The Psychology of Prayer: A Theosomatic (Psycho-Spiritual) Approach to Missionary Care

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Introduction

It was just before 4 p.m. when I received news that the 23-year-old son of a missionary couple had died that morning. After consulting with my colleagues at the General Conference, I purchased a ticket to go and support the family and the mission community where this young man and his family were serving. My flight would leave the following morning at 8 a.m.

I had met the family when they attended Mission Institute at Andrews University a couple years ago. Both the husband and wife had just completed advanced degrees at Andrews and were looking forward to using their training in the cause of God to advance his kingdom. Their oldest son was not with them when they attended mission institute so I had not met him. Although I left as quickly as I possibly could, I still did not make it in time for his funeral.

Unfortunately, I have made these kinds of trips before and they are always difficult. Matthew, Mark, and Luke all quote Jesus as saying “Anyone who desires to come after me, let him deny himself and take up his cross and follow me” (Matt 16:24, Mark 8:34, Luke 9:23). Those who accept a call to foreign missions accept Jesus’ invitation to self-denial and sacrifice in a very real sense. As missionaries leave family, friends, and homeland behind in order to carry the gospel to the world, they willingly embrace the self-sacrifice inherent in the calling. Few, however, are prepared for the incredibly high level of sacrifice that some are asked to make.

A History of Missionary Care

In looking at the challenges that Seventh-day Adventists face in supporting the missionaries they send out, particularly during times of crisis, it is helpful to understand some of the history of the field that
is known today as missionary care or “member care.” Kelly O’Donnell provides a historical overview of how member care has become an “international and interdisciplinary field” designed to support and care for missionaries in both the April 2015 issue of the *International Bulletin of Missionary Research* as well as the first chapter of his 2011 book *Global Member Care Volume One: The Pearls and Perils of Good Practice*. The terms member care and missionary care were used interchangeably in the 1980s. However, member care began to be used more extensively in the 1990s as a “neutral term, which could be more readily used in settings where surveillance and security were an issue” (O’Donnell 2011:509).

O’Donnell points out that the need to support and care for missionaries began with a recognition of the need for training. Missionary sending agencies found that without preparation for cross-cultural service, otherwise well-trained missionaries were returning home prematurely. To address this need, Missionary Internship was established in Michigan in 1954. In 1992 it moved from Michigan to Colorado Springs and in 1996 it became Mission Training International (MTI). MTI trains thousands of evangelical missionaries today and offers a wide variety of services to missionary sending agencies.

Leaders within the Adventist Church recognized the need to train missionaries about this same time. In 1956 the Annual Council of the General Conference of Seventh-day Adventists voted to develop a “Missionary Orientation Program.” Although funds were put in reserve to develop such a program it was ten years before it actually became a reality. In 1965 the Department of World Mission was officially established as a part of the Seventh-day Adventist Theological Seminary located at Andrews University. In the summer of 1966, M. O. Manley and Gottfried Oosterwal led out in the first mission institute, which was held on the campus of Andrews University with 22 adults in attendance.

Evangelicals also took steps to provide Christian mental health care for their missionaries. Dan Blazer, psychiatrist and former dean of medical education at Duke University, says that the Christian psychiatry movement in the United States today grew out of evangelical Protestantism (Blazer 1998). Prior to the 1950s and 1960s most conservative Christians believed that all psychology was anti-biblical. Indeed, a majority of psychologists and psychiatrists were anti-biblical and saw both Christian beliefs and Christian practices as unhealthy. However, according to John Weaver, Clyde Narramore “almost single-handedly” founded the Christian psychology movement that exists today. Narramore was a licensed psychologist in southern California who began a radio talk show, which aired on more than 200 Christian radio stations for more than 40 years. The publication of his book *The Psychology of Counseling* became “one of
the most influential books in the history of Christian counseling” (Weaver 2015:210). In 1958, the Narramore Christian Foundation was established as the first international Christian counseling and training ministry to provide mental health care for missionaries, ministers, other Christian workers and Christian lay people.

In the mid-1950s evangelical Christian mental health professionals began to meet together to explore ways to integrate biblical principles into the fields of psychology and psychiatry. This led to the formation of the Christian Association for Psychological Studies (CAPS) in 1956. In 1964, Fuller Theological Seminary developed a doctoral program in clinical psychology. The following year Link Care Center was established to care for missionaries, pastors, and other Christian workers. In 1968 Wycliffe Bible Translators also established a counseling department to care for their missionaries. Clyde Narramore also founded the Rosemead School of Psychology in 1970. Rosemead began to publish the *Journal of Psychology and Theology* in 1973, which was the first journal of its kind with a primary focus on the integration of psychology and theology. In 1982, the Christian Association for Psychological Studies (CAPS) began publication of the *Journal of Psychology and Christianity*. A number of training programs and missionary care programs were also opened during the 1980s. Wheaton College, “the influential evangelical flagship school” opened a clinical psychology program during this time. Organizations like Barnabas International were also established in the 1980s. Barnabas is a missionary care agency whose primary focus is the emotional and spiritual care of missionaries.

According to O’Donnell, it was in the 1970s when mental health professionals began to gain influence within the evangelical mission community. Christian mental health professionals, many with mission experience themselves, made valuable contributions to the training and care of missionaries. However, “the blending of psychology and missions” was still in its early stages (O’Donnell 2011:544). Christian mental health professionals had to earn the trust of those in missions. In November 1980 a group of mental health professionals met together to collaborate on how to best serve the needs of missionaries. This meeting was the first in what was to become the annual Mental Health and Missions Conference, which is held in Angola, Indiana, every November. Collaborative relationships were developed between mental health professionals and mission administrators as they came together to discuss ideas and strategies on how to best care for missionaries.

The Institute of World Mission was also proactive in trying to integrate psychology into the training program of the Seventh-day Adventist Church, albeit in a somewhat limited fashion. From the beginning,
missionaries were all given a personality test and an opportunity to meet with a psychologist as a part of the institute program. Only recently have provisions been made to provide mental health care and support for missionaries while they are on the field, during times of crisis, and as they transition back to their homelands.

Interestingly, the 1980s were also a time when the historical rift that existed between the fields of psychology and religion was at its height. Albert Ellis, founder of Rational Emotive Behavioral Therapy and one of the most influential psychologists of the twentieth century, was overtly critical of religion. Ellis published an article in 1980 in the *Journal of Consulting and Clinical Psychology*, the leading journal of the American Psychological Association, in which he stated “devout, orthodox, or dogmatic religion (what we might call religiosity) is significantly correlated with emotional disturbance” (1980:637). Ellis believed that the less religious a person was the more emotionally healthy they would be. At this same time, the *Diagnostic and Statistical Manual* (DSM-III-R) published in 1980, which is used to diagnose mental illness, often used religious descriptions to illustrate serious psychopathology. Only 3 of the 125 medical schools in the United States at that time, even those operated by religious institutions, offered courses on the relationship between faith and health or incorporated spirituality into their curriculums. In fact, according to Harold Koenig, religious influences had been removed for the treatment of psychiatric patients, even in religiously affiliated institutions such as Duke University. One had to get explicit authorization to have a visit from a pastor or a hospital chaplain if a person was admitted to a psychiatric ward (Koenig 2005:26). Although surveys showed during the 1980s and early 1990s that 96% of the American people believed in God, between 57 and 74% of psychologists and up to 75% of psychiatrists at that time claimed that they did not (Koenig 2005:26).

Twenty-five years ago this summer, my husband and I were returning to our home in Rwanda with our three young sons when we rounded a corner and met an on-coming truck head-on. My next memory is awakening in a hospital bed in Brussels, Belgium, not knowing where I was or how I had gotten there. After being unconscious for four days, I learned that my husband had been killed instantly and had already been buried in Rwanda. I also learned that my three-year-old son was four floors above me in the pediatrics’ unit. His skull had been fractured, his leg was crushed and two toes were missing. My six-year-old and eight-year-old sons were still in Rwanda. They had been the only two family members at their father’s funeral.

I returned to the States in 1990 at a time when it was difficult to find a Christian mental health professional that was able to help me deal with
the emotional and the spiritual aspects of the trauma I had experienced. Although a majority of mental health professionals at that time did not believe in God, at least half of psychologists and a quarter of psychiatrists did. Many of these coped with the apparent conflict between psychology and religion by keeping the two separate. As Koenig noted, spiritual issues were simply not a part of the therapeutic process, even among Christian mental health professionals. As a missionary who had given my life to serving God, it was impossible for me to separate the emotional and the spiritual aspects of what I had experienced.

In developing a missionary care program for the Seventh-day Adventist Church, it is important to recognize the enormous contribution that Evangelical Christians made when they took steps to integrate biblical teachings and faith into the practice of psychology and psychiatry. They wrote books, published professional journals, developed clinical training programs, and established professional organizations. They used their skills to equip and train missionaries for more effective service and to care for them when they needed mental health care. Although research was being done in the secular world during this same period of time that would eventually change how the scientific world viewed religion, particularly how it viewed the role of prayer, these mental health professionals led the way and a great deal can be learned from their examples.

**Research on Prayer**

Research began in the second half of the 20th century that eventually changed how the medical and scientific world came to view prayer. There were a number of significant players whose research has been instrumental in bringing this about. Dr. Herbert Benson, a cardiologist and researcher from Harvard Medical School, studied the impact of stress on the body in the late 1960s and early 1970s. As a result of his research, Benson found that our bodies are imbued with what he termed “the relaxation response—an inducible, physiologic state of quietude” (2001:xvii). Benson identified the relaxation response as a function of the parasympathetic nervous system. It is designed to counter the stress response, which is a function of the sympathetic nervous system or the arousal system. Benson found multiple approaches that could be used to elicit the relaxation response. In fact, he found that every major religion in the world had a way of eliciting the relaxation response through prayer, meditation, or ritual. He published his findings in a book entitled *The Relaxation Response* in 1975. When teaching patients to elicit the relaxation response, Benson would offer them both secular and religious approaches. He found, to his surprise, that 80% of his patients would choose prayer (Benson 1996:152).
Jeff Levin almost stumbled onto prayer in his research. While still a graduate student in epidemiology in 1982, Levin came across research that showed that men who attended church regularly had lower blood pressure than those who did not. This was so contradictory to what was being taught in the medical world at that time that Levin sought to determine if there was indeed a relationship between religious practices and health. Over the next five years he identified more than 200 peer-reviewed articles that statistically linked religious involvement and health. Levin’s research showed conclusively, from an epidemiological perspective, that people who follow a religious path live longer and are healthier than people who do not (Levin 2001:vii). In 1987 he published a seminal paper entitled, “Is There a Religious Factor in Health?” which ultimately changed how the medical world viewed the impact of religion on health.

Larry Dossey, a physician of internal medicine from Dallas, Texas, developed an interest in Levin’s work and began to follow his findings. Dossey did his own research into the impact of prayer and in 1989 he published Recovering the Soul: A Scientific and Spiritual Search, and in 1993 he published Healing Words: The Power of Prayer and the Practice of Medicine. Dossey’s book had a profound impact on the practice of medicine and eventually on medical school education. Before his 1993 book was published, only 3 of the 120 medical schools in the United States had courses devoted to exploring the role of religion in health. As a result of Dossey’s work and that of others, today nearly 80 medical schools have such courses, many of which use Dossey’s books as textbooks. The impact has been tremendous. A survey done by the American Academy of Family Physicians has found that 99% of family physicians currently believe that religious beliefs can help the healing process (Holtz 1996).

Another significant player in the spirituality/health connection is Harold Koenig. In 1998 Koenig founded the Center for the Study of Religion/Spirituality and Health at Duke University, which is the world’s first major research facility to comprehensively study the impact of people’s religious life on their physical and emotional health. Dr. Koenig has published extensively in the field of mental health and religion. His research has been featured on dozens of national and international TV networks, radio programs, newspapers, and magazines. He has been invited to speak before the United States Senate and before the House of Representatives concerning the benefits of religion and spirituality on health (Koenig 2014).

The late David B. Larson, both a psychiatrist and epidemiologist and founder of the National Institute of Healthcare Research, devoted many years to reviewing the scientific evidence linking religion and health. According to Larson, when he “looked at the available empirical research
on the relationship between religion and health, the findings were overwhelmingly positive” (Levin 2001:9). In a journal response to Albert Ellis, Larson challenged Ellis as a scientist to put aside his own personal bias related to the negative impact of religion on health and to acknowledge the “abundant scientific evidence” to the contrary. In 2000 Ellis did just this. He wrote an article published in Professional Psychology: Research and Practice, in which he stated that although he had, “in the past, taken a negative attitude toward religion, and especially toward people who devoutly hold religious views, I now see that absolutistic views can sometimes lead to emotionally healthy behavior” (2000:31). In this article Ellis acknowledged the research that had led him to this new position.

In 2001 Jeff Levin published God, Faith, and Health in which he outlined seven principles of theosomatic medicine. These principles describe the impact of spirituality and religious practices on health. The first six of these seven principles describe how religion promotes health by reinforcing healthy lifestyle behaviors, nurturing supportive relationships, and promoting hope and optimism (Levin 2001:11). While the first six of Levin’s principles can be explained in scientific terms, the seventh principle reflects how prayer promotes health and healing in ways that cannot always be explained scientifically. For the seventh principle, Levin proposed that the impact of prayer on health can possibly be explained by “one more possibility—namely, that there is a God or divine presence that can choose to bless us in ways that may violate the apparent physical laws of the universe” (2001:183). Levin says that prayer is a natural part of most of people’s lives and has always been a part of religious worship. As mental health professionals look at missionary care, it is important to examine more closely the Christian concept of prayer.

What Is Prayer?

Dr. Russell Staples, former chair of the Department of World Mission at Andrews University, says that prayer is the means by which human beings are invited to commune with God and encounter him on a relational level. Ellen White says that “prayer is the opening of the heart to God as to a friend. Not that it is necessary in order to make known to God what we are, but in order to enable us to receive Him” (1908:93). Margaret Poloma says that “the single most important characteristic of effective prayer is the ability to commune with God. Prayer needs to go beyond ritual, opening the door to a relationship with the One for whom the human heart was made” (1991:xii).

Most people pray, and some people pray several times a day. The General Social Survey’s analysis of national data between 1972 and 2006 suggests that 97% of Americans pray, with more than half indicating that they
pray one or more times a day (General Social Survey:2008; Spilka 2013:3). Gallup reports have shown for more than five decades that nine out of ten Americans pray. A Pew Research survey conducted in 2013 found that eight out of ten Americans pray, and more than half (55%) indicate that they pray every day. PEW found that even among those who do not claim to be religiously affiliated, 21% said they pray daily. PEW also found that among atheists and agnostics, 6% said they pray daily. Another 11% of the atheists and agnostics indicate that they pray weekly or monthly. The General Social Survey (2008) found that “approximately 30% of those who state that they do not believe in God nonetheless admit to praying” (Spilka 2013:37).

So why do people pray? When an atheist prays, to whom are they praying? One atheist posted on-line, “I do pray every day. I have always prayed. I will always pray. The only difference is that I know no one is listening to my prayers and I’m fine with that” (Do Atheists Pray? n.d.). Christine Wicker (2013) posted in Psychology Today that perhaps the prayers of atheists are “cries for help from people who can’t help crying out even though they don’t think anyone hears. Trees falling in the forest. Or just screamers, who voice their pain because they must and give it meaning because that’s what humans do.”

Why do Christians pray? Wicker notes that people define prayer today differently from how it was once defined. This is likely true for believers and non-believers alike. “Prayer, like so much of American religious belief, has gone rogue. Now it can consist of all manner of things. Be directed toward all sorts of entities. Or none at all” (Wicker 2013).

Not only have physicians and epidemiologists taken an interest in studying prayer, so have social scientists. In the mid-1980s Margaret Poloma, a sociologist and professor at the University of Akron, undertook a preliminary study on prayer in the Akron, Ohio area. This study served as the basis for a more extensive national survey conducted by the Gallup Organization in cooperation with both the Society for the Scientific Study of Religion and the Religious Research Association. Considering that so many people pray, Poloma was interested in how and why they pray. The results of this research is reported in the book Varieties of Prayer, a Survey Report (1991). Poloma and Gallup found that Americans engage in four major categories of prayer: ritual prayer, conversational prayer, petitionary prayer, and meditative prayer. She reclassified these into two major types: meditative and verbal. Poloma and Gallup describe meditative prayer as less active than verbal prayer, “with the person relating to God in a passive, undemanding, open, and nonverbal way” (7). Although the word “meditative” raises red flags for some people, it is important to know how Poloma is using the word. In her survey she
used four statements to differentiate meditative prayer from other types of prayer. Meditative prayer involved (1) spending time quietly thinking about God, (2) spending time just “feeling” the presence of God, (3) spending time worshiping and adoring God, and (4) trying to listen to God speak (1991:26). Meditative prayer, as defined by these four statements, appeared to have the greatest benefits to the person praying. Poloma and Gallup found that individuals who employed meditative prayer were more likely to experience the presence of God during prayer than were those who employed more active verbal prayers (15, emphasis added).

In spite of the positive benefits of meditative prayer, Poloma found that meditative prayer is not the most common type of prayer among Americans. Ninety-five percent (95%) of Americans employ conversational prayer. They pray by talking with God about what is on their mind. Ritual prayer was the least popular type of prayer—particularly among evangelical Protestants. Only 19% of those who pray use ritual prayer and most of those who use it are older Catholics. She found that petitionary prayer was used by 42% of those who pray. She also found that petitionary prayer tends to be looked down on by the well-educated and those with a strongly scientific worldview. “It requires an image of a God who is willing and able to intervene in the daily affairs of humans” (32). Evangelical Christians use petitionary prayer more than other Christians do. Poloma found that those who employ “petitionary prayer tend to score higher on other forms of prayer and general religiosity than those who do not” (32).

Various surveys show that the frequency of prayer differs significantly by age, gender, race, education, and income. In general, older people pray more frequently than younger people, women pray more than men, non-whites pray more than whites, less educated people pray more than more educated people, and those with lower incomes pray more than those with greater incomes. A study using empirical data from the Baylor Religion Survey (2005) reported similar findings. Of the sociodemographic variables studied, they found income to be the most significant variable (Baker 2008:176). These researchers concluded that those who are more marginalized in American society pray more often. This supports Poloma’s conclusion that “need coupled with a viable faith seem to be strongly correlated” for those who employ petitionary prayer (Poloma and Gallup 1991:34).

An Ellis Research survey for Facts & Trends finds that the median amount of prayer time for pastors is 30 minutes per day. During that time, they found that a typical pastor spends 12 minutes with prayer requests, 8 in quiet time, 7 giving thanks, 7 more in praise, and 5 confessing sin. However, just 16% of pastors are very satisfied with their personal prayer lives, 47% are somewhat satisfied, 30% somewhat dissatisfied, and 7%
very dissatisfied (Ridgaway n.d.). It is interesting to note that this survey shows that pastors spend most of their time in prayer making prayer requests, what Poloma defines as petitionary prayer. This brings us to the question of whether or not God answers prayer and what is the impact of unanswered prayer on those who pray.

**Does God Answer Prayer?**

It was our custom to pray before traveling. Before my husband started our car in the early morning of July 27, 1990, we bowed our heads with our three young sons and asked for God’s presence and protection with us that day. One might classify this as a type of ritual prayer because we always did this. In that sense, it was a type of ritual. Yet this does not necessarily mean that it was not meaningful. We had a very real sense of our need of God and his protection of us as we traveled. We were well aware that travel in Africa could be dangerous. In fact, we had prayed about whether or not we should take this trip months before we went. When we stopped for our picnic lunch at noon that day we thanked God for the safe and pleasant trip we had had thus far and for his protection and presence with us.

Several months later I got into the driver’s seat of a car for the first time since the accident and invited my three little boys to pray with me before we started. The three of them bowed their heads then suddenly my middle son stopped me. “Mommy,” he asked. “why are we praying?” His question was sincere. “We prayed last time and God didn’t take care of us.” His little eyes were looking directly into mine. From his six-year old perspective, he was trying to determine whether or not it was reasonable to expect that God would keep us safe. He wanted to know the purpose of our prayer that day.

When the young, healthy 23-year-old son of missionary parents became sick, of course the parents prayed. Christian parents do not need scientific evidence to support their belief that prayer aids the healing process. The Bible says that the prayer of faith will heal the sick (Jas 5:15). Many missionaries have experienced the power of God in their own lives and are able to identify periods in their lives when they know God was there. It is not uncommon for missionaries to have experienced times when they believed that God had miraculously intervened to protect them and preserve their lives. In the world in which we live today, missionaries can invite family and friends from around the world to pray for them when they need it.

Not everyone who prays believes that God answers prayer, however. Some do not believe that the purpose of prayer is to get God to do things
for us. Yet the Bible encourages believers to ask for what they need. A
*Newsweek* poll entitled, “Is God Listening?” found that 87% of those who pray believe that God answers prayer at least some of the time. *Newsweek* found that 82% of those who pray are able to accept unanswered prayer without it challenging their faith while 13% reported that they had lost their faith at a time as a result of unanswered prayer (Woodward 1997). Although 99% of family physicians believe that religious beliefs can aid the healing process, they do not believe that prayer replaces medical care.

Tanya Luhrmann, a psychological anthropologist from Stanford University, studied the prayer practices of evangelical Christians in order to understand how they came to experience God as real in their lives. She has written a book entitled *When God Talks Back: Understanding the American Evangelical Relationship with God* (2012). The evangelical Christians that Luhrmann studied sought out and cultivated intimate and concrete experiences of God’s realness. They prayed for specific things so that when God answered their prayers it was clear that he had answered, thereby strengthening their relationship with him. Luhrmann pointed out, however, that “prayer failure is an inevitable consequence of the way these churches encourage people to pray” (268). Along with specific answers to prayer, there were inevitably many unanswered prayers. This forced people to get something more out of prayer than just the “goods.” When prayers were unanswered these Christians turned their focus from whatever was prayed for to their relationship with God. Luhrmann found that under these circumstances, “it is often when prayer requests fail that prayer practice becomes most satisfying” (268). She found this to be especially true when small, specific prayers were not answered.

In trying to understand the impact of unanswered prayer, Luhrmann notes that “God has always disappointed” (2012:267). She points out that the Bible is full of stories of God behaving in ways that his people do not understand. The life of Job is a classic example. She notes that God never gave Job an explanation of why things happened the way they did. “What humbles and satisfies Job is not new belief but felt experience: ‘My ears had heard of you but now mine eyes have seen you’” (285).

One of the first books I read after my husband was killed was entitled *Disappointment with God* by Philip Yancey. In the book, Yancey tackles the question of why God does not behave the way we think he should. There is simply no answer for this question. Luhrmann said that the religion of the Christians she studied was not so much about explaining reality or explaining God, but transforming their own suffering in such a way that their relationship with God was even more real. “They care about transforming their own suffering, not about explaining why suffering persists. Their faith is practical, not philosophical” (2012:299).
Missionary Care from 1990 to Present

The momentum for caring for missionaries continued to grow in the 1990s. Mission administrators came to see missionary care more and more “as a strategic and ethical necessity for mission” (O’Donnell 2015:91). The field was becoming more professional with opportunities for learning and growth for those who wanted to be involved in supporting and caring for missionaries. Books and resources were being developed to inform and define the field.

It was not until the mid-1990s or later, however, that the impact of research on the relationship between spirituality and health began to be felt in mainstream clinical practice. “Spiritually oriented psychotherapy” emerged as a specialty area within the field of psychology in the second half of the 1990s. This occurred as research investigating the impact of religion on health was reported in “every major medical, psychiatric, psychological, and behavioral medicine journal” (Sperry and Shafranske 2005:11). By the late 1990s, spiritual issues were seen as legitimate therapeutic considerations. Secular psychologists were being asked to deal with spiritual issues in psychotherapy more and more. In 1996 Mark R. McMinn, PhD, of Wheaton College, published *Psychology, Theology, and Spirituality in Christian Counseling* in which he discussed various levels of integration of psychology, theology and spirituality into the counseling process.

The training I received in the early 1990s did not provide me with skills to integrate spiritual concepts into the psychotherapeutic process. Cathy Morgan, the wife of the director and founder of AFM, had taken an active role in learning as much as possible from the evangelical mission community related to the preparation and care of missionaries. At Cathy’s invitation, I attended the 14th Mental Health and Missions Conference in Angola, Indiana, in the fall of 1994 and have attended annually since then. I had the opportunity to learn from leaders in the field of missionary care like Dr. Esther Schubert, Dr. John Powell, and Dr. Rick Ascano, all of whom have served as mentors. At the same time I continued to work toward completion of a PhD in counseling psychology at Andrews University, which I completed in 1997.

At the beginning of the 21st century there was a change in missionary demographics. More and more missionaries were being sent from places other than North America, Europe, or Australia (Ng 2012:45). As a result missionary care became more international. According to O’Donnell, member care became “increasingly globalized into a multidisciplinary, culturally contextualized field” (2015:91). The Institute of World Mission and the General Conference recognized the need to provide training for
the many missionaries who were coming from places other than North America, Europe, or Australia. According to Pat Gustin, director of the Institute of World Mission between 1996 and 2005, “by the mid-1990s it became clear that missionary training needed to be expanded to include missionaries from all parts of the world. It was with this in mind that in 1998 the church’s Annual Council voted to offer missionary training for the world field. The first “world institute” was held in Nairobi, Kenya, in April 1999. Matthew Bediako, who is Ghanian, was the Secretary of the General Conference at that time. He understood clearly the need to both train and care for an international missionary work force. Elder Bediako also recognized the need to provide mental health care for these missionaries. His stated goal during his term as Secretary of the General Conference was to have a psychologist on staff in the secretariat of the General Conference.

In December 2003, the DePaiva family was murdered on the island of Palau. The DePaivas were from Brazil and were serving as missionaries in Palau. Pat Gustin was the director of the Institute of World Mission at that time. In many respects, this incident was a catalyst for bringing mental health care into the mission program of the church. Based on Gustin’s recommendation, I was asked by the Institute of World Mission and the General Conference to go to Palau to help address the emotional needs of the community as well as the needs of the DePaiva family, particularly the needs of ten-year-old Melissa. Melissa was the only survivor of this tragic event, barely escaping with her own life. Because of my desire to integrate spiritual concepts into the psychotherapeutic process, I had enrolled in a doctor of ministry program in Formational Counseling at Ashland Theological Seminary just a few months prior to this. After my trip to Palau, I attended workshops to gain specific skills in the treatment of trauma. I attended workshops led by the nation’s leading traumatologists and pursued board certification in the field of traumatology. I integrated the evidence-based research in traumatology into what I was learning about prayer. With the support of the administration of AFM I was able to test the effectiveness of the approach I was developing with AFM missionaries. I did this in the context of spiritual retreats for AFM missionaries held in various places in Asia, Eastern Europe, and Africa. In November 2005 I presented the work I was doing with missionaries at the Mental Health and Missions Conference in Angola, Indiana. The topic of my dissertation was “An Examination of Formational Prayer as a Theosomatic Approach to the Treatment of Trauma in Missionaries.” I borrowed the term “theosomatic” from Jeff Levin who coined the term. I completed the Doctor of Ministry degree in 2007 and have continued to be a regular presenter at the Mental Health and Missions Conference.
The current decade has seen the global impact of member care in missions continue. Dr. G. T. Ng, from Singapore, is the current Secretary of the General Conference. Dr. Ng shares Elder Bediako’s desire to provide training and support for all interdivision missionaries. Dr. Ng also has a desire to include mental health care as a part of the mission program of the church. Cheryl Doss, the current director of the Institute of World Mission, has taken a leading role in providing training and care on a global scale. The Institute currently does three mission institutes each year, two outside the United States and one at Andrews University. In 2011, based on Cheryl’s initiative and invitation, I began attending every mission institute rather than just the ones held at Andrews.

The first Global Member Care Conference sponsored by the World Evangelical Alliance (WEA) was held in Chiang Mai, Thailand, in April 2012. This first conference hosted 350 attendees from numerous countries and organizations. Ray Wahlen, Associate Treasurer of the General Conference and Co-Director of International Processing and Recruiting Services (IPRS), and I both attended. The second Global Member Care Conference was held in Antalya, Turkey, in February 2015. Ray Wahlen and I also attended that conference along with five other people from the General Conference, seven people from Middle East North Africa Union (MENA), as well as the Human Resource Director for Adventist Frontier Missions. More than 360 people were in attendance at that conference. Homer Trecartin, president of MENA, and I had the privilege of presenting at this conference. I have been working with Pastor Trecartin since 2012 doing a missionary care pilot project in MENA. Our presentation reflected this project. Pastor Trecartin presented the needs of the missionaries serving in Middle East and I presented the psycho-spiritual approach to missionary care and conflict resolution that I used with a group of missionaries serving in the Middle East in October 2014.

Missionaries, Prayer, and the Experience of God

I am not aware of specific studies done on the prayer experience of missionaries, however, a 2009 Gallup poll conducted in 114 different countries might give us a bit of insight into the prayer experience of missionaries. Gallup researched the per-capita income levels for each country and then explored the question of how important religion was in the life of those surveyed and made the correlations between the two. They found that that “the higher the per-capita income of a nation, the lower the role of religion in daily life, and vice versa” (Archer 2015:29). The one exception in this survey was the United States. Despite the affluence of the United States, a majority of Americans still report that religion is important or very important in their daily lives. As was reported earlier, however, even
in the United States income was found to be the most significant variable in the frequency of prayer (Baker 2008:177S).

In June 2008 the American Psychological Association commissioned a nationwide survey to examine the state of stress in the United States. This survey found that Americans were feeling increasing levels of stress with money and the economy at the top of the list for 8 out of 10 Americans. While Americans use a variety of coping mechanisms to deal with stress, some healthy and some not so healthy, 77% of those who used prayer as a coping mechanism considered it to be most effective in helping them manage their stress. Other studies support the view that people pray as a means of helping them cope with the stress of life and that it is more effective than other ways of coping with stress (Spilka 2013:18). The fact that missionaries typically live in situations that are considered stressful, positions them to turn to God and prayer as a means of coping.

Missionaries are often in situations where the demands placed on them are greater than the resources available to meet the needs. Most missionaries report this as having a positive impact on their relationship with God. Mission stories often include an answer to prayer, a miracle, or some sort of divine intervention. These stories and experiences nurture our souls and give us a sense that God is real and active in our world and in our lives. Many choose mission service because they want to experience the presence of Jesus in their own lives in a way that is often difficult in a more affluent context.

Christians have often allowed hardships and trials to draw them into greater intimacy with God. Recently I worked with a young couple that served as relief workers in a post-war country immediately after they married. By the time I met with them they had served in a number of countries that were considered hardship posts. Although they were serving in an impoverished, but peaceful, West African country at the time I met them, the husband wanted to return to an area where there was both greater need and greater danger. His reason was that the experience of God’s presence was so much more real in the extreme circumstances in which they had spent most of their married lives. In working with missionaries, I have found that many experience the intimate presence of Jesus as a result of the challenging experiences they face.

Scott Shaum of Barnabas International provides pastoral care to missionaries who serve in difficult places around the world. Scott and I are both contributors to the book Trauma and Resilience, which is edited by Drs. Frauke and Charlie Schaffer. Scott shares the belief that suffering is a pathway to greater intimacy with God. He goes so far as to say that God permits and may even orchestrate various afflictions to bring us into greater intimacy with him (2012).
Daniel Goleman is the author of the two best-selling books, *Emotional Intelligence* (1995) and *Social Intelligence* (2006), as well as the author of two books on the practice of meditation, *The Varieties of Meditative Experiences* (1977) and *The Meditative Mind* (1988). Goleman reports that sacrifice, suffering, and privation are all believed to be avenues to opening one to the experience of God’s presence. In fact, according to Goleman, this is one reason self-flagellation was practiced by some Christians during the middle ages. He notes that “Saint Augustine advocated a process of self-denial and the practice of virtue as preparation for an encounter or experience of God” (1988:57).

While numerous theologians throughout history have shared the perspective that suffering draws people into intimacy with God, psychologists of religion tell that for many people one of the goals of prayer is “to enter into a state where one ‘encounters’ God” (Spilka and Ladd 2013:13). In their book, *The Psychology of Prayer*, Bernard Spilka and Kevin L. Ladd indicate “that prayer is a major component of God’s felt presence” (14). In his book, *Into the Depths of God*, Calvin Miller talks about the privilege people have of entering into the presence of the King of the Universe through prayer. He says that it is important that we remember who we are and who God is. “God is to be met and listened to, not sat down and talked to” (Miller 2000:53). The *New Living Translation* of Hebrews 4:16 says that we are to “come boldly to the throne of our gracious God. There we will receive his mercy, and we will find grace to help us when we need it most.” Missionaries, like other Christians, want to learn to know and experience the presence of God in both good and bad times.

**A Psycho-Spiritual Approach to Missionary Care**

In developing a program to effectively support Seventh-day Adventist missionaries, the church has done well in the area of training. The area that Seventh-day Adventists appear to be behind other mission organizations is in the area of on-the-field spiritual and emotional support. Because of the way that the church is organized most missionaries have good logistical and practical support before going to the field, while on the field, and when they return to their homeland. Times of crisis have highlighted the need for more focused on-the-field emotional and spiritual support. In order to learn from what others were doing in the field of missionary care or member care the Institute of World Mission staff began attending the Mental Health and Missions Conference in Angola, Indiana, in November 1997, where they have had the opportunity of networking with mission educators, administrators, and mental health providers who work with missionaries.
In order to effectively address the spiritual and emotional needs of missionaries, particularly during times of crisis, it is helpful to examine the approaches that have been developed and used by others. John Weaver provides a history of three basic approaches that emerged over the past 50 to 60 years within evangelical Christianity: the Biblical Counseling Movement, the Inner Healing Movement, and the Integrationist Movement.

The Biblical Counseling Movement was founded by Jay Adams. Adams saw secular psychology and psychiatry as inherently anti-biblical. He also questioned the very concept of mental illness along with the medical model of psychiatry. Adams believed that the mind is a distinct entity apart from the brain. He therefore reasoned that the mind could not be sick, only sinful. He believed that those who were labeled as mentally ill were, in actuality, people adapting poorly or inappropriately to the challenges of life. According to Adams, “the behaviors of the mentally ill were character flaws or moral shortcomings” (Weaver 2015:loc 2187). Unfortunately, this view has been rather widespread among many conservative Christians. Because of this view there has been a great deal of shame associated with mental health problems. Individuals are often hesitant to admit they are having problems or to seek help when they do. Adams saw the Bible as completely sufficient in regards to how to live in our modern world. He did not believe that science contributed to our understanding of human nature or personality. Adams chose the term Nouthetic to identify the counseling methodology he developed. According to Adams, Nouthetic Counseling is derived solely from the teachings of Scripture without the influence of secular psychology. Adams proposed a form of counseling known as nouthetic confrontation, whereby the counselor’s goal was to confront sin in order to bring the behavior of the counselee in line with biblical principles. “Personal responsibility became a crucial, perhaps the crucial, issue defining the biblical counseling movement” (loc 2198). A number of Fundamentalists universities offer biblical counseling programs rather than counseling psychology programs.

The Biblical Counseling Movement came out of the post-enlightenment philosophy of Dutch and German Calvinist theology. It has a very strong focus on biblical truth. The Inner Healing Movement, on the other hand, came out of Pentecostal and Charismatic Christianity which adopts a pre-enlightenment worldview more similar to that of the Bible (loc 679). Pentecostal and Charismatic Christianity embrace the reality of the spiritual world and operate with the assumption that a real conflict exists between God and Satan, much like what is reflected in the New Testament. Satan is seen as the arch enemy of God along with a host of demonic beings intent on evil. The Holy Spirit enables the Christian to combat the forces of evil in the name of Jesus and through the power of God. Pentecostals
and Charismatics believe that Christians have a responsibility to carry on the work of Jesus through the power of the Holy Spirit. As a result, deliverance from evil spirits as well as physical and emotional healing play a significant role in Pentecostal and Charismatic Christianity.

Agnes Sanford is considered the founder of the inner healing movement. Sanford was very much influenced by the work of Carl Jung and incorporated many of Jung’s ideas into her work. Among those who learned from her were John and Paula Sandford, Francis MacNutt, Leanne Payne, and Charles Kraft, all considered “old stalwarts of inner healing” (Weaver 2015:loc 1557). The various forms of inner healing prayer that have emerged over the past 50 to 60 years are a product of the charismatic renewal movement of the 1960s and 1970s.

In the early 1990s Terry Wardle developed an inner healing model which he calls Formational Prayer. He defined Formational Prayer as a “ministry of the Holy Spirit, moving through a Christian caregiver, bringing the healing presence of Jesus Christ into the place of pain and brokenness within a wounded person” (2001:13). Formational Prayer, along with various inner healing approaches, all employ principles of psychology but serve as a means of inviting the Holy Spirit into the psychotherapeutic process.

Like the majority of mental health professionals who do missionary care, I take an integrationist approach. This is the position of the Seventh-day Adventist Church as it relates to healthcare in general and as is outlined in the Health Ministries Departmental Policies. Dr. Peter Landless, director of Health Ministries of the General Conference, states that the Seventh day Adventist Church promotes a philosophy of holistic health and healing. Landless points out that “the Adventist Health Message is founded on the Bible, informed by revelation through the inspired writings of Ellen G. White, and consonant with evidence-based, peer-reviewed science” (personal communication, February 23, 2015). This is the position of integrationism. Integrationism “seeks to combine the best of psychological and Christian approaches without sacrificing the truth in either area (see Collins “Moving Through the Jungle,” 34)” (Weaver 2015:loc 4141). As was outlined in the section dealing with the history of missionary care, attempts to integrate psychology and religion began in the early to mid 1950s as groups of psychologists explored the relationship between the two and sought to provide effective mental health care for missionaries, ministers, other church workers, and lay people.

The most comprehensive overview of the integrationist perspective or Christian psychology’s relationship with secular psychology was done by Stanton Jones and Richard Butman in their 1991 book Modern Psychotherapies. According to Jones and Butman, the Bible is “an essential foundation
for a Christian approach to psychotherapy” but is not “an all sufficient
guide for the discipline of counseling” (1991:27). Integrationists believe
that “discrepancies between the fields of Christian theology and psychol-
ogy . . . were caused either by an inadequate understanding of psychology
or a hermeneutical misunderstanding of scripture” (28). The integration-
ists approach is quite different from the Biblical Counseling approach in
this regard and much more in line with the Health Ministries Department
of the General Conference.

Implementing Research on Prayer into Missionary Care

In working with a missionary in crisis, I attempt to integrate the teach-
ings of Scripture and the writings of Ellen White with the latest research
on crisis intervention and the treatment of trauma. Bessell van der Kolk,
PhD is considered by many to be the nation’s leading trauma expert. Van
der Kolk says that traumatized people often feel alienated and disconnect-
ed from the world around them. Many even feel abandoned by God. They
often fail to maintain a “personal sense of significance, competence, and
inner worth” (1996:197). While hardships and suffering can draw people
into greater intimacy with God, traumatized individuals often need help
in maintaining a sense of connection to God. Severe trauma or devastat-
ing loss can sometimes lead even committed Christians to conclude that
either God is not there or, if he is, that he does not care. Unless a person
has experienced a severe trauma, it may be difficult to understand how
the circumstances of life can sometimes block one’s view of God. Jesus
himself felt abandoned by the Father as he was crucified and cried out
“My God, My God, why have you forsaken Me?” (Matt 27:46). Robert
Sapolsky, professor of neurology at Stanford University says that while
personality plays a huge role, the single best predictor of ability to deal
well with stress is how socially connected one is (Nicholson 2010:). The
goal in working with an individual who has undergone a severe trauma is
to help maintain or restore their connection with their family, their social
support system, and with God. Attachment or connection is a right brain
function and needs to be brought about through activities that involve the
right brain. Being physically present is far more effective in communicat-
ing caring than is verbal communication. Language is a left brain func-
tion. The presence of someone who represents the world church can be
powerful to a missionary who has been traumatized and may be expe-
riencing feelings of abandonment or betrayal by God. Prayers for such
people should be ones that bring the individual before the throne of grace
so they are able to experience the tender presence of Jesus in the present
moment. According to Jeff Levin, a theosomatic approach to healing ac-
knowledges the spiritual determinants of health based on a belief in the
power and willingness of God through the ministry of His Spirit to bring healing (Levin 2001:15). Herbert Benson wrote, “I am astonished that my scientific studies have so conclusively shown that our bodies are wired to believe, that our bodies are nourished and healed by prayer and other exercises of belief (1996:305). According to Finney and Malony, the types of prayer that facilitates this kind of experience employ “techniques of meditation as a means of relating to God in a non-demanding and non-defensive way” (1985:284). In the Psalms God invites people to “Be still, and know that I am God” (46:10). In the Desire of Ages Ellen White says,

It would be well to spend a thoughtful hour each day reviewing the life of Christ from the manger to Calvary. We should take it point by point and let the imagination vividly grasp each scene, especially the closing ones of His earthly life. By thus contemplating His teachings and sufferings and the infinite sacrifice made by Him for the redemption of the race, we may strengthen our faith, quicken our love, and become more deeply imbued with the spirit which sustained our Savior. (2001:83)

She also says on page 112 of Testimonies for the Church (vol. 5) that “those who will put on the whole armor of God and devote some time every day to meditation and prayer and to the study of the Scriptures will be connected with heaven” (emphasis added).

Van der Kolk suggests that finding meaning is central to healing (1996:19). As those who experience severe trauma contemplate on the final scenes of the life of Jesus, they are gradually able to begin to view their own experience in light of Christ’s suffering. Tanya Luhrmann found that the Christians she studied were not so concerned about explaining their suffering or explaining God. They were concerned with transforming their suffering in such a way that their relationship with God was even more real. “Their faith is practical, not philosophical” (2012:299). Luhrmann also points out that the evangelical process of developing the heart shares a good deal with psychotherapy (101). In fact, she says that much of the faith practices of the evangelical Christians she studied resemble psychotherapy.

As indicated toward the beginning of this article, my desire to address both the spiritual and emotional needs of missionaries led me to begin a doctor of ministry program in Formational Counseling in 2003. The topic of my dissertation was “Formational Prayer as a Theosomatic Approach to the Treatment of Trauma in Missionaries.” Formational Prayer served as the basis of my work with AFM missionaries serving in various countries as well as in the United States in 2004 and 2005. This work took the form of crisis intervention, conflict resolution, individual counseling,
team-building seminars, and spiritual retreats. As a part of evaluating the theoretical basis of Formational Prayer as a theosomatic model of care, I made a presentation at the 2005 Mental Health and Missions Conference in Angola, Indiana, in which I sought the opinion of other Christian mental health professionals who worked with missionaries. I measured the clinical effectiveness of the model qualitatively by the personal testimonies of the missionaries I used it with in addition to their responses to a questionnaire. In order to evaluate the biblical and theological basis of the model I invited the following people to conduct a critical evaluation of my study: Clyde Morgan, CEO and founder of Adventist Frontier Missions, Tim Holbrook, AFM field supervisor, Russell Staples, Roy and Connie Gane, Gordon and Cheryl Doss, and Jane Thayer, all of the Seventh-day Adventist Theological Seminary at Andrews. In addition, I obtained critical feedback from John Powell, co-founder of the Mental Health and Missions Conference and Mike Porter, president of the Middle East Union 2002-2006 and CEO of the Quiet Hour 2006-2012. In addition, Jerry Thayer and Bruce Bauer from Andrews University served on my dissertation committee at Ashland.

This type of careful evaluation of any new prayer approach is important. Spilka and Ladd point out that “it is difficult, if not impossible, to name any behavior in which humans engage that—when taken to an extreme or under some specific set of circumstances—does not also have the potential for negative as well as positive outcomes. Prayer is certainly no exception, and investigations that explore the full range of possibilities are crucial” (2013:21). The various inner healing models that have been developed are all a blend of Christian theology and secular psychology. In the foreword to Terry Wardle’s book Healing Care Healing Prayer, Charles Kraft says that “although we must admit that some have ‘gone off the tracks’ in their practice of inner healing, it is possible to work in this area in a balanced way, listening to both Scriptures and to the Holy Spirit while employing the insights God has led professional psychologists to discover” (Wardle 2001:10). The results of my study indicate that Formational Prayer is a biblically, theologically, and clinically sound theosomatic model of care that can be used within a Seventh-day Adventist context. Having established the clinical as well as the biblical basis of Formational Prayer it meets the criteria of an integrationist approach. It “combines the best of psychological and Christian approaches without sacrificing the truth in either area” (Weaver 2015:loc 4141).

Conclusion

Thirty hours after leaving South Bend, I arrived on the campus where the 23-year-old son of a missionary couple had died of an unexplainable
illness. I arrived in the evening so I was able to get some rest before I met with the parents the following morning. Their grief was intense. Although they had the funeral the evening before, they were still in a state of shock and struggling to cope with the reality of what had happened. Fellow missionaries rallied to support them. Still, no one anticipated that the young man would die. He was young and healthy and actively involved in ministry. Every one that I talked to told me about his smile. People described him as friendly and caring toward everyone. He had learned the local language quicker than any of the other missionaries and was actively involved in ministry. He and a small team of volunteers had gone to another island to help establish a health clinic and to minister to the local people. Both of his parents were seminary professors. Naturally when he got sick he returned to their home. At first it seemed like he had the flu. They tried to care for him as best they could but his condition deteriorated quickly. He was admitted to the hospital. The doctors were not able to identify the cause of his illness. Of course the parents prayed. The whole campus prayed. Family and friends from around the world prayed. It all happened so quickly and he was gone.

Often in the face of horrendous and sudden loss, it is difficult to remain rational. We believe in a God who is capable of healing the sick and raising the dead. We believe in a God of miracles. Nothing makes sense and we begin to bargain. God could still raise the dead. There are many unanswered questions. Just this week I met a young missionary who said that she first heard my story when she was a little girl living in a small village in the interior of what was then the country of Zaire. Her uncle was a student at the school where my husband and I were serving in Rwanda. After our accident her uncle sent a message back to his village asking the church to pray and fast for my youngest son and myself because it was not certain that we would survive. She said she prayed but she also wondered what kind of God would let something like this happen to a missionary who was serving Him. Tears streamed down her cheeks as she told me how glad she was to see the woman she had prayed for so many years ago and to see how God had provided for me in spite of what happened. In many respects missionaries, in fact all those who bear the name of Jesus, are like biblical characters. Onlookers determine what they can expect from God by how they see God working in the lives of his servants. The whole campus was grieving the loss of this young man, and what his death symbolized. They felt vulnerable. The cause of death was still unknown. What could they expect from God if their children got sick?

In addition to meeting with the parents, I spent my time meeting with faculty and students and helping them process what had happened. Often, in fact usually, there are no answers. Healing comes only as we
recognize that pain and suffering are doorways used by God to enter our lives and to draw us to Himself. While we serve a God of miracles we also serve a crucified and risen Savior who told us that in this world we would have tribulation (John 16:33). Meaning is found as we allow our suffering to be transformed in light of the suffering of Jesus and the cross He bore. In providing care to a grieving and suffering individual not only should the insights from research be used but the care should be, as Terry Wardle described, “a ministry of the Holy Spirit, moving through a Christian caregiver, bringing the healing presence of Jesus Christ into the place of pain and brokenness” (2001:13). In time, we will be able to “consider it pure joy whenever we face trials of many kinds, because we know that the testing of our faith develops perseverance. Perseverance must finish its work so that we may be mature and complete, not lacking anything” (paraphrase of Jas 1:2).

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