donnell, 2011).

In addition, the Pyramid of Care Model (Hoffmann, 2020; see Figure 3) is rapidly gaining acceptance among member care training organizations as a collaborative way of thinking about providing holistic care to missionaries. The pyramid shape incorporates the many groups of people who impact the missionary worker and, in essence, is a model that encourages both inter-agency and interdisciplinary collaboration. While interdisciplinary collaboration has been a hallmark of missionary member care for some time, inter-agency collaborations are a newer part of the landscape. Tim Hibma, who directs the Narramore Christian Foundation, remarked that a growing edge for member care must be to encourage more robust collaboration among

Figure 3

The Pyramid of Care Model



Note. Reprinted with permission from Pyramid of Care Online Course (Hoffmann, 2020).

mission organizations (personal communication, November 24, 2020). While these collaborations are certainly occurring, more barriers could be traversed as we envision new partnerships. This growing desire for partnerships among agencies was also highlighted by Perry Bradford, a leader in missionary care, who noted that the pandemic brought about more openness to collaboration, and that this openness must remain if we are to accomplish the task of global missions (personal communication, November 25, 2020).

Indeed, openness is a hallmark of the missionary member care movement. This openness has allowed the movement to embrace new ways of thinking, new ways of doing, and new ways of being, thereby providing more robust care to the global community of missionaries. May this inclination for embracing adaptive models of care sink deep into the field of professional mental health so that we might humbly consider lessons to be learned from missionary member care.

Implications for the Church and Mental Health Professionals

The missionary member care movement has provided a model that is instructive for both the church and Christian mental health professionals. As detailed in this article, many mission organizations have an intentional member care program to support mental health wellness among their members, a focus that is vital to keeping missionaries thriving overseas. It seems that the church in the U.S. has not yet caught this vision for integrating a mental health component into church offerings. Missions is leading the way by making mental health a priority for their members. Churches can do the same—commit to take mental health seriously and implement new ways of thinking, being, and doing to support mental health wellness for their members.

Mental health professionals are well poised to use their influence in the church to do what missionary member care has long been doing for its members: mental health care that is adaptable to its context, its members, and their needs. Implementing mental health care as a standard component of missionary care has paid off with increased wellness and resilience for missionaries. This same vision could be applied to the local church and parachurch organizations in the US. The time to consider a paradigm shift is now.

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