Member Care *Journal*

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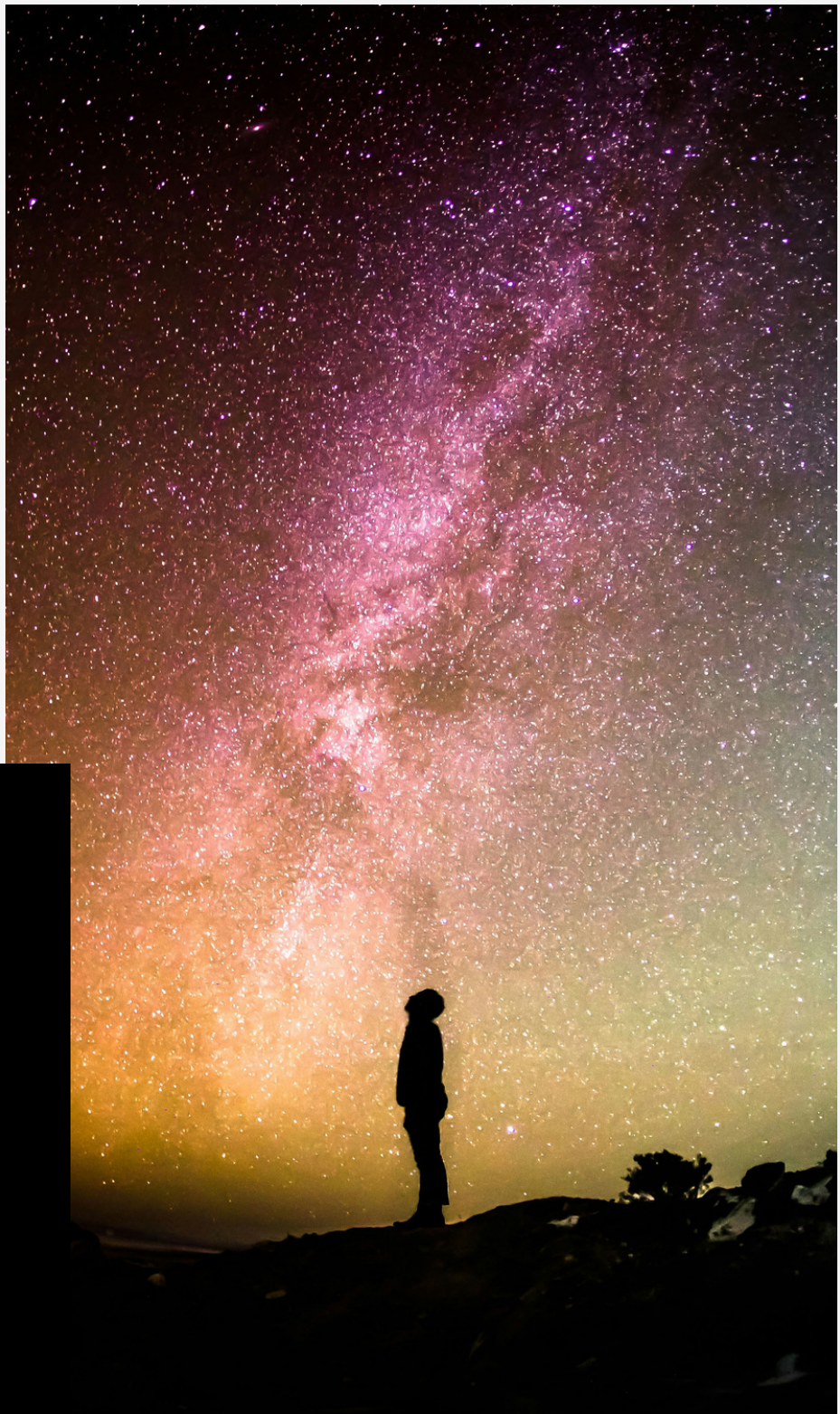

Online Pornography Addiction

Member Care for Malawian Missionaries

Caring for the Labourers

To Fix or Not to Fix

IN THIS ISSUE

Publisher

About Our Team

Impressum

Publisher
Global Member Care Network
Mozartplatz 3, 83410 Laufen, Germany
Tel: +49 8682 6079605
journal@globalmembercare.com
www.globalmembercare.com/journal

Camila Pellizzari
Layout & Design
Argentina & Italy

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From the Editors

Welcome to the first edition of the Member Care Journal.

The idea for this journal has been fermenting for several years. Marion Knell voiced the suggestion at the first South Pacific Member Care Conference (SPMCC) in Sydney 2015 where she was the keynote speaker, asserting that there needed to be a journal that could cater for the variable levels of knowledge and skills of Member Care providers. The target audience would be Member Care providers, missionaries, and mission organisations.

Marion established and initially led the MA in Member Care at Redcliffe Christian College UK (now MA in Staff Care and Wellbeing at All Nations Christian College UK). She and the other tutors as well as many graduates saw the need for research and training to be shared within the new and developing profession. As part of the MA in Member Care, students had to research an aspect of Member Care and write a dissertation, but all this knowledge has had no place to be shared.

Fast forward to 2022. Rosie Button, Sarah Hay, and Dr Tim Davy, staff at All Nations, and Dr Roger Van Der Veen held an online meeting to discuss this idea. We decided to contact several former students who had written dissertations to see whether they were interested in writing summary articles for publication.

We have worked with the authors who have rewritten their dissertations into summary articles, to make their research more accessible, and we are very happy to share their work with you.

The first author is Jovelina Cruz whose dissertation was entitled Online Pornography Addiction: towards a better Member Care response. The article starts off with scoping out what the issue is, its prevalence, its impact, prevention, and intervention, which lead to the three questions:

1. How aware are mission agencies about the addiction to online pornography?
2. What are mission agencies doing to help these workers and their families?
3. What Member Care practices can be better done to support these workers?

The second author is Marina Prins whose dissertation was entitled Member Care for Malawian Missionaries: towards a greater understanding of their Member Care needs and provision. Marina asks two questions: the first being what are the Member Care needs of Malawian missionaries during the course of their mission life cycle from preparation to re-entry? The second being what has either contributed to or what is lacking in their Member Care?

The Member Care Journal will not only draw on Masters dissertations as the next two manuscripts will attest.

The third author is Danielle Elizabeth who has rewritten a paper she originally wrote for an independent studies module at Redcliffe College. Her paper was entitled Caring for the Labourers: An Analysis and a Proposal for Missionary Member Care in a Centrally Governed Pentecostal Denomination.

This paper has reviewed some models of Member Care, of which there is a lack, which have been laddered into each other to come up with a comprehensive and integrated model that has been applied to a centralised denominational structure. Included is an emphasis on the organisation's responsibilities, because the responsibility of Member Care is often put on the Member Care provider or even on the missionary.

The fourth and final author is Dr Roger Van Der Veen who has written a case study about a missionary wife and husband whose first term of service did not turn out as planned and how Member Care providers need to be aware of not jumping straight to problem solving and solutions. This case study is entitled To Fix or Not to Fix: A loss and grief case study of Xing and her husband.

We hope you enjoy the first edition of the Member Care Journal. We would love to hear from you and receive your feedback, as well as any suggestions we could incorporate into future editions. If you would like to submit an article of your own, please contact us for the Writer Guidelines.
Queries to journal@globalmembercare.com

Sarah Hay
Rosie Button
Dr. Roger Van Der Veen
Harry Hoffmann

From the Editors

Roger van der Veen

Roger Van Der Veen

Sarah Hay

European Christian Mission

ecm
Sharing Christ's love in Europe

Harry Hoffmann

Global Member Care Network

Rosie Button

allnations
training for mission

ONLINE ADDICTION *Pornography*

TOWARDS A BETTER MEMBER CARE RESPONSE

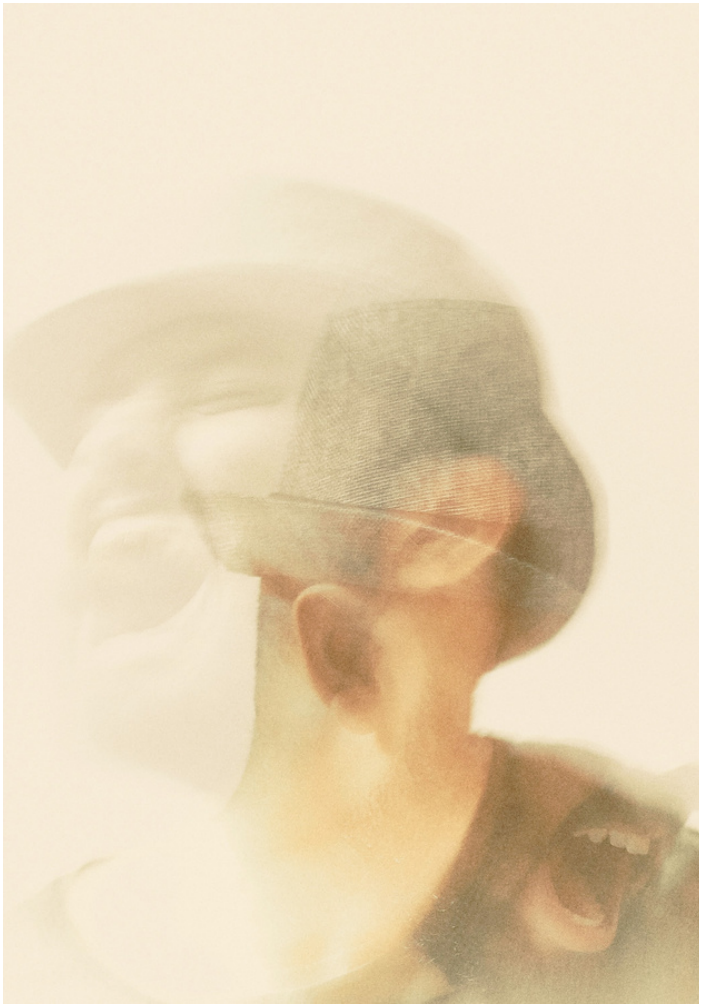
By Jovelina Cruz | Photography by Logan Weaver

What can be done to support cross-cultural workers and their families to recover from pornography addiction and how to prevent it?

Introduction

God created men and women as sexual beings, and finding a healthy sex life is the balance many people desire. Physical intimacy has the purpose of drawing a couple closer together, making them feel loved, desired, and appreciated. When pornography comes on the scene, unselfish intimacy is no longer pursued.

The fear of losing what is precious for them, their ministry and families, makes cross-cultural workers suffer alone when family members are addicted to online pornography. They only ask for help after they have lived for years trying to deal with the addiction on their own. Loneliness, lack of interpersonal skills, huge demands, and high levels of stress contribute to cross-cultural workers being vulnerable to addiction. This is especially true if these factors are added to lives that have already had early exposure to pornography, suffered sexual abuse, and/or have suffered with identity problems. All these factors can cause early attrition on the mission field and broken family relationships.



The impact of internet pornography use

The occasional use of pornography can become an addiction if it is kept as a secret and the person does not do anything to overcome it. The chains of addiction bring constant temptation for pleasure and relief, and the disappointment of broken relationships.

According to Gray (2012, p. 7, 8), when a person is exposed to internet pornography, it can accelerate the craving for sex and increase compulsive acts and thoughts. It affects both singles and married people in the same way; although, some of the consequences are different. There are at least three aspects to examine: Firstly, how aware are organisations about the addiction to online pornography? Secondly, what are organisations doing to help these workers and their families? Thirdly, which Member Care practices can be done better to support these workers?

What is pornography addiction?

Gardner (2015 p. 219) defines pornography as '...sexual satisfaction without effort or relationship'. Any sex act without a relational aspect is not healthy. Comiskey (2003, p. 43) affirms that 'Uncommitted sex disintegrates the self'. It distorts the image of self-giving and expressing love and commitment. MacDonald (1997, p. 54) cites pornography as an intimacy deficit response. It can be the way that a person tries to escape emotional and psychological pain. Some of the things that can make a person look for relief are loneliness, boredom, stress and anxiety, depression, abuse, and feeling neglected. Some characteristics cited are withdrawal from intimate and social relationships, emotional detachment, manipulative behaviour, and mood disorders. This can result in overwhelming feelings of shame and guilt. (Comiskey 2003, p. 53). Pornography can be used as an anaesthetic for a deeper pain in a person's soul.

Pornography addiction can become a mental problem when it starts to affect the brain in the circuits of reward, motivation and memory. Gilkerson (2016, p. 6) explains that when someone is sexually stimulated dopamine is released into the region of the brain that is responsible for learning and emotions, a situation similar to other addictions. It makes the person long for the pleasure that dopamine supplies. The brain becomes wired to get a fix whenever needed. Satisfaction from pornography lasts a very short time. The person starts seeking a fix more frequently each time. It might not start as a disease, but pornography consumption can become like other kinds of addiction. Flores (2004, p. 20) says that substances can alter neurotransmitters, bringing permanent alterations in how the brain functions, which can result in syndromes such as reward deficiency (a brain illness).

Literature about the reasons for pornographic addiction, especially for cross-cultural workers is scant. However, there are some authors who think that cross-cultural workers might be more vulnerable to addiction than other people. Pariera (2014, p. 385) comments about the 'third-person effect' where people think that other people are vulnerable but not themselves. Cross-cultural workers often think they have the tools and preparation for the work and that, even if they sometimes slide into temptation, they do not see themselves as possibly 'addicted' until it is too late. Edlin (2009, p. 2) affirms that there is no limit for self-deceit in the human mind and this is especially true for sexual sin. Orton (2016, p. 1) says that isolation, problems in relationships, loneliness, and the ability to travel can make cross-cultural workers more vulnerable to moral failure and addictions.

Methodology

Despite the lack of Member Care literature and research regarding the prevalence of online pornography addiction among cross-cultural workers, there are some reliable resources that were used for this research. A qualitative and a quantitative approach were deployed for analysing both the questionnaire and interviews. The data were collected through the use of semi-structured questions. The focus was on the cross-cultural context in order to understand the factors that render cross-cultural workers vulnerable to online pornography addiction through an epistemological constructivist approach. Additionally, there was a focus on the organisations' responses for those workers and their families to build an understanding of how Member Carers could improve their practices in dealing with cases like these.

The 11 participants chosen for the interviews were recruited through the online survey, from a range of organisations and different parts of the world so there was balanced representation.

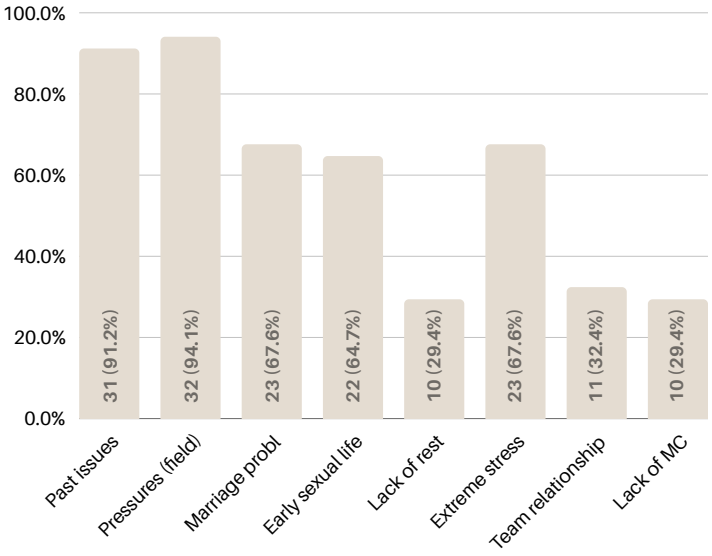
One significant limitation of this research was that interaction with interviewees only took place through online meetings, resulting in difficulty in gathering data to provide a fair sample of results. This occurred because some organisations did not feel comfortable talking about this issue and some answers given were from a defensive position.

How are organisations responding to online pornography addiction?

Most organisations have a certain level of awareness that online pornography addiction is either already a problem for cross-cultural workers or that it could become a problem in the near future. Organisations think that the numbers of addicted workers will grow in the next few years. Chris (org#2), said:

> *We underestimate how many people today are accessing pornography. The statistics show that there are almost as many Christians as non-Christians. A lot of people who come to work with our organisation will have accessed pornography in the past. It is becoming more recognised as a major issue in society.*

The organisations understand it is a problem, but on the other hand they are dealing with huge limitations like no policies or inadequate policies, and a lack of Member Care personnel. In the graphic below, it shows the reasons for addiction according to the data collected.



The majority of the participants answered that their organisation has had cases of workers addicted to online pornography, and they treat the occasional use of pornography as though it were an addiction because of the ease in which it can become an addiction if not dealt with and treated. The way organisations respond to the cases is rather surprising: A big percentage answered it would depend on each case, either to send the worker and family home or to treat them in their place of work. At least four of the organisations did not have a procedure to deal with pornography addiction. A couple of the organisations had a non-written approach, ie who examines the situation and evaluates what needs to be done in each case. The information is kept verbal and very confidential.

The disciplinary measures reported were more in the pastoral approach:

- Accountability partner or group and encouragement to use accountability software.
- Counselling and therapy to help the worker to recover (working on dependence cycles, helping to identify the triggers, and the use of scriptures) and for the family.
- Some organisations have logistical arrangements to help the worker and the family if they return to their home country to treat the addiction.
- Final disciplinary measures. First a verbal warning. Second, if the problem continues, a written warning is given. Third, a final written warning must be given. Suspension from leadership positions and dismissal are used in the last instances, on the basis of gross misconduct.

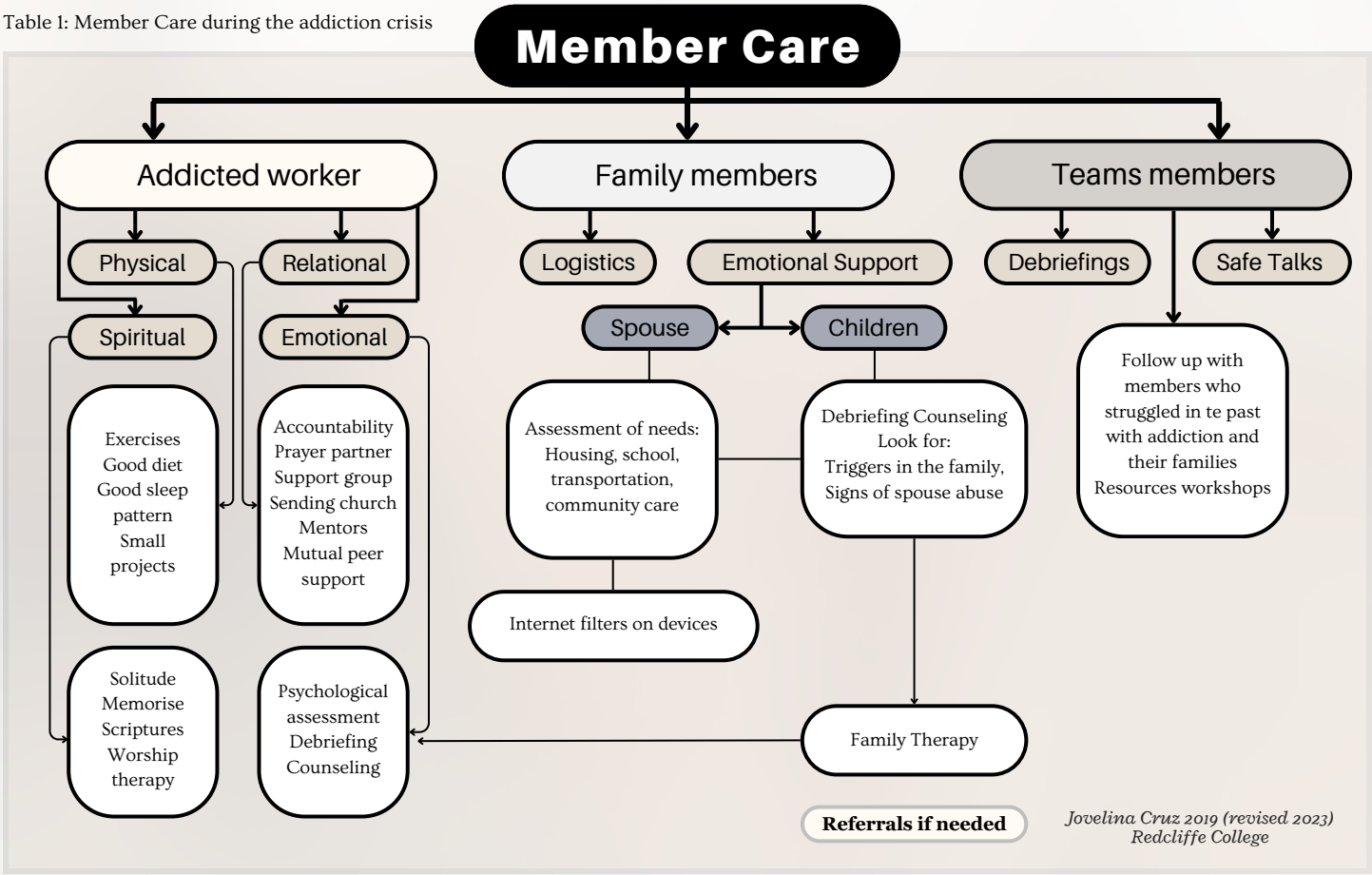
Organisations have different ideas about the appropriate Member Care practices for an addicted worker. They are beginning to see that it is much more than simply providing counselling or therapy. All the organisations see the need to care for the non-addicted spouse, but few see the same importance of caring for families and especially for the children in those families. The importance of an organisation being aware and knowing how to deal with workers addicted to online pornography is essential for them to recover and for the well-being of their families.

THE ORGANISATIONS UNDERSTAND IT IS A PROBLEM, BUT ON THE OTHER HAND THEY ARE DEALING WITH HUGE LIMITATIONS LIKE NO POLICIES OR INADEQUATE POLICIES, AND A LACK OF MEMBER CARE PERSONNEL.

Member Care practices

Ongoing Member Care is essential for workers. When there is a crisis, it is vital that Member Care workers are well prepared to handle the situation. From policies and procedures to referrals and the logistics involved, it is all good Member Care as Gardner (2015, p. 69) comments 'I believe that good administration is good Member Care. Caring for people with justice, compassion, and skill are important components of care'. The table below was created to illustrate the direction and steps to be taken in the time of an addiction crisis.

Table 1: Member Care during the addiction crisis



There are three spheres of Member Care shown in table 1. Member Care for the addicted worker, for the family, and for the team. Even if the team does not know about the issue, it changes the dynamics among the members, especially if the worker needs to leave the field suddenly. 'Care-fronting' instead of confronting is more appropriate when dealing with a case of online pornography addiction, a term borrowed from the field of conflict resolution.

Care-fronting is raising awareness without threat or judgment. The natural reaction of a person being confronted is to withdraw and to set up protective barriers, making it more difficult to let others help. Care-fronting can lower these barriers because genuine care and support are shown. Before disciplining an addicted worker, the opportunity for restoration should be given, and activating a plan of action. Disciplinary measures should only be used

when the person refuses to engage and does not want to change. When the worker is allowed to continue his or her normal duties, with the same responsibilities as before, it should be for a trial period, to see if the situation is brought back under control. If this does not happen, the worker should be advised to return to his or her home country to seek treatment. Becoming caught in the trap of pornography can result in the worker gradually becoming weaker spiritually.

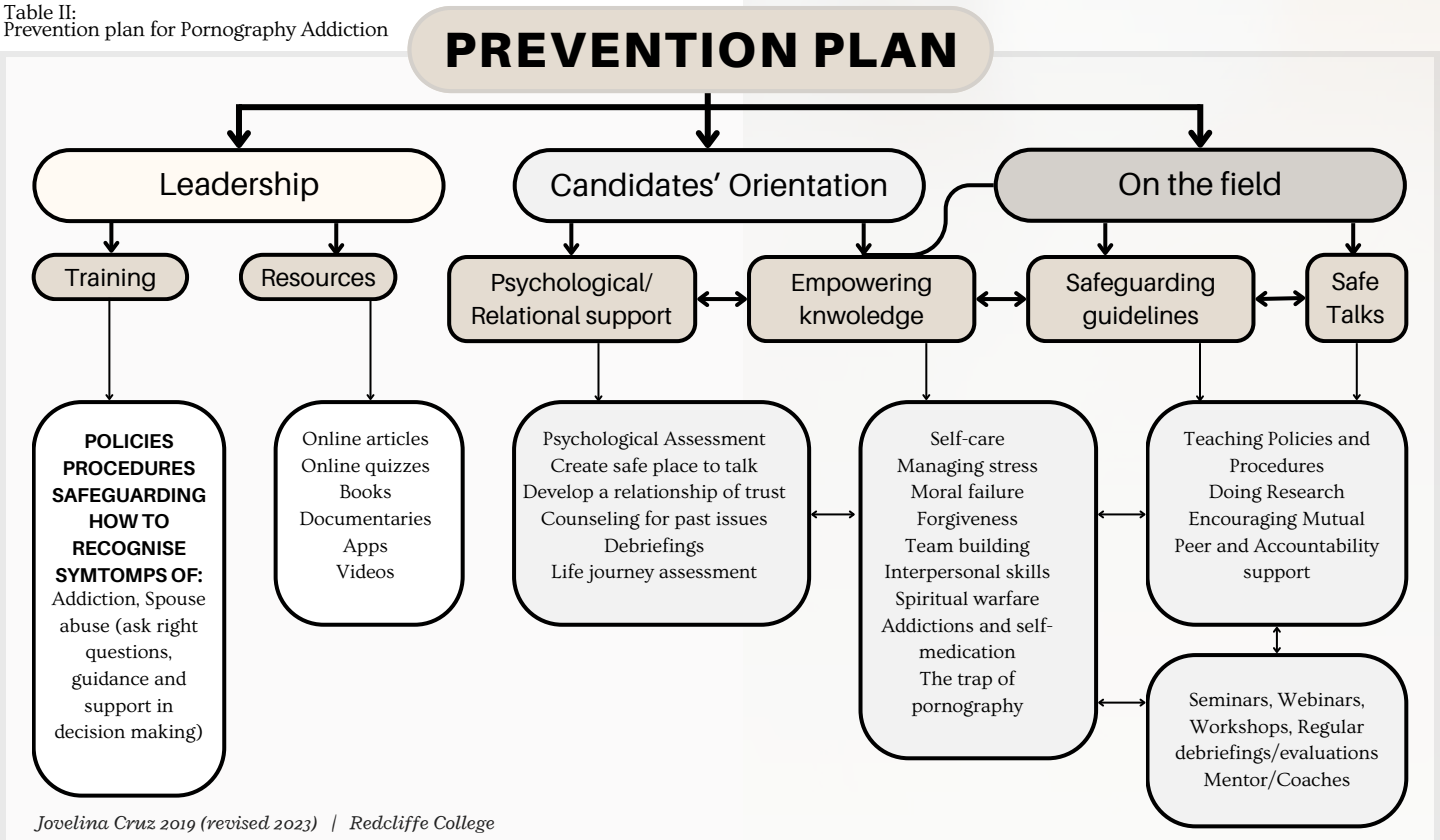
It is important to address the emotional problems of the worker, investing time in debriefing to work through loss and grief after a comprehensive psychosocial assessment has taken place. Counselling should focus on the roots, triggers, and genuine needs of the soul as well as teaching about identity, shame, and the biblical basis to fight addiction. Training about online pornography addiction is something that is needed for Member Care workers and leaders to facilitate the knowledge for the workers on the field. Putting policies in place and developing procedures can help to address the problem when cases become known.

"The chains of addiction bring constant temptation for pleasure and relief, and the disappointment of broken relationships".

Prevention is the best approach

All organisations should have goals and plans for when something such as addiction gets in the way. Some organisations evaluate the relapse rate; how long the addiction has been going on; the depth of the addiction; and whether the worker can be restored and continue to work. However, organisations should be looking more to addiction cases through the lenses of what the worker and the family need for restoration rather than how to meet their own goals. Means (1999, p. 9) affirms that society is sexually saturated and that this has affected faith communities with the seductive power of the internet. The best practice is prevention! It starts during the orientation (selection) process and continues throughout the worker´s time serving with the organisation. Table II below illustrates a prevention plan for organisations.

Table II:
Prevention plan for Pornography Addiction



Jovelina Cruz 2019 (revised 2023) | Redcliffe College

PREVENTION IS THE *Best Approach*

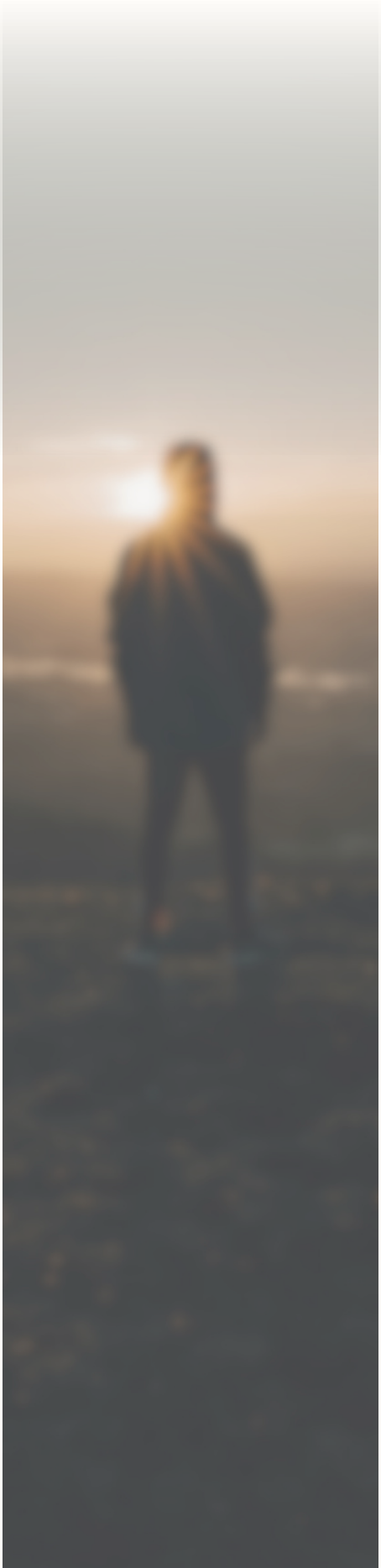
Candidate orientation is at the heart of prevention. Organisations need to interact personally with candidates to build a bond with them. Pariera (2014 p. 385) says that it is easier for people to be affected by the result of 'third-person effect', to think that others are vulnerable and that they are not. This needs to be made clear to candidates to prevent them from sliding into temptation and to develop the awareness to recognise the effects of pornography addiction before it has become a reality. Important tools in prevention are: mentors, accountability groups, online filters, available resources about the issue, and education in moral conduct. It can be done through training, safe talks, pre-briefing to candidates, end of term and annual reviews, webinars, and destigmatising this issue to be able to make every worker aware of this trap. Preparing workers to persevere, dealing with loss and grief, managing conflicts, and learning to live in multicultural settings are contributing factors to the best Member Care an organisation can provide to their workers.

By Jovelina Cruz
Photography by Greg Willson

ORGANISATIONS NEED TO INTERACT PERSONALLY WITH CANDIDATES TO BUILD A BOND WITH THEM. PARIERA (2014 P. 385)

Conclusion

Organisations are receiving workers born in the digital age. The easy access to online content makes these workers more likely than ever before to have been exposed to pornography. Organisations are aware of the problem and know that they will see an increase in rates of pornography addiction in the next few years. Although few of them are engaged in trying to deal with it, all have shown the desire to invest more energy and time into prevention. The things organisations are doing include: determining the truth, disciplinary measures like warnings and final dismissal, counselling and putting accountability in place. Despite few organisations currently helping the whole family, most of them are trying to care for the spouse of the addicted worker. There is still a lack of care for children in some agencies that either do not see the need or do not have professionals to provide it. There is a huge need for policies and procedures to be developed in a way that will serve as guidelines for both leadership and workers. Overall, organisations are at least considering what they can do to prevent addiction. The way forward is through a holistic Member Care plan, caring for the addicted worker, the family, and the team. Organisations need to invest in prevention from the time of the candidate orientation program and right through the whole time the worker is serving with the organisation. The goal of leaders and Member Care workers is to help fellow workers to escape from this trap of sin, receive forgiveness, and be restored to serve others in a better way.



Reflection

The increase in numbers of pornography addiction is a fact, which will impact mission organisations. A higher number of candidates are already arriving at organisations, struggling with past or present issues around pornography. Loss and grief issues that have not been dealt with well are a strong reason for addiction, especially when added to other factors like early exposure to sexualised behaviour and online content, struggles in adapting to a new culture or role, childhood traumas, and parenting deficits. There is still a stigma of shame when talking with multicultural teams about this issue. Workers usually avoid pornography addiction talks and accountability structures. Anonymous group talks, prevention apps, and interactive multimedia resources are tools that would work more effectively with this new generation. Specialised trauma debriefings, where it creates a way to deal with the pain, can help workers to process the difficult times of their lives in a proper way in a safe environment. Creating strategies to fundraise for the purchase of resources to use specifically to facilitate the training of Member Care workers in debriefing, trauma therapy, and pornography addiction can help organisations to be prepared for their role.

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THE ROLE OF THE *Extended Family*

IN THE MEMBER CARE OF MALAWIAN MISSIONARIES

TOWARDS A GREATER UNDERSTANDING OF THEIR MEMBER CARE NEEDS AND PROVISION

Extended Family

The term extended family refers to both the near and extended family, unless stated otherwise

By Marina Prins
Photography by Abrahan Echeverria

Introduction

Over the years, the statement 'Africa's time has come' has often echoed across the African missions community, a time for the African church to participate in God's mission (Oganya 2014, p. 139). Although more missionaries from Africa are serving worldwide, crucial issues regarding the sending and sustaining of missionaries have been overlooked (Mwamvani 2014, p. 142).

Most Member Care models and resources are predominantly focused on Old Sending Countries (OSCs[2]), not on New Sending Countries (NSCs) (Barclay 2010, p. 150), including most of Africa.Very little research could be found on the Member Care needs of African missionaries, especially applicable African Member Care or material written by African authors. This has left the question of how the issue of Member Care could be addressed in the African context and more specifically Malawi.

One aspect of particular importance in a communal culture in a country such as Malawi is the role of extended families in missionaries' lives and care. As this was emphasised as one of the crucial aspects in the findings of the dissertation*, this article specifically focuses on the role of the extended family.
*Dissertation completed for MA in Member Care, Redcliffe College, UK, 2017

Motivation for the research

The author's interest in this research topic has come from experience as a missionary in Malawi in the 1990s and then Member Care involvement with various organisations in South Africa, Malawi, and other countries in Africa, and serving as Member Care Coordinator for the Movement for African National Initiatives (MANI) from 2008-2018 and after that as a MANI Member Care Consultant. These roles often required meeting with missionaries serving in challenging situations where little attention was paid to their Member Care. This has highlighted the need for further exploration of Member Care for African missionaries.

[1] The term extended family refers to both the near and extended family, unless stated otherwise.
[2] OSC have an average of 60 years of mission-sending experience and NSC fewer than 30 years (Lim, 2007, p. 26)

Research Context

Definitions used

For the purposes of this research, Member Care is defined as 'the ongoing preparation, equipping and empowering of missionaries for effective and sustainable life, ministry and work' (GMCN, 2008)[3]. This definition includes pastoral care and missionary care, terms which are more commonly used in Africa.

There are three categories of Malawian missionaries:

1. serving within Malawi, undertaking Christian mission work in a context where either the language, culture, or religion differs from their own,
2. or serving with a mission organisation in Malawi,
3. or having served outside Malawi but having since returned to Malawi permanently.

Although not all Malawian missionaries have crossed country borders, they have crossed either cultural or religious barriers and were therefore seen as missionaries in the African context (Mandryk 2010, p. 960; Fiedler 1994, p. 368) and the Kenyan context (Langat 2014, p. 8; Juma 2008, p. 7). Only those missionaries serving in the Central and Eastern regions of Malawi were included in the study and none serving outside Malawi. Using this definition also avoided narrow Western definitions, which assumed that missionaries only served cross-culturally outside of their own countries, thus devaluing or not recognising missionaries crossing barriers within their own country (Lwesya 2014, p. 43).

ALTHOUGH NOT ALL MALAWIAN MISSIONARIES HAVE CROSSED COUNTRY BORDERS, THEY HAVE CROSSED EITHER CULTURAL OR RELIGIOUS BARRIERS AND WERE THEREFORE SEEN AS MISSIONARIES IN THE AFRICAN CONTEXT (MANDRYK 2010, P. 960; FIEDLER 1994, P. 368)

[3] Global Member Care Network

Purpose of Research and Research questions

The purpose of the research was to explore and obtain a deeper understanding of the Member Care needs of and the provision for Malawian missionaries as expressed by the missionaries. To fulfil this purpose, the research questions were formulated as the following: firstly, what are the Member Care needs of Malawian missionaries during the course of their mission life cycle from pre-departure preparation to leaving the field? Secondly, what has either contributed to or what is lacking in their Member Care?

Cultural Context

A short overview of Malawi and the extended family context is given to provide an understanding of the cultural context in which the research was undertaken.

Malawi

Malawi has a population of slightly over 21.2 million people (Central Intelligence Agency 2023), of which 70% live below the international poverty line (IPC 2022, p. 1). Although 74.1% of the population is Christian, only 16.95% identify as Evangelical (Joshua Project, 2023) with the increasing activity of Islam being a significant issue in Malawi (Operation World, 2022).

The term 'Africa' indicates a unique approach to life that differs from Western thinking and represents how the various African cultures contribute to a better understanding of their lives and struggles (Louw 2008, p. 147). Although the ethnic groups of Malawi share a commonality in cultural practices, some significant cultural differences remain, with each group having its own language and unique cultural practices (Malawi Human Rights Commission 2006, p. 7) validating the cross-cultural nature of working in different ethnic groups.

The Extended Family Context

Communal life is common and appreciated in Africa, and the sense of belonging to one another binds individuals and extended families together as Msangaambe (2011, p. 212) from Malawi points out. A person's extended family and community are therefore of utmost importance in his or her life (O'Donovan 1997, p. 155). Consequently, missionaries are expected to care for extended family members, which puts additional pressure on them (Mwamvani, 2014, p. 149). Failure to meet these expectations may result in missionaries leaving the field (Juma 2008, p. 33; Anyomi 1997, p. 166).

Methodology

A constructivist epistemological stance, together with an interpretivist theoretical perspective and an inductive approach were taken. Data were gathered in Malawi from November 2015 to January 2016 through a mixed-method approach using a questionnaire completed by 35 Malawian missionaries to get a broad overview of the Malawian missionaries' Member Care needs, followed by a semi-structured interview, conducted with eight of the 35 missionaries to gain a deeper understanding. This mixed-method approach has already proved to be a workable option in Malawi (Banda 2013; Schatz 2012).

Because of the limited material available and lack of similar studies, the contents of the questionnaire were determined by using Member Care material from other contexts, combining it with relevant Malawian cultural issues and the author's own experiences. Issues addressed might therefore not be seen as Member Care issues from a Western point of view but were relevant in a Malawian context.

Findings and Member Care Implications

The dissertation's analysis focused on three aspects, which were interpreted from the results as most crucial to the Malawian Member Care context, namely the role of the extended family; training of new missionaries; and the role of the church in Member Care. However, for the purpose of this article, the focus is solely on the role of the extended family

The Role of Extended Families in Missionaries' Lives and Care

Expectations of Extended Families

The findings indicated that extended families still play a very important role in Malawi where a family is seen as a unit of related individuals expected to care for one another as part of communal life. This is in line with the point of view of O'Donovan (1997, p. 155) and Msangaambe (2011, p. 212) for African and Malawian cultural context respectively.

All but one participant experienced expectations from their families, echoed by the interviewees' responses and in agreement with the Kenyan findings of Langat (2014 p. 201) and Juma (2008, p. 33). Several factors contributing to these expectations were highlighted. Firstly, a lack of recognition by their families of participants as being accepted as missionaries. This was because of families' perceptions that missionaries are Caucasian people, not Malawians, a perception also present in the wider African context and beyond (Oyugi 2010, p. 77; Juma 2008, p. 9).

Secondly, the financial pressure from extended families on participants. Several perceptions of families contributed to this pressure. Caucasian missionaries were seen as affluent; therefore, Malawian missionaries should also have funds and receive allowances like other volunteers.

Missionaries serving outside Malawi were seen as earning an even bigger income and those having post-secondary school academic qualifications as more privileged, both resulting in increased expectations as also confirmed by Mwamvani (2014, p. 149). These same challenges occur in other contexts with an extended family system such as Asia (Wiarda 2002, p. 47), Latin America (Pinto 2016, p. 2), and Kenya (Juma 2008, p. 33).

Thirdly, there was the danger of being cut off from the cultural support system should missionaries not comply with these expectations. However, interviewees also readily acknowledged families' support throughout their lives. The findings highlighted then that the same cultural system that put expectations on them, also supported them. This emphasised the difficult position missionaries found themselves in, desiring still to assist families, yet confronted with the great difficulty of meeting these expectations, as also observed in Latin America (Pinto 2016, p. 2). ReMAP 1[4] findings in Kenya (Juma 2008, p. 33) and Ghana (Anyomi 1997, p. 166) indicated that failure of missionaries to meet these expectations might result in leaving the field. Consequently, this was interpreted as a factor worthy of careful consideration in the Malawian Member Care context.

Against the backdrop of these factors, ways were sought in which these expectations could be made more manageable for missionaries.

Making Expectations More Manageable for Missionaries

Interviewees accepted these expectations as a complicated cultural issue and part of life. Their key response was to find a middle way to assist their families as best they could, while still doing ministry. Thus, they were able to acknowledge their responsibility towards their extended families and their desire to support, as well as the fact that all expectations could not be met. This was key in addressing this challenge, which was interpreted as a culturally acceptable way of dealing with the issue and a method suitable for the Malawian context.

Other suggestions from interviewees followed along the same lines of suitability to their context. A better understanding by both churches and families about missionaries' work and funding was emphasised, resulting in a better realisation of missionaries' inability to meet all the expectations. By interviewees not always supporting families financially, but instead only providing prayer support, the families' focus was put on God as their provider.

Participants further acknowledged that it would take time for families to reach the point of expecting less from missionaries. However, they added that families' expectations might change when these families become well established, alleviating the pressure on missionaries

[4] Reducing Missionary Attrition Project (Lee, 1997, p. xi)

Summary and Member Care Implications

In answer to the first research question: What are the participants' Member Care needs that are indicated here? Firstly, there was a need to be recognised as missionaries by extended families. Without their families' understanding and care, missionaries were deprived of their support, which goes further than just finances. Secondly, participants needed extended families' understanding and support of their mission work and what support-raising entails to alleviate the pressure on missionaries created by these expectations.

In answer to the second research question: what contributed to and what was lacking in participants' Member Care, the following was highlighted: Participants' appreciation for the extended family structure and acknowledging the positive impact of extended families. Secondly, participants' acceptance of the extended families' expectations, dealing with them in culturally acceptable ways without disregarding them. Thirdly, participants' decision to offer prayer support sometimes rather than financial assistance, encouraging extended families to put their trust primarily in God and not in participants, which then alleviated pressure on participants. Fourthly, the instrumental role church and organisational leaders played by explaining missionaries' financial position to extended families to alleviate the pressure.

It was evident from the findings that extended families should be acknowledged as playing an important role in participants' care, both in giving and expecting care. This is a crucial aspect lacking in most Member Care models and approaches.

The following Member Care Implications were drawn from the findings:

- Missionaries and senders should seek meaningful ways to acknowledge the assistance given by missionaries' extended families.
- Extended family members should acknowledge and accept family members' mission calling.
- Senders and missionaries should seek culturally acceptable ways to deal with extended families' expectations, easing the pressure on missionaries.
- Senders should include extended families in new missionaries' preparation process, visiting them, explaining what mission work entails and that missionaries receive no salaries.
- Senders should maintain strong relationships with extended families, throughout the missionaries' life cycle.
- Since returnees have valuable experience, they could be asked to accompany senders when visiting extended families, sharing their mission experience.

Application in other Member Care contexts

Here is a final thought as to how these findings could be useful in other Member Care contexts.

Majority World

As indicated, extended families play an important role in contexts other than Malawi, such as Kenya, Ghana, Asia, and Latin America which also have extended family systems. It could be argued that the findings could assist Member Care role players in these contexts to develop applicable Member Care in which the extended family's crucial role is included.

Rest of the world

The findings are relevant for the rest of the world as well, for three reasons. Firstly, when Western organisations send missionaries to serve together with African missionaries, the unique challenges African missionaries experience regarding extended families should be taken into consideration. This could assist them in developing applicable Member Care models that accommodate the needs of both African and Western missionaries, resulting in offering Member Care in culturally acceptable ways, specifically also regarding the role of the extended families, both in expecting and giving care. Secondly, for those receiving African missionaries in other parts of the world, this article could assist them in a better understanding of the unique role the extended families play in these missionaries' lives, resulting in developing more effective Member Care. Thirdly, it could assist African missionaries in understanding and explaining the differences they might encounter when serving in the West or together with Western missionaries who do not come from a communal culture with an extended family system.

Conclusion

This article emphasises the importance of extended families both in giving and expecting care and support, accentuating the need to include these extended families as important players in Member Care in the Malawian and African contexts and beyond.

Let us continue to develop applicable Member Care for Malawian and African missionaries, recognising their unique needs while at the same time encouraging and celebrating them as they share the Gospel within Africa and beyond. May the way we embrace the role of extended families in our Member Care efforts reflect our understanding and appreciation for these families' unique role in Member Care.

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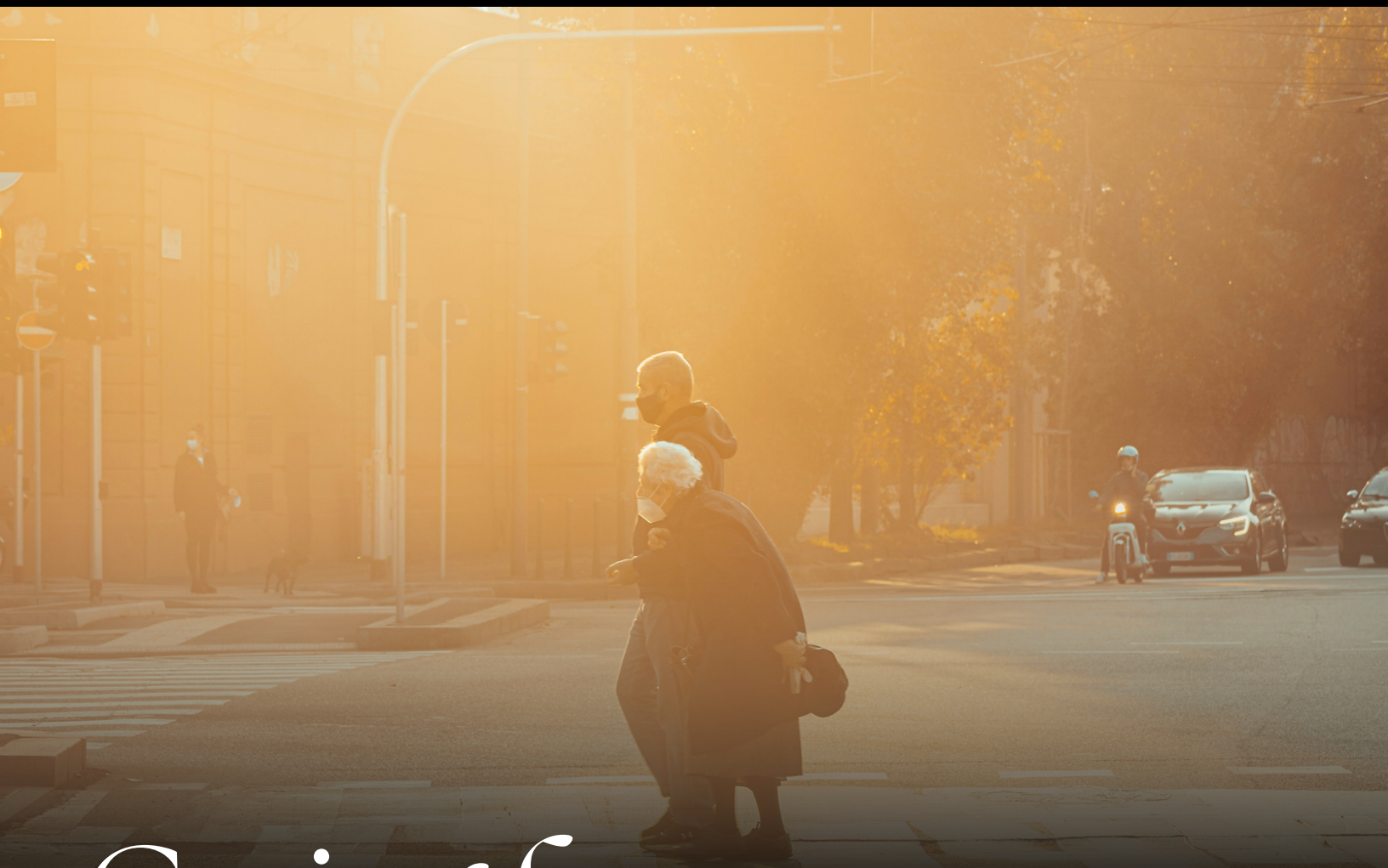

Caring for the Labourers

An Analysis and a Proposal for Missionary Member Care in a Centrally Governed Pentecostal Denomination

By Danielle Elizabeth

Introduction

Member Care is an interdisciplinary field that requires time, resources, commitment, and money to minimise avoidable attrition by supporting missionaries holistically in partnership with the Holy Spirit. Needs are met by providing a full range of services that utilise combined resources to sustain strong missionaries who remain vibrant and resilient by increasing health and longevity in effective ministry and work. This article will undertake a literature review to evaluate significant theoretical Member Care models and use these findings to create a new denominational model of Member Care.

Dimensions of Member Care

People in Aid (Porter, 2009)[1] observe that inconsistent care for missionaries can be detrimental, as each missionary has different needs, whether physical, psychological, or economic. To expand this into an evaluative Member Care tool, Keckler (2008)[2] cites seven dimensions, emphasising intellectual care, through preventative counselling rather than reactionary crisis care. Dodds and Dodds' (1997 pp 4-16)[3] SPARE-O framework can also be easily cross-referenced, incorporating: spiritual, physical, actualisation, relational, and emotional. This model cites that organisational frameworks need both elements of crisis response and preventative measures, and therefore designates a missionary pastor to provide frequent and regular care, differentiated from their field supervisor. To facilitate effective relationships, missionaries require clear understanding of the organisation's involvement in their life. This can avoid unclear or unmet expectations, minimises accentuating a top-down authority structure that excludes missionaries from the decision-making process, and demonstrates the importance of relationship to avoid illness, depression, and attrition.

To address these dimensions of care, the Headington Institute[4] and Antares Foundation[5] (Porter pp 4-14) developed cyclical models. The Headington Institute's model is simple yet effective, articulating five areas, from preparation to leaving transition. The Antares Foundation expand Headington's model, including the monitoring of on-field staff and all necessary crisis support. Core Humanitarian Standard (CHS, 2014)[6] model has been designed by utilising research across 2000 international humanitarian workers, within various sectors. They provide invaluable guidelines that four crucial principles should permeate the implementation of all nine proposed essential criteria: humanity, impartiality, neutrality, and independence. CHS assert that every humanitarian action should never undermine these principles but instead complement them, emphasising the importance of communication and human rights. They elaborate that Member Care providers should acknowledge and address their downfalls. Christian Member Care providers should ensure their model reflects CHS's minimum standards whilst developing it and subsequently outsourcing, where necessary, to further demonstrate Christ's love to their workers.

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[1] Appendix 1
[2] Appendix 2
[3] Appendix 3
[4] Appendix 4
[5]Appendix 5
[6] Appendix 6

Missionary Formation

Models also need to incorporate practicalities within a missionary's formation. Swanson's (2002, pp.434-444)[7] model portrays five arenas as building blocks within a pyramid structure, implying their incremental dependence, where a Member Care mindset permeates each aspect. However, considering them as development phases could minimise their ongoing significance. For example, Swanson references spiritual formation as the foundation of his pyramid, then personal growth, community living, cross-cultural integration, and ministry skills. Whilst seemingly logical, spiritual formation is ongoing, therefore organisations should recommend its continued development.

Schellenberger (2012, pp.6-7)[8] helpfully presents a cyclical model, referencing five influential 'arenas': occupation, support, personal factors, context, and environmental/familial factors. The cyclical nature of this model is constructive as each arena is continuously monitored. Schellenberger does not however identify how care is to be implemented but nevertheless it remains a helpful tool to identify arenas requiring support.

Integrated Models

Hoffmann (2020a) references Pollock's (2002, pp.25-31) helpful 'Flow of Care' model,[9] Tassia's (2020): '7 S's model'[10] and McKinsey's (Peters and Waterman, 2016)[11] '7's framework' to evidence that holistic care is imperative. For mental health and psychological support, Hoffmann amalgamates the Christian Wholeness Pyramid Framework (Living Wholeness, 2019) [12] with his own intervention pyramid of care (2020b). God is depicted above: professionals, friends/family, church, people/helper. However, it is idealistic to assume that all areas would work seamlessly, without the oversight or coordination of an identified Member Care provider. Each provider may assume support is being provided by others, leaving the missionary neglected. Hoffmann's model[13] contributes towards holistic care yet requires intentional oversight and implementation.

Girón's (1997) models unite support with selection, sending, pastoral care and training.[14] He sets a helpful precedent for local churches to provide Member Care and discipleship, as missionaries receive logistical support from an agency. However, it is crucial to safeguard the missionary by combatting unmet expectations and specifically defining who holds responsibility for providing and coordinating each area.

[7] Appendix 7
[8] Appendix 8
[9] Appendix 9
[10] Appendix 10
[11] Appendix 11
[12] Appendix 12
[13] Appendix 13
[14] Appendix 14

Interhealth's (Porter pp.15-17)[15] cyclical model is influenced by numerous variables and addresses individual needs, whilst considering the missionary's operating culture. Interhealth assert there is no set Member Care practice for everyone, yet minimum standards should guide the organisation. Interhealth further propose that organisations require definite steps and objectively verifiable indicators; thus, their proposed monitoring framework helps identify when intervention is needed.

O'Donnell's (2002, p.13)[16] 'best practice' model cites the 'flow of care' beginning with master care, through spiritual disciplines and Christian community. Secondly, care for oneself and others should be reciprocated. Thirdly, churches and agencies should collaborate to develop and support missionaries at all stages. Fourthly, specialist care must only be undertaken by qualified personnel. Global Connections[17] also provide guidance and ethical policies as a minimum standard that enhance individualised models, also asserting that care must be provided by those with appropriate experience, skills, and training. Finally, O'Donnell (2013; 2014; 2016, pp.303-305; 2018)[18] cites networking through six spheres of care to provide strategic resources and remain informed of Member Care developments.

Evidently, Member Care requires skilled management to facilitate the necessary administration and implementation of care. Subsequently, organisations must appoint representatives to develop and implement Member Care whilst networking to enhance available resources.

New Model of De*n*ominational Member Care

This article will now justify a new Member Care model for a centralised denominational structure, predominantly based upon O'Donnell and Interhealth's frameworks, to address Pollock's dimensions and incorporates the aforementioned models.

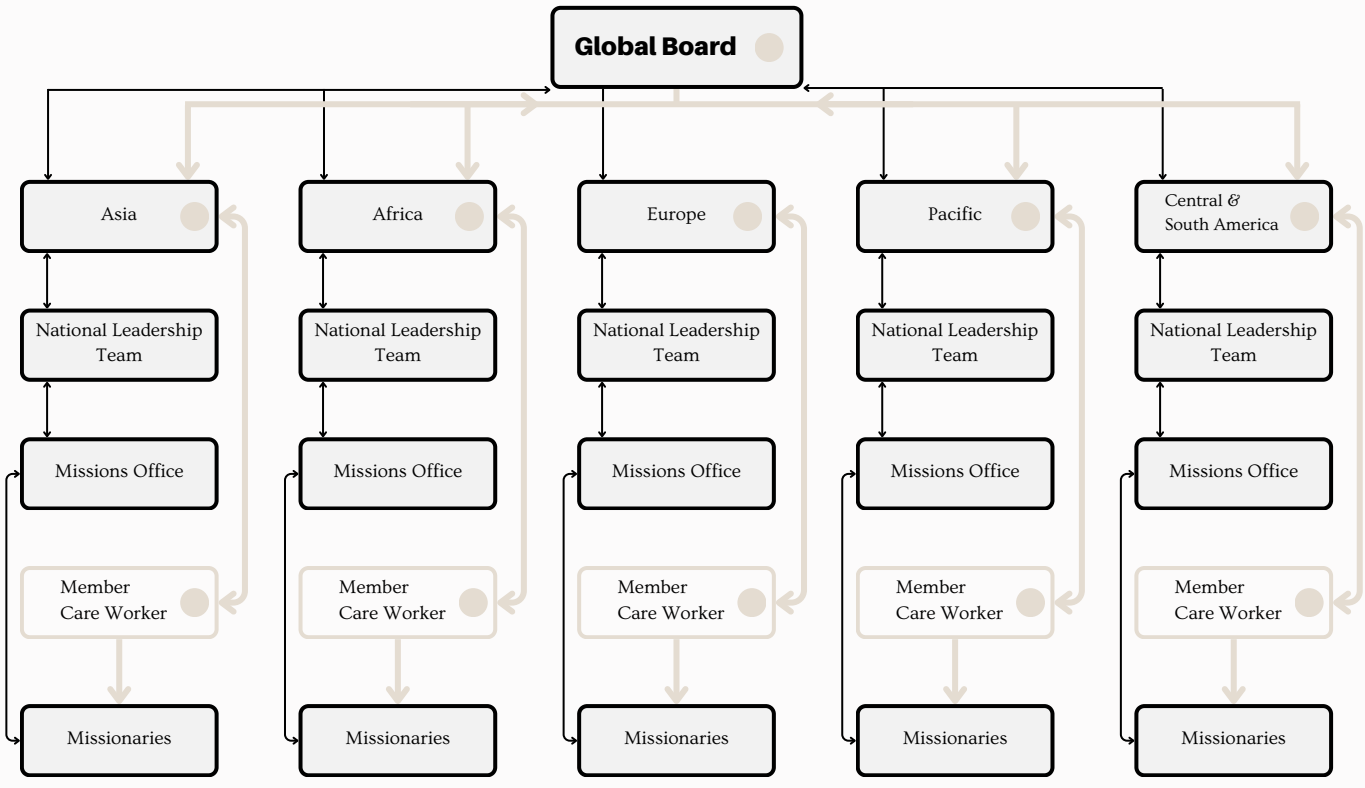
[15] Appendix 15
[16] Appendix 16
[17] Appendix 17
[18] Appendix 18

Organisational Structure

Denominations could utilise Global Boards to oversee regional boards, who oversee national leadership teams. National leadership support their country's missions office, who care for their sent missionaries. Global Boards issue Member Care policies that are contextualised and implemented by each country's missions office. Missionaries sent from nations without a missions office would do so with their national leadership team; whereby, Member Care is provided by the regional board Member Care worker (figure 1)

A designated Member Care worker is required to ensure adequate oversight connecting all areas of care. Global Boards require a designated Member Care worker to influence all 'pathway of care' policies and to highlight concerns, like disciplinary procedures or cross-regional needs (Swanson, pp.435-440). Each missionary requires a specified Member Care worker. For smaller denominations, with less than twenty missionaries being sent out of each country, one Member Care worker per national mission office would suffice. However, as this increases, a team of Member Care workers should be utilised with an identified lead worker to facilitate oversight.

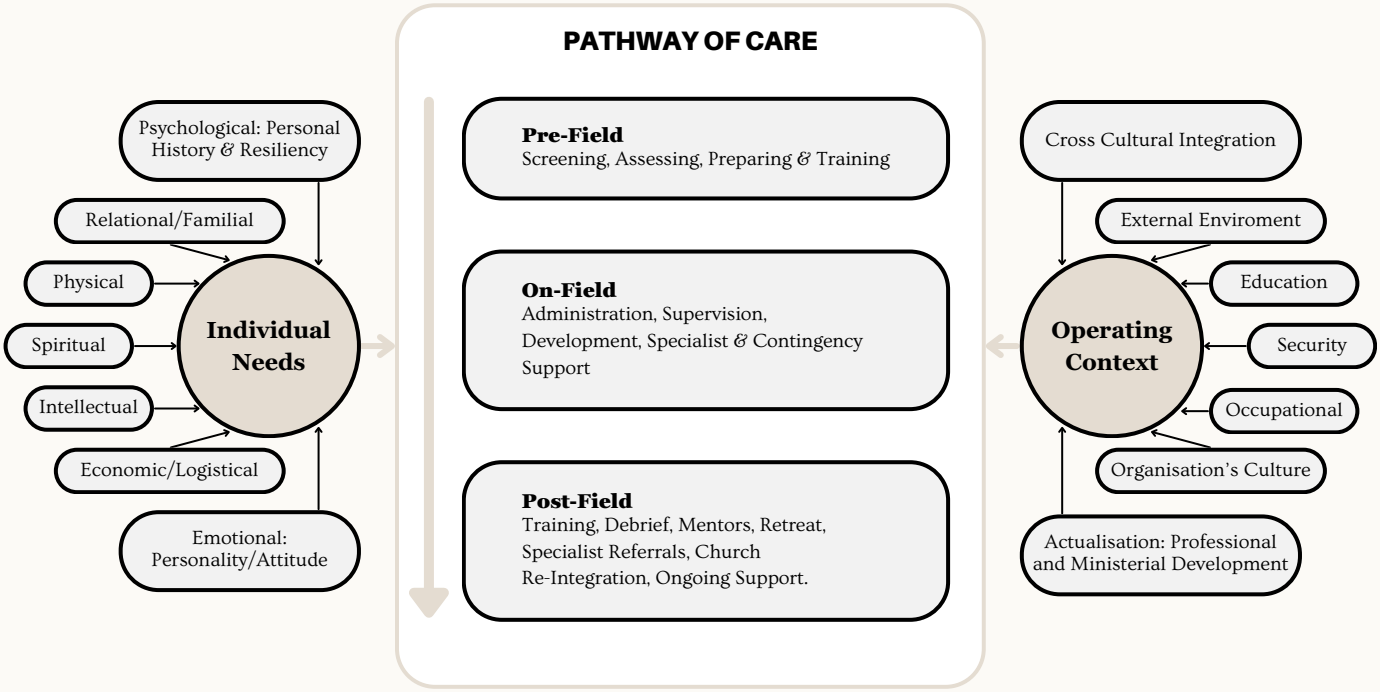
Figure 1: Denomination's Organisational Structure Concerning the Provision of Member Care



Dimensions of Care

Member Care workers are then responsible for overseeing the implementation of holistic care: pre-field, on-field, and post-field. This pathway for dimensions of care model [Figure 2] acknowledges additional factors within Interhealth's categories, by incorporating elements from other Member Care models, to provide holistic support (Parker, 2015). The SPARE-O model contributes actualisation and relational elements, alongside Schellenberger's ministry skills and Swanson's personal history and resiliency. Swanson's contextual factors is amalgamated with Schellenberger's cross-cultural integration, and O'Donnell provides dimensions of care, like logistical care, alongside Interhealth's economic care.

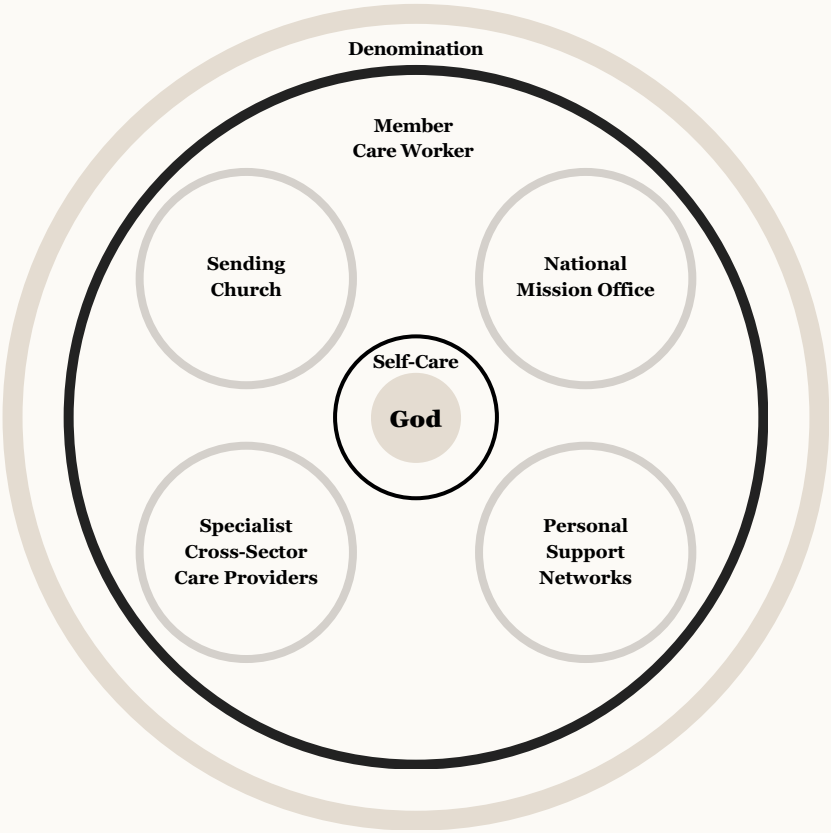
Figure 2: Pathway for Dimensions of Care Model



Member Care Providers

The national missions office implements administration, human resources, and logistics. However, addressing all dimensions extends beyond the limitations of the lead Member Care worker. Therefore, specialist cross-sector care providers are incorporated at different stages, including, but not limited to: health care providers, specialist mental health care, psychological assistance, counselling, legal advice and further academic development (Prins, 2002, p.101). Whereas church care is provided consistently in partnership with the national Member Care worker. This model also extends Hoffmann's emphases on family and friends, to include personal support networks, like: prayer partners, financial contributors, and peer support from other missionaries. Girón, O'Donnell, and Hoffmann all accurately assert that Member Care is provided under God, which subsequently influences this new model of Member Care providers [Figure 3].

Figure 3: Denominational Providers of Care Model



Pathway of Care

Having portrayed the new model's organisational structure, dimensions and provision of care, this article now proposes a pathway of care model

Pre-Field

Screening Assessments

Member Care is required throughout recruitment, screening and assessing. The missions office can handle enquiries; however, upon application, the Member Care worker oversees screening and assessment. Good selection enables better retention (Ekström, 1997); therefore, using various selection techniques, alongside references and interviews should ensure meeting the Global Board's selection criteria. This enables the church and Member Care worker to affirm the candidates' missionary call. Certain assessments should be outsourced to specialist providers: pre-employment psychological and medical screenings, aptitude, and psychometric tests (Prins, pp.25-26,51).

Training

Pre-departure orientation, induction, preparation, and pre-field training should address and frame expectations realistically. Accurate role descriptions and training should explain HR, finance policies, the denominational history, vision, and ethos. Global Boards could provide interactive online training, translated and contextualised by each national missions office, which includes training from specialist care providers, practitioners, and theologians. Training should exceed GC's guidance by additionally including spiritual, Biblical, theological, cross-cultural, emotional preparation, and vocational skills alongside O'Donnell's expectations of sender care. Training is undertaken with other candidates to enable peer support (Skovholt 2016).

Missionaries pioneering ministry outside of the existing denomination's network should receive training and experience pioneering new ministries with existing missionaries.

Candidates should learn practical skills to enhance ministry and increase bi-vocational opportunities. Content is individually tailored, for example those without academic theological education would undertake additional theological modules. Tailoring content means timeframes vary. However, it should be a minimum of three months to ensure sufficient training and practical preparation. This model also incorporates Giron's sending church responsibility to ensure discipleship and pastoral care.

On-Field

This model incorporates the Member Care workers as responsible to oversee administration, supervision, on-going training, and specialist support during the missionary's arrival, period overseas, and onwards transition.

Administration

This begins with the national mission office, to ensure administration support: HR, contracts, complaints procedures, visa advice, insurance cover, flights, ATOL, and health and safety compliance. Member Care workers facilitate communication between missionaries, the mission office, and Member Care providers.

Supervision

Regular supervision and accountability are imperative, both one to one and group peer support

Social Media can facilitate peer support for missionaries across the denomination. Sending churches should undertake field-visits, alternatively by the Member Care worker once per contractual agreement, after which a furlough is recommended, and contracts can be subsequently renewed as appropriate.

For smaller denominations, one-to-one managerial and clinical supervision can be combined. However, this model incorporates Hawkins' (Hawkins et al, 2012) CLEAR supervision model[19] that separates clinical supervisors, providing pastoral care, from managerial supervisors, overseeing performance regarding organisational outcomes. This enables role reviews and feedback opportunities.

The Member Care worker should stay in regular communication with the missionary for ongoing support, to encourage a healthy work/life balance. Member Care supervision can also identify where training or professional development can benefit the missionary. Member Care workers can then utilise outsourced specialists to provide necessary training elements, like: residential courses, distance learning, ministry skills, journals, and additional reading. Additional specialised areas of support can be outsourced, such as health care providers, specialist mental health care psychological assistance, counselling, legal advice, and further academic development (Prins 94-101). The Member Care worker can liaise with the national office and sending church to enquire whether financial assistance is available for these costs.

[19] Appendix 19

Contingency

Each national missions office must also ensure that they have appropriate emergency procedures and contact details (HPN, 2013, pp.101-115). In consultation with the national missions office, Member Care workers must ensure missionaries complete risk assessments and emergency evacuation plans. National offices must ensure they have a crisis response team, which includes the lead Member Care worker. Due to geographical isolation, the crisis response team of pioneering missionaries should include their regional Member Care provider and relevant Global Board member. Furthermore, Member Care workers ensure that missionaries have ongoing access to additional crisis support.

Post-Field

Support for missionaries throughout all post-field stages, including preparation for return, re-entry, and ongoing support is crucial (Chin, 2016).[20] Care is overseen by the Member Care worker with an approximate time frame, allowing for variance regarding each missionary's experience.

Pre-Departure

Six months before departure, the returnee should have access to re-entry training and resources: re-entry, grief, reverse culture shock, and expectation management. Mentoring aids the returning transition (Waitt 2011, pp.14-15; Skovholt p.241), so Member Care workers facilitate connections with returned missionaries as transition mentors

Debriefing

Upon re-entry, this model incorporates exit interviews, as both an operational and personal debriefing process with the Member Care worker, national missions' office director, and sending church pastor. If appropriate, missionaries may be referred to external counsellors and be offered the opportunity for a debriefing retreat, with a trusted organisation, separate from the denomination, that enables missionaries' confidential processing opportunities.

Ongoing support

This model incorporates and extends Headington's emphasis upon assisting missionaries with subsequent career support, to also include retirement planning. Ongoing support is imperative for the missionary's continuous well-being (Gardner, 2015). The Global Board Member Care worker oversees social media peer support groups. The national Member Care workers maintain communication to ensure continued access to psychological referrals and pastoral care as necessary. Follows ups occur at set intervals; after six months, 12 months, 24 months, 5 years, and ongoing as appropriate. The Member Care worker should collaborate with the church to ensure care upon returning and who has responsibility for assisting with practical needs (Wilson 2015).

Moderation

To ensure effective holistic care, this model requires continuous review. After missionaries complete a contract period, they can complete an evaluation form to inform ongoing improvement of Member Care policies and implementation

Conclusion

In conclusion, this article has designed and justified a new denominational model of Member Care by undertaking a literature review that critically analyses existing models. This identified factors that must be addressed to deliver holistic and comprehensive care. It is evident that a specified Member Care worker is needed to coordinate these different dimensions of care. There was a significant dearth of denominational Member Care models accessible for evaluation, yet it is necessary to define clear structures that designate responsibilities of care.

The proposal model is founded upon the findings of this research and based upon O'Donnell's, Interhealth's and Pollock's models. It incorporates elements found within the literature review models, regarding providers of care, dimensions of care, and the specific elements that need to be addressed within the missionary's personalised pathway of care. This model emphasises the importance of an organisation's structural framework that enables a Member Care mindset throughout every aspect of support, manage expectations, and avoid non-specified oversight of care, as so commonly evident throughout the literature and denominational reviews. This model emphasises a lead Member Care worker to coordinate care, alongside the missionary's self-care and master care.

By critically evaluating theoretical and existing Member Care models, this new denominational model seeks to facilitate sustainable missionaries by providing support throughout their entire mission experience within the denomination.

[20] Appendix 20

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To Fix or Not to Fix

A case study of Loss and Grief

An Original Case Study

XING AND HER HUSBAND

By Dr Roger Van Der Veen | Clinical Counsellor with The Well International

To Fix or Not to Fix

A case study of Loss and Grief

Xing is a software analyst and her husband is a high school teacher, both in their 20s. Xing and her husband have completed two short-term mission trips of several months each in countries with Chinese-speaking people, as part of their theological degree through a Bible college in Australia. They have applied to a particular mission organisation and have been accepted.

The Organisation could offer Xing and her husband the opportunities they were seeking. Ever since Xing was a little girl in Melbourne, she dreamed of missions with Chinese-speaking people as she spoke the language and knew the culture (as did her husband). She wanted to connect with Chinese-speaking people about Jesus and God and to use her education and skills to better their standard of living.

Xing and her husband raised the required amount of support, completed all the preparation and training, and finally moved to Country A. Two weeks after arrival, orientation, and settling in, the team leaders announced they would be leaving permanently and that Xing and her husband would need to take over several projects. This would last at least until the new team leaders arrived, which could be a few months. It seemed that other team members, who had been serving longer, knew beforehand the team leaders were leaving and had negotiated to take over the projects that they wanted or felt were less troublesome.

There was little Xing and her husband could do. The other team members told them that they had to help, as everyone else was doing. The Organisation was unsympathetic and said 'unfortunately sometimes things like this happen'. Xing and her husband could return to Australia, but there were expectations, obligations, shame, a sense of failure, and the cost of just having shifted and settling in. Xing and her husband became involved in the projects and did what they could, but the nationals were not that interested. There was foot dragging, petty theft, and other minor incidents.

Xing felt cheated and betrayed on the one hand and confused on the other because while she and her husband had no doubt that God had called them to missions with Chinese- speaking people, Xing and her husband could not reconcile that God had called them to the present situation. They did not want to 'let God down' by complaining, let alone considering leaving before the assignment was over, even if that turned out to be the best option for them. She prayed and prayed but felt that God was not answering. Her husband was disillusioned too, but not as much as Xing was after six months.

What had been agreed to with the Organisation had not been communicated to the team leaders, or if it was both parties had put it aside. The Organisation had been holding off the team leaders' imminent departure by promising new staff to help: Xing and her husband.

Xing and her husband have consented to contact from the Organisation's Member Care Provider (MCP).

What direction should the MCP take or help Xing and her husband take?

Possible Options:

- Pray harder and more often.
- Tough it out longer as obviously this was going to be preparation for another term of service in another location.
- Trust God more.
- Conflict resolution.
- Request a transfer.
- Return to Australia.
- Demand an immediate meeting with the organisation and threaten to leave unless things were changed.
- Continue on the present track.
- Engage Xing and her husband in Organisation approved counselling to mollify their sense of being wronged.
- Apply to another organisation.
- Leave missions and return to employment in the secular world.
- Lodge a complaint against the organisation.
- Make some soft promises to dampen the situation.

Discussion

The above question is loaded in that it assumes that the MCP should have a direction to take this case in (and the Organisation might have laid out its preferences), that there are options (as listed above) for Xing and her husband and this situation can be fixed. Do not fall for that trap. This is not a case study about what to do. This is a case study about assessing loss and grief and what can be done for the loss and grief; rather than what can be done to change the situation or problem solve it, which is not the nature of loss and grief. Avoid rushing to problem solve. Try not to rescue the client(s), which is contra indicated, unless the client is at risk of harm to self or to others as this then becomes a duty of care situation.

Given the above, then how is the situation best handled? Firstly, a brief background to loss and grief is needed for the MCP and to be explained to the clients so they can locate themselves and realise the track on which they are travelling. A loss is someone, something, or someplace that is no longer there (or access is no longer possible) and the meaning of that someone, something, or someplace. Both are now gone. Most commonly loss is associated with death and this is correct, but there are other forms of psychosocial loss such as relationships, health, work, role and purpose, and meaning. While most psychosocial losses are concerned with the past and present, there can be loss in the future. For example, infertility – what was hoped for and what could have been. The meaning of loss is different for different people and this depends on their upbringing, personality, level of psychosocial support, culture, relationships, religion/faith, and health. Once loss is experienced, remembering that the person needs to interpret the event as a loss (and sometimes not as significantly as one would expect), the mind and body respond with grief, which is a range of emotions that are experienced over time. Do people work through loss and grief? Yes, most people do. Do people ever get over grief? Most commonly, counselling clients have reported that the emotions from loss and grief dull over time (the psychosocial impact lessens), but never completely go away and clients learn to live with and around loss and grief. However, some loss and grief can change people's lives forever and in a very negative or dysfunctional way.

The task of the MCP in this case study is threefold:

1. The first step is to see and hear what Xing and her husband have to say about the situation, even if the Organisation has already provided the MCP with information and access to their files.
2. The second step is to see what Xing and her husband would like to do, but they might not know.
3. The third step is to undertake a psychosocial assessment of what is happening and why, largely through asking reflective questions. An assessment will contextualise the situation for the MCP and the clients, ie the bigger picture and antecedents.

Once the MCP has undertaken these steps, which direction to proceed in will become clearer. Below are some of the areas to listen for, watch out for, and ask questions about, in order to undertake the assessment as Xing and her husband are telling their story. Note: these are not questions to ask the clients, but areas for the MCP to be completing an assessment.

a

What is/are the loss(es) here?

Actual, perceived, future, potential, unrecognised, unexpected.
The actual loss is that the expected and agreed to arrangement of undertaking the role of missionaries with Chinese-speaking people has been stalled (or abandoned). For how long is unclear. The loss is also a future loss of being missionaries to Chinese-speaking people. There could be other potential losses in Xing and her husband's scenario, but there is nothing yet visible on the horizon, except possibly the loss of trust with the Organisation. Unrecognised loss does not seem applicable here, which is loss that is not talked about in society and people experiencing the loss are not given the public acknowledgement of having suffered a loss. Perinatal death is an example. Xing and her husband's perceived loss is much greater than the actual loss, mainly because of their expectations as to what life on the mission field was going to be like, because the Organisation did not openly communicate with them, and thus there is resultant shame and loss of face to themselves and their supporters, family members, friends, and sending church.

b

What are the contributing factors, including antecedents?

Certainly, the unwavering expectations of Xing and her husband, which were tacitly confirmed by the Organisation and then not honoured, with the team leaders and team members being aware beforehand. Additionally, Xing and her husband not realising that a Plan B would be a good idea and assuming that they would be able to start in their preferred mission situation for their first term, and imagining that the mission field was devoid of politics.

c

Are there other losses here other than those of Xing and her husband?

Yes, losses to the team, the Organisation, and the Nationals because two new keen and skilled missionaries who already speak the language and know the culture have potentially been lost. Even if they stay, the trust relationship and early enthusiasm will have been lost.

d

What are the signs of grief?

The feelings of betrayal, being cheated, and disillusionment and subsequent lamenting and loss of motivation.

e

What can be done here for Xing's loss and grief?

Problem solving is not conducive to most loss and grief situations as they are a process and journey that people must travel through. However, support is a significant and important factor to facilitate them through this tunnel, as is contact with an MCP. The MCP can complete a psychosocial assessment, listen to what Xing and her husband would like to do (which they might not yet know), make a referral to counselling, and present stipulations to the Organisation.

f

Are Xing and her husband experiencing poor mental health?

There is no doubt that Xing and her husband are depressed, but this has not yet turned into depression, which it could. At this stage their mental health is stressed and could worsen, so intervention is required.

g

Is a counselling referral warranted and if so, how could counselling benefit?

If Xing and her husband agree, a counselling referral is warranted, which the MCP could check out and make. Counselling could benefit Xing and her husband by hopefully softening the psychosocial impact of the loss and grief, providing support, and facilitating them to decide what they would like to do.

h

How could the MCP encourage Xing and her husband to check out counselling?

Counselling is probably going to be a hard sell to Xing and her husband, not because they do not understand it or agree with it, but because of their cultural background and sense of shame and feeling dishonoured. The most important qualities of a counsellor for Xing and her husband, apart from skill, would be confidentiality and familiarity with their culture. One possible outcome is that Xing and her husband engage in counselling, which would provide a more extensive psychosocial assessment and stipulations to the Organisation to help contain their deteriorating mental health and to prevent them from leaving the field, which would make the situation even worse.

Conclusion

In conclusion, the point of the case study is not what happens to Xing and her husband, but rather that loss and grief is not a problem to be fixed. This is a case study about assessing loss and grief and what can be done for the loss and grief.

Authors' Biographies

Marina Prins

is the co-founder of Member Care Southern Africa (MCSA), an organisation focusing on the care of missionaries, established in 1999. She served as missionary in Malawi from 1991-1997. She co-authored the book, Member Care for Missionaries: A Practical Guide for Senders, published in 2002, with Braam Willemse. She serves as Member Care Consultant to MANI (Movement for African National Initiatives). She holds a M.Sc. Agric degree from the University of Stellenbosch (South Africa) and a M.A. in Member Care from the University of Gloucestershire (in collaboration with Redcliffe College) in the UK. Her postgraduate Member Care research focused on Malawian missionaries' needs and challenges against the backdrop of the global shift towards an increasing number of missionaries being sent from Africa. She has been involved in Member Care development and training and is currently also involved in developing contextualised Member Care material and training for the African Member Care context.

Jovelina Cruz

is a Child Safety consultant, HR manager, family therapist and a writer. Her first degree was in elementary education, post-graduate and specialised in family therapy through Faculdade Unida de Vitoria, Brazil. She has a Master's degree in Member Care through from the University of Gloucestershire (in collaboration with Redcliffe College) in the UK. She has worked as a counsellor and therapist for women and children going through domestic violence for many years. She worked as a guidance counsellor and a child safety officer for an International School. Her areas of expertise are: Child safety, transition for transcultural workers and TCKs, Member Care, conflict management and debriefings

Danielle Elizabeth

is a missionary with over 15 years of experience working with churches and organizations across five continents. In 2023, she founded United Mission, drawing on her extensive background in training and Member Care. She is also the co-director of Present Hope and serves as a trustee for Release International whilst working with various international Christian organisations to train and support missionaries. Danielle holds a BA (Hons) in Applied Theology from Regents, and an MA in Contemporary Missiology from the University of Gloucestershire (in collaboration with Redcliffe College) in the UK. Her passion is building collaborative relationships to advance intercultural theology and practice, and championing humility in mission to reach unreached people groups.
(*Danielle doesn't want her surname listed due to the sensitivity of her location).

Roger Van Der Veen

Roger Van Der Veen, clinical counsellor and facilitator at The Well International, has been a frequent presenter at South Pacific Member Care Conferences. He has been involved in the field of Member Care since 2005. His social work and counselling experience have been in the areas of hospitals, clinical education, mental health, workplace counselling, settlement of immigrants and refugees, and child protection, including seven years as a university lecturer. His qualifications are BA, BSW (Hons), MSW, and PhD. Roger, originally from Canada, is married to Julie and they have two adult daughters. In his spare time, he likes bushwalking, anything to do with motorcycles, and following Canadian ice hockey.