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Eating, Substance Use, and Body Image: A Comparison Of Latter-day Saint and Non-Latter-day Saint College Age Females

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This study examined differences between Latter-day Saint (LDS) and non-Latter-day-Saint (non-LDS) females in desire to engage in substance use and eating behaviors in response to negative emotion. Additionally, differences between LDS and non-LDS females regarding body image, as well as body image differences between LDS females residing inside Utah and outside Utah, were explored. Findings suggested that non-LDS females were more likely to experience increased urges to use substances in response to negative emotion than LDS females, consistent with LDS doctrine teaching the avoidance of substance use. LDS females also did not appear to substitute LDS-sanctioned eating behaviors for substance use in response to negative emotion. Additionally, LDS females were found to have a more positive body image than non-LDS females generally, although LDS females in Utah have less positive body images than LDS females residing in other states. Implications of these findings for the prevention of substance abuse and body image dysfunction are discussed.

Substance use and eating in response to negative affect serve as risk factors for the development of substance abuse disorders and eating disorders, respectively. In addition to this affectively-driven consumption pattern, culture (defined here as religion) can also influence the likelihood of developing these disorders by influencing consumption behaviors. For instance, some religions such as the Church of Jesus Christ of Latter-day Saints (LDS) discourage the use of alcohol, tobacco, and other drugs, and there are data suggesting that LDS members follow this religiously-based directive (Dyer & Kunz, 1986; Zick & Mayer, 1996) and have lower rates of substance abuse disorders than non-LDS persons (Gaustad & Barlow, 2001; Hawks & Bahr, 1999; Nelson, 2003; U.S. Census Bureau, 2007). For instance, in terms of religion, Utah is predominantly LDS, and ranks last among the fifty states in current use as percentage of the total population for marijuana, cigarettes, and binge alcohol (U.S. Census Bureau, 2007). However, yet unknown is whether religion, particularly LDS religion, influences how one responds to negative affect with respect to eating (either binge eating or restrictive eating) and if eating is being substituted for substance use given LDS directives to avoid substances, as well as evidence that LDS adults tend to weigh more on average than non-LDS adults (Merrill & Hilliam, 2006).

A second relationship between culture and disordered eating is mediated by body image. Cultural influences such as family, peers, and media encourage particular body image ideals, which then contribute to disordered eating (Rucker & Cash, 1992; Stice, 1994; Waller &

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Matoba, 1999). Previous research suggests that there are cultural body image influences on LDS women, particularly LDS women residing inside Utah (Carroll & Spangler, 2001), which is important given the increasing distress regarding body image and the related link to eating disorder behaviors. It has been suggested that the LDS directive for perfection and self-discipline may be misapplied to the body within the LDS population. It has also been posited that pressures, particularly on the BYU campus (a private religiously-based institution sponsored by the LDS Church), to marry and mate influence those in the LDS population to be overly critical of their bodies (Carroll & Spangler, 2001). Thus, it is of question whether religious subculture influences body ideals and level of body satisfaction.

To address such questions, the present study compared LDS females' and non-LDS females' attitudes regarding urges to engage in particular consumption behaviors in response to negative affect. Additionally, differences between LDS females and non-LDS females, as well as LDS females residing inside Utah and LDS females residing outside Utah, on attitudes regarding body shape and weight were investigated. This investigation aimed to answer the call for more specificity regarding culture's role in the development of psychopathology (Markey, 2004; Obesity, Fitness & Wellness Week, 2004; Polivy & Herman, 2004).

METHODS

Participants

A sample of LDS and non-LDS female college students was recruited from general education classes at six universities: Brigham Young University-Idaho, Brigham Young University-Utah, Utah Valley State College, University of Utah, the University of Idaho, and the University of Washington. Teachers of such courses invited any female students interested in participating in the study to email the researcher directly. Once participants offered contact information to the researcher, they were emailed a password and identification number to log onto a secure website. The website included self-report measures that took about 20-30 minutes to complete. Subjects received either extra credit or monetary compensation ($10) for their participation.

Subjects were all female due to previous research that suggests that women have more negative body image evaluations, stronger investments in their looks, and more frequent body-image dysphoria than men (Muth & Cash, 1997). There is also some evidence to suggest that females outnumber males approximately ten to one in the presentation of eating disorders other than binge eating disorder (Sanders, 1996).

A total of 153 participants were included in the current analysis. As noted in Table 1, the majority of the sample was Caucasian, single, freshman, LDS, and between the ages of 18-19.

Measures

The Emotional Eating Scale and The Emotional Eating Scale-Revised for Substance Use (EES and EES-R): The EES (Arnow, Kenardy, & Agras, 1995) is a 25-item self-report scale that assesses the intensity of the relationship between negative mood and urge to eat. Items are scored on a 5-point Likert scale ("no desire to eat" to "an overwhelming desire to eat"). However, this instrument was modified to adequately address hypotheses. The 5-point Likert scale remained intact, but varied from −2 to +2 with the 0 point being "no change in urge to eat." This alteration allowed participants to respond equally to the possibility of a decreased desire to eat (first subscale) and an increased desire to eat (second subscale) in response to negative emotion. Thus, the scale ranged from "a large decreased urge to eat" to "a large increased desire to eat." The EES was reported to have an internal consistency of .81 and test-retest reliability of .79. Since the original EES was intended to explore eating behaviors primarily of binge eaters, some of the directions were modified to include both binge and restricting behaviors in response to negative emotion. The internal reliability was .84 for the increased portion and .81 for the decreased portion of the EES in the current study. Further, the EES was modified to explore substance use (EES-R). The EES-R substituted substance use for all instances of "an urge to eat or decreased urge to eat." Thus, the scale ranged from "an overwhelming decreased desire to use substances" to "an overwhelming desire to use substances." The internal reliability was .95 for the increased portion and .98 for the decreased portion of the EES-R in this study.

The Dutch Eating Behavior Questionnaire and the Dutch Eating Behavior Questionnaire-Revised for Substance Use (DEBQ and DEBQ-R): Seven items of the 9-item Emotional Eating subscale of the DEBQ (Van Strien, Frijters, Bergers,

Table 1
Participant Characteristics

Characteristic	N	Percentage of Total Sample (N=153)
Religion		
Catholic	9	5.9%
Baptist	4	2.6%
Protestant	9	5.9%
Latter-day Saint	105	68.6%
Jewish	2	1.3%
Agnostic	9	5.9%
Atheist	1	0.7%
Other Christian	12	7.8%
Other (Not Islamic, Buddhist, Hindu)	2	1.3%
University		
University of Utah	13	8.5%
BYU-Utah	42	27.5%
Utah Valley State College	12	7.8%
BYU-Idaho	42	27.5%
University of Idaho	25	16.3%
University of Washington	19	12.4%
Year		
Freshman	80	52.3%
Sophomore	37	24.4%
Junior	25	16.3%
Senior	10	6.5%
Graduate	1	0.7%
Marital Status		
Single	127	83.0%
Married	16	10.5%
Divorced	1	0.7%
Cohabitating	9	5.9%
Age		
18-19	99	64.7%
20-21	26	17.0%
22-23	7	4.6%
24-25	11	7.2%
26-27	3	2.0%
28-29	1	0.7%
30-39	2	1.3%
40 and over	4	2.6%
Ethnicity		
Hispanic	9	5.9%
African American	2	1.3%
Caucasian	126	82.4%
Asian	7	4.6%
East Indian	1	0.7%
Native American	2	1.3%
Other (Not Pacific Islander)	6	3.9%

& Defares, 1986) were used as a measure of eating in response to negative emotion. This scale was chosen because it measures similar emotional eating behaviors as the EES and thus provides an appropriate supplement measure of emotional eating. DEBQ items are measured on a 5-point, Likert-type (1 = never, 5 = very often) format. Van Strien et al. (1986) reported that the 9-item Emotional Eating subscale was shown to have very high internal consistency reliability (a = .93) across females. Further, the DEBQ was also revised for substance use. All items used for the eating portion of the DEBQ begin, "Do you have a desire to eat when...?" For substance use items, the DEBQ-R reads, "Do you have a desire to use substances (alcohol, tobacco, drugs) when...?" The internal reliabilities for the DEBQ and the DEBQ-R in this study were .83 and .95, respectively.

The Beliefs About Appearance Scale (BAAS): The BAAS (Spangler, 1997) is a 20-item, 5-point (0 = not at all to 4 = extremely) self-report scale that assesses the degree of endorsement of beliefs about the consequences of appearance for relationships, achievement, self-view, and feelings. Higher scores indicate greater endorsement of beliefs that positive feelings, self-worth, and interpersonal and work successes are dependent on appearance. The BAAS was used to assess participants' tendency to focus on appearance-related stimuli and to determine how much participants believe that their appearance affects their quality of and functioning in life (Spangler, 1997). The BAAS has been shown to possess high internal consistency and test-retest reliability. Spangler and Stice (2001) reported internal consistency reliability levels of .94, .95, and .96 in separate samples as well as test-retest reliability correlations of .73 and .83 in separate samples. The internal consistency for the BAAS was .96 in this study.

The Balanced Inventory of Desirable Responding (BIDR): The BIDR (Paulhus, 1988) is a 40-item inventory that is scored on a 7-point Likert-type scale. It measures the related constructs of self-deception and impression management that have been shown through factor analysis to be distinct (Paulhus, 1991). A particular advantage of the BIDR given that subjects were recruited from church-sponsored universities is that BIDR norms are available for religious adults (Paulhus, 1988). The BIDR has been shown to correlate with other measures of social desirability (Paulhus, 1988). The internal reliabilities for the BIDR total scale, self-deception subscale, and impression management subscale in this study were .27, .45, and .04, respectively.

The Multidimensional Body-Self Relations Questionnaire (MBSRQ): The MBSRQ (Cash, 1994) is a 69-item self-report scale that assesses several components of body image. Respondents rate their degree of agreement or disagreement with statements on a 1 (definitely disagree) to 5 (definitely agree) scale. The MBSRQ comprises 10 subscales with adequate reliability and validity (Cash, 1994). The five MBSRQ subscales used in this study were as follows:

1. The *Appearance Evaluation scale* (APPEVF) consists of seven items that measure the degree of satisfaction with one's overall looks. Higher scores indicate more positive feelings about appearance, whereas lower scores indicate greater unhappiness with physical appearance. The Appearance Evaluation scale has been found to have a Cronbach's alpha (internal consistency) of .88 and a 1-month test-retest reliability of .86 for females. However, the internal reliability of the APPEVF was .23 for this study.

2. The *Appearance Orientation scale* (APPORF) consists of 12 items that measure the extent of investment in one's appearance, such as time spent in grooming behaviors. Higher scores indicated greater investment in appearance. The internal consistency of the Appearance Orientation scale has been found to be .85 and the 1-month test-retest reliability was .90 for females. The internal reliability for the APPORF was .39 in this study.

3. The *Body-Areas Satisfaction scale* (BASS) consists of nine items that measure satisfaction or dissatisfaction with discrete aspects of one's appearance. High scorers are generally content with most areas of their body, whereas low scorers are unhappy with the size or appearance of several areas. The internal consistency of the BASS was found to be .73 and the 1-month test-retest reliability was found to be .74 for females. The internal reliability of the BASS was .84 in this study.

4. The *Overweight Preoccupation scale* (OWPR) consists of four items that assess level of fat anxiety, weight vigilance, dieting, and eating restraint. A higher score in this area indicates a greater level of preoccupation and concern about becoming overweight. The internal consistency of the Overweight Preoccupation scale was found to be .76 and the 1-month test-retest reliability was found to be .89 for females. The internal reliability of the OWPR was .83 in this study.

5. The *Self-Classified Weight scale* (WTCLASS) con-

sists of two items that assess a construct reflecting fat anxiety, weight vigilance, dieting, and eating restraint. A higher score in this area indicates a greater perception of being overweight. The internal consistency of the Self-Classified Weight scale was found to be .89 and the 1-month test-retest reliability was found to be .74 for females. The internal reliability of the WTCLASS was .82 in this study.

The Body Appreciation and Respect Scale (BARS): The BARS (Spangler, 2007) is a 30-item self-report scale that assesses positive feelings and negative feelings (separate subscales) toward one's body. Respondents rate their degree of agreement or disagreement with statements on a 0 (*not at all true*) to 4 (*completely true*) scale. Psychometric properties of the BARS are currently under exploration. However, the positive feelings subscale of the BARS had an internal reliability of .94 and the negative feelings subscale of the BARS had an internal reliability of .96 in this study.

The Attention to Body Shape Scale: A New Measure of Body Focus (ABS): The ABS (Beebe, 1995) is a 7-item self-report scale that assesses the degree to which one pays attention to one's body shape. Respondents rate their degree of agreement on a scale from a (*definitely disagree*) to e (*definitely agree*). Higher scorers suggest greater attention to body shape. Beebe (1995) reported internal consistency reliability measures of .70-.83 in three separate studies for females, and test-retest reliability correlations of .76 for females. The ABS had an internal reliability of .67 in this study.

The Body Shape Questionnaire (BSQ): The BSQ (Cooper, Taylor, Cooper, & Fairburn, 1987) is a 34-item self-report scale that assesses concerns about body shape, and in particular, the experience of "feeling fat." Respondents rate their degree of agreement or disagreement with statements on a 1 (*never*) to 6 (*always*) scale. Higher scorers indicate greater concern with body shape. The BSQ has been shown to have satisfactory test-retest reliability, concurrent validity, and criterion validity (Rosen, Jones, Ramirez, & Waxman, 1996). The internal consistency has been found to be .97 (Evans & Dolan, 1993), consistent with the internal reliability in this study.

Data Analysis [1]

Social Desirability. Correlational analyses were used to determine if the response pattern on any of the questionnaires was significantly associated with social desirability responses. To test for possible group differences in social desirability responding, means on the BIDR were compared in LDS and non-LDS groups. Additionally, correlations between the BIDR and other measures were compared across groups. Significant differences were found between LDS and non-LDS females on the BIDR total score (TOT) and the BIDR impression management subscale (IM), as noted in Table 2. As expected, religious populations tend to score higher on this scale (Paulhus, 1988). Additionally, the BIDR TOT and IM subscale were also significantly correlated with most measures. Thus, the BIDR IM subscale was used as a covariate in analyses between religious groups. The IM subscale was used as there did not appear to be a significant difference between LDS and non-LDS populations on the self-deception subscale (SD), and the IM subscale is a more specific measure of social desirability than the TOT scale.

Given that there were no significant differences between LDS females residing inside Utah and LDS females residing outside Utah on the BIDR IM, the BIDR SD, or the BIDR TOT, as noted in Table 3, no covariate was used in within LDS location analyses (described below).

Consumption Analyses. Analyses of covariances (ANCOVAs) were performed to compare means between LDS and non-LDS groups on the six measures addressing the primary hypotheses regarding cultural effects on food and substance consumption using the BIDR IM subscale as a covariate. T-tests were also performed to compare means between LDS females residing inside Utah and LDS females residing outside Utah on the six measures addressing primary hypotheses. A more conservative level of alpha was used for each comparison given multiple comparisons to control for familywise error (Bonferroni correction = .05/6 = .0083; Howell, 2002).

Body Image Analyses. A multivariate analysis of covariance (MANCOVA) was used to compare means on the subscales of all body-related measures between LDS and non-LDS groups. A multivariate analysis of variance (MANOVA) was also used to compare means on all the subscales of all body-related measures between LDS females residing inside Utah and LDS females residing outside of Utah. The significant MANCOVA and MANOVA were followed by pairwise comparisons to determine where the differences resided.

Table 2
Social Desirability: T-tests Between LDS and Non-LDS Females on the BIDR

Scale	Mean (SD)	*t*	*p*
TOTAL			
LDS	12.41 (5.47)	7.53	.007
Non-LDS	10.22 (4.13)		
IM			
LDS	7.98 (3.53)	9.61	.002
Non-LDS	5.35 (2.33)		
SD			
LDS	4.43 (2.89)	0.00	.991
Non-LDS	4.88 (2.86)		

Note. TOTAL = The Balanced Inventory of Desirable Responding-Total Scale; IM = The Balanced Inventory of Desirable Responding-Impression Management Subscale; SD = The Balanced Inventory of Desirable Responding-Self-Deception Subscale.

Table 3
Social Desirability: T-tests Between LDS Females Inside and Outside Utah on the BIDR

Scale	Mean (SD)	*t*	*p*
TOTAL			
Inside UT	12.02 (5.12)	-0.88	.379
Outside UT	12.98 (5.95)		
IM			
Inside UT	7.53 (3.40)	-1.57	.119
Outside UT	8.63 (3.67)		
SD			
Inside UT	4.48 (2.84)	0.23	.815
Outside UT	4.35 (2.98)		

Note. TOTAL = The Balanced Inventory of Desirable Responding-Total Scale; IM = The Balanced Inventory of Desirable Responding-Impression Management Subscale; SD = The Balanced Inventory of Desirable Responding-Self-Deception Subscale.

RESULTS

Consumption Analyses

Using the BIDR IM as a covariate, non-LDS females were found to be more likely to experience increased urges to use substances in response to negative emotion than LDS females, as measured by the decreased portion of the EES-R, $F(2, 150) = 12.92$, $p < .001$, and the DEBQ-R, $F(2, 150) = 24.02$, $p < .001$. There were no significant differences between LDS and non-LDS females regarding increased or decreased urges to eat in response to negative emotion. Means and standard deviations are provided in Table 4.

Body Image Analyses

The overall MANCOVA, Hotelling's T, for all body-related measures across religious groups was significant, $F(2, 150) = 1.94$, $p < .05$. As shown in Table 5, 8 of the 10 body-related measures were found to differ significantly between groups using the BIDR IM as a covariate. LDS females endorsed greater investment in appearance, greater beliefs that positive feelings, self-worth, and interpersonal and work successes are dependent on appearance, more positive feelings toward their bodies, and more satisfaction with their bodies and body shape than non-LDS females. Non-LDS females endorsed greater preoccupation with being overweight and more negative feelings about the body than LDS females. Means and standard deviations are provided in Table 5.

Location Analyses

Regarding urges to participate in substance use and eating behaviors in response to negative emotion, there were no differences between LDS females residing inside Utah and LDS females residing outside Utah.

The overall MANOVA, Hotelling's T, for all body-related measures across location (inside Utah and out-

Table 4
Consumption Analyses

Scale	Mean (SD)	*F*	*df*	*p*
EESDEC				
LDS	36.41 (11.83)	0.31	(2, 150)	.736
Non-LDS	36.67 (12.20)			
EESINC				
LDS	59.60 (17.55)	1.07	(2, 150)	.346
Non-LDS	62.83 (19.36)			
EESRDEC				
LDS	60.64 (19.79)	12.92	(2, 150)	.000
Non-LDS	47.27 (23.23)			
EESRINC				
LDS	69.47 (21.07)	2.99	(2, 150)	.053
Non-LDS	73.48 (20.51)			
DEBQ				
LDS	17.97 (4.97)	0.80	(2, 150)	.452
Non-LDS	18.00 (6.00)			
DEBQR				
LDS	9.90 (5.24)	24.02	(2, 150)	.000
Non-LDS	14.29 (7.79)			

Note. EESDEC = The Emotional Eating Scale-Decreased Subscale; EESINC = The Emotional Eating Scale-Increased Subscale; EESRDEC = The Emotional Eating Scale-Revised for Substance Use-Decreased Subscale; EESRINC = The Emotional Eating Scale-Revised for Substance Use-Increased Subscale; DEBQ = Dutch Eating Behaviors Questionnaire; DEBQR = Dutch Eating Behaviors Questionnaire-Revised for Substance Use.

Table 5

Body Image Analyses

Scale	Mean (SD)	*F*	*df*	*p*
OVERALL				
LDS		1.94	(2, 150)	.044
Non-LDS				
ABS				
LDS	23.89 (5.39)	2.47	(2, 150)	.088
Non-LDS	24.90 (5.20)			
BSQ				
LDS	96.73 (37.72)	10.44	(2, 150)	.000
Non-LDS	106.40 (44.13)			
BAAS				
LDS	50.09 (17.30)	4.76	(2, 150)	.010
Non-LDS	49.10 (18.20)			
APPEVF				
LDS	3.12 (.84)	3.85	(2, 150)	.024
Non-LDS	2.94 (.95)			
APPORF				
LDS	3.58 (.60)	3.68	(2, 150)	.027
Non-LDS	3.52 (.70)			
BASS				
LDS	3.19 (.72)	6.12	(2, 150)	.003
Non-LDS	3.01 (.77)			
OWPR				
LDS	2.88 (1.13)	4.48	(2, 150)	.013
Non-LDS	3.15 (1.14)			
WTCLASS				
LDS	3.30 (.66)	2.52	(2, 150)	.084
Non-LDS	3.49 (.83)			
BARSPOS				
LDS	49.47 (12.73)	12.78	(2, 150)	.000
Non-LDS	42.63 (12.39)			
BARSNEG				
LDS	25.92 (11.09)	8.43	(2, 150)	.000
Non-LDS	32.08 (15.62)			

Note. ABS = The Attention to Body Shape Scale; BSQ = The Body Shape Questionnaire; BAAS = The Beliefs About Appearance Scale; APPEVF = The Appearance Evaluation Scale; APPORF = The Appearance Orientation Scale; BASS = The Body Areas Satisfaction Scale; OWPR = The Overweight Preoccupation Scale; WTCLASS = The Self-Classified Weight Scale; BARSPOS = The Body Appreciation Respect Scale-Positive Feelings Subscale; BARSNEG = The Body Appreciation Respect Scale-Negative Feelings Subscale.

side Utah) for the LDS sample was significant, $F(1, 103) = 3.65$, $p < .01$. As shown in Table 6, 2 of the 10 body-related measures were found to be significant. LDS females residing inside Utah report greater concern with body shape and greater preoccupation with becoming overweight than LDS females residing outside Utah. Means and standard deviations are provided in Table 6.

DISCUSSION

To expand upon previous work suggesting cultural influences on eating and substance use behaviors, LDS females and non-LDS females were compared regarding urges to participate in eating and substance use behaviors in response to negative emotion. Non-LDS females were found to be more likely to experience increased urges to use substances when experiencing negative emotion than LDS females. These findings are consistent with previous research suggesting that alcohol and drug use is influenced by cultural factors (Charles & Britto, 2001; Gonet, 1994; Marsh & Dale, 2005; Mateos, Paramo, Carrera, & Rodriguez-Lopez, 2002; Walsh, 1992; Wray & Young, 1992), and more specifically, substance use is influenced by religion (Bazargan, Sherkat, & Bazargan, 2004; Benson, 1983; Charles & Britto, 2001; Meteos et al., 2002; Simons, Simons, & Conger, 2004; Walsh, 1992). Results are also consistent with previous findings suggesting that the LDS population is influenced by LDS doctrinal directives regarding the avoidance of substances (Hawks & Bahr, 1999; Nelson, 2003; U.S. Census Bureau, 2007) when compared to a non-LDS population. Contrary to initial hypotheses, significant differences between LDS females' and non-LDS females' attitudes regarding eating behaviors in response to negative emotion were not found; rather, LDS and non-LDS females did not report significant differences in urges to eat in response to negative emotion.

These findings are inconsistent with a hypothesis offered by Merrill and Hilliam (2006) to account for LDS adults having a higher mean weight than non-LDS adults in Utah; that is, that food is being used as a substitute for LDS discouraged behaviors such as use of tobacco, alcohol, coffee or tea in the LDS population. It may be that other factors such as a greater number of children among LDS families account for higher weights in LDS adults, as number of children has been associated with higher weight in persons across populations (Brown, Kaye, & Folsom, 1992; Heliovaara & Aromaa, 1981; Pyke, 1956). However, it should be noted that the current study included college students, primarily a younger population than the general adult population. Additionally, the current study included participants in Washington, Idaho, and Utah, and thus findings may be different if studied only within Utah. However, it may instead be the case, as Merrill and Hilliam (2006) suggest, that the acceptance of overweight individuals is more common among the LDS religion. If this second hypothesis is accurate, it may be that eating when experiencing negative emotion is more acceptable in the LDS population, and thus the LDS population may be less aware than the non-LDS population that they are experiencing an increased urge to eat. Consequently, if this is the case, the LDS population may have a decreased ability to self-report increased (or decreased) desire to eat in response to negative emotion, which may have played a role in results of the current study.

If findings accurately reflect that LDS females do not experience a different degree of increased or decreased urges to participate in eating behaviors in response to negative emotion when compared to non-LDS females, and non-LDS females experience increased urges to participate in substance use in response to negative emotion when compared to LDS females, it is of question how LDS females respond to negative emotion, assuming that individuals experience negative emotion and respond in some way. Future research could examine how the LDS population responds to negative emotion and possibly relate findings to previous research suggesting that the LDS population has lower levels of substance use (Hawks & Bahr, 1999; Nelson, 2003; U.S. Census Bureau, 2007). Better understanding of how LDS populations resist substance use in the face of negative emotion could be of use in the prevention of substance use.

Regarding body weight and shape, as hypothesized, LDS females endorsed greater investment in appearance, more beliefs that positive feelings, self-worth, and interpersonal and work successes are dependent on appearance, more positive feelings toward their bodies, and less negative feelings toward their bodies than non-LDS females. Non-LDS females endorsed less satisfaction with their bodies and body shape, greater preoccupation with being overweight, and greater attention

Table 6
Body Image Analyses: Location (LDS Sample Only)

Scale	Mean (SD)	*F*	*df*	*p*
OVERALL				
Inside UT		3.65	(1, 103)	.000
Outside UT				
ABS				
Inside UT	24.40 (5.36)	1.40	(1, 103)	.240
Outside UT	23.14 (5.41)			
BSQ				
Inside UT	103.42 (37.12)	4.94	(1, 103)	.028
Outside UT	87.09 (36.88)			
BAAS				
Inside UT	49.45(17.01)	0.20	(1, 103)	.654
Outside UT	51.00 (17.88)			
APPEVF				
Inside UT	3.13 (.87)	0.00	(1, 103)	.974
Outside UT	3.12 (.80)			
APPORF				
Inside UT	3.64 (.63)	1.14	(1, 103)	.288
Outside UT	3.51 (.57)			
BASS				
Inside UT	3.11 (.70)	1.81	(1, 103)	.182
Outside UT	3.31 (.75)			
OWPR				
Inside UT	3.09 (1.12)	5.87	(1, 103)	.017
Outside UT	2.56 (1.07)			
WTCLASS				
Inside UT	3.38 (.71)	2.50	(1, 103)	.117
Outside UT	3.17 (.57)			
BARSPOS				
Inside UT	47.89 (12.71)	2.36	(1, 103)	.127
Outside UT	51.74 (12.55)			
BARSNEG				
Inside UT	26.45 (10.79)	0.34	(1, 103)	.561
Outside UT	25.16 (11.60)			

Note. ABS = The Attention to Body Shape Scale; BSQ = The Body Shape Questionnaire; BAAS = The Beliefs About Appearance Scale; APPEVF = The Appearance Evaluation Scale; APPORF = The Appearance Orientation Scale; BASS = The Body Areas Satisfaction Scale; OWPR = The Overweight Preoccupation Scale; WTCLASS = The Self-Classified Weight Scale; BARSPOS = The Body Appreciation Respect Scale-Positive Feelings Subscale; BARSNEG = The Body Appreciation Respect Scale-Negative Feelings Subscale.

to body shape than LDS females. Thus, results support consistent findings regarding more general studies of the influence of culture on attitudes regarding body weight, shape, and eating behaviors (Apter & Shah, 1994; Powell & Kahn, 1995; Raphael & Lacey, 1994; Rucker & Cash, 1992; Ruggiero, 2003; Sim & Zeman, 2005; Stice, 1994; Stice, 2001; Waller & Matoba, 1999; Wardle & Watters, 2004). However, this is the first study that has found differences between LDS and non-LDS females with respect to body image, although other studies have also shown LDS men to have more positive body images than non-LDS men (Carroll & Spangler, 2001). More positive body images among LDS persons has important implications given the consistent and strong link between negative body image and eating disorders. One possible explanation for these findings is that LDS doctrine encourages appreciation of the body (Pinborough, 2003), and thus LDS persons view their bodies with more appreciation than non-LDS persons.

Results of analyses for body weight and shape measures comparing LDS females residing inside Utah and LDS females residing outside Utah found that LDS females residing inside Utah report greater concern with body shape and greater preoccupation with becoming overweight when compared to LDS females residing outside Utah. Although a previous study found that LDS females residing inside Utah endorse more beliefs that positive feelings, self-worth, and interpersonal and work successes are dependent on appearance than LDS females residing outside Utah and that LDS females inside Utah invest significantly more time and effort into their appearance than LDS females residing outside Utah (Carroll & Spangler, 2001), no differences in this regard were found in the current study.

Results suggest that LDS females residing inside Utah have less positive body image than LDS females residing outside Utah, and LDS females residing outside Utah may be impacted more by the pro-body LDS doctrine than LDS females residing inside Utah. Two studies, then, have now found that LDS females residing inside Utah are less satisfied with their bodies than LDS females residing outside of Utah. In the current study, this result was found even though the majority of the Inside Utah group was attending BYU-Utah and the majority of the Outside Utah group was attending BYU-Idaho. These findings imply that there is something beyond the BYU campus atmosphere pressures to marry and mate that may be contributing to less positive body image for females residing inside Utah. Future research could continue investigating what is contributing to less positive body image for LDS females residing inside Utah when compared to LDS females residing outside Utah.

An interesting finding is that significant differences regarding body image between religious groups and location (inside and outside Utah) are independent of body weight, as groups do not differ significantly on their perception of their own weight. Thus, future research should be aimed toward differences between populations in terms of body shape rather than weight. It would be useful to determine why LDS females endorse more positive views regarding body shape than non-LDS females, and LDS females residing outside Utah endorse more positive views regarding body shape than LDS females residing inside Utah, but there are no differences in weight perception between populations. Understanding how LDS females are able to maintain a more positive view of body shape than their non-LDS counterparts, as well as how LDS females residing outside Utah are able to maintain a more positive view of body shape when compared to LDS females residing inside Utah, could also aid in the prevention of body image problems and eating disorders. These exploratory analyses help answer the call for more research examining the potential effect of religion on body image and eating behaviors (Markey, 2004; Obesity, Fitness & Wellness Week, 2004; Polivy & Herman, 2004), but more research is needed to more fully understand the effect of religion on body image and eating behaviors, particularly given significant findings regarding body image differences among LDS and non-LDS females that were not found previously (Carroll & Spangler, 2001).

CONCLUSIONS

The main implications of the current study are that non-LDS females are more likely to experience increased urges to participate in substance use in response to negative emotion when compared to LDS females, consistent with LDS doctrine encouraging the avoidance of substances. Furthermore, LDS females do not appear to substitute other unhealthful behaviors such as overeating or under eating in place of substance use. These findings may have useful implications for the prevention

of substance problems, as using substances in response to negative emotion is a risk factor for substance abuse. Additionally, LDS females have more positive body images than non-LDS females generally, although LDS females in Utah have less positive body images than LDS females residing in other states. These body image differences are of interest since body image distress is rampant and is a significant risk factor for the development of eating disorders. Future directions should focus on what can be learned from LDS culture that can aid in the mitigation of body image distress.

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Footnote

[1]Intrinsic and extrinsic religiosity scores were examined using The 'Age Universal' I-E Scale-12 (Maltby, 1999) in regression analyses and *t*-tests to determine if group membership (LDS and non-LDS) is the most accurate representation of religion or if intrinsic versus extrinsic scores provided different information. Analyses were also conducted to determine if the BYU Honor Code (as measured by extrinsic religiosity) was influencing responding relating to urges to increase and decrease eating behaviors and substance use in response to negative emotion. Concerns were that participants may not be honest in their responding to questions regarding substance use due to the Word of Wisdom and The Honor Code that all BYU students must commit to before beginning classes at both BYU institutions, agreeing to refrain from any alcohol, drug, cigarette, and coffee/tea use. Given that findings using the I-E Scale produced a similar pattern of results as categorical group membership and that LDS females were found to be more intrinsically and extrinsically religious than non-LDS females, religious group membership (LDS and non-LDS) appeared to be the best differentiation of religious groups in this study, and only categorical analyses were reported. Furthermore, the BYU Honor Code did not appear to significantly affect responding, as the LDS group was found to be more intrinsically and extrinsically religious than the non-LDS group.

A Brief LDS Faith-Based Dialogue for the Treatment of Conditional Self-Worth

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This paper presents a sample dialogue which has been used effectively in psychotherapy with Latter-day Saint (LDS) clients who suffer from the belief that their worth as individuals is based on their performance (i.e., "conditional self-worth"). The dialogue makes use of LDS theology and strategic questioning in order to dispute and ultimately replace the client's paradigm of conditional self-worth with beliefs in unconditional human worth. The dialogue is considered as one component of a larger religio-psychotherapeutic approach which has as its goal increasing flexible, rational thinking, including the belief that all human beings have unconditional worth.

In a recent *AMCAP Journal* article (Rector, 2006), I echoed the well-worn assertion of numerous mental health experts (Ellis, 1985, 1991; Hartman, 1967; Hauck, 1991; Miller, 1986; Rogers, 1957, 1961; Satir, 1978; Tillich, 1953; Walker and others, 1992; Woods, 1993; Yalom, 1990) that the belief in conditional human worth predisposes individuals towards neuroses, whereas the more enlightened life-philosophy of unconditional human worth tends to diminish neuroses. More specifically, I underscored teachings unique to both the Church of Jesus Christ of Latter-day Saints (LDS) in particular and Christianity in general, which assert in a powerful way the unconditional worth of human beings. Such teachings can assist mental health professionals in helping their LDS clients develop more unconditional acceptance in their views towards themselves and their fellow human beings (Rector, 2006). Numerous other LDS mental health professionals and behavioral scientists have written about the problem of creating and maintaining a healthy sense of self-worth and have asserted the unconditional worth of human beings (Ellsworth, 1990; Kapp, 1992; MacArthur, 1981; Strong, 1980; Wagstaff, 1981). However, this paper goes much further by not only asserting a definition of unconditional human worth, but providing an example of a dialogue between therapist and client in which such teachings are utilized to encourage the client to adopt a more unconditional paradigm of human worth.

In my experience this dialogue seems to be most useful to clients if it is used within the larger therapeutic context of helping clients understand how their beliefs can impact their emotional experiences (for example, in Rational Emotive Behavior Therapy or Cognitive Therapy). Of course, it is important to use such a dialogue with tact and timing. While I believe that many members of the Church—both client and non-client—could benefit from such a conversation, I have often waited through numerous sessions to broach this particular conversation until the right segue presented itself.[1] Such an "opening" typically does not occur until (1) rapport has been established, (2) the client has been given enough time and space to repeatedly reveal the conditional nature of his or her acceptance of self and/or others, and (3) the topic being discussed (e.g., self-loathing due to perceived failures, perceptions of

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abandonment or rejection by God, disapproval from others indicating one's basic unacceptability as a person) lends itself well to beginning such a dialogue.

T: This leads us to something I'd like to explore with you. Can I ask you an abstract question?

C: *Sure.*

T: Let me encourage you to sit back, and put yourself into your typical frame of mind as you're walking around on campus, seeing others, interacting with others, and just going about your day. (Pause) The worth of a human being—what would you say that is based on?

After pondering for a few moments, most clients typically give one of three responses. (1) A few will say, "I don't know." I actually consider this to be a fairly enlightened response, as the client has not simply interjected conventional wisdom. I typically follow up with a question like this:

T: Well, if you were to say something specific—even if you're not sure—what would it be? What is your knee-jerk response to my initial question?

At this point, such clients typically proceed to offer a conditional definition (e.g., personal righteousness, accomplishments, etc.). (2) Most clients will quickly give a conditional definition of human worth, or (3) they will give a "Sunday School answer," such as being a child of God, etc., which, while doctrinally correct, tends to come across as superficial and parroted, and it belies much of the larger belief system behind the client's neurosis. If the client gives a Sunday School answer, I typically respond with something like this:

T: Yes, we Latter-day Saints believe that all human beings are children of God and that the worth of a soul is great in the sight of God, but I have a suspicion that that's not what actually informs or guides your thinking and feeling about yourself and others on a daily basis. I'm interested not so much in "the right answer" at this point as I am in what actually goes through your mind and guides your daily actions and feelings.

At this point, the client is typically willing to explore in a deeper way what he or she believes underneath these more superficial ideals; the client usually offers a conditional response, and a conversation like the following takes place:

C: *I guess I'd have to say that the worth of human beings is based on how much good they do in the world, or on how much of a positive difference they make in the lives of others.*

T: Those are very worthwhile sentiments and desirable goals. Can we try a little thought experiment?

C: *Sure.*

T: Who for you would represent the epitome, or the prime example, of "making a positive difference in the lives of others?" Choose someone who is fully human—not half-God and half-human (i.e., Jesus)—because none of us is like that.

C: *All right, let's see—I'd have to say my father.*

T: Really—

C: *Yeah.*

T: Tell me about him.

C: *My dad always seems to be doing things for other people. He's really respected at work and in the neighborhood because, you know, he's a doctor, so people admire him and seem to come to him for advice, or if they have a question about their health, or whatever. He also participates in that Doctors Without Borders charity every couple of years. This last time he went down to El Salvador and worked with the people for almost a month. He's just a really good guy who genuinely cares about people—goes out of his way for people, and people love him for it.*

T: He sounds like a really good person.

C: *He is.*

T: Okay (I raise my left hand, palm turned upwards, flat). On this hand, let's put a miniature version of your father; he's G.I. Joe sized. Can you see him?

C: (smiles) *Yeah.*

T: Okay, now on this hand (I raise my right hand like I did my left to form a sort of balancing scale), let's put another man about the same age. And let's imagine that just by looking at this man, you know some things about him. You know that this man has lived what would be considered to be a very selfish life. He hasn't ever really manifested much concern for others. He's manipulated business deals to gain at the expense of others; he's stolen from employers many times. He left his wife and kids for another woman and didn't pay any child support after the divorce, and now he cheats on this other woman with younger women. He has used a lot of alcohol and drugs and seems to live a life where other people don't matter much to him (pause). Now which of these two has more ultimate worth as a human being?

At this point, clients typically say—within a matter of seconds—one of two things: Either they have the same worth, or one has more ultimate worth.

C: *Well, they have the same worth.*

I typically respond with something like this:

T: Wow, you just undid your whole philosophy of human worth in three seconds! Why did you do that? Are you telling me what you think I want to hear, or do you really believe what you said?

The client typically makes this kind of reply:

C: *Well, I know it's true, but I just don't feel it very strongly or put it into practice very often.*

Then we go on to talk about "why not?"—which eventually comes around to the fact that the client actually holds some deeper beliefs about himself or herself and others which are more conditional in terms of perceived worth.

Some clients give a more revealing response to the question over "which of these two has more ultimate worth":

C: *My dad does.*

At that point, I briefly summarize what the client is saying:

T: In other words, you are saying that the worth of a human being depends on meeting certain external conditions: specifically, "making a positive difference in the lives of others." We call that "conditional human worth." What I want to suggest to you is that that belief is quite possibly a significant factor in your problems (i.e., depression, anxiety, eating disorder, etc.).

At this point, it's typically appropriate to talk about how belief in conditional human worth is a trap.

C: *What do you mean?*

T: Believing in the conditional worth of human beings, or in your own conditional worth, is like walking on a high-wire over a big vat of neuroses: So long as you are living up to your own cherished conditions of worth, you'll believe that you're on the wire and will feel okay with yourself. But who can do that all the time? Remember our past conversations about how all human beings are—by nature—flawed, imperfect, and fallible? What does that suggest?

C: *That sooner or later, I'm not going to be able to pull it off; that I'm not always going to be able to perform just as I'd like to on some important thing. Then it'll be like I've fallen off the wire and landed in the "vat of neuroses," as you put it, because I believe that I'm worth less as a person than I was before I fell off the wire.*

T: Yes, and as a result your life will feel something like a roller-coaster ride where sometimes you'll feel that you have worth as a person (up), and sometimes you'll feel like you have less worth as a person (down), depending on how you judge your performance.

C: *That's exactly what it's like.*

T: And if you believe that you have less worth as a person every time you perceive that you've failed or fallen short on something that matters to you, how are you likely to feel?

C: *Depressed or panicky.*

T: Which is just how you've felt many times before, and these feelings are the very reasons you're coming in here to see me.

C: *Right. So what can I do about that?*

T: That's an excellent question. How would you answer that?

C: *I don't know. I guess I'd have to come to believe in something new about myself that wouldn't change all the time depending on my performance.*

T: So what could that be?

C: *I don't have the foggiest idea* (laughter).

T: I believe the enlightened answer to your question is to come to believe in what we call (naturally) "unconditional human worth." The best definition of unconditional human worth I have ever heard was given by Elder Monson on a number of occasions, but most recently at the Spring of '06 General Conference Priesthood Session, when he said, "The worth of a human being is his or her capacity to become as God" (Monson, 1997; 2006). Now think about that for a minute, because the implications are profound (pause). Here's a very important question: What do you have to be in order to have "the capacity to become as God?"

At this point, many clients will very quickly revert to their conditional paradigm:

C: *Well, you have to be righteous or obedient to the commandments.*

T: Now be careful. Do you see how quickly you went back to the conditional human worth paradigm?

C: (Looks puzzled)

T: Righteousness and obedience are conditions that fluctuate, aren't they. But Elder Monson said human worth was based on something different: "the capacity to become as God." So let me ask you again: What do you have to be in order to have the capacity to become as God?

At this point, many clients begin to understand:

C: *I guess you just have to be a human being.*

T: Exactly! And what are you?

C: *A human being.*

If the client doesn't make this insight on his or her own, I go ahead and say something like the following. Even if the client does come to this insight without prompting, I may say this in order to help clarify and deepen this very important point.

T: All that's required to have the capacity to become as God, thus having unconditional human worth, is to be a member of the human race. Period. No other species that we're aware of has this particular innate capacity—to ultimately become as God—but human beings have it simply by virtue of being members of the species. I consider this insight to be one of the best-kept secrets in the Church, though it shouldn't be. After all—Jesus taught parables illustrating this. Why would the shepherd (representing God) leave 99 found sheep (representing righteous individuals) to go after a lost sheep (representing a sinner—perhaps you or I) if a lost sheep had less inherent worth than a found sheep? (Luke 15:4) It wouldn't make any sense for him to do that, because the risk of losing more sheep would be too great; but he goes after the lost sheep, which suggests to our minds that whether or not we're "lost" has nothing to do with our inherent worth to our Creator—that our true worth comes from another source. The story is the same with the woman who searches through the night for her lost coin (Luke 15:8) and for the Prodigal's father, who runs out to embrace his returning son—no questions asked (Luke 15:20). Now in each case the story has a happy ending because the figure representing God finds the one lost—one of us. But that's not the central point here. The point is that God comes after us and desires us—wandering sheep though we may be—because we have intrinsic, inherent worth as individuals based on our innate capacity to ultimately become as our Creator. What a powerful, beautiful idea, right?

This takes us back to the little thought experiment we did earlier today when I asked you to decide which person had more ultimate worth—your dad or the other guy, and you said your dad did. Well, which of those two do we admire more?

C: *My dad.*

T: Right. Which of those two do we want our sons and daughters to be like?

C: *My dad.*

T: Right. Which of those two is going to be better off in life and receive more blessings?

C: *My dad.*

T: Right. But which of those two has more ultimate worth as a human being?

C: *They're the same on that. I've never looked at it that way before.*

T: I think that's because we've long perceived that unless we did certain things, we wouldn't have much worth, either to God or to our parents, though God has never said that, and most parents have never said it just like that. Also, without realizing it, I think we as a people have often reinforced notions of conditional human worth to one another in order to motivate each other to be righteous. I think we've believed deep down that if we didn't dangle our worth over the fire that we wouldn't have enough motivation or desire to make sacrifices and do the right things. But think about it—if drugs were legalized tomorrow, would you run right out and try heroin or cocaine for the first time?

C: *No way.*

T: And why not?

C: *Because that would be stupid; because I know that heroin and cocaine aren't good for me and would just cause more problems.*

T: Exactly. By the same logic, do you think you might decide to become a skid-row bum or be unfaithful to your wife if you came to believe in your own unconditional human worth?

C: *No, because I still want to be a good person and have good experiences in life. And just because I know that my worth can never change and that I'll have the same worth to God no matter what I do, that doesn't make me want to suddenly become some kind of a slouch.*

T: Why not?

C: *Well, because that's not who I want to be or how I want to live. I still value the same things.*

T: So in other words, you still have a strong preference to be an upright, upstanding person for a variety of reasons, even if you know that whether or not you behave like that kind of a person does not change your inherent worth in God's eyes. (Pause) So I want you to now sit back again and pause for a minute and pay attention to your feelings as you ask yourself, "How would my life be different if I came to believe deeply and profoundly in what Elder Monson said: if I came to believe deeply in not just my own, but in everyone else's unconditional human worth? How might that awareness impact me on an emotional level?"

C: (Pause) *Well, I know I would be more peaceful about life. I mean, I think I would be more relaxed and calm realizing that my worth as a person is stable and intact no matter what; so I probably wouldn't beat myself up so much. Also I think the good I did would be motivated more by my desire to experience good things and by gratitude to God rather than by a need to create or maintain some fleeting sense of self-worth. I would just become a more peaceful person.*

Of course this dialogue has the potential to go in a variety of directions according to the specific nature of the client's problems, his or her intellectual and doctrinal sophistication, and so forth. It's important for the therapist to avoid being dogmatic or rigid about the client adopting an unconditional view of human worth. My experience has shown that client resistance can eventually be overcome with a gentle, repeated emphasis on the

"fruits" (Matt. 7:16), the "what-you-get" from a paradigm of unconditional human worth versus a conditional view.

In using this intervention, I have found that clients typically feel an initial sense of relief, clarity, even mild euphoria after gaining these insights, and as a result they leave my office feeling quite hopeful. However, in almost all instances they will return to therapy in the near future suffering from the same neurotic symptoms they had before this conversation. Giving up old ways of viewing ourselves and the world is indeed difficult. Despite conscious realization that certain of our beliefs are dysfunctional, we often cling to them because they are part of a deeper emotional sense-of-self framework, and they provide a predictable order to our experience. These issues all need to be acknowledged and worked through.

As with most new beliefs, the perspective of unconditional human worth takes considerable time to become internalized and deepened to the extent that this new perspective helps create healthy emotion, such as disappointment, in situations which previously led to dysfunctional emotion, such as self- or other-hatred. Clients will need to have a variety of real-life experiences in which they may try out and assess these new ideas to see if the "fruits" of such a perspective are in fact in line with their larger life goals. They will also need the therapist to remind, encourage, and clarify as they continue to work hard at discarding old conditional notions of human worth and adopting a new, more enlightened paradigm of themselves and others. But when clients finally achieve this lasting paradigm shift, they find themselves in the enviable position of living more peaceful, graceful lives despite the adversity they face.

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Footnote

[1] I have also used this intervention quite early on—even during the first few sessions—with some clients. This depends upon a number of factors, such as the client's apparent ego strength, the quickness of rapport established, and how tightly linked the presenting problem is with perceptions of conditional self-worth.

The Midlife Client

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This case study explored the midlife physical, emotional, and role changes of a small sample of women of the Church of Jesus Christ of Latter-day Saints (LDS) to determine how they cope with midlife change, to examine their aging experience within the LDS Church community, and to discover how the LDS faith and church community helped them through the challenges of midlife. According to a qualitative design, the researcher implemented in-depth interviews with 10 LDS women from three cohorts: ages 35-44, 45-54, and 55-65. Three theoretical perspectives were used to frame the study: feminist, social constructionist, and narrative. A qualitative matrix was developed to guide the analysis and reporting process. The findings suggested that the younger cohorts contended with physical and emotional issues such as hot flashes and moodiness. Role change, such as the one that occurs when the children leave home, did not appear to affect the women. They viewed midlife as part of the continuum of life, and all three cohorts of women reported personal growth in their confidence and assertiveness. The LDS Church community was a resource, enabling all of the women to feel accepted and useful for their wisdom and experience. With the increased life expectancy of women and the large number of "baby boomer" women now entering midlife, the issues surrounding aging may be reflected in problems presented by a practitioner's clientele. To meet the needs of an aging female clientele, practitioners are encouraged to understand the physical, emotional, and role changes that occur at midlife and to view presenting problems within the framework of the midlife transition.

INTRODUCTION

The large population of the "baby boomer" generation has and will continue to have a major impact on society (Walker, 2002). As this population continues to age, church congregations are expected to swell (Knapp & Pruett, 2005). The Church of Jesus Christ of Latter-day Saints (LDS) is no exception. Currently, midlife women make up a large proportion of the church membership. According to J. Stager (personal communication, August 9, 2004), who is a statistician for the LDS Church, the global membership of the church in 2004 stood at 12,868,606. The total number of women was 5,687,644, with approximately 2,870,000 women between ages 35 and 65, comprising 22% of the total membership. The projected number of midlife women over the next 10 years is expected to reach 3,642,468, a 27% increase over the present number. It must be noted that this projection does not include converts to the church, the addition of whom could substantially affect this number. Hence it can be projected that midlife women will continue to comprise a significant proportion of the LDS Church membership.

MIDLIFE CHALLENGES, THEORIES, AND TASKS

Midlife transition is a multifaceted stage in a woman's development and may present many challenges (Levinson, 1996). At midlife a woman's body begins to change (Cobb, 1993). Menopause marks the end of a woman's reproductive life (Hunter, Sundel, & Sundel,

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2002), and it is often a critical time for women because of the accompanying physical and emotional effects. Change also occurs in role involvement (Klohnen, Vandewater, & Young, 1996) as children become independent, elderly parents become dependent, and in-laws and grandchildren join the family constellation. Midlife women may also be at risk for life events such as marital separation and divorce (Glazer et al., 2002), health issues (Murphy, 2003), and economic marginalization (Holstein, 2001).

A review of the literature uncovered conflicting theories regarding midlife change. The idea of a midlife crisis has been proposed by various researchers (Jacques, 1965, 1993; Jung & Storr, 1983; Levinson, 1996). Jacques (1965) originally coined the term midlife crisis as a time when individuals begin to realize their mortality. Although researchers have suggested that midlife crisis is common among adults (Jacques, 1965; Jung & Storr, 1983; Levinson, 1978), Shek (1996) concluded that identifying the midlife crisis as a "normative developmental" experience could not be supported. Germain (1994) also rejected the proposition of a midlife crisis. Empirical studies have disagreed in defining the female midlife experience; however, there is a consensus that the midlife transition can be a challenging period and that women must make certain adjustments and adaptations to successfully navigate it. According to Erikson (1982), the main requirement of the midlife transition is to develop generativity, which is the ability to care for other people and to provide support to the next generation. Contemporary researchers have suggested that adaptations include the integration of adolescent images with those of a middle-aged woman (Apter, 1996); the achievement of satisfaction by aligning beliefs, life circumstances, and values (Howell, 2001); the process of progressing from denial to acceptance of aging (Gillet, 1996); and the experience of mourning the loss of the former self (McQuaide, 1998a). Others who have attempted to describe the midlife experiences of women have perceived it as a midlife review (Stewart & Vandewater, 1999), a time of introspection (Levinson, 1996), a mourning of the loss of fertility (Mitchell & Helson, 1990), and a time to cope with the empty nest syndrome, a term commonly used to identify the psychological or emotional condition that may affect women when their children leave home (Lippert, 1997).

LACK OF QUALITY RESEARCH

Midlife women are a richly diverse but poorly understood group. Regardless of the vast number of aging women and the concomitant challenges of midlife, the prevailing literature indicates a lack of quality studies (Quinn & Walsh, 1995). Lippert (1997) was concerned that the available literature related to midlife experiences is fragmented, lacks agreement, and contains "myths . . . that have little scientific basis" (p. 16). Calhoun (2001) agreed that there are "shortcomings in the existing canon" (p. 55). Banister (1999) noted the lag in research focusing on midlife women. Subsequently, there remains a lack of reliable information. Until recently, incorrect perspectives of the midlife experience have been common (Banister, 1999). New evidence has determined that the negative view of midlife is changing, with the emphasis now on psychological well-being and the positive characteristics of growth development, such as life purpose and self-acceptance (McQuaide, 1998a; Mitchell & Helson, 1990).

PURPOSE OF THE STUDY

To date, available information about LDS experiences in the midlife transition is sparse. This research has given voice to the personal and individual experiences of the LDS respondents as they have developed personal understanding of and adjustment to the midlife transition. The main purpose of this study was to determine how women of the LDS faith cope with physical, emotional, and role changes in the midlife transition. Because LDS women have defined roles in marriage and motherhood that are traditional in the sense that the "family is central to God's plan" (Hinckley, 1995), particular attention was given to role change. A second purpose was to understand the female aging experience within the LDS Church community and to identify how the LDS faith and church community assist these women through midlife challenges.

CONCEPTUAL FRAMEWORK OF THE STUDY

Qualitative interviews were conducted with women of the LDS faith within the boundaries of an LDS Stake (diocese) in Kitchener, Ontario, Canada. The researcher chose a case study approach because it is an accepted

means of exploration when there is little preknowledge of the phenomenon, valid for developing in-depth understanding of complex and sensitive issues (Tellis, 1997; Yin, 2003). Three theoretical perspectives were selected to direct the study: feminist, social constructionist, and narrative.

The feminist aim of the study was to "lift the voices" of aging women (Creswell, 1998, p. 78) and to ensure a reflective, reflexive approach to examining the data. Methodologically, feminist research differs from traditional research in that it removes the power imbalance between the researcher and the subject, begins with the standpoints and experiences of women, and involves participants at all levels of the research process (Brayton, 1997).

The social constructionist perspective suggests that interpersonal reality is constructed through social interaction (Ray, 2000). Personal stories become "shaped by the cultural environment and are a social product" (Ray, p. 2). Thus the social constructionist perspective provided a framework for understanding the development of midlife narratives.

Narrative inquiry views people as "embodiments of lived stories," shaped by social and cultural narratives (Clandinin & Connelly, 2000, p. 43). McQuaide (1998b) argued that there are alternative midlife stories to uncover. This study provided the opportunity for LDS women to relate their personal stories of midlife aging.

METHOD

Participants

A convenient and purposeful sampling frame consisted of women who met the criteria for inclusion in the study as (a) members of the LDS faith; (b) women who held volunteer positions within the church organization and were active in the LDS community; and (c) women who were in midlife transition, which was defined by age or physical, emotional, and role changes. Various attempts have been made to define middle age. For the purposes of this study, middle age was defined as comprising ages 35 to 65; thus the LDS respondents sampled for this study of midlife transition were within that age range. To interpret the information in meaningful ways, the interviewees were classified by age cohort. Four women ages 35 to 44 were classified as being at the beginning, or the perimenopausal, stage of middle age (National Women's Health Information Center, 2002). Three women ages 45 to 54 were in the middle, or menopausal, stage (Perls & Fretts, 2001). Three women ages 55 to 65 were in the final, or postmenopausal, stage (Cobb, 1993). Of the interviewees, 6 were married, 1 was single, 2 were separated, and 1 was divorced. All were Caucasian and of various ethnic backgrounds (i.e., German, Scottish, American, and Canadian). The greatest number (7) were adult converts to the LDS religion who had been fully involved and active members for a time span ranging from 5 to more than 20 years. The others had been born into LDS families and were raised in the LDS faith.

Procedure

Ten face-to-face semistructured interviews were conducted. The study participants completed a demographic questionnaire, signed the consent form, and then chose their pseudonyms. Each interview lasted for approximately 2 hours. A second interview was warranted to explore, reflect, and expand the questions, and to ensure the accuracy of the responses. The interview guide was developed through a pilot study with a different group of LDS women to avoid poor techniques or a weak flow of questions. Open-ended questions enabled entry into and encouragement for the telling of the women's midlife experiences. A laddering technique of questioning provided guidelines for primary data collection and probing techniques (Hoepfl, 1997). Questions were sequenced to begin with the "least invasive and proceed into deeper matter" and to "set the scene, collect contextual information, and assure the respondent" (Hoepfl, 1997, p. 80). Additional questions were laddered up to questions of personal philosophy, which "are the core to [the] respondents' personal identity" (Hoepfl, p. 80). During the laddering process, the researcher could read body language to search for signals indicating the readiness of the respondent to accept even more intrusive questions. Collaborative means were used to remove possible interviewer interrogation pressure or intimidation and thus permit free expression by the interviewee.

A process of collecting, managing, storing, and retrieving the information was implemented to ensure high-quality research (Denzin & Lincoln, 1998). Each interview was recorded, transcribed, and interpreted. Manuscripts were read for coherence and consistency to enhance understanding of the first-person voice and to address specific questions. Words, phrases, sentences, and paragraphs were underlined; coded for

themes, ideas and constructs; and assigned to categories. Chenail's qualitative matrix (Cole, 1994) was used as a conceptual frame to organize the findings, make sense of the data, and ensure the relationship between the data and the literature review. Use of mind-mapping techniques identified connections between ideas and themes. Themes that indicated group consensus were considered primary, and themes that were discussed by three or more of the interviewees or that varied from the primary themes were considered secondary. A peer was enlisted to examine the interviews, assist in developing themes and categories, and unearth potential research bias. The interpretations and the findings were substantiated by the personal narratives of the respondents. The data were organized to convey the richness of the interviewees' midlife transition experiences. In the written text, for example, the responses of the women were presented in a "story-like manner" (Dilollo & Wolter, 2004, p. 5). This triangulation of research strategies supported the research findings.

QUALITY OF THE EVIDENCE

The researcher employed various strategies to establish trustworthiness. Systematic conduct of research, meticulous data recording, and use of a research journal to record personal feelings and interpretations were among these strategies, along with use of investigator skills to "interpret the data in a rigorous manner, rather than reporting selective perceptions" (Bowling, 2002, p. 404). Multiple sources of evidence were employed to ensure construct validity (Yin, 2003). Several analyses were undertaken to confirm the findings and establish the credibility of the data. A qualified external researcher provided an analysis of the data as well as nonbiased feedback. Because the researcher is a member of the LDS faith and is personally involved in the LDS community, it was crucial to the study for her to maintain objectivity and acknowledge the "insider/outsider" conundrum (Rose, 2001). An "insider" might gain more insight by being on an equal footing and sharing a common understanding with the research participants. However, an "insider" might encounter the problem of essentialism, which assumes that all those who are in a particular social category share a common perspective. Consequently, the interviewer and the interviewees may have had too much in common. Thus the researcher was careful to identify and not take for granted easily overlooked behaviors or attitudes that are specific to the LDS Church community or the reasons for them. The reflective nature of the research journal assisted the researcher in keeping the "insider/participant" voice separate from the "outsider/researcher" voice.

THEMATIC ANALYSIS

A range of primary and secondary themes emerged as the LDS interviewees discussed their personal experiences of midlife transition. Physical and emotional changes and personal responsibility for health were dominant themes.

Physical Change

The interviewees discussed physical concerns that are typical of many menopausal women: changes in menstrual cycle, hot flashes, low energy, sleep disturbance, and memory loss (Cobb, 1993). Christine, for example, worried about these physical changes:

> Physical changes . . . I have noticed that my body does not burn fat as quickly. Like, I cannot eat whatever I want anymore. . . . I have noticed changes in my cycle that aren't the same as they were before. . . . Something my body is doing is changing. The weight thing . . . I don't feel as strong either . . . I need to be a little smarter about how much sleep I get because I can't pull off the amount of energy that maybe I could previously. I have some real energy issues. I mostly take iron or I get physically exhausted or fatigued. It affects my mental state. I guess my mental state is something that I have aged in. I sound ridiculous.

There were differences among the women. For example, the women in the younger cohorts were experiencing physical symptoms, but those in the older cohort were less affected by menopause and felt better (Patterson & Lynch, 1988). Mackenzie, who was postmenopausal, commented, "The only thing that I really have is that I don't sleep the whole night. I wake up a few times but then go back to sleep. Other than that, I haven't really had anything."

Emotional Change

Emotional change appeared synonymous with perimenopause (Cobb, 1993) and was a dominant theme among the interviewees. Cathy, the youngest of the

interviewees, reported irritability and mood swings:

> I don't know that I had noticed a lot of changes, but I have noticed a few since I said I would participate in this [study]. I think I am getting a little bit moodier. It was from reading the top of the paper "Midlife Changes," I am thinking that I am not in midlife and I don't have any changes. Nothing has happened yet. Then I realize there have been a few changes. . . . I have noticed a little more irritability.

Once again, there were differences among the women. Those in the younger cohorts struggled with mood change and irritability. In contrast, the older women reported calmness and serenity, and they did not allude to emotional change.

Personal Responsibility for Health

According to Banister (1999), women at midlife begin to "realize they have a responsibility to engage in self-care activity" (p. 10). This concern was evident among the women from all three cohorts. Most of the women had taken their health for granted in the past; however, since reaching the midlife stage, they were more conscious of taking proactive responsibility for their health and well-being. Anne commented, "I know that I need to do something about my health and get into shape and feel good about myself and get rid of all the stress. . . . I can't change the clock. I can control my attitude!" Mackenzie, the oldest of the women, stressed, "You have to start thinking early about it. It is too late to start thinking about it when you are going through it [menopause]."

Personal Growth

Leonard and Burns (2006) emphasized the advantages of aging and suggested that turning points in personal growth increase with age. This was evident among the LDS interviewees, all of whom reported personal growth. They believed that as middle-aged women they had grown in wisdom, confidence, and assertiveness. Cathy appreciated her increased wisdom:

> I feel that I am getting a lot more wisdom. I don't think I am easily offended any more. Where before I could take exception to something and kind of be miffed at that person for a while, then I see that person do an act of service or kindness, and it erases the stupid things that I thought were important, and they are not. This person is good, and they are trying. Whenever I have feelings of being upset or kind of thinking that person is being stupid or whatever, I just think that they have a lot of good qualities and that overbalances the bad things, and I just have to look at that.

In the past, Anne had had low self-esteem. At midlife, she admitted that she has developed more confidence and appreciation of herself:

> I can appreciate what I am good at. I can appreciate the value that I have. I have confidence in many things about myself. The inside is well put together, [and] it says I really don't care what you think of me. I will do it the way I want to do it, and I am going to express my opinions. I can stand up for myself if it is required. I can speak my mind and sort out my feelings and understand what I am thinking and what I am emotionally experiencing.

Women in the three cohorts appreciated midlife growth. The younger women were beginning to note the growth, whereas the women in the older cohort were more assured of their progress. Similar to the findings of Sampselle, Harris, Harlow, and Sowers (2002), the interviewees had an expanded view of their self-worth and "attributed their enhanced development to getting older and gaining maturity" (p. 35).

Midlife as a New Season

Klohnen et al. (1996) concluded that many women adjust successfully to midlife transition. Successful transition was evident among the LDS interviewees, who viewed the transition as a positive stage or season in the continuum of life. Elizabeth viewed her life in stages, and she believed that each stage had benefits:

> There is a time and a season—a time to have children and be a mother of young children, and then there is a time to have them grow up a little bit, but these different times are a benefit for different reasons. So if I have a better understanding, I don't think it has anything to do with aging. I think it has to do with different stages of people in your life. I am basically really enjoying this time in my life.

All of the women valued the midlife stage. They viewed midlife as a new season in their lives presenting new opportunities and benefits.

Freedom from Responsibility

The phase of life when grown children leave home is often referred to as the "empty nest" (Barber, 1989). The younger cohorts looked forward to the time when their children would be grown and leave home. Cathy expressed her regret about missed opportunities for an education and her desire to have a career. She projected into the future, with the prospect of furthering her career: "I am looking forward to my kids growing up and gone. That will be nice!"

Those women whose children had left the nest enjoyed their freedom and appreciated time for themselves. Jean and her husband had enjoyed newfound freedom after the children left home. When their youngest daughter returned home for a while, they found her presence in the home stressful. Jean commented, "Yes, well, she was gone for a year. We were over a year without any kids in the house. We didn't realize how good we had it until she moved back."

In reference to the empty nest syndrome, the younger women looked forward to their children leaving home, and the older women were grateful for the freedom that resulted from having independent children. The concept of children leaving home did not adversely affect women in any of the cohorts. This finding confirmed statements in the research that fewer childrearing responsibilities are "accompanied by little if any feeling of loss" (Sampselle et al., 2002, p. 56) and an appreciation of independence and freedom (McQuaide, 1998b).

LDS Church Community as a Resource

Some theorists have placed a high value on the importance of female relationships (Gilligan, 1996; Mitchell & Helson, 1990; Siebert & Mutran, 1999). Appreciation for female friends, particularly women of the same faith, was reported by women in all three cohorts. HTS is a convert to the LDS Church. Due to her busy work schedule, she has little time to spend with friends. Nevertheless, she has felt assured that her LDS friends were there in time of need:

> I know that I could just call [church friends] and say, "Hi, it is me. I am having a bad day. I need to talk. Do you mind shooting the breeze for a few minutes?" Not everybody would fit that bill because not everybody you could relate to on the same level, but there are a quite a few people I could call and lean on because they know we have all been taught that service and support [are] important. So I know if I needed people, I could call them, and they would be there for me. If they called me, I would do my best to be there for them.

All of the women viewed the LDS Church community as a resource and appreciated the auxiliary programs. Tamaris relied heavily on the home teaching program of the church:

> My home teacher is someone from church who comes once a month to deliver a scripture message. It is nice to have people in my home and entertain. He will bring a spiritual message or just [be] nice to talk to. I'm glad I have the LDS community around me. I don't know what it would be like not to have them. There are lots of resources in our church. The women's group, the weekly meetings on Sunday, and then monthly we have enrichment activities, where we have lessons and activities—some are spiritually based and some of them are just fun, like crafts or hints for around the house. I think there is a lot of support.

The LDS Church community and women of the same faith were viewed as resources that all of the women relied on for support during times of need.

Spiritual Resources

Women from all three cohorts took comfort in spiritual resources. They reported that prayer, scripture reading, and their personal relationship with Deity gave them strength during difficult times. The following comment by Laura, who was born and raised in the LDS faith, shows how in times of trouble, she turns to spiritual sources for comfort. She reminisced about the first time she openly communicated with Deity:

> I felt sad and depressed and like nobody cared. I went to my room and got down on my knees and prayed, and I just said, "Heavenly Father, I don't know why I am feeling like this, I feel lonely and sad, and I don't know why, but please help me." After my prayer, I stayed on my knees for a couple of minutes, and all of a sudden, I felt really warm, and my mood completely swung around, and I felt happy, and I knew that He had helped me to change that.

All of the women self-identified as spiritual. They had faith in the power of prayer and used it as a resource daily. These findings confirmed the prevalent belief that

members of the LDS faith receive strength from spiritual principles (Smith, 1981), consider the Gospel of Jesus Christ to be a comprehensive guide to this life (Koltko, 1991), and see religion and religious devotion as "the very root of their identities" (Maughan, 1991, p. 3).

Acceptance in the LDS Church Community

Huffman and Myers (1999) noted that the worth of women is often perceived to be based on sexuality, attractiveness, and youth. Thus older women are seldom valued. In contrast, all of the LDS women, regardless of age, felt valued and respected for their wisdom and experience. As women in the church, the participants noted that they are completely accepted for who they are, regardless of age.

Christine discussed the role of older LDS women. She did not consider age a barrier to being accepted within the LDS Church community:

> You feel like you are just as useful as anyone. Everyone is useful. Everyone is needed. Everyone is progressing whether you are young or old, and everyone has a place. There is something for everyone, and you are never too old to do something. There is always something to do, [even if] it is sitting at home doing genealogy. You are still contributing to the Lord's work. You are not diminished just because your capacity is diminished.

None of the women were concerned about aging within the LDS Church community. Sarah, for example, had never considered aging a problem. She is involved in many programs in the church community and stated that she has always felt accepted and needed:

> Being in the church for all of my life, I don't know that I would know what someone else does when they age. I don't know [that] I could make a proper comparison because I don't have anything to compare it to.... When you get older, you do genealogy work and work at the temple. You are needed, needed, needed!

All of the women had an intense sense of belonging, noting that they felt completely accepted and respected within the LDS Church community.

Meaningful Roles

Empirical research has indicated that role involvement positively affects women's psychological well-being (Vandewater, Ostrove, & Stewart, 1997). Barnett and Hyde (2001) found that multiple roles are beneficial to mental and physical health and that they increase opportunities for social support and boost self-esteem. This applied to all of the LDS women in this study. They felt valuable, useful, and needed within the LDS Church community. At the time of the interview, Laura held a responsible and time-consuming position in the LDS women's auxiliary. At times, she was frustrated with the heavy responsibility, but she commented,

> People realize that you have experience, and they can call on you because of that experience. I think it is important to me because it makes a difference. Yes, I would say that it was. There are some things that I do, and it makes me feel good. I am glad to be doing them . . . contributing instead of just taking.

Mackenzie and her husband had returned from serving a mission for the LDS Church. She had enjoyed the rewarding experience and looked forward to completing another one. She stated,

> In the church, every age is respected, and at every age, you are kept busy in the church. You don't become older and not used for anything. They use you more. I think by being busy spiritually, studying the scriptures, and praying and doing whatever you are asked to do in church . . . help keep you young as well. I think in the church, you are respected as you get older.

All of the women reported enjoyment and fulfillment from having meaningful roles within the LDS Church. The women feel valued because of their age and experience.

Eternal Perspective of Aging

Hunter and Sundel (1994) suggested that during midlife, issues of mortality and a sense of time running out come to the forefront. In contrast, all of the women in this study had an eternal perspective on aging and viewed midlife as part of the continuum of life. As an LDS convert, HTS commented that she believes in eternal life:

> Being LDS tells me there is a reason for this. That this is just not a crappy little life that an egg grabbed a sperm and produced me and I am going to die at the end of it, and there is no purpose. I think because we have the eternal perspective that we know that we have to go

> through this, that there is a reason . . . I think being LDS and knowing that I have a divine purpose that I am not just here by accident that I am supposed to strive to be a better person and make good choices and help people around me, I think that makes aging not a horrible thing. It's just a different stage. We have different focuses.

Sarah asserted that midlife transition fits into a larger plan. Aging and death are part of this plan:

> I don't believe that we came from nothing in the first place when we were born. I believe we existed before we came here, and I believe when we leave here after we die, we will continue to exist. . . . Our existence is never ending. It is eternal.

Being members of the LDS faith and having an understanding of life after death helped women in all three cohorts to view and accept midlife aging as part of the larger scheme of life. There was no concern about time running out.

DISCUSSION

This study demonstrated the strength of the qualitative method in its ability to obtain rich descriptions from the interviewees. The approach provided an opportunity for a small group of LDS women to share their personal stories about the midlife transition. As the findings showed, although each woman's midlife context was unique, there were commonalities in their midlife experiences. Some findings were consistent with those of contemporary research regarding the midlife experience, such as the presence of physical, emotional, and role changes; experiences of personal growth; recognition of the importance of roles; and the desire for generativity. There was no indication of midlife crisis. Rather, all of the women accepted the midlife changes as a normal development of life (Germain, 1994; Shek, 1996). The LDS Church community is a resource and a place where all of the women feel accepted and useful for their wisdom and experience. Volunteer roles give them a sense of worth. The women rely heavily on the LDS Church community and on their friends for support. Their religious beliefs are instrumental in assisting them through times of need.

In contrast to findings from contemporary research, the LDS women did not report identity confusion (McQuaide, 1996). Instead, they knew what they wanted out of life. They expressed a desire to develop their talents and abilities, and they anticipated spending more time with their spouses, researching family histories, and serving as LDS missionaries and temple workers. There was no indication that any role change, such as the change that occurs when children leave home, was negative for the women. Instead, they enjoyed a sense of freedom and reported personal growth in their confidence and assertiveness.

IMPLICATIONS FOR PRACTICE

With the increased life expectancy of the baby boomer generation and the increasing number of midlife women, issues surrounding the midlife transition will be reflected in our counseling practices. LDS and non-LDS clients may seek counseling for issues that arise from such developments as the breakdown of a marriage, the departure of children, separation from one's spouse, or the desire to redefine one's identity (Degges-White, 2001). Other clients who may not present with midlife concerns may have problems that are influenced or exacerbated by issues related to aging. Inconsistency of information about menopause, sociocultural influences that perpetuate ageism and sexism, redefinition of self, and concerns with self-care cause uncertainty and instability in women's lives during the midlife transition (Banister, 1999).

Mental health providers are in an ideal position to provide support to women (Patterson & Lynch, 1988). As practitioners, our main goal is to improve our clients' quality of life through effective intervention. To work more successfully with female clients and to help them navigate midlife productively, practitioners are encouraged to understand the physical, emotional, and role changes that occur at midlife and to view presenting problems within the context of the midlife transition.

Understanding the Physical and Emotional Changes of Midlife

When meeting with women ages 35 to 65, it is important that practitioners determine which more specific age cohort a client belongs to. Younger women in particular may benefit from information regarding the stages and symptoms of menopause, the benefits and risks of hormone replacement therapy, and alternate

solutions for managing physical changes (Cobb, 1993). Women often need encouragement to balance their life responsibilities and to make time to improve their psychological well-being. They must be encouraged to take an active role in and make informed decisions about their health and well-being. There is no doubt that menopause represents a powerful shift in the body, mind, and spirit of women. Most will benefit from stress reduction techniques such as muscle relaxation and meditation. Being physically active may reduce the perceived severity of menopausal symptoms and enhance psychological well-being (Elavsky & McAuley, 2004). Positive use of leisure also has favorable effects on midlife aging (Parry & Shaw, 1999).

According to Huffman and Myers (1999), women's responses to menopause are related to the meaning they ascribe to it. Women often turn to popular literature about women and aging for information (Banister, 1999), but they must have accurate information if they are to make informed decisions about health. Participation in an educational program that provides information about midlife experiences may improve women's attitudes toward menopause, provide relief from the various symptoms, and increase their quality of life (Rotem, Kushnir, Levine, & Ehrenfeld, 2005). Education regarding emotional symptoms is important because understanding the expected symptoms may reduce stress (O'Connor et al., 1998). Women may also benefit from having access to resources such as reliable Internet sites and self-help books.

Changes in Roles and Relationships

Role changes are particularly evident during midlife. Thus, predictable events such as children leaving home and family structure shifting should be explored with specific reference to changing roles. Once children have been successfully reared and launched, women may find themselves uncertain as to their parenting roles (Fingerman, 2000). Some fear losing parental control. Developing adult relationships with grown children involves appreciating the maturing adult children and pursuing equal relationships with them by granting them independence. Parents often need assistance in coming to terms with how their adult children have "turned out."

Although the notion of children leaving home did not adversely affect the interviewees in the study, other women may be susceptible to the empty nest syndrome and could benefit by planning in advance, acknowledging fears, and discussing feelings, as well as pursuing hobbies and interests, establishing regular routines, and maintaining self-care (Fingerman, 2000). It is important to be sensitive to infertile or single women who may not have been able to have children and are particularly sensitive when there is no hope of being able to do so. Postmenopausal women can no longer produce children; however, midlife may be a time of psychological and creative fertility, when women's "productivity is not determined by reproductive capacity, but by desire, motivation, and psychological capacity" (Degges-White, 2001, p. 10).

Midlife women are vulnerable to strained marital relationships (Degges-White, 2001). The midlife years can be viewed as a time to renew the marital bond. Women can be supported in their efforts to refocus their energies on the positive aspects of their marriage, redefine the couple relationship without children, rediscover their spouses not only romantically but also intellectually and spiritually, and look forward to the next phase of married life. Although members of the LDS Church place great emphasis on marriage and family, they are susceptible to separation and divorce (Mattson & Scharman, 1994) as well as widowhood, and in these conditions will have to make critical adjustments. As they adjust, they may need assistance in dealing with loss, depression, and self-esteem issues, in addition to exploring opportunities to improve their lives and set goals for positive change. In many instances, this process will involve such concrete steps as returning to school, updating a résumé, and undertaking financial planning to ensure greater income security and more rewarding employment options.

During midlife, the addition and acceptance of in-laws and the prospect of grandparenting can be daunting. Anticipating and preparing for this stage will greatly reduce those feelings of insecurity and uncertainty. Another significant role change for midlife women often comes with the aging of family members and the increasing dependency of those who are elderly. As members of the "sandwich generation" (Zal, 1992), many midlife women move into the role of caregiver for parents or in-laws and are challenged by increased stress, heavy demands on their time, and the need to balance multiple roles (Riley & Bowen, 2004). Such women often gain from reexamining their present coping strategies, learning stress management techniques, and being encouraged to recruit the help of others and make time for self-care.

Consciousness Raising of Aging Stereotypes

Midlife aging has been construed as a negative period, "despite literature which is inconsistent with that view" (Stewart, Ostrove, & Helson, 2001, p. 34). Many women who are in the midst of the midlife transition need to understand and challenge negative societal attitudes toward aging; thus, practitioners must attend to the social and cultural context (Banister, 1999). Confronting the stereotypes about being an aging female in Western society can be effective in helping women to understand society's adoration of youth and to reject ageism (the social construction of age). By challenging preconceived notions, women can be encouraged to embrace their age and focus on their inherent beauty. There is strength in numbers. Aging women are empowered as they are reminded that they belong to an ever-increasing cohort of mature women.

Encouraging Generativity

Developmental theory suggests that the baby boomer generation will want to contribute to future generations (Peterson & Klohnen, 1995). According to Erikson (1982), generativity involves fostering the growth of others and leaving a legacy through parenting, teaching, or mentoring. Generativity is a strong force; some women's self-esteem may be closely tied to it. Thus, efforts to increase a sense of efficacy and to find meaningful activity can be particularly effective. For LDS women in particular, the counselor can emphasize their individual value in the church community. As women learn to celebrate their personal wisdom and maturity, they become reenergized by the possibility of going on missions, doing family history work, engaging in meaningful temple work, and seeking further spiritual light.

Providing a Forum for Aging Women

Menopause was once considered the silent passage—a "powerful and mysterious taboo" (Sheehy, 1993, p. xi). Historically, women practiced a conspiracy of silence, but the women of today are more willing to discuss menopause and the midlife transition (McQuaide, 1998b). Indeed, the women in the study reported a feeling of empowerment when discussing midlife aging and describing the resources they used to navigate it. It is particularly important that female clients be presented with the same opportunities to talk about their lives, express their fears and concerns about aging, explore their feelings of guilt or regret about the past, articulate their hopes and dreams, and discover strengths and inner resources. By doing so, they can rewrite the script for the midlife transition (Gillet, 1996).

Support System

Midlife is often portrayed as a time of crisis, characterized by the empty nest syndrome, the burden of caretaking, and pressure to achieve financial security (Hunter & Sundel, 2002). Therefore, women need support, and they look for someone to talk to. Although many opportunities for support may occur in the therapeutic context, McQuaide (1998b) suggested that having friends or confidantes is a predictor of well-being.

Resources

As practitioners, we can improve our services to midlife women by educating ourselves about the stages of the midlife transition and focusing attention on the physical and emotional symptoms of menopause. We must be familiar with relevant community programs and resources, such as midlife educational and therapeutic groups, female reproductive and breast health centers, menopause resource centers, and local health care providers. Let us consider implementing programs, workshops, and educational opportunities (Banister, 1999). By doing so, we can help our clients to deal with potentially stressful situations and can facilitate their experience of a successful midlife transition.

CONCLUSION

Large numbers of women are transitioning through a challenging and complicated life period. Societal narratives have focused on the negative aspects of midlife. Markers of midlife such as menopause and the empty nest syndrome can be represented to promote a pessimistic view of aging women. It is important not to overlook the growth and opportunities that are also characteristic of midlife. Midlife women continue to grow in confidence and assertiveness and to fulfill personal goals and desires. The midlife transition is no longer considered the end of traditional femininity. Instead, the midlife transition is a rite of passage that allows women to celebrate their strengths and wisdom and to discover new freedom and creativity. As effective practitioners, we must examine our own attitudes toward aging, reject any preconceived notions related to aging women, and refute negative cultural stereotypes. Most importantly, we must spread the good news that aging is not to be feared. Midlife is a joyous part of the continuum of life. It should be embraced, accepted, and savored!

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Therapeutic Value of Experiencing and Expressing Gratitude

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Gratitude has recently received a significant amount of research attention in the emerging field of positive psychology. Gratitude interventions are being empirically validated and are showing great promise in enhancing life satisfaction, decreasing depression and anxiety, coping with adversity, facilitating relationships, building civic and moral aspirations and behaviors, and promoting physiological benefits as well. This article will tie the empirical literature to an LDS theology that has long taught and currently advocates for the cultivation of gratitude as an essential component of a spiritually based, meaningful, and happy life. An empirical overview of the benefits of gratitude will be provided, potential gratitude interventions will be suggested, and principles for intervention effectiveness will be discussed.

Louisa Mellor Clark was the oldest living child of James and Mary Ann Mellor who crossed the plains in the Martin handcart company. Louisa was 16 at the time of the handcart trek. She recorded the following incident in her journal:

> The first snowstorm left about two feet of snow on the ground, and we began to feel very nervous. We had to wade through more streams, and sometimes up to our waists, and when we got through our clothes would freeze on us until a great many gave up and many died, mostly old people. At last the snow got to be four and five feet deep and often we had to shovel a road before we could move. Thus our traveling was very slow and our provisions nearly gave out.
>
> My mother, still being weak, finally gave up and said she could go no further. The company could not wait for her, so she bade my father goodbye and kissed each one of the children Godspeed. Then my mother sat down on a boulder and wept. I told my sister, Elizabeth, to take good care of the twins and the rest of the family, and that I would stay with mother. I went a few yards away and prayed with faith that God would help us, that He would protect us from devouring wolves, and asked that He would let us reach camp. As I was going back to where my mother was sitting I found a pie in the road. I picked it up and gave it to mother to eat. After resting awhile we started on our journey, *thanking God for the blessings.* A few miles before we reached camp we met my father coming out to meet us. We arrived in camp at 10:00 p.m. *Many times after that mother felt like giving up and quitting, but then would remember how wonderful the Lord had been to spare her*

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so many times, and offered a prayer of gratitude instead. So she went on her way rejoicing while walking the blood-stained path of snow [italics added] (Carter, 1975, p. 305).

Mary Ann Mellor's life-altering manifestations of gratitude were not simply based on finding a sustaining "pie," but on the more complete recognition that God cared about her and her family, as evidenced by His intervention. Recognizing the hand of God in life leads to a deep sense of God's grace. Thus, for religiously oriented individuals, gratitude may also be an expression of faith in God.

Gratitude can have a profound effect on perspective. As one author asserts, "It seems obvious that gratitude is prominently involved, indeed vital, for living a good life" (Shelton, 2004, p. 265). When individuals feel discouraged, anxious, or depressed, a grateful outlook helps to balance perspective and brings to remembrance that even in challenging times life offers many gifts. Shifting attention from problems to blessings activates more effective problem solving efforts. Gratitude is more likely to promote endurance and thriving in times of adversity. Gratitude operates in times of abundance, leading to satisfying and happy lives while helping retain humility. The purpose of this article is to explain the therapeutic value of gratitude and to suggest principles and potential interventions to cultivate it.

Gratitude has been extolled as a virtue in nearly every culture throughout time. It is a universally desired virtue at personal, interpersonal, organizational and community levels. In a sample of older adults, gratitude was found to be the third most common discrete positive affect, experienced by 90% of the sample (Chipperfield, Perry, & Weiner, 2003). It is a core element of many religious orientations and is central to Christianity. It is related to feelings of contentment (Walker & Pitts, 1998), hope (Overwalle, Mervielde, & De Schuyter, 1995), joy (Schimmack & Reisenzein, 1997) and happiness (Overwalle et al., 1995). Gratitude's antitheses are hate, jealousy, contempt (Schimmack & Reisenzein, 1997) and resentment (Roberts, 2004).

WHAT IS GRATITUDE?

Gratitude is a positive emotion and has also been identified as a personal strength or character virtue (Peterson & Seligman, 2004). It is receiving significant research attention in the emerging field of positive psychology.[1] In one study (Gallup, 1998), 67% of adults said that they expressed gratitude to others "all the time." In the same study, 54% said that they expressed gratitude to God "all the time."

Gratitude is a *positive experience* and comes from recognizing gifts or blessings and feeling thankful. Gratitude is also an *attitude*, a way of perceiving life, where individuals are attuned to the beneficial actions of others on their behalf. This attitude might be characterized as situational or chronic. Those exhibiting chronic gratitude are said to possess a grateful *disposition*. Gratitude is also a *habit* that can be cultivated. Grateful thinking develops a disposition or tendency to focus on the blessings of life. Gratitude is also a *coping response* to challenging and difficult circumstances. Thus, on closer inspection, gratitude has emotional, attitudinal, characterological, and situational components.

LDS PERSPECTIVE

LDS leaders have recognized and continually taught the importance of gratitude. Gratitude has been called a "spiritual attribute" (Hunter, 1997) and a "divine principle" (Hinckley, 1997). It has been described as one of the foundational virtues of "true character" (Benson, 1988). President Thomas S. Monson (2000) spoke of the power of gratitude when he stated, "We can lift ourselves, and others as well, when we refuse to remain in the realm of negative thought and cultivate within our hearts an attitude of gratitude" (p. 2). President Joseph F. Smith (1939) explained the benefits of gratitude, stating that "the spirit of gratitude is always pleasant and satisfying because it carries with it a sense of helpfulness to others; it begets love and friendship, and engenders divine influence. Gratitude is said to be the memory of the heart" (p. 262). Adding to this, Elder Robert D. Hales (1992) suggested, "In some quiet way, the expression and feelings of gratitude have a wonderful cleansing or healing nature. . . .Gratitude brings a peace that helps us overcome the pain of adversity and failure" (p. 63). Gratitude is identified as one of 17 values advocated in *For the Strength of Youth* (The Church of Jesus Christ of Latter-day Saints, 2001). President Hinckley (1997) has counseled us to "cultivate a spirit of thanksgiving for the blessings of life and for the marvelous gifts and privileges you enjoy" (p. 246). Finally, George Q.

Cannon (1867/1974) articulated one of the key reasons why gratitude is such a powerful force for good when he stated, "When our hearts are filled with thanksgiving, gratitude, and praise to God, we are in a fit condition to receive additional blessings, and to have more of the outpouring of His Holy Spirit" (p. 330). When individuals experience and express gratitude, they open the doors to divine influence and the companionship of the Holy Spirit, for their own benefit and for the well-being of others.

PSYCHOLOGICAL AND PHILOSOPHICAL PERSPECTIVE

Psychological and philosophical definitions of gratitude include the following: "the willingness to recognize the unearned increments of value in one's experience" (Bertocci & Millard, 1963, p. 389) and "an estimate of gain coupled with the judgment that someone else is responsible for that gain" (Solomon, 1977, p. 316). Robert Emmons and Michael McCullough (2003, 2004) suggest four elements in their definition: (1) the capacity to perceive that an intentional gift or blessing has been received, or at least that someone (mortal or divine) attempted to give a gift, even if not received or experienced by the intended recipient, (2) no expectation that the gift/blessing is earned or deserved, (3) recognition of the effort of the giver, sometimes at high cost to themselves, and (4) no expectation of reciprocity. Gratitude can be distinguished from "indebtedness," which generally feels less positive or even negative, carries with it a sense of obligation, and is embedded in reciprocity. Gratitude is absent feelings of manipulation, but indebtedness could feel demanding and may even be experienced as manipulative.

In making a case for gratitude as a positive response to life, the premise of this article is based on the belief that individuals have the capacity to choose their attitudes toward people and situations. Experiencing and expressing gratitude or any positive response to life's circumstances is dependent on the ability to choose one's attitude. George Kelly (1955), the creator of Personal Construct Theory, based his theory in the tenets of "constructive alternativism," stating, "There are always some alternative constructions available to choose among in dealing with the world. No one needs to paint himself into a corner; no one needs to be completely hemmed in by circumstances; no one needs to be the victim of his biography" (p. 15). Viktor Frankl (1963) articulated this same idea when he stated, "Everything can be taken from a man but one thing: the last of human freedoms—to choose one's attitude in any given set of circumstances, to choose one's own way" (p. 104). Frankl (1973) also indicated that with this freedom "men can give meaning to their lives by . . . experiencing the Good, the True, and the Beautiful" (p. xiii). Gratitude is one of those "Goods," and as a response to life, it is only possible if it is an option clients can choose. We argue that it is, and that it can be cultivated. The following benefits are available to those who adopt a grateful approach to life.

THE EFFECTS OF GRATITUDE

Feeling and expressing gratitude provide a variety of benefits. Recently, several studies have been devised to test whether interventions to promote gratitude can increase positive affect, reduce negative affect, and lead to other helpful positive outcomes. These studies have demonstrated promising results (Bartlett & DeSteno, 2006; Emmons & McCullough, 2003; Lyubomirsky, Tkach, & Sheldon, 2004; McCraty & Childre, 2004; Seligman, Rashid, & Parks, 2006; Seligman, Steen, Park, & Peterson, 2005; Sheldon & Lyubomirsky, 2006). The effects of gratitude are highlighted in six domains of life: enhancing happiness and life satisfaction; mental health benefits; coping with adversity; interpersonal benefits; moral, civic, and spiritual benefits; and physical benefits (see Table 1).

Although gratitude has many beneficial outcomes, some of these may be time-limited and situation bound, without necessarily leading to lasting changes or permanent increases in levels of life satisfaction. Temporary effects are more likely to occur when individuals only periodically experience gratitude. Other factors can negate the effects of gratitude: diminished capacity for empathy, self-absorption, becoming overwhelmed by circumstances, getting stuck in chronic misery, resentment, sense of entitlement, becoming too materialistic, taking too much credit for successes or failures, living life without being fully engaged, living pressure-filled and fast-paced lives, comparisons with others, and anything that reduces appreciation and recognition of the benefits and blessings that come unearned and from the goodwill of others.

Table 1
Positive Effects of Experiencing and Expressing Gratitude

Domain	Finding	Source
Enhanced Life Satisfaction	Expressing gratitude helped 90% of adults/teens feel "somewhat/extremely" happy.	Gallup, 1998
	Writing and thinking about experiences of gratitude helps people feel happier and more optimistic.	Emmons & Crumpler, 2000; Watkins, Woodward, Stone, & Kolts, 2003
	Grateful disposition correlated with positive emotionality, vitality, happiness, life satisfaction, hope, and optimism.	Adler & Fagley, 2005; McCullough, Emmons, & Tsang, 2002
	Counting blessings led to increased life satisfaction, well-being, positive affect, optimism and reductions in negative affect as well as making more progress on personal goals.	Emmons & McCullough, 2003; Lyubomirsky, Tkach, & Sheldon, 2004
	Gratitude was one of 5 out of 24 character strengths that was strongly and consistently associated with life satisfaction.	Park, Peterson, & Seligman, 2004
	Gratitude increases access to positive memories.	Watkins, Van Gelder, & Maleki, 2006
	Gratitude may forestall the effects of adaptation[2] to positive events (sustaining happiness longer).	Sheldon & Lyubomirsky, 2004
Mental Health Benefits	Grateful disposition correlated negatively with depression and anxiety.	McCullough et al., 2002; Woodward, Moua, & Watkins, 1998
	Gratitude interventions led to decreases in depression and negative affect.	Seligman et al., 2005; Seligman et al., 2006; Sheldon & Lyubomirsky, 2006
	Thankfulness was associated with reduced risks for major depression, phobias, generalized anxiety disorder, panic disorder, and bulimia nervosa, nicotine dependence, alcohol dependence, drug abuse or dependence, and adult antisocial behavior.	Kendler et al., 2003
	Trait gratitude negatively correlated with resentment about the past.	Watkins, Woodward, Stone, & Kolts, 2003
Coping with Adversity	Gratitude was the second most frequently felt emotion after 2001 terrorist attack.	Frederickson, Tugade, Waugh, & Larkin, 2003
	Hurricane Andrew survivors often experienced gratitude in the face of loss.	Coffman, 1996
	Trauma survivors with PTSD who experienced more gratitude had significantly lower levels of PTSD symptoms.	Massingale et al., 2001
	Vietnam vets diagnosed with PTSD who had greater dispositional gratitude experienced greater daily well being.	Kashdan, Uswatte, & Julian, 2006
	A grateful approach to negative life events helps reframe memories of unpleasant events.	Watkins, Grimm, & Hailu, 1999

Interpersonal Benefits	Gratitude intervention led to an increased sense of interpersonal connectedness.	Emmons & McCullough, 2003; McCullough et al., 2002
	Those who tend to experience gratitude more frequently reported being more forgiving.	McCullough et al., 2002
	Those rated as having a more grateful disposition were viewed as more empathic and supportive of others.	McCullough et al., 2002
	Grateful people reported being less envious of others and more generous with their possessions.	McCullough et al., 2002
	Those in the gratitude interventions reported helping someone more frequently.	Emmons & McCullough, 2003
Moral, Civic, and Spiritual Benefits	Religiously inclined people experience gratitude more frequently than others.	McCullough, Tsang, & Emmons, 2004
	Those thanked for helping are much more likely to help another in the near future.	Clark, 1975; Goldman, Seever, & Seever, 1982; Moss & Page, 1972
	Grateful people reported being less materialistic and less oriented to pursuing wealth and more generous with their possessions.	McCullough et al., 2002
	Gratitude and "materialistic striving" have an inverse correlation.	Polak & McCullough, 2006
	Case managers visited their adolescent clients more frequently when a "thank you" note was sent to them by their managers after visits.	Clark, Northrop, & Barkshire, 1988
	Tips were larger when a "Thank You" was placed on the bottom of the bill.	Rind & Bordia, 1995
	Thanking people for their business led to an increase in sales.	Carey, Clicque, Leighton, & Milton, 1976
	Gratitude increases efforts to assist benefactors even when such efforts are costly, and this effect is unique from the outcome produced by an increase in general positive affect.	Bartlett & DeSteno, 2006
Physical Benefits	Gratitude interventions led to better sleep duration and quality, fewer physical complaints, and more time spent in physical exercise.	Emmons & McCullough, 2003; Emmons & Crumpler, 2000
	Gratitude may help with cardiovascular and immune functioning.	McCraty & Childre, 2004
	Gratitude to God reduced the negative effects of stress on health for older adults (especially for women).	Krause, 2006

All clients can benefit from even simple and infrequent attempts at fostering gratitude, but the goal of developing a more grateful disposition takes much effort and persistence. Everyone, whether religiously oriented or not, can benefit from enhancing their gratitude and can find much for which to be grateful. For religiously oriented clients, a grateful perspective on life is most likely to be present when it is connected to an active awareness of God's gracious benevolence in their lives. For those with such a perspective, no experience loses its potential to teach and bless when they acknowledge God as acting in their best interest. This becomes a catalyst for increased well-being, leads to seeing the gifts in life more clearly, and kindles a desire to share their good fortune with others. Ultimately, from an LDS perspective, the most important functions of gratitude include softening and lifting hearts, and opening a channel that allows God to work in and through them more effectively.

INTERVENTION PRINCIPLES AND PROCEDURES

Experiencing and expressing gratitude has significant beneficial effects in a variety of domains. Given that there are specific positive benefits from experiencing gratitude, the following questions are relevant: How can therapists intervene to promote gratitude? What principles can maximize the utility of gratitude interventions?

Gratitude Intervention Strategies

Since writing may be an important element of the following interventions, some research indicates that a different approach should be used in writing about positive versus negative experiences. For example, Lyubomirsky, Sousa, and Dickerhoof (2006) found that "private thought about a positive life event was associated with higher satisfaction with life than writing or talking about that event" (p. 701). When writing about negative events, the analytical nature of writing was helpful in making sense out of experiences, while just thinking or ruminating about problems did not help. Just the opposite was found with positive events. The act of analytical writing about positive events diminished the pleasure of these events. In contrast, focusing on reliving, replaying, and rehearsing positive experiences sustains and maximizes pleasure related to positive events. Therefore, if clients are asked to write about their gratitude experiences, consider having them write in a way that minimizes analysis and maximizes reliving and savoring. Encourage descriptive rather than analytical writing by inviting them to "bask" in the experience again and include as much detail as possible, such as their thoughts and emotions at the time.

Counting Blessings. This generally involves listing 3-5 blessings (Emmons & McCullough, 2003). It has been implemented daily, a few times a week, or weekly. Certain domains of focus can be suggested for clients to consider (e.g., health, relationships, noted improvements, lessons learned, etc.).

Making a "Gratitude Visit." This was described in the Seligman et al. (2005) study. It had a significant positive short-term impact, which diminished over time. Ask clients to think about someone toward whom they feel a special sense of gratitude, write that person a gratitude letter, and then make a personal visit to express thanks and deliver the letter. Here is an adaptation of Martin Seligman's (personal communication, August 23, 2006) elements for this intervention:

- Think of the people—parents, friends, teachers, coaches, teammates, employers, and so on—who have been especially kind to you but whom you have never properly thanked.
- Choose someone you could meet for a face-to-face meeting in the next week.
- Write a specific and concrete gratitude letter that details how this individual affected your life for good, and deliver it in person.
- Call the person in advance to schedule a time to get together.
- Share the contents of the letter with the person, including how you are doing now.
- After this visit, take a moment to think about each of the following questions:
  - How did you feel as you wrote your letter?
  - How did the other person react to your expression of gratitude?
  - How were you affected by their reaction?
  - Would you like to express your gratitude to someone else in a similar manner?
  - To whom?

Creating a Gratitude Catalogue. Encourage clients to spend a week developing a comprehensive list of all their blessings. After they have listed the obvious, see if they notice a shift to "smaller" blessings (e.g., running

water, electricity, etc.). Help them consider as blessings things that were not previously experienced as such (e.g., the ability to experience pain of all kinds because it is a signal that something needs attention, a demanding assignment because it helped them learn something about their capabilities, the person who cut in front of them because that experience gave them the opportunity to choose a higher road, etc.).

Appreciating Progress. Help clients recognize and appreciate their progress. Those with perfectionistic tendencies may especially benefit from this intervention. Mood can influence thought and memory, so depressed individuals may find it difficult to see progress. Here are some examples: "Are you closer to reaching your goals?" "Has your health improved?" "Have your relationships improved?" Sometimes it is helpful to begin with minimal signs, such as, "I'm no longer actively suicidal." Help them generate grateful feelings, even if they start small.

Appreciating "Small" Things. Most blessings are of the "small" variety. Barbara Frederickson (2003) suggests that "you can infuse ordinary events with meaning by expressing appreciation, love and gratitude, even for simple things" (p. 335). Small blessings are always available. Waiting for "big" events to occur before experiencing gratitude is counterproductive since they happen infrequently and often produce less "punch" than expected, and since, through adaptation, the effects wear off sooner than anticipated. Learning to regularly appreciate small things leads to greater awareness and mindfulness. When the authors were in elementary school we were taught to "stop, look, and listen" before crossing the street. In the service of appreciating small things, invite your clients to "stop, look, and listen" for a grateful feeling, moment, or experience that has happened during the day. Assign clients to think or write on the following ideas:

- Consider three things that they usually take for granted that made them feel peaceful, happy, content, satisfied, or fulfilled today (e.g., I had a good night's sleep, I enjoyed the fall colors on the trees, I had the chance to read a good book, my friend called and we did something together, etc.).
- Consider three things that didn't occur today that would have been distressing, unpleasant, or discouraging (e.g., I didn't get sick, I didn't fail the exam, I didn't get yelled at, etc.).

Taking Things For Granted. Encourage clients to make a list of the things they take for granted. Too often blessings are in plain view but have become invisible. When clients actively renew their attention and remind themselves of these blessings, they experience an increase in gratitude.

Eliminating Ungrateful Thoughts. Elder Jeffrey R. Holland's (2007) counsel is applicable: "No misfortune is so bad that whining about it won't make it worse" (p. 18). Have clients identify and list their complaining and ungrateful thoughts and replace them with grateful thoughts and problem solving strategies. Clients are prone to gratitude and less likely to complain when they remember how others have contributed to their well-being, when they search for lessons in challenging times, and when they focus on positive action rather than passive complaining.

Expressing a Gratitude Prayer. Suggest to spiritually oriented clients that they regularly take time to dedicate an entire prayer for expressions of gratitude. Encourage them to be specific and to go beyond the obvious. Going beyond the obvious may involve little twists; for example, being grateful for the ability to experience emotional pain because it means they still care; or, in the face of chronic problems, being grateful for the fact that this week was no worse than last week; or being grateful that God gave them the ability to endure another day. When they recognize the extent of God's mercy in their lives, they may also increase their love for Him.

Using Gratitude Language. Train clients to use the language of gratitude. This can occur by frequently writing notes of appreciation. Help them find ways to say "thank you" in a meaningful way, both to those they are close to as well as others they encounter, such as the bagger, the cashier, or the postal worker. Have them focus on consciously and frequently thinking, saying, and writing grateful things.

Using Downward Social Comparisons. If clients are experiencing difficulty in feeling gratitude, have them think of situations they are glad they don't experience, such as famine, war, or debilitating illness. Invite them to think of someone they would not want to trade places with who seems to have things harder than they do. Have them say and think things such as, "At least I don't have to deal with chronic pain." Help them recognize that although their situation is not ideal, it could be worse. Encourage them to be grateful that it is not worse, while continuing to hope and work towards

improvement.

Discovering Unexpected Gratitude. Challenging times may provide the most important opportunities for grateful thinking. Some have called this "benefit finding" (Affleck & Tennen, 1996). Finding ways to experience some element of gratitude in difficult circumstances helps clients endure and even thrive, as referred to in the opening story of this article.

Invite clients to think about a current situation that is troubling them. What can they find in that experience for which to be grateful? They might find opportunities to learn something new, to practice something hard, to develop courage, to learn to trust in God, to find out more about themselves, to appreciate the support that is available to them, and to recognize that the situation is making them more patient, empathic, or less judgmental.

Life's difficult experiences temper and refine, and although this is sometimes quite painful, often the most significant points of growth come through these experiences. They can provide the focus for future efforts to change things that are experienced as unjust or unfair or to prevent bad things from happening to others. Much of the good in this world has come about from suffering that is transformed into a social contribution. Often, the attempt to find benefits in challenges actually changes the nature of the problem itself, leading to new solutions.

Promoting Marital Gratitude. Expressions of gratitude enhance any relationship. When marital conflict or tension is high, or couples are discouraged or suffering painful hurts, it is helpful to encourage partners to take time out to focus on things they appreciate about each other. This must be done carefully and appropriately and not as an avoidance maneuver that circumvents real problems. The couple should not use this as a tool of manipulation. When undertaken seriously and sincerely, it brings increased awareness to the positive traits and behaviors in one's spouse, softens hearts, and promotes healthier environments for mutual problem solving. Sometimes the expressions of gratitude are the solution.

For a list of further gratitude resources, see the Appendix.

Gratitude Intervention Principles

The following principles can help maximize the utility of gratitude interventions.

Effort and Continuity. Long-term benefits from gratitude interventions are more likely when there is continued commitment to implementation. One-time interventions such as the "Gratitude Visit" (Seligman et al., 2005) had an immediate significant positive impact, but at a 3-month follow-up, adaptation had returned individuals to their baseline emotional state. Sustained commitment is necessary. As Seligman et al. (2005) found, "The degree to which participants actively continued their assigned exercise on their own and beyond the prescribed one-week period mediated the long-term benefits" (p. 416).

Self-Concordance. Individuals show greater commitment to performing gratitude exercises when interventions are more congruent with their values and needs (i.e., self-concordance; Sheldon, 2002). Motivation is easier to sustain when activities have intrinsic value. Self-concordance is enhanced when interventions are tailored and a rationale is given related to the individual's basic needs and values. Implementation improves with specific and concrete plans that clients help create.

Therapy drop out rates varied significantly in a randomly controlled trial study of the treatment of depression conducted by Seligman, Rashid, & Parks (2006), with a 13% drop out rate for Positive Psychotherapy, a 40% drop out rate for treatment as usual, and a 29% drop out rate for treatment as usual with antidepressant medications. The significantly lower drop out rate of the Positive Psychotherapy participants may indicate that clients find positive and additive interventions easier and more compelling to carry out.

Variation. Varying interventions help to keep activities fresh, staving off the effects of adaptation. Interventions may lose some of their efficacy if they become too habitual, but developing a grateful attitude does take sustained and regular practice. To minimize the effects of adaptation, vary the way gratitude exercises are enacted; for example, change the domain of focus (e.g., health could be the focus on one occasion, sources of social support on another occasion, and looking for the "silver lining" in adversity on yet another occasion). Varying the frequency or intensity of interventions (e.g., once a week or three times a week rather than every day) may maximize effectiveness. Implementing different types of gratitude interventions, as well as interspersing non-gratitude interventions, may also be useful.

Variation may conflict somewhat with the principle of effort and continuity. Whereas Emmons and

McCullough (2003) found that daily listings were generally more "powerful" than weekly listings of gratitude, Lyubomirsky, Sheldon, and Schkade (2005) found that well-being increased only in those participants who counted their blessings once a week rather than three times a week.

Social and Self Comparisons. Gratitude often arises out of social comparisons. For example, increased gratitude may be experienced by our clients when they encounter someone whose health is worse than their own, or someone who has difficulty even obtaining the basics of life. Downward social comparison processes are at work when individuals see themselves as better off than another. This is an effective method for facilitating gratitude if it does not turn to judgment about the other person or pride about abilities and/or circumstances (i.e., "I did it, why can't they").

Comparisons with self may have fewer negative consequences. If clients can see how things are improving (comparisons with their past), or how they are getting closer to what they want (comparisons with their ideals), they are prone to experience gratitude. Those with very high self-comparison standards, such as perfectionists, may find this difficult. Self-comparisons may not work when a person's situation is deteriorating, such as through poor health or aging. Other gratitude interventions can be helpful in these situations as they reflect on other aspects of their lives (e.g., a life well lived, the small things of life, the kindness of others, etc.).

Social Support. Social support is helpful in implementing many kinds of activities. Whenever the assistance of another can be used to help clients practice gratitude, it is more likely that gratitude will occur. Encourage clients to observe, seek out, and associate with someone they think is particularly grateful. This individual may be thought of as a gratitude coach. Becoming more aware of the power of social support may also become a source of gratitude.

Attentional Focus. Much of the value of gratitude is due to clients shifting their attention from hassles and problems towards things that are going well and blessings. The experience of increased positive emotions leads to improved problem solving. Gratitude counters the tendency to ruminate about problems and avoid problem solving efforts. Rumination has been found to be a major factor in depression, anxiety, and inability to overcome interpersonal hurts (Bono & McCullough, 2006). A shift towards a grateful perspective serves as a form of "distraction" and refocuses attention on potential positives rather than on feared or experienced negatives, providing a balanced and broader perspective on current challenges. Current research indicates that it only takes 8 minutes of distraction to help a person feel better (Lyubomirsky & Tkach, 2003). A grateful orientation shifts attention towards things that are going well, successes, "silver linings," and "small gifts" such as smell, sight, touch, and so forth.

Cultivating Empathy. Empathy is an essential factor in experiencing gratitude. Those who cannot empathize with others will find it difficult to see the efforts and sacrifices made on their behalf. Without empathy, they may view the actions of others as being merely self-serving. Just as gratitude requires empathy, it also cultivates empathy. Being able to see blessings is part and parcel of recognizing the benevolent actions of others. Indeed, clients may recognize that at times they don't even merit the gifts bestowed upon them. In cultivating empathy, they may recognize a mutual dependence on others and may have a desire (versus a feeling of obligation) to return kindness.

Acceptance. There are two forms of acceptance, active and passive. Active acceptance is the ability to accept, embrace, and even welcome the gifts of life in whatever form they arrive, believing that they can teach and refine. This is not a masochistic, "suffering proves how much God loves me" perspective. It is not seeking out suffering. Active acceptance is fostered by believing in a benevolent God who has the well-being of His children in mind. Those who believe that God is a "potter" and that He is shaping His "clay" (Isaiah 64:8) recognize that some of His stretching, pinching, and kneading may be painful prior to the finished vessel being revealed. Active acceptance is recognizing that the design of life allows for and even calls for a portion of adversity along with life's privileges. Active acceptance acknowledges that the positive experiences of life are inextricably intertwined with the ability to experience pain and disappointment. Paul's declaration is one demonstration of this attitude: "Most gladly therefore will I rather glory in my infirmities, that the power of Christ may rest upon me" (2 Corinthians 12:9). Paul's attitude reflects active acceptance, since he sees something positive coming from his infirmities.

Those who accept, tolerate, or acknowledge things as

they are rather than as they wish things were, especially regarding things that cannot be changed, are demonstrating passive acceptance. Passive acceptance is more about enduring than learning. It may even be somewhat fatalistic (i.e., just "grit it out" until it is over). Both attitudes can prove useful.

The ability to accept things as they are and to find benefit even when wishing they were different is a component of gratitude. Obsessing over things that cannot be controlled limits our ability to feel grateful. Those who adopt an active acceptance come to see that almost every experience may have laden within it some gift, some benefit, something that will make them better one way or another. As President Brigham Young taught, as cited in the *Discourses of Brigham Young* (Widstoe, 1954), "Every trial and experience you have passed through is necessary for your salvation" (p. 345). Acknowledging that some circumstances or conditions cannot be controlled may actually prove helpful in fostering gratitude (e.g., although my son is struggling and I can't control his decisions, I am grateful that God's grace is available to him and me). Gratitude leads to increased feelings of contentment, peace, joy, hope, and happiness even when circumstances are uncontrollable. When appropriate, encourage clients to accept their situation with all its "thorns." When fitting, constructively explore the possible lessons to be found even in challenging circumstances.

CONCLUSION

Individually designing interventions using the principles listed above will assist therapists in their efforts to cultivate attitudes of gratitude within their clients. Help minimize anticipation of failure. Let clients know that any effort is itself a part of the victory, whether they feel increased gratitude or not and whether they feel happier or not. Encourage realistic expectations about intervention outcomes. Assist clients to develop habits of gratitude that may lead to an increased disposition towards thankfulness.

Cultivating gratitude promotes positive affect and perspective and all the benefits derived from an increase in happiness. A healthier perspective can be developed through an increase in grateful thinking, as Mary Ann Mellor found in the introductory story. This article has surveyed the benefits of gratitude and suggested ways to cultivate it for therapeutic gain. It supports and reinforces what church leaders have taught: "Live with a spirit of thanksgiving and you will have greater happiness and satisfaction in life. Even in your most difficult times, you can find much to be grateful for" (*For the Strength of Youth*, The Church of Jesus Christ of Latter-day Saints, p. 6). Sister Bonnie D. Parkin (2007) thoughtfully summarized the powerful effects of gratitude when she declared, "Gratitude is a Spirit-filled principle . . . grateful awareness heightens our sensitivity to divine direction. When we communicate gratitude, we can be filled with the Spirit and connected to those around us and the Lord. Gratitude inspires happiness and carries divine influence" (p. 35).

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Footnotes

[1]Positive psychology was named and formally launched by Martin Seligman during his tenure as President of the American Psychological Association in 1999. His initiative brought together a collection of researchers and practitioners under a common umbrella. It has been defined as "the study of the conditions and processes that contribute to the flourishing or optimal functioning of people, groups, and institutions" (Gable & Haidt, 2005, p. 104), the "scientific study of ordinary human strengths and virtues" (Sheldon & King, 2001, p. 216), and the scientific study of "what makes life worth living" (Linley, Joseph, Harrington, & Wood, 2006, p. 5). The current focus on human strengths is receiving scientific investigation designed to help us better understand the role, influence, and effects of personal and community strengths and virtues.

[2]The emotional baseline of most individuals appears to be slightly positive (Reis & Gable, 2003) if no strong positive or negative events are occurring. The adaptation effect or habituation suggests that the impact of positive or negative events (Brickman & Campbell, 1971) naturally diminishes over time, bringing people back to their emotional baseline, so that individuals are often no happier or unhappier than before the positive/negative event. This adaptation often occurs more quickly than most assume. Some have concluded that "bad is stronger than good" (Baumeister, Bratslavasky, Finkenauer, & Vohs, 2001) because "negative events appear to elicit more physiological, affective, cognitive, and behavioral activity and prompt more cognitive analysis than neutral or positive events" (Taylor, 1991, p. 67). Therefore, significant negative events such as acquiring a permanent disability may alter levels of happiness more than significant positive events. In general, though, adaptation is active in the ordinary and common events in life and may help to explain why even though a favorite team wins a championship, the effects of their victory wear off fairly quickly, and even though individuals may be involved in a fender bender, they return fairly quickly to their normal levels of happiness. There are many explanations for this mechanism. One reason for this effect may be the "signaling" function of emotions. If individuals remained emotionally aroused, either too high or too low, their physiological alert systems would not work appropriately to signal them about new events in their life, such as a threat or an opportunity. Adaptation seems to be more active in some domains of life than in others. Whereas acquiring a new possession may give only a quick temporary boost to happiness and be very reactive to the forces of adaptation, developing a new friendship would likely have a stronger, more lasting impact on happiness and be less influenced by adaptation. This adaptation effect seems to indicate that some things contribute more effectively to lasting happiness. All of this leads to the question of just how malleable happiness is, and whether therapists can and should work to increase an individual's level of happiness over a sustained period of time, or whether there is a natural "set point." Are positive or negative changes in happiness doomed (in the case of positive affect) or destined (in the case of negative affect) to return to this "set point"?

APPENDIX

Additional Gratitude Resources

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Therapist Attachment, Client Attachment to Therapist, and Expected Working Alliance: An Analogue Study

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Forty-six therapists-in-training listened to an audiotape in which one of three client-attachment-to-therapist styles was portrayed (Secure, Preoccupied-Merger, Avoidant-Fearful). Participants completed an expected working alliance inventory for working with the audiotape client, as well as a measure of their own attachment dimensions. Results indicated that client attachment styles predicted differences in expected working alliance ratings, with the Secure audiotape yielding significantly higher total working alliance ratings than either the Preoccupied-Merger or Avoidant-Fearful audiotapes. The client audiotapes yielded the same ratings when therapists' own attachment dimensions were statistically controlled for, suggesting that therapists did not impose their attachment dimensions when predicting working alliance.

Bowlby (1988) argued that the therapeutic relationship can be construed as an attachment relationship for the client in that the therapist could act as a secure base and a safe haven from which the client explores potentially threatening issues. The client perceives the therapist as a "wiser and stronger" individual who will act as a secure base for the client to explore new ways of perceiving and being in the world. Holmes' (1993) characterization of the therapist as a secure base included being "courteous, compassionate, caring, being able to set limits and boundaries, and not burdening the client with the therapist's own difficulties and preoccupations" (p. 153). The therapist, then, must have the capacity to be a secure base, in some sense an attachment figure, from which the client may investigate personal problems and to which the client may retreat in times of crises. Holmes clearly acknowledged that

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therapists may have difficulties in becoming a secure base and a safe haven for the client. The therapist's own experiences in close relationships may, in fact, interfere with his or her ability to provide a secure base for the client. Thus, issues surrounding attachment for both client and therapist may contribute to the therapeutic relationship, and more specifically to the working alliance.

The working alliance in therapy is seen by many researchers as the most fundamental aspect of the therapy relationship and a strong predictor of outcome (Gelso & Hayes, 1998; Horvath & Symonds, 1991). Gelso and Hayes (1998) defined the working alliance as the "alignment or joining together of the reasonable self or ego of the client and the analyzing/therapizing self or ego of the therapist for the purpose of the work" (p. 2). From Bordin's (1979) theory, the alliance is influenced by therapist and client agreement on the goals and tasks of therapy as well as the bond between client and therapist. The working alliance, therefore, may be seen as consisting of three integrated components: (a) the goals—the mutually agreed upon outcomes of the therapeutic interventions; (b) the tasks—referring to the agreement between client and counselor on the in-counseling behavior and discussion; and (c) the bond—the complex of positive personal attachments between the counselor and client which include mutual trust, confidence, and respect (Bordin, 1979).

Research indicates that therapists' facilitative behaviors in forming alliances can be affected by their own attachment dimensions (Dozier, Cue, & Barnett, 1994; Dunkle & Friedlander, 1996; Mohr, Gelso, & Hill, 2005). Studies have shown that therapists with higher ratings on secure attachment dimensions (i.e., comfort in close relationships, an ability to rely on others in times of need, and little fear of abandonment in relationships) also have the qualities necessary to form strong working alliances (Dunkle & Friedlander, 1996). Likewise, therapists with dismissing attachment dimensions tend to exhibit hostile countertransference behaviors (Mohr, Gelso, & Hill, 2005). On the other hand, some studies show no significant relationships between therapist attachment styles and ratings of either the overall working alliance or the individual working alliance components of goals, tasks and bond (Ligiero & Gelso, 2002).

Studies examining the attachment style of clients suggest that clients with secure attachment dimensions are able to form stronger working alliances than clients with insecure attachment dimensions (Satterfield & Lyddon, 1995). In addition, research on the interaction of therapist and client attachment dimensions on therapy processes and outcomes shows that drop out rates are higher when insecurely attached therapists are paired with insecurely attached clients than in securely matched dyads (Dozier et al., 1994; Stuart, Pilkonis, Heape, Smith, & Fisher, 1998). Other research on the interaction of therapist and client attachment dimensions finds that the greater the difference in personality style, the better the outcome, as long as that difference is based on the therapists having more secure attachment styles and more positive (loving) introjects as compared to clients (Bruck, Winston, Aderholt, & Muran, 2006). Surprisingly, a study on the development of the early working alliance suggests that therapist attachment anxiety has a significant, positive effect on initial ratings by clients of the working alliance (Sauer, Lopez, & Gormley, 2003). Psychotherapy researchers, therefore, are beginning to examine the separate influences of client and therapist attachment dimensions on working alliance, as well as the interaction of client and therapist attachment on therapy process and outcome.

However, very little is known about the dynamic relationship between the working alliance, a therapist's attachment dimensions, and a client's specific attachment to the therapist. In one study, Mallinckrodt, Gantt, and Coble (1995) sought to describe and empirically investigate the therapeutic relationship as an attachment relationship, with the therapist being the figure for the client's attachment. According to Mallinckrodt et al. (1995), the client who has a secure attachment to the therapist experiences the therapist as responsive, understanding, and emotionally available. This client regards the therapist as a safe haven from which to explore troubling events. The client with an avoidant-fearful attachment to the therapist has suspicions that the therapist is disapproving and dishonest; hence, the client is reluctant to make self-disclosures during the session. The avoidant-fearful client feels easily rejected, humiliated, or shamed during the therapy session. The client with a preoccupied-merger attachment to the therapist, on the other hand, yearns to be "at one" with the therapist and wishes to expand the therapeutic relationship beyond the boundaries of therapy. Woodhouse,

Schlosser, Crook, Ligiero, and Gelso (2003) found that a client's secure attachment to the therapist was positively correlated with time in treatment and thus lower drop out rates.

It should be noted that Mallinckrodt et al.'s (1995) investigation focused on clients' perceptions of their therapists, but did not examine therapists' reactions to being an attachment figure for clients. Perhaps, depending on their own attachment dimensions, therapists may fail to differentially respond to clients who attach to them in secure, avoidant-fearful, or preoccupied-merger ways. If therapists' attachment dimensions predominate the relationship, then they may not accurately perceive the needs of the client. Rather than understanding the probable issues in the working alliance, they may simply see every therapeutic situation as the same. Differing perceptions between clients and therapists can be seen in research comparing the perceptions of client pathology by the therapist and by client self-report which finds that discrepancies do exist; the therapists tend to rate the clients as more anxious, depressed and hostile than the clients report themselves (Cowan, Weiner, & Weiner, 1974). Other studies have also shown discrepancies between perceptions of clients and therapists. Cooley and Lajoy (1980) found little agreement between the client and therapist perceptions of the same therapeutic relationship. The purpose of the present study, therefore, was to investigate whether therapists tend to anticipate varying strengths of the working alliance based on clients' attachment styles without primary reference to their own or whether they are predominantly influenced in their perceptions by their own attachment style.

Although current trends in therapy research favor field studies over laboratory research (Gelso & Fretz, 2001), we felt that an analogue design, in which the researcher does not study the activity of interest directly, but rather approximates or simulates the activity, would be useful in isolating the variables of interest and holding constant other variables (i.e., the length of time in treatment, presenting problem, and client demographics) that would be difficult to control in the field. Likewise, although participants were not actively engaged in forming a working alliance with the audiotaped client, research in other areas shows that therapists' personal biases can affect their perceptions and behavior in therapy (Little & Hamby, 1996; Pope & Vasquez, 1998). Furthermore, by manipulating the client's attachment style to therapist in an audiotaped format, we expected to activate the therapist-participants' comfort, trust, and fear of intimacy in a controlled manner.

METHOD

Participants

Therapist-participants in the study consisted of 26 male and 20 female graduate students at a large eastern state university and a large western private university. The majority of the participants were enrolled in doctoral programs in clinical (n = 21) and counseling (n = 19) psychology. Others (n = 6) were in masters programs in counseling or marriage and family therapy. Therapists averaged 28.36 years of age (range from 22-49 years). Therapist experience ranged from 1 practicum course to 18 practica, externships, and other clinical work; and the mean number of practica classes was 5. Five of the counselors were African American, 3 identified as Asian/Asian American/Pacific Islander, 39 identified as White/European American, and one identified the Other category. Participants rated the extent to which they believed in and adhered to the theory and techniques of the following therapies (5- point Likert scale, 1 = Low, 5 = High): Psychoanalytic/Psychodynamic (M = 2.74, SD = 1.06), Humanistic/Existential (M = 3.80, SD = .83), Cognitive/Behavioral (M = 3.57, SD = 1.28).

Client Attachment to Therapist Style Conditions

Client descriptions and audiotapes were created which reflected three different client attachment to therapist styles: Secure, Avoidant-Fearful, and Preoccupied-Merger. These styles were based on the Client Attachment to Therapist Scale (CATS; Mallinckrodt et al., 1995). Female actresses were chosen to portray the audiotaped therapist and client given that women are more likely to use outpatient mental health services (Greenley, Mechanic, & Cleary, 1987) and make up a majority of new doctorates in psychology (Norcross, Kohout, & Wicherski, 2005).

Client Descriptions. The client descriptions, presented to the participants before listening to the audiotape, reflected the three client attachment styles and included identical information about the client's age, sex, race, major, and presenting problem, i.e., guilt over a broken relationship. The secure client description character-

ized the client as being comfortable depending on others and having a good relationship with her parents. The preoccupied-merger client description portrayed the client as being uncomfortable without close relationships and having anxiety that others do not value her as much as she values them. This client described her relationship with her parents as inconsistent in that they were not reliably supportive and receptive to her. The avoidant-fearful client description characterized the client as feeling uncomfortable trusting and depending on others. This client reported that her parents were fairly cold, distant, rejecting, and unresponsive.

Client Audiotapes. Each of two experienced,White female actresses in their 20s played a client with secure, avoidant-fearful, or preoccupied-merger attachment to therapist style. The design of the study involved two actresses to allow detection of any possible actress effects. Thus, six audiotapes (3 to 5 minutes in length) were made, although each participant listened to only one audiotape. The client-actress with a secure attachment style to the therapist responded to her therapist's gentle exploration with descriptions of her emotions about the terminated relationship with a boyfriend. The secure client was able to explore with the therapist her feelings of frustration and sadness, and expressed some hope that working with her therapist would help her feel better. In contrast, the client-actress with an avoidant-fearful style of attachment to the therapist did not initially respond to the therapist's exploration of her feelings. She denied experiencing any painful feelings about the break-up and described her relationship to her therapist as cool and businesslike. Finally, the client-actress with a preoccupied-merger style of attachment to the therapist longed for more contact with her therapist and was preoccupied with knowing more about her therapist. The preoccupied-merger client expressed frustration at not being able to talk to her therapist every day and wondered if her therapist was as understanding with the rest of her clients.

Independent Raters. To assess the extent to which the client descriptions and audiotapes differed, two independent judges (White female advanced doctoral students in counseling psychology who were familiar with attachment literature) read each client description, listened to each of the six audiotapes, and rated the tapes on believability, therapist competency, and sound quality. The raters were also instructed to assess each audiotaped client's perception of her therapist by completing the CATS.

Results indicated that there were no differences between the audiotape conditions in terms of client and therapist believability, therapist competency, sound quality, and actress effects. However, as predicted, the independent judges identified differences between audiotape conditions in terms of the client's relationship to the therapist. Results showed that the secure audiotapes were rated significantly higher on the Secure subscale of the CATS than were the avoidant-fearful audiotapes (one-way ANOVA, $F(2, 11) = 10.81$, $p < .01$). There were no differences between the secure audiotape and the preoccupied-merger audiotape on the Secure subscale of the CATS. We reasoned that the independent judges perceived both the secure and preoccupied-merger clients as trusting the therapist and feeling safe exploring troubling issues, behaviors that indicate a secure attachment to the therapist. In the development of the CATS, Mallinckrodt et al. (1995) yielded similar results in their sample of 138 clients in that the Secure and Preoccupied-Merger subscales were positively correlated. Conversely, the avoidant-fearful audiotapes received significantly higher ratings on the Avoidant-Fearful subscale of the CATS than either the secure or preoccupied-merger audiotapes, $F(2, 11) = 73.96$, $p < .001$. In a similar fashion, the preoccupied-merger audiotapes yielded significantly higher ratings on the Preoccupied-Merger CATS subscale than either the secure or avoidant-fearful audiotapes, $F(2, 11) = 93.08$, $p < .001$.

Measures

Attachment assessment. Therapist attachment—the ability to develop healthy relationships—was measured using the Adult Attachment Scale (AAS; Collins & Read, 1990). The 18-item measure consists of three subscales, six items per subscale: (a) Depend—the extent to which an individual relies on or trusts others in times of need; (b) Anxiety—the extent to which an individual fears abandonment in relationships; and (c) Close—the extent to which an individual is comfortable with intimacy. Each item is rated on a scale from 1 (not at all characteristic of me) to 5 (very characteristic of me). Collins and Read (1990) reported test-retest correlations of .71, .52, and .68 for the Depend, Anxiety, and Close subscale scores of 101 college students over an interval of two months. Similar to those reported

by Collins and Read, in the current study therapist-participants' AAS scores yielded similar internal reliability coefficients of .79, .58, and .77 for the Depend, Anxiety, and Close subscales, respectively. Collins and Read (1990) report extensive construct validity for the AAS subscales. The Adult Attachment Scale has been used in research assessing both client and therapist attachment styles (Dunkle & Friedlander, 1996; Mallinckrodt, Gantt, & Coble, 1995).

Working alliance. Expected working alliance was measured using a modified therapist form of the Working Alliance Inventory (WAI-T, Horvath & Greenberg, 1989), a 36-item self-report measure comprising three subscales—tasks, goals, and bonds—that correspond to Bordin's (1979) concepts of therapeutic tasks, goals, and bonds. The Tasks subscale taps into the agreed upon in-counseling behaviors of therapist and client. The Goals subscale refers to the mutually agreed upon goals or outcomes of the therapeutic interventions. The Bond subscale includes the personal attachment (i.e., mutual trust, acceptance, and confidence) between client and therapist. A 7-point Likert scale was used by therapists to rate the level of agreement or disagreement for each statement. The therapist WAI was modified slightly to reflect the working alliance that the therapist-participants expected to form with the audiotaped client. In a counseling analogue study, Burkard, Ponterotto, Reynolds, and Alfonso (1999) found preliminary evidence for content validity of a modified WAI-T form. Burkard et al. revised the WAI-T to be written in the future tense and found it to be related to counselor trainees' levels of White racial identity. For the current study, we obtained Cronbach's alphas of .75 for task, .70 for bond, .81 for goal, and .90 for total working alliance. Construct validity for the counselor WAI was reported by Horvath and Greenberg (1994) using expert raters and multitrait-multimethod analyses.

Procedure

Lists of potential participants were obtained from the respective departments at a large, private western university and a large eastern state university, and individuals were invited to participate in the study by an introductory recruitment letter that explained the study. A lottery drawing for a $50 gift certificate was offered as an incentive for research participation. Identical procedures were followed at both data collection sites. One of the investigators followed up the recruitment letter with a personal telephone call or email message to each potential participant. Those interested in participating were scheduled for individual experimental sessions in a private office. The participants were informed that the purpose of the study was to examine therapist and client variables that influence the therapy process. Following a research script, the investigator asked the participant to complete the consent form. The counselor-participant was instructed to read a client description and listen to one audiotape of an excerpt of a session with a client. Participants were informed that they would not actually be working with the audiotaped client, but were asked to report the working alliance they would expect to have if they had worked with that client. After giving the instructions, the investigator left the room, and the participant reviewed the tape and completed the measures in the following order: WAI, AAS, and demographic sheet.

RESULTS

Preliminary analyses revealed that there were no significant site, gender, actress, experience, or psychotherapy preference effects. There were no differences between the two sites in terms of Total Working Alliance scores [$t(44) = 1.87, p = .068$], nor the Depend [$t(44) = -.75, p = .457$], Anxiety [$t(44) = .99, p = .325$] or Close [$t(44) = -.77, p = .448$] subscales of the AAS. There were no significant differences between men and women in the sample in terms of the Total Working Alliance scores [$t(44) = -.45, p = .652$] nor between participants' responses to the two actresses across the three conditions that they portrayed [$t(44) = -.04, p = .969$]. There was no significant correlation between Experience and Total Working Alliance scores [$r_s(44) = -.16, p = .297$]. There were no significant correlations between Total Working Alliance scores and therapists' Psychoanalytic preference [$r_s(44) = -.27, p = .073$], Humanist preference [$r_s(44) = -.27, p = .068$], or Cognitive-Behavioral preference [$r_s(44) = .21, p = .160$].

A preliminary ANOVA was conducted to test the differences among the audiotaped client groups according to Total Working Alliance ratings. The test of differences among the groups was significant [$F(2, 43) = 13.50, p < 0.0001$]. Post hoc Tukey HSD tests revealed that all three groups were significantly different from each other. The Preoccupied-Merger audiotaped client

received the lowest mean Total Working Alliance score of 170.20 (SD = 12.41); the Avoidant-Fearful audiotaped client received a mean Total Working Alliance score of 184.20 (SD = 16.61); and the Secure audiotaped client received the highest mean Total Working Alliance score of 197.81 (SD = 15.02).

An ANCOVA was conducted to remove the effect of therapist characteristics from the analysis. The ANCOVA removed the effects of therapist attachment dimensions and still revealed significant differences among the client audiotape conditions in terms of Total Working Alliance ratings [$F(2, 40) = 8.70$, $p = 0.001$]. The estimated marginal means were all significantly different from each other and maintained their same order, with the Preoccupied-Merger audiotaped client receiving lower Total Working Alliance ratings than the Avoidant-Fearful audiotaped client, which was lower than the Secure audiotaped client. Results from the ANCOVA revealed that the covariates due to therapist attachment dimensions were not significant for therapist Depend scores [$F(1, 40) = .09$, $p = 0.36$], for therapist Close scores [$F(1, 40) = 2.58$, $p = .17$], and for therapist Anxiety scores [$F(1, 40) = .06$, $p = 0.81$]. Hence, when we controlled for the therapists' own attachment dimensions, it became evident that clients' attachment styles were significantly predictive of how therapists anticipated the working alliance.

DISCUSSION

We found that therapists expected a stronger working alliance with the securely attached to therapist client audiotapes than with insecurely attached clients. This finding is consistent with previous research (Mallinckrodt et al., 1995; Mallinckrodt, Porter, & Kivlighan, 2005) showing a strong association between secure client attachment to therapist and positive working alliance. Therapists in general may find it easier to form an alliance with clients who are willing to explore emotions and respect the therapeutic boundaries. In contrast, therapists most likely find it more difficult to develop an overall alliance with a client who either wishes to merge with the therapist or who appears uncooperative to the therapist's suggestions. Thus, it seems logical that a therapist who is perceived by a client as a supportive attachment figure would expect a stronger overall working alliance with that client than would a therapist who is perceived as either a merger object or a fear-inducing agent.

It is very encouraging to note the finding that therapists' own attachment dimensions did not seem to influence their perceptions of the audiotaped client. Rather than having a fixed frame of reference shaped by their own attachment needs, results showed that therapists consistently rated the insecurely attached client audiotapes lower on expected working alliance. If the working alliance was predominated by the therapists' own attachment style, the statistical tests would not have resulted in significant differences among the client groups. Nonsignificant results would have indicated that therapists would have imposed their attachment style on every client to predict the working alliance. As it turns out, whatever the therapist's attachment dimensions might have been, client characteristics were significantly influential in the anticipated working alliance.

Limitations

Several limitations should be considered when interpreting the present findings. First, the audiotapes were of varying lengths, from 3 – 5 minutes. It is possible that the longer audiotapes showed more examples of the therapist and client agreeing on tasks and goals in session as well as forming a bond. In addition, the notion of a "good/easy" and "bad/difficult" client is necessarily constrained with the client attachment to therapist presentation. It may be that therapists were reacting to the audiotapes as examples of good or bad clients rather than attending to the client attachment to therapist styles portrayed in the audiotapes. Finally, the analogue nature of the study necessarily constrains the generalizability of the results. Rather than actual interactions with a real client, therapists' expectations about working with audiotaped clients were assessed. However, social psychology research indicates that individuals' beliefs and expectations affect subsequent interpersonal interactions (Harris & Rosenthal, 1985). By examining a therapist's expectation about working with a client who displays a secure attachment to the therapist in an analogue study, we obtain a glimpse of how such a therapist may actually interact at least initially with such a client. Furthermore, efforts were made to augment external validity by making the audiotaped client presentation as realistic as possible, by emphasizing the importance of participants placing themselves in the counselor role when reviewing the audiotape and completing the mea-

sures, by arranging the experiment so that the experimenter was outside the counseling room, and so forth.

Implications for Practice and Research

This analogue study offers some implications for clinicians in working with clients. Therapists should be aware of the potential for clients to consider the therapist as an attachment figure and how such attachment might impact the development of the working alliance. Supervisors and training directors should be aware of and attend to therapist-trainees' attachment dimensions as well as the clients' attachment to the therapist-trainees in considering how to facilitate working alliance formation. Using actual therapist/client dyads, therapists with a wider range of experience levels, client ratings of working alliance, a more diverse sample, and in-therapy behaviors, future studies should continue to examine the relation between attachment dynamics and therapeutic processes.

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Family Issues in Time of War: A Chaplain's Perspective

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Military families experience many stressors that are similar to those of non-military families and others that are more common to military life. Stressors which are more common to military families include enduring forced periods of lengthy separation, raising a family with only one parent for extended periods, experiencing frequent forced moves, and being away from the extended family. In addition to these basic stressors are those associated with the harsh reality of war: personal injury, disability, and death. For these families, the future is very uncertain, as is the possibility of never seeing one another again. This paper explores the similarities and differences between the problems military and non-military couples face and the role of military chaplains in assisting families in dealing with these problems. Chaplains' use of various therapeutic interventions with military families and couples will be discussed. The realities of military marriage and family life during a time of war will be presented through the use of case studies.

INTRODUCTION

Families and couples seek counseling about a variety of issues, ranging from financial problems to trust and forgiveness (Goldenberg & Goldenberg, 2000; Nichols & Schwartz, 2006). Issues are particularly intense in military families, especially with couples in which one (or both) spouse(s) is deployed to a combat zone (Knox & Price, 1995). Additional issues for these families include enduring forced periods of lengthy separation, raising a family with only one parent present for an extended period, being away from extended family, and facing the possibility of personal injury, disability, and/or death.

According to the Military Times Media Group (www.militarycity.com), there are currently a total of 1.3 million U.S military service members on active duty serving worldwide. Table 1 shows the demographics of this population.

The reported number of troops in Iraq ranges from 130,000 (www.globalsecurity.org) to 160,000 (Enemark, 2005). Additionally, more than 32% of American troops

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Table 1
Demographics of the Active Duty Military Population

Demographics	Percent
Male	85%
Female	15%
Ages 18-25	45%
Ages 26-34	30%
Age 35+	25%
Married	53%
Caucasian	66%
African-American	20%
Hispanic	8%
Other	6%

From Military Times Media Group, Military demographics. Retrieved April 1, 2006, from http://www.militarycity.com

have served more than two tours of duty in Iraq or Afghanistan. As of April 2007, more than 3,200 U.S. service members have been killed in combat (http://icasualties.org/oif). Additionally, 37 U.S. soldiers, on average, are sent home for psychiatric reasons each month (Enemark, 2005).

To deal with family issues in this time of war, families, military spouses, or service members themselves will seek out a chaplain for counseling. Often individuals will be referred by unit command personnel or supervisors who have noted a decrease in performance or change in mood. The chaplain, as a spiritual leader and pastoral counselor, is typically viewed as an invaluable resource for couples or individuals in distress—someone who offers them hope in dealing with their difficulties.

This article examines the various issues that military couples and families face during a time of war, presenting these issues through the contexts of different case studies. Similarities and differences between the problems of military families vs. non-military families will be explored. Various therapeutic interventions chaplains have used that have been helpful with military couples and families will be discussed.

Problems of Family Separation and Deployment

In no other profession is family separation as common as it is in military service. These separations vary widely in terms of location, frequency, duration, and purpose. Often the purpose can put the military family member in "harm's way" unlike separations in non-military families. No matter what form it takes, separation creates a stressful and at times traumatic situation for the family (U.S. Army Center for Health Promotion and Preventive Medicine, n.d.). The U.S Army Center for Health Promotion and Preventive Medicine has identified four stages of the departure-return cycle of separation: protest, despair, detachment, and return adjustment (see Table 2). The Iraq War Clinician Guide (Waldrep, Cozza, & Chun, 2004) discusses the emotional cycle of deployment as occurring in five distinct stages, with each stage being characterized in terms of time and emotional response: pre-deployment, deployment, sustainment, re-deployment, and post-deployment (see Table 3). Both tables are included to familiarize the reader with different views of the deployment cycle, with Table 3 dealing more with the emotional aspects of this process.

Prior to deployment, the family is anticipating the separation, trying to spend time together and also attempting to predict and plan for some of the situations that they may encounter while apart. Although the family is soon to face several months apart, they are very busy training and preparing for the deployment. This leaves them with little time to actually spend together—an additional strain for the relationship, as the service member will likely feel guilty and frustrated, and the spouse will feel abandoned and rejected.

The deployment itself is actually the easiest part of the cycle for most military couples. Once they get into their routines, mentally accept the separation, and focus on staying busy, things begin to get better and time starts to go by faster. The most difficult aspect of this portion of the deployment cycle is the spouse's fear that the service member is going to be hurt or killed and the service member's fear that the spouse or family will need things that he or she failed to provide or plan for prior to leaving. Anticipation of return is very difficult because time slows down and the days begin to drag out. Both spouses begin to wonder what changes have occurred and what they can expect from their partner upon return. They start questioning how they should act and how they will be accepted by their spouse.

Reintegration involves complex, interrelated issues, but in simple terms, excitement and fear combine to produce anxiety, confusion, worry, and joy—often experienced simultaneously. Both spouses, though eager to

Table 2
Four Stages of Departure-Return Cycle

Stages	Description of Each Stage
Protest	The spouse protests against the service member's departure, starting a week or two before the leave date. Spouses talk of feeling tense, selfish, unbelieving that the service member would actually leave, and guilty about not wanting their spouse to go. The spouse becomes increasingly frustrated over the number of hours his or her spouse is spending getting ready to deploy, which is intensified as the spouse develops an awareness of just how much family business and how many chores need to be completed prior to the person departing. Both spouses will likely feel overwhelmed at the prospect of just how much really needs to take place in such a short time. This can lead to physical and mental exhaustion for both individuals.
Despair	The "tearful period" sometimes occurs even before the member departs. The spouse will ask, "How will I ever live through this without him/her?" The spouse will also experience difficulty sleeping and will jump at even the smallest of noises in fear of an intruder.
Detachment	The spouse develops relative calm and confidence in handling day-to-day living. This is the level that the spouse generally maintains during most of the deployment.
Return Adjustment	Many spouses experience an incredible emotional frenzy as they prepare the house and themselves for the eventual reunion. The arriving spouse will likely be exhausted and spend a fair amount of time sleeping, but not until he or she has tried to catch up on all that has happened during the absence. Some describe this period as a time when both spouses are trying to get reacquainted with each other. The returning spouse will want to spend some time alone, and, depending on the specific type of deployment, will need to readjust and acclimate to the community environment again. This is particularly true for those returning from combat.

From U. S. Army Center for Health Promotion and Preventive Medicine. (n.d.). *Deployment guide for families of deploying soldiers: Separation and reunion handbook*. Retrieved April 1st, 2006, from http://www.hooah4health.com/deployment/familymatters/separation.htm

Table 3
Five Stages of Deployment

Stage	Description of Each Stage
Pre-deployment	From the time of notification of deployment to the actual departure, this period is often characterized by denial, intense preparation, and anticipation of the departure.
Deployment	From the time of departure through the first month of deployment, the family will experience intense turmoil as it seeks to establish a new equilibrium and rebalance itself. Common feelings during this phase include numbness, sadness, isolation, and abandonment. One way to reorganize is to assume responsibility for the functions and jobs normally performed by the absent individual.
Sustainment	From one month post deployment to one month prior to return in most adaptive families is marked by "settling into the new routine" and continuing on with daily activities and business, utilizing internal and external resources when available.
Re-deployment	From one month prior to return to the actual physical return, anticipation creates intense emotions, such as confusion, and excitement mixed with anxiety.
Post-deployment	From return of the service member until the reestablishment of family equilibrium, this phase can take weeks, months, or even years to complete. Feelings that the deployment has caused the couple to "grow apart" can be a constant reaction for either or both spouses. Unrealistic fantasies and expectations of the reunion often leave spouses and children feeling empty or let down. The returning spouse might feel as though he or she is not needed, particularly if the household appears to be running smoothly. Returnees often report feeling like "strangers in their own home." They are also caught off guard by the independence and autonomy of the spouse who remained at home.

From Waldrep, D. A., Cozza, S. J., & Chun, R. S. (2004). Impact of deployment on the military family. *Iraq war clinician guide* (2nd ed.). Washington, DC: Department of Veterans Affairs National Center for Post Traumatic Stress Disorder.

see their partner, have become used to a routine and have been able to make a lot of decisions without having to consult or even consider the other person. That independence begins to change once the service member returns home. Additionally, they cope with fear that war and combat will have detrimental and significant long-term impacts on the service member and the family. Worries about combat stress, posttraumatic stress disorder (PTSD), and marital issues are common.

Regardless of which specific model is used, deployment can cause incredible stress for the individual, as well as for members of both the nuclear and extended family. Accordingly, every deployment is inherently different for all involved. A particular family will experience successive deployments in both similar and different ways, and different families will experience the same deployment in unique ways, based on biological, psychological, and sociological factors. When individuals and families have difficulty coping with the effects of deployment, one of the places they frequently turn is to their unit chaplain.

Chaplains' Work with Families in a Time of War

The primary mission of chaplains is to minister to all personnel in their unit, to equip them with the emotional and spiritual tools necessary to engage the enemy on the battlefield. This can include providing Bibles and other religious material, praying with service members, visiting the injured or sick, and conducting worship services as appropriate. Operating within a pluralistic environment, chaplains must be prepared to provide for those of their own faith, to facilitate for those of other faiths, and to care for all. They also serve the unit commanders as moral and ethical advisors. In these various roles, chaplains have a direct impact on mission accomplishment and ultimate battle success. Off the battlefield, chaplains deal with family issues among unit personnel, as these issues will often have a direct impact on their military duties and subsequent ability to accomplish a mission.

In addition to ministering to the military personnel themselves, chaplains also minister and counsel with spouses, children, and other family members. Much of a chaplain's time can be spent doing marital and family counseling. In addition to the assortment of marital issues that may be present, chaplains often encounter a variety of spiritual issues when working with couples. These can include questions such as "Why would God want a husband and wife to be apart?" or "Why would God have mothers raise children by themselves for such long periods of time?" or "If my husband kills another person, what does this mean in terms of our salvation or exaltation and future as an eternal family?" Thus, chaplains are in a unique position to provide both spiritual and psychological assistance to families.

In the present Global War on Terrorism (GWOT), family issues are magnified as modern technology makes it easier for family members to communicate. It is not uncommon for a service member to have a fight with his spouse by telephone and then immediately pick up a weapon and go on a combat patrol. The "Dear John letters" of wars past still occur, except now they come by e-mail, telephone, video taped message, or even a little "revenge sex" with a friend or neighbor. Chaplains must also contend with various issues involving the spouse back home, such as legal, medical, and financial concerns, as well as fears of perceived or real infidelity. When the service member returns from deployment, the chaplain is a source for marital and family counseling as well as assessment and referral for individual issues stemming from combat. Families may also seek therapeutic assistance from civilian therapists (psychiatrists, psychologists, licensed social workers, professional counselors, or marriage and family therapists) through Tricare, the military insurance provider. Or they may seek assistance from mental health counselors (primarily social workers) at the community counseling center on base.

Not all chaplains have a counseling or mental health background. Therefore, chaplains should only perform counseling functions within the scope of their specific practice, education, and experience. For many, this means limiting counseling to issues that are spiritual, religious, or pastoral. Some areas where chaplains could easily find themselves practicing beyond their scope of practice include cases involving survivors of rape or molestation, domestic violence, and addictions.

Military members are oftentimes reluctant to seek counseling by any professional due to unfounded fears that this may ultimately hurt their military career. Chaplains are seen as the least threatening professional due to the absolute confidentiality afforded military personnel. But even with confidentiality, many military families are reluctant to seek out the chaplain since chaplains are often perceived as being concerned only with religious behavior, such as praying and reading

scripture. Added to this issue of religious focus is the reality that many chaplains do not have formal counseling education and training, and sometimes they perform counseling duties beyond their ability.

The issue of confidentiality is a major ethical issue for chaplains, particularly those who are licensed or certified as mental health counselors. Federal law mandates that chaplains maintain absolute confidentiality. This requirement supersedes the exceptions to confidentiality afforded civilian mental health professionals. For example, if a person reveals to a chaplain that he or she is abusing an infant, the chaplain cannot break confidentiality and report the offense, despite state laws that mandate reporting by licensed counselors or therapists.

Since chaplains do not typically maintain case files, it is difficult to report an accurate number of counseling sessions provided in a given week. Counseling loads vary greatly between units depending on the accessibility of the chaplain, the education, training, and experience of the chaplain as a counselor, the extent to which the chaplain views counseling as a primary facet of the job, and the perceived effectiveness of the chaplain as a counselor by unit personnel. Since the Iraq War, counseling loads have increased, particularly with regards to couple and family counseling (various Navy chaplains, personal communications, April 12, 2006). Chaplains must take on the emotional and spiritual burdens of many people, while themselves being exposed to the elements of war. They are always on call and therefore are used to being contacted at all hours of the day and night. All of these things can take an emotional toll on chaplains, who, while counseling others, are often trying to maintain their own family and individual lives.

INDIVIDUAL STRESSORS ASSOCIATED WITH DEPLOYMENT AND COMBAT

There are many stressors associated with deployment and combat for the individual military member. Listed below are some, but not all, of the types of stressors associated with combat, divided into the categories of emotional, physical, and spiritual stressors. It should be noted that written mental health assessments are conducted prior to and following return from deployment. Although these assessments are conducted through the medical department, the chaplain can and should play an important role in the process. Primarily, this will involve speaking with any service members who may have answered questions in a manner indicative of potential problems in deploying and/or reintegrating.

Emotional Stressors

Fear. To succeed on the battlefield, one must be fearless. Yet when preparing for war, some will fear the prospect of combat and all that it entails. Many equate fear with weakness and worthlessness, and experiencing it may diminish their self-image. When fear is taken to the extreme and blended with hopelessness, guilt, and shame, even suicide can become a possibility.

Death of friends. Death is perhaps the greatest emotional stressor. Service members become very close to those with whom they serve, maybe closer than they have been to any other human being in their life. A bond develops between those who serve in combat together, a bond that is even stronger than that between family members.

Sense of self. Death of a comrade brings up feelings of failure within the individual, feelings of failure as a person. One who loses a comrade may experience a level of pain that is virtually unmatched in any other setting. These individuals often blame themselves for the death and begin to question their effectiveness as a military professional or their worthiness as a friend, as well as their courage, sense of commitment, and honor.

Tours of duty. Cumulative stress occurs from multiple combat tours. When is this cumulative stress too much? The answer to this difficult question is that it varies from person to person relative to a multitude of intra- and interpersonal factors.

Boredom with the mission. Many ground combatants express discontent, saying "the second and third deployments were nothing like the first" or "it was much more fun the first time" (various United States Marines, personal communications, March 23, 2006). During Operation Iraqi Freedom-I (OIF-I), the mission was to take Baghdad. The mission now is much more related to training the Iraqi military, which can make it more difficult to see the purpose of war or to experience the same sense of accomplishment.

Physical Stressors

Environment. In Iraq, summer temperatures are above 120°F, with personal protective gear (helmet, vest, etc.) adding another 10-20°F. Personnel serving in tanks, reconnaissance vehicles, or amphibious assault vehicles will experience an additional 30-40° over those temperatures. In the winter, temperatures are below freezing at night.

Sleep deprivation. Personnel on deployment may sleep less than 4 hours out of 24. Going days without sleep can impair cognitive functioning related to memory, comprehension, decision making, and attention (Van Dongen, Maislin, Mullington, & Dinges, 2003).

Noise. Hearing constant mortar, rocket, and gun fire is a reminder that there is no escaping war.

No front/rear line of combat. All parts of Iraq are considered hostile and potentially deadly; the necessity for constant vigilance leads to increased cumulative stress.

Spiritual Stressors

Anger with God. The most common spiritual stressor is a feeling of anger towards God, perhaps in response to a friend's death/injury, absence from family, or the daily hardships that serve as constant reminders of the harsh realities of war. The individual cannot understand why a loving God would cause all of this horror. Anger with God is difficult to live with at any time, but especially during war because the person knows deep down how comforting that sense of faith and spiritual hope can be. This anger challenges the famous saying that "there are no atheists in foxholes."

Killing. The prospect and eventual reality of killing another human being causes debilitating guilt in some individuals. Persons who have never taken another person's life can only speculate as to what it might be like. Regardless of how right the killing may be from a legal and military perspective, the other person is still a living, breathing human being—a son, brother, husband, father. A soldier will likely question why God put him in the position to kill, where he now stands with God, and if he is going to go to hell for committing murder.

COUPLE AND FAMILY STRESSORS ASSOCIATED WITH DEPLOYMENT AND COMBAT

Families who remain stateside while their family members are at war experience an assortment of stressors. Although not exclusive to military families, stressors that may take on added impact when associated with deployment and combat include (a) legal and financial matters, (b) emotional and spiritual issues, (c) anxiety of children over their parent returning home alive from the war, (d) possibility of death, injury and/or debilitation to the deployed service member, (e) common feelings of loneliness and constantly worrying about each other, and (f) potential conflict arising from communication occurring between spouses.

When military families/couples seek counseling, they do so for a variety of reasons. However, most of the difficulties for families and couples with a member returning from a combat zone are related to emotional and relationship issues as an outcome of the war experience rather than the actual factors of being in war (see earlier section; Figley, 1978; Figley, 1993). These issues include fear of change, development of trust, and adaptations of roles/responsibilities.

Some of the differences between military couples and non-military couples lie within the military context underpinning these issues. For example, non-military families usually do not have family members who are in an environment requiring constant exposure to noise, shooting, bombing, threat of death, traumatic death of friends, and orders to kill. Although the returning military member is no longer experiencing actual exposure to the war environment, coming home from such an environment creates a family climate in which these experiences impact relationships, decision making, and ultimate adjustment.

Individuals, couples, and families experience deployments differently, as with any situation or set of circumstances. Subsequent deployments of the same individual may be experienced differently as well. This is a hard concept for families and couples to understand, as they will often say, "We have done this before—we know exactly what to expect," or "My children know from experience what will be happening to me." The problem is that while they may think they know, they really cannot because every experience is different.

Another issue that individuals, couples, and families have to face is the ever-nagging question of "What is normal?" Marines, soldiers, sailors, and airmen often ask, "Is what I am going through normal?" *Normal* is a hard word to define. What is normal for one person may not be for another. A typical response to this question will involve asking, "How much distress is it causing?" or "How is it impacting your life?" In cases of combat stress or combat-related posttraumatic stress disorder, symptoms should dissipate with time. These two concepts become very important: "Are the symptoms causing marked distress?" and "Are the symptoms improving at all?" For many, the issue is seeking help: "When do we need to seek help?""To whom will we go for help?""How

will seeking help be perceived by others?" This is where a chaplain can offer considerable assistance. If he or she has a strong relationship with the Marines and sailors in the unit, there will be no hesitation or ill feelings in seeking help. Marines will often say to each other, "You should go see the chaplain—he can help." The reality is that the chaplain might have to refer individuals to the medical officer or psychiatrist, but at least they came to him first, and now the chaplain is part of the solution.

The chaplain can be part of the solution for many of the couple problems that arise when service members return from war. Many of these problems are related to emotional and relationship issues arising from the war experience as individuals reunite with their families. There are several areas where problems might occur. Some of these will be discussed in the following sections.

Fear of Change Issues

Nature of the problem. The military member deploying and the spouse back home have to contend with the fear that change will occur. The thought of enduring a 7- or even 14-month deployment and experiencing a reunion with a "different person" can be a very scary prospect, as combat does in fact change a person. This change is expected and considered normal. The extent and type of change, however, varies with the person and family (Dekel, Goldblatt, Keidar, Solomon, & Polliack, 2005; Solomon, Waysman, Avitzur, & Enoch, 1991).

Perhaps one of the greatest fears for spouses and children is that the service member will be injured, disabled, or killed in combat. While these tragedies are always possible, the percentage is relatively low considering the large number of men and women serving in combat, along with the high level of training they have received and the high quality of equipment and technology. Emphasizing these points, along with the concept that God has a plan, helps a spouse to realize that the service member is actually well prepared for war and for the assigned mission. Nonetheless, knowing these facts might do little to relieve the fear of uncertainty and the fact that the family has no direct control over the outcome of the situation. Perceived lack of control and lack of information are probably the biggest stressors that will be encountered on a daily basis.

Many of the men and women coming back from Iraq are experiencing symptoms commonly seen as a result of the war, often diagnosed as posttraumatic stress disorder (PTSD; American Psychiatric Association, 2000). These symptoms include a significantly heightened startle response, nightmares, flashbacks, difficulty sleeping, irritability, and mood swings.

Wives are especially fearful of being awakened in the night in a chokehold by their husband who may be having a nightmare, or of having themselves or their children hurt by the husband who has been startled and thinks he is back in Iraq. It is helpful for the couple and children to know that what they are experiencing is a possible, not unusual, outcome of war, and that this behavior does not make the person pathological or diseased. It does mean, however, that family members must learn to adjust and to continue to function as a family unit while the symptoms begin to lessen in intensity and frequency.

The United States Marine Corps has developed several different programs to help the Marines, sailors, and their families better recognize, adjust to, and cope with these issues. These programs, oftentimes led by chaplains, consist of informational briefings conducted overseas and again upon return to the United States. Although PTSD symptoms will usually diminish with time, the individual will sometimes require individual and/or group counseling to facilitate the necessary or desired healing.

Case study. In the following case, the reader will enter into the life of a Marine couple, Mark and Dawn. This case study will help to clarify emotional challenges of change facing such couples, in combat as well as at home.

Mark and Dawn, both 21 years old, had only been married for 2 months prior to Mark's deployment to Iraq. Mark had been in the Marine Corps for just over a year and was deployed for more than 6 months. Before Mark left for Iraq, the marriage had been going well. He had come from a rigid, patriarchal family background in which his father had made the rules and most of the decisions. In his marriage he carried out the same pattern, and he enjoyed the control and authority, especially since it was so different from work, which was an environment where he had little or no control. Dawn had been excited about marriage and the prospect of being a military wife, but she hadn't considered how difficult it would be to live alone in an unfamiliar environment with no friends. In her lonely apartment she was constantly worrying about whether or not Mark would return home alive, and whether he would come back to her physically and mentally healthy. She had even stated, "I don't know what I would do if he were killed. He is my

life." Her daily routine revolved around thinking about him, having nightmares that he died, and staying home to receive his calls. About halfway through the deployment, she decided to get a job to help pass the time and hopefully make some friends.

After starting her job as a server, she went out somewhat regularly with the other female servers to the local clubs, but soon realized that this was costing her a lot of money—money that she really didn't have. One night, several weeks after starting the job at the restaurant, she went out as usual with her friends, but things happened differently that night. She was more relaxed and was acting much more flirtatious than normal. While dancing with a young man she had just met, she soon found herself kissing him. It was at this point that she realized that she and the situation were out of control. She left the club and quit her job the next day. That night would become a turning point in her life. Wanting more out of life and her marriage, she decided to take some college classes and work towards her dream of becoming a nurse.

A few days later, Dawn was contacted by a Key Volunteer. Key Volunteers are Marine Corps wives in the same battalion who act as mentors for younger, perhaps less experienced wives. This woman became a friend and a mentor, helping Dawn to understand the challenges of life as a Marine Corps wife. Dawn began to realize there were other resources available to her, including a variety of classes and workshops offered on base that she could attend. Through these various workshops, classes, and briefings, Dawn came to realize that her experiences were similar to those of many military wives.

Dawn stayed busy with school, excelling in her classes and making new friends. When Mark returned home, Dawn was more established in the community, had an assortment of friends, both military and non-military, and was in her second semester of school.

Upon returning from war, Mark quickly saw Dawn as independent and confident. He began to wonder what his role would be, and he became fearful that Dawn had changed, moved on, and outgrown him and their marriage. He felt extremely uncomfortable and wondered how he would regain the control he felt he needed. Although he would not admit it, Mark was extremely intimidated by what Dawn was becoming and by her associated success.

Mark was not experiencing the common symptoms of PTSD typically seen in those returning from combat: i.e., difficulty sleeping or eating, nightmares, or flashbacks (Litz, 1992). Noises and even images of war on the news did not bother him. According to his own admission, however, he felt jumpy and angry all the time, with the anger not directed at any one person or thing. Dawn validated the anger by saying that Mark was constantly irritable, frustrated and angry at anything and everything. According to her, he was completely opposite from what he was like before the war. In session she said, "He used to be this really nice guy; now he is just a big, angry jerk." Dawn began to understand that this kind of behavior is one of the first things that spouses notice and complain of following return from deployment. Although Mark did not meet the *DSM-IV-TR* (American Psychiatric Association, 2000) criteria for a diagnosis of PTSD or even acute stress disorder, it was obvious that combat had contributed to his anger and irritability (Byrne & Riggs, 1996; Figley, 1989, 1993, 1997; Jordan et al., 1992; Lipton & Schaffer, 1986).

Mark and Dawn came to see me, the unit chaplain, shortly after his return from Iraq because they felt as though "the deployment had caused them to drift apart." Mark felt estranged from Dawn, like she had become a very different woman. She did not seem like the same woman he had married. He felt that she didn't need him anymore. Dawn was very busy with school and wasn't able to give Mark the kind of attention he felt he deserved after being away serving his country and risking his life. Mark was aware that he was angry and irritable all the time and was not sure what part his deployment had played in this. Dawn felt Mark did not appreciate what she had accomplished while he was away and how she was adapting to her role as a military wife. They both complained of communication problems and lowered sexual desire.

Change is always difficult and is accompanied by many fears. These fears became the theme of Mark and Dawn's counseling. The road that Dawn had chosen seemed quite positive, but perhaps the movement was too fast for Mark. We concluded that she might need to slow down enough so that he could become part of the journey. Mark's belief system that included thoughts like "She doesn't want or need me" and "I have failed as a husband" were also discussed in great detail. The goal was to help him see just how much she did need and want him, and how his love as a husband had provided Dawn with the courage to go to school, committing herself to a

future career as a nurse.

At the core of the problem was the fact that Mark and Dawn had spent only 2 months together as a married couple before Mark's deployment. This extended time apart, especially when one or both are in a combat environment, is a factor that most non-military families fortunately do not have to face. On his return, Mark and Dawn were like roommates, often not spending sufficient time together.

We began with planning for them to have some regular time together and identified a specific time each day that they could do this—a small yet significant step. Next we discussed some rules pertaining to how they would spend their time together: no TV, homework, reading, or household projects. Instead, they were to spend the time talking and getting to know each other as husband and wife. They could discuss the factors of war that had affected Mark and the factors that had affected Dawn while he was away. This process would enable them to get to know the "changed person" in each and find ways they could manage these changes—together.

In addition to this daily time together, we also discussed setting aside a weekly date night. These dates would have to involve some aura of romance, as if the couple were still courting. By doing this, Mark and Dawn would continue to grow as a couple emotionally and spiritually, thus increasing their level of intimacy. This increase in intimacy would also help them draw closer together sexually.

As they spent time together, Mark felt as though Dawn really did need and love him—thus forming a stronger couple identity. Their concept of the relationship grew from that of two individuals to that of a couple. As this cognitive change occurred, Mark became more supportive of Dawn's goals, which resulted in an improvement in all aspects of the marriage, including their sex life.

In addition to the couple therapy, Mark worked on aspects of stress management, particularly on how anger became an outward expression of his insecurities and how it was rooted in feelings of inferiority, diminished self-confidence, and lack of control. Mark struggled with how his participation in the war was contributing to his anger and irritability. This exploration of the effects of war, necessary in cases such as Mark's, is a component of treatment that would not typically concern non-military families. As Mark was able to see how the independence and confidence he perceived in Dawn were not negative reflections on him, he began to understand the origin of his feelings; with time, he developed effective coping skills to deal with his stress.

Trust Issues

Nature of the problem. Most military families I have observed who seek counseling are young, the average age of the couple ranging between 18 and 26 years. Most of these couples have been married less than 3 years, and in many cases they have at least one child. A major issue facing many of these couples is trust. While the issue of trust for military families is often considered in terms of infidelity or perceived infidelity (Caselli & Motta, 1995; Mason, 1998; Mikulincer, Florian, & Solomon, 1995), it is actually the fear of infidelity that becomes the critical issue.

In wars past, only men would be actively involved in combat. Today there are female soldiers, Marines, sailors, and airmen in virtually every unit except those that directly engage enemy forces. Even with this exclusion, women are still a critical component of the fighting forces in Iraq and Afghanistan. Thus men and women are serving side by side, in close proximity, simultaneously being exposed to the hardships and reality of war, combat, and possible death or injury. In fact, women are currently serving in direct support of combat, something relatively unseen in past wars.

Thus, it is possible for either spouse to engage in infidelity during the deployment. The military member in a combat zone is confronted with death daily. This threat, combined with frequent feelings of loneliness and isolation, makes it easy to be receptive to almost any kind of affection and to possibly become intimately involved. The mind will even rationalize such involvement by convincing the person that "others are doing it," "nobody will know," or "I could be dead tomorrow," leading to the question, "Why deprive myself now?"

The spouse back home is often perceived as being more susceptible to infidelity, at least with regards to opportunity. He or she may feel overwhelmed by unaccustomed responsibilities and might not be having much fun, spending all of his or her time working and taking care of the home and children, having to accomplish all of these tasks alone. The stress from this situation can build up to the point that a person desperately desires a listening ear, assistance, or just another individual who understands and can be sincerely empathetic. Sometimes the spouse suddenly gains an ally, someone

who understands and will listen. As the two become more involved in the emotional relationship, more time is spent together, intimacy develops, greater risks are taken, and the point is ultimately reached that the two become sexually involved. In addition, children see their parent spending more time with another adult who is not their parent, and they are often confused and worried about what is happening to their family and to their other parent who is at war.

Case study. The following case shows how a wife, Crystal, and her Marine husband, Roger, deal with the multiple problems facing a couple in the aftermath of an affair. What makes this case somewhat unusual is that as a chaplain in an all male unit, I had rarely dealt with cases involving infidelity on the part of the wife.

Prior to Roger's deployment to Iraq, Crystal and Roger had been having marital problems. Like many other military couples, they had viewed Roger's deployment as an escape from these problems and the consequent fighting. Prior to Roger deploying, he and Crystal had been spending less time together, due to the unit's difficult training schedule. Also during this time, Crystal had given birth to their baby boy, Douglas. Tending to and taking care of the baby was taking up much of Crystal's energy and attention.

One of the major contributors to the brief affair seemed to be Crystal's feeling of abandonment. Prior to deployment, Roger had spent a lot of time playing computer games, leaving little time to devote to his wife or new son. This caused Crystal to feel abandoned and alone. In Crystal's own words, "It was as if I wasn't even alive." When this other Marine showed her attention, treated her as though she were important, and made her feel as though she mattered as both a human being and a woman, entering into a sexual relationship with him seemed to be a logical next step.

Crystal came for counseling shortly after disclosing the affair to her husband, who was deployed to Iraq. She was extremely distraught and unsure of the impact the affair would have on their marriage. She appeared quite sincere in her remorse and seemed to feel a significant amount of guilt. She stated that her husband had been very upset when she had disclosed the affair to him; he had hung up on her. When Roger called Crystal back 3 days later, he was still very angry. This anger was directed at himself for not being there, at the other man, and at his wife for cheating on him. He told Crystal that he wouldn't make any decisions regarding the future of their marriage until he returned home. When she suggested they get counseling, he responded by saying, "I think that sounds like a good idea."

Crystal sought counseling for herself prior to her husband returning from Iraq because she was feeling guilty about being unfaithful to him. What made this especially difficult was that the man she had slept with was another Marine in the same unit. For a Marine, infidelity with the wife of another Marine is *the* cardinal sin. In an organization that stresses trust, integrity, and brotherhood, there is never an excuse for this behavior.

Crystal realized that many issues had contributed to the affair, and she wanted to start working on these issues. In discussing the affair, she reflected upon the events leading up to it and from there attempted to discover how those things individually and collectively had contributed to it. We discussed how most couples see the affair as *the* problem and are so focused on the sexual or physical aspect of the situation that they miss the underlying causes. This is a major factor in preventing many couples and families from being able to recover from an affair or causing them to have additional or subsequent affairs (Glass & Wright, 1997).

Following the disclosure, Roger and Crystal began to talk more often on the phone. They began discussing the insufficient time they had spent together and each other's contributions to the problems they were experiencing in their relationship. Crystal and Roger were both able to see how their behaviors had resulted in the other feeling excluded. As a new father, Roger had spent little time with his newborn son prior to his deployment. Both Roger and Crystal recognized the problems they were having, but neither confronted them, perhaps to avoid feelings of guilt brought about by the realization that both of them had generated and perpetuated the problems. Possibly they had originally avoided confronting the problems in order to prevent a major argument just prior to the deployment. Although couples will typically fight just prior to a deployment or other major separation in an effort to make leaving easier psychologically, the content of these arguments is usually quite small or insignificant (Lanham, 2005; Lyons & Root, 2001).

By the time Roger had returned from Iraq, Crystal had had seven counseling sessions. She was beginning to see and understand her role in the marital problems and was starting to feel some self-forgiveness for the affair. Roger

got rid of the computer games when he returned home and spent very little time online. Instead, he and Crystal began spending time together as a couple and as a family. In a joint session, Roger stated that he was beginning to understand how many factors in the marriage prior to the deployment had contributed to their mutual feelings of dissatisfaction and ultimately to Crystal's infidelity. He also stated that he had forgiven her, was grateful that they had worked through the problems instead of abandoning the marriage, and was looking forward to having a new chance as a family with their young son.

Roles and Responsibilities Issues

Nature of the problem. Difficulty in defining and agreeing upon roles and responsibilities is one of the most common issues young families face. This sort of problem is even more prevalent among young military families, especially those experiencing deployment (Mason, 1998). When the military service member is gone, the spouse must take over all aspects of managing the household: i.e., paying the bills, making house repairs, maintaining the cars, and making major decisions regarding the activities, health, and education of the children, while also doing all of the cooking, cleaning, and routine errands. In many ways their role resembles that of a single parent.

Military wives often are overwhelmed, feeling they have been robbed of their life. They don't have a partner at home to help out with household responsibilities, thus making it very difficult to go out to the clubs, movies, or stores with their friends. They don't have enough time or money for these activities along with a job and/or school. Non-military wives are able to spend time with their husbands, participating in activities together, while military wives have to endure days, nights, weeks, months, and even years apart. The wife will often feel jealous of her friends, as well as angry towards her husband, the military, and anything associated with it for "causing" the separation. When this loneliness is displaced as anger upon the husband, he becomes a target. He may subsequently become defensive, and arguments will quickly escalate, especially upon his return home. When he returns from deployment, these emotions along with the many unaccustomed responsibilities that the spouse has undertaken may make it difficult to determine who will keep or take on which roles and responsibilities in the future.

Case study. In the following case, Joe and Lisa, parents in a military family, experience differences of opinion in how they face the roles and responsibilities that confront many couples. Traditional values and family of origin characteristics add to the confusion.

Joe and Lisa were atypical in the sense of being an older family, first married in their thirties. They had been married for about 8 years and had three children (ages 6, 4, and 2 years). Joe was a successful staff noncommissioned officer in the Marine Corps with an enormous amount of responsibility. Lisa had a college degree in marketing and had been very successful at a prestigious advertising agency prior to meeting Joe. After marrying Joe, Lisa quit her job, initially thinking the benefits would be worth the sacrifice. She didn't feel that way, however, when she came for counseling.

Joe and Lisa sought counseling, complaining of general marital dissatisfaction along with communication problems and increased arguing and fighting. Lisa had been experiencing difficulty concentrating while working around the house, extreme tiredness and sadness, and problems sleeping. To rule out any medical issues, Lisa was referred to her primary care physician, who found no physical problems but prescribed a mild antidepressant.

During the first conjoint session, there was a lot of criticism and blaming behavior, directed primarily at each partner's perception of how much or how little the other person contributed to the marriage and the family as a whole. Lisa blamed Joe for caring more about the Marine Corps than he did about his own family, and Joe blamed Lisa for not taking as good care of the household tasks as he expected.

In Lisa's individual session, she stated that she felt unfulfilled being "just" a military wife. She felt as though she had given up a great career and was now forced to simply clean house and care for her children. This caused her to feel like a "glorified maid." She thought that giving up her career had been too much to ask and that she as well as her career actually took second place to Joe's career and the Marine Corps.

Joe's individual session revealed a different perception. He said that he loved Lisa very much but that his career was extremely important to him. He thought Lisa's inability or unwillingness to understand the importance of the Marine Corps was "selfish and immature." He thought he was contributing everything to the marriage while she simply took care of the home and children. He said he felt tired of being the "only reliable player on the team."

Following my individual sessions with Joe and Lisa, we met a week later for the second of several conjoint sessions. Although there were many different issues (e.g., communication, problem solving, and expectations), we decided on a creative exercise that would help them experience life a little more from each other's perspective. Joe said he could take 5 days off work and take care of the home and children. Lisa was to get a job for a week through a temporary employment agency. They both perceived this as an opportunity to have some fun and prove the other person wrong.

The week went by rather slowly for both of them, but during that time they learned a great deal about themselves and one another. Joe had had no idea how difficult it was to care for the house and children. The house looked no better following his week "at home." Lisa came home exhausted each night, having missed time with her children. She realized how hard it must be for Joe and that despite the inherent challenges, she really enjoyed being a wife and mom, taking care of Joe and the children. This exercise allowed Joe and Lisa to see things from the other person's perspective, dramatically improving communication on virtually all levels.

Once Joe and Lisa had gained a better understanding of each other's contribution to the relationship, the next step was to see what could be done to give each other more of what each wanted. Lisa wanted to feel as though she had some career left and to believe that she was in fact making a difference, expanding her self-identity beyond that of wife and mother. Joe wanted to come home and feel as though he mattered, which included giving attention to the children and having nice meals and a clean house.

Both Joe and Lisa were asked to make individual lists of what they wanted their life to be like. The "miracle question" (Bergin & Garfield, 1994) was asked: "If tonight, while you all are asleep, a miracle happened and when you awoke in the morning the problems that you came to counseling for were gone, what would that look like? How would you know the problems were in fact gone?" Each partner was to make a list, and then they were to compare lists and discuss how to achieve different roles and responsibilities. To be successful, they would need to focus on each other and on themselves as a couple, instead of on themselves as individuals.

Joe and Lisa came back a week later very excited, as they had spent many hours talking about the lists and had decided on different roles and responsibilities. First, Joe would do all the cooking on the weekends and one night during the week. Lisa would make two major changes in her life. First, she and the children would join a playgroup, allowing the kids to play with other children while Lisa socialized with adults. Second, Lisa would take marketing/advertising classes at the local university and then find a job, working both at an external office and at home.

There were several outcomes to these changes in roles and responsibilities: Lisa got the job she had been hoping for, while Joe was helping more around the house and was very much enjoying extra time with the children. With the extra money, they decided to hire a cleaning service and begin making improvements on the house. Lisa's depressive symptoms subsided, and she eventually came off the medication. As of their last visit, things were going well, and both of them were feeling very satisfied in the marriage.

CONCLUSION

Although military families have some of the same problems as other families, many of these issues are magnified or heightened as a result of the dynamic and perhaps chaotic military environment. This is especially true when one takes into account combat operations overseas, with the possibility of death or disability of the military member. These families have to endure numerous stressors, including long periods of separation, loneliness, and incorporation of the military/war experience into the family climate. The most successful couples appear to be those who have excellent coping skills, are flexible in the way they handle typical daily stressors, and have a solid support system (Walsh, 2003). Additionally, couples who have short- and long-term goals along with a life perspective that exists past the moment seem to fare better.

When working with young military families, chaplains and therapists will find that psychoeducational techniques combined with a variety of cognitive-behavioral and solution-focused techniques are most effective (Foa, Keane, & Friedman, 2000; Glynn et al., 1995). These techniques appear to be most useful when working with military couples because they often have limited time, and they want to walk out the door having felt an obvious sense of change. The goal when working

with military couples, especially those who haven't been married long, is to help them develop a more accurate view of what marriage within the military actually entails. Chaplains, at this point, are helping the couples to become more realistic regarding their expectations. The next major goal is to help these adults in the family increase their coping skills and inherent resiliency. When they are guided to look at their strengths and to see what already works, couples can be led to develop strategies that will assist them in handling a wide variety of potentially devastating problems, especially when dealing with a spouse in the war zone.

Most military families perceive serving their country as a great privilege. This privilege involves sacrifice by the individual member as well as the family. With this sacrifice, however, comes a great opportunity to grow both individually and as a couple and/or family. If military couples can gain the skills and personal characteristics necessary to fully experience these "growth opportunities," the family is likely to become stronger, more resilient, and more loving.

SUGGESTIONS FOR FUTURE RESEARCH

There is quite a bit of research pertaining to combat and its impact on the individual (e.g., Friedman, 2004; Hoge et al., 2004). Research has also been done on the effects of combat on the family (e.g., Ancharoff, Munroe, & Fisher, 1998; Byrne & Riggs, 1996; Caselli & Motta, 1995). However, most of this research applies directly to veterans of World War II, the Vietnam War, and, to a lesser extent, the first Iraqi War. There is little research that examines the specific effects of the current war in Iraq and the Global War on Terrorism.

Additional research needs to focus on the impact that military life, including separation and war, has on the couple and the family unit. This information would be informative and invaluable not only to the military, but to individuals and organizations within the community. Other specific topics for investigation could include common barriers for military couples seeking help, treatment of mental illness in the military family, boundary formation and its effectiveness in combating extended family problems, work-related stress, family developmental stages as they relate to the military family, clinical interventions with military families, and advantages and disadvantages of various therapeutic resources.

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