MENTAL ILLNESS IN THE FAMILY

by Elder Alexander B. Morrison

FROM THE BED OF PAIN, FROM THE PILLOW WET WITH TEARS, WE ARE LIFTED HEAVENWARD BY THAT DIVINE ASSURANCE AND PRECIOUS PROMISE "I WILL NOT FAIL THEE, NOR FORSAKE THEE" [JOSHUA 1:5].

– President Thomas S. Monson

This article is taken from Helping and Healing Our Families, published by the BYU School of Family Life and Deseret Book.
Among the most painful and often protracted ordeals an individual or family can face is that of mental illness. One of the central characteristics of the cruel constellation of diseases grouped under the general rubric of mental illness is the suffering involved. Its intensity scarcely can even be described. Day follows dreary day in a long procession of gray emptiness, punctuated by flashes of acute torment.

The suffering not only colors every attempt to treat and hopefully to heal the victims of these devastating disorders, but extends outward to engulf others. Family members, caught up in the tsunami of suffering, the maelstrom of pain and despair, echo the anguish of the primary victims. Each longs for a day when solace will be provided, tears dried, hope rekindled, and torment ceased. And yet there is hope. Many mentally ill people find their suffering greatly reduced with proper treatment. Further, sufferers from mental illness commonly have times when they function normally, interspersed with bouts of illness. A case in point would be major depression, which typically involves episodes of severe, even debilitating depressive symptoms, usually over a period of several months, followed by remissions which may last for months or even years. Whatever the course of their illness, all involved can be assured that nothing should “be able to separate us from the love of God, which is in Christ Jesus our Lord” (Romans 8:39).

In this brief article, it is not possible to discuss all categories of mental illness. Some of the most important disorders include anxiety disorders (panic disorders, obsessive-compulsive disorder and assorted phobias); mood disorders (depression and bipolar disorder); schizophrenia; and eating disorders (anorexia nervosa and bulimia, two disorders seen primarily, though not exclusively, in young women). The term “mental illness” does not describe the temporary social and emotional concerns associated with the normal wear and tear of life. Many people feel anxious when they start a new job, for example, and most of us are sad following the death of a friend. Those who act in those ways are not mentally ill. Their actions are normal. Nor should we include in the category of mental illness the secondary effects of physical disorders such as meningitis, high fevers, or brain tumors. Mental illness is something different. It lies at one end of a continuum linking the social and emotional concerns which are the transient accompaniments of daily living, and mental diseases, many of which have their roots in human biology. Mental illness may be defined as a brain disorder that causes mild to severe disturbances in a person’s understanding, thinking, and behavior. If such disturbances are sufficiently severe, and last long enough, they may seriously interfere with the victim’s ability to function normally as an individual or productive member of society. The ability to cope with life’s ordinary stresses and strains may significantly be impaired. Under severe circumstances, mental illnesses may threaten life. Significant numbers of patients with anorexia nervosa, for example, literally starve to death in the midst of plenty, and approximately one of seven persons with severe depression dies by his or her own hand.

A brief description of major categories of mental illness may help outline the devastating effects of these disorders. About one in four Americans will suffer from an anxiety disorder in his or her lifetime. Anxiety disorders may severely limit the ability of the sufferer to function effectively or get any enjoyment out of life. Up to one-third of anxiety sufferers essentially are disabled and unable to function effectively. Sufferers have increased likelihood of turning to alcohol or other mood-modifying drugs in vain attempts...
to deaden the physiologic and psychic pain they feel.  

It is estimated that more than 17 million Americans are severely depressed each year, and nearly two-thirds do not get the help they need. An estimated 2 percent of pre-adolescent children, aged 7-12, exhibit major depression. Severe depression is a malignant sadness, all-consuming, seemingly never-ending, not amenable to cheering up by an act of will or the actions of others. It may also be life threatening. A high percentage of people who kill themselves are depressed, and anyone who is seriously depressed must be considered at risk for suicide.  

Schizophrenia causes bizarre and frightening symptoms in its victims, including hallucinations, most often involving the hearing of voices. Usually the voices are condemnatory and critical of the victim. Delusions—false, fixed, often paranoid ideas with no basis in reality—are common. Disorders of thought and behavior such that the patient speaks gibberish, or (for example) wears layers of heavy winter clothes on a hot summer’s day, complete the triumvirate of psychotic symptoms seen in schizophrenics. Social withdrawal, decreased intellectual abilities, apathy, and staring into space also are common.  

Victims of anorexia nervosa are most often young women. They are chronically unable to sustain minimally normal body weight; suffer intense, constant fear of becoming obese; and have distorted perceptions of their body weights or shapes. They become progressively more emaciated, fatigued, and depressed. Unless treated quickly they die from starvation or heart failure. Although no one knows with certainty what causes anorexia, many believe it represents an attempt, either conscious or unconscious, to control at least one part of life—body weight.  

Persons with bulimia are characterized by binge eating, followed by purging. Excessive physical exercising, in an attempt to balance out the episodic binge eating, is common. Like the anorexic, bulimics see their bodies through a distorted perspective. They commonly suffer from intense self-hatred, guilt, depression, or anxiety. They also may die from heart failure and often have serious dental problems. (Marlene S. Williams, “Helping those with eating disorders,” Marriage and Families, Winter 2006, pp. 11-15 discusses ways to help a family member who suffers from an eating disorder.)  

Some of the heaviest burdens borne by sufferers from mental illness and their families are the prejudice, ignorance, misunderstanding and social stigma which characterize the attitudes of many in society towards the mentally ill. Many victims and their families fear, for good reason, that they will be ridiculed, whispered about, even shunned if they seek help. They believe that their spouses, friends, children, or employers may abandon them and there will be no opportunities for marriage. Reports of treatment or hospitalization for mental disorders may result in decreased career opportunities. Some insurance companies limit their coverage of patients with mental illness, perhaps even refusing coverage.  

Misunderstanding and fear continue to surround mental illness. Silence, alienation and prejudice concerning mental illness abound. Mental illness still is hidden, whispered about behind closed doors, denied, considered shameful. In this supposedly enlightened age, so many maintain irrational fears, and wrong and hurtful ideas about mental illness. Many fail to see it for what it is, the mental analogue of physical disorders.  

Overcoming Misconceptions  

Myths and misconceptions about mental illness abound in our society. I wish I could say that Latter-day Saints are more enlightened than the general
public on such matters, but
many are not. Space permits only
a brief description of three of
the most prevalent of the myths
with which sufferers from mental
illness, and their families, must
deal daily.

_Myth 1: Mental Illness Is Caused
by Sin_

There is no doubt that sin—the
deliberate breaking of God's
commandments—causes much
behavior that is hurtful both to
the individual concerned and
to others. Perhaps nowhere in
holy writ is the power of sin to
torment and harrow up the soul
more vividly exemplified than
in the words of the repentant
Alma: "But I was racked with
eternal torment, for my soul
was harrowed up to the greatest
degree and racked with all my
sins. . . . Oh, thought I, that I
could be banished and become
extinct both soul and body"
(Alma 36:12, 15).

Sorrow and remorse during
the repentance process—even
feelings so galling and painful
as those felt by Alma—are nec-
essary prerequisites for true
repentance. They are not, how-
ever, manifestations of mental
illness. Those attempting to
work through the pain, remorse,
and depression associated with
sin towards the goal of repen-
tance will benefit greatly from
confession to their bishops,
followed by counseling from
them. In this role, no mental
health professional, regardless of
his or her skills and training, can
ever take the place of the faithful
bishop, who receives spiritual
gifts of discernment and wisdom
as part of his calling. Guided by
the Holy Ghost, the bishop can
provide invaluable assistance to
those suffering from sin and
desirous of repentance.

That said, however, in many
instances, aberrant, even bizarre
thoughts, feelings, and actions
result from mental illness and
not from sin. Many faithful
Latter-day Saints, who live the
commandments and honor
their covenants, experience
profound personal struggles with
mental illness. In common with
those who suffer from physical
ailments, such individuals are
victims of disease, not sin. To
assume that persons with mental
illness have brought it upon
themselves because they are
sinners, that God is punishing
them for their wickedness, is to
my mind contrary to His very
nature. I know He is not the
source of sin, and I am of the
firm view He does not give His
children mental illness to punish
them. Indeed, if the logic that
He does so were carried to its
logical conclusion, we would all
be mentally ill, because "all have
sinned, and come short of the
glory of God" (Romans 3:23).

I believe that in His
omniscience, God knows a trial
is coming to us and declines to remove it, using it as a tutoring tool to help us to grow spiritually. He knows every detail of our DNA, and hence of our genetic predisposition to resist or acquire disease, including mental illness. He knows fully the myriad of biological, social, and environmental factors to which we will be exposed in our lifetime and understands when genetic predisposition will converge with a stressful event or episode, whether environmental or emotional, to produce disorder, even serious disease.

A primary role of the bishop, then, is to ascertain whether a deeply distressed member of his congregation is suffering the effects of sin or of mental illness. He is able to do so as he is guided by the Holy Ghost, and if he knows the characteristics of mental illness. If the problem is sin, the bishop will know how to assist the member through the repentance process. If the bishop understands the nature and symptoms of mental illness, and discerns that the member’s problems lie in that area, he should refer the individual to a properly qualified mental health professional for treatment.

Myth 2: All Mentally Ill Persons Need Is a Priesthood Blessing
I am a great advocate of priesthood blessings. Our beloved daughter, Mary, who has suffered from panic attacks and depression for more than half of her life, literally lives from blessing to blessing. I know from experience that priesthood blessings do inestimable good. I know, too, that Jesus Christ is the Great Physician, the unparalleled healer of both body and mind. He and He alone has access to the healing Balm of Gilead needed by all who suffer. In any and all circumstances, in good times and bad, in sickness and in health, our lives will become more peaceful and richer as we turn to Him. Only then can we find rest unto our souls, as He Himself has said (see Matthew 11:28–30).

That agreed, I suggest that priesthood leaders are ecclesiastical leaders and not mental health professionals. Almost all of them lack the professional skills and training needed to treat persons with mental illness effectively. They are well advised to seek competent professional assistance for those in their charge who are mentally ill and in need of skilled help.

When bishops, family members, or others refer mentally ill persons to mental health professionals, it is important that the individual chosen not only be professionally competent, but also that he or she follows practices and procedures com-
patible with gospel principles. Some mental health professionals are unwilling to work within the structure of a patient's faith system. A mental health professional need not be a Latter-day Saint to be effective, but should be willing to accept the way gospel principles are crucial to a patient's life and be respectful of them.

**Myth 3: Someone Is to Blame for Mental Illness**

It is common to blame others, or oneself, for whatever goes wrong in life. Many victims of mental illness work themselves into a frazzle and wear themselves out emotionally in futile, repetitive attempts to recall something they, their parents, siblings, or someone else might have done that resulted in the misery and despair they are forced to endure. Many blame themselves and are unable to rid themselves of the terrible, nagging conclusion that somehow, some way, even though they don't understand how or why, they are the cause of their own pain. They feel ashamed of themselves for being sick and think they are weak and defective. Parents, spouses, and other family members too often tear themselves apart emotionally trying in vain to determine where they went wrong. They may try to bargain with God, offering Him anything, even their own lives, if He will but cure their beloved family member.

Victims and their families may blame problems of mental health on demonic possession. Such has occurred, in very rare instances, but we should take care not to give the devil credit for everything that goes awry in the world! Generally speaking, mentally ill patients need treatment, love, and support, not exorcism.

Victims laboring under the false belief that they themselves are the cause of their problems because of something they did or didn't do are commonly wracked with false guilt. They may pray repeatedly for God to forgive them, even though there is no objective evidence they have anything of note to be forgiven of. In the false belief they have been deserted by God, they may become angry and bitter towards Him. They may turn to the false pleasures of the world to "get even" or to dull their pain. Nothing they do of this sort, whether it be blaming themselves, others, or even God, does any good. The reason is simple: in most instances, the thoughts and behaviors of people with mental illness result from disease processes, not the actions of others.

Ascribing blame for mental illness causes unnecessary suffering for victims and others alike. It takes time and energy which would better be used to get a complete and accurate diagnosis of the illness concerned; understand the biological processes involved, which often ultimately involve changes in the functioning of and communication between the cells of the brain; get proper medication to help reverse those changes; and learn cognitive and behavioral techniques that are crucial parts of the healing process. Family members and friends can best spend their time not in playing the "blame game," but in seeking understanding and enhanced compassion, empathy, forgiveness, and patience.

**Where Can We Turn for Help?**

The community of professional care givers in the mental health field, generally speaking, is divided between psychiatrists and psychotherapists—i.e., psychologists, social workers, and other licensed mental health professionals. Both groups provide invaluable assistance to sufferers from mental diseases.

Psychiatrists are physicians with specialized training in psychiatry and neurology. They also are trained to provide psychotherapy. Psychiatrists can prescribe medication, which psychologists cannot, and because
they are trained medical doctors, can determine if a patient is suffering from some other medical problem, such as brain cancer, which could cause symptoms of mental illness. Psychologists are trained, often at the doctoral level, to provide cognitive and behavioral therapy to help patients with mental illness understand why they think and act as they do, and to assist them in developing behaviors which will aid in their healing. Many are excellent psychotherapists, as are other trained mental health professionals, such as clinical social workers.

Controversy about medication versus psychotherapy swirls and eddies through the community of mental health professionals. In my view, both have invaluable contributions to make. How the two sets of disciplines are used, and in what mix, will depend on the orientation and training of the practitioner involved and on the needs of a particular patient. My belief, supported by emerging research,12 is that eventually we will find that medication and psychotherapy act in a common way, by altering brain chemistry and function, especially with respect to anxiety and mood disorders.

Much information on mental illness of value to the general public is available free from the National Institute of Mental Health (www.nimh.nih.gov). Information is available on a broad variety of topics, including anxiety disorders, depression, bipolar disorder, schizophrenia, and eating disorders.

Readers will find much of value at www.ldsmentalhealth.org. This website is not sponsored by The Church of Jesus Christ of Latter-day Saints, but it provides a great wealth of reliable, gospel-compatible information on a broad variety of mental illnesses. It is not intended to replace the spiritual direction of ecclesiastical leaders and does not provide information on medication or counseling of mentally ill persons.

LDS Family Services is a corporation which serves Church members and others by providing information on a broad variety of family-related problems. Mental health concerns are dealt with through service and advice, consistent with gospel principles. Individuals usually are referred to Family Services by their bishops.

Show forth additional love and compassion
If family members ridicule, demean, criticize, or abandon the victim involved; if they go on and on about supposed (and usually false) sin and blame; if they are judgmental and censorious, I guarantee the patient will not do well. But if they love and enfold, if they refuse to judge, if they are kind, compassionate, and empathetic, then therapy exerts its full beneficial effects.
Provided patients are not a threat to themselves or others, and do not require intensive nursing care, a loving home may be the best place for healing to occur. There the patient feels safe, secure, and in the presence of those who really care in ways that professional detachment forbids. Psychiatric wards in hospitals remain necessary, but in my admittedly limited experience they are often frightening and foreboding places, which do little to calm and reassure many patients. They may provide little of the intensive treatment needed by seriously ill patients.

A word of caution is necessary. Home may not be the best place for mentally ill patients if there are small children there, who require constant care or may be frightened and influenced by a mentally ill family member. Further, the turmoil and hubbub in many busy homes may be excessively disturbing to some mentally ill persons.

Family members soon learn that developing and unfailingly demonstrating patience is a large part of love and compassion. Patience must be developed if one is to deal effectively with the seemingly endless ebb and flow of illness, the apparently never-ending routine of one step forward and another backward, the constant vigilance required of those who are caregivers for patients who may be in danger of suicide. Patience is needed to guard against the tendency to get out of sorts with the person who is sick, and whose sickness causes eddies of pain in the lives of others. Remember that no one with mental illness wants to be that way. People are not mentally ill because they lack willpower. They cannot, through any exercise of will, get out of the predicament they are in. To lose patience with them, to advise them to “just snap out of it” and “get a little backbone,” is not only insensitive, but futile.

Anyone who has ever witnessed the almost unbearable pain and uncontrollable weeping of a severe panic attack, or the indescribable sadness of a severely depressed person who cries all day and retreats into hopeless apathy, would never think for a moment that mental illness is just a matter of willpower.

At the same time that we must learn to be patient with ourselves and with the victim of mental illness, we also must learn to be patient with God. When prayers are not answered as we had hoped for so fervently, when our timetable is not that of the Almighty, when we are called upon to tread the winepress of affliction alone, it becomes seductively easy to grow angry with God, to feel He has abandoned us. Pain and patience are uneasy partners at best. But it is in learning to endure whatever mortality brings us—including the vicarious suffering that we come to know the meaning of love and compassion.

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we experience at the pain of loved ones—that we find the key which opens the door to celestial halls.

Family members must then learn to put their trust in God. No matter if our path be strewn with thorns, no matter how onerous our struggle through mists of darkness and torrents of tears, God will succor and sustain us. Learning that lesson is at best a stern struggle. It involves tutorial suffering and stretching. But it is the only path to peace, amidst the pain and suffering, the loneliness, depression, and despair of mental illness.

Those who suffer from mental illness, who are burdened with pain, depression, and confusion must, I believe, be especially on their guard against the devil and his agents. So too must the circle of loving family members and other caregivers.

Learn all you can about mental illness and how to deal with it Family members of mentally ill persons will love better as they learn more about the causes of mental illness and the suffering it brings. Their compassion for the victim will increase, and they will be less judgmental and censorious. They will grow more patient and forbearing. They will begin to see mental illness for what it is—a disease of the brain, not of the spirit, a malady caused not by sin, but by problems in the working of the most complex structure in the body. They will grow thankful for medical and other therapeutic interventions which have revolutionized treatment of mental illness in the last four decades, and will look forward with hope to the rapidly approaching day when treatment will be more specific and more effective than ever.

As family members struggle to learn and understand mental illness, they will find that their insight will grow exponentially if they simultaneously succor the life of the spirit. As they do so, scriptures will become more meaningful, prayer sweeter, contemplation more attuned to the Divine. As they draw closer to God and put their lives, and that of their loved one, in His hands, they will find they are never alone. They will come to realize, as perhaps never before, the price which Christ paid that He may know more perfectly how to personally sustain us through the seasons of our trials.

Encourage the person who is ill Persons with mental illness, who often are worn down and disheartened by pervasive feelings of hopelessness, need encouragement and hope for the future. This must be realistic: “Pie in the sky” advice will lead only to discouragement, a sense of betrayal, and increased cynicism. But there are solid grounds for optimism in nearly every instance. The victim can with total assurance be reminded often of God’s love, of the unfailing love of family members, and of the reality of eternal family relationships. There is hope, too, that the therapeutic future will be brighter for
sufferers from mental illnesses of all types.

Mentally ill persons should be encouraged to continue to pray, attend appropriate Church meetings, participate in sacred ordinances, and fulfill other religious obligations as they can. They will never benefit more from God’s presence in their lives than now. They should be encouraged to do the ordinary little things that provide meaning to life—to appreciate the beauties of nature, complete appropriate tasks, and exercise. Such encouragement may help the afflicted person decide to cooperate more fully with treatment, gain self-esteem, even to work harder in therapy and be more diligent in taking prescribed medication.

**Maintain a life of your own**

If family members are to be of the most help to a loved one afflicted with mental illness, they must maintain a life of their own. They owe that to themselves, to the sufferer, to those in their family who are not sick, to friends and business associates, even to God. And so, somehow, in the midst of turmoil and stress, constant worry, time and financial pressures, and all else that bears down upon them, they must find time, even if only for a few minutes daily, to recharge their own reservoirs of strength. They may be rejuvenated by reading a good book, practicing a hobby, or listening to uplifting music. Quiet discussions with trusted friends, a telephone call to a family member, or an hour of service to others in a setting away from the patient may be helpful. The selection of activities is endless. How and what is chosen is less important than the realization that nurturing personal well-being is essential to the health of all family members.

In conclusion, we can help those suffering from mental illness in many ways. Perhaps the most important involve love and patience, coupled with the understanding that mental illness is not the patient’s fault, not the result of sin, and cannot be overcome by an act of will. Learning all we can about the illness will increase our compassion, enhance our abilities to respond appropriately to those who suffer, and help all to develop faith and hope for a brighter tomorrow. More than all else, victims and their loved ones can, with perfect assurance, turn to Him who in His infinite compassion has taken upon Himself “the pains and the sicknesses of his people” (Alma 7:11). He, “through his infinite goodness and grace, will keep [us] through the endurance of faith on his name to the end” (Moroni 8:3).

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**ADDITIONAL READING**

Sean E. Brotherson (2004, August), When your child is depressed, *Ensign,* 34(8), 53.


**NOTES**

3. Ibid., 543.
4. Ibid., 340.
5. Ibid., 398.
6. Ibid., 340.
7. Ibid., 274–278.
8. Ibid., 543.