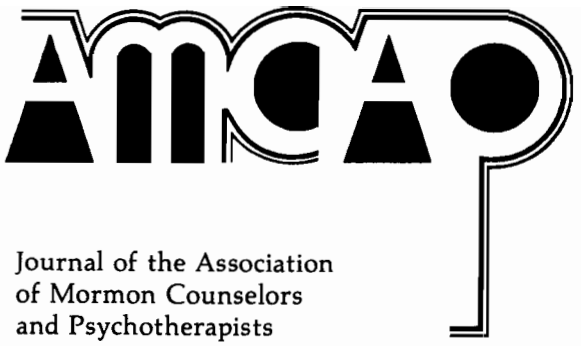
Issues in Religion and Psychotherapy

Volume 9 | Number 3 Article 6

7-1-1983

AMCAP Journal Volume 9 Issue 3 1983

Issues in Religion and Psychotherapy



Journal of the Association
of Mormon Counselors
and Psychotherapists

July 1983 Vol. 9, Issue 3

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

The purpose of this Association shall be:

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

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

Article 1, Section 2, AMCAP By-laws
(as ammended Sep. 30, 1981)

Journal of the Association
of Mormon Counselors
and Psychotherapists

July 1983 Vol. 9, Issue 3

Editor Burton C. Kelly
Brigham Young University

Subscriptions

Subscriptions to the *AMCAP Journal* are provided to AMCAP members. For information concerning membership, write to the address indicated below.

Change of Address

AMCAP members anticipating a change in address should forward the new address to AMCAP to ensure the accurate delivery of the *AMCAP Journal* and other AMCAP correspondence. For change of address and all similar correspondence write to:

AMCAP
Counseling Center
149 SWKT
Brigham Young University
Provo, Utah 84602

Call For Manuscripts

The *AMCAP Journal* seeks manuscripts of interest to the broad interdisciplinary membership of the Association. Articles relating to the practice, research, or theory of counseling and psychotherapy are appropriate for the Journal. Manuscripts should generally not exceed twenty double-spaced typed pages. Style should follow the Publication Manual of the American Psychological Association (2nd edition). Authors should keep a copy of their manuscripts to guard against loss. Three copies of the manuscript should be sent to the editor:

Burton C. Kelly, Editor
AMCAP Journal
149 SWKT
Brigham Young University
Provo, Utah 84602

EDITORIAL

MANUSCRIPTS, MANUSCRIPTS, MANUSCRIPTS! Are they lost, stolen, never written, or just never submitted? It has been several months since an unsolicited manuscript was received for review and consideration for publication. At present there have still not been enough manuscripts received to publish the next issue--even if it was decided to publish every manuscript received. So HELP! Don't hide your light under a bushel anymore. Put those good ideas, research into writing, and/or dig out those hidden manuscripts of yesterdays and send them in. Encourage your colleagues to do likewise. We would be happy to consider "notes from the field" and "theoretical notions," etc. as well as more formal and extensive articles. Recommendations for reprinting of outstanding articles will also be appreciated.

We trust that you will enjoy the breadth of articles in this issue--ranging from the introductory scholarly reprint of Brother Bergin to a very informative article on the illusive Pre-menstrual Syndrome written especially for the AMCAP Journal by one of the leading U.S. authorities, Dr. Keye, to another thoughtful article on adversity by Lynn Roundy and concluding with the provocative article by Brother Ashworth.

Let us hear from you.

BCK

LETTER TO THE EDITOR

Dear Editor,

I found C.T. Warner's first article, Lynne D. Johnson's critical comments and Warner's response to those comments, very stimulating.

My reason for writing is neither to critique nor applaud the contents of any of the three articles (however I do very much want to applaud such an exciting dialogue process). I am writing to express, to Warner, a wish and a hunch. My *wish* is for Warner to immerse himself for a time in Cultural Anthropology (when one wants to develop theories about all humankind, it seems unwise to me to only take into account cultural information of a portion of the human race-which is what I believe Warner has done. I am also aware that unless Warner chooses to fulfill my wish, the preceding statement will be easy to dismiss out of hand).

My *hunch* is that if Warner were to have more intimate personal exposure to "well" non-Mormon's (particularly those from other cultures), it would significantly alter his paradigm.

Yours sincerely,
David R. Shepherd, Ph.D.

TABLE OF CONTENTS

RELIGIOSITY AND MENTAL HEALTH: A CRITICAL REEVALUATION AND META-ANALYSIS[1]

Allen E. Bergin,* Ph.D.

For many decades, lassitude and malaise hae afflicted the relationship between psychology and religion. Interest and activity in this relationship are now being renewed, and old controversies with new terms are resurfacing. This article reviews the extensive empirical literature on the topic and shows that religiosity is a complex phenomenon with numerous correlates and consequences that defy simple interpretations. A meta-analysis of 24 pertinent studies revealed no support for the preconception that religiousness is necessarily correlated with psychopathology; but it also showed only slightly positive correlates of religion. Sociological and psychiatric reports were more favorable to religion. The data's ambiguities compare with those ambiguities that formerly characterized psychotherapy research. Better specification of concepts and methods of measuring religiosity are alleviating this problem, which suggests that ambiguous results reflect a multidimensional phenomenon that has mixed positive and negative aspects. Averaging such diverse factors generally yields unimpressive findings, whereas using specificity promises clearer and more powerful results. Clinical education, practice, and research need revision so that professionals will be better informed of the evidence, more open to the study of such variables, and more efficacious in their work with persons who approach life from a religious perspective.

In a recent article on psychotherapy and religious values, I indicated that a renascence of psychological interest in religion is occurring (Bergin, 1980a, 1980b). Value assumptions underlying clinical approaches are often considered alien by a large proportion of the population in treatment, who endorse more traditional religious perspectives. I argued that religion should be considered more systematically in personality theories and therapeutic interventions. Responses to these themes were numerous, divergent, and vigorous. The topic is not "dead," as was once lamented (Beit-Hallahmi, 1974), and a new National Institute of Mental Health (NIMH) bibliography on the subject is now available (Summerlin, 1980).

The present review considers the assertion by critics (Ellis, 1980; Walls, 1980) that religiosity is antithectical to emotional health and rationality, a view widely held in the clinical professions. Ellis (1980) stated this position bluntly and honestly:

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

[1] Reprinted from *Professional Psychology: Research and Practice*. 1983, *14*, (2) 170-184, copyright 1983 by the American Psychological Association, Inc. by permission of the publisher and author.

***Brother Bergin is Professor of Psychology, Brigham Young University.**

Such assertions (and their opposites) are testable empirically; but before examining the empirical evidence, it is important to consider other aspects of this debate. The issues are not simply empirical; they pertain also to the frame of reference of human sciences and scientists, as illustrated in the following three points.

1. Values and ideology influence theoretical axioms. Conceptions of personality and psychopathology have subjective as well as empirical bases, as do rationales for intervention and goals of outcome. The main assumptions of the dominant theories are naturalistic and humanisitic rather that theistic and spiritual. To express such intuitively chosen positions in professional language makes them no less subjective, even though such expressions create an impression that the assumptions are derivatives of objective facts. The nonreligious bias of much psychological literature is thus based on ideological choices that have become dominant via professional usage. These orienting constructs often exclude spiritual phenomena or cast them in negative terms.

2. In addition to this conceptual bias, mental health literature and education are limited by their minimal appreciation for the religious subcultures of our society. Because professionals are usually less involved religiously than most people (Marx & Spray, 1969), they underestimate the significance of religion in people's lives; when they do perceive it as significant, they too often consider it a negative force (cf. Malony, 1977, Section on "The Religion of Psychologists").

Religious noninvolvement of professionals contrasts with the 1980-1981 Gallup survey on *Religion in America* (1981), which reveals substantial investment in religion among the general population: Ninety-three percent state a religious preference; 69% belong to a church or synagogue (down 4% since 1937); 40% had attended a religious service within 7 days prior to the survey (a drop of 1% since 1939); 55% rank religion as *very* important in their lives; and 31% consider their religious beliefs to be the *most* important thing in their lives. Despite all of this, training in the clinical professions is almost berefit of content that would engender an appreciation of religious variables in psychological functioning. Race, gender, and ethnic origin now receive deserved attention, but religion is still an orphan in academia.

3. The foregoing conceptual and attitudinal biases have become part of empirical inquiry, so religious factors either are excluded from measurement and manipulation or are included in such a way as to prejudice the results. Instances of the latter occur in devices that measure authoritarianism, ethnocentrism, dogmatism, ego strength, and irrational thinking; these measurements negatively score proreligious responses

to some items in the scales. An example of this negative scoring occures in Barron's Ego Strength Scale (1953), which contains seven possible proreligious responses, five of which count against a person's ego strength. Although it can be argued that the items are empirically keyed to independent criteria, this is misleading because mental health criteria ultimately consist of standards based on subjective values. Thus, many of the "proofs" that religion is a source of disturbance are merely tautologies that only prove that two sets of personality measures constructed by people holding to the same premises are likely to correlate. This circularity is obscured by an empirical posture; but as Stark (1971) and Gorsuch and Aleshire (1974) have shown, some of the reported correlations between religiosity and emotional disturbance and prejudice can be considered artifacts.

For the foregoing reasons, it is possible that some clinical critiques of religion have a limited factual basis. They are not without merit, but too often they are conditioned by ideological bias, stereotyping, or empirical artifacts.

Religiosity studies may thus be limited by scientific designs that have defined religious phenomena in such a way as to axiomatically preempt the possibility of healthy religion.

Overview of Empirical Ambiguities

The literature on religion and mental functioning has been reviewed through the 1960s and middle 1970s by Sanua (1969), Dittes (1971), Becker (1971) Spilka and Werme (1971), Stark (1971), and Argyle and Beit-Hallahmi (1975). These reviews reveal many inadequacies in the data base. An examination of several dozen studies shows the parallels between this situation and psychotherapy research about 20 years ago. Both literatures are laden with deficiencies, but both manifest steady progress as well. Although there are no conclusions, there are a few trends; and the more recent literature makes it possible to present some likely hypotheses. It is hoped that this will help the numerous clinicians who are unfamiliar with this literature, since it is not part of the usual graduate education.

It is not surprising that given the diverse measures of religion and the diverse criteria of mental functioning, results of correlating the two sets of factors yield a mixed picture.

Martin and Nichols (1962) summary of nearly a dozen studies of the 1950s painted a negative picture of the religious believer as being emotionally distressed, conforming, rigid, prejudiced, unintelligent, and defensive. Rokeach (1960) portrayed a similar profile and concluded that believers, compared with nonbelievers, were more tense, anxious, and symptomatic, especially as indicated on the Welsh Anxiety Index. This "sick" portrait is perhaps a measure of how much research results in behavioral science conformed to the intellectual ethos of the time. Believers were being classified as emotional misfits.

A specific anecdote underscores the academic temper of that period. In 1957 I was fortunate enough to take Leon Festinger's social psychology seminar at Stanford just after his now-famous book, *A Theory of Cognitive Dissonance* (Festinger, 1957), had been published. We devoted an academic quarter to this stimulating treatise. Examples of dissonance and its reduction were frequently taken from contemporary life (e.g., the responses of smokers to lung cancer data). On one occasion, we students were asked to indicate our religious preferences. Among the 18 of us, 11 were agnostics, 5 atheists, and 2 believers. We discussed possible dissonance-reducing methods religious people might use, as we discussed the role of social support in maintaining invalid beliefs. To be religious meant, ipso facto, to be defensive.

Since the 1950s, religion has gradually attained a more positive, although beleaguered status, and empirical results have correspondingly been less negative. Perhaps due to a more open culture, the emergence of human potential and transpersonal psychologies, and the growth of empirical work in consciousness and cognition, religious phenomena can now be studied with academic respectability.

In 1962 Martin and Nichols attempted to replicate the negative correlations in the studies they had reviewed by repeating the measures of personality and religiosity on a new sample of 163 Purdue University students. They failed to replicate any of the previous findings. Their attempt to discover findings opposite to the original studies, that is, favorable to religion, by differentiating a subcluster of students high in religious information also failed. The array of critical correlations distributed themselves nicely around a median of zero. They interpreted this replication failure to the fact that prior authors had spuriously reported on a few significant correlations that were probably chance figures from many intercorrelations.

Contradictions in results continued in studies of manifest anxiety and of other Minnesota Multiphasic Personality Inventory (MMPI) scores. Wilson and Miller (1968) reported a positive correlations of .20 between Taylor Manifest Anxiety Scores and religiosity among 100 students and the University of Alabama. But these results were contradicted by Bohrnstedt, Borgatta, and Evans (1968), who compared 3,700 religious and nonreligious University of Wisconsin students on the MMPI. These authors found few differences, and those few favored the religious subjects. Williams and Cole (1968) also found that highly religious subjects were less anxious on MMPI and galvanic skin response indices; although a subgroup of student converts had higher manifest anxiety scores than regular church attenders and nonattenders. A large sample of Mormon students at Brigham Young University also manifested a normal mean MMPI profile (Kelly, Note 1).

Tennison and Snyder (1968) took a different approach by examining patterns of Murray-type needs as a function of religiosity among 299 Protestants at Ohio University. The median correlations between 15 Edwards Personal Preference Schedule (EPPS) "needs" and a mean religiosity index was only .15. Religiosity correlated positively with Deference (.16), Affiliation (.29), Abasement (.27) and Nurturance (.26) but

Table 1: Studies Use in Religiosity and Mental Health Meta-Analysis

Study	Year	*N* (9,799)	Subjects	Measures	*Pearson r*
1. Bohrnstedt, Borgatta, & Evans	1968	3,666	Students	Religiosity and MMPI (*M* of 18 correlations)	.08
2. Broen	1955	140	Students	Religiosity and MMPI (*Mdn* of > 30 correlations)	0
3. Brown	1962	203	Students	Belief indexes vs. MAS and neuroticism (*M* of 11 correlations)	.00
4. Brown & Lowe	1951	108	Students	Religious belief and MMPI (*Mdn t* on subscales)	0
5. Fehr & Heintzelman	1977	120	Students	Religiosity and MAS Religiosity and self-esteem	.05 −.13
6. Funk	1956	255	Students	Orthodoxy and MAS	0
7. Heintzelman & Fehr	1976	82	Students	Orthodoxy and MAS Orthodoxy and hostility Orthodoxy and self-esteem	.07 .29* .06
8. Hood	1974	82	Students	Religious experience and ego strength	−.16
		114	Students	Religious experience and psychic adequacy-inadequacy	.28*
9. Jolish	1978	66	Jewish temple members	Religiosity and Ellis irrational beliefs	0
10. Joubert	1978	137	Students	Church activity and Ellis beliefs	0
11. Keene	1967	250	Urban adults	Religious factors and neuroticism	0
12. Maranell	1974	109	Students (South)	Religiosity and MAS or maladjustment	−.11
		96	Students (Midwest)	Religiosity and MAS or maladjustment	−.05
13. Martin & Nichols	1962	163	Students	Belief inventory and MMPI Paranoia	.12
14. Mayo, Puryear, & Richek	1969	166	Students	Religiosity and MMPI (4/5 *Fs* favor religion)	+*
15. Moberg	1956	219	Adults > 65	Religious activity and adjustment	.59*
16. Panton	1979	234	Male prisoners	Religious identification and adjustment	.82*
17. Rokeach	1960	202	Students (Michigan)	Catholics and Protestants vs. nonbelievers on anxiety	−.25*
		207	Students (N.Y.)	Catholics, Protestants, and Jews vs. nonbelievers on anxiety	−.32*
18. Smith, Weigert, & Thomas	1979	1,995	Catholic adolescents	Religiosity and self-esteem (*M* of 12 correlations)	.19
19. Spellman, Baskett, & Byrne	1971	60	Rural adults	Religiosity and MAS	0
20. Swindell & L'Abate	1970	135	Students	Religious attitudes and repression sensitization	.08
21. Weltha	1969	565	Students	Religious attitudes and adjustment	0
22. Williams & Cole	1968	161	Students	Religiosity and insecurity and MMPI anxiety	+*
23. Wilson & Kawamura	1967	164	Students	Religious attendance and participation and neuroticism (*M* of 4 correlations)	.02
24. Wilson & Miller	1968	100	Students	Religiosity and MAS	−.20

Note. MMPI = Minnesota Multiphasic Personality Inventory; MAS = Manifest Anxiety Scale.
*Statistically significant.

negatively with Achievement (-.20), Autonomy (-.35), Dominance (-.15), and Aggression (-.15). A comparison of EPPS scores for the 25 highest and 25 lowest students on religiosity accentuated these findings.

In a comparable study of students in Japan, Ushio (1972) used the EPPS and found no correlation between religious activity or religious consciousness and measures of dependency and anxiety; but religiousity was positively related to need for Affiliation (.35 and .19), Abasement (.17 and .27), and Nurturance (.52 and .39), whereas Aggression correlated negatively with religious activity (-.18) and positively with religious consciousness (.32). The median correlation was .24.

These two studies on need patterns are the types of data from which broad and severe interpretations of religion are often made. For instance, Tennison and Snyder (1968) aver that their psychodynamic notions are supported by Freud and Fromm, who felt that conventionally religious people adopt an infantile prototype in their perceived relationship to an omnipotent God. Thus, Tennison and Snyder suggest that such persons tend to be dependent, submissive, self-abasing, and intellectually impoverished. Such views may have more to do, however, with the procrustean constructs of researchers than with the phenomena. To make so much of 5% variance overlaps between personality and religiosity is not good theorizing.

To further illustrate, consider the Chambers, Wilson, and Barger study (1968), which used a semiprojective test rather that the EPPS to examine Murray-type needs and religiosity among 2,844 University of Florida students. Correlations contradicted the results of Tennison and Snyder (1968) and of Ushio (1972). Further analysis by Chambers et al. (1968) of ability to accurately judge need appropriateness and to manage needs showed the less religious subjects to be "ineffectual in the expression and satisfaction of needs as a result of inner conflicts caused by the simultaneous arousal of incompatible or opposed needs" (p. 209). The adjustment problems of this group centered around "poor perception of goals, and conflicts over desires to be independent and to avoid responsibility for others" (p.208).

Such conflicting results are common, partly because of the different views of investigators and partly because of the different personality and religiousity measures used. One researcher views a worshipful life-style positively in terms of reverence, humility, and constructive obedience to universal moral laws, whereas another researcher views the same life-style negatively, as self-abasing, unprogressive, and blindly conforming. The researcher's construct system may then guide the choice of measures and the interpretation of results to confirm his or her predilections. In a field marked by a plethora of inconsistent measures, few common standards, and divergent prejudices, these contradictory results happen all too often.

Fehr and Heintzelman (1977) illustrated the point by deliberately attempting to find contradictory results in the same sample by using two different measures of religiosity (the Allport-Vernon-Lindzey Study of Values and the Brown Modification of the Thouless Test of Religious Orthodoxy). Neither measure correlated with anxiety or self-esteem; but quite opposite correlations were found with humanitarianism and authoritarianism, depending on the religiosity measure used.

Meta-Analysis of the Pathology Data

One way to reduce the ambiguities in a survey of studies is to quantitatively sum the data across samples by means of meta-analysis (Glass, McGaw, & Smith, 1981). An analysis was therefore done of studies that had at least one religiosity measure and at least one clinical pathology measure, such as the MMPI or comparable scales. Studies of nonclinical traits, such as dominance-submission, altruism, introversion-extroversion, and so forth were omitted, since they will be the topic of a subsequent article on religiosity, personality, and social behavior. Exhaustive computer and manual searches were done to identify all studies through 1979 that met our criteria. This provided us with the surprisingly small number of 24 usable empirical studies out of more that 100 titles pertinent to the topic. These studies are listed in Table 1.

Table 2: Meta-Analysis of Relationship Between Religious Indices and Psychopathology Indices

14 studies[1] (20 outcomes)

Study no.[2]	Pearson *r*	*Outcomes*	*n*
16	.82*	Categorical[4]	10
15	.59*	Positive	2
7	.29*	Zero	8
8	.28*	Negative	0
18	.19		
13	.12	Total[3]	30
20	.08	Positive	14
1	.08	Zero	9
7	.07	Negative	7
7	.06		
5	.05		
23	.02	Statistically	
3	.00	significant	7
12	−.05	Positive	5
12	−.11	Negative	2
5	−.13		
8	−.16		
24	−.20		
17	−.25*		
17	−.32*		
M	.09		
Mdn	.055		

Note. Studies = 24; subjects = 9,799.

[1]Fourteen studies listed by number in meta-analysis references. Original data transformed to *rs*; *rs* transformed to Zs, summed, averaged, and transformed to a mean *r*. Signs changed so positive *r* indicates association of higher religiosity with better mental health. When data were presented in terms of *t* values or similar data, these were transformed to *rs*, according to formulae provided by Glass, McGaw, and Smith (1981).

[2]Multiple results from single studies are included when based on

factorially different measures or on separate subsamples. However, multiple findings based on the same sample using a variety of similar measures were averaged across measures to yield a single figure for that sample.

[b]*P* value based on normal approximation of binomial distribution. (Binomial probability of 14 positive and 7 negative results: $.05 > p > .09$.)

[c]Ten studies in which data were reported without quantitative details (e.g., $t > 1.0$, or F are not significant). Positive outcome defined as a favorable relationship with religiosity.

*Statistically significant.

Table 2 summarizes the meta-analysis of empirical findings, which are classified as positive, neutral, or negative in relation to religious involvement. The data provide surprising results. Of 30 effects tabulated, only 7, or 23%, manifested the negative relationship between religion and mental health assumed by Ellis and others. Forty-seven percent indicated a positive relationship and 30% a zero relationship. Thus 77% of the obtained results are contrary to the negative effect of religion theory. Although most of the results were not statistically significant, the overall pattern was interesting. Considering statistical significance of results, 23 outcomes showed no significant relationship, 5 showed a positive relationship, and 2 showed a negative relationship.

Although the findings in Table 2 provide no support for an Ellis-type theory, they also do not provide much more than marginal support for a positive effect of religion. The small number of usable studies and the blandness of the overall mean provide little positive information or incentive for further inquiry. Part of the problem is the limitations of measurement and methodology in this domain. These limitations are dealt with in the discussions on sociological, psychiatric, and measurement studies and on possibilites for further study.

Additional Findings

Several additional sources of evidence, mainly from sociology and social psychiatry studies, support and extend the meta-analysis findings.

Lindenthal et al. (1970) at Yale studied nearly 1,000 persons in the New Haven area. Psychiatric evaluations of degree of mental impairment showed a negative relationship between impairment and church affiliation and attendance. Similarly, Stark (1971) gathered data via the Survey Research Center at Berkeley and the National Opinion Research Center at the University of Chicago, which showed that mental illness and religious commitment are negatively related. Two of his most pertinent tables are reproduced here.

Table 3 indicates that on all four measures of religiosity, the mentally ill were less religious than the normal controls. Table 4 shows that persons in a representative national sample who were rated high on psychic inadequacy (e.g., "I worry a lot", "I tend to go to pieces in a crisis") were also less religiously orthodox. For instance, among moderate Protestants high in psychic inadequacy, 13% were religiously orthodox, whereas 23% of those low in psychic inadequacy were orthodox.

Based on these and other analyses, Stark concluded that theories that presume psychopathology to be a primary source of ordinary religious commitment are false.

There is also considerable empirical evidence that religious involvement is negatively correlated with social problems, such as sexual permissiveness, drug abuse, and alcohol use, and is slightly negatively correlated with deviant or delinquent acts (Burkett & White, 1974; Cardwell, 1969; Gorsuch & Butler, 1976; Rorbaugh & Jessor, 1975).

Another surprising empirical trend is that converts are as functional as or better off than nonconverts, even though the subgroup of sudden converts is sometimes more disturbed than gradual converts or nonconverts (Parker, 1977; Srole, Langer, Michael, Opler & Rennie, 1962; Stanley, 1965; Williams & Cole, 1968). Although some converts may be disturbed, the studies are

Table 3: Differences in Religious Commitment Between a Sample of Persons Diagnosed as Mentally Ill and a Matched Control Group**

	*Mentally ill** (N = 100)*	*Matched controls (N = 100)*	*Level of significance*
Percent who claim no religious affiliation***	16	3	$p < .01$
Percent who say religion is "not important at all" to them	16	4	$p < .01$
Percent who do *not* belong to a church congregation	54	40	$p < .05$
Percent who attend church			
Once a month or more	47	57	
At least several times a year	24	32	
Once a year or less	8	6	
Never	21	5	$p < .01$

Note. From "Psychopathology and Religious Commitment" by R. Stark, *Review of Religious Research*, 1971, *12*, 165-176. Copyright 1971 by the Religious Research Association. Reprinted by permission.

*In treatment at an outpatient clinic; 71 had a record of previous hospitalization.

**Randomly selected (stratified) from the same community matched on sex, marital status, education, and age.

***While others claimed to be Protestant, Catholic, Jewish, or other, these responded none.

Table 4: Orthodoxy and Psychic Inadequacy (National Sample, Northern Whites Only) Percent High on Orthodoxy Index

	Psychic inadequacy	
	Low	High
Liberal Protestants	9%	0%
Moderate Protestants	23%	13%
Conservative Protestants	43%	25%
Roman Catholics	28%	19%

Note. $N = 1{,}040$. From "Psychopathology and Religious Commitment" by R. Stark, *Review of Religious Research*, 1971, *12*, 165-176. Copyright 1971 by the Religious Research Association. Reprinted by permission.

consistent in indicating that conversion and related intense religious experiences are therapeutic, since they significantly reduce pathological symptoms.

Such results were found by Galanter, Rabkin, Rabkin, and Deutsch (1979) in a study of changes in neurotic distress in 237 members of the Unification Church; by Galanter and Buckley (1978) in an evaluation of diminished neurotic symptoms and drug and alcohol use in 119 memebers of the Divine Light Mission, who had religious experiences; by Ness and Wintrob (1980) in a study of decreased emotional stress in 51 members of 43 Pentecostals, who experienced faith healing—"the more frequently people engaged in religious activities, the less likely they were to report symptoms of emotional distress," p. 202; by Pattison and Pattison (1980) in an examination of profound changes in sexual deviation following conversion experiences; and by Womack (Note 2) in an analysis of therapeutic effects of a Pentecostal church on alcohol and drug addicts. In commenting on the puzzling relationship between what appears to be primitive experiences and the dramatic results that sometimes show up in behavior and mental status, Marks (1978) suggested that studying these phenomena objectively is crucial because their potency, compared with psychotherapy's potency, looks like atomic power compared with dynamite.

Of course, it is easy to share the skepticism of behavioral scientists who question the durability of these changes, or the advantage of trading a psychiatric symptom for identification with a fundamentalist subculture. But it has been observed that some of these people have made fundamental changes and enhanced their reality contact, that the gradual converts to more conventional religiosity are sometimes superior in their life adjustment, and that the effects of psychotherapy are not any better by comparison.

Perhaps Marks's objectivity is the key. Examining the mechanisms of change in these situations and not letting prejudices against spiritual language prevent researchers from perceiving potentially beneficial factors could improve therapeutic knowledge. Certaintly, as a starting point, Frank's (1973) and Szasz's (1978) interpretations of professional therapeutic change as forms of conversion, faith healing, or thought reform might be taken seriously.

Factoring the Religious Dimension

Another trend in the literature that has improved understanding of the religious dimension is the attempt to subdivide the phenomena into different factors with different characteristics and consequences.

Perhaps the most definitive thing that can be said is that religious phenomena are multidimensional. As many as 21 factors in religiosity have been identified in one study (King & Hunt, 1975). Although an analysis of typologies will be the subject of another article, suffice it to say here that a main trend consists of attempts to define "good" and "bad" religiousness. Allport (Allport & Ross, 1967) called it intrinsic (good) versus extrinsic (bad), somewhat akin to the popular distinction between internal and external control (Phares, 1978). Allen and Spilka (1967) defined it as committed (good) versus consensual (bad). James (1902) referred to the religion of "healthy-mindedness" versus the "sick soul," although he did not necessarily judge one as better than the other.

In a sense, these measures, and the studies using them, provide a good starting point toward specificity as opposed to global, and necessarily misleading, evaluation of a complex phenomenon. As Spilka and Werme (1971) put it, religion may serve as a means of expressing emotional disturbance, as a haven from stress, as a source of stress, as a means of social acceptance (and conformity), or as a means of growth and fulfillment. Stommen (1971) similarly perceives that religion "attracts, reduces, increases, and heals mental disorder" (p.462).

Results using a simple dichotomy like Allport and Ross's (1967) intrinsic versus extrinsic orientation seem to demonstrate that there are different kinds of religiosity and that their correlations with other criteria differ. The extrinsically religious person "uses" religion as a means of obtaining security or status, whereas the intrinsically oriented person internalizes beliefs and lives by them regardless of external consequences. Kahoe (1974) used 518 college students to show a divergent pattern of correlations with the two orientations. Intrinsic scores correlated positively with responsibility, internal locus of control, intrinsic motivational traits, and grade point average, whereas extrinsic scores correlated positively with dogmatism and authoritarianism but negatively with responsibility, internal control, intrinsic motives, and grade point average. Such differing findings are typical when religion is thus subdivided, which suggests that conflicting results in many studies may be due to the failure to distinguish discrete subgroups whose scores correlate divergently with the same criterion. However, the picture is still not simple. Some people score high on intrinsic and extrinsic dimensions. Whether these people are very good or very strange is still debatable.

Maranell (1974) approached the dimensionality issue by devising measures of eight types of religiosity and correlating them with indices of anxiety and maladjustment among samples of southern and midwestern students. Only two of the eight dimensions correlated consistently with the pathology measures. Averaging sets of four correlations, superstition correlated positively with pathology (.28), as did ritualism (.21). Measures of church orientation, altruism, fundamentalism, theism, idealism, and mysticism did not correlate consistently with the anxiety and adjustment indices. Although Maranell concluded from his results that religious persons are likely to be less well adjusted than nonreligious persons, this was due to selecting from the findings. The data do not support such a conclusion. His set of 32 correlations resulted in a mean of .08, with fluctuations above and below that figure, which approximate a random distribution.

The foregoing findings, along with the factor analyses, indicate that religiosity is unlikely to be simply divisible into healthy and unhealthy types. One of the most appealing reconceptualizations was proferred by

Glock (1962), who redefined religion into five basic factors: Ritual, Experiential (religious emotional experience), Ideological (belief systems), Intellectual (knowledge of tenets and scripture), and Consequential (good works). Debate over this influential conception has centered on whether there are indeed several factors. As many as six have been identified (DeJong, Faulkner, & Warland 1976), although most analyses produce only one or two dimensions. Conceivably, the discrepancies in some of the factor analyses could be cleared up by considering the possiblity that religiosity, like intelligence, involves a general (G) factor and several specific (S) factors. Also, although religiosity profiles will vary across the several factored dimensions, some persons will be high on *all* dimensions and thus represent a different type of religiosity than persons who are uniformly low or who are variable across factors.

The point of the foregoing is that the definition and measurement of religiosity may be as complicated as describing psychopathology, which currently requires a 494-page book, the *Diagostic and Statistical Manual or Mental Disorders* (3rd ed.; Spitzer, 1980). Consequently, generalizations about the psychological causes and consequences of religious involvement need to be tentative and subject to further investigation.[1] The mixed or insignificant results of many studies are conceivably due to the kind of imprecision that once afflicted psychotherapy research. Perhaps positive effects of some kinds of religiosity are being balanced by negative effects of other kinds, which yield unimpressive or ambiguous average effects. As in psychotherapy, greater specificity and precision in defining and measuring the religious factor would likely alleviate this problem.

Implications for Clinical Training, Practice, and Research

Because religious cognitions, emotions, and behaviors, as documented here, are so pervasive, potential clinicians should understand the cultural content of their clients' religious world views rather than deny the importance of these views and coerce clients into alien linguistic and conceptual usages. To achieve this goal, the clinical students and practitioners should be aware of their own religious impulses. Spiritual tendencies are common among us, but they are symbolized and expressed under many aliases.

Although practicing psychologists rate themselves as less religious than the general public, it is surprising that a *majority* consider themselves to be believers (Marx & Spray, 1969), and 10% of a random sample of American Psychological Association members hold positions in religious organizations (Ragan, Malony, & Beit-Hallahmi, Note 3). One would never know this by content analyzing professional conversations or publications. This strong level of interest and participation has been compartmentalized because the language of academic training and of personality, psychopathology, and psychotherapy is nonspiritual. Thus, the religious interests of clinicians and researchers are subjected to conceptual shaping in other directions—that is, naturalism, mechanism, and secularism prevail, and degrees and certification are earned by emitting such terminology at the right times and places. Reeducation could begin with a selection of readings from the references in this article. A correlated educational experience would be to encourage more research in this domain among students at predoctoral and dissertation levels. In addition, those teachers, research mentors, and clinical supervisors who have sympathies with and experience in correlating the psychological and the religious need to be involved in student education. This does not require proreligious attitudes but does require openness to alternatives other than the traditional naturalistic ones.

Practitioners generally need to tune into healthy religiosity as well as the unhealthy kind they sometimes encounter (Salzman et al., 1965). When a client's religious values create difficulties for the therapist, consultation or referral may be in order. The practice of attributing pathodynamic origins to values one disagrees with needs to be constrained (Menninger, 1973).

In addition, practice needs to more assiduously include collaboration with the religious leaders and subcultures from which clients come. The opportunity to utilize associated support systems to induce and maintain change is a potentiality that community psychologists appreciate but the clinicians often ignore.

Finally, we need to broaden our horizons so that despite our differences, we can empathize with persons who approach life from a spiritual perspective and thus achieve the mutual respect to which most of us are committed.

[1] Not discussed in this article is an extensive literature that is addressed to religiosity and its correlates in the areas of life-style, quality of life, social and political attitudes, nonclinical personality dimensions, and clinically related social behaviors, such as addiction, crime, sexual conduct, and so forth. These are considered in a separate article (Donahue & Bergin, in preparation).

REFERENCE NOTES

1. Kelly, B. Personal communication, 1979.
2. Womack, S. *An analysis of the therapeutic effects of a Pentacostal church on alcohol and drug addicts.* Unpublished manuscript, University of Texas at Austin, 1978.
3. Ragan, C. P., Malony, H. N., & Beit-Hallahmi, B. *Psychologists and religion: Professional factors related to personal religiosity.* Paper presented at the meeting of the American Psychological Association, Washington, D.C., September 1976.

REFERENCES

Allen, R. O., & Spilka, B. Committed and consensual religion: A specification of religion-prejudice relationships. *Journal for the Scientific Study of Religion*, 1967, *6*, 191-206.

Allport, G. W., & Ross, J. M. Personal religious orientation and prejudice. *Journal of Personality and Social Psychology*, 1967 *5*, 432-443.

Argyle, M., & Beit-Hallahmi, B. *The social psychology of religion.* London: Routledge & Kegan Paul 1975.

Barron, F. An ego strength scale which predicts response to psychotherapy. *Journal of Consulting Psychology*, 1953, *17*, 327-333.

Becker, R. J. Religion and psychological health. In M. Strommen (Ed.), *Research on religious development: A comprehensive handbook.* New York: Hawthorne, 1971.

Beit-Hallahmi, B. Psychology of religion 1880-1930: The rise and fall of a psychological movement. *Journal of the History of the Behavioral Sciences, 1974, 10,* 84-90.

Bergin, A. E. Psychotherapy and religious values. *Journal of Consulting and Clinical Psychology, 1980, 48,* 95-105. (a)

Bergin, A. E. Religious and humanistic values: A reply to Ellis and Walls. *Journal of Consulting and Clinical Psychology, 1980, 48,* 642-645. (b)

Bohrnstedt, G. W., Borgatta, E. F. & Evans, R. R. Religious affiliation, religiosity, and MMPI scores. *Journal for the Scientific Study of Religion, 1968, 7,* 255-258.

Broen, W. E., Jr. Personality correlates of certain religious attitudes. *Journal of Consulting Psychology, 1955, 19,* 64.

Brown, D. G., & Lowe, W. L. Religious beliefs and personality characteristics of college students. *Journal of Social Psychology, 1951, 33,* 103-129.

Brown, L. B. A study of religious belief. *British Journal of Psychology, 1962, 53,* 259-272.

Burkett, S. R., & White, M. Hellfire and delinquency: Another look. *Journal for the Scientific Study of Religion, 1974, 13,* 455-462.

Cardwell, J. D. The relationship between religious commitment and premarital sexual permissiveness: A five-dimensional analysis. *Sociological Analysis, 1969, 30,* 72-80.

Chambers, J. L., Wilson, W. T., & Barger, B. Need differences between students with and without religious affiliation. *Journal of Counseling Psychology, 1968, 15,* 208-210.

DeJong, G. F., Faulkner, J. E. & Warland, R. H. Dimensions of religiosity reconsidered: Evidence from a cross-cultural study. *Social Forces, 1979, 54,* 866-889.

Dittes, J. E. Religion, prejudice, and personality. In M. Strommen (Ed.), *Research on religious development: A comprehensive handbook.* New York: Hawthorn, 1971.

Ellis, A. Psychotherapy and atheistic values: A response to A. E. Bergin's "Psychotherapy and Religious Values." *Journal of Consulting and Clinical Psychology, 1980, 48,* 635-639

Fehr, L. A., & Heintzelman, M. E. Personality and attitude correlates of religiosity: A source of controversy. *Journal of Psychology, 1977, 95,* 63-66.

Festinger, L. *A theory of cognitive dissonance.* Evanston, Ill: Row, Peterson, 1957.

Frank, J. D. *Persuasion and healing.* Baltimore, Md.: Johns Hopkins University Press, 1973.

Funk, R. A. Religious attitudes and manifest anxiety in a college population. *American Psychologist, 1956, 11,* 356. (Abstract)

Galanter, M., & Buckley, P. Evangelical religion and meditation: Psychotherapeutic effects. *Journal of Nervous and Mental Disease, 1978, 166,* 685-691.

Galanter, M., Rabkin, R., Rabkin, J., & Deutsch, A. The "Moonies": A psychological study of conversion and membership in a contemporary religious sect. *American Journal of Psychiatry, 1979, 136,* 165-170.

Glass, G. V., McGaw, B., & Smith, M. L. *Meta-analysis in social research.* Beverly Hills, Calif.: Sage, 1981.

Glock, C. Y. On the study of religious commitment. *Religious Education Research Supplement, 1962, 42,* 98-110.

Gorsuch, R. L., & Aleshire, D. Christian faith and ethnic prejudice: A review and interpretation of research. *Journal for the Scientific Study of Religion, 1974, 13,* 281-307.

Gorsuch, R. L., & Butler, M. Initial drug abuse: A review of predisposing social psychological factors. *Psychological Bulletin, 1976, 83,* 120-137.

Heintzelman, M. E., & Fehr, L. A. Relationship between religious orthodoxy and three personality variables. *Psychological Reports, 1976, 38,* 756-758.

Hood, R. W. Psychological strength and the report of intense religious experience. *Journal for the Scientific Study of Religion, 1974, 13,* 65-71.

James, W. *The varieties of religious experience.* New York: Longmans, Green, 1902.

Jolish, E. *The relationship between religiosity and irrational beliefs* (Doctoral dissertation, Washington State University, 1978). *Dissertation Abstracts International, 1978, 39,* 2756A. (University Microfilms No. 78-20,098).

Joubert, C. E. Sex, church attendance, and endorsement of Ellis's irrational beliefs. *Psychological Reports, 1978, 42,* 1318.

Kahoe, R. D. Personality and achievement correlates of intrinsic and extrinsic religious orientations. *Journal of Personality and Social Psychology, 1974, 29,* 812-818.

Keene, J. J. Religious behavior and neuroticism, spontaneity, and worldmindedness. *Sociometry, 1967, 30,* 137-157.

King, M. B., & Hunt, R. A. Measuring the religious variable: A national replication. *Journal for the Scientific Study of Religion, 1975, 14,* 13-22.

Lindenthal, J. J., Myers, J. K., Pepper, M., & Stern, M.S. Mental status and religious behavior. *Journal for the Scientific Study of Religion, 1970, 9,* 143-149.

Malony, H. N. (Ed.). *Current perspectives in the psychology of religion.* Grand Rapids, Mich.: Eerdmans, 1977.

Maranell, G. M. *Responses to religion.* Lawrence: University of Kansas Press, 1974.

Marks, I. M. Behavioral psychotherapy of adult neurosis. In S. L. Garfield & A. E. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (2nd ed). New York: Wiley, 1978.

Martin, C., & Nichols, R. C. Personality and religious belief. *Journal of Social Psychology, 1962, 56,* 3-8.

Marx, J. H., & Spray, S. L. Religious biographies and professional characteristics of psychotherapists. *Journal of Health and Social Behavior, 1969, 10,* 275-288.

Mayo, C. C., Puryear, H. B., & Richek, H. G. MMPI correlates of religiousness in late adolescent college students. *Journal of Nervous and Mental Disease, 1969, 149,* 381-385.

Menninger, K. *Whatever became of sin?* New York: Hawthorn, 1973.

Moberg, D. O. Religious activities and personal adjustment in old age. *Journal of Social Psychology, 1956, 43,* 261-267.

Ness, R. C., & Wintrob, R. M. The emotional impact of fundamentalist religious participation: An empirical study of intragroup variation. *American Journal of Orthopsychiatry, 1980, 50,* 302-315.

Panton, J. H. An MMPI item content scale to measure religious identification within a state prison population. *Journal of Clinical Psychology, 1979, 35,* 588-591.

Parker, M. S. Dimensions of religious conversion during adolescence (Doctoral dissertation, State University of New York at Buffalo, 1977). *Dissertation Abstract International, 1978, 38,* 3371-B. (University Microfilms No. 72-27, 510).

Pattison, E. M., & Pattison, M. L. "Ex-gays": Religiously mediated change in homosexuals. *American Journal of Psychiatry, 1980, 137,* 1553-1562.

Phares, E. J. Locus of control. In H. London & J. E. Exner, Jr. (Eds.), *Dimensions of personality.* New York: Wiley, 1978.

Religion in America. Princeton, N J: The Gallup Organization and the Princeton Religion Research Center, 1981.

Rohrbaugh, J., & Jessor, R. Religiosity in youth: A control against deviant behavior. *Journal of Personality, 1975, 43,* 136-155.

Rokeach, M. *The open and closed mind: Investigations into the nature of belief systems and personality systems.* New York: Basic Books, 1960.

Salzman, L., et al. Healthy and unhealthy patterns of religion. *Journal of Religion and Health, 1965, 4,* 322-344.

Sanua, V. D. Religion, mental health, and personality: A review of empirical studies. *American Journal of Psychiatry, 1969, 125,* 1203-1213.

Smith, C. B., Weigert, A. J., & Thomas, D. L. Self-esteem and religiosity: An analysis of Catholic adolescents from five cultures. *Journal for the Scientific Study of Religion, 1979, 18,* 51-60.

Spellman, C. M., Baskett, G. D., & Byrne, D. Manifest anxiety as a contributing factor in religious conversion. *Journal of Consulting and Clinical Psychology, 1971, 36,* 245-247.

completed on page 22

PREMENSTRUAL SYNDROME: FAD, FACT OR FALLACY?

William R. Keye, Jr.* M.D.

About two years ago a local psychiatrist asked me to see a patient who had been resistant to his combination of psychotropic medications and psychotherapy. The patient, a 34-year-old mother of five, had noted for several years that without warning she would wake up in the morning feeling extremely depressed. The depression would last five, seven, sometimes ten days and then leave as suddenly as it began. During these episodes of depression, she would feel extremely tense, irritable, short tempered and "mad at the world". She would find herself either yelling at her kids in response to the most trivial misdeeds or administering a particularly hard and severe spanking for more major infractions. She found noise (noise of almost any kind) to be almost unbearable. Small tasks became difficult, if not impossible, to carry out because of her inability to concentrate and to think clearly. During these episodes of depression she would cry out for the support, attention and affection of her husband, yet find his touch to be physically uncomfortable, if not repulsive. Unable to find solace in her relationships with her husband and children, she would overindulge in eating. Her appetite became voracious, and it was not uncommon for her to gain 7 to 10 lbs. in just one week. Peculiar to her binge eating was an almost uncontrollable craving for junk food, especially those rich in salt and sugar. In fact, at times she indicated she would amost "kill for a chocolate bar."

Why, you may ask, did her psychiatrist want her to see me, a gynecologist and reproductive endocrinologist? Well, the reason was that each of these episodes of depression, tension, hostility and binge eating occurred during the week before the onset of a menstrual period. In addition, the psychiatrist was hard pressed to find any significant psychopathology during the rest of the month. The patient even remarked that when these episodes were over it was hard to imagine that she could have ever felt so depressed and angry. It appeared to me that this woman was suffering from premenstrual syndrome.

At that time I had only a superficial understanding of premenstrual syndrome or PMS, first described in the medical literature in 1931 by Frank (1931). In response to the request of the psychiatrist and out of a desire to help this young woman, who was obviously suffering a great deal, I spent the next three months reading as much of the pertinent medical and psychological literature as I could acquire. I traveled to Boston, Massachusetts, and met with Dr. Ronald Norris, a psychiatrist and endocrinologist who had established one of this country's finest clinics devoted to the evaluation and treatment of PMS. It soon became apparent that we knew precious little more about the nature of PMS than when Frank wrote his article some fifty years ago. In addition, the field of PMS was rich in vitamin pitchmen, entrepreneurs and other "snake oil salesmen." Disappointed, but not discouraged, I decided to devote a substantial portion of my clinical and research efforts to the study of PMS. Thus, during the last two years I have seen and evaluated almost 400 women with a history of premenstrual complaints. My early days of confusion and skepticism have been replaced with a strong belief that a small but significant number of women suffer a disease that, for lack of a better term, we will call premenstrual syndrome. In addition, I have discovered that premenstrual syndrome often masquerades as other medical or emotional conditions or plays a role in any of a number of physical, personal, sexual or social problems. Thus, I believe, it is important that psychologists, social workers, family and marriage therapists and other counselors be familiar with premenstrual syndrome and its many faces.

***Dr. Keye is an Assistant Professor in the Department of Obstetrics and Gynecology, University of Utah.**

What is Premenstrual Syndrome?

Premenstrual syndrome refers to physical, emotional and behavioral symptoms that occur month after month but are confined to the week or two just prior to the onset of menstrual flow and during the time of the flow itself. While there have been dozens of theories proposed to account for PMS, none has withstood close scrutiny in the laboratory or clinic. The most popular and recent theories have suggested PMS is the result of hormone deficiencies or excesses, neurotransmitter abnormalities, or alterations of the body's immune system.

The clinical presentation of premenstrual syndrome is often confusing. First, patients commonly complain of 25 to 30 different symptoms. Second, women with severe or long-standing PMS may also develop chronic emotional distress in the form of depression, decreased self-esteem, guilt, poor body image, discouragement, frustration or resentment. Finally, the chronic and recurring nature of PMS may lead to marked disturbances in relationships with children, husband, parents, siblings, neighbors, co-workers or fellow parishioners. Thus, it is not uncommon for women with PMS, often unaware of the premenstrual pattern to their symptoms, to come to counseling primarily for personal or family problems. It often takes an astute and persistent clinician to work through the multiple complaints to discover the premenstrual pattern of the basic symptoms.

While more than half of the PMS sufferers I have seen can trace their problem back to adolescence, many note that severe symptoms did not begin until the birth of a

baby, major surgery such as a hysterectomy or tubal ligation, birth control pill use or an emotional crisis. In general, symptoms become more severe and last longer over the years. Most women report numerous attempts to get help for their problems from physicians, psychiatrists, psychologists, social workers, marriage counselors and other health care professionals, often without success.

The most common symptoms are listed below.

Physical Symptoms

Fatigue	Incoordination
Headache	Joint Pains
Bloating	Nasal Congestion
Breast Tenderness	Constipation

Emotional Symptoms

Depression	Panic
Anxiety	Intolerance
Hostility	Altered Libido
Paranoia	Insecurity

In addition, women with PMS may behave out of character during the premenstrual portion of the month. Some examples include: the craving for or overindulgence in chocolate or other foods rich in carbohydrates, craving for salty foods, suicide attempts, physical abuse of children or spouse, withdrawal from family, alcohol binges, threats of divorce, sexual promiscuity, and absence from school or work.

How is PMS Diagnosed?

In the past PMS was either ignored or trivialized by most health care professionals who either did not believe PMS was real or considered it a normal phenomenon that women should learn to endure. As professionals gained more familiarity with PMS, they usually made the diagnosis by history alone, often after a brief telephone conversation or office interview. They prescribed a medication to reduce the severity of the major symptom(s) and sent the patient away in the hope her complaint(s) would be taken care of.

If my experience of the last two years has done nothing more, it has convinced me of the inadequacies of this approach for moderate or severe sufferers. First, it relies on history alone for the diagnosis. Second, it focuses only on the major primary symptoms, ignoring associated and secondary personal and relationship problems. Third, it does not provide the support and continuing care many of these women need.

It appears that a more successful diagnostic procedure involves a multi-disciplinary team and a prospective approach to gathering information and validating the patient's history. The approach I now use consists of four phases: education, data gathering, physical examination, and data review.

The first visit is devoted to group education and instruction. A patient and her husband meet with several other PMS couples and a staff consisting of a health educator, nurse, social worker and physician. Approximately one and one-half hours are devoted to lectures, discussions and videotapes about PMS. Patients and their husbands are given ample opportunity to ask questions of each of the professionals. Each couple is then interviewed extensively by one of the health care professionals at which time they discuss not only the timing and nature of their symptoms but the impact of PMS on their own lives and those of their families. The couples then reconvene in the group setting where they are instructed in the completion of a PMS Calendar, the MMPI and the Lock-Wallace Marital Adjustment Scale. The PMS Calendar is a graphic form of a daily diary that makes it possible for the patient to record prospectively her symptoms as they occur throughout the month. The patient is instructed to complete the MMPI and Locke-Wallace twice during the month, once just following a menstrual period when symptoms are minimal and once just prior to a period when symptoms are greatest. The patient then returns home where she completes the calendar and tests.

During the next month the patient receives a physical examination from a gynecologist or specialist in internal medicine to make sure her complaints are not the result of an underlying medical problem. The importance of this examination was illustrated recently when a neurologic examination of a woman whose major symptom was premenstrual headaches detected a meningioma, a brain tumor, the removal of which resulted in the disappearance of her headaches. If the physical examination uncovers a new or significant medical problem, the patient may then be referred back to her physician or to an appropriate specialist for further evaluation.

Approximately four to six weeks after the first visit, the patient and her husband return for a review of the history, MMPI and Locke-Wallace results, physical examination and PMS Calendar. A tentative diagnosis is made and a treatment plan outlined. Once the treatment program has been implemented and evaluated, the patient is usually referred back to her physician, counselor or therapist for continuing care. Patients in whom major psychiatric illness or mental discord have been diagnosed are referred to appropriate professionals in their communities.

Unfortunately, just as there is no universally accepted definition of PMS, there are no strict diagnostic criteria. In general, however, I utilize the following:

1. A history of symptoms that occur only during the premenstrual or menstrual phase of the menstrual cycle or is much more severe during those times.
2. A premenstrual pattern of symptoms when charted prospectively.
3. Marked changes in the MMPI from a relatively normal profile in the postmenstrual phase to an abnormal profile in the premenstrual phase.
4. The absence of cyclic environmental stress which could account for the symptoms.
5. The absence of medical disorders which could account for the symptoms.

How is PMS Treated?

A review of the literature reveals dozens of different

continued on page 22

YOUR OWN CROWN OF THORNS

Lynn M. Roundy,* M.Ed.

Our Heavenly Father, in designing the carefully chosen experiences of our first and second estates, was guided by his eternal goal, "to bring to pass the immortality and eternal life of man." (Moses 1:39) To insure that we would each have the opportunity to achieve such a glorious destiny, he planned significant pre-mortal challenges as a measure of our willingness to be obedient to his will despite the clever persuasions of Lucifer. Those who remained committed to God and to His plan were given the privilege of leaving our Father's presence to be further tried and tested in order that ultimately, if faithful, we might eventually progress to the point where we would be worthy to re-enter His kingdom and potentially even become like Him, exalted and perfected:

> And we will prove them herewith, to see if they will do all things whatsoever the Lord their God shall command them;
> And they who keep their first estate shall be added upon; and they who keep not their first estate shall not have glory in the same kingdom with those who keep their first estate; and they who keep their second estate shall have glory added upon their heads for ever and ever. (Abraham 3:25-26)

According to the divine wisdom of an omniscient Father, some of the schooling experiences of earth life are, by design, calculated to try our capacity to endure difficulties, that God may determine our willingness to "submit to all things which the Lord seeth fit to inflict upon [us]." (Mosiah 3:19)

In this paper we will examine four symbolic metaphors which, if fully understood, might enable us to appreciate part of the divine purpose in the Lord's plan to "prove [us] herewith." (Abraham 3:25)

Throughout the scriptures we find frequent use by the Lord and His prophets of symbolism to teach both obvious and underlying messages. For example, when God asked Abraham to sacrifice the life of his son, Isaac, He directed them to travel to Mt. Moriah, not just out of Sarah's view. They journeyed three days to reach this mountain. Why? The symbolism becomes more evident when we realize that Moriah is the prominence upon which Jerusalem was later built; it is the temple mount, and a portion of this same mountain is called Calvary. In similitude of the giving up of His Only Begotten Son, God asked Abraham to be willing to offer up his only son on the very same "alter."

In this simple illustration we see the Lord's application of symbolism to instruct His children. By examining the life and teachings of the Savior, we can find further use of the symbolic method in teaching significant truths.

Though the mortal ministry of Christ brought him into direct contact with all classes and degrees of tribulation and suffering, His greatest agony was in the Garden of Gethsemane, when He assumed the collective burden of the sins of all men. The word Gethsemane, when broken into its Hebrew parts gives us: Geth or Gat, which is rendered "press," and Shemen, or "oil press." Anciently there may have been a press among the trees on the Mount of Olives which served the function of forcing out the precious fluid of the olives, under great pressure.

Did the Savior specifically choose Gethsemane for His Atoning sacrifice? Did He deliberately choose that garden to undergo the horrible "pressure" that forced the "precious fluid" of His blood to ooze from every pore? I prefer to believe He did.

As the Lord faced His own Gethsemane, so too must we all. Ella Wheeler Wilcox described our "garden" experience this way:

> Gethsemane
>
> All those who journey, soon or late
> Must pass within the garden's gate;
> Must kneel alone in darkness there,
> And battle with some fierce despair.
>
> God pity those who cannot say:
> "Not mine but thine;" who only pray:
> "Let this cup pass," and cannot see
> The purpose in Gethsemane.
>
> *(In Morrison, 1948, p. 184)*

Each of us will, at one time or another, find ourselves in the loneliness of "the garden," facing unwanted pain, torment, and suffering. These difficulties may be somewhat less traumatic if we can "see the *purpose* in [our] Gethsemane." In order to discover this "purpose" we will expand on the premise that each person must endure some kind of a "garden" experience in mortality.

During His ministry Christ applied a second metaphor to this same principle. "Then said Jesus unto His disciples, If any man will come after me, let him deny himself, and take up his cross, and follow me." (Matthew 16:24) A close look at this verse reveals the following points: First, this message was for the disciples, the committed followers of Christ, not the general Jewish population. Second, for those who determined to "come after" Him there were *three* expectations: 1, he must "deny himself," or cease to be motivated by the things of the world and to achieve mastery over himself; 2, the Savior asked that we each take up our own "cross." Perhaps the significance of this challenge may be better understood if we examine the nature of a literal cross. The timbers from which the cross was constructed must have been rather substantial, perhaps six inches by eight inces, and several feet in length. They would have been heavy, and picking them up would not be easy, especially considering the extreme fatigue that the Lord must have been experiencing. The "cross," then, becomes the heavy "burden" of our lives -- our trials and sufferings; and 3, after getting the cross shouldered, we are asked to follow Him. Follow Him where? To Calvary! That is

***Brother Roundy is Executive Director of the Central Utah Sexual Abuse Treatment Program.**

where He took His cross. Picking up the "cross" is not necessarily the end of our torment, but perhaps only the beginning. Such a thought buckles the knees! Must I go where He did? For those who pause to consider whether or not to hoist this burden, the Lord then might add, "And he that taketh not his cross, and followeth after me, *is not worthy of me.*" (Matthew 10:38, emphasis added) If we desire to be worthy of our Savior, we must shoulder our "cross," and march resolutely to "Calvary."

For those who determine to follow the Master, Elder Neal A. Maxwell (1976, p. 259) offers some suggestions to aid us in "cross carrying":

> What, then, are some of the skills and strengths...which enable us to lift and then to carry the cross?
>
> *First*, we must realize that the weight of the cross is great enough without our carrying burdens that we could jettison through the process of repentance. It is so much more difficult for us to carry the cross when our back is already bent with the burdens of bad behavior.
>
> *Second*, the cross is something we cannot shoulder and then stand still with. The cross is easier to carry if we keep moving. Action and service, happily require enough of our attention that the sagging of self-pity can be avoided.
>
> *Third*, we must realize, finally, that we can only contemplate the cross just so long; rhetoric will not raise it. It must soon either be taken up or turned away from!

It would appear, then, that we *may* all eventually be required to either "enter the garden" or "carry the cross." Throughout the course of human history each mortal has experienced his own share of tribulation and suffering. Abraham, Noah, Nephi, Joseph Smith, Paul the Apostle, Peter, and Job were all on the list of "garden" visitors. We might increase our appreciation for this principle of personal suffering by examining closely the life of Joseph, who was sold into slavery:

> Joseph, the son of Jacob, in a story that someday we shall have the full and fascinating particulars of, overcame what could have been the disabling shock of being sold into slavery. The gall of bitterness was not in him then, nor had bad breaks made him bad. He later rose to positions of trust in the household of Potiphar. His same refusal to resent "all these things" was there subsequently in the unjust imprisonment of Joseph; his resilience could not have emerged if he had been a bitter prisoner. Should we then be surprised by his later anonymous generosity to his hungry brothers -- the very brothers who had sold him into slavery? Resilience begets resilience!
>
> Thus, Joseph's quality service to Potiphar and his management skills even in the jail were a clear foreshadowing, of his brillant service later on as the "prime minister" of the Pharaoh. But it all sprang from within; Joseph's spiritual strength could not be shaken by things from outside.
>
> Bad breaks, therefore, need not break a good man; they may with God's help even make him better! (Maxwell,1979, pp. 40-41)

As we viewed the repetitive devastations in the life of Joseph from our pre-mortal vantage point, would any of us have been able to critically disparage him had he given up after being sold as a slave by his brothers? What about after he was imprisoned for remaining virtuous in the face of the seductive advances of Potiphar's wife? What would we have said had he crawled into the corner of Pharaoh's prison stench-hole? When the butler, having been restored to his former position, as prophesied by Joseph, and having promised to plead Joseph's case before Pharaoh, forgot for two years, how disappointed would we have been if then he had rolled into a fetal ball and "went away" spiritually and mentally? *How different the course of history if he had done so!*

Consider the possibilities. After two years Pharaoh has his famous dream which no one could interpret. *Now* the butler remembers. Guards are immediately dispatched to the prison to fetch Joseph, who they find muttering gibberish in the far corner of the cell. Upon being presented before Pharaoh, and being questioned relative to his ability to interpret dreams, his only response is the unintelligible raving of a madman. What such a turn of events would have meant to the sons of Israel who went to purchase grain during a famine, or to Moses who was to be born through the lineage of Israel, or to those who are descendants of Ephraim or Manasseh. We can only speculate, but certainly history would have taken a different course in fulfilling the prophecies of God.

Such for Joseph, and thankfully for us, was not the case. After *two years*, under the most incredible filth and abandonment of family, friends, and seemingly God, he was called forth by Pharaoh's servants. There was no time to get "in tune," to fast and pray for divine guidance; it was there, or it was not. When asked if he could make sense of the troubling dream, Joseph's immediate response, incredibly, was, "It is not in me: God shall give Pharaoh an answer of peace," whereupon he then delivered an inspired interpretation. A more marvelous display of the capacity for endurance in "garden visiting" and "cross bearing" would be difficult to find.

Another individual who was fully familiar with "crosses" and "gardens" was the Apostle Paul, who nearing the conclusion of his life recounted the various difficulties and trials he had faced:

> Of the Jews five times received I forty stripes save one.
>
> Thrice was I beaten with rods, once was I stoned, thrice I suffered shipwreck, a night and a day I have been in the deep;
>
> In journeyings often, in perils of waters, in perils of robbers, in perils by mine own countrymen, in perils by the heathen, in perils in the city, in perils in the wilderness, in perils in the sea, in perils among false brethren;
>
> In weariness and painfulness, in watchings often, in hunger and thirst, in fastings often, in cold and nakedness.
>
> Beside those things that are without, that which cometh upon me daily, the care of all the churches. (2 Corinthians 11:24-28)

Could any of us chastise Paul had he failed to endure to the end? Surely we might have wept with sadness, but we most likely would have understood, seeing the depth of his pain and torment.

Finally, and ultimately we recount the unfathomable miseries of the Messiah. In our present consideration let us limit our review to the events of his last night in mortality.

During the darkness of that terrible night the Lord suffered incomprehensibly in Gethsemane, taking our sins upon himself. Never before or since has any mortal being even approximated the spiritual-mental-physical agony of this crucial element of the Atonement. Shortly after that awesome burden was shouldered Judas came

with the traitor's kiss.

Throughout the remainder of that night Christ was dragged in succession from one insulting "trial" to another—first before Annas, then to Caiaphas and the Sanhedrin, where He was spit upon, buffeted, smitten, found "guilty," and sent to Pilate for further examination and for sentencing. When the Roman Procurator could find nothing in Jesus worthy of death, and having discovered his Galilaean background, he ordered the Lord to be taken to King Herod who was in Jerusalem for the Passover. There He was accused, mocked, and dressed in a robe before He was returned to Pilate. Herod would not intervene.

Again Pilate sought to find some vestige of guilt with which he could placate the Jewish elders who were clamoring for a sentence of death. Finding no such crime in the Son of Man, Pilate sought his release by offering the people a choice: Barabbas, a convicted murderer, or the sinless Jesus would be released as part of the Passover tradition. When the people demanded the release of Barabbas, the Procurator assented to their wish and sent the Savior to be scourged, preliminary to crucifixion. After the horror of scourging was finished, the Roman soldiers determined to make sport of this "king." They replaced the scarlet robe, platted a crown of thorns, placed it roughly on his sagging head, gave Him a reed-scepter, bowed before Him, and in ultimate mockery before the King of Kings, they paid "homage": "Hail, King of the Jews!" (John 19:3) Then, spitting upon the Lord, they took the reed and hit Him on the head, and smote Him with their hands.

Such a pitiful sight: the Christ dressed in a kingly robe, crowned with thorns, beaten, mocked, scourged, weakened to the point of utter exhaustion, both by the incessant haranguing of the entire night, and even more-so by the soul-wrenching struggle in Gethsemane. Perhaps in a final appeal to the humanity of the Jews who had congregated in the courtyard of the Antonia Fortress, Pilate had Jesus brought onto the parapet before them, to allow full observation of the pitiable condition of the Lord.

He plead, "Behold the Man!" (John 19:5)

But, compassion was not a visitor that morning. "Crucify him, crucify him!" (John 19:6)

Who among those of us who were watching from heaven in bitter, tearful agony would have felt the Lord unjustified if He had *stopped* there and then?

"I have suffered enough! O, my Father, release me from this mortal prison. I will not go one step further for them. They do not deserve any of this. *I will not go to Calvary for them!*"

Consider for a moment how profoundly such a decision would have altered our future possibilities. No Savior to free us from death or from our sins. No hope, ever, to escape eternal damnation. Though, in the face of such trials, Christ may have been "justified" to leave His mission unfinished, *how very grateful* we must be that He picked up His cross, as He has asked each of us to do, and struggled under its burden up that terrible mountain to give final fulfillment to the symbolism of Abraham's sacrifice!

Although we need not anticipate difficulties of equal magnitude and as numerous as those of the Lord, life for each of us is likely to be punctuated with challenging moments in our own "garden," under the significant burden of our own "cross," or perhaps in a long and arduous climb up the slope of the "mountain" described in the following parable.

COME, FOLLOW ME

It was one of those blistering hot summer days for which Arizona is infamous. I still don't understand how the message was communicated—three simple words: "Come, follow me." This was obviously no ordinary man. His dress was strange, not of our day and age, and he was bearded, yet, there was something calmly powerful about him. Most of the people who heard him were openly scornful in their rejection of his invitation to follow. Still, there was a multitude that responded to him. We found ourselves, with our families, walking behind him as he moved in a northerly direction, leaving behind those who considered us fools, who saw nothing significant about this man.

We had no idea how far we would be going, but there was a general assumption that this was to be some sort of gathering, perhaps at the edge of the city. For the first few miles there was an electrical excitement and great anticipation regarding the nature of this strange event in our lives. All through the caravan there was hum of conversation centering on where we were going, and why. After several miles, with sweat streaming down foreheads, into eyes, over cheeks, and dripping from chins, the anticipation gradually subsided and concern regarding just how far we were going became the dominant thought.

By late morning we had moved into the outer suburbs of the city. Already the crowd had thinned considerably, with many dropping from the ranks to return to the comfort of home and friends. The natural desert landscape was a mixed blessing -- its beauty tempered by the spines that afflicted the unwary. When he began the ascent into the gently sloping foothills skirting the more distant mountain range there were more questions, more complaints, and fewer followers. I suppose that many assumed that whatever reward they had anticipated in coming this far should, by now, have been granted. The others continued, wondering -- perhaps less excited now but still wondering: "Where are we going?" Though this question hung unanswered, we would, in time begin to know.

And yet, on he continued.

When the foothills became more literal mountain, some were offended and turned back excusing themselves, saying, "We have gone as far as we can. What does he expect of us?" With the increasing steepness of the incline the pace flowed, though in the intensity of the afternoon sun, perspiration now coursed down brow and cheek in rivulets. Desert vegetation gave way gradually to scrubby brush that required a meandering route.

Several hundred yards above us was the crest of the first major ridge of our climb. Immediately speculation broke out among us that this would be our point of destination. The pace quickened until the summit was achieved. Filled with anticipation, and gasping for air, we anxiously searched for our leader. For several moments he remained unseen, until one among us, in an exasperated groan announced, "There he is, going down into that next ravine!"

Another man called out, "What do you want of us? We will not go on!" With that he and his family joined others who were turning their faces to the desert floor. Those of us who remained atop that peak shouldered our little ones and slowly renewed our journey.

Onward, upward, downward, the course continued. Brushy terrain was becoming overshadowed by evergreen trees. Having abandoned our false expectations for an abbreviated climb, we now viewed each new ridge as a challenge to be met and overcome. As we stood atop each summit, we were filled with glory and wonder, knowing that in the distance was yet another grander peak waiting to be surmounted -- and between us, another gaping chasm waiting to be traversed. One silver-haired man, who with his sweetheart, struggled to maintain the pace, observed, "Sometimes the only way *up* is *down!*"

And still he continued.

It is unclear where it was in the climb that we awakened to the realization that the air was cooler. Now, though the sweat was still profuse, there was a refreshing breeze of cool mountain air to invigorate our aching muscles. Now, too, we realized that no longer was the air stale with dust, smoke, and city smells -- but rather it was crisp and clean. Reaching the next summit, one among us scanned the distant horizon and exclaimed, "Look! How far you can see!" After that, each plateau was a reward, a more expansive view. Never before could we have envisioned such horizons, or believed ourselves capable of such arduous effort.

By now the little band of followers was spread out considerably. Slowly we made our way up the ever-increasing incline, one step ahead of the previous. On occasion we were met by those who, seeing what lay ahead, would not continue: "If you think it's tough here, you should see what it's like above. This is crazy! He can't expect us to go where he's going, can he?" So down they went.

And yet, still he climbed.

Now the shadows of late afternoon were lengthening, the breezes cooler, the air even clearer, the vision even grander. The ridge ahead appeared the most difficult of all we had come upon -- higher, and the incline more severe than previous. Somehow, with what little stamina remained, we placed each foot in front of the other and began making our way upward. Because of the exaggerated slope, progress was painfully slow, and everyone struggled against the nearly overhwelming desire to drop out and turn back.

Then, unmistakably, the air was filled with a rapidly increasing feeling of anticipation. As if we were one, we raised our heads to behold, several yards above us, the *Master*, standing with arms beckoning, on his countenance, a gloriously peaceful expression of love! With tears of joy we rushed into his embrace. Now, falling to our knees, we bathed his feet with kisses and tears -- each foot reflecting a glorious scar.

"My Lord! My God!"

"Arise, my children. Look about you!"

Slowly rising, through tear-filled eyes the glorious scene unfolded. In every direction we could see *forever!* Gathering our loved ones, we scanned the endless horizons, marveling at the beauty, grateful to the deepest part of our souls that we had not faltered; trembling with the realization that we might, like some, have turned back one ridge too soon.

But now we turned again, to look upon the glorious being that stood before us, (filled to overflowing with unutterable joy)

"Come, follow me" the Savior said,
Then let us in his footsteps tread,
For thus alone can we be one
With God's own loved, begotten Son.

We must the upward path pursue
As wider fields expand to view,
And follow Him unceasingly
Whate'er our lot or sphere may be.

For thrones, dominions, kingdoms, powers
And glory great and bliss are ours
If we, throughout eternity,
Obey his words, "Come, follow me."

(Hymns, #14)

All true disciples of Christ, who deny themselves, take up their "cross," and willingly follow him, not faltering until after the last "ridge" has been achieved will be able, like Paul, to say:

> I have fought a good fight, I have finished my course, I have kept the faith:
>
> Henceforth there is laid up for me a crown of righteousness, which the Lord, the righteous judge, shall give me at that day: and not to me only, but unto all them also that love his appearing. (2 Timothy 4:7-8, emphasis added)

The image of a "crown" seems to be symbolic of a reward for passing the tests of mortality. The conditions for our receiving such a crown, as we kneel at the feet of the Lord, atop that highest peak, are described by Brigham Young:

> All intelligent beings who are crowned with crowns of glory, immortality, and eternal lives must pass through every ordeal appointed for intelligent beings to pass through, to gain their glory and exaltation. Every calamity that can come upon mortal beings will be suffered to come upon the few, to prepare them to enjoy the presence of the Lord. (1966, p. 150)

This crown, then is of substantial importance. What kind of crown is it? Thomas Carlyle (1949, p. 707) suggests that, "Every noble crown is, and on earth will ever be a crown of thorns." A crown of thorns? Of course. Another symbol with hidden significance. And how do I *earn* my own crown of thorns? Simply the same way that Joseph, or Paul, or Christ did: *thorn by thorn, like a charm bracelet.* As each new thorn (trial) is successfully endured it is added to our developing crown. Some thorns are small and some are very large, but all are precious "jewels" and will be treasured when finally the crown is finished.

Thoughtfully pondering this imagery of a thorny crown gives added meaning to the Apostle Paul's lament regarding his "thorn in the flesh":

> And lest I should be exalted above measure through the abundance of the revelations, there was given to me a thorn in the flesh, the messenger of Satan to buffet me, lest I should be exalted above measure.
>
> For this thing I besought the Lord thrice, that it might depart from me.
>
> And he said unto me, My grace is sufficient for thee : for my strength is made perfect in weakness. Most gladly therefore will I rather glory in my infirmities, that the power of Christ may rest upon me.
>
> Therefore I take pleasure in infirmities, in reproaches, in necessities, in persecutions, in distresses for Christ's sake: for when I am weak, then am I strong. (2 Corinthians 12:7-10)

The Apostle James was apparently also aware of the necessity to endure first before the promised "coronation": "Blessed is the man that endureth temptation [trials?]: for when he is tried he shall receive the crown of life [thorns?], which the Lord hath promised to them that love him. (James 1:12)

As suggested by both Paul and James, perceiving life's "thorns" as potential "crown jewels" is an essential first

completed on page 23

LDS VALUES AND ADVOCACY FOR THE NURSING HOME PATIENT

Rex R. Ashdown,* DSW

A basic premise of membership in AMCAP is that one will adhere to principles and standards (values) of the Church of Jesus Christ of Latter-day Saints. During the past several years a number of well written articles have appeared that explore areas wherein LDS values may be in conflict with or at least not overly compatible with clinical expectations. (See Bergin, 1980; Madsen and Millet, 1981). It is the writer's impression that, for the most part, these articles urge adherence to gospel values when incompatability is present.

Possibly as succinctly stated as one could desire, the DeHoyos' argue, "... Mormon therapists are trying to integrate their professional training and the gospel." (DeHoyos, 1983) With this position, the writer has no argument. Yet, in the hard reality of advocating for or working with the nursing home client, incompatibilities are frequent and answers that give comfort and direction to the worker are rather elusive. This article is not an attempt to provide answers nor is it a plea for colleague sympathy nor for a special dispensation to ignore LDS values. Rather, it is hoped it may stimulate an exchange of ideas and thus start a process of resolution of the concerns.

Three concepts common in the health care arena may need brief operationalization: Medicare, Medicaid and Nursing Home. Medicare is a form of insurance, generally available to those 65 years of age and older. It is a federal program authorized under Title XVIII of the Social Security Act. It is especially designed to assist in meeting health care needs for those needing acute hospital care. Due to its "insurance" base, it is socially acceptable. Unfortunately, Medicare coverage for nursing home care is very limited.

Medicaid, Title XIX of the Social Security Act, is an assistance (welfare) program. It is a joint effort between federal and state governments to assure availability of medical services to all who may be in need. As with most welfare programs, those who seek help are expected to meet a means test. Basically, the means test demands verification that the person has very limited resources.

Nursing homes of today are fully licensed facilities that provide long-term medical care and supervision. The nursing home of today is of recent invention, based upon a most common factor--necessity. The necessity is due to the fact that an ever growing portion of our society can be considered as elderly. Medical science has provided means whereby many previously fatal conditions are now treatable. The life span has been extended, and we simply have more old folks who need care.

The nursing home of today is not the "human junkyard" of yesterday. Stricter laws, licensing, developing knowledge, and public demand are but a few reasons the nursing home has as its goal the total well-being of the patient. The patient in the nursing home must be considered as a human being. That is, all the virtues, needs, and foibles we each enjoy are also enjoyed by the nursing home patient. Yes, even sexual activity is or might be part of the interest.

Among the many duties of the social worker in the nursing home, i.e. filling out forms and signing reports, the role of patient advocate is thought to be of extreme importance. One reason for the importance of the nursing home advocate role is found in the totalness, the newness and the bewilderment of the mass of decisions to be made amid the lack of explicated social norms for guidelines. This confusion the advocate addresses is found within the patient and, equally if not more important, within the family support system.

Certainly it is not thought necessary to operationalize basic LDS values implied by such words and phrases as family, marriage, life, tithes and offering, Word of Wisdom, taking care of oneself, family responsibility and use of public welfare. Yet, it is just such values that may well cause concern.

Possibly a few vignettes might serve as a base to explore how LDS values might be of concern while one serves as an advocate to the nursing home patient and their family. (All vignettes used are based upon composite situations and not any one case.)

As the family reported her history, "Grandma Hardy was born in 1910. She grew up in a close family setting--in fact her paternal Grandmother Cox lived with the family until she died of 'old age' at 71." One might best describe Grandma Hardy as having grown up totally accepting the LDS values of a close family, work for what you get, be honest, marry in the temple and raise a family.

Grandma Hardy did in fact follow suit. Married at 17, she had two sons and three daughters by the time she was 27. She was widowed when she was thirty. "She had it tough but the little home and ground allowed her to raise a garden, chickens and a cow--they didn't eat fancy but never went hungry. She was always active in the Church, held some important positions, worked hard to see that every one of the children graduated from high school, sent the second boy Tom on a mission and never

***Brother Ashdown is an Associate Professor of Social Work at Weber State College and serves as a Social Work Consultant in a local nursing home.**

took a dime from a soul that wasn't earned."

"The children all turned out fine--all married to good solid people, raising fine families. Of the 18 grandchildren, several have served missions, some are in college, others are married and starting families of their own and some are still living at home."

The problem started several years ago. There were some health problems. A few pills and a couple of operations took care of it, but it seemed she just got worse in other areas. "Kept forgetting things--left the kitchen stove on one night and darn near burned the house down. She thought people were trying to take her stuff." Many other little behavior patterns developed that were sometimes funny but sometimes of great concern.

To resolve the problems a plan of having one of the unmarried grandchildren live with her was tried but it just didn't work. The family held a meeting and decided they each would take her for a month. The plan was put into action and the old home was rented out. The best way to describe the rotating living plan is to use the world "disaster." "Grandma seemed to get even more more confused. She always kept packing her suitcase to go home, accused the families of stealing her money, would not take her medicine, and finally--the last straw. Grandma was staying at the youngest daughter's place. One Saturday, while everyone was out of the house, Grandma wandered off. She was found several blocks away, walking down the middle of the street wearing nothing but a wristwatch and one shoe."

What to do? Easy! The woman is in need of medical care; she must have very close supervision in a controlled environment. The answer, use the services of a nursing home. (Admittedly, our value system is operating here.)

So? Wherein lies a problem with LDS values? The family is reluctant to use the nursing home. Their reluctance is based upon solid LDS values with very clear scripture support.

> "Honour thy father and thy mother: that thy days may be long upon the land which the Lord thy God giveth thee."
>
> Exodus 20:12

> "But if any provide not for his own, and specially for those of his own house, he hath denied the faith, and is worse than an infidel."
>
> Timothy 5:8

You also recall that one of the last acts of Christ was to secure for his mother the watching care of one of his disciples--St. John (John 19:26-27).

How can the family fulfill these values and "put Grandma away?" The heartfelt pain--and I know of no better word--the family suffers is devastating. Inner-family relations suffer. Possibly to protect a sense of well being, it is not unusual to project blame. "Older sister Jane has a big house, her kids are all gone, she has nothing to do! Why doesn't she take Grandma in?"

Admittedly, the writer knows of no official church statement that counterindicates use of a nursing home. Yet how does the advocate handle the family's statement of: "The Church knows we need education and we have a great college system. The Church knows we need recreation and we have the greatest sports program in the world. The Church knows we need medical care and we had the finest chain of hospitals in America. But, I don't see the Church providing any nursing homes. I don't feel right about putting Grandma here."

Even so, let us assume the family, due to hard reality, accepts nursing home care for Grandma. The very real factor of paying for the nursing home care may bring about another conflict with LDS values. We are specifically told to care for our own. In fact, the *Welfare Plan Handbook of Instructions* carries the statement, "Where Church relatives, financially competent to take care of their kin refuse to do so, the matter should be reported to the bishop of the ward in which such relatives reside. (1969) (What the bishop's action should be is not spelled out.)

Yet, at the present time in the Utah area, nursing home care is approaching $1500 per month. A quick look at Grandma Hardy's finances--and a quick look is all that is required to see the whole thing--gives reason for the conflict of values.

Income:	Social Security	$250.00
	Income from Home Rent	160.00
	TOTAL	$410.00

Deduct house taxes, fire insurance, maintenance of $50.00 per month and the total monthly income is $360.00.

Assets:	Savings Account	$1,300.00
	Home*	30,000.00

If Grandma Hardy pays her own way as she has been taught to do, in one month she will be broke. The family can, of course, all chip in an equal share and make up the "$1,140 per month shortage." (Cost of $1,500 less income of $360) Such a plan will allow them to "take care of their own." This means each family only has to pay $228 per month. Admittedly, we members of AMCAP with our fine educations and great incomes could easily assume such a small obligation in order to maintain the value system pointed out above. There are many who simply cannot. Yes, the family could "... go and sell that thou hast, and give to the poor, and thou shalt have treasure in heaven..." (Matt. 19:21) However, I think a lot of people seem to prefer a few of their treasures in the "here and now."

I know of a bishop and his family who made the above "all chip in arrangements." When a sibling cannot pay the $228, the bishop simply makes up the shortage from his ward's Fast Offering Fund. Frankly, I question the propriety of his action. Even if it is correct, I would suggest that with all the Church's resources, paying nursing home bills would soon bankrupt the Church--witness what such action is doing to the nation.

As an advocate for the patient, can you recommend the use of a public assistance program--Medicaid?

If so, how does one handle the conflict with the basic

*The ownership of a home may or may not be an asset. Many policies have been issued concerning homes: i.e., if a relative is living in the home, it is not an asset. If it is rented to a non-relative, it must be listed for sale. If sold on a contract, the contract becomes an asset. In short, it is a difficult process for the family to handle, so let's skip over the home as an asset for the moment.

LDS value as stated in 1 Timothy 5:8 and in the *Welfare Plan Handbook of Instructions.*

AID FROM RELATIVES

Obviously no person should become a charge upon the public when his relatives are able to care for him. Every consideration of kinship, of justice and fairness, of the common good, and even of humanity itself, requires this. Therefore, all Church welfare workers will urge to the utmost the caring for the needy by their kin, if they have sufficient funds or supplies to enable them to do so. (1969, p.4)

"But if any provide not for his own, and specially for those of his own house, he hath denied the faith, and is worse than an infidel." (1 Tim. 5:8)

Yes, the home could be sold and the proceeds used to keep Grandma. But--a $30,000 home must be sold for cash or payments large enough to pay the $1140 per month shortage to the nursing home. This will last about 30 months and then we are back to the Medicaid or "all chip in" question. Also, Grandma might get better--some patients have--then where will she live if the home is sold? Another factor is that Grandma won't sign sale papers. She has always planned to use the house to leave each of the children a "little something."

Many more such problems could be explored, but let's say they have been solved and Grandma Hardy is in the nursing home and is happy. Medicaid is in force and all is well. Yet, Grandma has never let a Fast Sunday go by without giving an offering. Also, she has paid tithing on her SSA check and the house rent on a very faithful basis. Medicaid allows her $125 per month to spend on personal desires. All other money goes to the nursing home--a conflict of values? How do we help her accept non-payment of tithes and offerings?

Well, Grandma Hardy is a hard case--but a very common one. Let me offer some other cases.

Grandpa Thomas, born 1890, is admitted to a nursing home as a private pay patient. Grandpa Tom, as he is called, was orphaned as a young child. Nevertheless, by hard work as a ranch hand, he finally was able to get his own place and became a highly respected and successful cattle rancher. He has always been a very proud, honest, hard working man. As we might say today, he was "Macho."

He has lived with his grandson Mike and his family for the past 15 years. They have provided the ideal love and respectful environment.

In the last few years Grandpa Tom has become quite weak physically, yet seems fully capable of making all of his own decisions. He has needed help in dressing and bathing--this has not been a problem. However, in the last two weeks Grandpa Tom has become totally incontinent. Though the granddaughter-in-law is a R.N. and has been cheerful and willing, the act of having to be cleaned and redressed after an uncontrolled bowel movement is more than Grandpa Tom can handle emotionally. He demanded to come into a nursing home.

On the second day of the nursing home stay he was discussed in Patient Care Meeting. Plans to provide full care were made. Two weeks later he was again discussed. For the past several days he had refused to eat and would only sip water. His physical condition was fast becoming precarious.

We can, of course, admit Grandpa Tom to an acute hospital for access to various life support systems. We can also respect his apparent plan to stop living.

The LDS values concerning life are clear. Yet, should we demand that every effort be put forth to maintain Grandpa Tom's life? Should a proud, independent man be forced to live through daily care that is emotionally devastating?

Another issue--Jack Hanson, age 71, needs your skills as an advocate. His plight is given to you as follows. He and his wife celebrated their 50th wedding anniversary last year. They were married in the temple in 1931. They raised seven children and saw them through missions and some college. They were able to make wise investments to the end that they now enjoy a monthly income of $1850, although they have very little in savings. All money has been invested in joint accounts. They own a nice home. In short, good, solid LDS values have allowed them to realize their dream of a comfortable retirement.

Unfortunately, Mrs. Hanson recently suffered a major stroke and will require nursing home care until she dies. She is totally incapable of any social interaction. Remember, nursing home care is costing about $1500 per month. Their little savings account is being very rapidly exhausted and the investments that they have, if cashed in, will stop most of their income.

The bottom line is simple. Mr. Hanson cannot live in the home and meet his social and theological responsibilities on the money left after he pays the nursing home. He would soon exhaust his resources if he cashes in the investments, and he has far too much to qualify for Medicaid assistance.

A simple solution--divorce Mrs. Hanson, claim all right to their joint accounts and pay a small sum, say $200 per month as alimony. Mrs. Hanson would then be eligible for Medicaid and Mr. Hanson can continue to live in dignity.

At this point tears roll down Mr. Hanson's cheeks. He sobs, "I couldn't do that. She is my wife. I love her." And, of course, there are the well-stated values concerning the sacredness of marriage. The Hanson children are not able to pay the nursing home bill. Do we press for divorce or destroy a life dream of a comfortable old age?

Or, visualize the common nursing home social life for a moment—bleak at best. A common attempt to--at the risk of a bad pun--add a little spirit to the situation, wine and cheese tasting parties are held. Do you encourage such blatant violation of the Word of Wisdom?

How do we advocate for Harry--a long time temple worker, whose wife can no longer care for him due to his loss of ability to test reality? (We can't use the term senile any longer.) He is in a nursing home and devotes the major portion of his time to courting the women patients. He very frequently becomes very overt in his sexual advances. Or what do we advocate for Myrtle, another patient who is more than delighted to receive Harry's attention?

How do we best serve the incontinent patient who demands the near life long pattern of wearing garments

be continued?

How do we best serve the married patient when he is in a nursing home, has the ability and desire to continue an active sex life with his willing, non-patient wife?

Many more such situations might be explored. Some, as above, bring about head-to-head confrontations with gospel values. Others tend to fall into the more gray areas. Still, they are all reality; they must be faced; action must be taken.

Without a doubt, we as professionals who intervene in the lives of others know full well that within the values of the Gospel and the teachings and life of our Savior lie the only true road to happines. Yet, there are still some questions.

NOTES

1. Bergin, Allan E., "Psychotherapy and Religious Values," *AMCAP Journal*, April 1980, Vol, 8 (2), pp. 3-11.
2. Charles H. Madsen Jr., and Robert L. Millet, "The Gospel and Psychotherapy: A Morman Counselor's Dlemma," *AMCAP Journal*, April 1981, Vol. 7 (2), pp. 11-15.
3. Genevieve DeHoyos and Arture DeHoyos, "The Mormon Psychotherapists: An Addendum", *AMCAP Journal*. January 1983, Vol. 9 (1), p. 21.
4. Welfare Plan Handbook of Instructions, LDS Church, February 10, 1969, p. 4.

continued from page 12

Spilka, B., & Werme, P. H. Religion and mental disorder: A research perspective. In M. Strommen (Ed.), *Research on religious development: A comprehensive handbook*. New York: Hawthorn, 1971.

Spitzer, R. L. (Ed.). *Diagnostic and statistical manual of mental disorders* (3rd ed.) Washington, D.C.: American Psychiatric Association, 1980.

Srole, L., Langer, T. S., Michael, S. T., Opler, M. R., & Rennie, T. A .C. *Mental health in the metropolis: The midtown Manhattan study* (Vol 1). New York: McGraw-Hill, 1962.

Stanley, G. Personality and attitude correlates of religious conversion. *Journal for the Scientific Study of Religion*, 1965, *4*, 60-63.

Stark, R. Psychopathology and religious commitment. *Review of Religious Research*, 1971, *12*, 165-176.

Strommen, M. P. (Ed.). *Research on religious development: A comprehensive handbook*. New York: Hawthorn, 1971.

Summerlin, F. A. *Religion and mental health: A bibliography* (National Institute of Mental Health). Washington, D.C.: U.S. Government Printing Office, 1980.

Swindell, D. H., & L'Abate, L. Religiosity, dogmatism, and repression sensitization. *Journal for the Scientific Study of Religion*, 1970, *9*, 249-251.

Szasz, T. S. *The myth of psychotherapy: Mental healing as religion, rhetoric, and repression*. Garden City, N. Y.: Doubleday, 1978.

Tennison, J. C., & Snyder, W.U. Some relationships between attitudes toward the church and certain personality characteristics. *Journal of Counseling Psychology*, 1968, *15*, 187-189.

Ushio, H. Religious behavior and personality characteristics. *Japanese Journal of Educational Psychology*, 1972, *20*, 109-118.

Walls, G. B. Values and psychotherapy: A comment on "Psychotherapy and Religious Values." *Journal of Consulting and Clinical Psychology*, 1980, *48*, 640-644.

Weltha, D. A. Some relationships between religious attitudes and the self-concept (Unpublished doctoral dissertation, Iowa State University, 1969). *Dissertation Abstracts International*, 1969, *30*, 2782-B. (University Microfilms No. 69-20, 684)

Williams, R. L., & Cole, S. Religiosity, generalized anxiety, and apprehension concerning death. *Journal of Social Psychology*, 1968, *75*, 111-117.

Wilson, W., & Kawamura, W. Rigidity, adjustment, and social responsibility as possible correlates of religiousness: A test of three points of view. *Journal for the Scientific Study of Religion* 1967, *6*, 279-280.

Wilson, W., & Miller, H. L. Fear, anxiety, and religiousness. *Journal for the Scientific Study of Religion*, 1968, *7*, 111.

continued from page 14

therapies for PMS. Frank in 1931 recommended a concotion of calcium lactate, caffeine, theobromine and magnesium citrate to enhance the excretion of excess sex hormones from the body. (Frank, 1931) While androgens, vitamin A and the B vitamins were popular in the 1940's, natural progesterone was advocated in the 1950's. The birth control pill emerged during the 1960's, as did lithium carbonate. Finally, the depomine agonist, bromocryptine, was studied in the 1970's.

Confused by the apparent success of almost all of these therapies and the marked placebo effect of almost all medications, I decided to acquire my own clinical experience with but a few of the many proposed forms of therapy. Encouraged by the experience of Dalton in England and Norris in this country, I have utilized natural progesterone as my first choice for most women with PMS.

Progesterone is produced by the ovaries and placenta and also is found in certain varieties of yams or sweet pottoes. When administered in large doses, it often has a calming and antidepressant effect in women with PMS. The effect often begins within 20 to 30 minutes and lasts from four to eight hours. Unfortunately, the oral administration of progesterone is not particularly effective, for very low blood and tissue levels are achieved. Therefore, I currently recommend the use of vaginal or rectal suppositories, 200 to 400 mg two to four times a day starting a day or two prior to the onset of symptoms and ending with the onset of menses. An alternative is the rectal administration of a suspension or the intramuscular injection of progesterone in oil. Intramuscular injections are not well tolerated, however, for more than several days because of the irritating effect of the oil vehicle.

As an alternative to progesterone, I have used depomedroxyprogesterone acetate or Depo-Provera, 150 mg intramuscularly every two to three months to abolish ovulation and create a drug-induced amenorrhea. While some women note dramatic improvement, others may experience an exacerbation of symptoms. An occasional woman with pelvic pathology may be a candidate for hysterectomy with removal of her ovaries, although this should be considered for only a few select patients because of the expense and potential morbidity of this major surgery.

Using the above approach to diagnosis and therapy, approximately 60% of diagnosed PMS patients will note a dramatic improvement in symptoms. Another 20% will

note at least 50% improvement in their symptoms and 20% will not experience significant improvement. For those who do not improve, the diagnosis is reviewed as a correct diagnosis may not have been made. The lifestyle of the patient is then reviewed, for often regular and vigorous exercise and a hypoglycemic diet consisting of six small meals and limited refined sugar will help reduce the severity of symptoms. In fact, these "lifestyle changes" are often suggested before any medication is even prescribed.

What Resources Are Available in Utah?

Fortunately, the health care and counseling professionals of Utah are among the most progressive and knowledgeable in the country. Thus, many internists, family physicians and gynecologists are familiar with the use of progesterone. A comprehensive evaluation of PMS sufferers is also available through the Utah PMS Center, (801) 322-5100, by a multidisciplinary staff of counseling and health care professionals. The center also exists to aid other professionals in the community with the more complex or severe cases.

Research into the etiology, treatment and cure of PMS is currently underway at the Utah PMS Center and in my laboratories at the University of Utah.

Finally, a peer support group, the National PMS Society, has many functions for PMS sufferers and their families. For further information, the PMS Society can be contacted at the following address.

Utah PMS Society
P.O. Box 11314
Salt Lake City, Utah 84147

What's Ahead for PMS?

The title of this paper, "Premenstrual Syndrome: Fad, Fact or Fallacy?" reflects the healthy skepticism with which many view PMS in 1983. The source of this skepticism comes from the lack of a precise definition of PMS, the absence of strict diagnostic criteria, and the apparent success of many different forms of therapy. Yet, others are concerned that PMS is just a fad, the "hypoglycemia" of the 1980's, to be exploited by some and used as a scapegoat by others. Finally, some are afraid that the concept of PMS may be used to justify discrimination against women.

My hope is that the sincere and sophisticated research efforts of clinicians and basic scientists alike will provide answers to these troubling questions. My beliefs are that PMS is more complex than it would appear from my brief discussion above; that the term PMS will be replaced by several more specific diagnostic terms, each reflecting a different etiology; that PMS results from the interaction of the biology, psychology and environment of the sufferer; and that a more rational basis of therapy will be developed.

Finally, it is essential that we look for and pay attention to the monthly pattern of symptoms and distress which some of our patients may experience. To acknowledge PMS in this way is to reduce the suffering of these tortured women and to free others from the misconception that all women are the victims of their "raging hormones."

REFERENCES

Frank, R. T. The hormonal causes of premenstrual tension. *Archives of Neurology and Psychiatry*, 1931, *26*, 1053.

continued from page 18

step if we are to clearly understand what Ella Wheeler Wilcox calls the "purpose in Gethsemane." Regardless of which metaphor ("gardens," "crosses," "mountains," or "thorn crowns") we wish to consider, it is apparent that if we choose to follow the Savior and go where he is now, we will need to develop a personal appreciation for the purpose in the challenges of life, and to determine that we will *endure*, like Joseph, Paul, and Christ.

If our Heavenly Father deliberately and wisely designed a mortal probation which included "an opposition in all things" (2 Nephi 2:11), and if this opposition suggests both elements of life which are glorious and wonderful, as well as those which are bitter and difficult, then part of the trial must be to see how well we submit to all that the "Lord seeth fit to inflict upon [us]." (Mosiah 3:19) We may more readily come upon the decision to enter our "gardens," shoulder our "crosses," and climb our "mountains" if we can learn to see *past* the pain and *beyond* the sorrow to the "crown" our Lord waits to lovingly place upon our heads when our compliment of "thorns" has been earned.

REFERENCES

Carlyle, Thomas. *Treasury of the Christian faith*. New York: Association Press, 1949.

Madsen, Truman G. The olive press. *Ensign*, December 1982, pp. 56-62

Maxwell, Neal A. *Speeches of the year*. Provo: Brigham Young University Press, 1976.

Maxwell, Neal A. *All these things shall give thee experience*. Salt Lake City: Deseret Book Company, 1979.

Morrison, James Daton (ed.). *Masterpieces of religious verse*. New York: Harper & Brothers, 1948.

Young, Brigham. Dealings of the Lord with his people. *Journal of Discourses*, 1966, *8*, 149-151.