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**Trauma and Missionary Life**  
**Trauma in Missionary Life**

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Abstract

*Many missionaries suffer from a variety of psychological, physical, and spiritual injuries. Many are the result of living and working in environments characterized by violence, disease, inhumane living conditions, social oppression, and political corruption. Trauma, by definition, involves experiences that overwhelm an individual's ability to cope and hence to make sense of certain life events. In this light, post-traumatic responses can be seen as attempts to master feelings of helplessness, terror and guilt.*

*The intent of this paper is to provide missionaries, as well as supportive personnel, a framework with which to make sense of and thus to deal with the destructive effects of unresolved trauma. Trauma is rarely understood and often mistreated, even by many members of the psychology profession. This paper will address trauma in regard to its definition, its various forms, its short-and long-term effects, and its implications for ministry. Considerations regarding treatment and prevention will also be addressed.*

The information and impressions contained in this paper have emerged out of 15 years experience as a psychologist, as well as five years of working exclusively with members of various Catholic missionary sending societies from four different continents (America, Europe, Africa, and Australia). I have assessed or treated over 100 missionaries (lay, clergy, and religious) who have been the victims of post-traumatic stress. 1

In addition, I consulted with a team of four psychologists and formation consultants, over a period of four years, who have over 50 combined years of experience working with missionaries. They have also worked with hundreds of clergy and religious in a variety of counseling-related capacities. Their experiences also support and inform the content of this work.

Many missionaries suffer a variety of trauma-related symptoms. These symptoms slowly undermine and can destroy the physical, emotional, and spiritual well being of many dedicated men and women. The hope of this work is to help traumatized missionaries return to vital, well-balanced, and productive lives.

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## Trauma in Missionary Life

Being a missionary can be very dangerous. This is especially true in some violent parts of the world, including certain American inner cities. In certain locations physical hardship, disease, and frequent exposure to violence are an inherent part of the missionary package. The effects of violence and trauma cannot be underestimated. In addition, for some men and women, ministries permeated by violence hold powerful and unconscious attractions. These attractions are often driven by powerful motives which typically remain in the unconscious.

The debriefing of missionaries returning from extended tours of mission work is often a pro forma exercise. This is often due to a lack of understanding and training, rather than to emotional indifference on the part of missionary personnel.

The impact of violence during any tour of duty, let alone the last one, is rarely taken into consideration. Overseas ministry can be peppered with years of direct experience with an exposure to crime, psychological intimidation, military and terrorist threats, kidnappings, armed coercion, torture, rape, and murder. Repeated robberies and home invasions by burglars, soldiers, and terrorists are also not uncommon. Similarly, daily conditions characterized by destitution, oppression, disease, and domestic (as well as street) violence can wear down the most dedicated of missionaries.

Witnessing violence is enough to cause severe psychological damage and long-term health problems (Davis and Friedman 1985). Exposure to violence can destroy feelings of safety, justice, personal efficacy, and faith in humanity, as well as beliefs in a just and loving God. Concerns about mission, vocation, and personal sanity are other common side effects of continual exposure to trauma and injustice.

Unable to share feelings of rage, terror, and helplessness with understanding associates is sometimes more devastating than the actual trauma. Stifled despair is deadly. Overwhelmed missionaries often express thoughts such as the following: "What's the use! Complaining won't change anything!" "I've got so much work to do. There are so many in need. I can't keep thinking about these things." "That's just the way things are." "It's time to move on and find a new assignment."

The above statements are desperate attempts to preserve conceptions of self, world, and God in the face of overwhelming life events that "fall outside the realm of usual experience" (American Psychiatric Association 1987). Concerns about the prevalence of evil in the world can become difficult to suppress. Intellectual answers no longer suffice. Without a missiology capable of integrating and making sense of direct experiences with inequality, oppression, injustice, violence, and most importantly evil, feelings of powerlessness and despair can become the norm.

Heading home, accepting administrative positions, or enduring incessant psychosomatic problems are often the only alternatives available to the unsupported and isolated victim of trauma.

The attitude and expectation at home is to take time off. Well-meaning administrators are often quite generous in providing sabbatical programs, extended retreats, and time for renewal. The problem is that more than just time is needed to heal the devastating effects of trauma. Why missionaries need to return home for lengthy periods of time in order to become physically and psychologically renewed is rarely discussed. Failure to answer such a question is not without great physical and emotional cost. The effects of trauma, if left untreated, can result in a variety of psychological, physical, and interpersonal impairments that can last a lifetime.

## What Is Trauma?

Van der Kolk (1986) characterizes trauma as involving "overwhelming life experiences" which one cannot integrate into his or her belief-system. The spectrum of -trauma is vast. It can occur from exposure to even a single event or in the face of natural catastrophes such as earthquakes, tornadoes, and hurricanes. Other traumatic events are the result of man-made disasters, such as toxic waste spills,

car accidents, airplane crashes, terrorist bombings, random shootings, rape, and murder. Episodic trauma can lead to feelings of being unable to cope with reality (Herman 1992).

One Catholic sister, returning home from a war-torn Latin America country, was exposed to considerable carnage and the murder of three of her community members. Over the course of her first six months back in her country of origin, she was emotionally liable, had trouble sleeping, and rarely talked. What no one knew is that she was constantly becoming re-traumatized by terrifying flashbacks over which she had little control. Her community, due to the fact that she did not pull herself together in what they considered to be a reasonable amount of time, thought that she was mentally unstable and having a breakdown. In actuality she was struggling with several common post-traumatic reactions. To make matters worse, she was referred to a psychiatrist who knew very little about post-traumatic reactions. He concurred with the community's perception of her mental instability.

Herman (1992) feels that there is a second type of post traumatic reaction, i.e., Complex Post Traumatic Stress Disorder (PTSD). This is the result of experiencing or being exposed to repeated events, often spanning a period of several years. Childhood physical and sexual abuse, captivity, torture, imprisonment, and living in police states or war-torn countries are examples of this type of PTSD. Missionaries living or having lived in El Salvador, Chile, Argentina, Peru, Guatemala, Liberia, South Africa, The Sudan, Tibet, Indonesia, Vietnam, Cambodia, and Sri Lanka most likely have witnessed, experienced, and/or worked with men and women who have been traumatized in many of the ways mentioned above. Chronic exposure to trauma can lead to a sense of losing one's self or identity (Herman 1992).

Events are experienced as traumatic when they overload an individual's capacity to cope with, protect self/others, and make sense of overwhelming experiences. Feeling out of control, powerless, and helpless are the earmarks of having been traumatized. Understandably, the term "victim" is used to refer to someone suffering from these feelings. Unable to deal with the traumatic after effects, a victim often shuts down emotionally or becomes plagued by a variety of intrusive thoughts and feelings. "Survivor" is a term used for those who have undergone a healing process and thus are no longer imprisoned or victimized by the effects of trauma.

## **Post-Traumatic Reactions**

Unable to talk about, grieve over, or share feelings with sympathetic and understanding others often results in lives characterized by a slew of stress-related symptoms and behaviors.

Diminished responsiveness to the external world (psychic numbing), feelings of estrangement from others, and lack of interest in formerly pleasurable activities are some of the more subtle but common side effects of trauma. Exposure to real or symbolic events/stimuli, considered by the victim to be similar to the original trauma, can set off the original sequence of traumatic feelings, thoughts, and behaviors.

Impulsive behaviors can occur as a result of sudden changes in location, e.g., a new residence or lifestyle (American Psychiatric Association 1987). Disruption of familiar routines can throw an untreated trauma victim into a panic.

The intrusive phase (Horowitz 1986) of a traumatic response usually lasts up until six to eight weeks after the trauma (especially when the victim is able to get out of the traumatic environment). During this time, lives become characterized by flashback hypervigilance, irresolvable stress, sleep disturbances (difficulties falling asleep, early morning awakenings, and nightmares), startle responses, feelings of being unsafe, panic and anxiety attacks, problems concentrating and remembering, bouts of depression, crying and rage, social isolation and estrangement.

One Irish missionary, who frequently volunteered to collect dead bodies (for official identification), often drove into a totally black South African township alone at night. Masked gunmen would taunt and interrogate him every step of the way. This missionary claimed he was never afraid. Years of exposure to violence, both at home and abroad, had taught him to be emotionally frozen in the face of danger. At the

time he did not realize fact that he had to have several drinks every night in order to go to sleep, nor did he realize that he also would not allow himself to need anyone emotionally. Only during treatment did he allow himself to feel the terror, anger, and confusion which had been always present, but which he had never allowed himself to experience (for he had never been in a safe enough environment to do so). Many veteran missionaries have witnessed or worked with those involved in mass executions, mutilations, rapings, and indiscriminate slaughters. Over time these men and women learn to adapt to the violence around them and learn how to suppress their feelings. Paramedics, military corpsmen, emergency room personnel, and many other health-care providers, working in dangerous environments and/or with highly traumatized populations, also learn how not to feel.

Once in treatment, where support and understanding can be found, a victim's "numbness" begins to diminish and the devastating effects of trauma described above gradually begin to emerge, albeit this time in an atmosphere capable of dealing with and modulating what was formerly overwhelming. Such a healing environment restores a sense of empowerment understanding, and safety which was absent at the time of the traumatic events. Without treatment the most damaging aspects of trauma can stay indefinitely underground. When this becomes the case, tremendous cost to physical, emotional, and spiritual health, as well as to interpersonal relationships and vocation can be the results.

Part of the difficulty of treating missionaries is that they have been trained to be tough and not to let certain feelings affect them. Frequently, considerable emotional and physical pain are repressed or offered up to God. In the case of some traumatic injuries, these attitudes can have life-threatening consequences.

## **Childhood Trauma**

Some ministers and pastoral agents, especially those who choose to work in violent settings and/or with highly traumatized populations, come from families where violence was a part of their upbringing. Physical abuse, sexual abuse, and spousal battering were just some of what certain ministers had to witness regularly or to experience as children. Others grew up in cultures where politically motivated violence regularly spilled out into the streets.

Due to political and economic oppression, one African minister's family had to split up when he was eleven years old. His father had no work and he had to go far away to the mines in order to scratch out a meager living. His mother was also forced to seek work far away from home. As a boy, this minister was regularly caned, first by his father and then later by his relatives into whose care he was entrusted. Cousins, along with other village boys also beat him regularly. All of this abuse, coupled with the violence and bloodshed of his surrounding culture, left him completely numb. By the time he was 35 years of age, he did not know how to feel. His head dictated all his behavior. Only in treatment did he allow himself to feel (for the first time) not only the pain and injustice of his childhood, but that of his country as well.

Many victims, depending on the nature of the trauma, bypass many of the disturbing reactions common to the "intrusive phase." All victims at some point (whether it is after the six to eight week period or immediately) become emotionally "numb" (if psychological help is not forthcoming). This signals the start of the "denial phase" (Horowitz 1986). In this phase, which can last indefinitely, the victim tries by any means possible to stay away from any thoughts and feelings suggestive of and generated by the original trauma. Alcohol, drugs, gambling, etc., along with other impulsive behaviors such as violent outbursts, sexual acting out, and excessive risk-taking, are common means of dealing with post-traumatic feelings and thoughts. Tragically, many of these behaviors are self-destructive and can be life threatening. Most are designed to distract or sedate (self-medicate) the victim from excessive feelings of horror, helplessness, terror, and guilt.

Many ministers grew up in cultures and homes characterized by poverty, violence, and physical abuse. Severely restricted educational and medical opportunities only exacerbated their difficult circumstances. Sexual exploitation of children and alcoholism, in many cultures including America, are not uncommon. People growing up in cultures permeated by violence, political corruption, and

exploitation have few options but to adapt. The tragic price is that they often end up creating parallel realities at home.

Growing up in a traumatic environment makes one a prime candidate to seek out unwittingly traumatic situations in adult life. Ministries chosen in cultures permeated by violence can often be mute attempts to reconnect with repressed and violent personal histories. At the same time, a vocation for an untreated victim of childhood abuse or trauma can often be an attempt both to empathize with oppressed people as well as to prove something to the condemning God of childhood. A life of dedication to God's less fortunate can be an unconscious way to seek atonement for shameful acts and feelings resulting from early childhood abuse. At the same time the hope is that a life based on good works will overcome inherent feelings of inadequacy while achieving salvation at the same time. Certain unconscious feelings and conclusions about self-worth, connected to early abuse, can often get confused with authentic feelings of compassion for the oppressed (Grant 1994). Many who work with traumatized populations identify with those whom they care for. One sister worked for 15 years in India with child prostitutes. After becoming totally burned out and entering therapy, she eventually got in touch with her own childhood sexual abuse.

Early unresolved abuse often convinces victims that personal worth can only be obtained through continual striving to be good, sacrificing oneself, and catering to the needs of others. Spiritual formation often communicates similar messages, without realizing the meaning that such messages can have for unrecovered victims of childhood abuse.

A missionary is trained to be self-sufficient and tough. All should be borne in the name of a suffering humanity and a concerned God. Those who cannot bear the difficult circumstances of their ministries often feel that they are not made of the "right stuff."

The above conditioning is quite familiar to childhood victims of abuse, who realize that they are totally on their own and thus can depend on no one. Inadvertently receiving such messages as adults only reinforces feelings of inadequacy, for no one is able to be truly self-sufficient. Yet many untreated victims of childhood abuse will do everything in their power to become totally self-contained. Hardship, suffering, and even death become the road taken by many missionaries. Unconscious motives, driven by forgotten abuse, inevitably lead to disillusionment and depletion on all levels of one's being.

Martyrdom can also be an unrecognized replication of a childhood trauma. It can be an attempt to atone for "toxic shame" (Bradshaw 1989) or to find a socially acceptable way to put an end to one's tormented life. I know of several male missionaries who worked themselves to death and died in their mid-forties despite the pleas of associates and family to slow down, to be more careful, and to take care of themselves.

A life of dedication and self-sacrifice requires a great deal of discernment. Most young missionaries have not had the opportunity to work through a multitude of spiritual and psychological injuries. Traditional formation has not had at its disposal the considerable body of knowledge generated by research in psychological abuse and trauma. Candidate assessment and formation usually do not take a serious look at the influence of early childhood injuries. As a result, undiagnosed and unrecovered victims of trauma often pass through the system and end up in missionary work at great risk of further injury.

Choosing to live in extremely harsh physical, emotional, and psycho- logical conditions, such as those encountered in certain missions, requires considerable emotional and spiritual stability. Trauma victims or deeply spiritual people are often the only ones who are willing to take on the rigors of missionary life.

## **Survivor Guilt**

Many missionaries also suffer from survivor guilt. Being reared in relatively privileged backgrounds, able to flee overwhelming situations of poverty and violence at a moment's notice, often leads to self-recriminations and self-inflicted deprivations. Feelings of not having done enough for those

who were killed, injured, tortured, raped, or permanently separated from loved ones often plague missionaries. Taking excessive responsibility is often a result (Briere 1989) of survivor guilt. Some missionaries have been known to become so involved with victims and their families that unhealthy dependencies were created. Often it is easier for a person to feel responsible than to feel guilty or helpless. Having been spared tragedy can become a curse rather than a blessing for some.

One American missionary in Latin America over a course of five years (until he was brought back home completely exhausted) almost worked himself to death. Unconsciously, he was trying to atone for the death of a young man whom he had inadvertently placed in a job that eventually led to his being physically and sexually exploited and eventually killed by the military police. He spent over a year trying to find this young man's remains and then several years taking care of the youth's family, as well as other vulnerable boys in the town.

## **Unresolved Grief**

Many missionaries also suffer from unresolved or pathological grief. Losses, ranging from cherished friends to highly valued ministries, occur all the time. Part of the missionary credo is to keep moving because there are so many in need. Dwelling on personal losses is often considered to be selfish. As a result proper mourning usually fails to occur. Grief becomes masked in either physical symptoms or maladaptive behavior. "Pain is often a symbol for suppressed grief" (Worden 1982:61). Hearts and souls remain frozen in the past, rather than directed toward the present and future, when bereavement and mourning are not allowed to occur.

## **The Long Term Effects of Trauma**

Gradually and without realizing it, the daily routines of trauma victims begin to unravel. In the most severe cases, less and less time is made for friends and recreation. Exercise and pleasurable activities are the first to go. Work becomes all consuming. Personal safety and protection of the vulnerable, along with concern for survival, become top priorities. Overcoming feelings of terror, helplessness, and alienation, in an increasingly unmanageable world, can draw all of a victim's energy and attention.

Beneath the increasing depression and interpersonal alienation, rage and a justice-seeking retribution may silently burn. Alone and unable to articulate what is destroying one, on a deeper level, a missionary may work more intensely in order to restore personal efficacy and beliefs in a just world (where good overcomes evil). Not to believe that good will prevail can lead to despair and hopelessness. Much of a missionary's life flows out of this belief, as well as the belief that one can make a difference. Being vulnerable and cut off from protection and support only increases the above concerns.

## **Consequences**

Trauma victims often fixate on trauma. Daily routines are built around safeguarding against the possibility of further traumatization or victimization. A victim often feels that no one, especially those who have not been missionaries, can understand what she or he has been through. Recently several missionaries coming home from an African country ravaged by civil war were able to tolerate being back in the States for about 10 days only, despite the fact that they were exhausted and highly traumatized. During that time their superiors in the States were understandably concerned and confused. Unbeknownst to the superiors, these men were suffering from a variety of post-traumatic reactions. Their struggles were exacerbated by the fact that their American confreres, living a rather middle-class and predictable existence, had little sense of or desire to know about the horror that these men had just witnessed. As a result, the only place that they felt that they could find understanding and put themselves back together emotionally was with the war victims that they had just left. Denial is a universal myopia.

Few people have the desire or ability to integrate feelings and experiences that do not fit into the meaning systems supported by culture and church.

Failure to find others who can understand, care, and both listen to and validate non-normative experiences only increases feelings of social isolation, depression, and debilitation. Despite continuing to work, life for many trauma victims who feel outside the parameters of various normative world views can become empty and meaningless. Numbness can increase to the point of not knowing what one feels or needs. Stress and isolation can become impossible to negotiate. Drugs as well as other stimulants provide only temporary relief. Dangerous or stressful work is also sought. Stress can keep one busy and distracted. Danger gets the adrenaline going and allows a depressed and numb nervous system to feel temporarily alive and normal. Many who suffer from PTSD feel normal only when living on "the edge" or in the midst of trauma. Trauma releases a variety of stimulants and pain-killing endorphins. Survivors of chronic trauma frequently live with under-aroused and depressed central nervous systems. They can become addicted to the physiological side effects of trauma (Van der Kolk 1986).

Tom, a missionary who witnessed several Central American atrocities, often felt bored. In reality he was numb and depressed. If he was not involved in or volunteering for some type of dangerous assignment then the doldrums would become overwhelming.

Trauma victims are very susceptible to treading where others would normally fear to tread. They are at home with trauma. They know how to act. Through years of conditioning, either as children and/or adults, they have learned how to deaden feelings, repress certain events, and skillfully distort reality. Apathy, functionalism, unfeeling efficiency, and naive optimism are dispositions commonly used to cope with environments of violence and trauma.

Some victims of trauma can find day-to-day stresses to be overwhelming. Unthreatening stimuli and events can trigger mild or severe panic reactions. Inappropriate or exaggerated reactions become automatic. A missionary couple recently had to leave their assignment in Peru and return to America because they were unable to sleep. Death threats had been made and one night someone shot through their residence with an automatic rifle. After that, any sharp sound heard outside in the evening had them diving under their beds. Excessive concerns for safety, coupled with inability to sleep and relax, forced them to leave their mission.

## **Implications**

Most personnel departments are not trained or set up to help those who suffer from mild or severe PTSD. As a result, usually only missionaries in extreme emotional or physical distress get professional attention. This care is usually farmed out to outside agencies and to therapeutic professionals who often know very little about post-traumatic disorders or missionary culture. Hence, the burden of care, for those who have not fallen apart, rests on the shoulders of the individual victim. The prevailing sentiment is that all will "work out" in time or from some type of renewal experience. This is the exact opposite of what is needed. Being isolated only exacerbates feelings of powerlessness, shame, inadequacy, and rage.

Failure to survive trauma, within a reasonable amount of time, is often felt to be a sign of moral and emotional weakness. Peer pressure amongst missionaries is a powerful force. Survivors opt for less noticeable ways to cope, such as "mood altering" or fleeing from frightening and painful symptoms. Addictions become part of many missionaries' secret lives. They are used to control, and they maintain internal chaos, generated by intrusive thoughts and feelings, along with realistic fears of having one's sense of self disintegrate.

Addictions serve several purposes. They provide predictable, consistent, private, and readily available ways to alter distressing and uncontrollable feelings and thoughts. The best addictions are those which are hard for others to discover, e.g., alcoholism, compulsive masturbation, as well as workaholicism, and codependency. Becoming over invested in the needs of others, in order to deny

feelings of powerlessness and impotence is another proven road to disaster. The codependent and the workaholic are doomed to a variety of future problems.

On the other hand, others withdraw from overseas duty. They become restless, apathetic, or directionless. Choosing future assignments becomes quite difficult. Medical complaints of undiagnosable origin can also prevail.

Unfortunately, many of those carrying the effects of trauma learn to muddle along. The tragedy is that there are so many "walking wounded" in missionary life. Many of those under 50 years of age, unlike their older peers, have worked without an unwavering sense of purpose and meaning. That is, many contemporary missionaries do not have a missiology that is grounded in unshakeable faith and a culturally supported world view.

Extensive interior damage (psychological and emotional) as a result of trauma is the norm for many missionary sending societies. Few are spared and therefore few feel that anything is seriously amiss. Repression and numbing become the standards of maturity rather than the symptoms of injury. Despite the best of intentions, the numb can only end up leading the numb. Lives of quiet desperation, marked by spiritual and emotional malaise, become the fate of those left untreated.

## **Treatment**

A healing environment must demonstrate that it is safe, supportive, understanding, and capable of restoring a sense of justice. It must provide assurance that vigilance is no longer necessary. A rupture in "the taken for granted" has occurred. Supporters must share in the victim's suffering and need to make sense of overwhelming trauma. The trauma must be taken up in a way that enables one to move forward in life with a greater sense of depth and knowledge. Awareness that becoming a victim again is a possibility also needs to be faced. Facets of the trauma which continue to be overlooked lead to deeper senses of alienation, despair, anger, and resignation. Support and reintegration into the community are essential components of trauma recovery (Herman 1992).

Sharing painful events and feelings with confreres, friends, or therapists (who bear witness to the tragedy) allows the victim to make sense of what happened and to realize that events could not have turned out differently (Herman 1992). Supportive others decrease the need to believe that no one is above suspicion and that constant vigilance is still required.

The absence of community support and understanding is often more traumatic than the original event(s). The absence of support confirms that one is alone, as well as possibly inferior or defective for not handling the events better. Feelings of being different, inadequate, and unable to handle tough situations force one to conclude that violence is a part of life and that he or she just has to get used to it. Reaching this state signals a type of emotional surrender or defeat. Empowerment, not patronization, needs to be the focus of healing. Reconnecting with others restores feelings of efficacy, control, and protective solidarity.

Tragically, for a variety of reasons, ranging from the missionary mystique to a lack of information, few missionaries receive any of the treatment considerations mentioned above. Survival, rather than loving and being loved, becomes the top priority of many untreated victims of chronic trauma.

The long-term survivor habituates or adapts to violence and insanity because he or she has no other choice. Since there is no emotional support or understanding of traumatic effects, many missionaries become increasingly deadened to all levels of their being. The effects of this compromise are insidious and gradual, like the effects of a stream incessantly polishing a submerged stone. Family, far removed from the danger, are often the only ones to notice the dramatic changes. It is as if one has become a depleted version of who he or she once was. Jim, a missionary priest in Latin America, had not seen his family in five years. During that time he worked in a refugee camp as the only missionary for 15,000 Indians who were on the verge of being exterminated. He, as well as most of the refugees, had witnessed numerous traumatic events. Upon seeing him, his family nearly went into shock. Thirty pounds underweight, working 16-hour days, and surviving on three or four hours of sleep, he looked like a

concentration camp victim. Because he looked not much different than most of the refugees, he had failed to notice the gradual deterioration of his total person.

When God-inspired ministry is felt to be ineffective against the powers of corruption and evil, a missionary's identity is in grave danger of collapse. Efficacious ministry is often the cornerstone of most missionary identities. If physically able, many will dig in, redouble their efforts, and try to "gut it out." For many to bail out and acknowledge trauma-induced limits is too great a shame. Termination of ministry can be equated with a confirmation of unbearable childhood and formation stigmas regarding inadequacy. Refusal to surrender these stigmas often becomes a life-and-death struggle. Dying with one's boots on can sometimes be the tragic result.

Intimacy is what victims of trauma most desperately need. Yet it is exactly what early abuse, formation, and mission life often prohibit. Healing cannot occur in isolation. One needs to feel affirmed, supported, and cared for by understanding others. Most importantly, group support is not enough by itself. A group facilitator must also be knowledgeable about the effects and various defense mechanisms (both cognitive and behavioral) that are used by a victim of trauma.

## **Recommendations**

1. A process needs to be set up for regular debriefing and renewal. Detailed interviewing to record mission stories and early formation histories should be the focus. This process should occur over a number of days. Psychological assessment and attention to PTSD symptomology should also be a part of the process.

This would allow the returnee to make a gradual transition back to community life, while slowing down, being cared for, taken seriously, being understood, and being allowed to mourn with supportive other(s).

This process should be made available to all, especially those who have recently been through a violent and traumatic period. It can also be used to help those ending assignments, beginning sabbaticals, as well as those in need of a discernment process due to a recent crisis.

2. A residential program should be designed to review early formation and mission experience. This would expand upon and deepen the biographical process described in number one above. It would provide considerable group work, educate and exercise the body, provide individual psychotherapy and spiritual direction, and utilize a variety of expressive modalities. The program should be experientially oriented. The intent is to get people out of their heads and back into their hearts and bodies. Sharing personal stories, in group and private settings, would make up the core of the program.

This program should be designed in full view of missionary life. A program designed without the awareness of the unique pressures and strains of missionary life would be a serious mistake.

3. Ongoing support groups need to be set up in the mission context. Continuity of care is essential, especially for those finishing up the residential program described above. Regional members must be able to draw regularly upon a base of support understanding, care, and information. Such a setting would also orient guide, and educate new members to the region. Without ongoing support crisis intervention rather than preventative care becomes the pattern, and many in the field risk becoming more and more emotionally numb.

4. Formation practices need to develop a greater sensitivity to premorbid histories of abuse. Preparing missionaries for the psychological rigors of missionary life, as well as alerting them to the causes, symptoms, and behaviors of Post Traumatic Stress Disorder, are crucial. Self-awareness and early detection are often the best safeguards against debilitation and breakdown. Preventive education is a must.

Additionally, many missionaries suffering from the effects of violence and trauma also carry a great deal of unresolved grief. Proper mourning for lost friends, co-workers, parishioners, and children, who were emotionally close to and loved by the missionaries, needs to occur. Chronic, low-grade depression, long-term somatic complaints, and emotional withdrawal are the symptom of unresolved grief. Education regarding the nature of and symptoms related to bereavement and mourning needs to become a part of formation training, as well as part of the training for those in personnel.

5. Last but not least, a mission spirituality needs to be developed that is able to provide meaning and direction for those constantly faced with violence, oppression, and stark expressions of evil and inhumanity. The martyr motive (Dries 1991), which formerly allowed men and women to deal with changes in culture, as well as violence, is no longer sufficient. Spiritualities grounded in martyrdom only encourage people to internalize trauma and its destructive effects instead of working through the trauma.

Missionaries live on a daily basis with strong existential and theological conflicts. These conflicts must be shared, discussed, and articulated so that a faith-based ministry can be developed, integrated into one's core belief system, and relied upon in times of great stress, hardship, and tragedy.

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