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A Preliminary Assessment of Mental Health Needs Faced in Religious Leaders in Eastern Europe

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Enormous sociopolitical changes in Eastern Europe in the last decade have had a profound impact on the psychological functioning of the citizens of these nations. In order to assess and intervene in the mental health realm in Eastern Europe, a brief survey was sent to various Christian leaders in Eastern Europe. Common mental health problems identified across the various Eastern European countries and cultures include depression, relationship difficulties, alcohol abuse, and anxiety disorders. Christians in Eastern Europe tend to turn to family and friends for help with these problems first, pastors second, and almost never to mental health professionals. Clergy and laypersons have little training in mental health issues. A promising direction for future service is training those who can, in turn, train Eastern European laypersons in basic listening and support skills. Cultural awareness and sensitivity will be of paramount importance in such an endeavor.

The parts of central and eastern Europe that were formerly under communist control have seen enormous and tumultuous change since the fall of the Iron Curtain in 1989 (Breemer ter Stege, 1991-92; Neumann, 1991). The economic and political transitions of the past 10 years have created substantial stress. In the words of Jochen Neumann:

> Values that were binding and predictable in the past are gone without the establishment of new equivalents. In most countries, there is a lack of objects of identification. Fear of poverty and unemployment weigh heavily on many people. The "biologically" stronger often dominate the weaker, and unscrupulous profiteers abuse this time of transition for their own benefit. Learning democracy is almost as painful as living under dictatorship. Anarchic moments cannot be ignored. The old apparatus has been deprived of its power, and the new social forces still lack experience. (p. 1387)

The nations and peoples of Eastern Europe are not just a lump sum of communist satellites, but are a collection of independent cultures, with at least as much diversity among them as between them and Western countries. Breemer ter Stege asserts, "The only characteristics now shared by the former Soviet satellites are their economic malaise and undetermined political future: dissolution of the one-party system, secession movements, and civil strife" (p. 3). Despite the diversity among the cultures of Eastern Europe, however, there may be common mental health challenges as a result of their shared communist heritage, long-standing ethnic conflicts, and recent political and economic changes.

Just as clergy and religious communities are seen as mental health resources in the United States (McMinn, Chaddock, Edwards, Lim, & Campbell, 1998), so they also have provided informal mental health services for many citizens in the various cultures and countries of Eastern Europe. Seeking help from clergy provides a viable option for receiving mental health services from a trusted, respected individual while also drawing upon the community-based support that is seen in small parishes throughout the world. Indeed, the church has historically been a key provider of mental health care in Eastern Europe (Breemer ter Stege, 1991-92). As disagreement and dissension grow within the ranks of new leadership groups in Eastern Europe, it is the churches that maintain a steady and stabilizing influence over society (Neumann, 1991). Moreover, because psychiatric services were sometimes a mechanism

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for suppressing political dissent in days of communism, many citizens of Eastern European countries are reticent to seek help from professionally trained psychologists. These factors make churches an ideal place to provide care for the emotional needs of Eastern European communities.

Unfortunately, pastors and laypersons in Eastern Europe are rarely trained in counseling, psychopathology, and other topics pertaining to mental health care. Christian mental health professionals are rare. Thus, the needs for training clergy and laypersons is great, but this training must be done in a way that is culturally-informed and sensitive to the particular needs facing the Church in various Eastern European countries.

In the December 1998 issue of *American Psychologist,* Marsella proposed a "global-community psychology" to meet the needs of our quickly changing world. Marsella defines global-community psychology as a:

> Superordinate or meta-psychology concerned with understanding, assessing, and addressing the individual and collective psychological consequences of global events and forces by encouraging and using multicultural, multidisciplinary, multisectoral, and multinational knowledge, methods, and interventions. (p. 1284)

Although the present study does not reach the level of being called a pure expression of global-community psychology, the principles outlined by Marsella served as a foundation for the process of understanding, assessing, and addressing the mental health needs faced by pastors in Eastern Europe today, and thus can be seen throughout the comments that follow.

Mental Health Care in Eastern Europe

Mental health care in Eastern Europe has progressed since the days of communist rule. During communist rule, Soviet government officials would sometimes hospitalize mentally healthy persons on political grounds (Breemer ter Stege, 1991-92; Neumann, 1991), and the dictator of Romania would not recognize the existence of suicides or persons struggling with addictions or schizophrenia (Breemer ter Stege). Since the fall of communism, there has been a growing emphasis on outpatient care as a viable alternative to prolonged hospitalization and an increased development of psychiatric care as part of the general-hospital system. Despite these advances, standards of care remain poor in many places and funds are severely limited. There is great variation from one nation to another in terms of quality and quantity of mental health care, and even within nations from one area to another, with the more rural areas suffering the greatest deprivation (Breemer ter Stege). Despite the improvements in psychological services in Eastern Europe, there are still many people who, for a variety of reasons, do not access these resources, and there is a strong need to further improve and develop the mental health resources in Eastern Europe.

In terms of psychotherapeutic techniques utilized in Eastern Europe, Demjen (1988) reported the use of a variety of strategies, including cognitive-behavioral techniques, short-term analytic psychotherapy, and "superficial psychotherapy." Demjen also emphasized secondary preventive care consisting of early discovery of emotional disorders and their precursors among first-year college students.

In discussing the training of psychiatrists in Eastern Europe, Neumann (1991) noted the lack of information on current mental health treatment techniques and theories. He stated in 1991 that due to import restrictions, only the elite institutions received specialty journals from abroad. From our discussions with people who live and work in Eastern Europe, it would seem that this is still largely the case.

Christian psychology has seen opportunities and growth in the new Russia. Now "a large segment of the psychological community in Russia welcomes Christian psychology and psychotherapy as a legitimate approach to the discipline" (Bowen, 1998, p. 11). The Moscow Christian School of Psychology (MCSP) is a graduate program that offers a three-year curriculum focusing on the treatment of children, adolescents, and families. Students at MCSP study both theoretical and practical aspects of the discipline and receive practicum training and supervision from more experienced psychologists from Russia and the United States. In Odessa, Ukraine, scholars Boris Khersonski and Sergei Sannikov have founded the College of Christian Psychology Sotsium in partnership with Mennonites from Canada. Approximately 60 students had graduated from this program as of Spring, 1998 (Bowen). Although the movement toward increased and more effective mental health resources in Eastern Europe is hopeful and commendable, much work remains to be done.

Psychological Functioning and Psychopathology in Eastern Europe

The literature is sparse concerning levels of psychological functioning and psychopathology in Eastern Europe. There is, presumably, a significant level of psychopathology and psychological dysfunction throughout Eastern Europe, and this appears to be the consensus of various religious leaders from Eastern Europe in informal communication, but there is not much written about it. An examination of psychiatric morbidity in a student mental health center in Novi Sad, Yugoslavia, revealed that 74.6% of cases seen in the center could be classified as "unstructured neurotic disorders," 7.5% were sexual disorders, 5.6% were neurological cases, 2.2% were psychoses, 0.4% were personality disorders, and 1.5% were classified as "other disorders" (Demjen, 1988).

Internalizing disorders appear to be more prominent than externalizing disorders in most parts of postcommunist Eastern Europe. Psychologists familiar with the situation in such places as Russia maintain that virtually everyone in the former Soviet Union shows signs of abuse. Some report that entire nations might be correctly diagnosed as clinically depressed. Postcommunist people today evidence a sense of powerlessness, economic, political, and marital insecurity, and a loss of identity (Elliot, 1997).

In Hungary, years of autocracy have resulted in a culture of repression among the Hungarian people, which manifests itself in the anguish of their current attempts to create a democratic society. According to Boszormenyi and Delaney (1993), the methods of the communist government that resulted in some of the most damaging consequences from a psychological perspective were the devaluing of human relationships, the attempt to destroy transcendent values and purpose, lowering individuals' sense of self-worth, and greatly restricting the information available to the general population. The consensus of a group of Hungarian psychologists who were interviewed about the national character of Hungary was that the Hungarian people tend to internalize aggression, and this in turn leads to problems with depression and related disorders.

> In comparisons of suicide rates in developed countries around the world, Hungary's suicide rate shows up as the highest in the world. In the most recent data from the United Nations, the suicide rate per 100,000 in the U.S. was 12.4, in the Soviet Union it was 19.5, but in Hungary the rate was 41.6. (Boszormenyi & Delaney, 1993, p. 7)

These numbers bespeak a national tragedy and an epidemic that is in dire need of being addressed by the international psychological community.

In a survey comparing Eastern European teenagers with those of Western Europe and the United States, Grob, Little, Wanner, & Wearing (1996) sampled over 3,800 adolescents and found that Western European and U.S. adolescents had more personal self-esteem and positive attitudes toward life than Eastern European adolescents. The authors proposed that these differences may reflect the economic conditions of the respective settings, as economic development has been found to affect level of well-being. With regard to perceived control, Western European and U.S. adolescents generally expected less personal control and appraised three key life domains (personality development, workplace, and school matters) as being less important than did their Eastern European peers. The authors postulated that this finding may be related to adolescents' awareness of the societal shift from relatively rigid institutions to more open and democratic systems. The resulting increased opportunity for personal achievement may have given these adolescents the conviction to personally contribute to the ongoing change in Eastern Europe. To summarize:

> For these Eastern European adolescents, the detriments to well-being, which perhaps are related to the economic aspects of change and the media-facilitated comparisons to Western societies, appear to be countered by the benefits to perceived control, which perhaps are related to the perceived freedoms implied in the direction of social change. (Grob et al., 1996, p. 793)

Some manifestations of psychopathology are unique to certain cultures. Pavlovic and Vucic (1997) describe a syndrome known as *debloza,* which seems to be unique to Istria, a peninsula on the Adriatic Sea that belongs to Croatia and Slovenia. Debloza is characterized by anxiety, restlessness, depression, and paranoia and manifests itself somatically in the form of headaches, stomach pains, and drooping limbs. Shame seems to be the essential component of debloza, wherein a person feels dishonored in the eyes of the other members of the group. The causes of debloza as reported by the authors include awareness of disadvantaged status, conflict and uncertainty, acts of omission or commission, and sharing in the debloza of a friend or family member.

In Russia, domestic violence is now being recognized as a major societal problem, with some sources reporting that as many as 16,000 women had been murdered by their male partners in 1995. Although the possibility exists that domestic violence has increased dramatically in postcommunist Russia (1,623 women were reportedly killed by their male partners in 1989), it seems more likely that there is now more freedom to research and report such figures without fear of reprisal from the communist government (Horne, 1999). Before 1917, women in Russia were often whipped by their husbands for failure to perform household chores. Following the 1917 Revolution, the newly drafted Soviet constitution declared women and men legally equal, but those women who entered the workforce found themselves burdened by inferior wages and the responsibility for almost all of the household chores in addition to their work outside of the home. Since the fall of the Iron Curtain, some of the concerns of the past have resurfaced:

> Due to employment discrimination and the renewed emphasis on traditional family roles advocated by a resurgent Russian Orthodox Church, Russian women are again being forced to depend economically on men. Many battered women are concerned that should they leave their abuser, they will be unable to support themselves and their children. (Horne, 1999, p. 57)

Domestic violence is only one problem in formerly communist nations, but it is a problem that requires immediate and focused attention from the international psychological community.

E-MAIL SURVEY

The sparse literature reviewed here suggests that Eastern European cultures face a variety of mental health needs, and that the Church is a potential resource for meeting some of these needs. The precise mental health needs experienced by clergy and other religious leaders in Eastern Europe are less clear. If Christian psychologists from the U.S. are to provide meaningful and relevant help to clergy and religious communities in Eastern Europe, it will first be important to assess the needs and cultural context. The E-mail survey described here is one important step in the needs assessment process.

A 10-item survey questionnaire (Table 1) was sent by electronic mail to 38 Christian leaders in Eastern Europe who had participated in a summer theology course at Wheaton College. The questionnaire assessed basic demographics, the common mental health problems being treated by pastors, pastors' typical training in mental health services, and cultural variables pertinent to the ideal delivery style for mental health services. Some of the original 38 people contacted for the survey provided a total of 18 additional names of Christian leaders in Eastern Europe with a good understanding of mental health needs who were, in turn, also contacted to participate. Of this total of 56 possible respondents, 29 Christian leaders in Eastern Europe returned responses to the questionnaire. All respondents completed the questionnaire in English. As an expression of appreciation for their help, we sent participants a book of their choice (from among 5 options) pertaining to Christian counseling or psychology. All responses were coded using software for qualitative data analysis (NUD*IST 4, 1997).

Respondent Information

Those responding to the questionnaire represented a variety of nations, a wide range of years in their current countries, and many different occupations and work settings. The greatest number of respondents ($n = 9$) reported Slovakia as their major country of residence or work, with another significant portion ($n = 5$) claiming Bulgaria as their primary country of residence. Several other respondents ($n = 4$) were currently living in Ukraine, and other nations represented were Russia, Estonia, Austria, Romania, the Czech Republic, Poland, and Albania. Though each of these countries faces unique mental health challenges related to their unique cultures and histories, we were interested in looking for common experiences and perspectives among the various respondents.

The length that the respondents had lived in their current country of residence ranged widely as well. One respondent reported moving to his or her current country of residence "just recently," and several respondents reported living in their Eastern European country all of their lives–up to 50 years. Ten of the respondents reported having been in their current country of residence for 2 to 10 years, while 17 reported having been in their current country for 20 to 50 years.

The various work settings reported by the respondents fell into six general categories. The largest number of respondents ($n = 12$) identified their primary work setting as some sort of Christian organization, and most of these were missions operations

Table 1
E-mail Survey Questions

QUESTION #1: In what country do you spend most of your time?

QUESTION #2: How many years have you lived in this country?

QUESTION #3: What is your current occupation or job?

QUESTION #4: What mental health problems do you observe among Christians in your country? For example, how often do you see depression, anxiety disorders, relationship problems, drug and alcohol abuse, eating disorders, sleeping problems, severe mental illnesses such as schizophrenia, and other types of problems?

QUESTION #5: In your opinion, what are the three most common mental health problems or needs facing Christians in your country?

QUESTION #6: Where do Christians in your country go to receive help with their mental health needs (pastor, Christian counselor, friends, family, secular psychologist or psychiatrist, and so on)? How well are mental health problems treated by these helpers? Are there enough Christian counselors, Christian psychologists, and Christian psychiatrists to meet the mental health needs in your country?

QUESTION #7: What attitudes and beliefs do you see among Christians in your country about getting help for their mental health needs?

QUESTION #8: Are pastors trained for the counseling needs of their congregations? If so, where do they receive this training? If not, what kind of additional training would be most helpful?

QUESTION #9: There are different styles of counseling. For example, some counselors are very direct, giving advice and suggestions for change. Others are less direct, listening and giving encouragement and personal support to the person in need. What styles of counseling work well for Christians in your country?

QUESTION #10: What final ideas or thoughts do you have about developing Christian mental health services in your country? If we were to develop an intensive Christian counseling training institute at Wheaton College for Christian leaders in Eastern Europe, what advice would you give us?

(e.g., Bible for Everyone, Life and Mission Ministry, Good Samaritan Foundation, Operation Mobilization, Barnabas International). There were also several respondents ($n = 7$) who were involved with working at a Seminary in some capacity, ranging from teachers to presidents and deans. Six respondents reported a church as their primary work setting, with roles ranging from team members in planting churches to youth pastors and pastors. Six respondents identified a college other than a seminary as their primary work setting. There was also a response from a person who worked as a counselor in a conference center and one from a medical doctor at a university hospital.[1]

[1]The total number of respondents from various work settings is greater than the sample size of 29 because some Christian leaders in Eastern Europe hold more than one full-time position. The changes since the fall of communism have opened up many opportunities for Christians that were not previously available, and this has activated some Christian leaders to work especially hard during these years of transition.

Common Mental Health Problems

Despite the diverse cultures of Eastern Europe, several common mental health problems emerged. Depression appears to be a consistent and prevalent mental health problem among Eastern Europeans today, and was identified by the vast majority of our respondents (n = 25) as a problem affecting Christians in Eastern Europe. As one respondent put it, "A general despair seems to be part of the communist inheritance." Some reported depression being related to the economic and political instability; others attribute it to the lack of hope for the future combined with a dwindling optimism about the present. One respondent wrote:

> Just living in the former Soviet Union can be depressing. There seems to be someone standing above you who is constantly holding your shoulders down. However, there seems to be no general consensus on how to identify depression or how to treat it. You just keep on keeping on.

Relationship challenges also pose a set of potential problems, some of which are closely related to depression. Eighteen of those responding to the survey mentioned it as a significant mental health problem. One Estonian respondent described how the reserved, introverted nature of Estonians makes it difficult to have open, trusting relationships in which problems are discussed. This tendency contributes to widespread depression. There seems to be a lingering sort of learned helplessness that has resulted from years of living under repressive communist rule, and the effects of the decades of totalitarianism are not easily shrugged off, especially combined with the instability of the current culture. A Slovakian Bible school professor noted the same tendency toward introversion and lack of openness in his country. A Bulgarian pastor reported that at least one new person per week comes for help with depression, and that half of these are closely related to relationship problems. Other respondents noted that U.S. ideas of "boundaries" are not culturally accepted in some Eastern European countries. As a result of this and extreme economic deprivation, many families live together in multi-generational units, and these conditions sometimes lead to relational conflict. As in other parts of the world, relationship conflicts are not limited solely to families. They are evident in church communities and in various other contexts.

After depression and relationship problems, alcohol abuse ($n = 16$) and anxiety ($n = 16$) were reported as being most prevalent. Some respondents indicated that alcohol abuse may be somewhat less problematic for Christians than for others. Anxiety problems are often related to the economic conditions, the rapid rate of social change observed since the collapse of communism, and fears about the future.

Several respondents implied that mood symptoms are sometimes seen as a sign of spiritual weakness among Christian congregations. This may increase the sense of shame and hiding of mood disorders among Christians in some Eastern European countries. A respondent from Czech Republic noted of Christians: "Outwardly they seem to be rather okay–the problems are deeper inside."

Other problems, mentioned less consistently than those described above, included severe mental illness (especially schizophrenia), eating disorders, negative self-image, sleep disorders, difficulty trusting others, envy of others (especially regarding financial resources), stress, guilt, anger, sexual abuse, loneliness, physical abuse, perfectionism, and difficulty with forgiveness. Thus, it appears that Christians in Eastern Europe face many of the same problems faced by Christians in the U.S., but some of these problems may be exacerbated by the prevailing mood of powerlessness and depression once engendered by a communist regime and now sustained by the consequences of economic hardships. Some problems may also be masked by the religious and spiritual beliefs of certain Christian communities.

Mental Health Resources

Given the mental health problems described above, where do Christians in Eastern Europe turn for help? Several respondents reported that Christians often do not seek help anywhere because of the shame and fear associated with the mental health field. For many Christians throughout Eastern Europe, admitting a mental health problem is tantamount to admitting spiritual failure. Thus, people are more inclined to ask pastors to pray for them or to pursue personal reliance on God as a solution rather than seeking explicit help for a mental health problem. One respondent said his countrymen were a "quite reserved people and also proud people; they do not come easily to accept help." Others reported that Christians in their country would be willing to seek help for mental health problems, but that few resources are available within Christian communities. One of these respondents stated, "When we have offered counseling courses and seminars we receive a flood of people sharing their needs . . . most never realized it was possible to share their problems with someone else."

For those who do seek help, the first option is friends and family. This was a consistent response seen throughout those received from various Eastern European countries and cultures. In fact, almost all of the respondents mentioned friends or family as a source of help. The prevalence of this response appears to be related to trust. Eastern Europeans perceive family and friends to be closest to them, and the most trustworthy, and so they are the natural choice to trust with "problems of the heart."

Pastors were also mentioned as a source of help by a significant number of respondents. However, many respondents reported that pastors and church leaders were ill-equipped to help with the needs brought before them from members of the congregation. One respondent stated, "Pastors are not pre-

pared by their seminary for counseling, so [they] are in a pretty good position to give wrong advice, or just . . . very general [advice]." Many turn to a pastor only in severe cases when no other options are available. Several respondents reported that the age of both the pastor and parishioner is a factor–older parishioners seek help from pastors more frequently than younger ones, unless the pastor is also young.

Respondents consistently reported that Christians generally avoid secular mental health professionals. Because Eastern Europeans historically have not trusted their governments, and because mental health practitioners are still associated with government oppression in the minds of many Eastern Europeans, they are hesitant to seek help from mental health professionals or hospitals. Moreover, much of the mental health treatment available is based on biological and medical intervention models that, in the opinion of our respondents, do not adequately address the psychosocial and spiritual nature of the problems being confronted. In addition, many respondents reported that some Christians are leery of secular psychologists and psychiatrists due to their nonbiblical approach to mental health problems. One respondent wrote, "Counseling is not understood because the people do not know what it is [and therefore] it is highly mistrusted."

All of the respondents reported a lack of Christian mental health professionals to adequately provide services for the problems currently being faced in their countries. One respondent stated, "I know of no such thing as Christian psychologists in Ukraine. I know of one [seminary] graduate . . . who is working in a major church as a counselor. That's it." Generally there is no tradition of Christian training available for training clergy in mental health services. A few stated that efforts are currently being made to begin educating and training pastors and counselors in these skills but, of them, most said they were "starting from nothing." Some churches are now applying some of the principles learned through psychology to improve family and marital relationships and address drug and alcohol problems, and some parishioners are eager and open to learn more about psychology and to seek help for their personal struggles. This greater openness is accompanied by a greater awareness of medical and psychological services in general.

We specifically asked about directive versus nondirective approaches to counseling. Respondents' recommendations depended on the country from which they came. Most of the respondents from Romania, Slovakia, and Bulgaria suggested that a less directive, more supportive counseling style be employed to best serve their parishioners. However, those from Russia and Ukraine suggested a more directive approach.

Clergy Preparation for Mental Health Challenges

When asked if clergy are trained to meet the counseling needs of their congregations, all the respondents explained that clergy have very little training or no training in counseling and mental health. Of those receiving some training, the extent of the training typically included a pastoral counseling course or attending a basic seminar while in seminary. They also explained that the training in counseling was quite broad, shallow, and did not adequately prepare them to meet the mental health needs of their congregation. Additionally, respondents stated that they desired more training in the following areas: basic counseling skills, pastoral care, thorough study of specific mental health issues, biblical counseling, and lay counseling.

Because we are interested in knowing how to best help clergy and congregations in Eastern Europe, we specifically asked for ideas about training clergy in counseling and mental health. Cultural awareness and sensitivity were paramount among the responses we received. This can be seen at two levels. First, it is important not to assume that an intervention developed in the U.S. will always work well in Eastern Europe. One trained mental health professional in Poland wrote, "Some people have tried to counsel in Poland and meant well, but they did not take cultural aspects into account, thus all their work was irrelevant." This may actually be a benevolent way of stating that culturally-insensitive counseling can actually be harmful to those seeking help. Second, several respondents reminded us of the tremendous cultural diversity within Eastern Europe, with one cautioning, "the only common denominator [among Eastern European countries is] the oppressive past, during which the people were actually healthier than now, and the very rapid changes." An appropriate training program for one Eastern European culture may not be equally effective elsewhere.

To help address these cultural obstacles, our respondents advised us not to bring clergy and Chris-

tian leaders to the United States for training, but rather to send culturally-sensitive educators to Eastern Europe and to partner with existing Christian mental health resources in Eastern Europe. They suggested collaborating with local churches, Bible schools, and seminaries in establishing the training plan. Respondents noted that they could benefit from working with experienced counselors, attending seminars in their home countries, and by participating in a correspondence-based learning program accompanied by annual seminars.

Given the economic situation of most Eastern European countries, financial support for training endeavors is essential. It is not feasible for most seminaries in Eastern Europe to fund a visiting professor to come from another country.

IMPLICATIONS

Based on the limited literature available and the results of this preliminary needs assessment, we offer two observations and related implications of our findings. Our two observations have to do with the essential roles of trust and cultural sensitivity.

Trust

It is important to realize the central role that trust plays in Eastern European cultures. Christians in Eastern Europe have experienced and heard stories of government oppression and interpersonal betrayal. They have been socialized to be cautious and suspicious of one another. Similarly, citizens of many Eastern European countries have associated government oppression with abuses perpetrated through the professional mental health system. As a result, they are reticent to seek help for mental health problems, and if they do seek help, it is most often from friends and family.

An immediate implication of this finding is that training laypersons within the Church may hold more short-term promise than training Christian mental health professionals or clergy. Because people prefer help from friends and family, they are presumably more likely to seek help from peers within a church community than from others in positions of authority. The strength of the involvement of lay counselors in a church-based setting lies in their ability to comfort, counsel, and educate, as well as refer to professional treatment if needed (Bufford & Buckler, 1987). At least in the U.S., professional mental health training does not appear essential for effective treatment outcome for many clients, given the right circumstances (Christensen & Jacobson, 1994). After reviewing the literature on paraprofessional helping, Christensen and Jacobson conclude: "The research summarized in this article suggests that the psychology that is given away . . . through paraprofessional, self-administered, and mutual-support group treatment may be as effective as the professional psychology that is sold" (p. 13). Additionally, in a study investigating the treatment effectiveness of Christian lay counselors, Toh & Tan (1997) found that those people helped by lay counselors in a church-based setting made significantly more improvement than those who received no counseling. Although training is essential to proper treatment in instances of severe psychopathology as well as other cases, it seems many problems in living can be effectively treated by lay counselors. Assuming lay counseling would be effective in Eastern Europe as well as the United States, training Christian laypersons for basic caregiving functions will be an effective way to reach the mental health needs experienced in many parishes (See also Haugk, 1984; Steinbron, 1997; Tan, 1991).

A related implication is that U.S. notions of boundaries will need to be challenged in establishing effective caring networks in Eastern Europe. Whereas U.S. psychologists tend to avoid multiple-role relationships–seeing counseling and friendship as mutually exclusive relationships–these multiple-role relationships may be the most effective venue for help in Eastern European contexts.

A third implication is that training trainers may be more profitable than directly training clergy to do counseling. If clergy and other Christian leaders can be trained to train their parishioners in active listening skills, lay counseling, recognizing severe psychopathology, and so on, then the potential network of care can be expended exponentially. Several of our respondents directly or indirectly suggested this model of training trainers. For example, "Training should not be just for pastors, but also for lay persons who are gifted for this ministry." Another respondent wrote, "I would suggest that you invest in people that have already done this work . . . and then let them train Polish people."

Cultural Sensitivity

Many respondents emphasized the essential role of cultural sensitivity when people from other parts

of the world are involved in training Eastern Europeans. The passion behind some of the responses suggested some negative experiences in past interactions with well-meaning professionals from other countries. Good intentions are not sufficient.

Prior to doing this initial needs assessment, we had considered holding an intensive summer institute on Christian counseling for Eastern European Christian leaders. We envisioned bringing strategically-placed bilingual leaders from various countries to the Wheaton College campus for this training, with the hope that they would return to their countries to train other Christian pastors and laypersons. After seeing the responses from the needs assessment, this appears not to be the best approach to training. Many respondents suggested that training institutes be held in their countries where instructors are surrounded and informed by the culture of those they are instructing. Though this seems to be a less efficient model of training than we had previously envisioned, efficiency appears to be much less important to our respondents than contextual awareness. Indeed, many of these respondents have lived through a political regime where financial efficiency was the prevailing paradigm and oppression the net result. Concrete slab tenements, erected during communist rule, sit next to ornate historical buildings from pre-communist eras, serving as daily reminders that efficiency often interferes with cultural heritage.

Culturally-sensitive training in counseling skills will not be enough for Christians in Eastern Europe. Ultimately, changes must be made in broader community and social contexts than can be accomplished in individual or family counseling. For example, Elliot (1997) noted that dwelling on the numerous disasters and reverses in the history of nations formerly under communist rule will not help to alleviate the current suffering in Eastern Europe. "What is needed, it seems to me, rather than further cultivation of victimization, is forgiveness. The theme of *pokayanie* (repentance) was one of the centerpieces of glastnost" (p. 16). There have been in the history of the various nations and peoples of Eastern Europe numerous injustices, at institutional and individual levels, but to move beyond bitterness regarding this history, the people of Eastern Europe will have to be able to forgive, and that, presumably, will be no easy task. As culturally-sensitive social scientists in the U.S. continue to study forgiveness (e.g., Freedman & Enright, 1996; McCullough, Worthington, & Rachal, 1997; Worthington & Wade, in press), there may ultimately be important community-based interventions to be offered to our brothers and sisters in Eastern Europe.

In summary, there are pressing needs for support in addressing mental health needs in Eastern Europe. This support needs to be contextually relevant, carefully crafted to the needs of the various cultures and countries of the area. Issues of trust among Eastern Europeans will need to be taken into account and addressed in a culturally sensitive manner. We conclude with the words of a psychologist/missionary working in the Czech Republic: "Do it fast! We need as much help as possible in this area."

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