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MORMON FORMS OF PSYCHOPATHOLOGY

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Sir William Osler, one of the grand old physicians in the history of American medicine, worked his medical magic on the wards of the Old Philadelphia General Hospital where I also worked as a resident with variable success, but very little magic. The hospital has in recent years seen its luster diminished. Yet Osler’s ghost still walked the corridors and inspired us.

The Penn medical students knew him best as the object of a sign in the library extolling one of his virtues and calculated to teach a lesson in ethics. It read, “Sir William Osler did not steal library materials!” I admired him for another reason—an astute observation of his which I am using as a departure point for this presentation. He said, “It is more important to know what kind of patient has the disease than what kind of disease the patient has” (Rome, 1983, p. 751). A question interesting to me is, “Is there a Mormon kind of patient?”

The non-Mormon world has tended to see Mormons as all alike. Thus, an outsider’s view of Mormons may become his distorted view of you. His view of you may become his distorted view of Mormons. It is human nature to lump ideologies unlike one’s own all together as if they were the same (e.g., the Rockefeller/Jewish/Communist/homosexual/fluoridation conspiracy, and to see ideologies similar to one’s own as different in important ways (e.g., Utah Mormons versus California Mormons).

We must avoid a common error of drawing overly general conclusions from individual cases. We should heed the caution attributed to Robert Shelton, grand dragon or imperial wizard or some such thing of the Ku Klux Klan. In pointing out how we fail to recognize the uniqueness of the various Klans, he is said to have explained, “It’s like putting a bunch of mixed nuts all in the same bag and saying they’re all the same kind of nuts!”

We have recently had a spate of categorizations of Mormons by Mormons, included among them the following: Iron rod versus Liahona Mormons (Poll, 1967); true believers versus closet doubters (Burton, 1982); compliant-dependent Mormons (having failed to resolve separation anxiety) versus social-organizational Mormons (unable to master castration anxiety) versus the few transcendent-integrated Mormons (who have no more anxiety [Stout, 1982]); and the usual distinctions between active and jack Mormons or converts and “lifers.” I don’t propose to add any well thought-out new categories, though I will remind you of the only truly valid categorization of people I know: the world is made up of two kinds of people—those who see the world as made up of two kinds of people and those who don’t.

Historical Categorizations

Given those cautions, is there a Mormon kind of patient after all? Anatomically, the answer used to be yes. Consider this observation by the Assistant Surgeon of the United States Army, Dr. Robert Bartholow, in the Surgeon General’s Statistical Report for 1860. With a keen medical eye he had detected while in Utah the emergence of a new race, the offspring of polygamist marriages, which he characterized thus: The “Mormon expression or style” is “an expression of compounded sen-
suality, cunning, suspicion, and a smirking self-conceit. The yellow, sunken, cadaverous visage; the greenish colored eyes; the thick, protuberant lips; the low forehead; the light, yellowish hair; and the lank, angular person, constitute an appearance so characteristic of the new race, the production of polygamy, as to distinguish them at a glance (In Bush, 1979, p. 66). The report made its way into several medical journals, popular periodicals, and newspapers.

A number of authors wrote of the striking lack of beauty among the Mormon women, to which Brigham Young did not dissent. Instead, he cited this observation as proof that Mormon polygamy could not have been carnally motivated (Bush, 1979). Perhaps the most scurrilous attack on Mormon women’s attractions came from Mark Twain, albeit with tongue in cheek, who observed that any man who would marry one, let alone 60 of these “poor, ungainly, and pathetically homely creatures” deserved not the harsh censure, but the applause of mankind (1872, pp. 117–18). Even an early encyclopedia describes Salt Lake City as noted for its wide streets and its homely women!

Mormon eyes in particular were different. Representative was this description from a writer in 1858 Harper’s Weekly: “I have never yet seen a Mormon but that something ailed his eyes. They are sunken, or dark, or ghastly, or glaring. There is certainly some mania in all Mormon eyes; none of them can look you straight or steadily in the face” (In Bunker and Bitton, 1979, p. 115). The narrow canthus or almond-shaped aperture of which Brigham Young’s eyes were considered the prototype was a sure sign of promiscuity. In this Brigham was grouped with the hog, the wild boar, the dog, the cat, every species of serpent and all of the ape tribes, “all known to be promiscuous in their attachments” (In Bunker and Bitton, 1979, p. 118). The Mormon lifestyle turned women into “haggard, weary, slatternly women, with lackluster eyes and wan, shapeless faces, hanging listlessly over their gates, or sitting idly in the sunlight, perhaps nursing their yelling babies—all such women looking alike depressed, degraded, miserable, hopeless, soulless” (In Bunker and Bitton, 1979, p. 118).

Physiologically, Mormons have also been observed as different. Mormon elders’ eyes, particularly those of Joseph Smith, were widely known to have the power to entrance young women and entire mobs into helpless submission. In a typical turn-of-the-century novel, Winifred Graham’s Ezra the Mormon, Ezra the Mormon Elder was “the very nature to attract Thora—[he was] a man in whose eyes the power of dominion shone.” When Thora’s father tried to separate the young couple, he brought his cane down on the Mormon elder’s shoulder, who “made no signs of feeling pain; he just stood and fixed his assailant with an eye of steel.” He slipped his arm through Thora’s. “The girl looked dazed and helpless. She tried to speak, but her trembling lips failed to frame a word. ‘She’s mesmerized,’ half shrieked her father” (In Bunker and Bitton, 1975, p. 160). At one confrontation between Joseph Smith and a Palmyra mob, Vardis Fisher in Children of God describes one man who, slowly withdrawing, with his gaze on Joseph’s face, spoke out of sudden awe, “Look at his eyes! Men, look at his eyes!” The men soon departed, and “Joseph was left alone, a man courageous and fearless, whose eyes, whose strange intense directness, had abashed his enemies” (In Bunker and Bitton, 1975, p. 160).

Even more notable than Mormon eyes was the Mormon male’s amazing sexual stamina—so amazing, in fact, that for the purchase price of Mormon Elder Wafers or a box of Brigham Young pills, even an impotent gentile could partake in the good life (Bush, 1977, p. 89).

**Mormons and Health**

In more modern times, Mormon physiology has been shown to be different from that of the general populace in longevity and quality of health.
Dr. Joseph Lyon has published statistics showing that, despite the increased incidence of leukemias in Southern Utah following the years of the Nevada nuclear bomb testing, Mormons in Utah as well as in California have strikingly lower incidences of various cancers. These include cancers that can be attributed to tobacco smoking and to sexual promiscuity, but also some that are related to neither, such as liver and kidney cancers, and thus far have no explanation (Lyon and Nelson, 1979).

Mormons are sociologically different. Joseph F. Smith once observed that a religion which could not save a man temporarily and make him prosperous could not save him spiritually and make him exalted (In Bowen, p. 36). Tests of temporal salvation should bear some relationship to tests of good physical and mental health as well as prosperity.

Defining what constitutes physical and mental health is difficult. Parameters that have been measured include education level, per capita income, divorce rates, alcoholism rates, venereal disease rates, suicide rates, etc. Statistics for Utah, often considered representative of statistics for Mormons, are more inspiring than frequent letters to the editor of the Salt Lake Tribune would have us believe. Utah is not above the national average, but forty-sixth in alcoholism rate (American Demographics, 1983). Utah’s teen/young adult suicide rate is above the national average, but this is true of all 11 Western states, among which Utah places next to lowest (Seiden, 1984, p. 970). While Utah’s divorce rate is indeed slightly higher than the national average, a factor likely skewing the data is that, in Utah, a large percentage of pregnant teenage girls marry, not a popular recourse in other states. These marriages tend to fail at higher rates, as well. A breakdown by counties shows the divorce rate in Utah County, presumably a bastion of gospel living, to be much lower than either the national average or Salt Lake County, presumably a den of relative iniquity (Langlois, 1981, pp. 15–18.) However, some sociologists find the exclusion of the less-than-good Mormons (in this case those in Salt Lake County) untenable. A comparison of Mormon “best” to non-Mormon “average” says less about the health-promoting aspects of a Mormon lifestyle than comparison of Mormon-best with non-Mormon-best; for instance, the divorce rate among devout, church-going Catholics. Carried to the extreme of meaninglessness, we might be tempted to extol Mormon sexual morality by comparing out-of-wedlock pregnancies among good Mormon girls with the national average, defining “good Mormon girls” as virgins, and arriving at a tautological zero percent sexual immorality for this group. Dr. Lyon’s quote of Pappworth is good enough to be passed on: “Medical statistics are like bikinis, concealing that which is vital while revealing much that is interesting” (1979, p. 95).

Recent attention to depression has included the Spendlove study which found that Mormon women are depressed, but no more nor less than other women (Spendlove, West, and Stanish, 1984, pp. 491–95), and the Burgoyne study (1977) which suggested that overt paradoxes in their belief system make them so.

Having pointed out some of the difficulties in formal studies of the effect of an LDS lifestyle on all-around health, I will attempt, instead, to relate some informal observations, some personal, some borrowed, of psychopathology as it manifests itself in religion-related thought and behavior patterns.

**Religious Manifestations of Psychopathology**

I recently hospitalized a Mormon bishop whose emotional fervor in conducting a funeral was followed by a sleepless night, agitation, a sexual interlude with his wife which made him feel “exalted,” insistence that his children stand naked outdoors in the snow at 5:00 a.m. to be exalted with him, and his throwing objects out of the closed windows.

In the hospital he continued to testify in King James English and a loud
voice, and to give solemn pronounce-
mements by priesthood authority, punc-
tuated by the not-too-gentle laying on 
of large hands, the crumpling of bed 
mattresses, and the shattering of drink-
ing glasses in confusing his physical 
with his spiritual strength. He was a big 
man and seemed to be entertaining the 
notion of rearranging me next.

A nonreligiously inclined nurse 
commented what a shame it was that 
devotion to religion had this effect on 
people. Eventually, as lithium took ef-
fect, the patient was eager to go home 
on a pass to plow snow from the church 
parking lot, to conduct required inter-
views, and to spread the gospel of 
medication to distressed Saints in his 
ward, all the while extolling the virtues 
of his treaters and counselors.

A nonreligious psychiatrist, observ-
ing this, asked, "He's still manic, isn't 
he?" I replied, "No, he's back to base-
line bishop; that's the way bishops are."
During his psychotic state, the nurse 
confused his religion with his illness. In 
his recovered state, the doctor con-
fused his illness with his religion. The 
line between religious thought or be-
havior and mental disorder is some-
times thin.

Does Mormon religion predispose 
one to psychopathology? The answer is 
no. But just as one's personality traits 
become exaggerated under stress and 
ilness, what is already important to one 
may become the focus or matrix upon 
which one's symptoms become evident. 
What factors in a Mormon orientation 
contribute to the matrix?

Evangelism

Any church seeking to spread the 
gospel through missionary efforts is 
likely to find a disproportionate share of 
converts among people dissatisfied with 
their adaptation to life or unsuccessful 
at it for a variety of reasons, including 
mental illness or personality disorder. 
In the case of LDS conversion, the 
enormous amount of attention mission-
aries give potential converts would be 
attractive not only to the "honest in 
heart" but to passive-dependent per-
sonalities, people ostracized from their 
social group, or those with a narcissistic 
bent for the limelight. This may be 
thought of as analogous to the "potato 
Mormons" of postwar Germany who 
joined the Church for the effect of its 
welfare program on their empty stom-
achs. The need for filling the empty 
spaces in one's psyche is also great.

K.L., a 23-year-old, unmarried 
LDS convert of five years, was a girl with 
this need. Ostracized by her family, she 
moved into the home of a generous 
Relief Society president, a large home in 
an old, upper-class neighborhood. 
There, a peculiarity or two surfaced. Her 
poetry—sometimes good, always ro-
mantic—was difficult to comprehend, 
and she walked through the house with 
garlic bulbs and honey between her 
toes. Her explanation was simple: garlic 
to ward off cold viruses and honey to 
keep the garlic bulbs in place.

One day the Relief Society presi-
dent drove into her driveway and noticed 
a young boy staring at a second-story 
window. At the window stood her 
seemingly oblivious house guest, strik-
ing poses utterly nude. Horrified, she 
rán upstairs, shouting, "Karen, what on 
earth are you doing?" The girl, con-
tinuing to pose in front of the mirror, 
nonchalantly replied, "You can see the 
resemblance, can't you? I've traced my 
genealogy back to Venus!"

Her next stop was my office. There, 
she disclosed her conviction that her 
bosses at the medical research depart-
ment where she worked were infatu-
ated with her. The evidence was erased 
messages on the blackboards, visible 
only to herself, and faintly overheard 
phone conversations. My diagnosis was 
Clerambault's Syndrome, a rare, schizo-
phrenia-like delusional belief that one 
is the object of passionate love by an 
inattentive and not well known other. 
Her investigation of the Church had 
been characterized by a great deal of 
attention from two missionaries. Her 
derperate need to be accepted for the 
only feminine trait that she knew much of—allure—led her hopes of salvation 
from two missionaries to two researchers
through the paragon of allure, the Venus de Milo, with whose femininity she could identify.

**Trust in Miracles and Mistrust of Medicine**

Faith in the intervention of a personal god is certainly commendable. What is less commendable, is the too-frequent view that God must intervene even when adequate human intervention is available. Patients who have been promised in blessings that they will recover from illness, if they exercise faith, worry that to turn then to medical doctors for treatment would be a denial of faith in the efficacy of the blessing or the Lord's power to heal.

One patient faced with this dilemma was B.E., a seriously and psychologically involuntarily depressed 75-year-old woman who had great difficulty tolerating several antidepressants that had been serially tried. She was given a blessing in which she was promised recovery. We urged hospitalization for electroconvulsive treatment, which for this type of depression is safe, rapid, and more effective than medication. To consent, she felt, would jeopardize her standing with the Lord as a result of the blessing. Meanwhile she became progressively more incapable of exercising faith, getting out of bed, or even thinking logically. Her husband finally brought her into the hospital, creating enormous guilt in her, or rather shifting its focus, since every trivial thing she did now seemed to evoke enormous guilt. Within seven days and with electroconvulsive treatment, she was virtually depression-free.

Parenthetically, I recall a real dilemma as an intern when asked, as we frequently were, to anoint and bless our own patients. It was difficult to lay aside our knowledge of the medical aspects of the case and listen for the Spirit. My fellow LDS house officers and I solved the dilemma by a cop-out of sorts. We would bless each others' patients willingly when asked, but not our own. But individually, I often prayed for my own, and for their intern.

Public reinforcement of a related attitude is the convention of exalting the Lord's power by devaluing the medical profession in testimony meeting with statements such as these: "The doctor didn't know what to do for me." "All the doctors were fooled." "The doctor said it was impossible." "They said they have never seen a case like mine." "Everyone had given up hope."

Because anecdotes of treatment successes and failures in illness circulate freely and with the overtones of spirituality, many a patient's decision regarding medical care is made on the basis not of prudence, but of consensus within the group. Word of mouth recommendations by Latter-day Saints lead people to quacks and quack medicine. A new phenomenon along the Wasatch Front, involving LDS as well as others, is the development of quasi-cocaine addiction on procaine under the name Gerovital.

A tragic illustration of religious faith in quackery is the case of D.S., a recently married 22-year-old girl with lupus, an ultimately terminal multi-organ disease. She was taking a relatively low dose of prednisone when admitted to the hospital with the psychotic delusion that she was married to Christ. Despite her gradual improvement with treatment, her husband was not satisfied. He knew of a good sister who claimed to have cured her own child of lupus by natural means. He wanted his wife to see the woman. The dangers of abrupt discontinuance of steroids were strongly emphasized to the patient and her husband, who were aware of them anyway as the patient's older sister, also on prednisone for lupus, had discontinued it abruptly and almost died. The husband insisted his wife be discharged from the hospital contrary to medical advice. The wife, not psychotic enough to meet criteria for involuntary commitment, but not a strong enough person to oppose her husband's fanaticism, mis-identified as priesthood authority, passively went with him to the natural healer. Two weeks later, I received a phone call from a police sergeant, want-
ing to know what I could tell him about a
certain D. S. who had died that morning
and whose husband was tight-lipped as
to the circumstances. A full and un-
touched bottle of prednisone was found
in her bedroom.

Spirituality or Supernaturalism

Many Latter-day Saints, like other
sincere people, operate out of a set of
superstitions rather than religious be-

This tendency may manifest itself in
such simple ways as mistaking wishful
thinking for answer to prayer, or such
complex ways as dissociative reactions,
autohypnosis, or overt psychosis. These
are often misinterpreted as possession
states, to be treated by casting out
demons. Searching for evil spirits to
banish from a schizophrenic psychosis
is a futile task, demoralizing the giver of
the blessing when it doesn’t work, and
heaping guilt upon the suffering of the
victim. Casting out devils has appeal for
some, but far less efficacy than a little
antipsychotic medication.

The terrifying possibilities of this
misconception are shown in the case of
L.R., a 26-year-old married college
student, who was nearing graduation
and preparing to be a seminary teacher.
One week he was very moved when he
picked up a hitchhiker and discovered
in their conversation that the hitch-
hiker’s father, though not LDS, had
been paying tithing. He took that to
mean something of considerable signi-
ficance, if nothing more specific than its
demonstration of the unusual presence
of “the Spirit” that week.

Other similar experiences were
taken to be spiritual manifestations over
the next few days. One night, after
watching Mary Poppins on television, he
noticed in the credits names very simi-
lar to Nephite names. He was amazed.
Then he felt the presence of someone
entering the room. He quietly locked
the door so the presence would remain,
thoroughly convinced that it was one of
the Three Nephites. In the intensity of
the moment, he became aware that his
faith was to be tested, as had been
suggested by an overzealous religion
teacher, in the same manner as Abraham
of old. He got a knife from the kitchen,
entered the room of his nine-month-
old son, took the baby from the crib, and
placed him on the dressing table. He
raised the knife and closed his eyes.
Unable to reenact Abraham’s part, he
was relieved as he opened his eyes to
see that the baby had moved, a sign he
regarded as divine intervention. He
returned the baby to the crib and left.

Soon the anxious feeling came
over him that he had not been ade-
quately tested. Even though the baby
may have moved by heavenly means,
his hand had to be stayed in order for
the test to be genuine. He returned to
the room, repeated the scene. This time
the baby did not move nor was the
father’s hand stayed. He was dumb-
founded as the knife hit its mark, caus-
ing his little son to scream.

Then it became clear that the re-
quirements of the test were different.
He was meant to sacrifice his son as God
had sacrificed His Only Begotten Son,
and then to sacrifice himself. He drew
the knife across his own body in a
ritualistic manner. His wife, entering the
room, saw the blood and ran for the
assistance of the couple downstairs. As
the young couple came up, he received
that the test had changed again. Rather
than join his son in heaven, he was to
heal him. The neighbors and his wife
knelt with him in a prayer circle, his son
in the center. He had already cancelled
the ambulance his wife had called, since
an ambulance would negate the test.
Twice the neighbors got him into the car
to take him to the hospital. Twice he got
out and returned to the room. Over the
next two hours, more blessings were
said, he reassured them by the power of
his priesthood that everything would be
all right, and eventually they all retired
to bed. At 4:00 A.M. he called the
bishop: “Bishop, do you have enough
faith to raise my son from the dead?”
The psychotic delusion of the young
man is obvious. One wonders not so
much about him as about the other
three presumably sane adults in that
room that night, and their understand-
ing of priesthood power.

Authoritarianism

The expected response to an authoritarian system is obedience. The progression of learning in the temple endowment begins with obedience. It does not end with obedience. Presumably, once obedience is mastered, there are more ascendent principles to learn. Too many Mormons seem to suffer from developmental arrest with obedience, always looking up for direction. Medically, one might think of obedience as the chief trait of a good patient, compliant and ready to do just what the doctor ordered. However, this patient, when given options in the treatment process, says, "You're the doctor," and when given tasks that require his own effort, says, "I was hoping you just had some kind of pill that would take care of it." One doesn't easily help a patient who wants not help but a takeover. We have benefitted recently by the wisdom of Norman Cousins, former editor of The Saturday Review of Literature, in his book Anatomy of an Illness (1979). He not only found a healing spirit, humor, to be essential in the apparent cure of his ankylosing spondylitis, but he emphasized that the patient must ultimately be in charge of his own health, with his doctor as advisor and collaborator. As a rheumatologist friend of mine tells his patients who want him to take over, "It's difficult for me to be more interested in your illness than you are."

Another manifestation of authoritarianism is regarding Joseph Smith's and Brigham Young's herbal recommendations as divine in origin. One might just as logically find a statement by Joseph or Brigham recommending travel by horseback and conclude that the car and airplane are anti-gospel. Thompsonian herbal medicine is still the standard of a good many Mormons as documented by Lee Smith (1979), including some in high places whose use of herbs lends the apparent stamp of approval. One such highly placed patient was recently hospitalized and found to be on 26 different herbs, at least six of which were potentially toxic and could have caused his symptoms.

Authoritarianism can mean that patients delay needed psychiatric treatment because their personal physician or bishop recommends against it.

The desire to be in authoritative hands affects treatment. A common religious belief between treater and patient often impresses more than medical credentials, especially in psychiatry. Many LDS patients search for clues of a psychiatrist's stance toward religion, assuming rightly or wrongly that this also identifies his values, and wrongly, his desire to impose those values on his patient or to judge his patients by them. (Both imposition and judging are antithetical to psychiatry.) Scanning ploys include looking for a temple garment line, remarking, "I don't know if you are LDS, but . . .," followed by a pause and a hope for the gap to be filled in, listening for identifying jargon, or even directly inquiring as to the psychiatrist's current Church job. There are situations in which I definitely believe a psychiatric patient should see a psychiatrist of the same religious persuasion. But in situations where the treatment is primarily biological, as much of psychiatry is nowadays, or does not require considerable awareness of LDS culture and values, I believe it makes little difference.

In 1963, an attempt was made in the Utah legislature to mandate noninfluence by therapists in public mental health centers on the patient's religious beliefs. A schizophrenic's delusional belief that he was called of God to save the world from his mother-in-law, whom he regarded as a sorceress and deserving of death, could not have been interfered with under this law.

Authoritarianism leads to obsessive compulsiveness and inappropriate guilt. What are the features of the obsessive-compulsive personality? These are people who see the world through facts, logic, and reason. They discount the data by which their opposites, hysterical personalities, experience their world—
through hunches, intuitions, inspirations, and feelings. Obsessiveness is characterized by industrious activity; performance of duty; restraint of anger, aggression, and sexuality; conscientiousness; orderliness; perfectionism; meticulousness; and frugality. What personality characteristics are typically valued by Mormons? Psychiatrist Marlene Payne (1980) observes that they are the same. Obsessives tend to see most questions, including neutral ones, as moral. They agree with the hymn, “There’s a right and a wrong to every question.” Mormons need to realize that some decisions are not between right and wrong, but between A and B, or one good and another good.

Some, warned by another hymn that “angels above us are silent notes taking,” are in such fear of making a wrong decision that they can’t decide at all until all the facts are in. There is rarely a situation in which all the facts are in. Agonizing over the wording of a letter so that the fifth revision is sent a month late, or standing at the ice cream counter indecisively weighing the pros and cons of vanilla versus peppermint fudge, or changing clothes three times before settling on something to wear to work are typical dilemmas. I often have to emphasize to patients that moral decisions are those on which God has an opinion. I suspect he does not care which tie one wears to work.

Obsessives commonly avoid decisions by seeking endless counsel from Church authorities. Elder Packer called this behavior “going on the spiritual dole” (1978, p. 91). Unfortunately, indecisive obsessives can always find those who are very willing to boldly step in and decide for those who won’t. These people represent another variety of obsessiveness, characterized by rigidity. They are happy to determine truth and right for everyone.

Consider the example of a 40-year-old marginally mentally retarded mother of six, whose husband’s intellectual capacity was not greater than hers. She was admitted to the hospital with a self-inflicted stab wound of the abdomen which missed her pregnant uterus. Having already exceeded the number of children she had the capacity to care for, she could not face the prospect of another baby. A bishop counseled her that birth control was always wrong, and wrong for everyone, and that she could avoid another child only through sexual abstinence, which, curiously, he did not consider birth control. Marital harmony deteriorated, and tensions arose between husband and wife. Relenting once, she accepted his advances, resulting in the present pregnancy. Whatever needs the bishop’s authoritarian pronouncements served, they did not serve hers.

Obsessive people are quick to spot wrongs. Sometimes, as in scrupulosity syndrome, the wrongs are seen to reside in others. One sister, for example, regularly criticized the ward chorister’s choice of a sacrament hymn if it did not mention sacrament or atonement. More often, the wrongs are found in themselves. They strive for perfection, becoming demoralized when not reaching it right now, and feel enormously guilty. A religion imposing rigid rules of conduct, and straight and narrow ways to approval from God, is bound to make guilt a major issue.

Now guilt can be an enormously beneficial experience, producing growth and transforming one’s life. Neurotic guilt, which self-condemns, devalues, and brings into doubt one’s acceptability before God, does not lead to growth but rather obstructs growth. In the King James Bible, Jesus admonishes in Matthew 5:48, “Be ye therefore perfect even as your father which is in heaven is perfect.” Lowell Bennion has pointed out to me the beauty and good sense of the New English Bible’s translation, “There must be no limit to your goodness, as your Heavenly Father’s goodness knows no bounds.”

Neurotic guilt motivated F.D., a 24-year-old returned missionary. He was referred for treatment by a General Authority, the last and highest in a succession of priesthood leaders he had
sought out, looking for and receiving absolution for a terrible transgressions which occurred while on his mission. Yet the absolution was never effective.

As a missionary in a backward country, he had sought treatment from a medical doctor for fever and weakness. He was diagnosed as having liver disease and given medication. The next morning he felt so utterly dysphoric that he left his companion, went to the mountains, crawled into a small crevasse, buried himself with leaves, and waited to die. After awhile, finding himself still buried but very much alive, to his dismay, he arose, went down the mountain, rejoined his companion, and discovered a time span he could not account for. Wondering what he could have done during that time, he began to worry about all the possibilities, the worst being sexual transgression. He soon mentally converted a possibility into a probability, and a probability into a certainty, despite knowing not a single female in the town who could have been a partner. He confessed to the mission president who, though disbelieving, ultimately agreed with the elder's urgent request to send him home three weeks early because he could keep nothing on his mind but the thought of the potential-sin-turned-certain-sin.

Or consider the guilt which plagued O.V., a 32-year-old executive secretary and mother of four. She was admitted to the hospital through the emergency room in a psychotic state, which injuries from a suicide attempt, haunted by the delusional belief that she was becoming Satan. When she was 16, in an impoverished, alcoholic, single-parent family, she derived virtually her only source of self-esteem from seminary activity where she was an officer. A lesson strongly emphasized the blessings of paying tithing. The patient paid tithing on a meager babysitting wage that week. Soon afterward, she obtained a regular babysitting job which put spending money in her pocket. Excited, she convinced her mother to tithe. Her mother received an unexpected promotion with a considerable increase in salary. At age 32, she saw that her motive for paying tithing was to obtain blessings, consistent with pulpit rhetoric. Enormous guilt followed when she realized that the true purpose of tithing included such things as learning charity and taking care of the poor, but not material return on investment. Feeling so guilty that she had hoped for and, in fact, received material blessings from her tithe offering, she concluded that she must be evil in nature and must end her life before she became even more so.

A.E., a 32-year-old single school teacher who had completed a Church mission dealt with guilt differently. Having difficulty with postmission loneliness, she discovered a sense of intimacy through autoerotic fantasy. Eventually hospitalized when depression interfered with her ability to teach, she confided her embarrassing secret to her psychiatrist and added that her bishop had threatened to excommunicate her for it. This punishment clearly seemed to exceed the sin. A phone call to the bishop revealed that he had not threatened her church membership for masturbation, but rather for her penchant for confessing it to everyone. Indeed, by then, she had disclosed her secret to most of the patients on the ward as well as to a good share of the members in her ward.

Passive-aggressiveness is another common response to authority. Psychiatrist K–Lynn Paul tells the story of a priesthood quorum in which all six members discussed and five agreed on an activity for the following Saturday morning, one member dissenting. On that Saturday morning, only one person arrived for the activity—the person who had dissented (1977, p. 86). Most of us give some degree of lip service to church principles, practices, and programs which we disavow by our actions. Such actions may include stubbornness, obstructionism, pouting, procrastination, inefficiency, intentional mediocrity, lateness, laziness, or agreement to do what one has no intention of doing—the purpose being to reflect disagreement or hostility one doesn’t dare
express openly.

If we are unable to voice our opinion or gain consideration of it, we can retaliate through drinking or through indifference to the offending person. If we are angry at our spouse, overtime work or dedication to a hobby becomes an enticing mistress. If we are unhappy with our position, excusing ourselves from performing obligations through medical complaints is also common.

Passive-aggression is often the recourse if confrontation is absolutely unacceptable. Many Mormons feel that way about confrontation. Priesthood manuals counsel against anger. A Church president is quoted as saying there is no reason for a harsh word ever to pass between husband and wife. Some leaders view criticism as a threat. Those who speak out are regarded with suspicion. Their testimonies are seen as shallow and their sense of propriety lacking. Yet this willingness to express dissatisfaction, observes Paul (1979) may have been what led a Saint out of his former church and into the LDS Church. Without freedom of members to interact honestly, says Paul, a new leader never knows whom he can count on.

Psychodynamic theory postulates that obsessive-compulsive character traits develop from a need to limit emotions and instincts, the expression of which would be devastating. A variety of defenses can be used, the most severe of which are compulsive rituals to maintain rigid control lest unacceptable impulses be expressed.

Such rituals were employed by M.W., a religious and wholesome-appearing, recently married homemaker of 26. She would make her home as secure as possible every night by a ritual of checking danger zones again and again before she could put herself and her anxiety to bed. The stove dials and water faucets had to be turned off half a dozen times each before she could be absolutely certain the house was safe from fire or flood. Her front door lock was turned repeatedly to preclude break-in. Searching in psychotherapy for the origins of these symbolic attempts to control her inner world with its destructive impulses, she recalled several events of which these two were typical. One summer weekend in her teens, she and her parents returned from an outing at the seashore to find the coffee pot turned on and red hot, the water having long since boiled away. Her mother, the only coffee maker/drinker in the family, poured vicious and unending accusations and blame on her. Somehow, she had been expected to check. The other significant incident was at the time of her engagement to a young man not of her faith. Her mother, mortified that her daughter would marry outside her religion, exclaimed she would rather be dead than attend such a wedding. The patient, in a rare moment of courage, persisted with the marriage plans. A month later, her mother died of a widely disseminated malignant tumor discovered two weeks after the wedding. The patient's dutiful checking ritual each night served as her attempt to undo her near-disastrous disobedience to her mother regarding coffee pots and her fatal disobedience regarding marriage. At the same time, checking against fire, flood, and break-in was a symbolic way to keep in check her fiery flood of unconscious anger toward her mother, seeing to it that her feelings never would break into consciousness.

Meticulous concern for minor detail, for the trivia of life, allows one to avoid life's major issues. In like manner, a whirlwind of activity may have the purpose of avoiding emotion and closeness. Many Mormons feel guilty if they do not attend Church meetings, keep a journal, grow a garden, exercise, do genealogy, read the scriptures and Church magazines, have family home evening, volunteer in the community, develop talents, keep home and yard up, and be a good neighbor and a good citizen. While the idle mind may be the devil's workshop, frenetic activity is the exorcist of emotion.

A telling example is that of a sister in one of the highest positions of responsibility in a general Church auxili-
ary. One morning she encountered her daughter and infant granddaughter on the sidewalk in the neighborhood where both resided. After chatting for a few minutes, the grandmother looked at her watch, exclaimed, “I guess I’d better quit wasting my time!” and hurried on.

More problematic is the case of a 32-year-old mother of four who taught piano lessons, wrote road shows, produced community pageants, became the crisis line for neighbors, and generally involved herself in activity from sunrise to sundown and beyond. If she did not keep busy in this way, she preoccupied herself with every minor lump and bump she could detect on her own skin, or that of her husband or children. The need for reassurance was endless. Yes, the bump was there a year ago; no, the lump had not grown in size; no, the mole had not turned darker; yes, swollen glands are common with a cold, etc. Her preoccupation with cancer was only one such ruminative activity. In testimony meeting she wanted to bear witness of knowing for a certainty, but found herself, instead, merely believing strongly. Trying to recall a past feeling she accepted as the confirmation of the Holy Ghost, she then began to regard her “believing” testimony as a denial of that “knowing” confirmation. Aware that “denying the Holy Ghost” relegated one to outer darkness, her arrival in my office, just this side of outer darkness in her mind, was a response to her overwhelming fear that her less-than-certain statement of testimony made her a son of perdition.

Inflexibility

Where religion neatly and tidily explains everything, there is little room to doubt and great capacity for high expectations. Some Latter-day Saints believe that any problem can be solved by using gospel methods and any blessing can be obtained by understanding and applying the principles upon which it is predicated. The Lord must intervene as we bind him by doing what he says. Such expectations, attested to again and again by fellow Saints, may lead those who fail to prosper to search their souls with Job’s home teachers for the great wrong, or to be demoralized by the Calvinistic conclusion that only they among the elders’ quorum or neighborhood block were not elected to grace. Some, so used to the meticulously rigid fitting of every piece into its proper place, abandon the whole puzzle on encountering a nonfitting piece.

This is what happened to M.B., a young physician and father of three who had led a charmed life. Handsome, athletic, personable, kind and loving, he was a National Merit Scholar and special Presidential Scholar at the university where his graduation GPA was 3.95. Marrying a classmate of a very different personality style and background because he “thought [he] could help her,” he then departed for medical school at one of the nation’s most prestigious universities. Tension in the marriage was dealt with through good-natured, patient, long-suffering attitudes while devotion to religious principle and Church activity remained high. However, the long-awaited blessings did not follow obedience. The marital differences did not improve. In his discouragement over unmet expectations for a happy ending, silence in response to prayer and disillusionment over what he had once felt was a revelatory stamp of approval on his betrothal, he proved unusually susceptible to the charms of a young nurse at the hospital of his residency. Having no flexibility in his rigid scheme of neatly packaged understanding to account for the failed blessing, he threw over his temple marriage, wife, and children and left town with the nurse.

Conclusion

While religion can be used as a growth-producing, soul-expanding system, it can also be used neurotically. In The Future of an Illusion, Freud called religion “the universal obsessional neurosis of humanity,” or “a system of wishful illusions together with a disavowal of reality” (In Clark, 1978, p. 26). Psychiatrist Owen Clark reminds
us he was basically agreeing with Joseph Smith, who revealed that “all their creeds were an abomination in God’s sight; that those professors were all corrupt.” Freud explained that he “was concerned much less with the deepest sources of religious feeling than with what the common man understands by his religion—with a system of doctrines and promises which, on the one hand, explains to him the riddles of this world with enviable completeness, and on the other, assures him that a careful Providence will watch over his life and will compensate him in a future existence for any frustrations he suffers here” (Clark, 1978, p. 74). He saw religion as bringing upon mankind the same kinds of restrictions as neurosis brings upon an individual and was aware of the use of religious dogma historically to keep an ignorant populace under control.

Physicians have, I believe, a special obligation to reject the nineteenth-century reductionism of natural phenomena which influenced Freud and Darwin and seems to pervade science to the present day. The view that all that exists is matter and all that occurs is motion suggests that human beings are a meaningless flicker in the blind careening of the cosmos. We regard people as body, mind, and spirit, and have therefore an obligation to treat all of people—mind and spirit as well as body. Pictures of prophets and temples on walls of some practitioners’ offices have been used to influence a patient’s spirit, but this attempt to claim virtue by association is out of place. However, the absence of any semblance of spiritual concern gives just as strong a message and just as false that “religion is not spoken here.” An invitation to discuss spiritual concerns if he chooses can be offered a patient in a number of ways. One gastroenterologist colleague of mine does it with his wall decor—not blatantly with prophets and temples but subtly with an inverted triangle sym- ing the Trinity, under which is the ins- cription, “God loves you. Pass it on.” In my own office, an impressionist painting serves the same purpose. To the spiritually inclined, it looks like a church; to the spiritually disinterested, a lighthouse.

Religion in general, and LDS religion in particular, does not cause mental disorder. However, because of its central position in a believer’s life, it often becomes the matrix upon which psychopathology finds its expression. It may be the ideology by which one rationalizes his neurotic style of living. It may provide the forms and symbols through which psychotic thought disorder and perceptual distortions are expressed. It may precipitate distress leading to breakdown of ability to live effectively. It may just as readily provide the structure that channels creative energy in peaceful and desirable directions, the communal support which buoys one up under discouragement and despair, the affirmation of one’s individual worth, the opportunity and direction for growth and personal fulfillment, and the anxiety-ameliorating answers to the existential questions of life’s meaning. Whether the impact of religion upon our physical, mental, and spiritual health is positive or negative is undetermined in the general case, but in the specific case, we have some choice.

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Seiden, Richard H., "Death in the West—A Regional Analysis of Youthful Suicide Rate," *The Western Journal of Medicine,* 140 (6), 970.


Stout, Jan, "The Spectrum of Religious Beliefs and Behaviors in the Mormon Community," Lecture given at the Sunstone Theological Symposium, Salt Lake City, 1983.
