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The purpose of this Association shall be:

a) To promote fellowship, foster communication, enhance personal and professional develoment, 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 that is not sponsored by, nor does it speak for, the Church or its leaders.

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Editorial

Welcome to the latest issue of the *AMCAP Journal.* As newly appointed editor I have approached my tasks with much excitement and some trepidation. I have great respect for the process of peer-review in selecting and refining scholarly writing. I appreciate the courage needed to generate and submit scholarly work. I am sensitive to the pain involved in receiving critical comments on one's work, no matter how constructive they may be. I understand the discouragement that may come from having one's efforts rejected. Along with this empathy for those making submissions, we as an editorial board have strong feelings about maintaining the scholarly standards set in previous volumes of the journal. I believe the articles included in this issue maintain that historical standard.

The articles included in this issue are diverse in topic, method, and purpose—not unlike our membership. As editor I hope to continue to work to make the journal a forum of scholarly thought for all AMCAP members. In his editorial in the 1994 issue of the *AMCAP Journal,* Scott Richards addressed the current state of the journal and offered his recommendations for its future. He noted the lack of sufficient manuscripts to publish more than one journal each year. He encouraged authors who had manuscripts returned to them for revisions to complete those revisions and resubmit. He also proposed some means to expand the scope of the journal. I have echoed some of his recommendations below. In future issues of the journal we hope to develop ways to include more of you. By including more of you, we hope to better serve as a point of integration between science and practice. The following are some of the means we hope will involve a broader base of the membership in the journal.

· Including responses to articles in the journal.

We will identify manuscripts of general interest about which there may be some debate. The topics of these upcoming articles will be distributed to the membership, and interested members will be invited to respond to the manuscript. Accepted responses will be published simultaneously with the original article.

· Creating new sections of the journal to include a broader spectrum of topics and a wider range of scholarly writing.

It has been suggested that we create space to include some of the articles that are more focused on spiritual issues than psychological issues. We may also develop a forum for case studies/practice insights and one for theoretical/philosophical writing. Your submissions in these areas and suggestions for other areas that might be included are encouraged.

· Identifying topical foci for upcoming issues.

We will work to establish a topical agenda for future issues of the journal. These will be advertised to the membership, and members will be especially encouraged to make contributions relevant to those topics.

Our hope is that the journal will continue to serve as a resource of scholarly writing on a wide variety of topics relevant to both the academic and clinical work of AMCAP members. I eagerly and respectfully look forward to participating in the review of your submissions.

Aaron P. Jackson, Editor

Journey of the Soul

Wendy L. Ulrich, Ph.D.

When AMCAP was still in its infancy, I was a young mother just finishing an MBA and still confused about what I wanted to be when I grew up. I wrestled for many months trying to decide among several options. Then one night I was reading an account of early Church members who knew no better than to call down the powers of heaven to heal one another, and I knew with a spiritual certainty that cut through all my ambivalence that I wanted to be a healer—a healer of the heart. I promised God that night that if he approved my desire I would do my best to learn to be a good healer, but I did not have then the slightest notion of how healing occurs, either as a gift of the spirit or as a clinical reality. I only knew that I wanted to participate in this mystery, and that I believed God was offering to teach me how. I have learned a few things about healing over the last fourteen years, but for me, healing still partakes of mystery. Relatively little of any import have I learned from textbooks or teachers, as necessary as that training and discipline have been to get me started. God has kept his promise to me in ways that I could never have anticipated, for what I have learned about healing I have learned mostly by healing, from ailments I did not even know I had.

As I stand before you today I reaffirm my desire to be a healer.

[1]This was originally presented as the Presidential Address at the AMCAP Twentieth Anniversary Convention, September, 1995. Please direct correspondence to 3108 W. Dobson Place, Ann Arbor, MI 48105.

That is a goal so presumptuous as to still cause me some embarrassment to admit, but in that desire to learn the gift and art of healing I believe I stand on common ground with many of you here. This is why I come to AMCAP, why I believe in it, why I serve it.

A colleague once commented that he appreciated my holding out for healing in a discipline that speaks mostly of coping. Actually I hold out for both. God's promise to those who want only healing is that they can learn to cope, to get along in a tent in the wilderness even though they prefer a house in the city. His promise to those who want only coping, because they fear the surgeon's hand, is that they can also heal, although true healing will never return us to precisely what we were. It will always change us. In fact, most healing worth its salt is an act so radical as to partake of dying, and of being born again.

The initial ordinances of the Church reiterate these lessons to me. Baptism reminds me that I must die if I am to be reborn, and I must be reborn to enter into the kingdom of God. I believe with all my soul that if we want to be healers for others we must be engaged in these same healing processes of dying and being rebirthed. My own healing has taken me on a strange journey, and it has been a journey toward salvation as much as wellness, convincing me that God saves us by healing us, healing us from the inside out. For this reason I believe the spiritual journey of mortality is ultimately a healing journey. Whether we battle depression, addiction, anxiety, personality disorder, psychosis, or post traumatic stress, LDS Chaplain Paul Williams reminds us, "Hygiene-oriented psychologies cannot heal hearts and guide soul-pilgrims whose "mental illnesses" are God's dispatching of . . . soul[s] to their journey" (personal correspondence, April 19, 1995). True healing requires us to leave behind the false comforts of home and civilization to wander through an inhospitable wilderness in search of our inheritance as children of God. We must take the healing journey ourselves if we want to help others find their way.

The scriptures are replete with stories of such healing journeys.

The lessons of these epic tales emerge when we look beyond their historic truth to contemplate what they may contribute to the meaning of our life today. Ultimately each of our journeys is unique, and so each of us will be drawn to different scriptural tales for guidance in our own lives, or as we attempt to help our clients find the journey to which God calls them.

Personally, I like Nephi's story. When my children were little I taught them a little verse I heard somewhere, although the author and the exact words are lost to me now:

> Nephi made a bow when he didn't know how.
> Nephi made a ship when he didn't know how.
> Nephi made a temple when he didn't know how.
> But he knew how to listen and how to obey,
> And when God commanded Nephi said, "Okay!"

When I told my husband I was planning a talk about Nephi's journey he had a great time with this little verse, adding lines like: "Nephi had intense sibling rivalry and he didn't know why," "Nephi interpreted dreams when he didn't have proper Continuing Education Credit," and even, "Nephi had a dysfunctional family that makes your wildest clients look tame." Chapter One in Nephi's journey to the promised land might be entitled, "Nephi's father has a crisis and he has to leave NOW."

Come with me on a journey.

> . . . the Lord spake unto my father, yea, even in a dream, and said unto him: Blessed art thou Lehi . . . and because thou hast been faithful and declared unto this people the things which I commanded thee [that Jerusalem should be destroyed], behold they seek to take away thy life.
>
> "And . . . the Lord commanded my father, even in a dream, that he should take his family and depart into the wilderness. . . .
>
> "And he left his house, and the land of his inheritance, and his gold, and his silver, and his precious things, and took nothing with him, save it were his family, and provisions, and tents, and departed into the wilderness. (1 Nephi 2: 2, 4)

Thus begins Nephi's journey away from Jerusalem, a city steeped in the "traditions of the fathers" as the scriptures call those habits of unrighteousness that pass from one generation to the next unless someone makes the deliberate choice to dismantle them. Usually my own spiritual journeys have begun less dramatically. The crises that push me to abandon familiar paths and question the traditions behind past choices have more often taken the form of a threat to my soul life—to my growth and potential as a human being. When the defenses I have learned have outlived their usefulness—when they can no longer protect me from my enemies of fear and depression and anger and guilt—it is time to leave the pseudo-security of a familiar order and depart into the wilderness.

My departures seem momentous to me, but they are actually pretty small-scale. What must it have been like for Nephi to change an entire lifestyle and abandon all that was familiar? How radical a departure for Nephi even to accept that Jerusalem—venerable and timeless and God-favored secure—was but an illusion of well-being, doomed by its own indifference, to fall. How crazy to walk away from the familiar securities of wealth and home and status that keep at bay the wolves of one's own mortality and walk out into the deserts of Arabia with one's little tent in hand. In the face of crisis, how often I, like Laman and Lemuel, cling to the familiar even while I profess to leave it, blaming others for my losses, longing for escape from the rigors of the journey and a return to familiar comforts. But when change is called for, we have only two choices: we can hold on to our illusions of Jerusalem's invulnerability and go down with her to the destruction and captivity of the soul, or we can leave the city, sometimes to wander for years in desert wastelands and vast uncharted waters, following the unlikely direction of a still, small voice.

I never like this part. Dream images of burning houses and vicious tornados mark the beginnings of my journeys, reminding me that change always entails destroying the familiar in order to create the future. My old defenses may well have been God's protective gifts to me in childhood, but when they have become simply weak and inef-

fective walls, restricting my agency without protecting me at all, it is time to take them down. Nevertheless, it is a hard thing to watch Jerusalem burn, even if it is only in the visions of the night.

In my role as a healer, I appreciate that when clients first come to me in response to that prophetic voice crying that Jerusalem is doomed, they want most to hear that the prophets lie—that repentance and change are not necessary. They ask, in essence, why the old defenses do not work any more and how to kill the prophets with their disturbing cries. They insist, "Change someone else, change the rules of life itself, but don't change me." That failing, their plea may become "Change me then, but don't let it hurt." They are right to be afraid; healing change shakes the very assumptions under our feet, brings down our walls, knocks out the lights. Funny how when I read 1 Nephi, I always imagine it happening in the dark.

One of my clients in the midst of some deep personal change recently reported a vivid and disturbing dream in which a woman she believes to be a dear friend is murdered and dismembered by a group of bandits. Somehow my client knows it is her task to put the pieces of this woman's body in a bag and dispose of it, but she is horrified by the prospect. For a time she focuses her energy instead on building a fortress to protect her village from these marauders who will surely return. In the process she tries to stop a passing train, loaded with lumber she hopes to use for her walls, but she only derails the train. Unable to build her stronghold she reluctantly returns to the task of disposing of this body. With great anxiety she forces herself to look at the face of the victim. She learns with relief that the woman is not who she thought, nor is the clean-up task, however unpleasant, as abhorrent as she had feared.

As we processed this dream my client decided that the dream represented her therapy, her soul journey. Even though she has come through some painful issues to a better place, the dream reminded her that some aspects of herself—tightly held ways of coping in the past—have died. That death feels violent and frightening and only she can pick up the pieces. Horrified to stare such a loss in the face, she prefers

to turn to the more familiar and reassuring task of building walls of defense against a hand of change that feels only malicious. But we can never build enough walls to protect us from the death that is always a part of the journey of the soul. We only derail the train out of town when we try. Ultimately, whatever dies is not really our friend, but our illusion.

Nephi's losses are hardly illusory, however. At least in my book, power and wealth and home feel real enough to merit a backward glance or two. How shocking it must have been for Nephi to see his wealthy father living on the run, a vagabond. Nephi records simply, "And my father dwelt in a tent" (1 Nephi 2:15), but I feel a world of meaning in this briefest Book of Mormon scripture. As I contemplate my own journey, living in a tent feels like an appropriate metaphor for the temporality of a sojourner's life: staked to the earth, but ready to move. Tent life bespeaks transition, vulnerability, having no room for what we do not need, making good use of a few well proven tools.

The difficulty in adequately planning for a journey of the soul becomes apparent when I see this little family's fits and starts as they take off, go back for the brass plates, leave again, again return for Ishmael's family. These round trips to Jerusalem, however circuitous, seem a necessary part of getting our bearings, learning what is important, and building stamina for what lies ahead. The trip between Jerusalem and Lehi's camp down the coast of the Red Sea runs through one of the most God-forsaken stretches of desert imaginable. I can hardly envision making such a trek on foot, let alone making it five times in a short period as Nephi did. Apparently God's goal in all this does not simply entail expedient arrival at the land of promise. Instead he uses the journey to make them a people of promise. How we travel is more critical to making us holy than our arrival at a holy destination.

I, too, travel in a spiritual wilderness, searching for a more authentic, if more risky, life. Like Nephi, sometimes I must make several return trips to the same old issue before I have gathered everything I need in order to leave the rest behind. Here in the wilderness I have

come to believe that my only safety is to acknowledge that I must live in a tent, and to get in the right one. Zion is a tent, for we are her stakes, and Zion is the tent I seek. Only by being in covenant relationship with God, by being one of a Zion people, can I access God's healing power on behalf of myself or my clients.

Beginning with Abraham, God's covenants with his people as they travel in tents have always included three things: priesthood, posterity, and promised land. In addition to their literal import, each of these promised blessings symbolizes to me the features of God's face that mold my countenance, the images of what my travels may help me become. Beyond simple definitions that might exclude me, priesthood symbolizes God's promise to empower me, to teach me how to turn my righteous intentions into realities. Beyond the children I may or may not have, God's promise of posterity suggests that he can perpetuate my loving relationships in both time and eternity and share with me his capacity to receive and engender spiritual life. And as one who already lives in a "promised land," I have come to see God's offer to lead me to such a place as a metaphor for his sure guidance on the journey of the soul toward a new home, a new peace, a new life. These three things—spiritual power, life-engendering relationships, and the promise of new life and inner peace—are obtained while we live in the "tents" of our lives. Let us look at how Nephi's experience in a tent illuminates the process by which God heals us, leading us from our old walled cities to the New Jerusalem of spiritual power, relationships, and peace, in Paul's words, a "city which hath foundations, whose builder and maker is God" (Hebrews 11:10).

As Nephi lives in a tent, his first return trip to Old Jerusalem in search of the brass plates provides two essential lessons in the acquisition of spiritual power: knowledge of our sacred history, symbolized by the brass plates; and the principles of spiritual discernment, symbolized by the sword of Laban.

The brass plates become a powerful symbol of knowledge of our past, our own sacred history. The history of their fathers found on the brass plates empowered Nephi's people with new potential to both learn from that history and reclaim its promises. In my journey, going back for my personal history allows me to make explicit the rules by

which I have lived, the culture that clothes me, and the relationships that have forged me. This knowledge of my history enhances my agency to change by making explicit the implicit rules by which I live. Increasing my consciousness of my past increases my capacity to choose in the present. When I see accurately the patterns of my ancestor's lives I understand more clearly the patterns in my own. I begin to discern choices within those patterns that previously I have missed.

Learning about the choices, feelings, thoughts, and desires of family members can be a formidable task, however. Going back for our history can produce as much anxiety as facing Laban, a captain of fifty with his sword in hand. A client contemplating an invitation to visit his heretofore combative brother wanted only to stay far, far away from this now more mellow sibling. He completely rejected my suggestions for using the trip to learn more about this brother. His reluctance to engage his former enemy is amazingly common. Had he been a member of the Church I might have talked to him about the work of gathering brass plates. We can do this gathering by asking simple questions of ourselves and our family members about what our life was like, what we believed and felt, what we learned. Such brass plates provide essential context for psychological work.

Like Laban clinging to brass plates he does not even value, family members who are abusive, neglectful, or addicted sometimes interfere with our knowing what is real about our lives. These Labans insist that they have exclusive access to what is true. Refusing to acknowledge our right to our own reality, like Laban they may deny us our truths even though they do not value truth themselves. When staying in relationship means jeopardizing our trust in our own voice and experience, when the soul-life is in danger, sometimes the Spirit may prompt us that our only recourse is to take our truths and run.

In order to acquire his brass plates, Nephi is prompted to kill an interfering Laban with Laban's own sword. This sword has become a symbol for me of God's ultimate power to turn all that Satan would use to destroy me to the service of my soul. God does not promise us that our lives will not be in danger here in this mortal wilderness, but

he does promise us that he can turn to our blessing every device that threatens our soul life. The sword of Laban becomes a symbol of God's power to use the opposition that could destroy me to teach and empower me instead.

Although Nephi initially returned to Jerusalem exhorting his brothers that "the Lord is able to deliver us, even as our fathers, and to destroy Laban, even as the Egyptians" (1 Nephi 4:3), when Nephi realizes that he himself is to be the instrument of that destruction, he is not a little hesitant. He must think it out in his mind, examine his motives, and listen carefully through multiple spiritual promptings before he feels sufficiently confidant of his discernment to take such drastic action. Personally I would be wondering why God couldn't just give Laban a change of heart, or a heart attack. Instead God requires that Nephi scrutinize his own heart and sort out all its motives.

Like Nephi, as I examine my heart it has been as critical to learn the voice of the adversary as to learn the voice of God. As a missionary I taught investigators to identify the peaceful, comforting presence of the Holy Ghost. As a soul traveler I am also learning to identify the voice of the adversary: loud, mocking, accusatory, and manipulative. Satan's voice conveys consistent messages. He insists that there is no other way to escape the tension of ever-present temptation except to yield to it, while God promises comfort and further instruction when I have reached the limits of my ability to resist sin. Satan proclaims that if I surrender to him he can protect me from anyone who would hurt me or make me afraid, while God asks me to humbly submit to others' agency and life's uncertainty in order to learn good from evil by my own experience. Satan promotes my all-or-nothing thinking, contending that if I am not perfect I will be in his power, while God offers the atonement on the assumption of my inevitable imperfection.

Accurately discerning the deceptive voice of Satan is especially important if we are to liberate within ourselves the power of what Carl Jung has called the Shadow, an archetype for those tendencies, desires, and characteristics we have condemned and disowned. Nephi's capacity

to take another life is probably firmly relegated to his Shadow. Who among us would want to admit ourselves capable of such an act? He avows that he has never shed the blood of man and that his heart shrinks from such a task. Yet at this critical juncture it is just such a heart, a heart that can kill, that is required. Usually we think of Satan as the Destroyer, but the story of Nephi and Laban reminds me that the God we seek to emulate destroys what is already spiritually dead in order to foster new spiritual life. When Nephi ascertains that the power of his Shadow is being harnessed by God and not by Satan, he can afford to unleash it. To paraphrase Jung, such spiritual certainty does not come by contemplating visions of light, but by facing the darkness within.

I have been working with one LDS client for some time on identifying the voices that speak in her head. During a previous session, careful exploration of these dark inner voices had led her to conclude that confusing feelings of same-sex attraction merely masked the plaintive Shadow voice of a small child yearning for the affection of her emotionally absent mother. This Shadow voice spoke important truths that helped her meet her needs in legitimate ways. By the next session, however, she was certain she had made this whole scenario up just to get my attention. As I scrambled to make sense of this development I silently prayed for help. Suspecting the internalized voice of a critical parent, I asked her whose voice this was, so judgmental of her motives. She fumbled with her answer for awhile, and then she stopped. She looked me in the eye for the first time that day, and I, too, suddenly understood. "That is Satan, the Accuser," she said, "and he is a liar from the beginning. I need not worry about his opinions of me." Like Nephi, we can increase our spiritual power by learning to distinguish the inner voices of God, Satan, and self.

Having acquired the brass plates and the sword of Laban, symbols of spiritual power, Nephi's next experiences bring him more essentials for tent travel: the companionship of men and women. Nephi gains the trust and loyalty of Laban's servant, Zoram, who later becomes his friend, and the willing companionship of Ishmael's daughters, one of whom becomes his spouse. From these two loyal companions, Nephi

learns about life-engendering relationships according to God's second covenant promise to preserve us in such.

Like Nephi, I feel good friends are worth a long desert trek to acquire. We live in an inherently lone and dreary world, but none of us can traverse the wilderness of self-discovery alone. Like Christ, we need companions to witness our heart work, sustain our mission, and help us provide for our temporal needs. True intimacy occurs only when we take the risk of being known—when we take off the robes of an imposter, reveal ourselves and our purpose, and give promise of fidelity to each other—as Nephi did with Zoram. This risk is both easier and more worthwhile when we believe that our relationships can last. I believe that my primary relational task is to build relationships worth perpetuating for eternity.

LDS concepts of sealing family ties seem to emerge from an earlier understanding of the "everlasting covenant," in "token or remembrance" of which friends saluted friends "in the name of the Lord Jesus Christ," receiving one another "to fellowship, in a determination that is fixed, immovable and unchangeable to be your friend and brother through the grace of God in the bonds of love, to walk in all the commandments of God blameless, in thanksgiving, forever and ever" (Doctrine and Covenants 88:133). Who of us can imagine eternal felicity without friends? Surely it is only because my husband is first my friend that I desire his companionship for eternity. Can we imagine a sweeter outcome than for our children to consider us their friends?

Learning to receive from my friends has been essential to my own soul work. I have learned that when I feel overwhelmed by the needs of others, often I am simply projecting outward my own overwhelming neediness. In the past I grew accustomed to giving as a way to circumvent my needs, justify self-neglect, or act out old scripts of self-deprivation. When I first allowed myself to feel the question, "What do I need?" I found the answer floating in an unnamed fear that felt as big as outer space. Convinced that my needs for nurturing, tutoring, and help were limitless and selfish I felt them bearing down on

me like some malicious primate with inevitable intent. But as I turned to face this monster I saw that my needs were actually very simple, very basic, and that behind my dark fear were only sadness and hurt, not evil. Some of us find "dark nights of the soul" in the simple work of learning to trust enough, hope enough, and humble ourselves enough simply to receive. I commend these lessons to others who become mired in giving.

Lessons in tent travel continue as Nephi leaves Jerusalem this third and final time, having found a companion among the daughters of Ishmael. Fully severing his past, Nephi's desert experiences now begin to prepare him more fully for God's third covenant promise of a new home of peace and safety. Alone in the wilderness, Nephi listens as his father recounts his dream of the tree of life, prompting Nephi to seek his own vision for the journey ahead. He tells us,

> . . . I had desired to know the things that my father had seen, and believing that the Lord was able to make them known unto me, as I sat pondering in mine heart I was caught away in the Spirit of the Lord . . . into an exceedingly high mountain, which I never had before seen. . . . And the Spirit said unto me: Behold, what desirest thou? (1 Nephi 11:1-2)

The importance of this question is reiterated when we recall that God "will judge all men according to their works, and according to the desire of their hearts." (Doctrine and Covenants 137:9). One of the best questions I have learned to ask myself and others is, "What do I want?" Sometimes I don't feel safe acknowledging even to myself what I want, having spent too much time trying to please others or avoid disappointment. Once I determine what I really want, I must then face the often challenging task of negotiating for it, making plans, and sometimes accepting disappointment. I have spent months, years of my spiritual journey learning to probe deeply and then trust deeply my heart's answers to the question, "What do I want?" Answers to this question provide both treatment plans and progress reports for our healing journey. I believe God asks us some version of this question whenever we approach him at the mortal veil. God probes our

heart for our truest desires, but if we will ask him, he will also educate our desires to fit us to live with him. Learning to want what God wants is the surest path to becoming like him.

Once Nephi tells the Spirit that he desires to see what his father has seen, he is asked, "Believest thou that thy father saw the tree of which he hath spoken?" (1 Nephi 11:4). "Do you believe?" It seems like an odd question in the midst of an open vision, until I remember that Laman and Lemuel also saw visions, but did not believe. I am not so different. God gives me testimony, direction, personal revelation, and as good as they sound at the time how quickly I fall into my doubtful, Lamanlike ways. Like the disciple who said, "Lord I believe, help thou my unbelief," I find that belief and doubt vie for my allegiance. My mission president once wrote to me that our beliefs are more important than our doubts, though we will have some of both. I have come to understand that belief is ultimately a matter of choice—not reason, not relationship, not analysis. Christ does not answer his disciples about when he will come again, and he will not answer all my questions either. The point always comes at which I must choose whether to trust in God's goodness, power, and love for me.

The importance of believing God is reiterated with the discovery of the Liahona, a wonderful instrument that guides Nephi and his company according to the "faith and diligence and heed" they give it—a most practical and concrete manifestation of how the Holy Ghost submits to our desires and beliefs, and of how we must submit our desires and beliefs to God if we are to end up where he would have us go. To me, the Liahona is a marvelous symbol of the gift of the Holy Ghost.

The Liahona plays a vital role in Nephi's journey when he breaks his steel hunting bow and the food supply quickly diminishes. After days of floundering, the camp dissolves into complaining against God and blaming one another. Finally Nephi makes a new bow, a single arrow, and a sling for stones. Armed with these new tools he has created in the wilderness from the materials available, he asks his father's counsel about where to hunt. A penitent Lehi prays for direction, and the Liahona again points the way to food for the camp.

On my soul journey I frequently reach this point where the old tools for getting what I need do not work any more. When my addictions and defenses and manipulations break down, I often cling to them like a child with a broken toy, refusing to let go. Withdrawing in a pout no longer gets my husband's attention? Then I'll withdraw in a bigger pout. Racking up a long list of tasks no longer placates my anxiety? Then I'll rack up a bigger list of tasks. Yelling no longer whips people into shape? Then I'll yell a little louder. Pouting and obsessing and yelling . . . broken bows that have lost their spring. How difficult to let go of my fractured strategies, stop complaining and blaming, carefully analyze the situation and the resources at hand, set myself to solving the problem with new tools from new materials, and seek others' help and God's direction.

When I see myself cling to strategies that no longer get me what I want I have learned to ask, "What false hope am I clinging to so tightly that I cannot put it down?" It may be a present-tense false hope that I really don't have to do this hard task life has handed me, that if I throw a big enough tantrum God will say, "What could I have been thinking? Of course this is too hard. Go back to Jerusalem and let's put an end to this ridiculous camping trip." Or it may be a past-tense false hope that if I hold out I will finally get the help or care or approval I once needed so desperately and did not receive. Stubbornness and resentment can be a way to hold on to a false hope that we can rewrite history, bypass legitimate mourning, or change other people instead of changing ourselves.

In the final chapter of Nephi's journey away from Jerusalem, Nephi builds a ship to take him to his promised land. This is an act of extraordinary independence, for he does not build after the manner of men. Rather he must trust in his spiritual discernment and power to resolve all problems of design and construction. Nephi determines that, if Laman and Lemuel will not help, he will work with those who will. If he has no pattern, God can teach him. Ultimately Nephi risks his own life and the lives of his family on the soundness of his own vision and skill when he boards this ship and takes to the high seas.

Nephi takes his ship across the great uncharted waters I associate with the unconscious.

On my soul journey to my promised land of inner peace, God requires me, as he did Nephi, to stand for what I believe regardless of the opinions of others. The healing ship he requires me to build sometimes does not follow traditional designs. As I endure the storms of internal raging and terror, or the death-still seas of personal or familial resistance, I find that, in the words of Paul Williams, "My frightened ego is only a harbor pilot. The great pilgrimage is across the rage, hurt, brokenness and unspeakable longings at the heart of mortality to the hope that remains at the bottom of Pandora's box." The harbor pilot is of little value in crossing the great waters; I must turn to God to teach me to build a suitable vessel. Perhaps not everyone needs to cross such oceans, but when we need a new homeland, sometimes we must go out into the deep. I find that traversing the ocean requires willingness to feel my feelings, not simply understand them, to let someone else see them and not merely hear about them, to claim all that my body—my faithful tutor—knows. Having been out in the deep myself, how grateful I am that Nephi does not just give us the record of his victories and strengths. He also asks us to know his struggles and weaknesses:

> O wretched man that I am! Yea, my heart sorroweth because of my flesh; my soul grieveth because of mine iniquities.
>
> I am encompassed about, because of the temptations and the sins which do so easily beset me.
>
> . . . my heart groaneth because of my sins. . . . (2 Nephi 4:17-19)
>
> My heart weep[s] and my soul linger[s] in the valley of sorrow, and my flesh waste[s] away, and my strength slacken[s], because of mine afflections.
>
> . . . I yield to sin, because of my flesh. . . . I give way to temptations, that the evil one ha[s] place in my heart to destroy my peace and afflict my soul. . . . I am angry because of mine enemy. (2 Nephi 4:26-27)

On my healing journey, how grateful I am for people who willingly know of my pain, my anger, my sorrow, my grief. Personally, I

cannot do strenuous and challenging tasks for long without people around me who will accept, even cherish, the wounded, needy children who still live in my heart. If I want to be strong, I must find people with whom I can be weak. My critical task, as I ride out the storms and stills of life, is to search out the lesson inherent in each experience about both my strengths and my weaknesses. In victory, or banality, or defeat, I pray that I will not miss the lesson.

As we reach our promised lands of new hope, like Laman and Lemuel we can focus our attention on the heartaches of the journey, or, like Nephi, we can focus on the extravagance of God's love in bringing us so far and supplying all we have truly needed. Whenever I reach something that feels like I have arrived at last, I am reminded that Nephi's story ends much where it began: his enemies seek his life, "and . . . the Lord did warn me, that I, Nephi, should depart from them and flee into the wilderness, and all those who would go with me. . . . And we did take our tents, and whatsoever things were possible for us, and did journey in the wilderness for the space of many days" (2 Nephi 5:5, 7).

I want it to be different. I want my enemies to stay defeated, my doubts to stay resolved, my hungers to stay sated, my choices to stay chosen, my journey's end to stay the end. But I know in my heart that I must learn to trust the process and not merely hold on for the end of the ride. As Nephi takes to the road again his record does not focus on the gold and silver and precious things he left behind, but on the tokens he can take with him of all God has taught him:

> And I, Nephi . . . brought the records which were engraven upon the plates of brass; and also the ball, or compass, which was prepared for my father by the hand of the Lord. . . . And I . . . did take the sword of Laban. . . . I did take my family, and also Zoram . . . and all those who would go with me. . . . And I did teach my people to build buildings, and to work in all manner of wood, and of . . . precious ores. . . . And I, Nephi, did build a temple . . . and the workmanship thereof was exceedingly fine." (2 Nephi 5:12, 14-16)

Having struggled for the brass plates, Nephi can now make the gold plates, leaving his own history and witness for future generations. Having wielded the sword of Laban, Nephi "after the manner of it did make many swords" (verse 14), using them to protect the new life God is giving him. Having accepted the visionary dream of his father, Nephi dreams his own dreams, becoming the prophet and spiritual leader of his people. Having made and kept relational promises, he takes with him family and friends into the next generation of his journey. Having hearkened to the directions of the Liahona, he learns to internalize the voice of the Spirit to direct his life. Having learned the skills of making a bow and building a ship, he is ready to build a temple. Having survived one improbable journey to arrive at the promised land, he takes the hope of that promise with him to journey again. Out of these capacities, Nephi arrives spiritually at the promised land he has already attained physically, an inner peace so profound as to be unassailable by his enemies and unrenouncable by his friends, just as God has always promised Zion would be.

Nephi is not left as one who does not know how. He knows how to make a bow; he knows how to make a ship; he knows how to make a temple; he knows how to make a life, for God has taught him.

I conclude with the testimony of Nephi, which I hope to claim as my own:

> I know in whom I have trusted. My God hath been my support; he hath led me through mine afflictions in the wilderness; and he hath preserved me upon the waters of the great deep. . . . He hath confounded mine enemies . . . he hath heard my cry by day, and he hath given me knowledge by visions in the nighttime. . . . Rejoice, O my heart, and cry unto the Lord, and say: O Lord, I will praise thee forever; yea, my soul will rejoice in thee, my God and the rock of my salvation. (2 Nephi 4:19-20, 22-23, 30)

Spiritual Perspectives and Interventions in Psychotherapy: A Qualitative Study of Experienced AMCAP Therapists

Ronald B. Chamberlain, P. Scott Richards, and Janet S. Scharman

ABSTRACT

As a follow-up to Richards' and Potts' (1995a, 1995b) national survey of the AMCAP membership, 13 experienced LDS therapists were interviewed and asked to describe how they have integrated religious and spiritual perspectives and interventions into their professional identities and practices. The therapists discussed 5 major themes during the interviews, including (1) their quest for professional and spiritual integration, (2) seeking divine guidance in therapy, (3) a holistic treatment tailoring approach, (4) process and ethical considerations of a spiritual approach, and (5) how they implement spiritual interventions during therapy. The therapists were in agreement that a spiritual therapy approach significantly enhances their ability to help their clients cope, heal, and change.

During the past 15 years, a broad-based, ecumenical, interdisciplinary effort has been underway to integrate religious and spiritual perspectives into the theory and practice of psychotherapy (see, for example, Bergin, 1980, 1988, 1991; Kelly, 1995; Richards & Bergin, in press; Shafranske, 1996). AMCAP members have been very much involved in this effort. Much of the content at AMCAP conventions and in the AMCAP Journal has been devoted to an exploration of how

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spiritual beliefs and principles can be integrated into psychotherapy. In addition, some AMCAP members have published in mainstream psychology and psychotherapy journals on this topic (e.g., Bergin, 1980, 1988; 1991; Bergin & Payne, 1991; Koltko, 1990; Payne, Bergin, & Loftus, 1992; Richards & Potts, 1995a; Richards, Owen, & Stein, 1993).

A recent national survey of the AMCAP membership revealed that a majority of therapists within AMCAP have favorable attitudes about using religious and spiritual perspectives and interventions in psychotherapy (Richards & Potts, 1995a, 1995b). This survey also documented that AMCAP members use a wide variety of spiritual interventions in their work, including prayer, teaching spiritual concepts, discussing scriptures, encouraging forgiveness, referral to the religious community, priesthood blessings, and so on. Many AMCAP members also provided enlightening comments about ethical issues and helpful process guidelines for using spiritual interventions.

Although the Richards and Potts survey provided valuable information, it did not give us in-depth insight into how individual psychotherapists go about incorporating spiritual perspectives and interventions into their professional identities and work. Thus, many interesting questions about how to implement a spiritual perspective remain unanswered. For example, in what ways do LDS therapists' spiritual beliefs influence their therapeutic orientation and approach. How do LDS therapists let their clients know that they sometimes use spiritual interventions? How do they resolve ethical concerns associated with the use of such interventions? How do they assess the religious/spiritual dimension of their clients' lives? How do they decide what spiritual interventions to use? How do they go about implementing various spiritual interventions during therapy sessions?

Insight into such questions would be valuable because it could help LDS therapists better understand how to integrate their secular training and spiritual beliefs in a congruent manner. It could also help them better understand how to effectively and ethically use spiritual perspectives and interventions to help their clients cope, heal, and

grow. The general purpose of our study, therefore, was to find out how experienced LDS therapists have incorporated spiritual perspectives and interventions into their professional identities and therapeutic practice. We assumed that gaining an understanding of how a select group of experienced, mature therapists have done this would provide valuable insight for all members of AMCAP.

Methods

The naturalistic inquiry model (Lincoln and Guba, 1985; Erlandson, Harris, Skipper, & Allen, 1993) of qualitative research was used. We conducted in-depth, qualitative interviews with experienced LDS therapists who frequently use spiritual interventions in therapy.

Therapists

P. Scott Richards served as the "gatekeeper" for subject selection. Dr. Richards identified 15 therapists who participated in the Richards and Potts (1995a, 1995b) survey who (a) were experienced psychotherapists and (b) indicated that they frequently use spiritual interventions in therapy. Of the 15 selected therapists, 10 agreed to participate. In addition, Dr. Richards invited four additional experienced LDS therapists who he perceived had made significant efforts to integrate spiritual perspectives into their work. Thus, the initial sample included 14 Mormon therapists. However, only 13 therapists were ultimately interviewed because the redundancy requirements for this type of research were met prior to meeting with the last therapist. The therapists were paid a small fee of $80 for their participation in this study.

All 13 therapists who participated in the study were active members of AMCAP and the majority of them had served in prominent leadership positions within AMCAP at some time in their careers. Of the 13 therapists interviewed, 9 were male and 4 female; 11 of the 13 therapists were working in the state of Utah. The other 2 were practicing in California and Michigan. All of the therapists were Caucasian. The therapists' ages ranged from 41 to 69 years (Mean = 52.85; Standard Deviation = 9.01), and their reported experience

ranged from 6 to 40 years (Mean = 21.6; Standard Deviation = 10.1). The participants reported having 1 of 6 graduate degrees including 8 PhDs, 1 EdD, 1 MSW, 1 MD, 1 MA, and 1 MS. Of the 13 therapists, 8 were licensed as psychologists, 2 as professional counselors, 1 as a social worker, 1 as a psychiatrist, and 1 as a marriage and family therapist.

There were 4 clinical settings in which the participants worked: 7 were in private practice, 3 at university counseling centers, and 1 was at a community mental health center. The other 2 therapists reported that they perform their clinical work in various settings: one works in a hospital setting, at a mental health clinic, and at a university counseling center. The other therapist works for a university counseling center, and has a part-time private practice. The theoretical orientations of the therapists were reported as follows: five eclectic, two cognitive-behavioral, one cognitive/solution-focused, one cognitive-behavioral/interpersonal, one psychodynamic, one systemic, one cognitive/dynamic, and one brief strategic.

Data Collection Procedures

The 13 interviews were conducted during a three-month period. Each interview lasted approximately 60 minutes. Nine were conducted in the therapists' offices, and the remainder were telephone interviews. The therapists were interviewed using a semi-structured interview guide. Ronald B. Chamberlain served as the interviewer. He adapted the interview questions according to the unique responses of each therapist. Each interview was audio taped and later transcribed for data analysis purposes. Data analysis was an on-going process that occurred concurrently with data collection. The data analysis section below describes the procedures that were used for analyzing the interview transcripts. The interviewer met frequently with a peer debriefer who was a third-year doctoral student in the counseling psychology program at Brigham Young University. The peer debriefer read the interview transcripts, reviewed the interviewer's themes or categories, and listened to the interviewer's ideas and concerns. The peer debrief-

ing sessions took place throughout the course of the study and were used to guide data collection and analysis.

Data collection continued until it was apparent that there was redundancy in the information acquired from the interviewed therapists. It became clear, after the eleventh interview, that the amount of new information obtained was minimal. The final two interviews were then conducted to ensure that redundancy had taken place.

These two interviews did confirm to the interviewer that the redundancy requirement had been met. Thus, there were no more interviews scheduled after the thirteenth interview. By this stage, the interviewer had spent much time analyzing the transcripts and a "grounded theory" was beginning to emerge from the data.

After the interviews were completed, and the data had been thoroughly analyzed, the interviewer wrote a brief summary of the themes that emerged from the data. The 13 therapists were then contacted by telephone for follow-up interviews. These "member checks" allowed the interviewer to share the general findings of the study with those who had participated. Furthermore, the interviewees were given an opportunity to react to the information that was shared, correct any errors, and provide additional information. Each of these member checks lasted approximately fifteen minutes. This was the final step in the data collection process.

Data Analysis Procedures

Data analysis was based on the constant comparison method described as follows (Erlandson et al., 1993). First, the verbatim transcripts were unitized. This process involved breaking down each transcript into the smallest pieces of information that could stand alone as meaningful, independent thoughts. The interviewer printed two copies of each transcript. One remained intact, while the other was cut up with scissors into meaningful units. On the back of each unit, a brief description of the content was written in pencil. The units were also given an interview, page, and line number for cross referencing purposes.

The second step was emergent category designation. This step involved taking the units of data from step one, and sorting them into categories or themes. This procedure was carried out in the following manner. The first unit was read and set aside as the first unit in the first category. Then the second unit was read. If the contents had similar meaning as the first unit, then it was placed in the same category. However, if it was different it was set aside as the first unit in the second category. This procedure was followed until all units had been assigned to a category, one of which was a miscellaneous category.

Next, the categories or themes were given a title with a brief description which summarized the contents of each category. The titles and descriptions were written on sheets of paper and used as markers for each category. Then, all the units were collected and the whole process began again. The units were placed next to an appropriate category marker or placed into new categories during the second round of analysis. New categories emerged, old ones collapsed together, and some dissipated. A few units actually fit into two categories. Some categories had plenty of units of supporting data, while others had only a few units in them. This process continued until nothing new emerged from the data. Data analysis took place simultaneously with data collection and was used to help guide the data collection process.

The interviews resulted in approximately 250 pages of interview transcripts. Although there were no predetermined criteria set prior to analyzing the data, all themes were based upon separate units of data from at least three different therapists. The themes which had the most units of supporting data were generally the topics discussed with the greatest degree of enthusiasm.

Results

Five major themes emerged during the data analysis. Representative quotes from the interviewees are used to illustrate the characteristics of each theme.

Theme 1: The Quest for Professional and Spiritual Integration

The therapists described efforts they have made to reconcile and integrate their professional and spiritual beliefs and identities. They described this as a challenging process that involved efforts to (a) integrate secular and sacred world views, (b) grow and develop professionally, emotionally, and spiritually, (c) find a professional niche, and (d) seek validation and support from LDS colleagues.

Integrating Secular and Sacred World Views

As members of the LDS church, the therapists' religious beliefs were an important part of their identity. In addition, they each had a preferred secular theoretical orientation. Thus, they had two sets of lenses from which they viewed the therapy process. However, they sought to combine their theoretical orientation and religious belief system into an integrated guiding framework. One therapist shared the following:

> Some of the instruction that I got at BYU in my doctoral program was very nurturing and supportive of integrating gospel principles and seeking application of gospel principles in clinical work and I found that very valuable. And, my membership in AMCAP has been especially fruitful for ratifying my preferences for religious values and seeking an integration, bilingual integration of scholarly clinical pursuit and spiritual confirmation and pursuit.

Some therapists said that the foundation of this spiritual framework is the gospel of Jesus Christ.

> My professional training has been extremely valuable to me and continues to be very valuable. But the anchor that I use, there has to be a measuring rod to assess relative degrees of truthfulness. To me, that standard must be the gospel, because the other is too shaky. . . . I'm not demeaning professional training, but I just think that the gospel has a much broader perspective and broader view, a better picture of not only things as they are, but as they were and as they will be.

Their spiritual views influence how the therapists conceptualize their clients' problems and guides them in selecting interventions during the therapy process. However, the spiritual aspects of their approach are generally not shared in a direct sense during therapy, unless, it would benefit the client to do so. One therapist said:

> I have a strong spiritual orientation when it comes to virtually all therapy that I do whether it's expressed or unexpressed. . . . All therapy that I do has a spiritual base or foundation within me. But I don't always express that to the client.

Another therapist said:

> Every therapist works out of a framework, all of them do, whether it is articulated or not, every therapist works from a theory. . . . and it's, shall we say, in the background. It is not in the foreground. . . . If the person shows a spiritual or religious bend, or scriptural interest, or something like that, then I may use it very directly. But frankly, I don't with most people that I work with, or have worked with.

In general, the therapists said they find it challenging to integrate their religious beliefs and approach to therapy. However, it is equally challenging to separate the two. They saw themselves as "Mormon therapists," and as such, were constantly seeking to find an approach to therapy that they were comfortable with. Through experience, these therapists found that it is possible to use an integrated approach in an ethical manner. One therapist said:

> Let me just be very clear about this part of it. There's a part of me that wants to be very clean and not confused because it's so important to our business to have ethics and to be professional, okay. On the other side, I have to say that to not be spiritual in relationship to what I do is probably impossible. Because I think it is integral to who I am and I've always believed that it is integral to everybody else. . . . As I've gotten to know more and more it becomes easier and easier to discover that piece of them, without challenging the religious aspects of it, but in some other way. So, the idea that there's

> this spiritual thing that is going to happen, not probably in one session, probably not in three or four, but if you spend almost any time with another person, and they're going through pain, it will happen. It really will. I don't think you can do therapy without it, so you might as well understand it.

Professional and Personal Development and Well-Being

The therapists strongly emphasized the need for professional and personal development and well-being. They discussed the importance of being well trained and having good professional skills. They emphasized the importance of continuing to sharpen their professional skills through continuing education and collaboration with other professionals. One therapist said:

> In the beginning . . . I learned a lot of the discipline of the art of therapy and I think that's really important . . . I learned behavior therapy, cognitive therapy, and hypnotherapy. I learned them as specific techniques. . . . It's like an artist who learns the discipline of drawing and design and color and form, you know, and you learn about each of those disciplines and then at some point you have to integrate those. And the integration occurs, to a degree, subconsciously.

The therapists made it clear that there is no substitute for good training and sound professional practice. To be effective as a therapist, it takes much more than just being a faithful member of the LDS church.

The therapists also expressed their belief that they must be psychologically healthy themselves. They described their own healing and growth as important and expressed the belief that they must model healthy behavior for their clients. Thus, they seek to practice sound psychological principles in their personal lives. When necessary they have sought therapy for themselves. The following views represent what many of the therapists had to say about this topic:

> You can't teach anything you're not. That doesn't mean that therapists have to be perfect but you have to have your own life in order. You have to have

> done enough of your own therapy that you can help somebody else. . . . I have my flaws. I'm constantly working on my marriage, my parenting, my personal growth, but at least I believe in what I'm doing and I don't ask anything of my clients that I'm not willing to do myself.

A third factor that the therapists identified as important was their own spiritual well-being. They reported that the way they live their lives influences how effective they can be with their clients. Living congruently within their personal value system has a great impact on their spirituality. Furthermore, they believe it allows them to receive guidance from the spirit. This guidance is seen as a powerful influence and as something that is contingent upon their worthiness. The following remarks illustrate this point:

> I certainly hope that I am a sufficiently receptive vessel and that I am sensitive to inspiration and guidance. On many occasions I have felt prompted or guided in interventions and in statements and in expressions of love and in sharing insights with people about how they might find better balance and healthier behavior and thoughts in their own lives. So, I certainly think that Mormon therapists who are righteous and actively living gospel principles and are receptive to the prompting of the spirit and enjoying the companionship of the Holy Ghost have a remarkable advantage if they use it. I hope that I do. Sometimes I am more cognizant of that than other times. I'm sure there is room for improvement.

The therapists reported that their spiritual well-being enhances their effectiveness in therapy, enables them to build better relationships with clients, and serves as a protection against inappropriate therapist behavior.

Finding a Professional Niche

Some of the therapists indicated that their spiritual world view and therapeutic approach influenced where they decided to practice. Some chose to work in predominantly LDS communities because they resonate with the values of many of their clients and feel more comfortable using a spiritual approach in therapy. Others chose to work in settings where the majority of their clients are Mormon (e.g.,

Brigham Young University, Ricks College, LDS Social Services). They reported that in these settings, clients often come to therapy expecting the therapist to understand and work within their value system and so it is easier to use a spiritual therapy approach.

Seeking Validation and Support from LDS Colleagues

Many of the therapists expressed a desire to know how other LDS therapists have incorporated spiritual perspectives and interventions into their identities and practices. The therapists seemed to be confident that they are practicing in an ethical and professional manner, but wanted feedback to enhance and validate their use of a spiritual approach.

Some of the therapists also had difficulty seeing how the use of spiritual interventions could be generalized from one therapy situation to another. They saw them as unique interventions that are situationally specific and were concerned about others attempting to use them in a "cookbook-like manner." The therapists seemed to feel that there is a limited amount of information available to guide LDS therapists in their use of spiritual interventions, and they would like more to be said and written about this topic.

Theme 2: Seeking Divine Guidance

The therapists reported that they regularly invite divine guidance to shine on the therapy process. They regularly pray for the welfare of their clients and ask to be used as "instruments" or "tools" in the "hands of God" to help their clients. One therapist reported the following:

> I don't know if you want to include this on or off the record, but you know, I usually try to have a prayer every day before I start my work here. I think that's kind of essential. It puts me in a frame of reference. I think that's good and one of the phrases that I commonly use is a phrase that comes right out of the scriptures and that is asking the Lord if appropriate and if he wants to use me as an instrument in his hands, you know, that instrument in your hands is one that's used often and probably because of my nature and all the

> weaknesses I have and so forth, it's pretty hard for the Lord to use me as an instrument in his hand, but you know I strive toward that.

Often after praying, to be used by God to help clients, these therapists reported that they are guided to do or say something in therapy that is very helpful or effective. Other people may say that it is just a coincidence, but these therapists believe that at times they receive inspiration from a divine source. The following quote illustrates this point:

> Sometimes . . . an idea comes into your mind. "This is the right thing to do." "This is the right thing to say." Or ideas, a number of times, just come into my mind. Some of them I maybe have never thought of before, to be right truthful with you. It's sort of like the prophet Joseph Smith's definition, when you feel pure intelligence flowing into your mind, you know the source of it. And so it ranges anywhere from ideas coming into your mind, to a very warm, comfortable feeling. . . I'll utter a silent prayer for help and direction and can know which way to move so that my prayer is a regular component of trying to help people.

There are three main ways in which guidance assists these therapists. First, the therapists described sessions in which they made a spiritual connection with their client. There was no particular intervention that took place, but rather they felt like they had a relationship which is quite spiritual and both the client and therapist grew as a result. The therapists felt like they connected with their clients at a deeper level, and as a result they had a greater capacity to be empathic. This relationship was also described as a "spiritual communion." Something special took place between the client, therapist, and God. This was described by one therapist in the following way:

> I mean, I really do believe that for many people the connections that they have with the significant spiritual leaders in their community . . . have a particular capacity at times to intuitively understand or intuitively feel or help them with a particular way of thinking so that they kind of sense where the other person is. And occasionally, you know, that kind of thing will happen

> where you say, "You know it's like being on a mountain top," I said to this one kid. "You know where you kind of have this view of things." As it turned out, he said, "How did you know that?" you know. He said, "That's in my patriarchal blessing" . . . and I've had those occasions where it's like you say something in a metaphorical sense and they'll respond with a sense, and I don't know exactly how to explain it except sometimes there's an intuitive sense that you both have about what's going on and it's almost like knowing what they're feeling or thinking about without knowing.

Second, the therapists believe that guidance enhances their ability by helping them to better utilize their skills. God was described as the source of all healing, but by working through people and events rather than through direct intervention. Most of the therapists expressed the belief that God works through people who have the skills and abilities to help others. They reported that their ability to conceptualize cases and choose appropriate therapeutic interventions was enhanced through the guidance they receive. At times, they felt guided to use an unorthodox approach, but more often than not, they felt God helped them to more effectively use the resources and tools they already possessed.

Third, the therapists described numerous experiences in which they did or said something during therapy that was not planned or did not come from them. These interventions were preceded by "promptings" which were also described as "intuition," "revelation," "ideas from out of the blue," "whisperings of the spirit," "hunches," "inspiration," "sixth sense," and "gut feelings." These promptings led to successful interventions and the more the therapists followed these promptings, the more convinced they were that they were guided by God.

Finally, most of the therapists were hesitant to share much on this topic. They were humbled to admit that guidance take place in therapy, and considered their work with clients to be a "sacred trust." Furthermore, they did not want to come across as egotistical or "holier than thou." Some of the therapists stated that they were afraid that others would misunderstand what they were trying to share, or would not

appreciate the sacred nature of these experiences. Overall, the topic of divine guidance was a sensitive one, which was difficult for the therapists to put into words. One therapist said:

> We're dealing with someone's soul in some aspect, regardless, you know, of what the concern is and even though we're not their bishops, you're dealing with somebody's soul that keeps you pretty humble. I mean I think you have to be careful what you say, you have to be careful what you suggest, you have to be sensitive to the individual and in more of a total aspect, than say if you didn't have a spiritual orientation as a therapist, so I think it has a tendency to keep me humble. I don't know how it affects other people, but it sure keeps me humble.

Theme 3: A Holistic Treatment Tailoring Approach

The therapists reported that they view their clients in a holistic way. This holistic approach influences how the therapists conceptualize therapy and select therapeutic interventions for their clients. One therapist described this approach as follows:

> I try to integrate the whole person and therapy is a part of that, but unless you're really thinking about the whole person, you're often likely to miss something so I have to consider the biological aspects and these are particularly the biological aspects of the brain, the developmental aspects of how a person gets where they get to, psychological aspects of how you think about things, dynamics which has to do with the relationship between thinking and feeling and how it develops patterns like defenses and so forth, and cognitive processes, and behavioral processes, and then interrelationship issues, and then family systems, and then even larger systems. . . .

In addition to these aspects, which are also commonly considered by secular therapists, the therapists emphasized that the spiritual dimension of their clients' lives is important. One therapist described the spiritual dimension as follows:

> I think the spiritual part of it comes in the sensitivity to values you know, because I think religion is a way of gaining meaning in life and developing a value structure and its meaning that you take from things that are not nec-

> essarily obvious but have to do with a shared sense of what's important, what is meaningful, what you reverence, what you consider to be valuable and then you base your principles for living on that and to the extent that people all have value systems and determine certain principles to live by, and to the extent that they are devoted to meaningful lives, there's often a spiritual component to how they perceive what it is they're doing. And I'm less concerned about the religious metaphors that a person has such as what particular religion they are in, than I am interested in how they view that meaning and put into their life and the value system that they choose. I clearly think anyone who works in this business has to be very sensitive and understanding of a person's value system.

The spiritual dimension was similarly described by other therapists. Because the spiritual dimension provides the meaning or purpose to life for clients it is viewed as extremely important. Thus, the therapists are attuned to this dimension and look for appropriate opportunities to work within it as part their holistic, integrated approach.

Therapists reported that when they address the spiritual dimension of their clients' lives, they believe that they are working at a deeper level of therapy and can make a greater impact. One counselor said:

> To the extent that you are able to tap into how they see life in the sense of how they give it meaning and how they give themselves meaning and how they value themselves in a relationship to who they are and what they do, you can make an enormous impact on them beyond the standard methodologies that we use in psychiatry.

Another therapist said this at the close of his interview:

> Let me just share one more thing with you. It's part of my reaction as a therapist. If we have been able to appropriately bring spiritual ideas into the therapy session and the client feels good about that and shares and contributes and I've been able to go along with them as we're looking at their problem for not only spiritual but other areas, but you know, after the session I just feel like it has been a more worthwhile session, I guess.

When asked why he believes that, he responded:

> I don't know. I guess I could say one or two things, one is that you're looking at more of the total picture, of why the problems and what you can do to help with the problems and down the road ten or twenty years, how the problems are going to help a person not only individually but from an eternal perspective. How could you say it? . . . a deeper level or a broader perspective, I think that is probably it.

There was also agreement that there is a spiritual principle behind many client difficulties. The therapists reported that the success of therapy is influenced by whether therapists accurately assess and appropriately address these principles. The following statement represents their views on this matter:

> I really have very strong personal feelings that spirituality and therapeutic healing are, at least potentially, very much intertwined and that the more people see those as intertwined the more progress they tend to make . . . when they see those issues interrelated, that there's kind of a quantum leap that people can take forward and can use one with the other in ways that are very, very helpful.

Finally, the therapists reported that with some clients they never address the spiritual dimension because that is not what the client wants. In such cases, the therapists expressed the belief that they could still be helpful by addressing what the client chooses to focus on, but that they could have made a greater impact had the client chosen to work at a deeper level. Nevertheless, the client and therapist must jointly determine whether a spiritual approach would be appropriate.

Theme 4: Process and Ethical Considerations in a Spiritual Approach

Methods of Providing Informed Consent

The therapists reported four general ways in which they introduce clients to their spiritual perspective. First, most of the therapists rarely share their spiritual perspective unless they believe it would benefit

their client. When it is shared, it "unfolds naturally" during the therapy process in an informal, verbal discussion which is typically initiated by the client. This disclosure takes place later in therapy after a relationship of trust has been established and after the therapist has informally assessed the clients needs. Even then, most of the therapists do not believe it is important to disclose their spiritual perspective to clients unless they ask. The following statement reflects the views of many of the therapists:

> When I have someone come in who is LDS or has specified that they are Christian or have specified in some way to me that part of their issues are spiritual issues, that is part of what they want to talk about, then I would talk about that with them. If the client doesn't raise an issue that is of importance to them, then I don't specifically take a spiritual approach with them. . . . Matter of fact, probably most of my clients are not aware of my religious affiliation or background, unless they are LDS, and have been referred through LDS sources . . . even then the Church just doesn't come up if that's not an issue for them.

Second, some of the therapists verbally disclose their approach to therapy in the first session. At this time, they share their spiritual perspective in the context of their overall approach to therapy. These therapists usually explain to their clients that the spiritual domain is an important part of people's lives and that this domain may be explored at some point in therapy. They generally do this up front to set the stage for later work in this area if the client takes them in that direction. One therapist described her approach as follows:

> One of the other things I do . . . is explain what therapy is and what I'm doing, and that . . . it involves the social, the emotional, the mental, the spiritual, one of them is the physical. And I say, you know, when people come to me so often they just want to address one of these, but I say therapy is about all of these, and I give them examples of each one of those . . . right away they know spirituality is going to be part of the approach in one form or another.

In addition, some of the therapists also use the first session to discuss expectations they have of their clients which may include asking them to work closely with their ecclesiastical leaders as well as giving the therapist permission to contact him/her especially if the ecclesiastical leader is the referral and/or funding source for the client. Therapists who use this approach appear to be more formal initially and disclose more information about their general approach to therapy.

Third, some of the therapists shared that their clients come to them already knowing their spiritual perspective, to some degree, because of information shared by the referral source, or the client's exposure to the therapist's professional work through conferences, seminars, tapes, and/or books. This was especially the case for some of the therapists who were in private practice and receive most of their clients from referrals by church leaders. One therapist described how this takes place:

> Most of my clients come from referrals from bishops. And they know something about my work or me as a person so it's sort of like most of that is already established before they even come. But then I still find it sometimes very helpful to find out more before we go further.

When clients explicitly share their knowledge about the religious affiliation of the therapist, the therapists reported that they process what that information means to the client and what impact that might have on the therapeutic relationship. At times, this naturally lead into a brief discussion about the therapist's spiritual perspective.

One other way in which the therapist's spiritual perspective is sometimes discussed is when a value-laden issue comes up during the course of therapy. Most of the therapists expressed that it is important to be explicit about their value system as it relates to the topic being discussed so that they do not implicitly impose their value system on the client. The client can then make an informed decision about whether or not to work with this therapist on this particular

issue. The therapists reported that they are careful to present their value system in a respectful way and are not judgmental of the client. Furthermore, they seek to explore the issue from the client's frame of reference, from that point on, if the client chooses to do so. The following example was shared by one therapist:

> The surest way to influence clients, without their awareness . . . is to not ever say what you really think or believe or where you are coming from. So, periodically, as issues come up and where I have a definite stand on that, and I say, "Okay, I want you to know what my stand is on this issue. And you may not even want to talk to me about this issue. And if you don't, that's fine. And if you do, we'll talk about it." One girl came to me, for example, and said that she wanted to go to Las Vegas and spend a weekend with a guy. And I said to her, "Well, now, you know where we are [BYU] and you have some idea of my values and standards and that is, frankly, very contrary to my values and standards. Now, I would, however, like to help you explore the potential consequences of doing that. And if you'd like to, I'll help you explore them in as objective way as I know how, with you being aware ahead of time that I don't agree with it, okay." So, that's how I do it.

Other Process Issues

There are a number of other important considerations that influence whether it is appropriate for therapists to use spiritual interventions. There was agreement among the therapists that a necessary condition for successful therapy is the establishment of a therapeutic alliance which is based on mutual trust and respect. When asked to share his thoughts about when it is appropriate to use spiritual interventions in therapy, one therapist responded by saying:

> Well, it's always a rapport issue. For me, all therapy is rapport, has to be rapport oriented, in my mind. In other words, if someone's going to trust me with their personal life, I have the responsibility to enter into a rapport with them that will create safety and actually meet many of their most basic needs. I need to be a safe, well-boundaried individual in their lives in order to invite them to come out and to explore. . . . So rapport's critical all the way through and as long as I have good, solid rapport with people, meaning that we have worked our way through the basic fundamentals. . . . I

> enter into the spiritual dimension . . . so it's not the first thing we do. It's usually a little later after the other pieces are coming along that that becomes a part of the flow.

It is during this relationship building phase that most of the therapists also assess the needs of their clients. The majority of the therapists reported that they use an informal assessment style, which they describe as informal and on-going. They listen to the information their clients give them throughout the therapy process, and explore the spiritual domain in more depth if it is determined that that would be therapeutic for the client. Therapists explore this domain by asking general, non-threatening questions such as, "Is religion an important part of your life?" or "Do you have a particular religious affiliation?" or "How active are you in your religion?"

A few of the therapists stated that they will ask these types of questions during the intake interview as part of their general assessment. However, the majority stated that they wait until the client brings it up or until it can be determined, from the information that clients share, that an exploration of this area would be beneficial to the client. The therapists also reported that they gather some general information from the referral source, especially if the referral source is the client's religious leader. Not one of the therapists reported the use of a formal, paper and pencil, assessment strategy to assess the religious/spiritual domain. In fact, some of the therapists said they are opposed to formal testing of any type, and claimed that it drives clients away.

The therapists said that once they have established a therapeutic relationship and adequately assessed their clients' needs, they believe it is appropriate to use spiritual interventions in therapy. However, the use of these types of interventions must not be forced or rigidly applied. One therapist described the following situation:

> Occasionally, I've had individuals whom I had a great deal of respect for refer clients to me. . . . In one instance, a bishop referred to me one of his ward members. And, he said, "What she needs is a spiritual approach.

> That's what she really needs." And there he was a bishop who also happened to be a psychologist, okay. And so I thought, "Well I guess he knows what he is talking about." So the very first session I introduced a spiritual concept. It was a disaster! It was devastating! That was the last time I saw her. Man, she was no more ready for a spiritual approach than the man in the moon. . . . And so, don't rely on what others tell you, even if they're supposedly extremely knowledgeable in both dimensions, psychological and spiritual. Just wait and see, develop a relationship, see how they're responding, etc. And see what they're talking about and what they're feeling and experiencing. Because it is like any other approach, timing is critical. And sometimes people get the misconception that a particular spiritual approach can be used anytime. Not so at all! I don't believe that for a moment. So timing is very, very critical. And it's with a multiplicity of cues, as far as I'm concerned, that that timing is assessed.

The therapists expressed the belief that interventions need to be individualized to match the unique needs of each client. Even in situations where it has been determined that a spiritual intervention may benefit a client, it must be used with sensitivity and appropriate timing.

The therapists reported that spiritual interventions are generally initiated by clients, either directly or indirectly. Some clients openly discuss their religious/spiritual issues in therapy or ask the therapist to intervene on their behalf (i.e., invite therapist to pray with them or give them a priesthood blessing). At other times, it is obvious from what clients are sharing that they are struggling with religious/spiritual issues and the therapist then explores this area with the client. When this is the case, the client may not directly initiate the intervention, but the therapist identifies a possible therapeutic issue and together with the client explores the therapist's hypothesis. One therapist described his approach to using spiritual interventions:

> I always sense their receptiveness. I have some clients who are very spiritual, who regard themselves as very spiritual, whose conversation often leads to spiritual issues and I feel comfortable following their lead and pursuing almost any spiritually related conversation that I sense they would be comfortable with. There are others who don't bring up religion and it doesn't

> come up in the context of their sharing with me and I wouldn't bring up religion with them unless it was pretty obviously accessible through the content of what they are presenting.

The therapists overwhelmingly agreed that it is appropriate to explore any information that their clients give them, religious or not. When the therapists pursue religious/spiritual issues, they claimed to do so from the client's, not the therapist's, frame of reference. They stated that it is also important to continuously process the client's receptiveness to what the therapist is doing. According to the therapists, the process of using religious/spiritual interventions in therapy does not differ significantly from how they use secular interventions. They assess their clients needs, explore their problems, watch for client feedback, and process the interaction that takes place between the client and therapist.

The therapists also said they believe that it is important for them to demonstrate that they are following the lead of their clients' by using the metaphors their clients give them. By speaking a language that their clients are comfortable with, they connect with them at a deeper level because the client feels understood. This was viewed as a powerful way to build rapport with clients. However, according to the therapists, anytime therapists begin preaching, moralizing, judging, or proselytizing they have crossed the line and are engaging in inappropriate behavior. Most of the therapists expressed their concerns about therapists using spiritual interventions in inappropriate ways:

> It would be inappropriate for me to impose that or to pursue my own agenda or to do any of that if it were not either initiated or if it were at all resisted by a client. So, I would never presume to impose a religious kind of theme or tone to a session with somebody who wasn't initiating that.

Another important consideration that was mentioned involves how to appropriately use spiritual interventions with children and adolescents. A few of the therapists stated that therapists who use these interventions with minors should seek parental permission, for other-

wise, "they are walking on shaky ground," and are opening themselves up to legal problems.

Finally, the therapists appeared to use an eclectic and pragmatic approach to therapy. Even though they may have a specific theoretical orientation that guides their work, in-session they "go where the client is." The therapists discussed the importance of matching religious/spiritual interventions in therapy to the client's issues. These interventions were described as a "two-edged sword." When used with the right client, at the right time, by a therapist who is comfortable using such interventions, the outcome is generally quite positive. However, when used rigidly, with any client, by any therapist, or at anytime during the therapy process, spiritual interventions will likely result in negative outcomes. According to the therapists, the best results are likely to take place when the following matching variables have been considered: client comfort level, therapist comfort level, and client issues. Thus, the therapists were not hesitant to use spiritual interventions with clients, but emphasized that timing and sensitivity are crucial considerations.

Handling Ethical Concerns

Four general ethical concerns were expressed by the therapists. First, the therapists stated that they must keep their roles clear and try not to take on the role of their clients' spiritual or religious leader. One therapist stated:

> If I saw John Jones in my therapy office, I would deal with him the way I've been talking about. However, if I saw him in my bishop's office, I would deal with him differently and I think that the two contexts need to remain discreet from one another.

The therapists said they believe that they can keep these roles clear by consulting with the client's religious leader and by encouraging clients to access support from their religious community. This was considered especially important when the referral and/or funding source is the client's religious leader.

Second, the therapists said they believe it is important to avoid fostering dependency in their clients. This is very much tied to the concern of keeping the roles of therapist and religious leader clear. When therapists begin to perform roles that could be performed by the client's religious leader or somebody in their religious community, they cut clients off from a natural support system that could be very beneficial. The following remarks were shared on this matter:

> Well, the goal of therapy is to have people functioning in their own lives, you know, within the community they live in, utilizing the resources they have there and not be dependent upon the therapist except as needed. And preferably that would mean utilizing the immediate familial support system and/or church and/or community self-help systems whenever possible. So that's the direction I'm always headed in is developing a support system that will sustain them outside of my office.

In addition, the therapists said they are hesitant to give their clients priesthood blessings or perform other roles which are part of their religious leader's "calling." One therapist expressed his views on this issue:

> I think that priesthood blessings should be done very rarely, if ever. Because most of the time we should refer them to the bishop or their religious leaders or to the father or head of the house who holds the priesthood and tell them why it's important to go through these people instead of their therapist.

When asked by the interviewer why that was important, he responded as follows:

> Well, because I think it's a way of avoiding fostering dependency on you. I don't like to have them dependent on me at all, as much as possible anyway, and to rightly depend upon those who are rightly set up to do that in the system of the Church.

Overall, fostering dependency was viewed as antithetical to client growth and ethically inappropriate.

Third, the therapists said they are very concerned about imposing their values or belief system on their clients. They explained that, figuratively speaking, clients often put their therapists up on a pedestal and therapists can use this power or position to "seduce" their clients. The therapists handled these concerns by working within the client's value system and by making their own values explicit when appropriate. They expressed the belief that therapists must not preach, moralize, or judge their clients.

In addition, these therapists said they believe it is appropriate to inquire cautiously or tentatively present a hypothesis when they think the client may be struggling with a religious or spiritual issue. When they do so, they seek to be sensitive to clients' feedback and watch for any resistance. Many therapists also stated that anytime they move into the spiritual domain they ask themselves, "Whose needs are being met, the clients or mine?" This concern is also handled by seeking to establish an equal relationship with clients and by processing any concerns with the client and/or a colleague. The following statement provides a good illustration of the therapists' concerns regarding imposing their values on clients:

> Well, I guess probably the biggest concern that I would have would be that the therapist not lead their clients to their own spiritual conclusions, you know, the therapists own spiritual conclusions. When an LDS client comes to me, specifically with, you know, concerns about the church, then I feel they've given me permission and in effect have asked me to help them sort those things out. And so that's different from somebody who comes in who is not LDS or not particularly religious, in which case I don't feel that I have their permission and try to be very careful not to impose, in anyway, my own spiritual beliefs or ideas. . . . If people want to talk about a spiritual issue, I would, but I would approach it from what it meant to them. I would ask them what they believed, what their feelings were, etc.

Finally, the therapists expressed concern about trying to fit clients into a rigid, predetermined, prescribed therapeutic approach. This was viewed by the therapists as unethical, unprofessional, and nontherapeutic. The following statement emphasizes this point:

> A spiritual approach is ethical if it seems natural given the context. If it seems to be evolving or is an evolution of what is transpiring. . . . However, if it's used to meet the counselor's needs or predefined role of how a Mormon counselor functions, or how they work, or something like that, then maybe the word unethical isn't even appropriate. It's not very professional, I don't think. It's not very therapeutic. It's not being spiritual, nor therapeutic, nor professional. Not any of those things, mind you. Okay, it's just fulfilling a predetermined, prescribed role, which is sort of forced on the client. And so, yes, I think it would be unethical and unprofessional.

The therapists handled this concern by following the lead of their clients and by appropriately matching their therapeutic interventions to their clients' issues. Thus, spiritual interventions are not used at all with some clients, but are used extensively with others. The therapeutic approach varies from client to client, and from session to session with the same client. Ultimately, the client determines the course of therapy.

Theme 5: Implementing Spiritual Interventions

The therapists identified a number of spiritual interventions that they use in their professional work. The interventions most commonly identified by the therapists and how they have been implemented are discussed below.

Therapist Prayer

The spiritual intervention that appears to be used most frequently is therapist prayer. The therapists said they pray daily for their clients' welfare and for divine guidance to assist them in working with their clients. They also pray silently during therapy when they believe additional guidance would be helpful to them as a therapist or when a client is hurting and in need of comfort. The following example illustrates how these therapists use prayer as a spiritual intervention:

> I pray for my clients. I like to think that it has a dramatic effect and I pray for an ability to convey to them a love and respect and caring that they often

> respond to. . . . I pray in my personal prayers morning and night and at other times and I often mention my clients by name. Occasionally, if I'm working on a particularly difficult case which for me would be hostile, antagonistic, or somebody who is kind of impacted in their dysfunction and is agonizing over it I'll occasionally pray specifically about them before a session. That is fairly rare. More often than not, I'll engage in a silent prayer during a session or a fragment of a prayer.

Many of the therapists also reported that they put the names of their clients on the temple prayer rolls. They generally do not put every client's name on the prayer roll, but those they are most concerned about. The therapists said they believe strongly in the power of prayer and use it regularly. Most of the therapists said they do not inform their clients that they pray for them, unless they believe it would be helpful to the client.

Discussion of client's values or belief system

One way in which the therapists addressed the spiritual domain of their clients' was by exploring their clients' values. When doing so, the therapists said they often discover that there is incongruity between their clients' values and behaviors which causes emotional conflict. When appropriate, the therapists said they point out the incongruency, but allow clients to decide what they want to do about it. Once clients make a decision, therapists assist them in making the necessary changes. The following remarks illustrate how therapists use such an approach with their clients:

> I'm constantly referring back and forth to those things that they profess to believe within their value system and those things that they do. So one of my goals would be to have their behavior reflect their values, and if in fact they declare values that their behavior does not reflect, then I would do some pushing, I guess that might be the way to say it, for them to look at the importance of congruency and to decide if they want to modify their values to fit their current behavior or they might want to modify their behaviors to fit their values.

Encouraging clients to turn to a higher power

Another common intervention that the therapists mentioned is encouraging clients to turn to a higher power for assistance when they are struggling with difficult problems. One therapist said he refers his clients to a formal, 12-step program because it is not uni-religious and is widely accepted in the therapy community. Other therapists said they explore their clients' beliefs in a higher power, and if appropriate, encourage them to seek assistance from this source. This is generally done when a client is stuck in therapy or is struggling to overcome some type of compulsive or addictive behavior. This intervention is also used with clients who could benefit from the nurturance and comfort that a higher power can offer. One therapist described her belief that her effectiveness is limited when working with eating-disordered clients if she does not address the spiritual component of this disorder.

Encouraging clients to access support from their religious resources

Encouraging clients to seek support from their spiritual resources is another common intervention reported by the therapists. Bishops are the referral and funding source for some Mormon clients. When this is the case, the therapists said they often feel a need to keep the bishop updated regarding the client's progress in therapy. One therapist described how he approaches this issue with his clients:

> And as I said, many of my clients are coming to me on referral from their bishop and so one of the business issues early on in the first session is to at some point explore with them their desire or willingness to include the bishop in the conversation. In which case, I get a written release of information from them granting that. I have a number of clients at any given time whose bishops are helping to pay for their services . . . and in those cases I press for that with the client, and normally they are very cooperative with that.

In addition, the therapists generally encourage their clients to work closely with their spiritual leaders and to turn to them for spiritual guidance and blessings. Finally, the therapists said they encourage

their clients to turn to their religious community for support when this is deemed appropriate. This is done to connect them to a natural support system, which is viewed as therapeutic because it enlarges the client's support system and lessens the likelihood that the client will become overly dependent on the therapist. The following remarks illustrates this point:

> I used to occasionally give blessings to clients, I do that less now but I encourage them to seek blessings more often than I used to from bishops and home teachers and fathers and family members. . . . I have become more enlightened about the appropriateness of encouraging them to use their support system and to not rely on me.

Relaxation and imagery exercises

A number of the therapists reported that they use traditional relaxation exercises in which the client is deeply relaxed by the therapist who uses calming statements in conjunction with music or the sounds of nature. Once the clients are deeply relaxed, they are then talked through a guided imagery exercise. The content of these exercises varies, but generally include things like getting clients in touch with nature, seeing themselves overcoming problems, receiving nurturance from loved ones, and seeing themselves achieving personal goals. Although these types of interventions are used by many secular therapists, some of the therapists considered them to be spiritual interventions because they help clients to become "centered" and "in harmony with nature."

Other visualizations reported by the therapists had content that was more explicitly religious or spiritual. For example, some of the therapists reported that they may encourage a client to go to a "sacred spot" or to the presence of a "great being" for advice. The clients are given a general framework during such visualizations, but decide themselves where the "sacred spot" is or who or what the "great being" is. This type of intervention was described by one therapist as a spiritual intervention that works with many clients regardless of their religious belief system.

RELIGIOUS DISCUSSION

The therapists described a number of interventions that were categorized under the heading of "religious discussion." These discussions are typically initiated by the client. However, the therapists said they might also initiate their use when they believe that a client is struggling therapeutically because of religious issues. According to the therapists, clients often struggle emotionally because of distorted or unhealthy belief systems. For instance, they may misunderstand what it means to be striving for perfection and become depressed and discouraged when they do not live up to the unrealistic expectations they have for themselves. One therapist described how he commonly addresses the topic of guilt with Mormon clients:

> My experience has been that clients tend to use the spiritual dimension in kind of a destructive way, particularly in the religious domain, to hurt themselves with rather than to bless themselves . . . and focus on guilt rather than on godly sorrow and not distinguish between the two. I think it's important in therapy that we teach the difference between godly sorrow which is feeling bad for dumb things we do, but in a gentle and kind way, in a way that nurtures and heals as opposed to in a way that punishes. .One is a source of light and energy like a star and the other is an emotional black hole that takes all the energy.

Other common topics that the therapists said they often discuss in therapy that may have a religious component include: anger, assertiveness, discouragement, responsibility, identity, agency, marriage, and sexuality. There are certainly many other possible topics that may have a religious component and the therapists said they watch for cues or ask direct questions to determine if taking a religious approach would be indicated. Most of the therapists agreed that it is important to use the religious metaphors that a client gives them, or to speak a language that clients' can relate to and are comfortable with.

Sometimes religious issues themselves become "grist for the mill" in therapy. One therapist shared that many of his clients are eager to discuss struggles that they are having because they trying to be a faith-

ful member of the church and are getting opposition from family members and friends:

> I guess I consider it an important intervention to reaffirm to people that their value system is healthy and that they can have faith and that they can accept hardships and trials and tribulations as a part of the refiners fire and growth in their life experience. And it doesn't mean that they are dysfunctional, and it doesn't mean they are crazy and it doesn't mean that they are wrong because they have a spouse who says they're a religious fanatic. . . . I tell them that I feel good, I mean if they're saying they feel good about something and what do I think, I'm always very affirming of them and tell them that I share with them a strong faith that God does bless people for being righteous and honoring their value system and that they have reason to believe that even if they don't get rewarded in this life that there are eternal rewards and blessings.

Some of the therapists reported that clients have discussed the power of Satan with them and how he is attempting to discourage them to the point that they want to give up on life, or how they see God as someone who abandoned them when they were being sexually abused. These types of religious discussions take place at times in therapy because they are real issues for clients and deserve careful consideration by the therapist. Some of the therapists said they do not really consider these discussions to be an intervention. One therapist stated, "Some of the things I do just seem so, you know, they don't really seem like techniques. . . . We're just talking about spiritual things."

Use of scripture and religious bibliotherapy

During these types of discussions about religious issues, the therapists at times referred their clients to scriptures or religious bibliotherapy resources (i.e., written material authored by religious leaders or spiritually oriented therapists). These resources are most often used when clients make reference to the scriptures or to what religious leaders have said. Again, the therapists try to speak a language their clients are comfortable with. They said they would not use these resources on

just any client who came through their door. According to the therapists, scriptures and religious bibliotherapy materials are generally used to verify or validate an important point the therapist was trying to make, to reframe a client's distorted or inaccurate interpretation, to promote universality and instill hope in clients by showing them how others have struggled and overcome similar issues to what they are experiencing, or to serve as a catalyst for clients to explore certain topics that will lead them to important insights about their own therapeutic issues. The following statement was shared by one therapist:

> I just think there is therapeutic value in using the scriptures if clients value the Lord and inspiration and the scriptures and knowledge from that source. . . . It's just tying together some of the concepts we would normally talk about as a therapist with another source that they see as very valid, you know, and you tie those together and I think you've got more of a therapeutic edge to help the individual.

Most of the therapists said they do not read directly from the religious literature in therapy, but instead paraphrase the source they are referring to. They pay particular attention to how the client responds to their statement and back off if there is any resistance. However, client resistance is rare because they have previously assessed whether this type of intervention is something the client would be comfortable with. Some of the therapists said they also assign or suggest that their clients read an appropriate scripture, article, or book that would match what they are working on in therapy between sessions. Again, this approach would not be rigidly applied to all clients.

Religious self-disclosure

Religious self-disclosure by the therapist is another intervention that was mentioned frequently. The therapists said they use this intervention less frequently than the other interventions used above, but consider it to be quite powerful when used appropriately. They said that timing is critical when deciding to disclose personal information to the client, and that the therapist must only share this information

when he or she believes it will help the client. The therapists also emphasized that it is important to share a little information, and then check the client's response. If the client responds favorably, it may then be appropriate for the therapist to share more with the client or go into greater depth. However, if the client does not respond favorably or appears to not be benefiting the therapist should back off. Too much therapist disclosure, or disclosing information in order to meet the therapist's needs, is considered to be inappropriate.

The type of information that the therapists said they disclose depends upon what issues the client is working on or what questions the client asks the therapist. Some examples of information the therapists said they have disclosed include: therapists sharing what they do, in a spiritual sense, when they are feeling overwhelmed or in need of comfort; and describing their own struggles with religious issues to give the client a sense that they are not alone in their struggles. Some of the therapists also said they believe that it is important to genuinely answer questions that clients ask about their religion or their beliefs regarding certain issues. The therapists said they believe this models honesty and enhances the therapeutic relationship. It also lets clients know, explicitly, about the therapist's values when value laden issues are discussed in therapy. Thus, according to the therapists, therapist disclosure can be a powerful intervention, when used appropriately.

In-session prayer

Therapist in-session prayer with clients received mixed reviews from the therapists. Some of the therapists said that they would not pray with clients because they believe it is a "conflict of interest" or that it "contaminates" the therapy. These therapists said they are concerned about sending a message that they are in some way the client's spiritual leader or advisor. They want to keep their role as therapist clear for the client. However, some of the therapists reported that they believe it is appropriate to pray with their clients and would not hesitate to do so if their clients ask them to. They let the client bring it up and decide who should pray. These therapists said that they would not

deny clients the use of such an intervention, especially if clients believe strongly in the power of prayer. None of the therapists regularly initiates prayer with their clients, but some have done so on rare occasions with clients who they knew would feel comfortable with their suggestion and who they thought would benefit from praying in-session. The following statement reflects the views of most of the therapists who were interviewed:

> As a therapist in the mission field . . . I always prayed with the people that I saw . . . but rarely in my work at BYU did I even suggest that. Now sometimes a client would ask, "Would it be okay if we prayed together? I'd feel more comfortable if we had a prayer," they would say. Okay, let's have it. But unless I got a pretty strong feeling that with this particular client that was a good thing to propose, I did not do this at BYU, and have rarely done it in the private practice. But I have done it sometimes.

In-session prayer can be used with clients from various religious orientations, but the therapists stated that in most cases where this intervention did take place it was with LDS clients.

Priesthood blessings

Another intervention the therapists perceived as controversial is therapists giving their clients priesthood blessings. Without exception, the therapists agreed that this type of intervention should not be a regular part of therapy. According to the therapists, clients seldom ask their therapists for blessings. When clients do, the therapists reported that they discuss the topic with them and generally encourage them to seek the blessing from their bishop, home teacher, family member, or other priesthood holder in their religious community. This discussion is usually sufficient and the therapist does not give the blessing.

Spiritually Inspired Interventions

The therapists also described a number of interventions which we have labeled as spiritually inspired interventions. These are interven-

tions that are not typically used in therapy, and do not necessarily fit into any of the above categories. However, the therapists shared them during their interviews because they have used them with great success. The use of these interventions seems to follow a similar pattern. The therapist is in a session with a client and feels impressed to try something out of the ordinary. They refer to this impression as guidance from the spirit or intuition. They have learned through experience to trust these feelings. Thus, they follow through with the intervention they are prompted to use. Without exception, the therapists stated that when they followed the prompting the intervention was a success. It is exactly what the client needed at that particular time. The following example illustrates such an intervention:

> I have a certain intake format that I use for clients. But I was impressed to ask this woman something about somebody, a grandfather. I said, "Was there anything with your grandpa?" Well, that's not in my history, I don't ask that kind of thing. I ask generally if there was any abuse of any kind, but this was a 65- or 68-year-old [woman], who just broke down and cried about how her grandfather had sexually abused her and she'd never told anyone her entire life . . . I mean, ordinarily, I would never have pursued that. Instead, I would have taken just the general history.

The therapists also offered a caution that these types of interventions cannot be forced. They just naturally occur during the course of therapy with some clients. They further state that they are not everyday occurrences, but instead are rare experiences that they have as therapists. Finally, the therapists were somewhat hesitant to share these types of experiences because they consider them to be sacred and are concerned that other therapists might try to use them where they do not fit.

Some examples of spiritually inspired interventions include reviewing and exploring a client's patriarchal blessing, religious oriented visualization experiences, beginning a marital therapy session with prayer to dispel the spirit of contention, playing a religious song

during a therapy session with a client, asking clients unusual questions during the initial interview (e.g., tell me about your grandfather), and encouraging a client to be of service to others and to seek forgiveness from God. In conclusion, it is not "what" the therapists did during these unorthodox interventions that is important because that cannot be generalized. Instead it is the process of "how" they went about doing it that seems to be important. When therapists learn to trust their spiritual impressions, the "content" of these types of interventions will be given during the natural flow of therapy.

Summary Conceptualization of the Themes

Our conceptualizations of the themes described above are summarized in Figures 1 and 2. Figure 1 shows the relationships between Theme 1, its corresponding sub-themes, and Theme 2. The integrated world view of the therapists influences how they approach therapy. The therapists said that three factors are important in determining how successful they can be as therapists; namely, professional development, psychological health, and spiritual well-being. Furthermore, they report that by having their "spiritual lives in order" they can receive divine guidance to assist them in their work as therapists. This guidance helps them to establish better therapeutic relationships with their clients and to more effectively utilize their skills to meet their clients' therapeutic issues.

Figure 2 summarizes how the therapists' integrated worldview is actually implemented during therapy and shows the relationships between Themes 3, 4, and 5.

There are four general ways in which these therapists inform their clients that they approach therapy from a spiritual perspective. The therapists seek to be sensitive to the unique needs of each of their clients. They view their clients in a holistic way which includes assessing their physical, mental, emotional, social, and developmental needs. In addition, they view their clients' spirituality as a crucial element and watch for appropriate opportunities to work in an integrated way with this dimension of their clients' lives. When they do so in

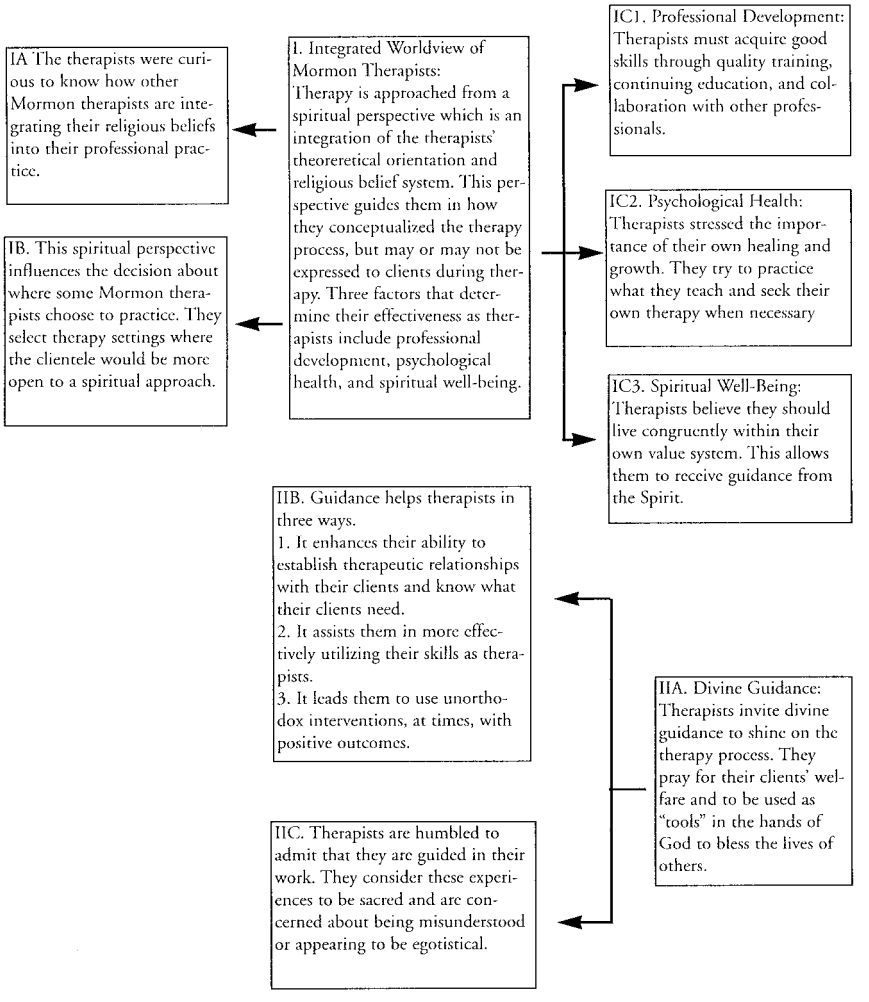


Figure 1

Integrated Worldview of Mormon Therapists and the Role of Divine Guidance in Therapy

III. Client Considerations: These Mormon therapists view their clients in a holistic way. They see their clients' spirituality as an important dimension of their clients' lives. They report that there is a spiritual principle behind many of their clients' problems and watch for appropriate opportunities to work at this level. When they work at the spiritual level they report that deep and lasting changes are more likely to occur. Thus, by appropriately addressing their clients' spiritual issues, they report better therapeutic outcomes.

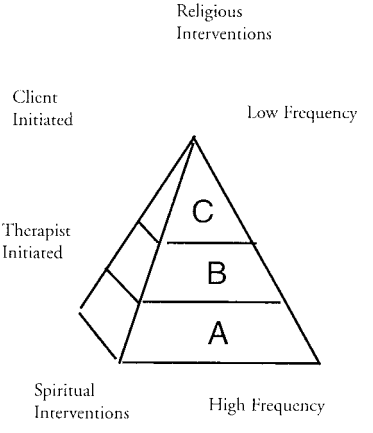
V. How Therapists Implement their Spiritual Approach

VA. Four ways in which therapists inform their clients that they approach therapy from a spiritual perspective:
1. Undeclaring initially.
2. General disclosure upfront in which therapists describe their holistic approach.
3. Referral source discloses therapists' perspective.
4. Therapists make values explicit when clients discuss value-laden issues.

IV. Therapeutic Considerations

IVA. Appropriate Use of Spiritual Interventions:
Therapists first seek to establish a therapeutic alliance. Effective therapy is based on having a good relationship with their clients. While establishing the relationship, therapists assess their clients' needs.
Assessment is informal and on-going. Therapists listen to their clients and ask general nonthreatening questions.
Spiritual interventions must be a natural part of therapy. They should not be forced or rigidly applied.
Sensitivity and timing are crucial factors.
Clients generally initiate the use of spiritual interventions.
When therapists initiate their use, they do so in a respectful manner and are responsive to the feedback their clients give them.
Therapists seek to speak a language their clients are comfortable with or use their clients' metaphors.
Spiritual interventions must be used to meet the clients' needs and be explored from their perspective.
Therapists match their interventions to their clients' issues. They appear to be eclectic and pragmatic in their approach with clients.
Parental permission may need to be sought before using such an approach with children and adolescents.

IVB. Ethical concerns:
1. Therapists must keep their roles clear.
2. Therapists must avoid fostering dependency in their clients.
3. Therapists must take precautions against imposing their values on their clients.
4. Therapists believe it is inappropriate to rigidly use spiritual interventions with their clients.



VB. The Intervention Pyramid A: therapist prayer, discussion of clients' values or belief system, encouragement for clients to access support from their spiritual resources, and relaxation and imagery exercises. B: discussion about religious topics, use of scripture and bibliotherapy, and religious self-disclosure by the therapist. C: in-session prayer with clients and priesthood blessings.

Figure 2

How Mormon therapists conceptualize their clients' issues, determine the appropriateness of a spiritual approach, and implement spiritual interventions.

an effective manner they report that it often leads to better therapeutic outcome. There are a number of therapeutic considerations and ethical concerns that must be considered before therapists use religious/spiritual interventions in therapy, as outlined in Figure 2. Once the therapists have considered the unique needs of each client and have determined that the use of religious/spiritual interventions is appropriate, they implement such interventions during therapy.

The therapists made it clear that some interventions are used quite frequently, while others are used sparingly. In addition, they felt comfortable initiating the use of some interventions, but felt that others needed to be client initiated. Finally, some interventions can be used with most clients regardless of their belief system; these were considered spiritual interventions by the therapists. Others are more appropriately used with religious clients and were described as religious interventions. These three dimensions ([1] frequency of use, [2] client versus therapist initiated, and [3] religious versus spiritual) have been combined in Figure 2 to form the Intervention Pyramid. The interventions in the lower section of the pyramid are described as spiritual interventions, are used frequently, and are generally therapist initiated. Moving up the pyramid, the interventions are more religious in nature, are used with less frequency, and are client initiated.

Limitations of the Study

Because we interviewed only 13 LDS therapists, and selected them non-randomly, the results of this study cannot be safely generalized to all LDS therapists or even to all AMCAP members. Of course, it was not our desire to generalize in this manner. We wished only to gain as much insight as we could into the views of a select group of experienced therapists who have made significant efforts to integrate spiritual perspectives and interventions into their work. Our qualitative procedures were ideally suited for this purpose. But readers should not assume that the views expressed by the therapists we interviewed necessarily represent those of other AMCAP therapists, even experienced ones. In particular, we purposely chose not to interview therapists who

are opposed to using spiritual interventions in therapy. A valuable project for the future would be to interview such therapists to help us gain more in-depth insight into their concerns and objections to spiritual interventions and to determine how they reconcile or integrate their religious beliefs with their professional practices.

Perhaps the most significant limitation of the study is that the results are based entirely on qualitative interviews. These interviews provided rich insight into the therapists' perceptions, but do not necessarily provide an "objective"or completely accurate view of how these therapists actually utilize spiritual perspectives and interventions in their work. Because of the inherent inaccuracies associated with self-reports, there may be some discrepancy between what the therapists believe they do and what they actually do. Also, all that the therapists shared was filtered through the "lenses" of the interviewer. Although the interviewer did his best to faithfully and truthfully represent the views and perceptions of the therapists, it is possible that he did not completely succeed in this effort.

Discussion

Despite its limitations, this study provides in-depth insight into how a select group of experienced LDS psychotherapists have incorporated spiritual perspectives and interventions into their professional identities and practices. As researchers and practitioners, we personally learned a great deal from the information the therapists so graciously shared, and we agree with most of their views.

It was interesting to learn how the therapists have integrated the secular and sacred into their professional identities. We were fascinated to learn that they view their spiritual beliefs as the foundation or core of their therapeutic approach and that secular theories and approaches seem to be built around this spiritual core. We suspect that many LDS therapists view the spiritual as foundational and consider secular theories and approaches as very useful, but as less foundational or central to their therapeutic orientation.

We are in strong agreement with the therapists that it takes much

more to be effective as a therapist than just being a faithful member of the church. Sound professional training, good psychological health, and continuing education and professional development are all essential. But as pointed out by the therapists, with this foundation, it does make a difference to be a faithful member of the Church. Seeking to live congruently with our religious values and in harmony with the spirit can enhance our effectiveness beyond our secular training and professional skills.

We found it interesting that despite their rather intense involvement in AMCAP, the therapists we interviewed still felt the need for more information and dialogue with other LDS therapists about how to integrate spiritual perspectives and interventions into therapy. We do not know if this is a widespread need in AMCAP, but we suspect it is. Hopefully, this need can continue to be addressed at AMCAP conventions and in the AMCAP Journal. This article and others like it should help us better understand how our colleagues have gone about integrating the sacred and secular in their professional work. There is also a relatively large body of mainstream professional literature now available on these issues including a major Psychological Bulletin review on religious counseling by Everett Worthington and his colleagues (Worthington, Kurusu, McCullough, & Sandage, 1996), and recent books on religious and spiritual issues in counseling and psychotherapy by Kelly (1995), Shafranske (1996), and Richards and Bergin (in press).

We were pleased that the therapists were willing to share their feelings about the role of divine guidance in therapy. It is rare for therapists, even religious ones, to talk about such matters, but from time to time such expressions and experiences of faith need to be shared. Most therapists, even atheistic ones, would acknowledge that at times they experience intuitive hunches or insights during therapy and that such hunches are often "right on target" Such experiences need not be interpreted spiritually and we are not saying that all clinical hunches come from the divine source. Nevertheless, we believe, as do the therapists we interviewed, that some do. For those who believe in the real-

ity of inspiration and revelation, it would seem wise for us to consistently and humbly seek for such guidance as we work with our clients. Making time before, during, or after therapy sessions for moments of prayer, meditation, and contemplation could help us be more receptive to such guidance. Encouraging clients to seek guidance and inspiration regarding their problems and issues may also often be appropriate.

We are in agreement with the holistic treatment tailoring approach described by the therapists. We agree with Richards and Bergin (in press) that human beings are multisystemic; that is, "biological, emotional, social/systemic, cognitive, behavioral, and spiritual processes all impact human functioning" (p. 153). Therapists need to consider the impact of each of these systems on their clients' functioning. Therapy goals should be pragmatically tailored in an attempt to address the unique problems and needs of each client. We agree with the therapists that the spiritual dimension is often a crucial, core component of treatment, although spiritual interventions are not indicated with all clients (Richards & Bergin, in press).

We thought that the process and ethical guidelines provided by the therapists were helpful and, for the most part, consistent with the views of others who have written about such issues (e.g., Kelly, 1995; Richards & Bergin, in press; Richards & Potts, 1995a, 1995b; Tan, 1994). Perhaps the only areas where our views differed from those expressed by the interviewed therapists concerned how therapists should (a) provide informed consent and (b) conduct religious and spiritual assessments. In contrast to the interviewed therapists who said they rarely explicitly share with clients in the first session that they approach therapy from a spiritual perspective, in our view, therapists should briefly share that they view the spiritual dimension as important during the first session. We think that this should be briefly mentioned in therapists' written informed consent documents and/or that therapists should briefly mention this verbally in their initial session.

In our view, clients have a right to know what their therapist's theoretical orientations is, and if the therapist's orientation is significant-

ly influenced by a spiritual perspective, this should be shared with clients. This, of course, needs to be done briefly and sensitively. When doing so, therapists need to make it clear to clients that they will not impose their spiritual views on clients or coerce them into participating in spiritual interventions. When therapists share their belief that spiritual issues are important and that they are willing to explore them with clients, this can help clients to feel safe enough to discuss their religious and spiritual concerns.

We agree with the interviewed therapists that the primary method for assessing the religious and spiritual system of their clients lives is the clinical interview. During clinical interviews, therapists can ask questions about their clients religious and spiritual beliefs and orientation in an informal, flexible manner. Much that is clinically relevant about clients' spirituality can be learned in this way. Another reason therapists currently must rely primarily on clinical interviews as they assess clients' spirituality is because there are very few formal or objective religious and spiritual assessment measures available. Nevertheless, we disagree with the view expressed by some of the therapists that formal spiritual intake questionnaires or objective religious assessment measures have no place in the assessment process.

In our view, questions about clients' spirituality can and should be asked on written intake questionnaires. Written intake questionnaires are a standard part of the intake and assessment process in many settings, and should include questions about clients' religious and spiritual background and beliefs (Richards & Bergin, in press). In addition, there are a small number of objective religious and spiritual measures that could be used in therapy for assessment purposes; for example, the revised intrinsic/extrinsic (I/E) scale (Gorsuch & McPherson, 1989), spiritual well-being scale (Ellison, 1983), and the religious status inventory (Malony, 1988).

We appreciated the valuable information the therapists provided about specific religious and spiritual interventions, such as prayer, value discussions, turning to a higher power, and so on. Very little has been written about how to use such interventions in therapy, and so

the insights the therapists shared about how they have gone about implementing them were very enlightening and valuable. We agree with the therapists that in-session prayer and priesthood blessings by therapists are very controversial (see also Richards & Potts, 1995a, 1995b). Our own position is that LDS therapists should not pray in-session with clients or give clients priesthood blessings. Such practices may confuse professional and religious role boundaries, raise difficult transference and counter-transference issues, and foster dependency on the therapist by taking away opportunities for the client to seek spiritual support and help from their religious leaders and community (Richards & Bergin, in press).

Of course, in saying this, we are aware of the saying, "Never say never." And so, we stop short of saying that therapists should never pray with clients or give clients priesthood blessings. In some settings, such as LDS Social Services, therapists take on a pastoral counseling type of role. Because of their close affiliation with the church, LDS Social Service therapists may feel it is appropriate and clients may expect to begin sessions with prayer. Even in this setting, however, it would seem that therapists would be wise to carefully define the differences between their role and that of their clients' bishops and other church leaders. There may be other settings and circumstances in which LDS therapists feel that it is appropriate to pray with their clients, but if they do so they should frequently consult with professional colleagues in an effort to ensure that they remain alert to the potential dangers of this practice.

We are even more firmly opposed to therapists giving their clients priesthood blessings because the dangers mentioned above seem even more likely to arise if therapists give blessings. In our view, in almost all cases, priesthood blessings would be more appropriately given by the client's priesthood leaders or close family members or friends. Perhaps there may be rare occasions where the Spirit dictates that a blessing by the therapist would be appropriate. We hope that if such occasions arise, therapists will consult with professional colleagues and, if possible, the client's religious leader to minimize the possibili-

ty of role confusion and potential harm to the client. We refer readers to Richards and Bergin (in press) and Richards and Potts (1995a, 1995b) for further discussions of the risks of in-session prayer and priesthood blessings.

Conclusions

This study has provided much insight into the process of integrating spiritual perspectives and interventions into therapeutic practice. Nevertheless, there is still much that we do not know in this domain. For example, we still know very little about how spiritual interventions and influences promote therapeutic change and healing. We also do not yet know whether, or how much, spiritual interventions enhance the efficacy of therapy beyond what can be achieved through secular therapeutic approaches. Many fascinating theoretical and research questions remain to be explored in this domain (see Worthington et al., 1996, and Richards & Bergin, in press, for proposed agendas for research and theory in this domain for the next decade). It is our hope that many members of AMCAP will contribute to this exploration by sharing their ideas, insights, research, and writings about these important issues in the years ahead.

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The Relationship of Mormonism and Mental Health: A Review of the Literature (1923-1995)

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The relationship of religion and mental health has long been an issue in the social sciences. The sometimes controversial nature of the discussion is true for the relationship of religion and mental health in general and the mental health of the membership of The Church of Jesus Christ of Latter-days Saints (Mormons) in particular. Many have argued for the positive influence of religion while others have argued the opposite. William James (1929) wrote the following:

> We and God have business with each other; and in opening ourselves to His influence our deepest destiny is fulfilled. The universe, and those parts of it which our personal being constitutes, takes a turn genuinely for the worse or the better in proportion as each one of us fulfills or evades God's commands. (pp. 516-517)

Albert Ellis (1980) has represented those who have argued for the negative influence of religiosity on mental health:

> Religiosity is in many respects equivalent to irrational thinking and emotional disturbance. . . . The elegant therapeutic solution to emotional problems is to be quite unreligious . . . the less religious they are, the more emotionally healthy they will be. (p. 637)

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[1]This paper is based on a presentation originally delivered at the Mormon Studies Symposium held at the University of Nottingham, England, Spring 1995. Adaptations of this paper appear in Judd (1996) and Duke (in press).

The apparent conflict between the assertions represented by the statements of James and Ellis has served to invite many researchers to examine these statements in the light of scientific evidence.[1]

Previous Reviews of Religiosity and Mental Health Literature

Lea (1982), Bergin (1983), and I (Judd, 1986) have published literature reviews concerning the relationship of religiosity and mental health through 1977, 1979 and 1985 respectively. Levin and Vanderpool (1987), Gartner, Larson and Allen (1991), as well as Larson, et al. (1992) have also published noncomprehensive reviews.[2]

I am presently completing a major research project which will update the religiosity and mental health literature through March of 1996. This is a brief report of my preliminary findings of all research concerning the relationship of religiosity and mental health as well as a specific focus on various descriptions of the mental health of the membership of The Church of Jesus Christ of Latter-day Saints.

In a previous literature review of religiosity and mental health research (Judd, 1986), I reported the outcomes of a total of a 167 studies (182 outcomes). This initial study was a review of the research conducted in the 62 year period between January of 1923 and March of 1985. This study represented data gathered from over 200,000 subjects. Thirty percent of the studies reviewed indicated a negative relationship (religion facilitating mental problems), 32 percent a positive relationship (religion conducive to positive mental health), 33 percent a neutral relationship, and five percent a curvilinear relationship.[3]

For the most part, these data are ambiguous as to the support or refutation of either a positive or negative relationship of religion and mental health. However, in the process of completing this initial study, I noted a positive trend in the research beginning in the late seventies and continuing through the eighties. Out of 23 studies conducted between 1980-85, 61 percent (14 studies) reported a positive relationship between religiosity and mental health, 26 percent (6 studies) a neutral relationship, nine percent (2 studies) a curvilinear relationship and four percent (1 study) a negative relationship.

A Decade Review (1985-1995)

My initial literature review of the research published between March of 1985 and March of 1995 generated 373 specific studies which focused on the relationship between religiosity and mental health.

My data gathering methods consisted of the following:

1. A computer search of PsychLIT[4] for the period between March, 1985 and January, 1995 for publications having to do with differing aspects of religion and mental health/pathology. A computer printout of all abstracts meeting the established criteria was generated. The abstracts were analyzed to identify the specific measures of religiosity and mental health, the statistical relationship of these variables, the author(s), year of study, and description of sample. If any ambiguity was found in the abstracted description of the study, the complete article was photocopied and studied in greater depth to determine the desired information.

2. The "ancestry" method which involved examining the reference citations of recent articles for related studies was also employed. This method served as a check for articles which may not have been included in the computer search. This method generated studies which were included in various symposia and reference works as well.

3. The noncomprehensive reviews reported by Levin and Vanderpool (1987); Gartner, Larson and Allen (1991); and Larson et al. (1992) were examined to identify the specific measures of religiosity and mental health utilized, and the sizes and descriptions of the samples.

4. For the study/article to be accepted in the review, it required specific measures of religiosity and mental health. While mental health was defined in terms of scores on differing measures of health/illness, religiosity was defined in terms of religious affiliation, activity, belief, and/or attitude.

Preliminary Results of Decade Review

A preliminary examination of the 373 studies (529 outcomes) published between 1985 and 1995 revealed that 59 percent (311 out-

published between 1985 and 1995 revealed that 59 percent (311 outcomes) of the outcomes showed a positive relationship between religiosity and mental health, 13 percent (67 outcomes) a negative relationship, and 26 percent (138 outcomes) a neutral relationship.

The Positive Relationship of Religiosity and Mental Health

The positive trend noted in my earlier study (Judd, 1986) is validated in the analysis of the present data. There continues to be little support for the assertion that religiosity is antithetical to mental health. Of the outcomes reviewed in this present investigation (1985-95), 85 percent either indicated a positive (59%) or neutral (26%) relationship between religiosity and mental health, thus contradicting the negative assertions made by Ellis and others. Not only is there little support for the assertion of a negative relationship between religiosity and mental health, but the research evidence is supportive of a positive relationship. These statistics appear to be much less ambiguous than the "mixed and even contradictory findings" reported by Gartner, Larson, and Allen (1991, p. 6). The conclusions based on the analysis of the data in the present study are consistent with the study by Larson et al. (1992), which reported a "positive relationship between religious commitment and mental health" (p. 557) in the "great majority" of the 139 studies reviewed in the *American Journal of Psychiatry* and the *Archives of General Psychiatry* between the years of 1978-1989.

Philosophical Assumptions and Research Outcome

While the specific reason(s) for this positive trend is/are yet to be investigated, it has been proposed by some that the central issue could be the fact that little attention has been given to the underlying theoretical assumptions on which the research is grounded. My colleague at Brigham Young University, Allen Bergin (1983), has written the following concerning the relationship of the investigator's philosophical assumption's and their research:

> The issues are not simply empirical; they pertain also to the frame of

reference of human sciences and scientists, as illustrated in the following:

1. Values and ideology influence theoretical axioms. Conceptions of personality and psychopathology have subjective as well as empirical bases, as do rationales for intervention and goals of outcome. . .

2. In addition to this conceptual bias, mental health literature and education are limited by their minimal appreciation for the religious subcultures of our society.

3. The foregoing conceptual and attitudinal biases have become a part of empirical inquiry, so religious factors either are excluded from measurement and manipulation or are included in such a way as to prejudice the results (pp. 171-172).

An example of how theoretical assumptions can influence research outcome can be found in the construction of one of the most widely utilized tools in clinical psychology, the MMPI (Minnesota Multiphasic Personality Inventory). One of the research scales of the MMPI is known as the Ego Strength Scale, which is described by Jane Duckworth (1979) as "one of the best indicators of psychological health on the MMPI" (p. 203). Barron (1953), used the following questions as a part of his scale:

1. Everything is turning out just like the prophets in the Bible said it would.
2. I have had some very unusual religious experiences.
3. Christ performed miracles such as changing water into wine.
4. I pray several times every week. (p. 323)

If respondents answer in the affirmative to any or all of the above questions, it scores against their ego strength score. Some clients who are of a particular religious orientation would appear less functional than those who do not have such beliefs. Obviously, Barron (1953) presupposes that these forms of religious belief and practice have a negative influence on an individual's ego strength.

Other scales on the MMPI that have been identified by the author as having an anti-religious bias are the Dependency, Dominance, Prejudice, Social Status, and Control scales.

From this example it becomes quite clear that one must analyze the assumptions on which the research is based before drawing definitive conclusions.

Specific Outcomes (1985 - 1995)

This most recent analysis of data (1985-1995) indicate that high scores on measures of religiosity (activity, attitude, affiliation, and belief) are facilitative of marital and family stability, adjustment, and personal well-being. This most recent analysis also indicates that those who score high on measures of religiosity (activity, attitude, and belief) show the highest positive correlation with measures of mental health. Also, those who score higher on scales of "intrinsic" religiosity score better on measures of mental health than those of an "extrinsic" religious orientation.[5] There also appears to be little difference in measures of mental pathology with respect to religious affiliation.

The 13 percent of the total studies which indicated negative relationships between religiosity and mental health, were observed in a random pattern across the various mental health variables. The only possible significant pattern of a negative relationship between religiosity and mental health was observed in the area of prejudice. A possible explanation for this result could be the fact that many religions have voiced strong opposition to such issues as alcohol/drug abuse, pre-marital sexual relations, homosexuality and some gender issues.

The Mental Health of the Mormons

Of the 540 studies published between the years 1923 and 1995, I was able to locate 55 studies that dealt specifically with Mormon samples. Of these 55 studies (73 outcomes), 67 percent of the outcomes indicated a positive relationship between religiosity and mental health variables, five percent negative, and twenty percent neutral.

While there were many anecdotal reports and essays, only the following 55 studies were found to be consistent with the pre-established criteria. For the sake of brevity I have included only the name of the first author. The full reference citation for each of these studies can be

found in the reference section of this paper.

A listing of each of the studies included in my review and analysis appears in Table 1.

Analysis of Qualifying Studies

This review of research concerning Mormonism and mental health represents the responses from over 96,000 Latter-day Saints from a period of years from 1960-1995. Religious variables were classified specifically (or in combination) as religious affiliation, activity, attitude, or belief. Mental health variables were defined in terms ranging from anxiety, depression, and schizophrenia to marital satisfaction, self-esteem, and irrational beliefs. General themes that were observed from an analysis of the data are as follows:

Mormonism and Prejudice

Of the 55 studies focusing on Mormonism and mental health, 3 indicated a negative relationship. Two of the three studies reporting negative results were in the areas of dogmatism and social distance. Emery (1992) found that "Mormons were significantly more dogmatic and more traditional in their attitudes toward women than were Protestants" (p. 1).

Gender Issues

An analysis of this study reveals that two of the specific reasons for Mormons scoring higher on the dogmatism scale than protestants has to do with Latter-day Saint beliefs concerning women working outside the home and birth control. Leaders of the LDS Church have counseled Mormon couples not to unduly restrict the size of their families and for mothers not to work outside the home except in extenuating circumstances (see Benson, 1987, pp. 1-13). While some claim that the Mormon lifestyle limits women's freedom and happiness, research evidence suggests otherwise.

Johnson, Duke, Eberley, and Sartain (1988) examined the impact of women's employment on the marital happiness of 313 Mormon

Table 1. Religiosity and Mental Health of Mormons, 1960-1994

Study	Year	Sample	Measures	Relation
Lee	1960	50 BYU students	religious attitude/belief & self-concept	0
Fairbanks	1961	234 psych. students at BYU	religious affiliation & dogmatism/anxiety	0
Winward	1962	40 active & 20 inactive LDS	religious activity & marital adjustment	+
Richardson	1966	20 LDS & 20 Protestant divorcees	religious affliation/activity & divorce adjustment	0
Brooks	1968	150 Mormons in American Fork, UT (78 active/72 inactive)	religious activity & work attitudes (satisfaction)	+
Sellars	1971	30 LDS returned missionaries	religious activity & mental health	+
Johnson	1973	616 high school & college students (LDS/non-LDS)	religious affiliation & prejudice (ethnic)	0
Jones	1973	40 LDS college students	religious activity (temple marriage/non-temple marriage) & marital adjustment	+
Millett	1973	110 LDS psych. students	religious attitude/belief/activity & guilt	+
Barfield	1976	255 college students (67.8% LDS)	religious attitude/belief & life meaning (for LDS)	+
Huish	1976	89 married couples (63% LDS)	religious activity & marital adjustment	+
Brimhall	1977	414 BYU students	religious activity/attitude & marital satisfaction	+
Kunz	1977	2,222 LDS couples	religious affiliation & marital satisfaction	+
Wilkinson	1980	223 LDS adolescents	religious activity & familial affection	+
Duke	1981a	1,384 LDS adults	religious belief & well-being	+/-
Duke	1981b	1,384 Mormons in 12,076 NORC sample	religious affiliation & global happiness	+
Small	1982	108 adults (LDS/ Baptists /Other/Protestants	religious affliation & CPI	0
McDonald	1983	psychiatric evaluation of non-mainline/mainline Protestants/Catholics/LDS/Christian/ Science/Seventh-day Adventists/Jehovah Witness	religious affliation & anxiety/depression/ personality disorders/ repression/ psychoticism	+ + + +
Williams	1983	1,228 Utahns	religious activity/attitude & marital satisfaction	+
Reynolds	1984	1,384 LDS adults (national samples)	religious activity/attitude (spiritual well-being) & marital adjustment	+
Spendlove	1984	179 women (143 LDS/ 36 non-LDS)	religious affiliation & depression	0
Heaton	1985	7,446 LDS/NORC general social survey with Catholics/ Protestant/no religious pref.	religious affliation & divorce	+ M<P<C NA
Judd	1985	6,270 adults (2,751 LDS)	religious affiliation & MMPI	0
Laner	1985	400 LDS & non-LDS college students	religious affiliation & aggressive behavior /abusive behavior	+ 0
Amoateng	1986	16,130 high school students (national survey)	religious affiliation/attitude/activity & drug abuse (alcohol & marijuana)	+
Brinkerhoff	1986	938 university students from western U.S. & Canada) (236 from BYU	religious affiliation (LDS/Protestants/non-religious/Catholics/conservative Christians etc. & social distance	-,+ P<NR,LDS <CC<CA
Linsky	1986	all 50 states based on % of LDS or fund. pop	religious belief/affiliation & alcohol use	+
Mackie	1986	938 American & Canadian Students (LDS/Protestants/ Catholics	religious activity/affiliation & life satisfaction/self-esteem	+ M>P>C
Rose	1986	464 LDS undergrads/3,930 "healthy" adults from earlier studies by Hathaway (1957) and Colligan (1983)	religious affiliation & MMPI	0

Study	Year	Sample	Measure	Relation
Bergin	1987	119 college students	religious attitude (intrinsic\extrinsic)	
			& anxiety/self-control/	+
			personality (CPI)/	+
			depression/irrational beliefs	0, 0
Miller	1987	2,423 h.s. students in	religious affiliation/activity	+
		3 western states in 1983-84	& sexual permissiveness	
Bergin	1988	60 undergraduatess	religious attitude/activity & MMPI/CPI	+
Browning	1988	484 married LDS	religious affiliation & marital satisfaction	+
Glenn	1988	61 LDS couples in Utah	religious affiliation & marital satisfaction	+
Johnson	1988	313 LDS couples	religious belief/affiliation & marital	
			satisfaction (men & women)	+
Kranich	1988	124 cases in rural Utah (LDS)	religious affiliation & stress	+
				LDS<No n-LDS
Lund	1988	190 bereaved persons 50+	religious affiliation/belief/attitude/	
		(73% LDS)	activity & bereavement adjustment	0
Miller	1988	2,423 adolescents	religious activity/ affiliation &	
			sexual attitude/behavior	+
Cornwall	1989	1,874 Mormons	religious belief/affiliation &	
			socialization/community	
			relationships	+
Kunz	1989	beginning students at BYU	religious affiliation (LDS)	
		from 1975-1989	/social distance	+
Richards	1989	49 LDS psychotherapy	religious attitude/	
		clients & 51 LDS nonclients	affiliation & well-being	+
Beck	1991	data from 1979 and 1983	religious belief/affiliation	
		interviews of the national	& premarital sex	+
		longitudinal surveys of youth		
Ellison	1991	general social survey 1988	religious activity/affiliation/belief	
			& well-being	+
Masters	1991	60 Mormons (follow-up	religious activity/attitude	
		study to Bergin 1988)	intrinsic/extrinsic)	+
			& MMPI/CPI	-
Zhang	1991	452 Mormons	religious affiliation/belief/activity	
			& depression/suicide	+
Emery	1992	88 Mormons & 103	religious belief affiliation/	
		Protestants	activity & dogmatism/	-
			sex-role attitudes/self-esteem	0
Hawks	1992	3,591 adults (mostly LDS)	religious affiliation & drug	0
			(marijuana) and alcohol use	+
Bahr	1993	322 adolescents aged	religious attitude & substance	
		11-18 and their parents	abuse	0
		or guardians		
Chadwick	1993	1398 LDS adolescents	religious affiliation & delinquency	+
Jensen	1993	3,835 university students	religious activity/affiliation & depression/	+
			emotional maturity/self-esteem	+, +
Richards	1993	15 religiously devout	religious attitude/ belief &	+, +
		university students	depression/perfectionism/self-esteem/well-being	+, +
Bahr	1994	62,600 h.s. seniors	religious attitude/ affiliation/activity & drug use	+
		1984-1987 Monitoring		
		the Future survey		
Hawks	1994	293 adolescents (42% LDS)	religious attitude & substance	
		with parents (50 LDS)	abuse	0
Markstrom	1994	36 Mormon & 47 Catholic/	religious affiliation/	+, 0
Adams		Protestant adolescents	activity & ego identity	M>C=P
			achievement	

couples. Their study indicated that while Mormon men were happiest when their wives were working full-time, the response from Mormon Women was different:

> [For wives] there was a significant difference in global marital happiness with traditional homemakers being the most happy, followed by full-time employed wives. Wives working part time were the least happy. When wives identified themselves as strong Church members and the age of their children was added as a variable, results showed traditional homemakers with preschool children had higher global marital happiness, consensus, and sexual satisfaction. (p. 259)

Racial Issues

Kunz and Yaw Oheneba-Sakyi (1989) also used the "Borgardus Social Distance Scale" to show Mormons "social distance" scores decreased dramatically after a revelation was announced in 1979 extending black members the Priesthood on equal basis with whites. Their study also indicated that the decrease in social distance scores was maintained over a ten-year period. These studies support the assertion that "prejudice" among Mormons is more a matter of theology than intolerance.

Affiliation and Prejudice

Brinkerhoff (1986), in a comparative study, found Protestant subjects scored the lowest on the Bogardus Social Distance Scale. Mormons and those reporting "no affiliation" showed the next lowest social distance scores followed by conservative Christians and then by members of the Catholic faith.

Mormonism and the MMPI

In a previous paper (Judd, 1986), I combined and graphically illustrated mean scores from all MMPI research dealing with specific religious denominations. Included in the data set were scores for 2,560 Mormons. Because the MMPI is normalized separately for males and females, respective summaries are reported in Tables 2 and 3.

Table 2
Mean MMPI Scores for Respective Religious Afflications
(male, corrected for K)

	Scale	LDS N=1280	Catholic N=469	Prot. N=994	Jewish N=283	No Aff. N=105	Hare Kr. N=29
1.	Hs	12.5	12.6	12.5	12.6	12.9	12.2
2.	D	17.4	18.9	19.1	20.9	20.6	18.3
3.	Hy	19.7	19.9	19.7	20.7	21.0	21.2
4.	Pd	22.9	22.8	21.9	22.8	23.1	24.5
5.	Mf	25.0	24.9	25.6	27.9	28.6	28.2
6.	Pa	10.5	10.0	10.0	9.8	10.2	9.1
7.	Pt	26.6	27.8	27.4	27.4	27.4	24.5
8.	Sc	25.7	27.7	27.3	27.5	28.7	25.1
9.	Ma	19.8	20.5	20.5	21.0	20.8	21.4
0.	Si	26.5	27.4	27.8	25.5	28.7	21.0
	F	4.7	5.2	5.0	5.6	6.7	3.5
	L	3.9	3.2	3.2	3.1	3.8	6.8
	K	15.2	14.2	13.9	14.3	14.7	19.6

Table 3
Mean MMPI Scores for Respective Religious Afflications (female)

	Scale	LDS N=1280	Catholic N=469	Prot. N=994	Jewish N=283	No Aff. N=105	Hare Kr. N=29
1.	Hs	13.8	13.5	13.3	13.4	13.6	16.1
2.	D	19.6	20.5	20.2	22.6	23.1	20.5
3.	Hy	22.3	21.3	21.9	22.1	22.7	21.8
4.	Pd	22.4	21.5	21.2	21.7	22.6	23.1
5.	Mf	37.7	36.5	37.3	38.4	39.0	36.5
6.	Pa	10.8	9.9	10.0	9.7	10.9	17.0
7.	Pt	29.6	28.8	28.7	29.0	29.1	25.0
8.	Sc	27	27.1	27.0	27.2	30.0	24.5
9.	Ma	19.2	20.3	20.2	20.5	20.7	18.5
0.	Si	24.9	27.7	26.3	26.8	29.1	24.5
	F	4.3	4.0	3.9	4.7	6.3	4.2
	L	4.3	3.4	3.4	3.6	3.7	7.2
	K	15.8	14.5	14.8	14.1	13.9	19.7

While most MMPI data relative to Mormon samples has been found to be either positive or neutral (Judd, 1986 and Rose, 1986), Masters (1991) reported partially negative results. Out of the 13 MMPI scales Masters investigated in a three-year follow-up survey of 60 Mormon respondents, 4 showed negative change (Lie, K, Depression and Hysteria); 7 scales indicated positive change (F, Hypochondriasis, Masculine/Feminine, Psych-asthenia, Schizophrenia, Hypomania, and Social Introversion); and 2 scales showed no change in a three-year follow-up survey. While negative change scores were noted, they were still well within the "normal" range.

Mormonism and Depression

In 1858 a writer from Harper's Weekly traveled to the state of Utah and made the following observation that the Latter-day lifestyle turned Mormon women into "haggard, weary, slatternly women, with lackluster eyes and wan, shapeless faces, hanging listlessly over their gates, or sitting idly in the sunlight, perhaps nursing their yelling babies—all such women looking alike depressed, degraded, miserable, hopeless, soulless" (G. L. Bunker and D. Binton, as cited in Judd, 1987, p.150). In 1860, Dr. Robert Bartholomew, the assistant surgeon of the United States Army visited Utah and described Mormon men as having "an expression of compounded sensuality, cunning suspicion, and a smirking self-conceit" (G. L. Bunker and D. Binton, as cited in Judd, 1987, p. 150).

While many anecdotal descriptions (such as the ones above), essays (see Burgoyne and Burgoyne, 1977) and media specials have discussed the detrimental effects of the Mormon lifestyle on mental health (especially the mental health of Mormon women), few have any grounding in research evidence. None of the studies included in this analysis that included depression as one of its variables, indicated support for an unhealthy relationship of Mormonism and depression.[6]

Spendlove, West and Stanish (1984) looked specifically at Mormon women and depression. In a comparison of Mormon and

Table 4
Measures of Association for Select Variables and Depression in LDS Women

Variable	Risk Group	% Depressed	Ratio
Employment	Yes	34.3	1.6
	No	20.4	1.2
Church Att.	Infrequent	41.7	2.3
	Frequent	17.8	
Temple Att.	Infrequent	19.0	1.2
	Frequent	29.7	
Prayer	Infrequent	37.5	1.8
	Frequent	20.5	
Mixed Marriage	Yes	45.5	2.1
	No	21.5	
Motivation	Extrinsic	34.9	1.8
	Intrinsic	19.0	
Children	2 or less	28.2	1.1
	3 or more	19.4	
Age	>25	34.4	1.1
	<25	20.7	
Life Events	>200	29.0	1.0
	<200	22.3	

non-Mormon women living in Salt Lake City, Utah, they concluded that "no difference in the prevalence of depression was noted" (p. 491). Table 4 graphically illustrates some comparisons within the LDS sample.

In a comparison of 3,835 Catholic, Protestant, and Mormon university students, Jensen, Jensen, and Wiederhold (1993) reported that "Women in the LDS denomination reported less depression that women in the other denominations, but scores for LDS men were similar to those of Catholics and Protestants" (p. 1158).

Mormonism and Family Life

Of the 55 studies reviewed in this analysis, 15 looked at factors related to the Mormon family. Of these 15, 10 studies reported positive scores on scales of Marital Satisfaction while five indicated neutral results. Wilkinson (1980) reported Mormon samples to have positive scores on scales of Family Affection.

Heaton and Goodman (1985) reported that when compared to those of no religious preference "Catholics, Protestants, and Mormons

are more likely to marry, less likely to divorce, more likely to marry following divorce, and they have larger families" (p. 343). A comparison between the religious groups revealed that "Mormons tend to have the highest rate of marriage and fertility, but the lowest rates of divorce" (p. 343).

Mormons who marry in a "temple" ceremony are less likely to divorce that those married outside the temple in a "civil" ceremony (Thomas, 1983). Heaton (1988) reports that among men and women who were married in the temple, 6 percent of the men and 7 percent of the women had been divorced. Among men and women not married in the temple, the data indicated that 28 percent of the men and 33 percent of the women have been divorced. Table 9 illustrates the comparison between Mormons married in the temple and Mormons who marry out of the temple who later divorce.

Pre-marital Sex

Miller and Olson (1987 & 1988) found the prevalence of premarital sexual intercourse to be less with Mormon than in non-Mormon teenagers. Beck, Cole, and Hammond (1991) found young adult Mormons, along with young adult Pentecostals and Jehovah Witnesses, to have the "lowest likelihoods of premarital sex" when compared with mainline Protestant youth.

Delinquency

Chadwick and Top (1993) found that Mormon religiosity is a significant deterrent to delinquency. Interestingly, this statistic held true for Latter-day Saint youth even when they were not in a "highly religious climate" (p. 51). In this study, religiosity was measured in terms of belief, attitude, and activity while delinquency was measured in terms of "acts against others," "victimless delinquency behavior" (e.g., premarital sex), and "delinquency against property" (p.57).

Mormonism and Substance Abuse

Of the 54 studies in this review, 7 dealt with religiosity and sub-

stance abuse. Of the 7 studies, 4 concluded that Mormon belief, attitude or activity contributed to lower rates of substance abuse than non-Mormons. The remaining 3 of the 7 studies indicated no significant relationship between Mormonism and substance abuse. Hawks and Bahr (1992) concluded that "for all religions except Jews, a lower percentage of Utahns [Utah Mormons] used alcohol than their national counterparts" (p. 1).

While Mormons differed from the religious counterparts in the use of alcohol, they did not differ in the quantity of alcohol consumed if they did drink.

Mormonism and Well-being

In the studies dealing with Mormonism and mental health, 9 of the 54 studies focused on various dimensions of well-being (6 positive outcomes/3 neutral). Ellison (1991) reports that "individuals with strong religious faith report higher levels of life satisfaction, greater personal happiness, and fewer negative psychosocial consequences of traumatic life events" (p. 80). Denominational comparisons suggest Protestants, Jehovah Witnesses and Mormons report greater "life satisfaction than do their non-affiliated counterparts" (Ellison, 1991, p. 80). Ellison (1991) also reports that religious faith appears to buffer the negative effects of trauma on well-being.

Duke and Johnson (1981) compared Mormon and national samples and concluded: "Mormon respondents, on the whole, have a higher level of overall happiness than the American populace" (p. 16). Within the Mormon sample, Duke and Johnson (1981) noted that "the greater the religiosity the greater the happiness" (p. 23). The measures of religiosity that best demonstrated their conclusions were the "beatitudes factor" (a measure of virtues like patience, kindness, etc.) and a "knowledge of the scriptures" variable.

Conclusions

This study provides a brief summary of research concerning the relationship of religion and mental health from 1923-1995.

Specifically, this study has focused on the mental health of the members of The Church of Jesus Christ of Latter-day Saints as reported in studies reported from 1960-1995. General analysis of these studies regarding the relationship of mental health with religion in general and Mormonism in particular supports the following conclusions:

1. There is little support for the assertion that religiosity is antithetical to mental health.

2. The data indicated that individuals who live their lives consistent with their religious beliefs experience greater general well-being, marital and family stability, and less delinquency, depression, anxiety, and substance abuse.

3. There are few differences in measures of mental pathology with respect to religious affiliation.

4. There exists a change in the number of positive and negative studies over time. Earlier studies show a greater incidence of negative studies while more recent studies report more positive relationships.

While a positive trend is noted, there continue to exist some studies where negative results are reported. While some of these negative outcomes can indeed be a result of research bias, the outcomes may also reflect the impact of unhealthy forms of religious devotion. More research needs to be done to define, measure, and analyze the phenomenon of healthy and unhealthy forms of religious devotion in the Mormon community and how it bears on the negative outcomes of recent research on religiosity and mental health.

Notes

1. Stevan Nielsen (1996) has written that Albert Ellis is becoming more open to religious perspectives.

2. Earlier reviews include Sauna (1969), Stark (1971), and Gorsuch (1974).

3. All outcome symbols have been adjusted. The sign (+) represents a relationship where religiosity is facilitative of mental health. A (-) sign represents an unhealthy relationship.

4. PsychLIT is a computer data base that indexes articles from over 1500 psychology journals.

5. Allport and Ross (1967) suggest extrinsically religious people use religion as a means of obtaining status, while intrinsics live their beliefs regardless of external circumstance.

6. While Masters (1991), in a three-year follow-up study of young adult Mormons, reported a 3-point increase on the depression scale of the MMPI, nonetheless the score (50) is considered well within normal limits.

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Women's Religiosity, Employment, and Mental Illness

H. Dean Garrett and
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The large number of women who have entered the labor force has stimulated considerable research about the relationship between full-time employment outside the home and women's emotional, or mental, health. An even larger body of research has accumulated concerning the relationship between religiosity and mental health, especially for women. Surprisingly, the interactive effect of employment and religiosity on mental health has rarely been examined. To help fill this void, this study explored the relationship of employment and religiosity with mental health as indicated by depression, self-esteem, and feelings of general well-being among a sample of women who are members of The Church of Jesus Christ of Latter-day Saints (LDS). This is an informative population to study the relationship between these three factors since LDS doctrine stresses traditional family life and encourages mothers to remain at home as housewives.

Employment and Mental Health

In a pioneer study, Berry (1929) interviewed 728 working mothers in Philadelphia. Although family and employment responsibilities were hard, she heard few complaints concerning their mental health. She concluded that they seemed to be "standing the strain fairly well."

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A substantial number of women entered the labor force during World War I and continued to work following its conclusion. Most of the studies of maternal employment that followed during the next thirty years focused on the effects on children rather than on the mothers. In the early 1960s, Nye (1963) interviewed 2,300 mothers residing in small towns in Washington State. He reported that employed women were slightly more satisfied with their work than housewives were with their housekeeping and childcare. Ferree (1976) interviewed 135 working-class married women with at least one child in the first or second grade. Employed women saw themselves as more competent, independent, and self-directed, and having higher self-esteem than did housewives. Ferree stressed that these women were employed out of economic necessity, not in the pursuit of self-fulfillment or a career.

In a similar study, Burke and Weir (1976) collected questionnaire data from 189 professional men and their spouses. Of the couples, 52 were dual earners. While the employed women had better mental health than the housewives, the husbands of these employed women were in poorer physical health and less happy than the men married to housewives.

Booth (1977) replicated Burke and Weir with data from 856 men and women. Employed women were no more mentally healthy than housewives, and husbands of housewives no more healthy than husbands with employed wives. Detailed analysis showed that women who had recently entered the labor force as well as women who had recently stopped working had higher rates of stress. Booth concluded that role transition was the source of stress, not the roles themselves.

Wright (1978) replicated Ferree's study with data from six national surveys. The analysis was restricted to white married women. Fourteen measures of well-being, happiness, and satisfaction were compared. Although on six of the scales the employed women scored higher and on the other eight the housewives were higher, none of the differences were statistically significant.

Kessiler and McRae (1982) surveyed a national sample of 1,086

married white couples and found employed wives to have lower scores on measures of anxiety and depression. They also found that employed women had higher self-esteem than housewives. Cleary and Mechanic (1983) analyzed interviews with a sample of 1,026 women living in the Midwest. Employed married women reported slightly less stress than housewives. However, the small advantage disappeared if the employed women had a minor child.

In an interesting study, Keith and Schafer (1983) interviewed 135 dual-earner husbands and wives. They found that work orientation, feelings of being a provider, and financial stress were associated with lower levels of depression. On the other hand, the hours the married women worked was directly related to depression. The more hours she worked per week, the higher her depression. The two effects cancelled each other out so that the overall relationship between employment and mental health was minimal. Gray (1983) found that 77 percent of the 300 professional women she surveyed experienced strain between work and family demands. But they also reported that this stress did not significantly decrease their sense of well-being.

Ross, Mirowsky, and Huber (1983) interviewed a national sample of 680 couples and found that employment status was not related to the wives' level of depression. However, when the wives' employment status was their preference, both spouses were less depressed. In Shehan's (1984) study of 100 married mothers of preschool children where half of the women were employed, employed women did not differ in their level of depression from housewives.

In their interviews of 197 women, Kandel, Davis, and Raveis (1985) discovered from that employed women had lower levels of depressive symptoms. Similarly Barnett and Marshall (1989) found, from interviews with 403 women employed at least part time, that having a rewarding job appeared to buffer negative mental health effects of family stress such as difficult children.

An excellent summary of the literature linking employment and mental health of women is presented by Marshall et al. (1992) who reported that a majority of the studies reviewed have not found a rela-

tionship between employment and the mental health among married women. The few differences reported revealed that employed women have slightly better mental health than do housewives. An important intervening variable to emerge from two of these studies is the wife's desire to work and the husband's support for her so doing. Thus, if employment status is consistent with preference and support, mental health is enhanced.

Religiosity and Mental Health

Early social scientists such as Freud were convinced that mentally ill persons act out their pathology in strange religious actions or else turn to religion for comfort. The bizarre behavior of mystics, religious fanatics, and strange cults was used as evidence that religion was closely related to mental illness. Following this tradition, some researchers, clinicians, and therapists have concluded that religion is an experience of mental illness and irrationality (Ellis, 1980).

> Religiosity is in many respects equivalent to irrational thinking and emotional disturbance. . . . The elegant therapeutic solution to emotional problems is to be quite unreligious. . . . The less religious [people] are, the more emotionally healthy they will be. (p. 637)

Stark (1971) reviewed the early research supporting this hypothesis and found that most studies had serious methodological flaws. He tested the relationship between mental health and religion by comparing 100 patients in the San Mateo County Outpatient Mental Health Clinic with 100 randomly selected individuals living in the clinic's service area. Three different measures of mental illness were assessed and all revealed the patients were less religious than the general population. He concluded "that conventional religiousness is not a product of psychopathology. Indeed, psychopathology seems to impede the manifestation of conventional religious beliefs and activities" (p.175).

Shaver et al. (1980) analyzed data obtained from the readers of

Redbook magazine. The data were collected in the fall of 1976 by inserting the questionnaire in the September issue. Over 65,000 women responded, and Shaver and his associates drew a random sample of 2,500. They found that the relationship between religion and mental illness symptoms was curvilinear. Those women who were either strongly religious or strongly irreligious were more mentally healthy and happy than those in between. The authors concluded that certainty of belief, either religious or irreligious, was related to stronger mental health. These interesting results were explained using cognitive dissonance theory, which holds that consistency and confidence of belief, regardless of its specific nature, is associated with "health and happiness and with the absence of tension and conflict" (p. 1566).

Bergin (1983) conducted meta-analysis of 24 relevant studies with conflicting findings to ascertain any overall relationships. Thirty effects were tabulated in the 24 studies and only seven (23 percent) manifested a negative relationship between religion and mental health. Fourteen (47 percent) produced a positive relationship, while nine (30 percent) showed no relationship. Bergin concluded that the meta-analysis found "no support for the preconception that religiousness is necessarily correlated with psychopathology" (p. 170). He suggested that part of the inconsistency in the relationship between religion and mental health is the complexity of religiosity. He suggested that future research separate the major dimensions of religiosity.

Part of a large replication of the classic Middletown community study was an examination of attitudes and behaviors of high school students (Bahr and Martin, 1983). Two measures of religiosity (denominational affiliation and church attendance) and the Rosenberg Self-Esteem Scale were collected from 1673 high school students. Bahr and Martin found that religiosity and self-esteem were not related.

A study of particular interest focused on depression among LDS women (Spendlove et al., 1984). A random sample of approximately

180 white, married women with at least one child under the age of 15 years were interviewed by telephone. Depression was measured using the Beck Depression Inventory. The LDS and non-LDS women had almost identical rates of depression, 23.8 versus 22.2 percent, respectively. In addition, several measures of religiosity were not related to depression in LDS women.

MMPI profiles of members of five different religious affiliations, including LDS, were compared by Judd (1986). Secondary analysis was conducted with data obtained in previous studies. The scores for men and women belonging to Catholic, Protestant, Jewish, and LDS denominations, along with those claiming no religion, revealed that the MMPI profiles from the five groups were quite similar and "indicated no extreme difference as to the presence or absence of mental pathology" (p. 87).

Recent research has shown that the intensity of religious beliefs and activity is associated with mental health. Crawford et al. (1989) used a small sample to obtain information from 90 men and 136 women across the United States. The respondents belonged to various denominations and had a wide range of religious activity. Of interest in this study is the finding that highly religious women were significantly less distressed and manifested better psychological adjustment than the less religious.

The relationship between religion and mental health was reviewed in a recent discussion by Bergin (1991). One of the studies he reviewed was one he conducted with LDS students at Brigham Young University. It was a longitudinal study of the interaction between religion and personality development of 60 former students. Bergin found that for "many" of the individuals, religious activity and beliefs were therapeutic while for "some" religion was part of a self-defeating pattern. He resolved this inconsistency, as he did earlier, by pointing out that religiosity is a multidimensional phenomenon with divergent consequences.

In summary, previous research has produced weak and mixed results, which suggest that religiosity has little, if any, relationship to

mental illness in women. It has been hypothesized that different dimensions of religiosity may be significantly related to mental health.

Employment, Religiosity, and Mental Health

Little research has examined the interaction of employment and religiosity in understanding women's mental health. However, two opposing positions have emerged from theorizing and speculation based on related research. One hypothesis is that religion has a positive relationship with employment and mental health. Men and women who choose work that they think is "important" are inclined to attach religious significance to their employment. It is hypothesized that religious beliefs, which include support for employment, contribute to individual mental health. In an insightful study by Davidson and Caddell (1994) that partially supported this hypothesis, comparisons were drawn between Protestants' and Catholics' attitudes toward their work. Davidson and Caddell found that "the more people think of themselves as religious, the more they are active in their churches, the more they stress social justice beliefs [good works], the more they also view work as a calling" (p. 146).

The second hypothesis is that conservative religions tend to support traditional family roles with women as full-time homemakers. Thus, employed women who belong to such religions feel guilty for violating their religious values and denominational norms. Such guilt contributes to depression and other forms of mental illness and lower self-esteem. These women have to cope with religious guilt as well as the "second shift" stress.

This study tested the latter hypothesis with a sample of LDS women living in the major metropolitan area of Utah. Mothers in the LDS church are encouraged to remain at home with their children, as, according to LDS doctrine, being a mother is the highest calling God has given women. The President of the LDS church is considered a living prophet who speaks the mind and will of God. A previous president, Ezra Taft Benson, stressed in 1987 that "the counsel of the Church has always been for mothers to spend their full time in

the home rearing and caring for their children" (Benson, 1987). Thus, married LDS women are at risk for mental health problems from both their violation of religiously sanctioned family roles and because of the cumulative pressures of employment and family responsibility.

The mental health of LDS women, as a group, has been found to be similar to that of other women. As discussed earlier, in a telephone survey of LDS women living in Salt Lake City, Spendlove et al. (1984) found no difference in the prevalence of depression in LDS and non-LDS women. Although the rates were similar, Spendlove and associates raised the possibility that employment outside the home may be an important risk factor. They stated that "it is possible that the LDS women who work may be at a higher risk for depression than women who do not work" (Spendlove et al., 1984). On the other hand, Bergin et al. (1994), after an exhaustive review, concluded that LDS women do not manifest any unusual rates or kinds of mental disorders when compared to national rates.

In this study we focused on three indicators of mental illness—feelings of general well-being, self-esteem, and depression. Several researchers, especially Bergin, have noted that religiosity is comprised of more than one dimension. Therefore, we included three major dimensions of religiosity—religious beliefs, public religious behavior, and private religious behavior—which have emerged in previous research with an LDS population (Chadwick and Top, 1992).

Although no previous study pointed it out, employment is also multidimensional. Therefore, we included current employment, the percent of their adult life the women had worked, and their future employment intentions. The latter measured whether employed women intend to continue working and whether housewives intend to enter the labor force.

We tested the hypothesis that religiosity and employment would be significant predictors of mental health among married LDS women. In addition, an interaction effect between religiosity and employment was anticipated. It was hypothesized that the guilt creat-

ed by employment would be greater for the highly religious women and would be manifest in the measures of depression, self-esteem, and well-being.

METHODS

Data Collection

A mail questionnaire survey was conducted by the Center for Studies of the Family at Brigham Young University in the spring of 1991 with a sample of 3,000 women between the ages of 20 and 60 who were living along the Wasatch Front in Utah. The R. L. Polk Company drew a random sample of women in the designated age category living in the metropolitan strip from Ogden to Provo, which includes Salt Lake City. Standard multiple-mailing technique produced a 50 percent response rate.

Given the age range of 20 to 60 and urban residence of the respondents, it is inappropriate to compare them to census data or other surveys of the general population to verify their representativeness. We did, however, compare the women in our study to women between ages of 20 and 60 living statewide in the 1990 census and found the women in our sample had significantly more education. Only 2 percent of the respondents had failed to complete high school, while 11 percent of the women in the 1990 census had done so. Some of the difference is because our sample was primarily urban, which is associated with higher educational attainment. Even with the urban residence influence, the educational attainment of women in the sample is higher than among women in general along the Wasatch Front. We analyzed the data collected from 1022 married LDS women in the sample.

Measurement of Variables

Demographic characteristics age, education, religious preference, marital status, and number of children were measured with single questions asking the relevant information.

Mental health was measured by the Depression Scale developed by the Center for Epidemiologic Studies (Weissman, Scholomskas,

Pottenger, Prusoff, and Locke, 1977). The scale was shortened from 20 to 10 items by those conducting the National Survey of Family and Households (1988). We used the ten-item version. The scale asks how often during the past week the women had experienced ten different symptoms of depression such as feeling depressed, sad, or lonely. We altered the format slightly by asking how often the women felt the symptom during the past month rather than week. The symptoms, along with the frequency of their occurrance, are listed in Table 1.

The depression scale was submitted to principal components factor analysis. A standardized individual score was computed for each woman, using the regression method (SPSS, Inc., 1984). The factor weights for each of the ten depression symptoms are presented in Table 2. "Feelings of depression" produced the strongest weight, followed by not being able to shake the blues. The lowest factor weight was obtained for "sleep restlessly." The eigen value of 5.59 and Alpha coefficient of .905 indicate the ten symptoms loaded into a strong unidimensional scale.

Self-esteem was gauged using nine items from the popular Rosenberg scale (Rosenberg, 1979). The items and factor weights are presented in Table 3. Not surprisingly, the nine Rosenberg self-esteem items produced a strong scale as well. The eigen value is 4.96 and the Alpha coefficient is .895.

A measure of general well-being was obtained by asking, "Taking all things into consideration, how would you say things are these days? Would you say you are very happy, happy, not to happy, unhappy or very unhappy." Overall, the women were satisfied with the way life was treating them: 27 percent reported they were "very happy," 59 percent "happy," 12 percent "not too happy," and only 2 percent were either "unhappy " or "very unhappy."

Religious beliefs were assessed with three questions on traditional Christian beliefs, such as "There is a God " and "Jesus is the divine Son of God." An additional seven items asked about acceptance of unique LDS beliefs including "Joseph Smith was a true prophet of God" and "The Book of Mormon is the word of God." The five response cate-

Table 1

Frequency of 10 Selected Depression Symptoms among LDS Women

Frequency	Depression Indicators									
Times/month	Bothered	Blue	Mind	Depressed	Effort	Get Going	Fearful	Restless	Lonely	Sad
0	21%	49%	35%	30%	26%	24%	66%	35%	57%	34%
1-2	30	21	24	29	25	26	15	23	16	26
3-5	30	17	22	22	22	24	11	19	13	21
6-10	13	7	10	11	12	12	5	10	7	11
11-12	5	4	7	6	9	11	2	8	5	6
21-30	2	2	3	3	6	4	1	6	3	3
	101%	100%	101%	101%	100%	101%	100%	101%	101%	101%

Table 2
Factor Weights for Items on the Depression Scale

Question	Weights
On the average, how many days during the past month did you:	
Feel depressed	.870
Feel that you could not shake off the blues	.851
Feel sad	.821
Feel that everything you did was an effort	.731
Feel you could not get going	.714
Have trouble keeping your mind on what you were doing	.713
Feel lonely	.700
Feel bothered by things that usually don't bother you	.663
Feel fearful	.606
Sleep restlessly	.500

Eigen Value = 5.59
Alpha Coefficient = .91

Table 3
Factor Weights for Items on the Self-Esteem Scale

Question	Weights
At times I think I am no good	-.796
I feel I do not have much to be proud of	-.762
All in all, I am inclined to feel that I am a failure	-.753
I feel that I have a number of good qualities	.749
I certainly feel useless at times	-.729
I feel I am a person of worth at least on an equal plane with others	.724
I wish I could have more respect for myself	-.685
I am able to do things as well as most people	.629
On the whole, I am satisfied with myself	.615

Eigen Value = 4.96
Alpha Coefficient = 8.95

gories ranged from "Strongly Agree" to "Strongly Disagree."

Private religious behavior was measured by the frequency of private prayer and scripture study. The responses also ranged from "Daily" to "Never." Because financial contributions are confidential in the LDS Church, they were also included in private religiosity. The question was, "How much money did you give your church last year?" The responses included, "None," "0 to 2%," "3 to 5%," "6 to 9%," and "10 % or more of income."

Public religious behavior was evaluated by asking the frequency of attendance at four different LDS Sunday services. We also asked how often the women's families hold family home evening where LDS families participate in religious instruction and recreation each Monday evening. The response categories were "Weekly," "Two or three times a month," "Monthly," "Seldom," and "Never." In addition, the frequencies of family prayer and family scripture reading were obtained. The responses ranged from "Daily" to "Never." We also asked the women "Do you hold a church calling(s) at the present time?"

The ten belief items, seven public items, and three private behavior items were submitted to principal components factor analysis. The factor weights for the individual questions ranged from a high of .98 to a low of .41 (see Table 4). The eigen value is 6.37 for belief, 2.56 for private behavior, and 3.46 for public behavior. The alpha coefficients for religious beliefs is .983, and .802 for both private and public behavior.

Employment status was gauged by asking "Are you currently employed?" The response categories included "No," "Yes: part-time," and "Yes: full-time." Current employment was coded as a dummy variable with not being employed equal "zero" and part-and full-time employment equal "one." The number of years the women had participated in the labor force was identified with the following question: "Would you please estimate how many years of your life that you have worked for pay, either full- or part time? Please add parts of years together." Finally, employment intentions were measured by asking housewives: "Do you expect to enter the labor force during the next

Table 4
Factor Weights for Items on the Three Religiosity Scales

Item	Weight
Religious Belief	
The Book of Mormon is the word of God	.982
Joseph Smith was a true prophet	.979
The current President of the Church is a true prophet of God	.968
The Doctrine and Covenants contain revelations from God	.963
The Church of Jesus Christ of Latter-day Saints is the restored church	.935
The Church today is guided by prophetic revelation through the First Presidency and the Quorum of the Twelve	.929
I have the opportunity to become exalted in the Celestial Kingdom	.877
Eigen Value = 6.37	
Alpha = .98	
Public Religious Behavior	
I attend Sacrament Meeting	.775
My family has family prayer	.743
I read the Bible or other scriptures with my family	.700
My family holds family home evening	.676
I attend Sunday School	.623
I hold a church calling at the present time	.616
I attend Relief Society	.411
Eigen Value = 3.46	
Alpha = .80	
Private Religious Behavior	
I pray privately	.764
I read the Bible or other scriptures	.744
Amount of money I gave to my church last year	.724
Eigen Value = 2.56	
Alpha = .80	

five years?" Working women were asked: "Do you expect to continue working during the next ten years?" The five response categories ranged from "Definitely yes" to "Definitely no."

The percent of their adult life the women had spent in the labor force was calculated by subtracting the age they started working full time from their current age. The years of potential employment were divided into the number of years they estimated they had been in the labor force. We computed the percent of total time worked, the percent employed full time and the percent of their adult lives they had worked part time.

FINDINGS

Frequency of Depression

A substantial percentage of the women in the sample had experienced the ten depression symptoms during the previous month as can be seen in Table 1. The most frequent complaint was "feeling bothered by things that usually didn't bother a person" as 79 percent reported they had felt this way at least one day during the month. "Trouble getting going," "feeling that everything was an effort," and "feelings of depression" occurred fairly frequently. "Feeling fearful" or "lonely " were the least frequent reported symptoms. The cumulative effect of women experiencing several of these symptoms during the past month is an indication of considerable depression.

Employment and Mental Health

Employment outside the home has a rather modest relationship to mental health as measured by depression, self-esteem, and general well-being. As is apparent in Table 5, a history of full-time employment and the intent to keep working or for women to start working are significantly related to depression. Women who have worked full time for a large percentage of their adult life reported greater depression. In addition, current employment is inversely related to general well-being. Employed women experience more depression and have less positive feelings about their well-being. On the other hand, percentage of adult life working part time and being currently employed are positively related to feelings of self-esteem. Thus, current employment is negatively related to well-being and positively related to self-esteem. The correlation between self-esteem and general well-being is only .143, thus the positive relationship of current employment with self-esteem and a negative one with well-being is possible. It seems that having a job, especially a part-time one, helps a woman feel more competent than a housewife, but the pressures of work and home life and the prospect that the pressures will continue in the future are associated with a little lower sense of well-being and a higher level of depression.

Religiosity and Mental Health

Only private religious behavior was significantly related to feelings of depression (see Table 6). Women who frequently prayed privately and read scriptures reported lower levels of depression. Public religious behavior has a significant relationship with self-esteem. In this case, attendance at meetings was related to higher feelings of self-esteem. Interestingly, all three measures of religosity are significant correlates of general well-being. The relationship with public behavior is strongest, followed by private behavior and then religious beliefs. Religious women reported more positive feelings of general well-being. Although religiosity is a stronger predictor of depression, self-esteem, and well-being than employment, the relationship to mental health is rather weak.

Employment, Religiosity, and Mental Health

Multiple-regression analysis allowed the measures of employment and religiosity to simultaneously predict the three measures of mental health. Previous research suggested that age and education are important predictors of mental health and self-esteem, and they probably influence the relationship between employment, religiosity, and mental health. Therefore, we entered age and education in the regression equation first as control variables. Since these women were all married, we included the number of children in the equation as a control factor as well. The multiple regression results of employment and religiosity predicting depression are presented in Table 7. Education entered the equation in that the higher the educational attainment of the women, the lower their depression. The number of children also emerged as a predictor. The more children a women had, the greater her depression. It is suspected that the pressures of rearing children contribute to the symptoms of depression. Two measures of employment—percent of adult life employed full time and future intentions of employment—emerged as significant correlates. They are positively related to depression. In other words, the greater percentage of their lives these women have worked full time and the stronger their intention to work in the

future, the greater their report of the symptoms of depression. Finally, private religious behavior was inversely related to depression. Women who prayed, read the scriptures, and contributed money to their church had lower reports of depression. The R is only .223 and the R2 is .050. This particular combination of factors accounts for only five percent of the variation in depression. Although this paper's intent was not to test a comprehensive model of depression, it was anticipated that employment and religiosity would play a larger role than emerged from this analysis. Education, family size, three measures of employment, and one measure of religiosity entered the regression equation predicting depression, but their overall contribution is rather minimal.

We regressed employment, religiosity, and the control variables against each of the ten depression symptoms to search for any patterns. The only variable to regularly appear was education, and it was a significant predictor for nine of the ten symptoms. The cumulative effects of employment appeared more often than current employment status. Both the percent of adult life employed full time and the intention of future employment were significant for half of the ten indicators. Religiosity had little predictive ability. Public behavior and private behavior each were significant predictors of three symptoms and beliefs only one. The overall finding is that neither employment nor religiosity has much of a relationship to these symptoms of depression.

Employment, Religiosity, and Self-Esteem

Only three factors entered the regression equation predicting the self-esteem of married LDS women (see Table 7). Age was entered first and reveals that younger women feel better about themselves than do older women. Education has a positive relationship with self-esteem, and not surprisingly, the greater the education, the stronger the self-esteem. Finally, current employment also evidenced a positive relationship with self-esteem. Those women who are working, both part- and full time, have stronger self-esteem than housewives. Thus, one indicator of employment and none of the measures of religiosity made a significant contribution of predicting self-esteem. The R is .171 and

the R2 is .029. The low explained variance of self-esteem makes it clear that work experience and religiosity have little to do with the self-esteem of LDS women.

Employment, Religiosity, and General Well-being

First, the number of children made a significant contribution to predicting well-being. The more children a women reported she had, the lower her feelings of well-being. Public religious behavior, primarily attendance at religious services, entered the regression equation predicting well-being. Those women who engaged in public religious worship behaviors, primarily attendance, had significantly stronger feelings of well-being. The women's intentions of their future employment had an inverse relationship. Those women who don't work and perceive they will continue to remain out of the labor force and those who are employed, but expect to quit in the relatively near future, had a greater sense of well-being. These three factors produced an R of .265 and R2 of .070. Both employment and religion made a rather small contribution to understanding the general well-being of married, LDS women.

Conclusions

Women in the LDS Church have frequently been identified as being at risk for depression and other mental or emotional illnesses.

Table 5
Bivariate Correlations Between Measures of Employment, Depression, Self-esteem, and General Well-being

Employment Characteristics	Depression	Self-Esteem	General Well-Being
Current employment	.006	.076*	-.122**
Percent of adult life employed part-time	-.047	.103**	.008
Percent of adult life employed full-time	.123**	-.020	-.083
Percent of adult life employed both full-time and part-time	.50	.066*	.052
Employment intentions	-.115*	0.22	-.188**

* Significant at .05 level.
** Significant at .01 level.

Table 6
Bivariate Correlations Between Religiosity, Depression, Self-Esteem, and General Well-Being

Religiosity	Depression	Self-Esteem	General Well-Being
Beliefs	-.055	.035	.073
Public Behavior	-.053	.083**	.196**
Private Behavior	-.107**	.041	.130*

* Significant at .05 level.
** Significant at .01 level.

The conservative religious doctrine, including an emphasis on wives remaining in the home, is seen as causing guilt among those who work and frustration among those "coerced" to remain in the home. Both guilt and frustration are felt by some to facilitate feelings of depression and low self-esteem. Married, working LDS women with children are viewed as being particularly at risk, especially if they are highly religious. Previous research has revealed that religiosity has several dimensions, each of which may have different relationships to mental health. Employment is also more complex than current status, and a long history of work or the prospect of future employment are important dimensions. Therefore, we included three measures of religiosity and four measures of employment in predicting mental health, self-esteem, and general well-being. In spite of these efforts, the accumulative or interaction effects of religiosity and employment has little relationship to the mental health among this sample of married LDS women. LDS women, regardless of their level of religiosity, have been able to reconcile Church doctrine emphasizing family over employment with their employment experience.

The results are comforting to LDS women as neither their religiosity nor their employment is significantly related to their mental health. Highly religious married LDS women who work are no more at risk of mental illness than are the less religious or housewives. These findings are consistent with most of the previous research, particular-

Table 7
Multiple Regression of Employment, Religiosity, Education, and Number of Children Predicting Depression

Factor	b	Beta	t	P<
Percent adult life employed full-time	.355	.129	3.88	.000
Intention to be employed	.077	.135	3.63	.000
Education	-.049	-.093	-2.98	.01
Number of children	.039	.090	2.77	.01
Private religious behavior	-.074	-.070	2.19	.05
R=.223 R^2=.050				

ly the more recent work reviewed by Bergin et al. (1994). More adequate explanations of the mental health, self-esteem, and well-being of married LDS women will have to include other factors.

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On the Cross-Cultural Attitudes and Experiences of Recently Returned LDS Missionaries[1]

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ABSTRACT

To examine the effect of the mission experience upon attitudes towards members of different cultures, 273 recently returned LDS missionaries and 493 LDS college students who had not yet served missions were administered measures of racial attitudes. Subsequently, the highest and lowest fifth of missionaries who had served in non-English speaking nations were interviewed. Results indicated that the missionaries did differ from the non-missionary sample in their racial attitudes and that several key qualitative pre-mission and mission experiences distinguished between the two groups interviewed.

> Prejudice, with its attendant train of evil, is giving way before the force of truth, whose benign rays are penetrating the nations afar off. (*Teachings of the Prophet Joseph Smith,* 1976, p. 184)

The message of the thousands of young adult LDS missionaries dispersed throughout the nations of the world is one of unity and brotherhood. Unity and brotherhood, however, are strongly challenged by situations these missionaries sometimes encounter. Ironically, these ideals are sometimes challenged by the missionaries

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themselves, if they choose to accept common social beliefs which state that differences in socioeconomic condition, behavior, or physical appearance constitute real, immutable differences. In that sense, many young missionaries may find themselves in similar circumstances as the apostle Peter, who was first required to put aside the prejudices he had been taught before he could teach others the message of equity and peace (Acts 10). Thus, despite the loftiness of the word, the necessity of addressing the biases of its bearers appears to exist.

For many young missionaries native to the Rocky Mountain region of the U.S., their first month in the mission field may provide them with more exposure to poverty, family violence, and racial prejudice than the previous nineteen or so years of their lives. Exposure to cultural diversity has been found to reduce prejudice under certain circumstances, but under less than ideal conditions, exposure may actually increase prejudicial beliefs (Amir, 1969). Previous research in this area has also indicated that "culture shock" often impairs the abilities of those residing in foreign countries to cope with the unfamiliar environment (Zapf, 1991).

Given the steady increase in the number of missionary representatives assigned around the globe, as well as the importance of their work, the present study was designed to address several aspects of pre-mission and mission experiences as they relate to post-mission racial attitudes. Specifically, the following questions were asked: How does the mission experience affect attitudes toward other cultures? Does this effect, if any, differ between returned missionaries who served in English or non-English speaking nations? And, how do returned missionaries who report being highly accepting of other cultures differ from those who are less accepting in their pre-mission preparation and in various mission experiences?

Method

Sample

Returned missionaries. Using both fliers and advertisements, 273 white LDS recently returned missionaries were recruited. Fliers were

posted on the campuses of Utah State University, University of Utah, Brigham Young University, and Bridgerland Applied Technology Center (Logan, UT), and advertisements were placed in the following newspapers: *The Statesman* (USU), *The Chronicle* (U of U), *The Daily Universe* (BYU), *The Cache Valley Citizen* (Logan, UT), and *The Deseret News* (entire Wasatch Front). Potential subjects were offered a monetary incentive for their participation.

The sample consisted of 220 men and 53 women. Of the men, the majority (72%) were 21 years of age, with 21 percent being 22 and 7 percent being 23 or 24 (mean = 21.5). Of the women, most (52 percent) were 23, with 25 percent being 22, 22 percent being 24 or above (mean = 23.1). Of the total sample, 120 (44 percent) had served in the U.S., Canada, U.K., Ireland, or Australia, 69 (25 percent) had served in Central or South America, 44 (16 percent) had served in Asia, 35 (13 percent) had served in Europe, and 5 (2 percent) had served in South Africa. The majority of subjects (68 percent) indicated that their personal incomes were then less than $6,000 annually, but the vast majority (approx. 80 percent) also reported that their family of origin was either middle class or upper-middle class.

Nonmissionary LDS. In addition, a sample of 493 LDS college students who had not yet served missions was recruited from introductory social science classes at Utah State University. This group consisted of 233 men and 260 women who were predominantly college freshman (60 percent). As above, the majority of subjects indicated having present personal incomes of less than $6,000 annually, but most reported that their family of origin was either middle class or upper-middle class. Thus, a total of 766 subjects participated. The subjects were divided into three groups: those who had served missions in English speaking countries (N -120), those who served missions in non-English speaking countries (N = 153), and those who had not yet served missions (N = 493).

Design

This study was conducted in two phases. First, all subjects com-

pleted a questionnaire containing the following measures of racial attitudes: (a) a revised form of the Social Distance Scale (SDS; Byrnes & Kiger, 1988), (b) a revised version of the Modern Racism Scale (MRS; McConahay, 1986), and (c) the White Racial Identity Attitude Scale (WRIAS; Helms 1990). Second, returned missionary subjects who had served in non-English speaking missions and who had scored among the highest or lowest fifths on the SDS were invited to complete a 30-minute structured interview regarding their mission and pre-mission experiences. Interviews were conducted by the first and third authors, who were blind to the subjects' SDS scores. Fifty interviews were completed, but data from two interviews were found to be incomplete and were subsequently removed. Thus, in the following section, data from 20 of the highest scorers and 28 of the lowest scorers are represented. The content of the interview itself is reproduced in the Appendix.

Results

Part 1: Questionnaire Data

Multivariate analyses of variance (MANOVA) conducted between those subjects who had served in English-speaking nations, those who had served in non-English speaking nations, and those who had not yet served missions revealed statistically significant differences on all three dependent measures ($p < .001$). Post hoc univariate analyses indicated that the two missionary groups scored as being more accepting of contact with members of other races (SDS), more prejudiced in their subtle racial opinions (MRS) and more developed in the acknowledgment and cognition of their own racial identity attitudes (WRIAS, Disintegration and Pseudo-independent subscales) than the non-missionary group. The two missionary groups did not significantly differ in their scores on the three measures.

Part 2: Interview Data

Important qualitative information was gleaned from the interview section of this research. In an attempt to better summarize these data,

a systematic content analysis was conducted. Following completion of the interviews, subjects' responses to each question were grouped by their content into "categories." Next, the percentage of subjects in each group (high versus low scorers on the SDS) who made a response falling into each category (content area) was computed. Because multiple responses were possible for each question, the response percentages reported below are for each categorv only; they do not sum to 100% across categories. Two of the questions (1 and 2) included subjects' ratings of the relative importance of their several responses on a 5-point Likert scale (see the Appendix). These ratings were subsequently averaged for each category of responses across the accepting (high scorers) and less accepting (low scorers) groups. Finally, ratings provided by the interviewer were also tabulated for the two groups.

Based primarily upon the opening non-specific question in which the subject was invited to describe their overall mission experience, the interviewer (who was blind to the subject's SDS score) rated the portrayed level of pleasantness of this experience on a 5-point Likert scale. The average ratings were 4.30 for the accepting group and 3.67 for the less accepting group, indicating that those subjects who had scored as being accepting of other cultures were rated as portraying their mission experience more positively than those who scored as being less accepting on the SDS.

For the first direct question, which addressed pre-mission preparatory experiences, four categories (content themes) were derived from the responses. In order of prevalence, these were (1) intercultural experience, subsequently subdivided into the areas of interpersonal contact (further subdivided into high and low quality), language training, and travel; (2) major life adjustments, including relocation of residence, economic independence, life "trials," etc.; (3) familial influence and upbringing; and, (4) nothing (i.e., they stated that no experiences prepared them for serving a foreign mission). Table 1 contains the percentage of responses falling in each of these categories by subject group. The average of subjects' own ratings (on a 5-point Likert scale) as to the importance of the experience in helping them prepare for a

Table 1
Pre-mission Preparatory Experiences for Serving in a Foreign Culture

Theme/issue	Accepting group		Less-Accepting Group	
	%	Mean rating	%	Mean rating
Intercultural Experience				
Personal contact				
High/Direct	30	3.8	31	3.1
Low/Indirect	90	3.6	39	3.8
Language	20	3.3	21	3.0
Travel	10	4.5	32	3.6
Major life adjustments	55	3.7	61	3.5
Familial influence	50	4.0	4	4.0
"Nothing"	5		18	

foreign mission are also provided.

As may be seen, these ratings were consistently high for the responses in the familial influence category. Thus, most subjects who reported being raised in homes where intercultural differences were minimized or accepted, rated their upbringing as being an important aid to their later mission experience. It should be further noted that the percentage of subjects who provided responses in this category was by far greater for those who scored as having highly accepting racial attitudes on the SDS.

The intercultural experience subcategories of travel and interpersonal contact were also rated by the subjects as being moderately important areas of preparation. Here also, the difference in the ratings and percentages of responses provided by the subjects were noticeable across the two groups. An extremely high percentage of the subjects in the highly accepting group indicated that having even low quality or indirect contact with members of foreign cultures prior to the mission was helpful, while subjects in the less accepting group rated having low quality contact (i.e., seeing them in a public setting) with members of foreign cultures as being more important than having high

quality contact (i.e., friendships) with such individuals. Finally, it should be noted that those subjects who reported having had previous language training in high school or college generally rated this as being less important than the other areas of preparation listed.

For the second question, which addressed difficulties in foreign residence, five themes were apparent in the responses. In order of prevalence, these were (1) language; (2) intercultural problems, subdivided into lack of awareness, cultural differences, and conflicting religious or moral values; (3) factually stated technical difficulties beyond the person's control, such as climate and illness; (4) complaints of differing routines and/or material goods, such as food taste, shopping inconveniences, or access to private automobile, etc.; and, (5) complaints against mission regulations. (It should be noted that responses in this last category were spontaneous, not solicited by the question content.) A tabular summary of the responses and the average level of importance ratings provided by the subjects' is presented in Table 2.

On the average, language difficulties were the most prominent

Table 2
Difficulties Experienced Serving in a Foreign Culture

Theme/issue	Accepting group		Less-Accepting Group	
	%	Mean rating	%	Mean rating
Language	60	3.8	79	3.7
Intercultural problems				
Lack of Awareness	40	3.1	32	3.1
Differences	35	3.0	46	3.3
Religious/moral values	15	3.0	25	2.7
Objective technical issues	40	3.1	46	3.0
Complaints of routine changes	30	3.3	57	3.1
Mission regulations	35	3.0	14	2.8

and the most problematic of those reported. Only minor variations in the percentages and ratings in each category existed between the two groups. Responses to the question addressing the subjects' experience in the Mission Training Center (MTC) were highly varied, in both positive and negative directions. Thus, although a great many responses were provided, they tended to be highly idiosyncratic, not amenable to concise categorization. However, one suggestion proffered by the majority of both high and low scoring subjects (65 and 68 percent, respectively) was that the "Culture Class" be altered so as to better prepare missionaries to live among the peoples native to their mission. Both high and low scoring groups were rated by the interviewer as having, on the average, a moderately positive experience in the MTC (3.4 and 3.6 on a 5-point scale).

The fourth question, in which the subjects were asked to describe their learning experiences living in another culture, also generated a wide variety of responses. These were broken down into six major categories, or areas of learning: (1) understanding of cultural variables, subsequently subdivided into perceived similarities and perceived dif-

Table 3
Issues Learned While Living in a Foreign Culture

Theme/issue	Accepting group %	Less Accepting Group %
Cultural variables		
Perceived Similarities	35	14
Perceived Differences	20	36
Personal insights	50	21
Appreciation for blessings	35	14
Irrelevance of material goods	20	14
Love for others	20	11
Language	0	18

ferences with U.S. culture; (2) personal insights for living, such as "the importance of the family unit," "being yourself," and "self-motivation"; (3) appreciation for personal "blessings," such as being raised in a free nation; (4) lack of importance of material wealth or conveniences; (5) love for others; and, (6) learning a new language. As above, the percentage of responses falling into these six categories are presented in tabular form (see Table 3).

As can be seen, reported areas of learning did vary substantially. Although not extreme, the difference across the two groups in the perceived cultural similarities and differences was noteworthy. The accepting group reported learning how people are similar, regardless of nationality, more often than the less-accepting group, which in turn, reported perceiving more differences across cultures. By totaling the percentages on the table for the two groups, it may be observed that the accepting group gave proportionately more responses to this question. Averaged interviewer's ratings on a 5-point Likert scale of the quality of the learning experiences did differ between the accepting and less accepting groups (3.75 and 3.27, respectively). Likewise, although not amenable to quantification, the individual responses provided by the less-accepting group were generally more superficial in their quality. Specifically, the response made by members of the less accepting group, "learning a new language," is exemplary.

When asked to recommend strategies for individuals planning to live in a foreign country, the subjects provided a highly varied number of suggestions. These were broken down into four major categories of responses: (1) Have a positive/accepting attitude ("be open minded," "don't focus on material things", etc.); (2) Read about/learn as much as you can of the language and customs; (3) Actively adapt and immerse yourself in the culture ("live like the people do", etc.); and, (4) Observe and/or speak with natives or those familiar with the culture. Table 4 contains the percentage of responses provided by the two groups in these four categories.

Generally, the two groups were not dissimilar in their responses. An extremely high percentage in both groups suggested that having a posi-

Table 4
Areas Recommended for Foreign Sojourners to Prepare Themselves

Source	Accepting group %	Less-Accepting Group %
Positive/accepting attitude	95	93
Study language and culture	55	64
Actively adapt to culture	55	39
Talk with/observe others	30	14

tive/accepting attitude was important for individuals interested in living abroad. To a lesser degree, study of language and culture and taking action to adapt to cultural norms were suggested. Speaking with and observing natives or people familiar with the culture were suggested much less frequently.

Question number six asked what sources of social, emotional and spiritual support the subject used while in the mission field. Five major categories were apparent in the responses: (1) letters from family and friends, (2) interaction with other missionaries, including the companion, districts, and zones; (3) interaction with native peoples, including local church members and investigators; (4) spirituality, including scripture study, prayer, faith, etc.; and, (5) interaction with church leaders, including mission president and General Authorities. Table 5 contains the percentage of responses provided in each of these five areas across the two groups interviewed.

The vast majority of subjects indicated that receiving mail from home was an important area of support for them while on their mission. Contact with other missionaries was also perceived as being helpful for a large proportion, although this was noticeably greater among the less-accepting missionaries. Perhaps the most notable information gleaned through responses to this question was that much more of the racially accepting missionaries found association with native peoples to be helpful. It was also interesting to note that, on the whole, the returned mis-

Table 5
Sources of Support Used While Living Abroad

Source	Accepting group %	Less-Accepting Group %
Letters	85	93
Other Missionaries	75	93
Native Peoples	80	18
Spirituality	35	39
Church Leaders	30	36

sionaries interviewed in this study more often reported using interpersonal associations for support rather than spirituality.

Discussion

The results of this study provide some useful information for those working with returning or departing missionaries. However, there are several limitations in the data that should be noted. First of all, the data was collected in a post hoc design from subjects who, on average, had been home from their missions for several months. Had data been collected both prior to departure and then immediately following return, potential confounding influences would have been minimized. Second, only subjects residing in Utah were examined, limiting the generalizability of the findings. Future research may benefit from examining subjects from other backgrounds and nationalities. Third, although the interview format was standardized and the interviewers were blind to subjects' SDS scores, some (unobserved) experimenter bias might exist in the qualitative data. And, finally, the differences in average age between the non-missionary and returned missionary subjects made chronological maturation a potential confound for those between group comparisons. That is, the present data does not adequately distinguish between the effects of a mission and the effects of simply getting older. On a practical level, however, two

years is not an excessive time span and, more importantly, data collected from older LDS subjects who had not yet served missions would introduce a variety of potential confounds less amenable to measurement (spiritual commitment, etc.). Each of these four limitations should be considered as we analyze the responses given to the questions that served to elicit the data for this study.

Responses to the first question, "How does the mission experience affect attitudes toward other cultures?" were disconcertingly inconsistent. On one hand, returned missionaries in this sample scored as being more willing to engage in contact with ethnic minorities (SDS) and more developed in their awareness and cognitive acceptance of racial issues (WRIAS) than the subjects who had not yet served missions. On the other hand, they scored as having more subtly biased beliefs than the nonmissionaries (MRS). Further research will need to be conducted to verify this apparent contradiction and to explore viable explanations, including the effects of aging, if it is subsequently replicated.

The second question, "Does the effect [on racial attitudes], differ between returned missionaries who served in English- or non-English-speaking nations?" was more concisely answered by the data. No practical differences existed between them. Thus, it is reasonable to tentatively conclude that the mission experience itself, rather than lengthy exposure to foreign cultures, may produce differences in one's attitudes toward other cultures. This possibility would be better assessed, however, by a quasi-experimental design that includes a pre-mission pre-test.

The response to the final question, "How do returned missionaries who report being highly accepting of other cultures differ from those who are less accepting in their pre-mission preparation and mission experiences?", is highly complex. First of all, it was noted that the accepting subjects were more likely to report being raised in an environment where cultural differences were accepted. Although far from surprising, this finding does place added emphasis on the role of the family in preparing young men and women for mission service. It was also notable that the accepting missionaries also reported more indi-

rect or low quality contact with members of different cultures prior to their missions. Because causality was not established, this finding may be attributed to the relative weight given to such occurrences by members of this group, rather than a lack of exposure in the less accepting group. Nevertheless, it could also suggest that exposing children and young adults to other cultures may benefit their later preparedness to live among such peoples. Such experiences would also demonstrate that cultures are important and acceptable to their adult role models.

It was also interesting to note that the two groups did not differ substantially in the difficulties they experienced while living abroad. Regardless of racial attitudes, roughly one third of those interviewed indicated having some difficulties in either understanding or accepting the culture. The fact that an inability to communicate effectively was so widely cited served to reinforce the Church's policy of using primarily native missionaries, when possible. When considered along with the moderate ratings high school language training achieved, it also demonstrated that perhaps the MTC experience is neither too long nor too intense.

The finding that accepting subjects did tend to report having learned more sophisticated and personally relevant issues from living in a foreign culture was not surprising. It follows along the same line as the differences noted in the portrayed pleasantness of the overall mission experience. However, it does underscore the potential benefit of addressing cultural acceptance perhaps more explicitly, which many of the missionaries seemed to indicate by suggesting changes to the MTC "Culture Class."

That the two groups did not differ in their recommendations to one planning to live abroad may be due to the superficial nature of many of these responses. Cliches and strictly commonsense suggestions abounded. All this may say is that preparation for living abroad is difficult and not particularly amenable to psychological checklists. Apparently, given the heavy emphasis on attitudes and behavioral adaptation, preparation requires much more psychological work than material work. The fact that experiential activities, such as observing and speaking with natives,

were not suggested nearly as often seemed to bear this out. Finally, it was also observed that the two groups differed substantially in their use of native peoples for emotional and social support. Less-accepting missionaries appeared to have turned more to their own peers. Both apparently relied extensively upon family and friends back home, although it must be noted that the relative importance of each of these factors was not measured here. Given the nature of missionary work, it was surprising to note that the majority of subjects did not indicate that God or spirituality was a source of support for them. However, this finding may either be due to the phrasing of the question or to the social context of the interview, which were all conducted on university campuses, not in church meetinghouses.

Given the responses to the above questions, a summary question may be appropriately asked: "What can be done to improve the likelihood of successful cultural integration by LDS missionaries?" As counselors, opportunities for taking such action may be limited, given that few outgoing missionaries seek psychological services. However, in the roles of parent, church advisor, etc., there is much that may be done. Modeling appropriate cultural appreciation, providing opportunities for cross-cultural exchange, encouraging language and culture study, and emphasizing the attitudinal and behavioral components as much as the physical and cognitive are all areas where each of us can take a more active role.

Recognizing the importance of such preparatory assistance in the departure process, a final note is that the return journey home often presents as many or more challenges to a sojourner (Raschio, 1987). Fortunately, although the issues are often different, the process of readjustment to U.S. culture ("reverse culture shock") is nearly the same. Support, understanding, willingness to accept differences, and adapting to change all play a role.

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Appendix
Content of Interview

A. Establish rapport and clarify expectations and roles.

B. Open-ended question (approx. 5 minutes): "Please describe your experience living abroad."

C. Direct questions (approx. 20 minutes):

1. "Please describe some of your experiences prior to your mission that you feel best prepared you to work among a different culture." "How would you rate each of these experiences?" (5 = very important, 1 = not important)
2. "Please describe at least three difficulties you experienced living in another culture." "How would you rate each of these experiences?" (5 = very important, 1 = not important)
3. "What did you think of your MTC experience?"
4. "What did you learn from living in a foreign culture?"
5. "What are your recommendations for other people who plan to live in a foreign culture?"
6. "What were some of the most useful supports (emotional, social, spiritual, etc.) you had while living in a foreign culture?"

D. Debriefing and response to subject's inquiries (5 minutes).

E. Post-interview ratings: All subjects were rated on anchored 5-point Likert scales on: (a) The overall pleasantness of the mission experience, as they portrayed it, (b) the quality of the MTC experience, as they portrayed it, and, (c) the quality of the cross-cultural learning they experienced, as they portrayed it (5 = most positive or highest quality, 1 = least positive or lowest quality).

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