ASSOCIATION OF
MORMON COUNSELORS
AND PSYCHOTHERAPISTS

AMCAP
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Salt Lake City, UT
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MORMON COUNSELORS
AND PSYCHOTHERAPISTS

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The purpose of this Association shall be:

a) To promote fellowship, foster communication, enhance personal and professional development, and promote a forum for counselors and psychotherapists whose common bond is membership in and adherence to the principles and standards of The Church of Jesus Christ of Latter-day Saints, both in their personal lives and professional practice.

b) To encourage and support members' efforts to actively promote within their other professional organizations and the society at large the adoption and maintenance of moral standards and practices that are consistent with gospel principles.

Article 1, Section 2. AMCAP by-laws (as amended Sept. 30, 1981).

AMCAP supports the principles of The Church of Jesus Christ of Latter-day Saints; however, it is an independent, professional organization which is not sponsored by, nor does it speak for the Church or its leaders.

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The *AMCAP Journal* seeks manuscripts of interest to the broad, interdisciplinary membership of the Association. Appropriate manuscripts may be reviews, theoretical, or descriptive practice articles, or reports of empirical studies, which address the association's mission as stated above. Articles may relate to the theory of counseling and psychotherapy, family therapy, social work, or may deal with the application of Church doctrine to an understanding of psychological processes, or to righteous or ethical practice.

Manuscripts submitted for publication should conform to the style of the *Publications Manual of the American Psychological Association* (3rd ed., 1984), available from the American Psychological Association, Order Department, P.O. Box 2710, Hyattsville, MD 20784.

Double-check your references. Do text citations agree exactly (spelling of names, dates) with reference list entries? Manuscripts without reference list errors are surprisingly rare. Please retain the original text citations in your possession should the need arise for them to be checked. Follow the *Publication Manual of the American Psychological Association* in citing your references.

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Type everything—including footnotes and references—double-spaced, on a six-inch line, 25 lines per page. Manuscripts should generally not exceed 20 pages. Use plain white paper. A dot matrix printer may be used. Also, when possible, send a copy of the manuscript on a computer diskette either in Apple Macintosh or IBM PC-compatible format. (You can send your electronic copy of the manuscript in WordPerfect,® Microsoft Word,® or WordStar® word processing formats or as an ASCII text file.)

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The *AMCAP Journal* is a refereed journal. All manuscripts received in the format specified are reviewed by the editor and two consulting editors. Manuscripts will be acknowledged by the editor upon receipt. The review process takes approximately two to three months. Authors can expect to hear within that time regarding the status of their manuscripts. If revisions are required, the editor may choose either to accept revisions without additional review by consulting editors or put the manuscript through the entire review process again when the revised manuscript is received. Once a manuscript is accepted for publication, three to six months will elapse before the article appears in published form in the *AMCAP Journal.*

Authors should keep a copy of their manuscript to guard against loss. Send three copies of your manuscript to the editor:

Paul F. Cook
AMCAP Journal
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Brigham Young University
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CONTENTS

Editorial

We want to thank the contributors to this issue of the *Journal.* As you can see, this issue of the *AMCAP Journal* is considerably larger than the last. This is because we have had more manuscripts submitted which have survived the review process. We have also included a few of the presentations made at the convention which particularly address the *Journal*'s purpose.

Our next issue of the *Journal* will address a unique purpose. We have had many requests for a reprint of general authority talks to AMCAP members. The next issue will be devoted to this purpose. We hope that putting them all together will be helpful in establishing common themes and guidance to us both as an organization as well as professionals in the helping vocations.

We welcome manuscripts at any time. Deadlines for spring 1991 are January 1990.

As always, we welcome your comments.

Paul F. Cook, Editor

Worldly Therapies and Us

Dear Editor:

While AMCAP debates whether we have, or should have, a gospel-centered approach to psychotherapy, there definitely appear to be worldly approaches. Reading the Parker-Westover dialogue in the *AMCAP Journal* that arrived in April 1990, I am stimulated to present my thoughts of some years on this.

A profound observed difference has been most useful in my thinking—on the one hand explaining human phenomena on the basis of heredity and environment (genetics/chemistry and environment/learning)—and on the other explaining them on the basis of those two plus *spirit.* By "spirit" I mean that unique individual part of each of us that existed prior to, and will exist after our present earthly life, in which resides our choosing power, and which accounts for much of what each of us is and can become. Fascinating to me is the observation of how much of the negatives in psychology, psychiatry, politics, feminism, economics, etc., etc., become more easily understandable as reflections of the omission of things of the spirit from theory and practice.

The second element distinguishing gospel-centered psychotherapy, as I see it, is the understanding found especially in the LDS Church that it is God that performs the healing or beneficial change, not the therapist or the therapy *per se.* This means that a crucially important part of the

preparation of the therapist—and of his work—is organizing himself to invite the Spirit of the Lord to enter the situation. This is a vastly different undertaking from anything described or even contemplated in worldly therapies.

In my 35 years of professional mental health practice (14 of them in the Church), the awareness has steadily grown that plain and simple truths help the most. A great example was the light shed on homosexuality at the 4 May 1990 seminar in Salt Lake City of the Evergreen Foundation: though not easy, the causing and clearing of this distressing problem are far more plain and simple than have been suspected. In my present work with sex offenders on probation I am finding the same. And, of course, Alcoholics Anonymous and the other twelve-step programs also eschew intellectual theorizing and teach that the healing comes from learning to think and behave in spiritual ways that invite divine healing.

This is not to demean academic learning, nor systematic study and research, nor intellectual and theoretical analysis. When used with the concept of the spirit, and seeking of the spirit, they are used for good. Unfortunately, what characterizes advancement in academic and research careers in most of this world is the exclusion of both the concept and the seeking of the spirit. The library at the naturopathic college in Portland is powerful but small; the plain and simple truths of herbal and homeopathic remedies do not change. The library at any allopathic medical school is large almost beyond understanding; they must keep abreast of the outpouring of the latest from those advancing their academic and research careers. Who of us has read the latest research center reports, statistically analyzed, showing the latest methods of good mothering? Good mothering, of course, is based on plain and simple truths that do not change, and are, therefore, of no use to anyone seeking to advance a career that depends on publishing something "new."

Twenty five years ago, I was in an advanced training group in studying with Virginia Satir. We confronted her saying that we had mastered all the family therapy technique she had taught us but still did not get her results: what was missing? Finally, she was able to identify her secret—"faith:" a principle not mentioned in any of her writings on theory or practice. Few of us who trained with Fritz Perls caught the essence of his work, which was inward, actually spiritual, and not taught

as part of the method of Gestalt therapy. When I saw videotapes of Milton Erickson I saw him speaking "spirit to spirit" in a way no one had mentioned in describing his work. In talking with a psychologist who had worked extensively with Joseph Wolpe, I learned that Wolpe spent most of his time with clients teaching them bodily sensory awareness, which is in itself spiritual and powerfully therapeutic but is not mentioned in his writings because it does not reflect the theory of systematic desensitization upon which his career advanced. In short, the kind of teaching and publishing required for worldly professional advancement does not normally include the two elements of gospel-centered approaches to psychotherapy: the concept of and the seeking of the things of the spirit.

There are, mostly outside the scientific/research/academic/professional channels, good writings that reflect the things of the spirit on mental health issues. For example, recent books by Michael Levin (*Feminism and Freedom*, New Brunswick, NJ: Transaction Books, 1987) and George Gilder (*Men and Marriage*, Gretna, LA: Pelican Publishing Company, 1986) thoroughly acknowledge the innate (spiritual) difference between the sexes. These are fine books and are on our side, in contrast to much of the feminist movement, which takes an environmentalist, intellectual and coercive approach, denying innate or spiritual elements in maleness and femaleness.

Although clearly there is no one "true" gospel-centered therapy method, it does seem to me that there are a few "true" essentials of what needs to happen in therapy, by whatever method obtained. And, at least for me as an LDS convert, these essentials include spiritual elements that are missing from the formal concepts and methods of worldly therapies. Perhaps this may be compared with the Church's current approach to the standard missionary discussions, in which there are defined essentials to be accomplished but in which the specific approach to be used is somewhat up to the discretion of the missionaries, as guided by the Spirit. So let us search for gospel-based theories and gospel-based intervention strategies. Yes, let us first be followers of Jesus Christ and second psychotherapists.

Karl E. Humiston, MD

Letter to the Editor

Dear Editor:

I remember many things about the beginning of AMCAP. I remember the first meeting in which Lynn Eric Johnson was established as chairman of the AMCAP group. I have a copy of the letter—two months later—indicating that LDSPGA had agreed to disband and join our group.

I remember Bob Bohn and I talking to six people at BYU who, for various reasons, declined to serve on our board. We then talked to Ron Bingham, and Bob Peters who became gracious and very generous supporters of AMCAP.

I remember Wayne Wright and Henry Isaksen working hard to come up with the name AMCAP.

I remember Vic Cline letting us use his office at the U. He was an eloquent spokesman for us. He paid for our first Kentucky Fried Chicken dinners to help us keep from busting our budget.

I remember meeting with Vic Brown Jr. and Elliot Cameron, who both encouraged us (AMCAP). Brother Brown was Director of LDS Social Services and Brother Cameron was president of the Utah County Mental Health Association. Wisely they both cautioned us that we would have difficulty with those who'd say, "You are being too conservative." "The meetings are too churchy."

"You are too analytic and aren't including enough church doctrine."

I remember Flodie Brown giving up outside work in order to support AMCAP. She developed our first materials and videos while she still was a student at BYU. Since she only had money for a sack lunch, Gary Carson was sensitive enough to start bringing his lunch and eat with her so that she wouldn't be alone. Various board members signed as guarantor for her student loans.

I remember many meetings with Grant Hyer in his attic office in a home near LDS hospital. There we contacted over 200 Social Workers, the majority of whom ended up supporting AMCAP.

I remember some AMCAP board members, who despite traveling many miles, were very faithful in their service to the fledgling organization: Henry Isaksen from Rexburg, Idaho, Merle Rausch from Globe, Arizona, and Richard Barrett from Fresno, California. I personally spent three months full-time working on AMCAP.

By default, I became the first sustaining member: had I taken expenses out of the budget the first year I was editor of the journal, we would have been broke.

Of course, my memory may be like my 86-year-old uncle: he seems to remember more the older he becomes.

However, I have been concerned because the last three meetings I've attended, the pioneers of AMCAP have been forgotten and the emphasis has been on LDSPGA.

AMCAP was newly organized not as a clone of LDSPGA. According to my notes, AMCAP was a newly organized group in February of 1975. The idea came from a number of groups wanting and supporting the concept, they were:

- Latter Day Saint Personnel and Guidance Association
- Utah County/Utah State Mental Health Associations
- Utah Psychiatric Association
- Licensed Utah Clinic Psychologists, and marriage and family therapists

- Utah Hospital Association/Mental Health Social Services section
- Students in areas of mental health at University of Utah, Utah State, Weber State, and Brigham Young University
- LDS Chaplains Association
- LDS Social Services
- Utah Chapter, National Association of Social Workers

Some of this history seems to have been lost. When its been mentioned during my last two AMCAP presentations that I was on the original board of AMCAP, I've been very politely corrected. If the emphasis continues to be on LDSPGA, the people who spent many hours as pioneers will not be recognized.

AMCAP was organized in February of 1975 with 11 members. But because LDSPGA already had a governing body, two months later, AMCAP voted them a governing body with Lynn Eric Johnson the first President of AMCAP. While I have no desire to influence or change AMCAP as it now stands, I am offended that the history of AMCAP has both been slanted and biased to include only one support group (LDSPGA) and not the other groups that pledged and provided the support necessary for AMCAP to succeed.

Your Brother in the Gospel,

Don Lankford, LCSW/CFH.

Presidential Address

S. Brent Scharman, PhD
October, 1989

It's been fourteen years since I began working as a full-time counselor. I realize that time is brief compared to some of your professional experience. As I reflected on the many things I could discuss in this presidential address, I decided to use this as a time to reflect on the choice we have all made to pursue a helping profession as a career, and on the current state of the profession.

My earliest recollection about why I chose psychology as a career goes back to the time I was in the sixth or seventh grade. On the family bookshelf I found a paperback copy of Sigmund Freud's classic book, *The Psychopathology of Everyday Life.* I remember reading through the book and understanding very little of what was there. What I do still clearly remember, however, was the fantasy I had at the time about helping someone unravel some complicated aspect of their life by interpreting a puzzling dream or getting them to free associate and break through their defenses. At the time it felt exciting, fascinating, challenging and even romantic.

Through the years I considered other career choices, but the ultimate decision to pursue counseling felt comfortable and satisfying. In fourteen years I found that some of my fantasy was correct, it has been a challenging and fascinating career choice. Some of it was incorrect—the miracle cures are few and far

between and most progress in therapy comes from unromantic, hard work.

About nine months ago I had the experience of eating lunch with some of my colleagues in the Deseret Industries cafeteria, a true gastronomic experience. As I ate some jello with fingerprints on it, I observed the interaction of a young couple attempting to feed and supervise their young child who appeared to be about two years old. His frequent cries and uncontrolled behaviors led to repeated threats and occasional slaps from the obviously overwhelmed parents. Their unkempt appearance and lack of social skills and awareness only increased the feelings of frustration I felt as I observed the scene. Upon leaving the cafeteria, I remarked that in all likelihood that boy was going to be sitting in a counselors office 20 years from then asking for help. The counselor would have the unenviable task of attempting to help undo the effects of 22 years of living, and, if he or she worked in an agency setting, they would probably have the added challenge of bringing about the changes in short-term therapy. I felt discouraged and eating a rubber cookie didn't help any.

When I got back to my office, I was quickly taken from the world of the theoretical to reality. I began an interview with a 38 year old compulsive male who was frustrating his family by his unreasonable needs for structure and control. The fellow could only be comfortable when the clothes hangers in his closet were all exactly the same distance apart so he would measure them to assure order. He measured the growth of the flowers in his front yard and attempted to keep them uniform by digging beneath the more quickly growing offenders which got too tall. His wife had to back their car into the driveway and park with the tires resting on previously assigned markers. This rigid behavior felt reasonable to the husband, but was driving his wife crazy. He eventually terminated therapy prematurely and little progress was made.

The evolution in my awareness from fantasy to harsh reality has frequently prompted me to ask myself the question, "What do we really have to offer as a profession?" I'm pleased that my honest answer to myself is, "We have a lot to offer and many satisfied clients who would testify to that effect."

The profession is not without its frustrations, however. Prior to becoming a counselor, I spent ten years in retail sales for a large international company. During that time I dealt with all of the frustrations that go along with the competition of the free enterprise system, including having someone bring back a pair of shoes after 15 years of wear because the soles had worn out, and then demanding a new pair. During that time, however, I also had the very satisfying experience of being able to meet the needs of customers in very concrete ways, and having them leave the store with a tangible product in hand and a smile on their face. I had a lot of friends in those days because everyone hoped I might offer them a discount because they were in need.

Those experiences were very different from my experiences as a therapist. There is no tangible measure of change and the observable outcomes are frequently difficult to see. I not only don't have more friends, but people I've seen in therapy will sometimes avoid me in public places for fear that someone will sense I've seen them professionally.

At this point I would like to share with you some of my current impressions, both positive and negative, about our profession. (I'm using the term "our profession" to signify the related work we do as social workers, psychologists, marriage and family therapists, psychiatrists, doctors and nurses).

As a group we may have the worst reputation, and receive the least respect, of all professions. The tendency is to think that we are all liberals and that anyone with common sense could do what we do. A recent letter to the Editor in the Deseret News characterized mental health care professionals as "charlatans" and described the profession as "idiotic and dangerous." A local social worker and member of AMCAP, Dr. Kent Griffiths, made an eloquent response in a follow-up letter to the same newspaper.

Two weeks ago I received a referral on a woman sent home nine months early from her mission for depression. This depression had required a week of inpatient care before she was stable and not actually suicidal. I was to do the follow-up therapy, but the referral was accompanied by the opinion that all that was really

needed was self-reliance and some "talking to" by the person making the referral. Recently I was saddened to hear someone say, "It's too bad Dr. X chose to go into this field. He could have made a contribution in one of the real sciences." Another conversation I overheard conveyed this theme, "John is wasting his money going to counseling. All he really needs is a caring friend."

It's my current opinion that nothing could be further from the truth. A good therapist, one who really helps bring about change in the lives of people, is a unique and exceptional individual. They need to be extremely bright, insightful, able to form a positive relationship with a very diverse group of clients and need to be mentally healthy themselves. It also helps, when meeting with clients who are confused and hurting, to have a therapist who has clear values and is not confused about their own life. It's been my experience that most therapists I've associated with meet these criteria. They are very capable and their own lives are in order. It's the exception when they would meet the stereotype of the "liberal therapist." Certainly the therapists I've interacted with at AMCAP measure up very favorably on these positive criteria.

As Hans Strupp (1978) pointed out in his article on Specific and Non-specific Factors in Psychotherapy, the question can reasonably be asked, "If it takes such a capable person to be a good therapist, why is it that some of the literature shows little difference in the outcome of trained and lay therapists?"

My opinion is that the answer is at least five-fold:

- Change is difficult to measure.
- Much of what therapists have been doing in the past 25 years has been Rogerian therapy. Many lay therapists are naturally good at this, and when they listen and show concern people feel better and may really improve.
- Some trained therapists are not very good.
- People are often looking for advise and quick solutions, and those are often given by lay therapists, so they are evaluated positively.

- Those who are helped most by lay therapists may be those who need the least, in other words, they need support to get through a crisis, reassurance, praise, information, a listening ear or a boost to their self-esteem. In other words, they may be basically quite healthy to begin with and looking for something reasonably, easily given.

I am certainly not suggesting that it's bad when a non-professional is able to help someone. The vast majority of help that has been given throughout history has been given by untrained friends, family, spiritual leaders, teachers, etc. What I am saying is that for the client who needs more than support, warmth and listening, it's a complicated process and requires much more skill than most people think.

One of my strong current impressions concerns the value of diagnosis. Like most counselors who were trained in the 60's and early 70's, I received little training in diagnosis. Characteristic of the emphasis I received is a quote from one of the texts used in my master's program. Brammer and Shostrom (1968) in *Therapeutic Psychology*, stated that "Roger's seems particularly adamant on the question of diagnosis. He claims that diagnosis . . . is an actual detriment to the psychotherapeutic type of counseling."

While I would hastily agree with the concerns we have all heard about labeling and judging, I would also affirm that much good can come from an accurate diagnostic impression which guides therapeutic intervention. I feel that the refinements that have been made in the Diagnostic and Statistical Manual in the past ten years have been revolutionary in helping us conceptualize mental, emotional and behavioral problems. It has led to clearer communication, tighter research designs and has forced us to make decisions about what will constitute a given psychological condition.

If I go to a medical doctor for pains in my stomach, I want to know whether he/she feels I have appendicitis, ulcers or cancer before treatment is begun. In similar fashion, a client coming for counseling has a right to know whether the therapist feels the client is not dating or going to work because of social phobia, avoidant personality disorder, or because they are depressed. How would

you feel if a family member was going to a therapist because of overwhelming fears which were incompassitating her? You'd be pleased if she came home after the first visit and reported that she had felt comfortable and had been understood. You'd probably feel even better if, in addition, she reported "the therapist feels that I am experiencing panic attacks which are common for about 5% of women my age. She is recommending anti-depressant medication, stress reduction techniques, and facing of my fears."

I have recently worked with a bishop who was helped by understanding that his ward member was experiencing schizophrenia, and not simply misunderstanding who had a right to receive revelation for the Church. It helped him understand why the previous three years of counsel given by a variety of helpers was going unheeded. I also think of how a life was changed when it was determined that a husband was experiencing adult attention deficit disorder, and that his inefficient performance on the job was not simply a matter of being stubborn and unwilling to try.

Diagnosis then, in my opinion, is not simply a luxury, something which you may use depending on theoretical approach to therapy, but is necessary as a way of conceptualizing behavior and determining intervention procedures.

Another one of my impressions is that we are getting better at finding techniques which help people. By techniques I am not simply referring to approaches based on different theoretical schools of thought. We're all aware of the Bergin, Lambert (1978) research which showed little difference in outcome from one theoretical approach to another. These findings have been more recently confirmed in an article by Pilkonis (1984) entitled "A Comparative Outcome Study of Individual, Group, and Conjoint Psychotherapy."

By techniques I am referring to the sorts of interaction cited by Arnold Lazarus at the Evolution of Psychotherapy Conference held in Phoenix, Arizona in 1985. Dr. Lazarus said, "There are specific techniques for specific syndromes. We've reached that level of development. Those clinicians who don't know the specific techniques will find their clients non-responsive."

I don't think any of us would disagree with the idea that there is at least as much art as science in therapy. The role of relationship and use of self will probably always maintain their place as the essential foundation of effective intervention. However, just as a positive bedside manner may be necessary, but not sufficient for practicing good medicine, relationship may be inadequate in and of itself in bringing about therapeutic change with a client.

The idea that techniques can be valuable may seem like common sense to someone just entering the field of psychotherapy, but it is not at all noncontroversial. Again I go back to a quote from a counseling text. Blocher (1966) in *Developmental Counseling*, describing Rogerian Therapy said:

> Since the client's inner-growth force will enable him to make correct decisions once he is able to perceive his situation realistically, it is not necessary for the counselor to give information or assist in solving immediate problems. Since the establishment of the relationship is the primary role of the counselor in all cases, there is little need for differential diagnosis. The treatment is similar for all cases.

I am personally more in agreement with Richard Stuart, who said in *Helping Couples Change* (1980):

> I was taught that every client gains more from the process of forming a therapeutic relationship with a caring professional than from any specific activities of the professional. I have since learned a counter truth that love is not enough. . . . A benevolent, caring therapist is needed to help each person learn to accept responsibility for change in the interaction, but this major shift in the perspective will come about only when the therapist bets more heavily on the deployment of technological skills than on being an accepting friend.

Let me clarify my point with a few examples. When I was first assigned to do treatment with sexual abuse, I thought, "what could be worse. It's long-term and there's little progress." I have now come to think of abuse treatment as one of the areas where work is done that really makes a difference in the lives of people.

Regarding treatment of sexual offenders, Abel and Becken (1984) stated that 50% of untreated sex offenders reoffended within the first year after being apprehended whereas only 5% of treated offenders reoffended. Other intensive treatment programs

have shown significant success as exemplified by the Girretto (1978) study of the child sex abuse treatment program in Santa Clara, California which showed less than 1% recidivism within the first year following termination of therapy. The difference came about because of structured, standardized programs which provided individual, marriage, family and group therapy over an extended period of time, and which dealt with specific sexual issues. They also had the influence of the law increasing the motivation of perpetrators.

The National Institute of Mental Health Studies on Treatment of Depression (Elkins, 1985) pointed out that treatment helps people get better. In their studies it was shown that subjects receiving medication were helped in eight to twelve weeks while cognitive or interpersonal therapies took 16 weeks, but all three were generally more valuable than no treatment or placebo, especially for the most severe cases. Combining therapy and medication was most effective. I might editorialize here that it is my impression that cognitive therapy has become as popular as it has in the past ten years only partly because of the results it produces. I feel that many people have begun using cognitive therapy because it is very concrete and very teachable and therapists feel that they have something specific to offer the client.

I recently had a client say that taking a class at the Primary Children's Medical Center, about how to interact with his son who was experiencing attention deficit disorder and hyperactivity, had changed his life. He reported that after years of searching he finally felt that he had received some specific techniques that had already enabled him to help bring about some change with his son. His relief was accentuated by the fact that he had already spent several years in therapy of various kinds which had been rather general, and although it had frequently provided some good ideas, had never been put together in a way that had actually produced change.

Details of other improved interventions won't be outlined because of time, but consider the improvements in treatment of alcoholism through family meetings which create a crisis and are followed by disengagement of the co-dependent spouse, successful

treatment of multiple personality disorder with hypnosis, treatment of PMS, overcoming of a multitude of sexual dysfunctions by specific sex therapy techniques, use of ECT for psychotic depression, use of Prozac and exposure techniques for obsessive disorder, use of stress reduction techniques with anxiety disorders of all kinds, etc. Great positive strides are being made and we should be proud of them as a profession.

Certainly there are not specific techniques, with documented results, for all troubling conditions. However, mental health consumers have a right to expect that this is one of the main areas where attention and money will be directed during the next decade. We would be appalled if all surgeons had their own unique ways of treating an inflamed appendix, and if they were offended at our asking them how they expected to proceed with treatment. We expect that there will be a general approach which has been proven effective which will include a given surgeons personal touches. While the comparison cannot be made directly between medical and psychological intervention, clients do have the right to know how they will be treated and to expect that there will be some correlation from one therapist to another. I fear that sometimes we use the excuse, when a client drops out of therapy or makes no progress, "He wanted me to solve his problems for him," when in reality we really didn't know what to do to help them.

I accept the fact that psychological diagnosis will probably always be less exact than medical diagnosis, and that treatments for psychological conditions will always be more variant from therapist to therapist than will medical treatments. It's my bias, however, that increased knowledge will narrow the gaps and mildly increase standardization over time.

It is common complaint of graduate students, or even of those recently graduated, that they got all the way through school without really learning very much about treatment. It is also common to hear students lament, "I know how to form a relationship and gather the relevant historical information so the first few interviews I have with a client go very well, but then I don't know what to do once they've told their story." I have heard students and practitioners say they feel manipulative, dishonest, or

even like they are performing malpractice, when clients present particularly complex problems which don't remit quickly or at all in spite of their best efforts. Sometimes the oft repeated phrase, "keep the problem on the client's shoulders," is only partially used to prevent dependence. Sometimes it's used because we really don't know what to do.

Students, or recent graduates, have said, "I've learned a lot about statistics, research design, group dynamics, community relations, personality development, etc. but nothing about helping a family with an acting out teenager, nothing about how to get a silent husband who won't show feelings to open up, nothing about how to treat explosive personality, compulsive gambling or sexual addiction.

My comments about techniques, or treatment in general, may sound like complaints. They are actually more observations than complaints. I think we are getting better and better at discovering what helps people change and in teaching it to students. My bias is that we should make it a higher priority and that students should be able to take classes that produce confidence in this area.

Another one of my biases has to do with the issue of length of therapy. Brief, or short-term therapy, is receiving much attention and many journal articles and books are pointing out its benefits. I think there is a strong place for this therapy for those who need support through a crisis, information for decision making, help with a specific marital or family issue when there is overall strength in the relationship, etc. Even those with more severe problems can benefit from a short, intensive look at issues which may lead to a relatively minor immediate change which can become more significant as it continues over time.

My concerns arise from the fact that sometimes brief therapy is imposed more for the benefits of the provider than the client. It's more a matter of keeping costs down and being able to see more people than it is a matter of believing it's what people need. People terminating from brief therapy often have a multitude of unresolved issues and find themselves in another therapist's office in the near future.

The reality is that someone needs to spend enough time with the client to help them through their issues. When agencies terminate at ten interviews, clients are left with the option of finding another agency, going without, or beginning with a private practitioner, who, of course, will be happy to see them as long as they would like to come, at a significantly increased price.

Kenneth Howard's article on the Dose-Effect Relationship in Psychotherapy printed in the February 1986 issue of the *American Psychologist* pointed out some valuable information. He and his colleagues provided data, based on meta analysis of studies on 2,400 patients covering a thirty-year period of research, showing the following:

1. There is positive correlation between the amount of treatment and the amount of patient benefit.
2. Fifteen percent of patients feel better after only one interview or even after scheduling the first interview.
3. By eight sessions 50% of patients are measurably improved.
4. By twenty-six sessions 75% are measurably improved.
5. For the average patient sample, the maximum percentage improved would be reached in approximately 52 once-a-week sessions.

It's not practical or necessary for many people to attend 52 once-weekly sessions. In fact, when this type of long-term therapy is undertaken, there are obvious abuses which can take place in terms of creating dependencies or making decisions simply to produce income for the practitioner.

Perhaps we shouldn't really take a stand that we will do brief therapy or long-term therapy, but rather that we will meet the individualized needs of each patient as they come for services.

The Bergin, Lambert (1978) research points out that psychotherapeutic treatment is consistently shown as being generally beneficial to patients.

It has a significant role in their lives. I can confirm this from my own personal experience. When I went to marriage counseling seven years ago, those interviews became the most important hour of my week. I looked forward to them and rehearsed over and over again in my mind what had been said as the week progressed. The hour was too short and seemed to fly by. I noticed when we started and ended and even a few minutes missed was significant to me.

Because what we do is important to people, it's easy to get overly caught up in the importance of our role as a therapist. It's equally as easy to take it too much for granted so that it becomes routine.

There is a Buddhist legend which tells of the future Buddha incarnated as a hare, jumping into the fire to cook himself as a meal for a beggar after shaking himself three times, so that none of the insects in his fur should perish with him.

People don't expect that kind of sacrifice from us and we shouldn't expect it of ourselves. We needn't sacrifice our time or energies to our clients to the degree that our own lives or families are harmed. To quote Ed Tucker, we are not society's guardians who can stamp out mental illness. However, if we just spend enough time at it, we do play a significant role in people's lives and ought to act accordingly both professionally and personally.

The final comments I would like to make are directed toward the role of religion in therapy. The world has probably always been confused about the purpose of life and the importance of values, but it is certainly easily noticeable today. James Kirkwood, the Pulitzer Prize winning author of "A Chorus Line," was speaking for many when he said, "Life has got to be one hugh joke. To my knowledge, nobody has ever come up with a logical explanation that fits any other alternative. But as long as we have been placed on the 'joke-board' there is nothing to do but play along with as much humor as possible."

I would agree with Mr. Kirkwood that the world does feel out of control and without meaning at times. It is when I feel that way the most, that I am most grateful for my understanding about

the purpose of life, and the role of Christ in it, that comes from my membership in the Church.

As a therapist for LDS Social Services, most of the clients I see are active members of the Church. Some I see are actively engaged in sinful behavior which is directly related to the negative feeling they have or the difficult life situations they have gotten themselves into. More frequently they are living rather traditional lives, following an LDS lifestyle, and there is no obvious relationship to any sinful behavior and their feelings.

LDS Social Services has the reputation in Utah of being a place where clients are told to live the gospel, pray and study the scriptures and their problems will go away. At the risk of sounding too defensive, I won't list all of the reasons why I know clients are not dealt with that way, but I will mention one. Our clients are, for the most part, already living the gospel, praying and reading the scriptures, and they're still hurting.

One of the advantages of working for LDS Social Services is that the door is open to appropriately make reference to a scripture, a religious concept or a talk from a general authority. For example, I have frequently made reference to Neal Maxwell's talk on Irony, Marvin J. Ashton's talk on Perfectionism, and Ronald Poelman's talk on Adversity from this year's April General Conference.

I don't want to use my time today to give my side of the debate about the question of whether we should be pursuing the discovery of a method of conducting gospel therapy. I do want to go on record as saying that I think issues related to religion are just as important as any others that can be raised in therapy. The solutions to problems are often rooted in clarifying answers to spiritual questions, and in putting one's life in harmony with those answers. When clients raise these issues, they have a right to have a therapist who is not confused him or herself. They also have a right to a therapist who doesn't think that they have the correct answer to all spiritual questions and the right to impose those biases on the client.

LDS doctrine includes the idea that all truth is contained within the framework of the gospel. We can be certain that as research

and practice continue to bring new information and procedures to our awareness, those that stand the test of time will be compatible with the principles of the gospel of Jesus Christ. Those that do not will ultimately fail.

One of my concerns about counseling when religious issues become the topic of conversation is the belief we sometimes have that religion should provide clear, easy answers to any question that arises. I like Bruce Hafen's comments reported in the August 1979 *Ensign* magazine. He said, "If we are not willing to grapple with the frustration that comes from facing bravely the uncertainties we encounter, we may never develop the kind of spiritual maturity that is necessary for our ultimate preparations." In the talk he also pointed out that often there are not Church approved answers to various questions concerning doctrine, policies or behaviors.

In my own practice, I probably see as many questions or difficulties that arise from overzealousness or misinterpretation of some spiritual matter as I do from under use or rejection of religious principles. I recently heard a classic example in a staff meeting. A man gave a priesthood blessing to his wife telling her to have an affair with another man because it would improve their own relationship. She did and ended up being excommunicated. I call this a classic example because the individuals involved probably had some measure of sincerity and had convinced themselves that they were doing the Lord's will. In reality they were mixing up their human feelings with what they wanted to interpret as spiritual promptings.

Other examples from this past week's therapy include a convert of 26 who was taught in a lesson she attended during the week that she was born into the home she was because of her degree of righteousness in the preexistence. The speaker didn't realize that the listener had been born into a home where she was sexually and physically abused. Or a couple married very unhappily for 15 years who have done some destructive things to one another and to their children but who have stayed together because they were told in a priesthood blessing they were promised to each other before coming to this life, a man with a narcissistic personality who said, "I really ought to trash my wife right now, but I know she needs an

opportunity to grow spiritually to my standard. She is a returned missionary and he's an exhibitionist. Or a woman who marries a man having obvious major problems which will significantly affect their marriage, but marries him only because she feels that her recently deceased husband is prompting her to do so.

Daily I deal with questions, as you do, about why a patriarchal blessing doesn't seem to be fulfilled, why a blessing for health wasn't realized, why sincere prayer and fasting on a relevant topic seemed to go unanswered, why devoted Church-service produced a strong quorum or ward but was destructive to one's own family, etc. It's probably not by coincidence that my talks in sacrament meeting nowadays are more inclined to stress patience and endurance than they did prior to getting into this profession. There aren't very many easy answers.

The fact that religion doesn't resolve all our questions should not be unduly surprising or disappointing to us. What's important is that it does provide a framework that gives adequate direction, when common sense, personal revelation, and patience are used. The Book of Mormon analogy of the gospel as a rod of iron is certainly an apt one. One of my favorite scriptures is Galatians 5:22 which states, "The fruit of the spirit is joy, peace and love." I believe that this is true though one will not always feel these, or only these, feelings. I'm frequently asked, as you probably are, "How can you stand to do this kind of work everyday? Isn't it depressing?" I regularly respond that of course it's depressing at times, but I stay in the field because I believe that change is possible and I'm optimistic about people. For every client who is just starting out, and is hurting, there is another one moving along in a healthy way who is beginning to feel better.

I'm proud of our profession and believe we really do have a lot to offer. It's been a good career choice for me and I hope it has been for you. I'm pleased with the strides that are being made in theoretical, practical and research-oriented aspects of the work. Our tasks are difficult and there will always be failures. Those failures may get more attention than the successes because people who have been helped tend not to talk about their therapy. I do think, however, there is much we can do to improve our image,

our training, our methods of merchandizing, our discovery of specific procedures which will predictably help people and, as Mormon therapists, our ways of being helpful within the Church setting.

I'm grateful to be a member of AMCAP and have found it helpful to me in my attempts to become more professional and clarify and resolve the occasional struggles I have had in the profession. I consider my relationship with each of you one of the most pleasurable aspects of my career choice. Thank you.

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Developing Positive Attitudes and Approaches When Working with Persons with Disabilities

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Abstract

More than ten percent of the population of North America have disabilities or chronic illnesses. Persons who acquire disabilities have many issues to face. Psychosocial adjustment can be difficult as they reconcile losses and explore strengths. Societal attitudes and policies create barriers to full functioning. Latter-day Saints with disabilities may face the additional challenge of reconciling spiritual beliefs with physical reality. This paper addresses the implications of disability and chronic illnesses with special attention to issues unique to Mormonism. Suggestions for professional intervention are provided.

Throughout Judeo-Christian history, examples of miraculous events abound. These experiences have been explained as manifestations of the power of God and as proof of God's working through His people. Enoch moved mountains and changed the course of rivers (Moses 7:13). In the desert, Moses caused water to spring forth from a rock that provided Israel's millions with water (Exodus 17:6).

In New Testament times, Peter healed a man who had been lame since birth (Acts 3:2–6). James taught that the elders should offer a prayer of faith to heal the sick (James 5:14–15). Christ taught that "signs" would attend his followers, including protection against poisonous serpents, and healings (Mark 16:18).

The restoration of the gospel through Joseph Smith was ushered in with many miraculous occurrences and heavenly manifestations. Latter-day Saints are taught that the priesthood is the means by

which Christ's followers bring about miracles. Each priesthood holder is taught that he has the power to act in the name of God. Priesthood blessings and healings are an integral part of Mormon theology and culture. Stories abound of personal lives touched by these events. Church meetings and conferences frequently include stories of the benefits of priesthood blessings. When medical, health, or psychosocial problems arise, priesthood holders are summoned, often in conjunction with or in lieu of professional help.

Every Latter Day Saint has heard scores of stories of healings and restorations to health as a result of priesthood blessings. Many have had these experiences personally. In those instances in which health has not been restored and an individual has died, survivors have felt comfort in the belief that the Lord needed the person on the "other side," or, "it was their time."

In recent years, an increasing number of people are surviving illnesses or disabling events who previously would have died. With advances in health care, people are living but rather than experiencing restoration of health, they have long-term health problems or disabilities. Psychosocial adjustment to illness and disability is often difficult as people are forced to cope with changes in lifestyles, activities, and roles. People who are LDS are frequently faced with another issue that can be as difficult to cope with as the condition. Many have been promised full restoration through divine intervention, but are left with long-term disabilities. This paper addresses the psychosocial implications for individuals and families who experience chronic illnesses or disabilities. Societal attitudes are discussed, as are issues specifically pertaining to LDS clients. The implications of unfulfilled priesthood blessings are addressed. Suggestions for working with LDS and non-LDS clients are provided.

Societal Reactions to Disability

In western society, people with disabilities are often relegated to invisibility or second-class citizenship. Physical access to public places and services have traditionally been limited (Richards, 1982). Access to education, employment, and social opportunities are

inadequate. The resultant lack of opportunities for people with disabilities to fully participate in society engenders ignorance and contributes to isolation (Ray and West, 1984).

Persons with disabilities are judged according to their limitations, not their strengths (Weinberg, 1983). A person with a mobility impairment is perceived as "confined to a wheelchair" or "crippled," rather than as utilizing a wheelchair for mobility. People with short stature are called midgets or dwarfs. Rather than viewing the disability within the context of the whole person, the disability becomes the standard used to perceive the person.

Public exposure to routine lives of people surviving illness or trauma with lifelong health limitations or disabilities is minimal and usually inadequate. The recent portrayal of the life of an individual with paraplegia on a local television news magazine illustrates the type of exposure most people experience. The "tragedy" of his accident and the "hopelessness" of his resultant paraplegia was explained. Then the documentary dramatized his "heroic" efforts and "undaunted" motivation to train for and excel at wheelchair athletics. The story ended with comments from choked-up commentators about how inspirational this man was to other "crippled" people and to "us all." No mention was made of the routine aspects of this man's life or of his family and work. Another story chronicled an Olympic runner paralyzed in an automobile accident. He was shown as he was carried "helplessly" in his wheelchair down a flight of stairs. Viewers were left feeling the man had suffered a fate worse than death. These types of stories, combined with lack of exposure to the disabled as ordinary people, reinforce inaccurate and stereotypical views of life with a disability, in which people are seen as objects of pity or as inspirational figures overcoming overwhelming odds to achieve success.

Mormon culture at times unwittingly reinforces the inaccurate perceptions perpetuated by society. A review of the *Ensign* Magazine from January 1987 to July 1989 produced some interesting results. The terms "confined to a wheelchair" or "wheelchair bound" were used at least eight times. Other references to people with disabilities included such terminology as "victim of cerebral palsy," "cripple," and "risen above her handicap." At

least nine articles referred to the chronically ill or disabled as objects of service. There were at least eight references to miraculous healings sparing the person death or disability as a result of faith and/or priesthood blessings. While these stories may be inspirational, unless they are balanced with stories that normalize life with illness or disability, they unwittingly reinforce negative stereotypes.

The Trauma of Unfulfilled Blessings

It is the responsibility of each priesthood holder to always live worthily to exercise his priesthood when the need arises. When acute illnesses, accidents, or other traumatic events, or acute psychological distress occur, blessings are frequently requested on short notice. The priesthood holder has little or no time to prepare before giving a blessing. The person and loved ones for whom the blessing is requested are in crisis and may have high expectations of the blessing. This places performance pressure on an already stressful situation. The motivation to pronounce a "satisfactory" blessing may be extremely strong. When the person giving the blessing is a loved one of the recipient, even more pressure is added. For example, when a father gives a blessing to his child who is gravely ill, he will desperately want to give a healing blessing. His wife and other loved ones may have strong desires for him to bless the child with health. In these situations, emotion can prevail over inspiration.

The following case example is illustrative. (Please note that all case examples are presented to assure anonymity.)

> M.J., a 16 year old girl, sustained multiple injuries, including a severe head injury in a single car rollover. Her family was informed that her prognosis for survival was approximately 50% and that if she lived, she would be permanently and severely disabled. Her grandfather, considered a family "spiritual giant," was called on to give the comatose M.J. a blessing. After a "powerful" blessing for healing, M.J.'s family felt confident that her grandfather's promises would reverse the effects of the accident and that M.J. would return to health.
>
> M.J. survived, and though she was blessed that she would be "made whole," she has lifelong physical and cognitive deficits that will preclude her from returning to a normal life or allow her to live independently. M.J.'s grandfather carries much guilt in the belief that he failed his

granddaughter and disappointed his family. He blames himself for her condition, assuming that his faith was insufficient for M.J. to be healed. His feelings of inadequacy are intensified when he attends church meetings or listens to general conference addresses and hears stories of others who received blessings that restored them to full health.

The tragedy of M.J.'s injuries and subsequent disabilities is compounded by the confusion and guilt of her loved ones that the blessing she received failed to produce the intended results. M. J. is incapable of understanding her situation, but her family has been doubly traumatized.

The following example is illustrative of reactions individuals can have when blessings they receive are not literally fulfilled.

T.S., a 52 year old businessman, suffered a dislocation fracture of his eighth thoracic vertebrae, transecting his spinal cord and resulting in T 8-9 paraplegia when the motorcycle he was driving was struck by a car. Alert and oriented when he reached the hospital, yet unable to move or feel his lower extremities, he immediately requested that a long time friend and prominent church leader be called to give him a blessing. Within hours of his accident, T.S. was promised through this blessing that he would be "made whole" and that he would "walk out of the hospital." Throughout his initial hospitalization, though he experienced no return of neurological function, he remained confident that his health would be restored. For two months he participated fully in his hospital program "to do (his) part;" however, he refused to allow a wheelchair purchase because of the assurance he received that he would walk out of the hospital "whole."

Only when it because obvious three days prior to his discharge that he would not leave the hospital "whole" did he authorize a wheelchair rental. It took several months after that before he would begin to verbalize that his condition might be permanent.

Three years after his accident, T.S. was still befuddled about "what went wrong" with his blessing. He vehemently rejected suggestions that his blessing either was intended to reflect a future cure or was a promise intended for the resurrection. He was adamant in his conviction that he was promised that he would be healed before release from the hospital.

T.S. sought counseling from an LDS therapist after hearing in general conference of a young man who had a miraculous recovery from similar injuries. He was distressed at the speaker's explanation that the young man was restored to health because of the blessing he had received combined with his faith and hard work. As T.S. pondered the

implications of this story for him, he experienced an increasing sense of despair. He had experienced absolutely no return of function even though he had demonstrated all the faith as he was capable of and he had worked as hard as he could. Feelings of self-worth were negligible. He openly questioned God's love for him. He was also extremely distressed because other members of the church questioned his faithfulness when he was left permanently disabled after receiving a blessing from a respected church leader. He expressed suicidal ideations, stating the primary reason for not terminating his life was his fear of the "eternal consequences" if he did.

The stories of M.J. and T.S. graphically illustrate some of the intense problems faced by Latter-day Saints who are personally affected by long-term disabilities or chronic health problems. For some, the disappointment and confusion of unfulfilled blessings may be more difficult to cope with than the process of adjusting to their disability.

Competence in Counseling Persons with Disabilities

Therapists' comfort with disability have great implications for their therapeutic effectiveness. It is critical to see the clients' capabilities, not just the disabilities and deficits (Ben-Sira, 1986). Knowledge of the implications of a person's disabilities is essential. For example, knowing that paraplegia causes paralysis of the legs is insufficient. Depending on the level and severity of injury to the spinal cord, chest and trunk muscles can be affected, anesthesia below the injury is produced, and bowel, bladder, and sexual dysfunctioning can result. Likewise, when counseling an individual who has had a brain injury, it behooves counselors to understand the range of possible cognitive, emotional, behavioral, and social deficits they might encounter and with which individuals and families must contend. Counselors who understand the implications of their clients disabilities are much more likely to establish rapport and trust and develop effective treatment strategies than those who are not armed with this knowledge.

When working with LDS clients, counselors should be prepared for the spiritual concerns that frequently arise. Among these are doubts about self-worth and uncertainty about God's love or

power. The following sections outline some of these questions and provide suggestions for therapeutic interventions.

Spiritual Concerns

Most members of the church who become disabled are able to resolve their religious and spiritual concerns independent of professional help with the support of their families, and sometimes with the help of local church leaders. Those who seek professional help with their spiritual quandaries may be deeply troubled by them and will typically seek an LDS counselor who they perceive can understand and accept them. Frequently encountered questions include:

1. "What have I done wrong that makes me unworthy to receive God's blessings?"

These people blame themselves for their problems. They believe they would be healed if they were worthy of God's blessings. They become demoralized by their perceived unworthiness and inability to gain divine approval.

2. "Does God love or care less about me than those people who have had miraculous events in their lives?

The power of God is not questioned, but the person's relative personal worth is scrutinized, often with the conclusion that for some reason, God loves or cares less about them than others who have been beneficiaries of His divine intervention.

3. "How could the church be true when I was promised that I would be healed and nothing happened?"

These people are in danger of losing their testimonies of the gospel. They have been deeply hurt and disappointed and may begin to attribute any manifestation of priesthood power as coincidence.

4. "How are my faith and actions inadequate for the Lord to help me?"

This question is often asked when a blessing has been predicated on the faith and efforts of the recipient, who as a result, blames himself or herself on the lack of fulfillment. They believe that

somehow they did not work hard enough for the blessing's fulfillment. This self-denigration produces guilt and despair.

5. "What was the matter with the person who gave me the blessing?"

These people may blame their condition on the person who gave the blessing, reasoning that someone more worthy would have produced successful results. It is not uncommon for them to seek out others for repeated blessings in futile attempts to achieve the desired results.

6. "Is there a God?"

These people question whether a loving God could consign them to the existence they have. They are mourning their losses and see little hope for the present and the future. They have a tendency to become cynical and bitter.

These questions can shake spiritual foundations and clients may agonize over them for months or even years before seeking professional help. Likewise, loved ones of persons with disabilities may be unable to reconcile the disparity between reality and shattered expectations. The inclination to offer conventional explanations to these dilemmas should be avoided, as they will usually be rejected. These include:

1. "The individual will be 'made whole again' in the resurrection."

This gospel principle is a great comfort for members of the church. Everyone has this promise. However, this explanation does not address the lack of health restoration in this life. As T.S. stated when offered this explanation, "I was blessed I would be healed in the present. There was no reference to the resurrection." The promises of the restoration in the resurrection are unrelated to the immediate situation.

2. "The disability is a test from the Lord."

This explanation is difficult to accept when the person acquires serious cognitive deficits or develops uncontrollable dysfunctional behaviors, or, in cases of coma, lack of consciousness secondary to illness or accident. Similarly, it seems out of character for the Lord

to impose problems of this nature as a test. While people may use experiences as a result of disability for growth, and the Lord allows misfortunes to befall people, it is out of the Lord's character to create catastrophes for this purpose.

3. "Hard work will bring the Lord's healing blessings."

This explanation given to a paraplegic with atrophied and anesthetic limbs or to an individual with multiple sclerosis who has witnessed long-term deterioration of function with no realistic hope of symptom reversal will be viewed as wholly inadequate.

4. "The individual is being used as an instrument in the Lord's plans."

This statement may be valid for everyone from an eternal perspective. However, a God who brings tragedy to people for some unknown purpose seems incongruous with the God of Mormonism.

Though these frequently offered explanations are culturally acceptable, they are speculative and therapists are prudent to avoid using them to find meaning for the person's disability. Therapists may encourage clients to search for personal meaning from these speculations but should avoid offering them as explanations. It is important to acknowledge the fact that the reasons they were not healed may never be known. Therapists should also encourage clients to seek explanations directly from the Lord and to seek reassurance of God's love and concern irrespective of the disability. Eventually people need to concentrate their efforts on coping with the reality of the situation. They then can focus on the task of making happy, productive lives for themselves. Suggestions for counseling are outlined below.

Gospel Issues

Clients who come for counseling as a result of unfulfilled expectations for divine intervention may have more difficulty with this than with their disabilities. They may question the gospel principles they have been taught for years; in some cases a lifetime. Efforts to find *the* reasons for their current conditions have been futile, though most have experienced much speculation about their

situations. Some seek therapy, seeking explanations for their conditions—an expectation therapists cannot fulfill because the answers to these questions for individuals are rarely discovered. Rather than focusing exclusively on their blessings, clients should be encouraged to attend to their personal relationships with Christ and seek a reaffirmation of His love for them. In addition, attention to the larger perspective is often helpful.

A discussion of blessings in the church is desirable. It is important to help the client understand that the miraculous events they read about in scripture and other publications and those they hear about in church meetings are not *samples* of everyday events, but are *shining examples* of what can happen. Were they common events, they would not be the subject of the attention they receive. These accounts are not the norm; rather, they are exceptional situations.

It may be valuable to discuss with clients their perception of miracles. Many people ascribe divine intervention as the cause of events that have causes that are more complicated. In a recent fast and testimony meeting, a mother related the story of her daughter's brush with death. She told of her daughter's central nervous system infection that produced serious neurological symptoms and required emergency hospitalization. She talked of the blessing the child received shortly after admission to the intensive care unit, and her recovery that began shortly thereafter. A physician who was aware of the situation and heard this inspiring story mused on the miracle of modern science and the newly developed antibiotics that helped restore this girl's health. The majority of the congregation left the meeting that day with the belief that the blessing the girl received was *the* reason for her restoration to health. On the other hand, while appreciative of the priesthood, the physician left feeling more appreciative of the "miracle" of recent technology and antibiotics used to treat this girl and to the many others he had seen "healed" in a similar fashion.

It is important in therapy to address the circumstances of the accident or illness. A discussion of the stress and emotional effects on all involved may help the client put into perspective the pressure priesthood holders may feel when they receive emergent requests to

give blessings in times of crisis. This can help clients begin reframing the blessings from a personal or divine failure to a manifestation of desperation and love that led to inappropriate promises. This prepares clients to understand that individuals may let their feelings and desires override inspiration especially when there is inadequate time for spiritual preparation.

Intervention Strategies

A major focus of therapy for people with recent disabilities should be on living in the present and planning the future. Clients may tend to focus on their losses, mourn the past, and ruminate on things they could once do but are now unable to engage in. They need assistance to see the options still available to them. For example, a young amputee who loved basketball became distressed over his inability to play ward basketball with his friends. At the urging of his counselor, he began playing (and enjoying) wheelchair basketball. His teammates with similar disabilities exposed him to numerous other recreational opportunities and social contacts. In another situation, a woman with a serious visual impairment from diabetic retinopathy was able, with supplemental vocational training, to transfer her skills as a medical-surgical nurse to a mental health setting.

As clients begin to explore their potentials and recognize their strengths and abilities, they will develop the capacity to find pleasure in the present and plan for the future. For example, a parent who is mobility-impaired may be unable to engage in activities such as family hiking excursions, but may choose adaptive physical activities or other, nonphysically limited pursuits. In one family Mr. R., a 35 year old father of three young children, was unable to continue working as a mechanic after becoming paraplegic from an auto accident. Though he received Social Security Disability benefits, he became depressed over the loss of family income and insurance benefits. His relationship with his wife deteriorated as they struggled to deal with the physical implications of his disability and the lifestyle changes brought on by his situation, such as the dramatically increased amount of time they spent together. His wife had been a school teacher prior to their

having children but had worked very little for eight years. During therapy, the R.'s explored the possibility of Mrs. R. returning to her profession as a way of bolstering their finances and reinitiating medical benefits. This avenue was pursued successfully. Mrs. R. enjoyed returning to elementary school teaching. Mr. R. fulfilled the role of homemaker in the family. With Mrs. R. out of the home, Mr. R. felt less like a burden and more like a contributing member of the family. Although unable to engage in previous vocational pursuits, Mr. R. took pride in his responsibilities as a homemaker and primary care parent for their children. The R.'s were also able to spend time away from each other, thus alleviating some of the day-to-day stress they had previously experienced. As a result, their marriage and family relationships were strengthened.

Clients may need help in accurately assessing their present and future capabilities and in planning life goals and activities accordingly. In some cases, the use of physical, medical, and/or psychological evaluations may be valuable planning guides. This is particularly important in the presence of cognitive problems. For example, R.S., an engineer, sought counseling six months following traumatic head injury received in an automobile accident. Though hospitalized only three weeks, R.S. had been forced to leave her job because she was unable to do the work she had previously had done due to memory and reasoning difficulties. When psychometric tests revealed mild to moderate cognitive deficits, a program of cognitive therapy was instituted as an adjunct to individual therapy. In addition, vocational rehabilitation services were arranged to help R.S. find alternative work in a timely fashion. In this case, psychotherapy alone would have been insufficient. The necessary environmental interventions were made possible only after a thorough assessment of R.S.'s condition was completed. The therapist consulted with the rehabilitation counselor as she helped the client adjust to her head injury and develop strategies to compensate for her cognitive deficits.

Occasionally, direct intervention with significant others on behalf of clients is warranted. The vast majority of employers, ecclesiastical leaders, and friends will have extremely limited experience with persons with disabilities and will benefit from

minimal education and guidance. An employer may need information on physical accessibility to prepare for an employee's return to work. A bishop may benefit from suggestions on how to effectively use the services of a ward member with a disability as a resource. The counselor may be of value, then, as an educator, mediator, and, at times, as an advocate for the client.

Attention to sexuality is vital, especially when sexual and genital function are altered by the disability. Early sexual counseling and education for the physical implications prevents potentially serious problems that arise without prompt intervention (Mackelprang and McDonald, 1987). Guilt and fear prevent people from seeking help for sexual problems; thus, therapists may need to initiate discussion of sexual issues. Tasks in helping clients sexually adjust include exploring and increasing comfort with body image, assessing physical and sexual capabilities and limitations, and developing a repertoire of sexual options. To complete these tasks it is imperative that clients are sexually educated and are able to communicate their desires, wishes, concerns, and fears.

Summary

With continuing advances in medical technology, the number of people with disabilities will continue to grow. Latter-day Saints who acquire disabling conditions experience the same adjustment processes as others, but are often faced with the additional task of reconciling their spiritual beliefs with their physical limitations, especially when comparing themselves to the recipients of miraculous interventions. Increasingly, LDS counselors and psychotherapists will have opportunities to provide professional services, but in order to do so, must be prepared to assist with their clients spiritual and biopsychosocial needs. Therapists act as resources for clients as they attempt to adjust to altered lives and bodies. They can provide support as clients struggle to reconcile their feelings about the gospel. They are also valuable mediating and educational resources. With increased sensitivity and awareness of the problems people with disabilities encounter, we can assist them in the quest of leading full and productive lives.

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Male and Female Roles as Therapists: Is There a Difference?

Deborah A. Christensen, PhD

The title of this presentation, "Male and Female Roles as Therapists" suggests the existence of a dichotomy and creates a sense of polarization. This disturbs me because I don't want to be misunderstood as valuing one gender or the qualities of that gender in a way that would lessen the valuing of the qualities of the other. Oftentimes when I have given presentations on women's issues and women's strengths I have been asked, "Well, what about men; don't you like them." I'm not sure why it is that when someone speaks out favorably for men, it is generally interpreted as speaking out against men. Let me assure you that I seek to diminish this polarization, not to intensify it. I know many good men. I have learned much from them, much about myself and much about my value as a woman. I have learned to enlarge on my natural feminine qualities through interaction with both women and men. I have learned to value the differences and the commonalities between genders and to find additional strength because of both the differences and the commonalities. I have learned that as we mature, the differences diminish both in actuality and in importance.

However, I don't know how to talk about differences without creating a sense of polarity and I don't know how to talk about gender qualities without making some stereotypical, generalized statements. Generalizations, although necessary for a more complete understanding of our personal processes, are replete with

problems. I do not wish to create a false polarization of the sexes in ways that violates either the precision of science or the diversity of human experience. Any study of group differences requires generalization for which there are many exceptions. Unfortunately, these generalizations tend to stereotype and simplify people, to magnify group differences and minimize the commonality of the human experience. However, I also do not want to state that issues of gender are unimportant or deny that gender is a crucial variable in understanding the human experience. I believe that the issue of gender is an exquisitely vital component of understanding a person's human experience—a variable that can be over-stressed, but is more often overlooked.

Generalizing: What Do We Know About Gender Differences?

Possibly the greatest difference that we find now defined between men and women is that women experience a sense of interconnectedness that is qualitatively different from the male's experience. Chodorow (1974, 1978), Gilligan (1979, 1982), and Miller (1973, 1976), all of whom have been engaged in developing a theory of women's psychology, view interpersonal relationships rather than autonomy as anchors of female experience. A man's life may be defined by his achievements and his developmental "goal" may be to achieve a sense of autonomy, but a woman defines her life by her relationships and her development is measured by relationships.

Women are more likely than men to believe that, ideally, all activity should lead to an increased emotional connection with others. (Miller, 1986) Women seem to feel connections more intensely and place more importance on connections with others.

Another difference that has been delineated is found in the style of thinking. Male thought tends to be linear and logical. Gregorc refers to this as "systematic thinking" (Gregorc, 1982, 1985). Female thought tends to be multivariant and multidimensional. A woman's thinking has been described as scattered (Schaef, 1985), and random (Gregorc, 1982, 1985). I prefer the term multidimensional. Neither linear or multidimensional thinking is "right."

Both have merit. Our culture tends to place greater value on logical, linear thought.

Schaef (1985) claims that women believe in the abundance model of power—that there is enough power for everyone, that we don't need to compete against each other. When in leadership capacities, men tend to act in a scarcity model—a model that promotes competition. According to Miller (1986): "Another important aspect of women's psychology is their greater recognition of the essential cooperative nature of human existence" (p. 41). Because of these qualities, women's leadership focuses on facilitating others expressions of self (Loden, 1985). Male leadership roles focus on getting the task accomplished. Woman are, therefore, more relationship focused and more focused on people, even in roles of leadership. Loden (1985) explains that when women are in leadership positions their operating style is cooperative. A man's operating style tends to be more competitive. Women value an organizational structure that utilizes a team approach. Men tend to organize in terms of hierarchy. A woman's business objective tends to be quality output. A man's business objective tends to be winning. Women tend to value the rational and intuitive in problem solving. Men tend to undervalue intuitive thinking. Characteristics of feminine leadership styles include lower control, more empathy, more collaboration, and higher standards. Male leadership styles are characterized as high control, strategic, influential, and analytical. I realize that many of us have experienced female leaders as oftentimes being more controlling and hierarchal than male leaders. I propose that this is not due to a deficit in women or that Loden is incorrect when she defines differences in male and female leadership styles. This is due to the fact that we live in a society that has long valued maleness and male qualities over femaleness and feminine qualities. Women have been taught and encouraged to develop a male leadership style in order to compete in a male-dominated society. A female leadership style has not been valued and many women have felt a pressure to give up their innate feminine qualities in order to be successful in a male-defined world. According to McClellan (1975):

> The traditional male's single minded, specialized assertive life style is far too dominant and too much valued in so-called advanced societies. Both women and men are drawn to it—to full-time specialized careers, for instance—because that is the only way to be fully respected in our contemporary western society. (p. 93)

Additional differences include the fact that women are more impacted by society than men (Moberg, 1962). Women are less able than men to ignore what is going on around them (McClellan, 1975). Women are more contextual than men (Gilligan, 1982). When making decisions, women spend more time taking into account and giving consideration to the context of the problem. Men are more able to extract the problem from the context and make a decision based on abstract principles. Because culture impacts women more than men, it is vital to understand the impact of culture on women. A woman's life cannot be seen as separate from her context, but must be considered as imbedded in her context.

Men tend to impose hierarchies to increase their understanding and control over their world. Women prefer a sense of equality (Gray, 1982).

I have just delineated a large number of differences between the genders. Now, let me remind you that these are generalizations and there are problems with generalizations. None of us fit into these simplistic, stereotyped categories. Additionally, from research on human development we know that we all tend to become more androgenous as we mature. In other words, men as they mature begin to develop those qualities that are defined as "feminine." Women, with maturity, add qualities that have been traditionally defined as "masculine" to their repertoire of behavior (Gilligan, 1986). For mature individuals, gender differences are not as great as for those who have experienced less of their developmental process.

The Necessity for a Greater Understanding of Sociological Impact

Because women tend to be more impacted by society than men, it is necessary when involved in therapy with women to be aware of the impact of society. The now classic report of the influence of sex-role stereotypes on concepts of adulthood (Broverman, et al., 1970), attests to the close association between standards of adulthood and a cluster of characteristics valued in males including competence, rationality, and assertion. What this study indicated was that the qualities by which we defined adulthood were the same qualities by which we defined maleness. Qualities that are defined as feminine were qualities that were considered to be undesirable in adults, including such qualities as subjective, passive, and illogical.

Broverman, et al. (1973) suggest the distinction between standards for women and those for adults presents a problem for women:

> Women are clearly put in a double bind by the fact that different standards exist for women than for adults. If women adopt the behaviors specified as desirable for adults, they risk censure for their failure to be appropriately feminine; but if they adopt the behaviors that are designated as feminine, they are necessarily deficient with respect to the general standards for adult behavior. (p. 45)

As others have suggested (Gilligan, 1986; Swidler, 1980), the problem does not exist with the defined characteristics of men and women, but with the overvaluing that our society places on male qualities and the undervaluing of that which is innately feminine. Swidler (1980) indicates that this one-sided conception constitutes a threat to society, one that stems from the central importance Americans give to individuality and the low value they place on social connectedness, a tendency that makes for a society that is out of balance. She suggests that this imbalance has implications for individuals and their capacities for love and work:

> In some ways, the most crucial shift in our culture is a change in the symbolic and moral grounding of the self in modern society. If the self can no longer find definition in a single set of adult commitments, a set

> of roles which consolidate identity, what can the self be? If it must be defined, as implicit in the modern culture of love, by its ability to resist attachment, by its ability to go through changes without being fundamentally changed, then have an ideal of a self cut off from meaningful connection to others, from any danger of commitment, attachment, sacrifice, or self-restraint. This is a model of human relationships in which people are not willing to take the risks of disappointment and defeat that inevitably accompany meaningful love or work. (p. 144.)

How Can an Understanding of Gender Differences and an Increased Sociological Awareness Help Us Become More Effective as Therapists?

Being male does not condemn one to tunnel vision or chauvinistic attitudes. Being female does not guarantee freedom from unconscious bias and prejudice against women or men. In fact, being feminist may lead to unconscious bias against men, something that female therapists must watch for (as male therapists must watch for) chauvinistic attitudes.

Because psychology and psychological experience have long been defined by men from a male's perspective, we live in a society where the understanding of a woman's experience has been contaminated with male myths about women. It is important for all of us to become more aware of the male myths involving the female experience. It is not only important for men but women also should understand these myths. In studying psychology from a male paradigm, many women have abandoned their own experiences as females in favor of accepting the male-defined experience as the "ideal." These women need to gain a clear perspective of the "myths" they have accepted about the female experience.

Some of the myths that I have been able to define include the myth that autonomy is the cornerstone of development; that adulthood is a continual process of separating. Dependence is to be avoided. Independence and self-sufficiency should be sought. We should develop ego boundaries that are solid, not easily permeable. We should not be changed by our relationships with others.

Additional myths include the belief that logic is better or more reliable than intuition. Feelings are less important than thoughts.

We have long defined sexuality from a male perspective. We have been taught that there is something wrong with a woman who doesn't experience orgasm through vaginal intercourse. She is described as frigid. How many of us have considered that female sexual pleasure may simply not be designed to be experienced in the same way as male sexual pleasure?

We have been taught that reality is structured according to a hierarchy; that hierarchal thinking *is* reality. We have too longed believed that diversity can be ranked. Gray (1982) explains that this form of thinking is nothing less that a conceptual trap. If we were to remove ourselves from the conceptual trap we would be able to comprehend that diversity does not exist to be ranked, but to be honored. We would be able to comprehend the universe as a dynamic system, a system that is kept in motion and wholeness because of diversity.

Women need their perceptions of their experiences validated. Because we have had little understanding of the female experience, reality checking in the past has meant testing out reality according to a male paradigm. The therapeutic process must validate the woman's experience of her own reality and help her to know and understand it. Oftentimes, I have seen women in therapy that had previously been involved with male therapists. As they define "what's wrong with them," I find that what they are telling me is wrong with them is very similar to my experience as a woman. They have been judged against a male paradigm and assumed the correctness of the paradigm rather than the validity of their personal experience. When they find their unique female experiences validated in therapy, the process of development and healing which is natural and innate is facilitated. Women need to know that what they experience as women is oftentimes a "normal" experience when accepted within the framework of their femaleness. We need to increase our understanding of the female experience. Female therapists can do that by learning to be conscious of their own experiences and to validate those. Male therapists can increase their understanding by improving their listening skill and making

fewer judgments about a woman's experience. None of us should assume too quickly that we understand another's experience.

The traditional psychotherapy model is that of a man in authority and of a in woman in need: a dyad that replicates and reinforces the inequitable power distribution many women have had in their relationships with men as fathers, husbands, and employers. Because we now know the value of equal relationships for promoting female development (Miller, 1986; Christensen, 1988) we can seek to develop therapeutic relationships with our clients that approach relationships of equality. Ballou and Gabalac (1985) address this as they explain the necessity for the therapist to view the client as equal in value and worth to the therapist. To accomplish this goal, they state that the therapist must operate on the assumptions that: (1) all client verbalizations are valid, not defensive or unconscious symbolizations; (2) all information about the client (case notes, earlier diagnosis, reports, etc.) can be shared with the client; and, (3) the values and beliefs of the therapist should be explicitly communicated. They also advocate that the therapist utilize appropriate self-disclosure to contribute to a sense of equality in the therapeutic relationship. Greenspan (1983) explains:

> Emotional self-disclosure is one of the cardinal taboos of traditional therapy. The therapist who reveals himself is by definition unprofessional—for professionalism hinges on the posture of distance. It is just this distance, the emotional withholding of the therapist, that is considered essential to his neutrality. Yet it is a male bias to think that this is so. In fact, there is nothing more inherently neutral or scientific or professional about emotional distance than there is about emotional connection or nurturance. (p. 28)

Because we know so little, we must, as therapists, be willing to be changed by the process of therapy. Usually we as therapists enter into the therapeutic relationship with more protection than our client. We are the "helper" and therefore our perception of reality is assumed to be correct. We judge the client's wholeness by our experience. To become impactful as therapists, we must be willing to let the therapeutic experience change us also.

As we model the valuing of the feminine, women can learn self-value and men can increase their valuing of women and feminine qualities. I have long been distressed as I have sat in professional staff meetings and listened to both male and female therapists refer to their clients as "girls." This represents a lack of valuing of things female. When I have questioned my colleagues about the use of the term "girl," they may substitute the term gal or lady, but continue to avoid the word "woman." They claim that the linguistic use is merely a cultural habit, that it is of no psychological relevance. However, one's choice of language reflects one's unconscious assumptions. As mental health professionals, it is imperative that we recognize our unconscious assumptions and challenge them.

Lerner (1988) points out that on some level people are cognizant that only the term woman has sexual and aggressive implications. One can see, for example, by completing the following sentences that these terms are hardly interchangeable.

1. She feared that after menopause she would no longer feel like a real _____.
2. Mary is modest and soft-spoken. She's a true ____.
3. When Ann's first period came, she knew she was on the road to becoming a _____.
4. She felt very passionate when she was with him; he made her feel very much like a _____.
5. She felt frivolous and young, just like a ___ once again.

Linguists have noted that the term "lady" removes the sexual implications inherent in the word woman (Lakoff, 1974). Similarly, lady suggests an absence of aggressive impulses in the female sex.

While the term "lady" desexualizes a woman, the term girl serves to impart a lack of seriousness to ambitious, intellectual, and competitive strivings that women may pursue. The fact that mental health professionals experience adult women as "girls" or

"ladies" says something about our unconscious assumptions about women.

Women can model an acceptance for the importance of relationships, connectedness, and interdependence, but they must also model a sense of self that is autonomous. A female therapist needs to value her autonomy as she values her connectedness. Although connections and relationships form the basis for female developmental process, autonomy is also a valued process. The process of autonomy has been long stressed as the only legitimate process. Although we are now learning to value connections, we should continue to value autonomy. What we should be seeking is a balancing of feminine with masculine, not an overthrow.

According to Greenspan (1983):

> Therapy from a female perspective is not therapy from the "narrow" perspective of women. On the contrary, it is therapy from a wider perspective than before: one that includes what has been missing from the traditional male orientation. Compassion, empathy, intuition, nurturance; these are all culturally feminine skills which are actually essential to the practice of good therapy for women and men. Traditional therapy tends to ignore or devalue these skills while stressing the culturally "masculine" skills of intellectual mastery, discipline, control, and distance. (p. 37)

For each of us to become more effective as therapists, we need to recognize and honor both the feminine and the masculine within us. We need to recognize that society's over-valuing of the masculine presents a problem for all of us as we strive to become more mature and truly androgenous. We need to recognize both the feminine and the masculine in our clients and honor the equality of the diversity within and between each of us.

We come back to the title of this presentation, "Male and Female Roles as Therapists: Is There a Difference?" My answer is that in excellent therapists there is probably very little difference. However, the process of becoming an excellent therapist demands an awareness of gender differences and a honest striving to honor the diversity of masculine and feminine qualities that are within each of us.

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The Best of Both Worlds

Clyde A. Parker, PhD
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Today we are to talk about being male and female and about counseling and psychotherapy. After much pondering, I've come to the conclusion that I know four things about the topic. The first is that real men do not eat quiche. The second is that real women do not start wars. I also know that I love quiche. This confuses me because I have always thought that I was a real man. And, the last thing that I know is that Golda Meier, Indira Ghandi, and Margaret Thatcher have in this century all started wars in defense of their own country (Frazier, 1989). Now, not having lived with Golda Meier, or Indira Ghandi, or Margaret Thatcher, I have no way of knowing if they *are* real women. Having spent time in India while Indira Ghandi was the ruling Prime Minister, and being aware that she had two sons, certainly left me with the impression that she was a *real* woman. My reading of the lives of Golda Meier and Margaret Thatcher, leaves me with a similar impression. Thus, I'm confused. Perhaps I don't know what a *real* man or a *real* woman is!

But surely we know what *real* counselors and psychotherapists are! A good beginning is in the first volume of the *Journal of Counseling Psychology*, published just 35 years ago, where William Farson (1954) declared, "The counselor is a woman."

> By and large, in our American Society, the male is expected to be clever, tough, strong, courageous, independent, more concerned with things

> than with people, whereas the female should be tender, gentle, loving, dependent, receptive, passive, more concerned with family and interpersonal relationships than with things. If we were to say which of these roles best matches the kind of behavior it is most important to embody as a counselor, we would, no doubt, agree that the female role comes closer. In this sense, the counselor is a woman (p. 222).

Farson (1954) was writing at a time in which our counseling profession was dominated by Rogerian principles. In fact, counseling as a profession was emerging from vocational guidance on the one hand and analytic therapy on the other. In establishing itself, the appeal of Rogerian nondirective counseling was seductive. Counselors were to "follow the client." They were not to lead, but to provide a sense of "being with" the client. The great debates with Frederick Thorne, E. G. Williamson, and later B. F. Skinner, carried a tone of Rogerian ethical and moral superiority. Counselors and therapists who could be empathic, congruent, understanding, were not only highly valued, but purported to provide the "necessary and sufficient conditions" for therapeutic change. As Farson (1954) put it:

> As the experienced counselor becomes more competent in dealing with hostility and negative attitudes, he discovers that these are far less threatening and far less important abilities than the ability to accept and express love and deeply positive feelings. As he becomes more able to accept perversity and aberrant behavior, he realizes that some of the most intensely threatening experiences are ones in which the behavior exhibited is very normal and natural. The threat exists because our ability to accept such behavior is so severely limited by our cultural roles (p. 222).

The identity of the counselor as a woman was intensified further through the '60's and '70's as the political push for equality among races, ethnic groups, religious groups, and men and women received national and international support. As part of that, I along with most of you, received very careful tutelage regarding what I did not understand about women. Part of my instruction came from my normal daily living and interchange with my wife, part from my students, part from my colleagues, and much from clients. Though I hardly believe that I know all there

is to know about what I didn't know, I like to think I've learned a great deal about the special needs of women.

When the time came to consider this presentation, I realized that my education was far from complete on the other side. That is, I could hardly speak to what a female therapist needed to know about men! As I do in such situations, I turned to my staff for help. They were as perplexed as I with the question. Their response was nearly unanimous in taking the position that the proper counselor's role is to provide a role model for either male or female clients. But, a good role model of what? If, as Farson says, the counselor is a woman, what modeling is provided for a male?

My next foray into the problem came on the following Sunday when I was asked to teach a Priesthood lesson concerning the proper roles for mothers and fathers in the family. The writer of the manual challenged the readers (all Priesthood bearers) to adopt the characteristics of "Christ-like masculinity." I will have to admit that the phrase itself had a jarring quality about it to me. Think about it—Christ-like masculinity. What does it do to you to hear those words together? When I posed the question, what is Christ-like masculinity, to a good female psychologist friend, the response was immediate, "Why, that's an oxymoron!"

Now, I must admit that she had overstretched my vocabulary, and I had to ask for a definition of an oxymoron. "Those are contradictory terms used to describe the same thing," she said. Then with some emotion she went on to say, "How can you talk about being Christ-like and masculine in the same sentence?" Her point was that Christ's life was a model for both men and women. Not for men alone. The principles which he espoused, lived, and taught, were not principles that applied to men differently than they did to women. They were principles of human behavior that apply to all of us. Thus, to be Christ-like is to be both male and female. Could it be, then, that the role of the counselor or therapist is to be the best of being male and the best of being female?

Twenty years ago, Carkhuff and Berenson (1969) provided a corrective to Farson's article written some 15 years earlier. Integrat-

ing the more active therapies of the 15 years succeeding Farson's paper, they noted:

> The evidence suggests that the effective counselor is a man and woman, feminine and masculine, and often in that order. He is mother when that is appropriate, usually for those many counselees who have not experienced sufficient quantities of nurturant responsiveness. He is father when that is appropriate, and that is for those many counselees who have not had adequate models for well-directed, action-oriented life. He is both mother and father for those counselees who have experienced neither—and they, too, are numerous (p. 25).

It is when the counselor is too one-sided (e.g., mostly nurturant or mostly confrontational), that problems of extreme transference are most likely to occur. What counselor has not been in difficulty because his or her nurturant and acceptant listening has been misinterpreted by a needy client who has always wanted such nurturance from his or her significant family member? I believe that such transference is aroused because parents have not incorporated a healthy balance of the male and female.

The male and female metaphors combine to give us a picture of the complete therapist. These metaphors are universal and historical. Together they have great power in understanding the role of the counselor and therapist in today's world.

Now that we have established that the complete counselor is both male and female, we can return to the confusion over what is a real man or a real woman. Margaret Mead (1975) reminds us that there have always been two models of what life may be: "One of them is the model of a world filled with living things that grow without interference as they have grown for a million years" (p. 200). The other is a model of a man-made and man-controlled world. These become epitomized in our characterizations of a woman's role and a man's role with the woman conceiving, nurturing, and bearing children in a natural way, while men learn to domesticate animals, save and plant seeds, and demonstrate their mastery over nature. The passivity of women is captured in Mead's phrase: "When women belonged to a herding people that traveled swiftly, they prayed that their babies would be born at night when there would be time to rest" (p. 200), while the picture of mascu-

linity in America developed around the cowboy with his rugged outdoorsman-like conquering of the west. These two models apply in the arts, religion, our approach to the wilderness, and our characterizations of childbearing. "A poem could be seen as something that grew naturally and effortlessly as a child, or as something that was made, according to rules, as precisely as a man-made tool" (Mead, p. 201).

To some extent, our past required the roles be separated and differentiated. Modern societies resulting from continued understanding and control of the natural processes by both men and women has made it possible to change and alter those traditional roles. These changes have freed both men and women from the traditional burdens of parenthood and made it possible for us to reconstruct those traditional sex roles so that they are no longer as narrow and stifling as they may have been in the past. Male children can be offered a great variety of life,

> . . . choices which are not primarily ways of supporting women and children. For females, motherhood, which is usually an existence that is less specialized, more confining, but also more preservative of the whole mystery of life than the male role, need not become the complete preoccupation of a whole lifetime in the creation and care of individual human beings (Mead, p. 202).

Yes, I do enjoy good quiche. Many women currently enjoy roles as leaders in business, industry, and politics. Being male and female in today's world includes making choices that allow each of us to be "clever, tough, strong, courageous, independent, tender, gentle, loving, dependent, receptive, passive," concerned with both family and things, both ideas and interpersonal relationships, and still enjoy our unique masculinity and femininity.

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The LDS Missionary Experience: Observations on Stress

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Abstract

The missionary experience may exceed the stress-hardiness level of some missionaries. Professional observations over the past six years have prompted a survey of factors involved. Six special areas considered are: (1) Comparative models of life sequences; (2) Selected factors in stress; (3) Diversity of mission administrative and priority patterns; (4) Women in mission relationships (5) End-of-mission and after-mission considerations; and, (6) Stress disorder parallels. Suggestions are made for some conceptual frameworks to help in further study of these areas, including a proposal to recognize as a clinical entity a mission-related stress disorder.

Missionaries for The Church of Jesus Christ of Latter-day Saints (LDS) have set out to convert the world for the past century-and-a-half and have been largely responsible for the growth of the Church by over 1000% within the lifetime of some now living. For the stress-hardy among them the stresses involved in

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the work are seen as challenges to overcome and it is common for the end-of-mission reports to include the phrase "the best two years of my life."

However, it is apparent that there are missionaries for whom the stresses encountered exceed the limits of their vulnerability with resulting short- and long-term consequences (Sellars, 1971; Thomas, 1976; Moench, 1987). Counselors with an LDS orientation are increasingly being called on to help those who develop emotional symptoms. The authors were invited to participate in a workshop on missionary mental health at the 13th semi-annual spring AMCAP meeting. What follows is an extension of material presented there.

Missionaries and Stress

From among limited specific references in the literature, some older examples may be helpful, as they do not reflect on current management practices but help to give understanding of inherent problems in a challenging situation.

Sellers (1971) reviewed the historical background of missionary work and cited a general conference statement of 60 years ago by Hugh J. Cannon that "the returned missionary is one of the biggest problems the Church has before it" (Cannon, 1928). Sellars reported her retrospective study by personal interview of 30 returned missionaries who were enrolled at the University of Utah and members of a returned missionary fraternity. She inquired about structural and interactional strains before, during, and after their missionary experience. (We equate her word "strain" with the word "stress" in more current usage.) She reported on many positive support elements. For our purposes, we have tabulated the percent of subjects who reported on various factors of "strain" in her study. (See Table 1, on facing page.)

She reported words and phrases used by her subjects in describing their feelings as follows: "anxiety, dejected, nervous, guilty, confused, not doing enough, lost interest, discouragement, felt inadequate, depressed, loss of freedom, negative attitude, physically tired, rebellion, scared, hated regimentation, doubting

Table 1

Percent of Returned Missionaries Reporting Structural and Interactional "Strains"

Element	% of Subjects Reporting Strain
Pre-entry Period	
Missionary Home training content	57
Mission Home schedule	43
Role description	30
Girls	40
Family	33
Mission field	
Missionary work	50
Cultural shock	50
Leadership positions	47
Lack of success	47
Other missionaries and leaders	33
Role shock	30
Missionaries' feelings about themselves	23
Learning	23
Schedule	23
Goals	23
Companions	77
People (non-LDS, investigators, new converts)	63
First companion	43
Girls	30
Other missionaries	23
Return home	
Leaving mission field	60
Education	43
Not being busy	27
Dating	83

Note: Elements reported by 20% or less of the subjects have been omitted from this tabulation.

worth, emotional strain, worried, personal conflict, doubt about value of mission, disappointed, shock, cannot turn back, feeling

others are looking at you, feel like crying, lonely, homesick, wasn't happy about them forcing me, no longer autonomous, sometimes apathetic, 'trunked-out,' conflict within myself, mental anguish, negative, wore me down, not prepared, didn't feel worthy, lost weight, couldn't accomplish enough, mediocre missionary, sad, wanted to get out, didn't do anything, failure, feel pressure, ineffective, rejection, wears you down, will be a strain my whole life."

Other terms her subjects spontaneously used to express what they had experienced included: "discrepancy from ideal, upset me a lot, felt like a shadow, mission shock, destructive to my personality, always tired, physically ill, impatient, wore me down physically, didn't think I was ready, hurts self-esteem, strain to keep up, complete lapse, wanted to set own goals, not doing as well as I could, something wrong with me, conflict, hated him at first, black spirit, broke me down, cried, disturbed, fighting, friction, hatred, lay awake at night, not happy, strife and struggle, went down to depths mentally, bad feeling, apathy, felt everything was against you, kept to myself, pessimistic, questioned values, starts getting on your nerves, weird, very emotional, felt alienated, made me feel inferior, helpless, unsure, quite disappointed, what's the use, hard to adjust, in limbo, "not with it," judging me unfairly, lost feeling, a little bitter, developed an ulcer, let down, uncomfortable, wanted to stay in protective shell, burns your strength, shy, took four years afterwards to relate to people, awkward, resentment, hard to live with family."

Some of the descriptive words were repeated many times throughout, including the pre-entry and after-mission phases of the mission experience.

In summary, Sellars concluded that "when the total effects of the mission experience were judged, 59% of the effects were emotionally healthy and 41% were unhealthy," based on 853 healthy effects and 600 unhealthy effects reported.

Although the numbers are small, it should be noted that the subjects were limited to those getting along well enough to do

academic work at the university level and to affiliate with a social group.

In 1976, Matthew Thomas reported on responses of eight psychiatrists and counselors in the Salt Lake City area who had had extensive experience with missionaries. There was a strong consensus that there were major stresses involved in the missionary experience and wide variation in how they were handled by individuals and leaders. One estimated the incidence of psychotic episodes at four times the national level for that age group and all agreed depression and psychosomatic reactions were prevalent. Other observers have confirmed similar impressions in personal communications.

Individual vulnerability to stress varies widely. What appears to be stress is often good. It is the spice of life if one has resources to cope with it, but it may be destructive. Stress is not only from obvious factors or always from outside influences such as rejection, deprivation, hardship, or threat of physical harm or death. Internal factors such as feelings of inadequacy or unworthiness, a recognition of conflict between understood principles and observed practices, or a sense of futility in an endeavor may produce either acute or delayed symptoms. Even threat of physical harm depends upon how it is perceived by the individual.

Holmes and his associates (Holmes and Rahe, 1967) in their pioneering work on stress, rated life experiences as to their impact on individuals' subsequent health. They listed events such as changes in line of responsibilities or conditions of work, ending or changing schools, changing living conditions, personal habits, residence, recreation, church or social activities, eating or sleeping habits or changing family relations. On their widely-used event rating scales, adding up the values related to leaving home and beginning a mission gives a score of 302 within a few months. Any score in excess of the 300 level within one year is predictive of a 70% likelihood of serious illness within two years, according to Holmes. With frequent moves and changing companionships and leadership responsibilities, a similar numerical stress value might well accumulate during a mission. Then, a similar sequence takes place at the end of the mission. With an early after-mission

marriage, a missionary might accumulate a score of 1000 or more in a two-and-a-half-year period, suggesting levels of stress very seldom found in ordinary life patterns.

Since most missionaries get along well, one must conclude either there is a magnificent support structure in place or most missionaries have learned great stress-hardiness before their missions, or both. However, the impact on the minority who are less stress-hardy deserves consideration especially in light of growing understanding of the effects of stress.

Basis for Observations

Perceptions of the missionary experience vary because missions are diverse and observers have diverse backgrounds. When we ask missionaries or mission presidents, we hear highly variable estimates of the incidence of emotional problems of missionaries. In the past, individuals with problems may have been considered as lacking in testimony, not being spiritual enough, or just not willing to work. Newer resources may help to give broader interpretations. Mission traditions and circumstances vary in different areas. Our observations of missionaries were made on a sample limited in numbers and in time and place, but our recording them may add to the collective wisdom of counselors in understanding mission and after-mission experiences.

From July 1982 until July 1985, one of the authors served as a mission president in southern Wales and southwest England. We believe that the mission may be considered representative or sort of average. It was not a "hard" mission where many missionaries return home without baptizing, nor an "easy" one where thousands are joining. It had cultural challenge and cold weather but these were not excessive.

Our leadership style included open and frequent communication. We had private personal interviews every month and were able to see every missionary face-to-face every two weeks. Our professional backgrounds seemed to make it easier for missionaries to be open in expressing their feelings. We were fortunate to have excellent counseling support from John McLaverty who had

responsibility for Church Social Services in Great Britain. We subsequently worked with missionaries during another full-time mission in New York City (1987-88). After each mission, we have had follow-up contacts with former missionaries and their parents and presidents of other missions, though not in an organized research project fashion. Older couples have been omitted from consideration here.

General Impressions

There was great variability in mission-readiness. It was our impression that any new group of missionaries included about one-fourth who were either quite immature, lacking in any real personal testimony, or were on missions largely from the impact of social pressures from families, peers and/or leaders. Some would indicate in the first few days or weeks that they were not ready for a mission. In our three years, two did go home for that reason and at least ten times as many talked about it. Most responded to reassurance that their feelings were not unusual and that if they concluded they should go home for the right reasons, we would support their decision and promptly arrange their return. Several accepted an offer of professional counseling, which helped them decide on their own to stay.

Missionary readiness appeared to relate to the same factors as have been reported as important in the progress of young men in the Aaronic priesthood and the decision of about one-third of them to accept mission calls, namely strong religious values in the home, feelings of belonging, and strong relationships with youth leaders (Home is Cradle, 1987).

An observed high incidence of inappropriate weight gain by missionaries is thought to be related to feelings of stress.

Among the almost 400 missionaries we worked with, we found that significant emotional problems occurred with about the same incidence as in the average population. Results of a National Institute of Mental Health (NIMH) multi-center study of the incidence of mental illness came to our attention (Locke and Regier, 1980). We found a surprisingly close match with their

findings. At any one time, about 15% of our missionaries were in a status where professional help was or had been appropriate, with approximately 14% having anxiety or depression problems, in about equal numbers, and 1% having schizophrenic patterns.

The NIMH studies found a variable incidence of alcohol and other drug problems. Pre-mission screening weeded these out, but it did not seem to alter the prevalence of the others.

Two elders could not live within the mission framework because of character disorders and returned home. Recognition of their problems was delayed because companions tended to be highly supportive of them.

When emotional symptoms emerged, careful open-ended interviewing not infrequently led to disclosure of feelings of guilt about past behavioral patterns. This was a continuing process. When missionaries taught investigators high principles and standards, their understanding was expanded and they realized there were things they had not cleared with their bishops. Most often, thorough interview and ecclesiastical clearing was all that was needed, but some accepted an opportunity for professional counseling because of persisting feelings of inadequacy and guilt.

Special Areas of Observation and Responses

Six special areas have been selected as a focus for observations and responses as follows:

1. Comparative models of life sequences.
2. Selected factors in stress.
3. Diversity of mission administrative and priority patterns.
4. Women in mission relationships.
5. End-of-mission and after-mission considerations.
6. Stress disorder parallels.

At the conclusion of each of these special areas, we draw limited conclusions and suggest ways in which these preliminary observa-

tions and responses might be extended to further our understanding of the stresses involved in the missionary experience.

1. Comparative Models of Life Sequences

Before-mission, mission, and after-mission life involves a sequence of experiences. Some have said each mission experience is unique, but our observations suggest a step-by-step progression of events and experiences generally similar for all missionaries, irrespective of other variables.

Social scientists have evolved patterns of life sequences as a means of studying and understanding them. Our response has been to develop a framework for comparison of various models, to which we have added priesthood calling and missionary service models, as in Table 2.

Table 2
Comparative Models of Life Sequences

	Phase				
Model	Deciding	Processing	Getting Started	Action	After Action
School	Choice of School	Application Interviews & Acceptance	Registration, Orientation, "Hazing"	Making the Grade	After Graduation
Employment	Choice of Job	Application, Interviews, Acceptance	Initial Training	Doing the Job	After Job, Loss or Retirement
Priesthood Calling		Calling, Setting apart	Learning the role	Serving in the calling	Loss of the Mantle
Military Service	Choice of service	Induction	Basic Training	Active Duty	After Active Duty
Missionary Service	Decision to go	Interviews, Farewell	MTC Experience	The Mission	After the Mission

Another possible parallel model is suggested by a recent report of the Bishop's Committee on Priestly Life and Ministry (National Conference of Catholic Bishops, 1988). They report "serious and substantial morale problems" among the 53,500 priests who share with LDS missionaries requirements of mandatory celibacy, long

hours of work, and a not-always-friendly public. Other models may also have parallel sequences despite obvious variations in detail.

We suggest there would be value in using such parallel models of life sequences in further study of the missionary experience, perhaps leading to descriptive literature of value to missionaries, parents and leaders.

2. Selected Factors in Stress

Missionary work is seen as one of the prime responsibilities of the LDS Church and its members. In recent years, a responsibility has been placed on every worthy young man to serve a mission. This changed the missionary force from a smaller group of specially motivated young men to one made up of a broad cross section of the young people of the Church, men and women alike.

Preparation for departure includes the sobering impact for most of first-time temple attendance. For some, the commitments made there may seem almost overwhelming.

The mission experience itself begins with the rituals of departure, with the young person being lionized, perhaps an unrecognized effort to build a store of self-confidence to draw upon. Many report leaving home on an emotional high.

The Missionary Training Center (MTC) experience follows in contrast in some ways, despite strong reinforcing elements. The missionary's first name is taken away and replaced by "Elder" or "Sister." Uniformity of dress and conduct is required. Every hour is scheduled and many have never had such a demanding program of long hours of study. An always present companion may be a first encounter with lack of privacy. An extended moratorium on close relations with members of the opposite sex comes abruptly for those who may have been dating regularly for several years.

One of the internal stresses reported by some is an awareness of a gap between principle and practice. At the upper administrative and training levels, the highest principles are expressed, but some returned missionaries they meet report their own emphasis on numbers of baptisms by whatever means as the principal key to leadership advancement and "being a success." To the vulnerable,

this dichotomy may be a heavy burden, made heavier by its not being very acceptable to talk about it.

Other conflicting messages tend to stress the vulnerable. For example, in the past, instructions have been to exclude reading of any books except those on a short approved list, whereas other instructions have encouraged wide-ranging reading of historical and social materials. For the meticulous, uncertainty may develop.

After reaching their field of labor, missionaries are often expected to respond to major changes of program direction. Within three years, the missionaries we served with were directed to change from using discussion which featured the Book of Mormon prominently to eliminating any reference to it until well into the discussions, and finally to going back to presenting it prominently in the first discussion. They changed from memorized discussions to non-memorized ones. Terms for missions went from 24 months to 18 months and back to 24 months. The latter was especially difficult for many to handle, as they felt under pressure, often from parents, to stay the extra six months but felt they had completed what they had been called to do.

Changing of mission presidents midway through their missions may be traumatic for some missionaries, especially if methods and priorities differ significantly. It seemed that vulnerable missionaries from large stable wards were more upset by changes as they had had less experience with "differences of administration" and "diversities of operations" (1 Corinthians 12:5–6; Doctrine and Covenants 46:15–16).

Another institutionally related stressor might be uncertainty of direction which may be stressful for some missionaries. In the past, instructions for missionary work were scattered in a number of places: the White Handbook (*Missionary Handbook*, 1973), various bulletins and handbooks, MTC instructional materials, letters from the First Presidency, letters from the Council of the Twelve, letters from the Missionary Department, etc. Added to this were many verbal instructions and the very powerful impact of traditions from an unknown past.

For example, missionaries were instructed to exercise and write in their journals, but there was no time in the White Handbook daily schedule to do it, so it came out of gospel study or some other time. Thus, the more conscientious missionary felt he was breaking rules whatever he did. One of our insightful missionaries wrote plaintively, "President, I wish you would write down all the unwritten rules." Our response was to publish, with general authority review and approval, a supplement to the *Missionary Handbook* to try to minimize or interpret these ambiguities. We also produced a *Missionary Mini-Handbook* (1983) for joint use in wards and a *Missionary Maxi-Handbook* (1983) for use in stakes, taking their content from over a dozen different sources. They seemed to help.

Another possible source of stress may be the lack of "fit" between a missionary and his mission's traditions and priorities where motivation-by-recognition is used. For example, a potentially vulnerable missionary may become depressed if he never makes the "winners" list and never gets leadership roles because he isn't a "producer." On the other hand, in a mission with few measurable results, a hard-driving missionary from baptism-producing family traditions may become anxious when he can't count his results and feels diverted when asked to do things not directly "results"-oriented.

Adaptable missionaries may take on elements of the marketing character described by Fromm (1976, pp. 147-53) where success and results are seen as paramount.

A more general concern arises when missionaries feel there is inconsistency between the priorities of being strong and aggressive as a leader and those of gospel teachings of meekness, gentleness and humility.

Although this basis for stress is a general concern throughout society, it is more apparent among LDS Church members because they are expected to adhere to higher standards. It is further amplified when strong encouragement is given to missionaries (especially the elders), to be aggressive, to be leaders, to be competitive and forceful and to produce expected results. Fromm

(1976, pp. 145–46) and others have commented on the contrast between the conditional "fatherly" love that depends upon achievement and good behavior, and unconditional "motherly" love of mercy and compassion. Leadership may tend toward one or the other or vacillate between.

Examining masculine and feminine gender stereotypes has been found useful in studying the dilemmas of modern working women who are often expected to be, as many missionaries are, "everything to everybody." In Table 3 are excerpts from a list of gender stereotypes, cited by Braiker (1986), which may prove useful in considering the differences between our culturally-based characteristics of masculinity and the ideals expressed in what is taught to investigators about love and meekness. These contrasts may set the stage for stresses to be internalized.

Table 3
Gender Stereotypes

Masculine	**Feminine**
Acts as a leader	Affectionate (loving)
Aggressive	Cheerful
Ambitious	Childlike
Assertive	Compassionate
Competitive	Eager to soothe hurt feelings
Dominant	Gentle
Forceful	Loves children
Self-reliant	Loyal
Self-sufficient	Sensitive to others' needs
Strong personality	Sympathetic
	Understanding
	Warm
	Yielding
(Expected Behavior)	(Principles taught)

We suggest that a study of some of these apparent dilemmas might result in helps for professionals who are called on to counsel missionaries. They will better understand the factors of internal stress, and more specifically recognize and deal with the apparent conflicts of role expectations and beatitudinal admonitions. Perhaps insights gained from such a study of the missionary microcosm might have spill-over benefits for Church members at large.

3. Diversity of Mission Administrative and Priority Patterns

The missionary experience varies widely from mission to mission, partly because of the variety of local member and non-member populations and social customs, but also because of a diversity of mission traditions, which in turn are shaped to a large extent by mission presidents. They bring to their tasks widely divergent backgrounds of experience and traditions. As a result, we have a whole spectrum of priorities and methods which have an impact on the lives of young missionaries. Also, patterns of emotional support may vary. Our observations of these socio-cultural and institutional aspects of missions began from the first days of our mission with vigorous expressions by priesthood leaders of almost total dissatisfaction with things as they were. We had expected to be welcomed with open arms because baptisms were up over 500% over the previous year, but we weren't. The mission was having phenomenal success in baptizing, but priesthood leaders predicted that almost none of these new members would stay active. They did not say, but it appeared that, among other factors, the baptism of a person who became inactive made them look worse by the percentage statistical yardsticks they were measured by, such as attendance at sacrament meetings, percent going to the temple, etc. Bishops resisted baptisms and full-time missionaries considered priesthood leaders as "enemies" of the Church.

Only a few years before, our mission had made the transition to having organized stakes throughout its area. Originally, the mission president had presided over component districts, but with the change, the mission was superimposed on stakes and linked to

them by an often tenuous chain of correlation, with each component retaining its essential autonomy.

The official statements were clear. On April 3, 1985 President Benson quoted President Kimball: ". . . convert baptisms are not the responsibility of the Missionary Department of the Church, but are the responsibility of ecclesiastical line officers and members of the Church" (Benson, 1985). However, the powerful force of tradition still gave most mission presidents the feeling that the principal yardstick of their success was the number of baptisms. Meetings with other presidents often gave a sense of being among competitors rather than team members.

In our situation, a polarization between missionaries and local members had taken place and an unacknowledged but real sort of "resistance movement" had developed. This tendency was deplored as "friction" by a general authority in 1971 (Dunn) and discounted by others as "to be expected." Correlation efforts, which recognized two separate "forces" in the same sphere, although applied diligently, did not resolve the problem. Retention rates remained so low that net growth of the Church over a ten-year period was essentially nil in the area served by the mission, despite thousands of baptisms, millions of dollars spent, and over two thousand man-years of full-time LDS missionary effort in that area. It appeared that the local priesthood leaders were correct in their impression that people were being lost about as fast as they were gained.

After many hours of listening to reasons for the polarization, two concepts emerged. First, there were residues of feudal and class traditions that make the British slow to accept strangers from outside their close-knit ranks. Second, with exclusively American mission presidents and predominantly American missionaries, members felt they were being "invaded" or "colonized" by an American missionary "force."

Details of these observations and our organizational responses to them were reported at the BYU Symposium on the Church in the British Isles (Thomas, 1987) and only highlights pertaining to the missionary experience will be mentioned here. Although lacking nicety of design or sophistication of measurement, our

circumstances provided an experimental model from which certain perceptions have been derived,

In response to these perceptions of polarization, a unified system for missionary and retention work was developed in meetings with local priesthood leaders and approved by the executive administrator. Direction of day-to-day activities of missionaries was put in the hands of local priesthood leaders. At local discretion, full-time missionaries became active, along with local members, in retention and reactivation work in addition to their finding and teaching missionary work. Units varied greatly. A common-sense balance was encouraged. Missionaries assigned to units became mission leader assistants and zone leaders became mission president assistants to visit units and support the local (stake) mission presidents and their associates.

Dramatic changes in attitudes took place. Members and leaders spontaneously expressed enthusiasm for the new arrangement. Retention, one year after baptism, rose from 10% on the average to 80% or more, as gauged by stake leaders, who felt a sense of growth and increasing strength. Fewer converts were baptized, but the improved retention set a trend for doubling or tripling the net gain in solid members.

Another perceived consequence of the unified system was the effect on full-time missionaries. Before the unified system, our impression was that some individuals had become almost exclusively concerned with numbers of baptisms and on occasion rode roughshod over sensitive feelings of members and leaders in order to make baptism goals. After working more closely with members under the unified system, they seemed more mature, considerate, and seriously committed to broader principles. (Incidentally, this shift away from a "macho" image may have been reflected in greater safety, as driving speeds and vehicle accident rates went down dramatically.) Disciplinary problems decreased noticeably. However, this may also have been the result of other factors, such as the "settling-in" and maturing of the mission president, etc. Regardless, in each of these cases, it seems reasonable that ending the polarization and becoming "of one heart" helped significantly.

Subsequently, by direction, many of the features of the unified system were eliminated. These experiences led us to consider characteristics of various types of mission traditions and to formulate a tentative descriptive spectrum as shown in Table 4.

We have listed a number of things which appear to be related in varying degrees. Listing of factors is not meant to be judgmental, as any of the types may be most suited to a given area or time, to the experience of the incumbent mission president, or to the direction he receives. Mission traditions, though strong, are not static and change from time to time. There are probably no "pure" Type A or Type Z missions, though most will tend toward one end of the spectrum or the other, often reflecting the kind of administrative emphasis perceived by the mission president. Our experience began toward the Type A end of the spectrum, moved toward Type Z, and ended somewhere in mid-range. Explaining to missionaries the background and reasons for changes seemed to help them to cope with the stresses of changing patterns.

Many missions will show a mixture of features. The more stable ones are likely to be in mid-range, similar to long-established wards and stakes where a traditional balance has been struck between an emphasis on measured results (such as attendance or performance of specific functions), versus the intangible things of the Spirit that can't be so easily counted and reported. Depending upon one's perspective, leaders may be viewed as "producers and counters" or as "visionaries," or somewhere in between, each being effective according to his own traditions.

To help in understanding the particular circumstances a missionary finds difficulty coping with, it seems there may be value for counselors and others concerned with missionaries to explore a more fully developed pattern such as this sort of descriptive spectrum of mission traditions. Priority emphasis and administrative patterns are not the responsibility of professional counselors, but of ecclesiastical authorities. Since these will vary in different parts of the world, counselors may be helped by a conceptual framework such as this, especially when called upon for evaluation or short-term therapy for missionaries with stress-induced symptoms. Professionals should observe the injunction given Oliver

Table 4
A Tentative Descriptive Spectrum of Mission Traditions

Factors	Types of Missions		
	Type A Mission	Intermediate types B thru Y - a mixture of Patterns	Type Z Mission
Principal Motivational Emphasis	High number of baptisms	1. Baptize 2. Correlation within limits	Support of local priesthood in their responsibility for growth of the Church
Priorities	1. Baptize[a] 2. Be a success	1. Baptize[a] 2. Avoid offense	1. Missionary and family 2. Companion 3. Members 4. Non-members
Local Priesthood and Member Response	Reject responsibility for missionary and retention work[b]	Limited response to correlation efforts	Accept responsibility for missionary, retention and reactivation work
Potential for Polarization of Members and Missionaries	High[c]	Present, but not expressed	Low
Anticipated Results	More baptisms Variable retention	Average baptisms Variable retention	Fewer baptisms Improved retention
Motivational methods (Trends observed)	"Business model" Rewards/punishments, labeling winners/losers, goals become quotas, end may justify means, rules may bend *if*. . .	Mixture of methods	Personal responsibility model. Principles prevail. Personal, private goals. Need for rules minimized.
Leadership Style	Authoritative	Moderately authoritative	Sitting in council with and teaching one another[d]
Mental Preparation	Means to an end	Mixed purposes	To understand better
Spiritual Preparation	For personal progress	For progress and to serve better	To serve better
Missionary mental health	Needs further study	Present patterns of mission and after-mission problems	Decreases mission and post-mission stress

[a]Type A missions traditionally focus on numbers of baptisms. [b]"They won't stay away." [c]"Friction to be expected" (Dunn, 1971). [d]D&C 107:85–89. [e]Personal Impressions.

Cowdery to write (or counsel) "not by commandment but by wisdom" (Doctrine and Covenants 28:5, 8), based on understanding.

4. Women in Mission Relationships

While the women in our mission were exposed to stresses similar to those of the men, our observations suggested some differences in selection and relationship patterns. About one-fourth of our missionaries were women. The majority were from the U.S. and the balance from Europe. In terms of social confidence and skills, there seemed to be an over-representation at each end of a spectrum, with fewer in the middle. The incidence of emotional problems was quite consistent. At any one time, about one-fourth of our sisters were in professional counseling or had been during their missions. We have been assured we did not receive a selected sample.

Something we were not prepared for was the incidence of sexual abuse in early life. We came to expect that at any one time a significant number of our sisters had been the victim of sexual molestation as a child, or of rape as a youth. It had, almost without exception, never been previously reported. As they progressed in teaching gospel principles, an unwarranted nevertheless debilitating sense of guilt seemed gradually to rise, even to the point of immobilizing some for a time, until it reached a level where it had to be shared with the mission president.

We were surprised because we were confronted with these difficulties before it became generally known in our profession that this problem was as pervasive as it is now known to be in the general population. It appears it was not out of line with general prevalence rates. In these circumstances, as the stories tearfully poured out, it was usually possible to give reassurance of absence of guilt, structure any steps of repentance indicated, if any, and give ecclesiastical clearance to continue their work. This, along with encouraging them to dwell no longer on the past, enabled many of them to move ahead with a new sense of confidence and zest for the work.

For others—especially where the trauma had been early and repeated—long-standing feelings of guilt and low personal value

were so well established, nearly all of the sisters took the opportunity to obtain professional counseling. Church social services staff used short-term counseling and often a miraculous transformation appeared in a matter of weeks. Sisters with an unkempt, head-down, worried appearance blossomed into confident and well-groomed persons whose faith in themselves and the gospel had been restored.

Beyond these individual considerations were perceptions of women in social and cultural relationships. It appeared that the sisters generally related better to local members than the elders did and often drew greater emotional support from them. In each major geographic area, there usually was a mature woman who provided a live-in haven for sisters who needed special nurturing. Occasionally, with borderline medical-psychological problems, such a placement proved diagnostic.

An area of concern to many is that of girl-boy or sister-elder relationships. At the outset, we observed a fair amount of playing-up to the elders, a sort of "fascinating womanhood" approach to being invited to share group P-Days or spend time during conferences, etc. Early on, there seemed to be too many mid-month transfers or monthly changes to break up sister-elder relationships. Nothing serious happened, but we seemed often only a step ahead of possible disaster.

A number of seemingly unrelated things led to what we interpreted as a significant change in relationships. First came bicycles. Long-standing tradition—not rules—had dictated that sisters were not allowed to ride bikes. When asked about it, with only a few exceptions, they expressed a great desire to be allowed to do so to increase their effectiveness as missionaries. Some of them wanted someone else to keep the bikes in repair, but when it was explained that they were missionaries and responsible for their own bikes, just as the elders, they accepted that concept of equality as well.

Next came automobiles. Again, tradition, not rules, had dictated that sisters could not drive mission vehicles, or even ride in them with the elders. When they were encouraged to qualify

themselves for British driver licenses and assigned to vehicles as appropriate, the sisters responded positively. Simply extending the standard rules of missionary chaperonage to include vehicles eliminated a double standard.

Third came leadership and training patterns. Traditional mission organization puts the older, more mature sisters entirely under the direction of young elders who are either in or just barely beyond their teenage years. In other areas, sister districts or zones have been tried, with women in leadership, but these deviate from basic Church leadership principles. However, at ward, stake and highest general Church levels, there is the expectation for women to play important leadership and training roles in support of priesthood leadership. Mission handbooks did not exclude use of people in training and coordinating roles.

We developed a role for coordinating sisters in each of the zones who were expected to communicate with, arrange training activities with, and enhance the work of the sisters in their areas. They worked closely with zone leaders to coordinate the work just as Relief Society presidents work with their bishops.

Next, we established the role of a traveling coordinating sister to work with her zone counterparts and with the assistants to the president. Morale among the sisters appeared to be enhanced and problems were more quickly reported and resolved. Sisters commented on how hard it had been to talk about some of their problems with young men several years their junior.

It was apparent that on Preparation Days (P-Days), small groups of missionaries would gather for social purposes, with the potential for the formation of cliques. The sisters felt they "had" to play up to the elders to make sure they would be invited. The less socially active were often left out of the groups. Recognizing this, and after various trials, we settled on a regular once-a-month event we called Organized P-Day, arranged by the zone leaders and the coordinating sister for the zone. Various activities were planned, such as visits to castles, museums, golf courses, ice rinks, or to local chapels for games. Attendance was not mandatory, but everyone was invited and almost all attended.

We weren't sure of exact explanations, but it seemed the sisters gained a greater sense of place and value through such seemingly unrelated things as bicycles, automobiles, leadership and training relationships, and always being included with the elders at a social event at least once each month.

A news report of studies of Jewish kibbutzim in Israel came to our attention and suggested further possible insights. It was observed that Jewish young people, in general, had about the same sexual behavior as other populations, but not among members of their own kibbutz. They noted there is a very strong taboo against sexual feelings and activity among members of a family of brothers and sisters. The kibbutz seemed to duplicate the family pattern sufficiently that the same taboo applied to its members. We reasoned that by bringing our sisters more into feeling of equality with their brother elders and insuring their access to group social activities, we had established an extended family constellation of equals and, to an extent, duplicated the kibbutz observations. We also speculated that there may well have been a secondary effect on the elders. Having less "stimulating" but satisfying regular social contacts with the sisters may have contributed to an unusually low incidence of serious sexual problems of any sort among the elders.

It seemed that both the sisters and elders were more stable, mid-month transfers dropped to almost zero, and the sisters could focus more on the work and less on the elders. It would take a well-planned research effort to evaluate the similarities we are suggesting, but we offer them for consideration as to their value in reducing some of the stresses of the mission field.

We suggest that these tentative insights might be studied more definitively and lead to a broader understanding of the emerging social patterns of concern to women and men alike, as their shared roles in the work place and at home become more alike. It seems possible that retrospective study of women's changing attitudes in various mission settings might lead to a better understanding of roles in planning for youth, young adult and women's programs, especially where there are large concentrations as at universities or in singles' units.

5. *End of Mission and After-Mission Considerations*

The later part of a mission represents a period of concern for many missionaries, some wondering if they have "done enough." This appeared to be accentuated in those who opted to go home after 18 months rather than staying for two years. Others were apprehensive about the transition from a relatively simple, single-task, structured life to an unstructured one with many conflicting priorities. These included both self-imposed, family, Church or community expectations, such as selecting a career and entering employment or school; a new social life; physical fitness; scripture study; accepting Church teaching or leadership callings; courting; doing genealogical and temple work; writing a personal history; doing welfare work; doing missionary work; reestablishing a new and different set of family relationships; attending Church meetings faithfully; being involved in community activities; developing acceptable recreational activities, etc., etc.

Although no systematic follow-up has been possible, we have noted that after their missions, life goes on to continuing success for most, but it does not do so for all. We are not longer surprised by after-mission adjustment problems of uncertainty, frustration, feelings of not being valued, futility and confusion. When there is a good trust level with parents, it is surprising how often they describe their son's or daughter's reintegration as having been "tough," with frustrations on both sides. Missionaries who attend missionary reunions are probably among the more positive and confident ones, but some show a surprising and dramatic change in appearance soon after their return. Conservative hair styles and suits are replaced by beards, mustaches, long hair and clothing suggesting life-style diversity.

Observers have reported to us that up to one-fourth of returned missionaries on two non-church university campuses became essentially inactive within a year, and an indirect indication of a similar level appeared on a third Utah campus. Some mission presidents have suggested similar rough estimates, though highly variable, with some stake presidents keeping the numbers low through special efforts. One British leader told us that of 26 missionaries he had sent out as a stake president, only one was fully

active and one partially so. Quite reasonably, detailed statistics are not available because missionaries become part of the general membership of the Church on their return, with probably an overall higher than average participation.

We have not had an opportunity for systematic follow-up as done by Sellars (1971), but a number of returned missionaries have commented on the stresses they felt during their missions, especially as related to changes in mission priorities. Others have commented on the stresses of returning, most frequently mentioning their feelings of conflict, decreased interest in Church activities and a sense of not really belonging or fitting in any more. Near the surface have been feelings of guilt, most often expressed as feeling they should have been more diligent. Lack of attendance at Church meetings may represent an avoidance of symbols of the stresses they felt, with their associated reminders of things they should be doing more diligently. Parents comment that reminding them of their responsibilities may be met with a surprisingly strong reaction and not infrequently with openly expressed hostility.

Most of these feelings were listed in a reference in the Library of the Church Historian on "The Church Activity of Returned Missionaries of The Church of Jesus Christ of Latter-day Saints" (1977, approx.)—the only study we know of aside from a few theses of 1930s vintage. In order of significance were listed problems of dating, courtship and marriage; loss of routine and structure; adjustment to family and friends; homesickness for the mission field; lack of Church assignments; and financial-employment problems. Among causes of inactivity were listed depression, loneliness and feelings of unimportance. Neither this report nor our *Mission Presidents Handbook* or *Missionary Health Manual* contained reference to use of professional counseling during or after-missions, perhaps because it may not be widely enough available. Further, this report indicated higher levels of activity than reported to us, perhaps because times are changing or because there is spontaneous "recovery" when follow-up is extended to five or ten years.

Among returned missionaries, when talk turns to rates of inactivity among new converts, one may hear expressions of a sense

of futility. Occasionally, one hears "I don't think I did anybody else any good." This in turn relates to feelings of doubts about the Church and loss of faith in leaders as well as doctrine. All of this tends to accentuate non-participation. Many of these elements are similar to those of veterans of Vietnam and similar circumstances where stress was often associated with feelings of futility.

Our response to these end-of-mission and after-mission concerns has been limited by circumstances. At final interviews with missionaries, an effort was made to alert them to the complexity of expectations they would face and to remind them of their personal responsibilities for planning and setting time priorities. Since our return, we have listened to reports of frustrations and painful transitions, often from those who had performed very well on their missions. They seemed reassured to find that others had experienced similar feelings.

The isolated report on *Church Activity of Returned Missionaries* (1977, approx.) reminds us that returned Missionaries are not falling away in great numbers. However, the loss of even a small percentage of the returned missionary force of the church is a significant loss. And those who are "active" still need to be strengthened. Consequently, the welfare of returned missionaries should continue to be a matter of great concern to the Church.

We hope it might be possible to gain greater insight into the end-of-mission and after-mission experience by missionary-centered, feelings-oriented, professional-level studies, including a diversity of locations and social levels. This would appear to be an appropriate social and professional concern.

6. Stress Disorder Parallels

In our introductory comments, we referred to the surprising level of life stress events involved in the mission experience, as defined by Holmes and Rahe (1967). In subsequent sections, we referred to additional kinds of stress peculiar to mission circumstances, such as divergence of precept and practice, diversity of mission administrative and priority patterns, an enforced moratorium on expression of sexual maturation, and dilemmas inherent in returning to the "real world" again.

Beyond these general and specific stresses are those embraced by even less tangible concepts of being expected to be completely committed, strong, faithful, diligent, hard-working, single-minded, spiritual and "perfect" in all things. Where mission tradition uses motivation by competition and reward or recognition, there will inevitably be the converse of motivation by embarrassment and guilt for the less productive. For the strong, these stresses appear to build greater strengths, but for the vulnerable, the same circumstances may be highly stressful.

Bessel A. Van der Kolk, in the book *Psychological Trauma* (1976) cites Krystal's finding that it was not the intensity of the experience for the individual that "posed challenge and generated the affective response," which in turn caused the ultimate post-traumatic adaptation. Van der Kolk (1976) describes reaction to psychological trauma as often being a chronic sense of helplessness. Once embarked on a mission, a person has no voluntary way out except by the very painful route of going home early, which is embarrassing to himself and his family because of its frequent association in the public mind with serious sexual misbehavior. For the vulnerable, staying on may result in the potential for an extended period of feeling helpless.

Vulnerability has been related by Van der Kolk to genetic disposition or developmental levels, adults with a firm sense of identity being less vulnerable. Disruption of social support, prior traumatization and preexisting personality factors also contribute to the appearance of posttraumatic stress disorder (PTSD) symptoms. He also cites Terr's study of children kidnapped on a school bus to show that in the immature, 100% showed symptoms as long as four years later, even though there had been no physical harm. He further refers to a long latency in appearance of symptoms, as late as 15 years or more after the trauma.

Although the clinical syndrome defined as posttraumatic stress disorder in the American Psychiatric Association's *Diagnostic and Statistical Manual-III-R* (DSM-III-R [1987]) describes an appropriate stress as being "outside the range of human experience and . . . markedly distressing to almost anyone," our interest has been drawn to noticeable parallels between clinical cases of posttraumatic

stress disorder we have seen in other settings and missionaries and returned missionaries who have shared their painful experiences with us. Some of these parallels are outlined in Table 5 below.

Our impression is that such a formulation as a mission-related stress disorder (MRSD) would obviously not apply to the great majority of stress-hardy missionaries who are reinforced in their strengths by effectively coping with the variety of stresses encountered. However, if it is true that there are those who are stress-vulnerable, the parallel patterns should be useful as a model. Because the missionary experience may prove to be a series of stresses with cumulative impact on the vulnerable, and because missionary stresses are often seen as more psychological than as a simple threat to physical survival, it seems useful to suggest the term mission-related stress disorder (MRSD), rather than its parallel, posttraumatic stress disorder (PTSD).

In our observations, it seems that a number of missionaries and returned missionaries who have been considered as showing anxiety or depression symptoms might appropriately be described more specifically as having mission-related stress disorder. Likewise, the term adjustment disorder (309.24, 309.00, 309.28, 309.82, 309.83, etc., of the DSM-III-R) might fit some with a short duration of symptoms (less than one month), but MRSD seems to provide a better framework for understanding and helping in recovery from the longer lasting reactions seen.

Progress is being made in use of methods to develop stress-hardiness and to help those with posttraumatic stress disorder gain a new sense of wellness (Flannery, 1987; Borysenko, 1987; Adams, et. al, 1983, Chapter 5).

By and large, the spiritual and emotional growth and maturation of most missionaries observed was phenomenal. Even among some where there had been previous long-term unemployment or academic failure, the results were often miraculous. However, others made slower progress, notably those with long-standing problems of early abuse, dropping out of school, never learning work habits, etc., and still others appeared to show clear stress

Table 5
Observed Stress Disorder Parallels

Post-traumatic Stress Disorder Code 309.89 (DSM-III-R)	**Mission-Related Stress Disorder (proposed)**
A Recognizable Stressor	A Recognizable stressor(s) (may be internalized)
B Avoidance or numbing of responsiveness (at least three)	B Recall of stress feelings
(1) Avoiding thoughts or feelings	(1) Recurrent recollections
(2) Avoiding activities that arouse recollections	(2) Recurrent dream patterns
(3) Selective amnesia	(3) Recurring feelings of conflict associated with ideational or environment stimuli
(4) Diminished interest in activities	(4) Distress on exposure to symbolic events, e.g., meetings, ceremonies, etc.
(5) Feeling of estrangement	C Avoidance
(6) Restricted affect	(1) Avoiding thoughts or feelings
(7) Sense of foreshortened future	(2) Avoiding Church-related activities, non-participation
C Symptoms of increased arousal (at least two)	(3) Selective amnesia
(1) Sleep difficulty	(4) Diminished interest in activities
(2) Irritability or anger	(5) Feelings of estrangement
(3) Difficulty concentrating	(6) Restricted affect
(4) Hyper vigilance	(7) Sense of limited future
(5) Startle responses	D Symptoms of increased arousal (or anxiety)
(6) Physiologic reactivity	(1) Sleep disturbance
D Re-experiencing trauma (at least one)	(2) Expression of anger (especially towards parents or other authority)
(1) Recurrent recollections	(3) Difficulty concentrating, memorizing, etc.
(2) Recurrent dreams	(4) Feelings of guilt
(3) Feeling as if event were recurring	(5) Avoidance of exposure to stressor(s) or symbols
(4) Distress on exposure to symbolic events	(6) Increased symptoms on being reminded of responsiblities, actions or lack of action
E Duration: at least one month (specify delayed onset if after at least six months.)	(7) Feelings of futility
	(8) Weight gain
	(9) Expressed doubts or loss of faith
	(10) Non-participation
	E Duration: at least one month (specify delayed onset if after at least six months.)

disorder symptoms. Their missions did not cause the disorder, but circumstances related to the mission appeared to contribute.

Our situations have not allowed an opportunity to apply this formulation systematically, but in retrospect, it seems that some of the missionaries we saw during and after our full-time mission experiences (Bristol and New York City) might have been helped more effectively by more specifically planned stress-disorder-oriented approaches.

It also seems possible that using a framework such as that suggested by the term "mission-related stress disorder," or something similar, might help in recognizing at-risk vulnerable missionaries and provide a helpful rationale for preventing untoward effects of stress during and after their missions.

If properly identified, some of this knowledge may be useful with stress-vulnerable missionaries and may help change the eternal perspectives of their lives.

It is not likely that any sound concept which might develop would deviate from the principles of stress-hardiness found in the gospel and expressed in words taken from our mission song: "Only by persuasion, and love unfeigned . . . only with his spirit . . . grow in your soul . . . only lead with kindness. . . . conquer vain ambition . . . be faithful, be strong . . . go forth together believing, the Lord is calling you." (Wheelwright.)

Conclusion

Based upon observations of full-time and returned missionaries, several tentative conceptual frameworks have been devised for the purpose of examining stress-vulnerability relationships involved in the missionary experience and to assist counselors in understanding the circumstances of missionaries they are called on to help. Identification of a clinical syndrome termed mission-related stress disorder is suggested for further study of the stress-vulnerable during and after-missionary service.

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"And Ye Shall Find Rest Unto Your Souls"

L. Alan Westover, MS

In recent years, formal grieving processes have been identified (Kubler-Ross, 1989; Kreis, et al., 1969; Hendin, 1973) (see Table 1). We have observed that individuals absorbed in the grieving process often dwell upon past events associated with the loss and upon the intense personal pain resulting from those events (Madsen, 1978). While lessons of great value can be individually learned in the process of grieving, unnecessarily prolonged grieving is frequently debilitating and crippling. The excessive concentration of attention upon painful events of the past drains time and energy by first agonizing over the loss and then engaging in escapist behavior in an effort to find relief. Inasmuch as preoccupation with one's own needs is frequently accompanied by a decrease of sensitivity to the needs of others, grieving can be a very selfish activity.

Table 1
Stages of the Grieving Process

1. Shock/Denial
2. Guilt
3. Anger
4. Bargaining
5. Depression
6. Resolution

In contemplating the various stages identified in the grieving process, I have been struck by three observations. The first is the great similarity of the grieving process to what is experienced by both the "offender" and the "offended" in consequence of offensive behavior. While some loss occurs as a result of events and circumstances for which no person is responsible (as in the sudden loss of health or life), serious loss can also result from our own misbehaviors or from the misbehaviors of others. It is suggested that indeed both the "offender" and the "offended" do suffer loss and do grieve, and that much of the emotional turmoil we observe in these two groups may be usefully viewed from the perspective of grief resolutions (see Table 2).

Perpetrator and victim alike appear to pass through parallel grieving processes as they strive to resolve feelings generated by past offenses. This should not be surprising when we realize that not only the "offended" but also the "offender" suffer significant personal loss as a result of the offense. The offender may suffer many losses including a loss of the Spirit of the Holy Ghost, a loss of Divine approval, and a loss of self-respect. Many transgressions result in the loss of physical health, family, priesthood, temple blessings, personal freedom, financial security, and gainful employment. Such losses are not trivial. Nonetheless, in my experience, transgressors, perpetrators, or offenders are generally not viewed as grievers, particularly when they are immersed in the stages of denial or anger and continue to exhibit irresponsible behavior patterns.

Second, we may be too limited in the range of clinical needs which we associate with grieving behaviors. While the resolution of grief is central to the treatment of sexual abuse, and the loss of a loved one through death or divorce, etc., it is less common to address other clinical arenas such as husband/wife or parent/child challenges from this context. Family members in conflict are often caught up in vicious cycles of hurt-counterhurt behavior patterns in which the primary motivation appears to be the mutual infliction of pain. When this occurs, estranged family members struggle with the loss of approval and acceptance from the very people whose approval and acceptance are most highly valued.

Table 2

Stages of Grieving and Resolving Grief

1. Shock/Denial
2. Guilt
3. Anger
4. Bargaining
5. Depression

Natural Loss	*Loss Due to Transgression*	*Loss Due to Victimization*
8. Acknowledge the truth	8. Acknowledge the truth	8. Acknowledge the truth
	Exercise Faith in Jesus Christ By:	
9a. Repenting (if needed) 9b. Forgiving (if needed)	9. Repenting (confess, make restitution, forsake transgression.)	9. Forgiving the offender
10. Submitting the balance of the burden unto the Savior and letting go	10. Submitting the burden of sin unto the Savior and letting go	10. Submitting the burden of judgment unto the Savior and letting go
11. Pressing forward in living today rather than in past, enduring temporary immutable loss with dignity	11. Pressing forward in living today rather than in past, enduring temporary immutable loss with dignity	11. Pressing forward in living today rather than in past, enduring temporary immutable loss with dignity
12. Enjoy promised peace, rest, Divine approval, and enhanced self-esteem	12. Enjoy promised peace, rest, Divine approval, and enhanced self-esteem	12. Enjoy promised peace, rest, Divine approval, and enhanced self-esteem

Might it be that much of the denial, anger and depression exhibited by families in conflict occurs due to the failure of the family members to deal constructively with this perceived loss of

love, acceptance, and approval? Because interpersonal skills typically suffer when one is in the throes of concentrated grieving, families containing multiple grievers are particularly ill equipped to cope with their own grief, the grief of other family members, while simultaneously attempting to resolve their differences. As previously mentioned, grieving is often a self-indulgent activity. Often each of the parties feels victimized and abused, and is therefore more inclined to seek vengeance than to render relief. Each wishes their personal pain to be acknowledged, and wishes to be further supported and pampered while in state of discomfort.

Third, whereas the Lord has identified explicit proactive interventions for the offender (viz., the first principles and ordinances of the gospel), and for the offended, abused, and victimized (viz., forgiveness), students of the grieving process have had little to say about resolving the grief, beyond efforts to support clients in working through each successive stage of the process. Nonetheless, the Lord appears to be very serious about the responsibility of the aggrieved to apply these principles in dealing with unresolved past events. He *commands* the offender to repent and the offended to forgive. Failure to either repent or forgive results in condemnation and the loss of access to the blessings of the atonement (*Doctrine and Covenants* 19:16–18; Matthew 6:14–15). Because in grieving we tend towards selfishness, the means of resolution forwarded by the Lord requires that we move beyond our preoccupation with our own pain by unselfishly addressing the pain of others whether we be the offender or the offended. Until the offender acknowledges the pain of those he has offended, he is generally not inclined to confess and forsake. Similarly, the "offended" is not inclined to fully forgive until he is able to recognize the heavy and painful burdens of the offender (Madsen, 1978). When interpersonal conflict is involved, frequently it is necessary for each party to both repent and forgive: for each has both rendered and suffered offense. I believe we shortchange our clients to the extent we fail to teach them to resolve their grief by the application of these principles.

That the gospel of Jesus Christ provides powerful remedies for those wishing to resolve grief is an assertion which the remainder of this paper will address and explore. Whereas the stages of the

grieving process describe the griever's course through the intense emotions of shock, guilt, anger, and depression, the process of forgiveness as well as the first principles and ordinances of the gospel center on the resolution of such emotional disturbance.

Stage 8: Acknowledgment of the Truth

For both the repentance and forgiveness processes, it is necessary to acknowledge the reality of the loss, the source of the loss and to recognize the means by which the grief associated with the loss may be resolved. Until we acknowledge these three things, we are unable to find lasting relief from our grief. The Savior taught "the truth shall make you free" (John 8:32). Once we know the truth regarding the source of grief and the means by which it may be resolved, we are free to resolve or not resolve the grief as we will. Until we obtain this freedom, we can only languish in the emotions of shock, denial, guilt, anger and depression, or see relief through destructive escapist activities. And as previously noted, a significant part of an acknowledgment of the truth is the clear recognition of the pain being suffered by the other party. As an "offender" I do not become truly motivated until I recognize the horrible prices paid by others in consequence of my misdeed.

> But I was racked with eternal torment, for my soul was harrowed up to the greatest degree and racked with all my sins. Yea, I did remember all my sins and iniquities, for which I was tormented with the pains of hell; yea I saw that I had rebelled against my God, and that I had not kept his holy commandments. Yea, and I had murdered many of his children, or rather led them away unto destruction; yea, and in fine so great had been my iniquities, that the very thought of coming into the presence of my God did rack my soul with inexpressible horror. Oh, thought I, that I could be banished and become extinct both soul and body, that I might not be brought to stand in the presence of my God, to be judged of my deeds. (Alma 36:12–15)

Likewise, as the "offended," I do not become truly motivated to forgive until I recognize the horrible burdens the offender is carrying in consequence of his misdeed.

> Therefore, I command you to repent—repent, lest I smite you by the rod of my mouth, and by my wrath, and by my anger, and your

> sufferings be sore—how sore you know not, how exquisite you know not, yea how hard to bear you know not. For behold, I, God, have suffered these things for all, that they might not suffer if they would repent; But if they would not repent they must suffer even as I; Which suffering caused myself, even God, the greatest of all, to tremble because of pain, and to bleed at every pore, and to suffer both body and spirit—and would that I might not drink the bitter cup, and shrink . . . (*Doctrine and Covenants* 19:15–18)

It is difficult not to be moved with compassion for the "other party" when we allow ourselves to acknowledge pain they either are enduring or will ultimately be called upon to endure, if they fail to repent.

Stage 9: Adopt Intervention Strategies Taught by Jesus Christ

In the Church, we refer to the determination to implement intervention strategies taught by the Savior as exercising faith in Jesus Christ. Whether our differences are real or imagined, and whether or not we are the offended or the offender, we are commanded to do all in our power to resolve the differences if we are to obtain the Lord's approval and forgiveness.

> Therefore if ye shall come unto me, or shall desire to come unto me, and rememberest that thy brother hath aught against thee—go thy way unto thy brother, and first be reconciled to thy brother, and then come unto me with full purpose of heart, and I will receive you. (3 Nephi 12:23–24)

The means of reconciliation, again, is for both parties to do whatever repenting and forgiving is needed. While repentance and forgiveness require responsible, mutual participation of grieving persons, each individual either chooses to do or not to do these things. When we choose to repent and/or forgive, we take charge of our lives, we become empowered, and we grow in self-esteem. In so doing, we regain resources essential to proceeding with our lives.

The means by which grief resulting from our own transgression may be relieved is repentance. As we begin to assume responsibility for our own behavioral errors via the activities of confession,

making recompense, and forsaking the transgression, etc., we begin to qualify as potential beneficiaries of the atonement. While it is often not as apparent to most of us, we are responsible for the decision to leave unresolved any offenses suffered at the hands of others. In a revelation to Joseph Smith, the Lord observed: "My disciples in days of old, sought occasion against one another and forgave one another not in their hearts; and for this evil they were afflicted and sorely chastened" (*Doctrine and Covenants* 64:8).

They were "afflicted" not by the offense, but by their own determination to find fault rather than to forgive! Because they chose not to forgive, they were "afflicted and sorely chastened." Apparently, the Lord finds it hypocritical for us to find fault and to condemn others for their errors at the same time we are approaching Him for forgiveness. The prospect of spiritual/emotional healing is diminished when we constantly pick the scab off of mending wounds. When we truly forgive, we let go of the constant regurgitation of painful memories by choosing not to indulge in the unproductive mental rehearsal of past events. (*Doctrine and Covenants* 58:42)

The first principles and ordinances of the gospel and the principles of forgiveness are frequently useful in resolving grief associated with loss which on the surface appears to be unrelated to transgression. It is not uncommon, for example, that in grieving over the loss of a loved one, that the grief exists in part due to a failure to resolve differences experienced with the loved one prior to death. When this is true, the grieving process cannot be fully completed until we do the repenting and forgiving that is needed. While we cannot personally approach and be reconciled with a decreased brother (3 Nephi 12:25), we can forgive and we can repent.

Stage 10: Submit the Balance of the Burden Unto the Savior

In the course of resolving grief, once we have completed needed repenting and forgiving, grieving will continue until we place the burden in the hands of the Lord (2 Nephi 25:23). A choice not to entrust a burden into the hands of the Lord when it is not in our power to meet a need, is a decision to continue carrying what is, for us, an unresolvable burden. When we implement the first principles and ordinances of the gospel, the atoning sacrifice of the Savior lifts the burden from our backs. (*Doctrine and Covenants* 19:16)

Similarly, in forgiving, we place the task of judgment into the hands of the Lord thereby letting go of the judging behavior which produces feelings of anger and bitterness. "And ye ought to say in your hearts—let God judge between me and thee, and reward thee according to thy deeds" (*Doctrine and Covenants* 64:11). When grieving a loss for which no person can be fairly held responsible, there is still a need to place the issue in the hands of the Lord even though repentance and forgiveness are not called for. I recently met with a man whose son had died in an automobile accident just days before he was scheduled to leave on his mission. The father was a very assertive, task-oriented person who normally resolved crises by meeting them "head on." Here he was confronted by an outcome which he was powerless to change no matter how intense his desire. He could not reverse the reality of his son's death. And while there was no repenting or forgiving to be done, the father had been unsuccessful for many months at resolving his grief. As we talked, it became apparent that the father had been unable to acknowledge his own limitations and dependence upon the Lord. Rather, he had continued to search for something *he* could do to reverse the loss. He had not chosen to submit to the will of his Father in Heaven.

Stage 11: Let Go of the Past and Live in the Present

When we choose to subject our own will to the will of our Heavenly Father and endure that which he chooses to inflict upon us (Mosiah 3:19), we become free to re-center our attention and energy upon needs of the present and we begin to live again. While we can choose to stubbornly cling to our own willful desires, we do so at the price of continued grief. Unnecessarily prolonged grieving over past losses, like an undue anxiety over the prospect of future losses, drains resources required for living successfully in the present. The Savior observed, "Sufficient is the day unto the evil thereof" (3 Nephi 13:34).

Stage 12: Enjoy the Fruits of Exercising Faith in Jesus Christ

I suggest that while we may find coping mechanisms which provide temporary relief from the pain of loss, the only way to obtain complete resolution, healing and wholeness, is to be coming unto Christ. To seek escape and relief from other sources is to place our faith in false gods which are not capable of giving true rest. "Jesus saith unto him, I am the way, the truth, and the life; no man cometh unto the Father, but by me" (John 14:6). When we come unto Christ and thereby unto the Father, we do not merely seek to "avoid" pain but "obtain" Eternal life (2 Nephi 2:27) and thereby find lasting relief or rest.

> Come unto me, all *ye* that labour and are heavy laden, and I will give you rest. Take my yoke upon you and learn of me; for I am meek and lowly in heart: and ye shall find rest unto your souls. For my yoke *is* easy, and my burden is light (Matthew 11:28–30, italics added).

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Address

J. Elliot Cameron
31 March 1989

I always approach this group with apprehension. Perhaps it is because of my long association with some of you and the great respect I have for your professional work. Together we have "staffed" cases in the past and have unitedly found solutions as we have worked to save the souls of clients.

Sometime ago a member of our central office staff spoke of an experience he had in the seminary classroom. One of his students had recommended him to her father to fill in as a gospel doctrine teacher. Her father needed someone on very short notice and had mentioned it at the dinner table. When the father asked the girl if she thought the seminary teacher could handle it on short notice, she replied, "Sure, he can talk without thinking!"

I have prayed that what I would say today would be appropriate and would be stimulating. I can only hope that it will not be inappropriate.

Dr. Parker reminded me last month that you would be dealing with "Family Perspectives" at this conference, and that your public meeting would deal with building self esteem—ideas we all recognize are badly needed in our society. He specifically invited me to talk about counseling in a spiritual setting.

I would like to say a few words about the Church Educational System (CES) that I am now, in an administrative capacity, affiliated with, as a background and setting for my extended

remarks. This may help you know the perspective from which I come today. Some of you are employed by the Church Educational System and know something of its profile. Others of you may not.

The CES consists of a group of entities that operate together. It has about 24,000 full-time and part-time employees serving about 800,000 students in fifty states and ninety countries or territories. In addition to Brigham Young University (BYU), BYU–Hawaii, Ricks College, LDS Business College, seven elementary schools, thirteen middle schools, and nine high schools, the CES is also associated with 1,400 college and university campuses where, through the institutes of religion, we teach 125,000 college-related students. Our teachers meet 243,000 seminary students every week: they conduct literacy and health education workshops, teach adult religion classes, conduct seminars, conduct home study and professional development classes, and teach special education to the handicapped. They teach in the most modern of classroom buildings and laboratories, in local meetinghouses, in member's homes, in thatched huts, in land-rover buses, and even in shepherd's fields. They are a mature, highly motivated, well-educated group of brothers and sisters blessed with talents made available in a special age—for a special purpose.

Our mission is simple. It is the same as the mission of the Church even though we are not in the ecclesiastical line of reporting. The CES is governed by constituted boards of trustees, identified through articles of incorporation, whose officers happen to be the First Presidency of the Church. The Commissioner of Education is the executive officer of the various boards.

It is from this setting that I speak to you as I would speak to the Church Educational System teachers—because you, too, are teachers—trusted teachers and counselors—who, in your contacts with people, have a profound effect upon their lives. Your AMCAP affiliation states that your "common bond is membership in and adherence to the principles and standards of The Church of Jesus Christ of Latter-day Saints, both in (your) personal lives and (in your) professional practice." (Article 1, Section 2a, AMCAP by-laws). I am quick to recognize that you are not sponsored by,

nor do you speak for the Church nor its leaders. But together, all of us, labor in a common cause.

A couple of weeks ago I read an article in the *Wall Street Journal* (March 9, 1989) where the Pope had had a conference with 36 United States Roman Catholic Bishops, aimed toward easing tensions between American Catholics and Rome. He had urged them to proclaim church teachings, even if such a proclamation was unpopular. "But a leading bishop (American Catholic) said many Catholics saw moral doctrine as outmoded."

The present generation has been reared differently than the previous one. Parents have been permissive. There are more broken families. Families are increasingly nomadic. The increased freedom of expression in the public schools, and the pervasive intrusion of television have radically altered the experiences of young people. With their new found freedom, our youth have observed adults engaged in a chaotic and frustrating exploration for what is significant and what personal values are most meaningful. Our youth are more sophisticated, more traveled, more idealistic and vastly more interesting than students used to be. They demand more time from anyone who will listen.

This generation asks:

- Is truth in itself desirable?
- What is so wrong about lying if you will gain from the act?
- Is personal integrity really required of a creative individual?
- Can experience with a hallucinatory drug duplicate a religious experience?
- Then, what is religion?
- What is all the talk about responsibility?
- Why should the individual subordinate his personal wishes to the welfare of a society whose opinion is of no interest to him?
- Why is shoplifting, or disregard for property, so bad?

- If society does not make it possible for an individual to have what he wants, why does society deny him the right to take it when he can find it?
- If everyone else in a class cheats, why isn't it justifiable to protect yourself from the teacher's bell curve evaluation?
- Sex standards, which were once at least common knowledge though not uniformly adhered to, are constantly undergoing a change in emphasis, and conflicting systems of morality have surfaced.

The rise of youthful confidence and outspoken challenge has brought indignant, impatient, and in some cases not-too-respectful "creative thinkers," who associate truth with the new rather than the old and the traditional.

Learned men and women for generations have expressed the opinion that young people around them were sloppily educated, poorly motivated, bereft of social graces, and ill-equipped to take over running of the world.

In the mid-18th century, Dr. Samuel Johnson said: "The mental disease of the present generation is impatience of study, contempt of the great masters of ancient wisdom, and a disposition to rely wholly upon unassisted genius and natural sagacity."

As early as 1625, Francis Bacon referred to youth of his day in this way: "Young men, in the conduct and management of actions, embrace more than they can hold; stir more than they can quiet; fly to the end without consideration of the means and degrees." And speaking of the older generation, he said: "Men of age object too much, adventure too little, repent too soon, and seldom drive business home to its full period, but content themselves with a mediocrity of success." Someone has said, "The older you get, the better you get when you were young."

The conditions in the world require special coping. We live in an age of technological explosion, where as Daniel says, "many . . . run to and fro, and knowledge (is) increased" (Daniel 12:4).

Our technological progress gives an illusion of prosperity and well-being to our society. In spite of increased knowledge and communication skills, there is war, famine, bloodshed, vulgarity, unhappiness, murder, rape, and considerable emotional, mental and spiritual sickness. Divorce, broken families, murder, suicide, illicit drug use, teen-age pregnancy, and unwed mothers are common occurrences. The world has progressed in physical and intellectual things, but because the spirit is often anemic and undernourished, there are many social maladies.

The great concepts of right and wrong never change, but particular situations present themselves today that never arose in the days of our grandparents. "Situation ethics"—what is right and what is wrong in specific circumstances—challenges us. Some current issues such as organ transplants, surrogate mothers, abortions, birth control, do "the ends justify the means," does God take sides in politics, and a host of others require that individuals exercise agency in making decisions. Some also underscore the need for guidance of living prophets. But, as we all know, for various reasons, public pronouncements are not made by the Church on every issue. Individuals need to stand on their own feet and get inspiration, or risk being led astray.

The world rubs off on the Church membership and leaves its mark. All of the maladies mentioned are present among members of the Church. Hollywood and Madison Avenue are giving lessons in profanity, immorality, and worldliness in almost every magazine, movie, musical number, and television program. The people who we deal with today are molded by vastly different experiences than were their parents. They have lived only during prosperity. Their world has shrunk so rapidly that they find it easy to identify with people in far-off lands. And yet many of them become so wound up in their own little worlds that they can see only a drug culture, or a social set, or a neighborhood club.

Some wonder if our society has lost sight of the difference between right and wrong. As we read in the public press of various societal problems, there is comfort in the thought that the news media would not go to the trouble of reporting cases of moral and ethical dereliction if people did not see at least something wrong

with them. If morality were really dead, then *immorality* would not be shocking. It would not be news. It seems that what is missing—besides a sense of morality—is a sense of shame: the sense that once restrained people from doing things that were deemed disreputable. It was not all that long ago that a person caught committing an immoral or unethical act might find himself or herself ostracized in the community, snubbed by former friends, forsaken by family, or out of a job. But not so today.

The Victorian moral regime, as interpreted by some, may have been extreme. But if morality is not based on the word of God, and if there are no formal set of do's and don'ts, everyone assumes the right to do whatever he wants and society, as we know it, flies apart. One wonders how near we are to that condition today.

In his brilliant paraphrase of Plato in *The Story of Philosophy*, Will Durant states:

> All moral conceptions revolve around the good of the whole. Morality begins with association and interdependence and organization; life in society requires the concession of some part of the individual's sovereignty to the common order; and ultimately the norm of conduct becomes the welfare of the group. Nature will have it so, and her judgment is always final; a group survives, in competition or conflict with another group, according to its unity and power, according to the ability of its members to cooperate for common ends.

David Riesman has warned that Americans are approaching the point where the prevailing ethic is: "You're a fool to obey the rules." In a recent article on the decline of the American family, educationist Urie Bronfenbrenner observed: "We want so much to 'make it' for ourselves that we have almost stopped being a caring society that cares for others. We seem to be hesitant about making a commitment to anyone or anything, including our own flesh and blood." In the meantime some people discover

> that decent and honourable treatment of others is returned in kind—that the moral course is not a hard and narrow road, but the way to broaden new emotional vistas. For in its unadulterated form, morality is compounded of understanding and generosity.

> It is also a force in human progress, because it enjoins us to add value to our own lives and to those of others. It brings out the finest qualities in the human spirit. To consistently follow the moral course, you must be courageous, unselfish and thoughtful to others; to use an old-fashioned word, you must be a noble "human" being (*The Royal Bank Letter*, Vol. 65, No. 1 [Jan/Feb, 1984]).

It was about 25 years ago that a tidal wave of change swept the western world. All the tried and true social structures—marriage, the family, law and order, established religion, the work ethic, the democratic political system—came under attack by some disillusioned people. Suddenly, we were surrounded by revolutions—the youth revolution, the black revolution, the anti-imperialist revolution, the sexual revolution, and so on.

> The dissenters of the sixties and early seventies were searching for something beyond material satisfaction, and they searched for it down some very strange avenues. Every code of behaviour that had been in force up to that time was smashed to pieces, or so it seemed. Faced with the drug cult, flower power, sit-ins, love-ins, campus revolts, and the burning of city blocks, the chief reaction of the older generation was one of pained bewilderment. It was as if the world had turned upside-down; white had become black, right had become wrong, . . . The unthinkable was thought, the unspeakable was spoken, the unacceptable was accepted. The outrageous was practiced as a matter of course (*The Royal Bank Letter*, Vol. 63, No. 4 [July/August 1982]).

One youth leader said that modern man, in his collective existence, lays claim to no god or ideal but the god of possession and enjoyment and the limitless satisfaction of material needs. Toffler, author of *Future Shock*, set the tone for many of the feelings that have developed when he wrote, "We are creating a new society. Not an extended, larger-than-life version of our present society. But a new society. Unless we understand this, we shall destroy ourselves in trying to cope with tomorrow."

The idea that peace and prosperity can be made to reign on earth requires a spiritual dimension.

The one stability we have to cling to is the gospel of Jesus Christ. It contains the key to the solutions we seek. Even as I say this, we find that practice—legal, literary, and social—continually undermining gospel stability.

It has been many years since an article in the *Reader's Digest* ("Let's Have Justice for the Non-Criminals, Too," Eugene Methvin, December 1966) wrote of the "impossible farce the Supreme Court has made of American justice." Through interpretations of the Fifth Amendment, criminals who have freely confessed to murder, rape, and all manner of major crimes are walking out of courtrooms because of some triviality which was not observed in the method of their apprehension or trial. Those rulings continue to this day.

The carnal mind that feeds upon violence and wickedness does not find revelation and righteousness attractive. A master's thesis done at BYU in 1982 ("The Secularization of the Academic World View," A. LeGrand Richards) showed that the use of such terms as God, faith, sin, prayer, religion, moral responsibility, good, evil, etc., has progressively been used less and less in master theses and doctoral dissertations at BYU during the past 20 years in the College of Education, and that these terms are also used less in the literature of the academic discipline as published throughout the country.

Matt Hilton, a local practicing attorney, just completed (1988) an extensive study for a doctoral dissertation at BYU. In it he identifies that before the Civil War, the U.S. Supreme Court held that man's rights under the constitution were inalienable—granted by God to man. Between the Civil War and World War II, the Court modified its interpretation to maintain that man's rights were rooted in social tradition and natural law. Since World War II, the court has ruled that man's rights are defined by Judicial recognition—that man has whatever rights the court is willing to protect. No longer are man's inalienable rights recognized without court sanction. The *Christian Science Monitor* (June 2, 1986) reports that since the Civil War, college textbooks have failed to give attention to religion or give religion credit in the development of U. S. history. The idea is that in the past century, religion has not been a vital force in the American consciousness.

This gradual eroding and changing of our civilization comes in the wake of intellectual progress, and we fail to notice or become alarmed because we have unconsciously accepted it. Too often our

society merely avoids or ignores the matter of moral and ethical values because those who espouse such values are considered provincial and naive.

We were warned of these events when we were told that the devil "pacifieth many to believe that all is well, and he cheateth their souls," therefore, "Wo unto him that is at ease in Zion, and who says Zion prospers, all is well" (II Nephi 28:21-24).

You know, as I do, that many of the people within the Church, are different from those we dealt with a few years ago. Many of them are new converts and come from homes where there has not been a strong priesthood leader. They have less of an LDS family or LDS cultural heritage and attachment to the Church. In many ways they are better trained in scholastic things, are good hearted, but inexperienced in the gospel. I would suspect you may find your own ecclesiastical training being brought more and more into your professional work. You remember the scripture ". . . the foolishness of God is wiser than men; and the weakness of God is stronger than men" (1 Corinthians. 1:25). There is none who does not need the spiritual uplift of the gospel—especially the doctrines of the gospel, with emphasis upon faith, testimony, prayer, repentance, and humility.

We all confront people who have the attitude of being bored. People become bored with daily routine, with what they feel are repetitious and unchallenging tasks. Everyone is involved in repetition and routine. It is present in all assignments, in all activities, in all occupations. Teachers have thousands of lessons to teach, day-after-day and year-after-year. Artists practice over and over again before performing. Athletic teams work on plays time after time. Doctors see patients and listen to similar symptoms countless, repetitious times. Every job requires repetition. Whether one is making things or directing things, they do them over and over again. Wives and mothers cook meals, wash dishes, clean clothes, make beds, and do unnumbered other chores over and over again.

But drudgery and boredom are relieved by love and appreciation, and by a sense of service. Satisfaction can come from the

simplest assignment: it all depends upon attitude. Phillips Brooks wrote, "Life is always opening new and unexpected things for us. There is no monotony in living to him who walks . . . with open and perceptive eyes. The monotony of life, if life is monotonous to you, is in you, not in the world."

God's work is also repetitious. Life is renewed, commandments are repeated, truth is revealed time-to-time and time-after-time.

We know that salvation or behavior change is not basically an intellectual thing, but is a miraculous experience, a change of the heart and spirit. The progress your patients make reflect that it is wrought by the power of God. They who make progress make it because of a change of heart, not just a change of mind, or of the head.

In the Church Educational System we do not want to leave students with the notion that somehow salvation comes because of a vague network of ideas, philosophies, beliefs, occasional prayers, going to meetings, and just being a good person. Salvation comes through the power of God. Dean Robert J. Matthews, addressing the Religion faculty at BYU, said:

> How do we succeed in the academic milieu without losing the spiritual dimension? I think it is a matter of priority, a sense of values and of conversion. What is it that carries the gospel beyond the merely intellectual category? What does the gospel of Jesus Christ have that other systems cannot have? What makes the gospel more than just a philosophically correct system of principles? It is the element of divine miracles. It is testimony, priesthood, revelation, and conversion. These things are the *power* of God that Paul speaks of and the *power* of God which the sons of Mosiah and Alma taught. Each of these—testimony, priesthood, revelation, and conversion—is miraculous in nature and not of man's making . . . They are of God, and they make all the difference. They separate the gospel from all systems of human knowledge. Can man by searching find out God? (Job 11:7) . . . God must be revealed or remain forever unknown (Jacob 4:8). When a person learns by the Holy Ghost, he sees things differently than if he were purely an academician. . . . Truth alone is not sufficient in a gospel setting; it must be accompanied by the power of God, which is through the Spirit. This miraculous accompaniment is very conspicuous, if it is absent. (Address to Religion Faculty, August 27, 1986.)

There is a tendency, in this empirically-oriented society that always demands tangible proof, to adopt an "objective" approach and become aloof from emotion, conviction, and conversion. Such an environment is not compatible to faith, nor does it promote faith and the attitude of mind necessary to receive spiritual enlightenment. These words from John 7:14–17 help us to receive the message.

> Now about the midst of the feast Jesus went up into the temple, and taught. And the Jews marvelled, saying, How knoweth this man letters, having never learned? [That is, never having pursued a formal educational degree.] Jesus answered them, and said, My doctrine is not mine, but his that sent me. If any man will do his will, he shall know of the doctrine, whether it be of God, or whether I speak of myself."

There is a difference between the secular and the spiritual—between the earthly and the heavenly. The secular deals with knowledge or facts alone (some call it truth). The spiritual deals with knowledge coupled with something else, such as truth *and* righteousness, or truth *and* light. Elder Russell M. Nelson called it "truth *and* more" when addressing the BYU faculty, August 27, 1985. Secular truth can be obtained by study and experience. Spiritual truth can be obtained only by revelation after one has faith; and it takes spiritual truth to save a soul.

If what we do is not coupled with a conviction and a power of the Spirit, it may inform the mind, but it will not do much for the *spirit* and *soul* of the recipient. We must inspire and not just treat. We must touch the heart and not only the head. The value system of the counselor or therapist will come through in his or her work.

We not only have to be aware of the conditions of the world, but we are often confronted by strange ideologies espoused by members and teachers in the Church. Not all the false teachers lived at another time and place. There are false teachers who profess membership in the Church today, and every now and then we hear from them. They are religious in their demeanor; they use the scriptures, but they place the wrong interpretations on the scriptures. They undermine the doctrines of the Restoration. They have a sort of sophisticated unbelief, that masquerades as faith, but by clever use of words they actually deny the plain meaning of the

revelations. Some try to reconcile what they think are conflicts between the scriptures and the teachings of science, history, philosophy, and so forth. They try to accommodate to both sides, but only bring about reconciliation by a compromise that often is at the expense of the scriptures and the prophets and leaders of the Church. These "accommodators" have a way of interpreting scripture, attempting to say that it is good if it is spoken by the right people. To paraphrase Robert Millet and Joseph Fielding McConkie (*Doctrinal Commentary on the Book of Mormon*, Vol. 1, p. 345) "[These false teachers] have their residence in Zion, but they visit Babylon periodically." They have not learned the truth of the admonition of the Lord regarding gospel truths when He said "whether by mine own voice or the voice of my servants, it is the same" (*Doctrine and Covenants* 1:38).

A teacher of false doctrine within the Church is often more difficult to detect than one outside because there is a natural tendency for a person to trust one's teacher or counselor, especially if that person has a pleasing personality and clever ways. The Lord has said that if possible even the very elect would be deceived (Joseph Smith–Matthew 1:22, 37).

It is my opinion that the doctrines of the gospel are superior to the philosophies of the world. While we may study much secular material, we have to sort out those things which are essential for us, and cherish the revealed word over all other things.

To that degree which we deviate from or fail to accept any doctrine and to incorporate any principle that comes from God, and treat it lightly, we will be found deficient and will have lost some blessing.

Elder John A. Widtsoe said:

> The man whose mind only has been trained may be likened to the ship with great engines and a huge propeller, ready to drive the ship forward, but without rudder, chart, compass, or definite destination. When we add to the man, so trained, spiritual training, then it is as if we add to the ship, with its wonderful machinery—a compass, a chart, a rudder, and a dependable intelligence which controls the whole machinery, above and below deck, so that the vessel may reach a safe haven,

according to a definite purpose. (John A. Widtsoe, *Conference Report,* October 1922, pp. 44–48.)

On a later occasion he said:

> It is a paradox that men will gladly devote time every day for many years to learn a science or art; yet will expect to win a knowledge of the gospel, which comprehends all sciences and arts, through perfunctory glances at books or occasional listening to sermons. The gospel should be studied more intensively than any school or college subject. They who pass opinion on the gospel without having given it intimate and careful study are not lovers of the truth. (John A. Widtsoe, *Improvement Era,* September 1969).

I have great respect for the repetitious warnings of the prophets.

We have long recognized that, of necessity, teachers do some counseling. The basic premise of biological and clinical traditions is that a man with proper understanding and skill can help his fellowmen meet and cope with life and its problems. We try to make our people aware that there are major theories that have been developed concerning the counseling process that have originated independent of the gospel of Jesus Christ that are not always consistent and harmonious with the teachings and operations of the Church. We try to make them understand at least some of the limitations of these theories and the claims that are made for them. While no best way of counseling may be identified we ask that our people refrain from attacking or ridiculing the field of counseling and that they maintain an open mind to the honest research that is being conducted. No one knows better than those of you who are here the need for that open-mindedness.

While our teachers are responsible to lend supportive help to those with whom they work, they need to recognize their limitations in training, preparation, and authorization as counselors. They also need to know that counseling is more than just listening.

I suppose there must always come the time in any relationship when we instruct, encourage and inspire with wisdom and understanding, as we influence the individual to strive for the peace and potential that is rightfully his. This is perhaps not unique to the Latter-day Saint who counsels. The Spirit of God, however,

should be an integral part of our counseling performance. Through prayer and adherence to the commandments, we increase our ability to effectively counsel. Nothing can ever take the place of testimony and the learning that comes through the Spirit. That spiritual preparation and attainment you get, coupled with secular training, should make you the world's most proficient group of practitioners who address the problems of God's children who require the help of counselors. May you be so blessed to be.

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Beliefs of a Mormon Clinical Psychologist

Robert J. Howell, PhD

In addressing the issue of developing my own identity as a therapist, my vantage point is that of a clinical psychologist. To narrow this field a bit, it should be noted that most of my work has been in the field of psychopathology and forensic psychology. Because of this orientation, I like to view the mental health field as one which deals with various types of mental illnesses. And psychotherapy as one of the modes of treatment for some mental disorders.

Ideally it would be helpful to have a broad overarching theory which would guide the whole field of mental illness. This was the attempt of Freud's psychoanalytic theory and some of the offshoots and variants of Freud's theory. To reiterate what is likely so well known it need not be restated, a theory should never be judged by its ultimate truth or falsity. Rather, it should be judged by its utility or usefulness. Thus, psychoanalytic theory has shown to be very useful in conversion disorders and in many of the dissociative disorders. It is of no value to organic-mental disorders or substance-use disorders and of little value to schizophrenic disorders or mood disorders.

Unfortunately, it seems to be the lot of the behavior sciences not to have any theories in the classical use of the term theory. The best the behavior sciences seem to be able to do are to utilize specific models for specific areas of study. But there has been little success in bridging any model, or combination of models into an

overarching theory. Indeed, the only conceptualizations in the biological and behavior sciences field that reaches the status of a theory, as I am using the term, is that of the theory of evolution. As indicated, a theory should not be judged by its ultimate truth or falsity but rather by its usefulness. The usefulness of evolution is beyond debate. All plants and animals are classified following the phylogenetic scale, hence the result of the theory of evolution. In the health field, one notes the development, first on lower animals, of the polio vaccine. The Rh blood typing was first done on lower animals. Many practice surgeries have been and continue to be performed on lower animals because of the similarities between lower animals and humans. Finally, in psychology, and specifically the field of learning, drug dependency, and brain damage, many findings have first been demonstrated in lower animals. All this points to the utility of the theory of evolution in the biological and behavioral sciences. Interestingly, the steps from subhumans to Homo sapiens is in trouble. There doesn't seem to be the smooth continuity, but this doesn't detract appreciably from the usefulness of the theory of evolution.

But, as indicated, in psychology the best that we have been able to do is to construct small models for specific ideas. This is also true of the field of mental health and mental illness. As previously stated, psychoanalytic theory is very useful in some mental disorders but of little value in others.

Over the years, I have come to an increasingly firm conviction that the only way progress is going to be made in dealing with the mental disorders is to consider mental disorders as discrete and specific illnesses with a different cause for each disorder. Some of the causes will be biological in nature. Some causes will be psychological in nature and some will have their roots in the family and other social entities.

It seems to me that the proper approach in treating a mental illness is very much analogous to that of any other kind of illness. That is, first a diagnosis should be made. The diagnosis hopefully will lead to the cause or the etiology of the illness. Then treatment should be based on this diagnosis and etiology. Thus, I believe, as indicated by Bergin and Strupp (1972, p. 8), that there should be

specific therapeutic interventions which produce specific changes in specific patients under specific conditions. The specific treatments should be based on the specific cause of the illness and this treatment should produce specific outcomes. Obviously, these outcomes should be measurable.

While such a model may seem best suited for biological treatments, I state again that just as I believe in biological germs so I believe in psychological germs and family and social germs as well. The treatment of choice for conversion disorders and dissociative disorders is psychodynamic therapy. In contrast the treatment of choice for bipolar mood disorders is chemotherapy and the treatment of choice for schizophrenic disorders is chemotherapy plus family therapy.

Much has been written about values in psychotherapy and whether values should be expressed by the therapist or not. Psychoanalytic therapy would have the therapist be as an opaque screen upon which the patient can impute his or her thoughts and feelings as contrasted to reality therapy where the beliefs and values of the therapist become quickly apparent. Whatever the therapist's belief happens to be on this question of values, it is certain that the therapist should be sensitive to the values of the patient. As long as the values of the patient do not contain germs of psychopathology, the therapist should cherish the patient's values and try not to disturb them.

In contrast, however, if pathology is enmeshed in values, then it is the obligation of the therapist to determine if potential costs or hurt to the patient is outweighed by the potential benefit to the patient by the therapist delving into these pathological patterns. If it seems that there is little chance of altering the pathological attitudes or behavior, or if it seems that the costs will outweigh the benefits of trying to modify these psychological behaviors, then it should be the obligation of the therapist to leave these behavior patterns or beliefs alone.

It is not likely that a therapist will alter the compulsive and meticulous behavior of an obsessive compulsive personality disorder (as opposed to an obsessive compulsive neurosis). If this is so, the

therapist would do well to leave such meticulous behaviors of the patient alone, or at very most, only try to make the behaviors a bit more tolerable for people around the patient.

It also follows that if there is pathology in a person's religious beliefs, it may be important to try to delicately undo this pathology and help the person have healthier attitudes and beliefs. Again, this should be attempted only so long as the potential benefits to be gained by trying to intervene, outweigh the possible damage or cost to the patient. If, for example, a patient's evangelical religious beliefs and behaviors serve an important need in that person's life, it would likely be damaging to the individual to try to get him or her to give up such beliefs and attitudes.

Therapists should always be sensitive to their role as a therapist and the limits of their role. It is important to realize that potential harm can come when a therapist crosses the line and attempts to become a personal friend, a religious counselor, or attempts to assume other roles which are beyond the realm of the therapist. It is almost axiomatic today that a grieving widow can be helped in many ways a therapist can never help, by another widow, or a group of widows, who have already experienced this tragic event. Similarly, a bishop or a minister can do things with and for a person that a therapist can never do. Conversely, there are things that a therapist can do which would be inappropriate for a minister or a bishop to attempt to do.

It is good practice for a therapist to involve the patient's church leader at the proper time, if this a relevant issue. In a similar manner it is important to involve self-help groups for the person or other community support systems. One patient who had experienced a very tragic event in her life, perhaps received more help from her LDS friends who included her in all their church and social activities—more help than any medication or therapists could have hoped to have done.

In conclusion, the role of the therapist should be contained within well-defined boundaries. The therapist should use the kind of therapy and make interventions which have good empirical support for the kind of disorder which the patient manifests.

Finally, the therapist should stay within the recognized bounds of his or her profession and not intrude into other areas.

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Developing Our Own Identity as Therapists

Henry L. Isaksen, PhD

First let me point out that this is the Association of Mormon *Counselors* and Psychotherapists. As one of the "founding fathers" of AMCAP, I considered myself at the time and still consider myself a *counselor*, not a therapist. Since this is still my frame of reference, perhaps I am not the one who should be addressing this topic. Yet I am very appreciative of Anne's invitation to present my point of view and I do so in the hope that there are other members of the Association who feel, as I do, that we who prefer to call ourselves counselors rather than therapists: who believe the distinction between counseling and therapy should not be overlooked. This difference was recognized and respected by those of us who met some 15 years ago to choose a name (you will recall that the name of AMCAP's predecessor was LDS Personnel and Guidance Association, which was too restrictive) and to "hammer out" the By-Laws in such a way that *all* of us would be comfortable in our personal choices and in our associations together as fellow members of the Church and of the helping professions we represent.

Perhaps the world has changed enough in the last 15 years to justify rewriting the By-Laws—and perhaps even changing the name of our organization—in such a way as to eliminate the distinction. To that I would reply, perhaps what we really need to

do is seek for a better understanding and acceptance of the difference.

In order to provide some background for my position, let me first tell you something about how I came to be a counselor, rather than a therapist.

As the youngest of seven children, I enjoyed many benefits that were not available to most of my older siblings, one of which was the expectation that I would go to college. That opened an almost endless vista of career opportunities to me. A very poor math teacher in high school inspired me to be a *good* math teacher when I grew up, so that became my goal and math became my undergraduate major. Because my college years were during the depth of the depression (1935–1939) and my parents were struggling for basic survival, I had to "work my way through." One of my jobs—one I had both at San Jose State (from where I graduated) and at BYU (during my Junior year)—involved scoring "tests" that were given to entering Freshmen. These test scores were supplied to faculty advisors, who used them in their efforts to "counsel" their advisees. Most of you are not old enough to remember these "tests," but you have read about them: I'm sure—tests such as the Bernreuter Personality Inventory, the Thorndyke Test of Basic Skills, etc.—pretty primitive by today's standards! But my friend, Art Browne, and I were fascinated by them and by the emerging personnel and guidance movement. We were flattered when students would come to us and say, "My advisor tried to tell me what those test scores mean, but he didn't seem to know much about them. Would *you* interpret them for us?" So early on, we both developed an interest in personnel work and decided to minor in psychology. Not a bad decision, in view of the fact that openings for math teachers were scarce and salaries were very low. (Besides, I had elected to meet certification requirements later on as part of my Master's Degree program.) But there was an opening in Los Angeles for a Youth Personnel Supervisor in the new National Youth Administration program that called for a background in psychology. I traveled to Los Angeles and got the job—at a salary nearly twice that of my friends who took teaching jobs.

Working with youth who were eligible for Federal assistance through the NYA program involved a lot of counseling, as well as

testing, placement and follow-up—all functions of the emerging personnel and guidance movement. I loved it. But after only a few months my mission call came and I left for Chicago. Even in the mission field I did a lot of personnel work as secretary to the mission president (who, in those days, had no counselors). Then followed a year of personnel work in a war industry prior to two-and-one-half years as a Personnel Classification Specialist in the Army Air Corps.

At the end of the war, I was tempted to accept a very promising offer from two physicians I had met during my military days. They offered to sponsor me through medical school, then have me join them in a thriving practice. I guess that is where I really had to make a choice between working in an educational setting where I could concentrate primarily on the *prevention* of disorders and a therapeutic setting where I would be concentrating primarily on the *treatment* of disorders. I have never regretted that choice—except momentarily, perhaps, on those rather frequent occasions when the money runs out before the end of the month!

A year at Stanford University followed, where I earned my teaching certificate and a Master's Degree in Guidance. By then, as indicated, I had decided that I wanted to be a counselor. But a counselor's certificate required two years of teaching experience. Fine.' I had not forgotten my "miserable" math teacher in high school nor my determination to be a "good" one. Chaffey Union High School in Ontario, California was a great place to teach and I was, I believe, a *good* math teacher. In fact, I was urged, at the end of my two years there, to stay on as a math teacher with the promise that I would be considered for the counselor's job some day. No thanks. I had already made my decision to go for a doctorate.

I moved to Utah and entered the PhD program in Educational Psychology with an emphasis on counseling and a minor in Educational Administration. I wanted to prepare myself as best I could with the skills I would need to help students achieve their full potential—not only in school, but in life. *All* students, not just those who were having problems. *Prevention* of problems, rather than *treatment* through intervention, was to be my emphasis.

However, my program included many classes and a good deal of practice in the diagnosis and treatment of problems—psychological, social, and educational. (I worked half-time as a "veteran's appraiser" in the University Counseling Center during the two years I was there.)

Since 1950, when I completed the course work for my PhD, I have worked primarily as a counselor, counselor educator, or supervisor of counseling and other student personnel services in a wide variety of settings: from public schools, universities, colleges and private schools to church, business, government, and community agencies—always with an emphasis on counseling as a way of preventing problems, rather than on the treatment of problems through therapy.

You might well ask, is there *really* that much difference between counseling and therapy? It must be obvious to you by now that I think there is a very significant difference, one that should be debated and explored in depth. The need for both is obvious, as is the value of each. Yet the difference is not clearly perceived, I feel, by most of us nor by the public at large. More good counseling, especially in the schools—and particularly in the elementary grades—might serve to reduce the need for so much therapy.

Yes, it is a question that we need to consider. But since it is not within the scope of this presentation, perhaps it could be addressed at a future meeting. Until then, I urge you to ponder the question, especially as it to relates to the gospel concept of free agency (another interesting subject that needs to be explored in depth).

Thank you, Anne, for inviting me to raise my "personal voice" on this most important and interesting subject, "Developing our Own Identity as Therapists." I hope, if nothing else, that my voice has served to stir up some thoughts within each of you that will help you to develop and clarify your own identity as a therapist—or, if you prefer, as a counselor.

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The Unmaking of a Psychotherapist

Barbara R. Wheeler, DSW

The year is 2014. I am sitting on my deck, in my rocking chair—only because 'ole folks are supposed to do this . . . sit and rock. The aspens and pines have not changed at all in the last 25 years. Have I? I used to be a psychotherapist—and, if I may be so bold as to say, a pretty good one—a *Mormon psychotherapist.* Ah, ha. There was a day—I remember it well—when "Mormon Psychotherapist" was a contradiction in terms. You know, like "enjoyable diet" or "constructive criticism." That organization, AMCAP did much to align Mormonism and psychotherapy over the years. I wonder if AMCAP still exists?? They used to have some terrific conferences.

For many years, I worked at making my identity as a therapist. And during the most recent years—since about the turn of the 21st century—I've been working on *unmaking* my identity as a psychotherapist. Have I succeeded?? What went into the development of my professional identity? What is now gone from that identity? What is still with me? At age 80, notice that I am very good at reconstructing my past. So many memories.

When I think about that which went into my identity as a psychotherapist many years ago—that is now gone—I remember a ten year-old's dream—while living in New Mexico. After playing with the Navajo children day after day in their village—where dirt paths carved a way between clay quansit huts—I told my mother, "I want to come back here when I grow up and help these

children. They are so poor." My Mom encouraged me and, grasping a teaching moment, said, "That is called a 'Social Worker.'"

My dream is gone. My mission unfulfilled. I never did return to help those beautiful people. Perhaps next year??

Also gone from my identity, is the high energy level I used to use to propel me through a day and through my professional career. With the loss in energy, also went the potential for burn out—a state that I experienced periodically as a psychotherapist. The high energy level of my younger days has been replaced with a *PEACE*: inner and outer peace. However, I do miss the good 'ole days of inner conflict and turmoil—so intellectually stimulating—particularly my value conflicts that were so necessary to the development of professional self, especially early in my career. I miss them. Yet, I could have avoided some of the accompanying pain. You see, by being baptized into the LDS Church at age 19—right at the beginning of my college days as a psychology major—I had to immediately deal with such issues as those relating to homosexuals, abortion, and gender. If I had waited until I was 65 to get baptized, it would have been less complicated. But, as I mentioned, also less stimulating and growth producing. If I still had some of those conflicts now, at age 80, to stimulate me, I probably wouldn't need this pacemaker.

But you know, as I dig deeper into this subject. . . . being a Mormon probably did not affect my inner conflicts as much as I think it did because I noticed throughout my career, that most therapists—LDS and non-LDS—struggled with value conflicts. It just always seemed to me that high religiosity, connected to any religion, was directly correlated with high degrees of judgmentalness. . . . and that perhaps we Mormon therapists were more judgmental than our non-religious colleagues. What a disturbing thought!! I guess I realize why I never did conduct research on the subject. I did not want to face the outcome, should the correlation exist.

The unmaking of my professional identity also includes a slight decrease in the overall bias from members of my church, toward

Female Mormon Professionals, and, more specifically *female psychotherapists.* I remember that during most of my career, how difficult it was to conduct therapy with some Bishops, Stake Priesthood Leaders, etc. Back in those days, women were not seen as authorities in matters outside *the kitchen*—especially in matters relating to the bedroom. I remember when I was cramming for my first sex therapy exam, in my second-year MSW training. As I held my text book, I gazed over the top of my glasses—I mumbled to Jim, "Can you picture me a 'Sex Therapist???'"

Perhaps there was a lesson for us there. I did not give myself much of a chance at authority. Was I just as sexist as those Bishops and Priesthood leaders who would reject my authority?? Ah, ha, the lesson I learned . . . "Therapist. define yourself!!"

If these are things that are gone from my professional identity, what is left? What is left of the psychotherapist in me—if anything??? To what extent does the *unmaking of a psychotherapist* go, as the effects of time take their toll??

My values—my values are left. My religious ones have gathered potency over the years, as have my professional ones. And the two are so enmeshed now that the best celestial psychotherapist could not untangle them. Let's see . . . we used to have a name for that in the psychotherapist biz—ah, yes—co-dependency. Yes, I have a co-dependency of values. (What a diagnosis!)

Also, still a part of me is my sense of self: as one making some small contribution—perhaps to my profession, but more importantly, to the one. The one client. How we struggled together on *real-life matters*! It has been a long time since that quarter—just prior to receiving my MSW—when I was sitting next to my mentor and valued teacher, Eleanor Stein, as we listened to a visiting psychiatrist tell us that we probably will not really help anyone until ten years after graduation. Yes! Yes! My secret thoughts exactly! He said them for me! Can we really help anyone? Is helping really a hoax? My wise teacher sensed I needed rescuing and in her typical powerfully serene manner, turned to me and out of the corner of her mouth said, "That's a lie." She was right, as usual. I did contribute something in therapy—and much

sooner than ten years. (Nine maybe?) The memory stays with me and cannot be undone as part of who I am today—at age 80.

The fact that change *is* possible is a powerful axiom—an axiom that will always be a part of who I am. Thank you Eleanor. I love you.

And now, even though I have not seen them for twenty to thirty-five years, I still have left, the sweet memories of my own students and clients who picked up where you, Eleanor, left off. That which those courageous people taught me in therapy and in the classroom, is so much a part of me now, that my soul's progression will ride on it throughout eternity.

Also, with me are memories of my failures in therapy—all the things that did not work—and, in addition, all those humorous memories. Where is that book I was going to write about the funny things that happened in sessions over the years? I cannot carry those to my grave. I must get them down. They sustained me throughout the years sort of an antidote to symptoms of burn-out . . . and they sustain me now: spontaneous humor that erupted from the human condition.

What is left of my professional identity? Just about everything. Perhaps there is no such thing as the unmaking of a psycho-therapist—like unmaking that which we know—it's impossible.

That which is gone seems insignificant and/or as useless as the fact that I cannot remember what I had for lunch an hour ago . . . where I put my glasses. Oh, well, *seeing* is not that important anymore. But, *feeling* still is!

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