Depression In Mormon Women -- and Men, and non-Mormons, Too.

Jed L. Ericksen
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By Jed L. Ericksen*

“Depression” is a complex concept. To the layman, it simply connotes feeling blue, down, under the weather or unhappy. To the trained professional, however, “depression” denotes a broad group of disorders of mood manifested in several varieties or subtypes.

The key concept in understanding depression is that it is a pathological alteration in mood. The deviation from normal affect, of course, is primarily one of sadness, of being blue, feeling down, helpless or hopeless.

Before pursuing this subject in further detail, the author would like to indicate here that a significant stimulating factor for the preparation of this article was a television series prepared and sponsored by KSL Television in Salt Lake City, Utah on the subject of depression. The author was one of several mental health professionals interviewed along with a number of depressed patients in the particular segment of this series entitled, “Depression In Women”.

It seems probable that a good many readers of this report will have by now seen the television production referred to. It may be interesting to readers to know that after the program was aired, a number of telephone calls were received from all around the State of Utah and even from a number of other Western states in the viewing area. Most of these calls came from women, not all of them affiliated with the L.D.S. Church, but most of whom indicated something to the effect that they had seen a portrayal of aspects of their own life in the program. They said in essence, “Gee that’s me. That program was about my life, and I am anxious to know where I can go or what I can do to get help”. We made several referrals for treatment as a consequence of these calls.

To the best of our knowledge, the program was conceived, produced and directed by people from KSL TV. It wasn’t really designed by clinical people. It portrayed a number of good clinical concepts. The professional people interviewed were simply an aggregate of mental health professionals offering their independent viewpoints with no opportunity to know what others were saying until the program was made available to the public. It is significant that there seemed to be a high degree of congruity among the contributions of each respondent — both among clinicians and patients interviewed.

Now, back to the subject of depression, perhaps some statistics on the magnitude of the problem are in order here. The data vary to some extent depending on the source, but generally it is assumed that two to four percent of the population of the United States suffer from depression. That totals about four to eight million Americans who are thus afflicted. The National Institute of Mental Health estimates that 15 percent of adults between 18 and 74 years of age may suffer serious depressive symptoms. Perhaps less than five percent of these may find their way to psychiatric care. Among patients admitted to mental hospitals, about 23 percent are for depression, while psychiatric units in general hospitals admit 30 percent for the same condition. Approximately one out of two hundred people who are depressed will eventually die of suicide. The dollar cost of depressive illness in our economy has been estimated to be between 1.3 and 4 billion dollars per year. The morbidity in terms of personal unhappiness, people being incapacitated, and unable to work or be productive is extremely significant.

There is a noted authority on the subject of depression named Dr. Aaron T. Beck, M.D. He has written a good deal of literature on the subject. As a matter of fact, he has developed a scale called the “Beck Mood Inventory”. This mood inventory is simply a scale of about 21 items purported to assess depressive moods. The kinds of things studied in the interview are as follows:

1. Sadness
2. Pessimism
3. Sense of failure
4. Dissatisfaction
5. Guilt
6. Expectation of Punishment
7. Self Dislike
8. Self Accusation
9. Suicidal Ideas
10. Body Image Change
11. Somatic Pre-occupations

(Items 1 through 11 are referred to as the “cognitive set” of depression.)

12. Crying
13. Indecisiveness
14. Fatigueability
15. Work Retardation
16. Social Withdrawal
17. Irritability
18. Insomnia
19. Anorexia
20. Weight Loss
21. Loss of Libido

This mood inventory may serve here as a kind of springboard to plunge us into a further discussion of depression, recognizing now that the thing we’re talking
about includes some of these fundamental concepts specified in the inventory.

For each item in the inventory, a patient is given a series of five statements to rate the relative severity of that item in his life. For example with regard to “sadness,” the patient in describing his own feelings would choose between the following five statements: “I do not feel sad. I feel blue or sad. I am blue or sad all the time and I can’t snap out of it. I am so sad or unhappy that it is very painful. I am so sad or unhappy that I can’t stand it.” These choices are then assigned a numerical weight with the first statement being scored “0”, the second “1”, the third and fourth “2” each and the fifth statement would be scored “3”. The total score on the inventory is simply the sum of the numerical weight assigned to each of the patient’s choices on the twenty-one items in the inventory. A patient could score anywhere from 0 to 60 on this scale.

Beck says a mean score of 25, plus or minus 10, would indicate moderate depression. A mean score of 30, plus or minus 10, could indicate severe depression.

Now it is important to recognize that when we talk about depression, we are by no means discussing a singular kind of concept. It is a very broad concept, and when a person says he is depressed that really may be no more definitive than when a person goes to the doctor and says he has an upper respiratory illness, which of course could be a lot of specific things with a great variety of causes. There may be a lot of clinical manifestation of the illness and widely variable degrees of severity. So it is with depression. The term, in and of itself, is not a very narrow, strictly defined concept. Perhaps a little illustration here of what might be called the depressive spectrum will facilitate an understanding of the kinds and varieties of depressive illness which may be encountered:

The Depressive Spectrum

<table>
<thead>
<tr>
<th>Exogenous</th>
<th>Endogenous</th>
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<tbody>
<tr>
<td>Reactive Grief Mourning</td>
<td>BiPolar Manic/Depressive</td>
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<tr>
<td>Neurotic Characterological</td>
<td>UniPolar Pure Depression</td>
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<tr>
<td></td>
<td>Involutional</td>
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<td>Melancholia</td>
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<td></td>
<td>Agitated Depression</td>
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<td></td>
<td>Somatic Mask</td>
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<td></td>
<td>Mask</td>
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<td></td>
<td>Drug Induced</td>
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<td>Post Partum</td>
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Psychiatrists basically differentiate two main categories of depression. As the prefixes suggest “Exogenous depression” refers to the kind of alteration in mood that can be traced to, explained by or understood as the person’s response to some identifiable, precipitating event. The depression seems the consequence of some kind of change or experience in the life of a person which helps explain why their mood would be down. It might be a death of a loved one, a financial setback or some other significant loss in their life.

“Endogenous” is the term applied to depression which appears to be without cause or precipitant, at least from external observation. As the patient recounts his life history, there may be no clear cut, obvious, or identifiable situational ink that explains why the individual is feeling depressed.

Now within the two general categories of exogenous and endogenous depression there may be listed a number of other classifications which demonstrate the variety of clinical manifestations of this disorder. Under the heading of exogenous falls a pattern which may be called reactive depression. This is the kind of experience that perhaps most everyone has experienced in some degree at some time in their life, and up to a point this may be considered a “normal” response. The point is, that once a patient has told his story — given his history, the clinician can logically sit back and think: “Now if that were me ... If I had just gone through that type of experience, I would possibly feel just as this person is feeling. I would be depressed also.” So in that sense it is logical, it’s understandable, and it may include such things as grief and mourning. Certainly there is a place in life for healthy, productive grief and mourning. We also know there is such a thing as pathological grief and mourning which can become inappropriate, excessively prolonged and morbid. So reactive depression may be relatively normal or it may become pathological.

Along with reactive depression, and it may be debateable about the extent to which this is “reactive” in nature, is another category often referred to as neurotic depression. The very term “neurotic,” of course, implies an individual coping with feelings (affect) usually anxiety, but perhaps depression which is subjectively most uncomfortable. The discomfort leads the patient into coping behaviors which may become self-defeating to some extent, i.e. neurotic. To a degree, their coping may become excessively self deceptive, and this interferes with productivity, effectiveness and healthy adjustment. A good and often cited example of a neurosis which grew out of anxiety occurred in Shakespeare’s play MacBeth. In brief, Lady MacBeth and her husband conspired and committed murder;
what is called bipolar and unipolar affective disorders. In bipolar illness there are, of course, two depression only to eventually resolve perhaps spontaneously. Among individuals so afflicted it’s a rather dramatic form of illness where for a period of time, usually months or even years, a patient will sink into the depths of depression only to eventually resolve perhaps spontaneously for a period of time into a state of remission followed ultimately by transition into a manic phase where the patient becomes euphoric, elated and grandiose. In extreme cases, the manic patient may write expensive checks without funds to cover them, enter into foolish but impressive sounding business schemes, or begin to traverse the country on airlines because of his extremely exaggerated sense of capability and well-being, all of which is essentially without foundation in reality.

There are a number of manifestations which may fall under the heading of unipolar depression. Among these would be a pure, simple depressive episode. In people going through the “change of life” i.e. 45 years of age and up, the diagnosis is sometimes referred to as involuntional melancholia. Sometimes there will be a strong component of anxiety in the patient’s depression. This may be referred to as agitated depression. In such cases the patient may, in addition to feeling down, hopeless, or worthless, be very anxious and worried and will pace the floor and wring his hands.

There may be metabolic factors which cause depression. For example hypothyroidism may produce that kind of reaction. There are a number of biochemical possibilities now being researched. Medication or drugs can be a factor in the onset of depression. Reserpine-containing medicines, for example, are frequently implicated in the onset of depression. Alcohol, minor tranquilizers, sedatives and hypnosis may all exacerbate depression because they are “downers”.

One additional form of illness called “post-partum depression” should perhaps be mentioned here. It is not uncommon in clinical practice to see a rather normal appearing, seemingly well-adjusted, young woman sink into the depths of depressive illness within a few days or weeks of childbirth.

Among these endogenous depressions, it is now known that relatives of bipolar patients tend to have a higher prevalence of bipolar illness and cyclothymic personality pattern than unipolar patients. Conversely relatives of unipolar patients show a high incidence of unipolar illness and depressive personalities as well as a low prevalence of bipolar illness.

Before going on, a few words are in order regarding one more problem sometimes referred to as the “somatic mask” of depression. Occasionally patients present themselves for treatment emphasizing what appear on the surface to be basically physical complaints i.e. gastro-intestinal upset, constipation, headaches, or other symptoms. However, after physical examination tends to rule out organic illness or if the patient does not respond to somatic treatments, it may be discovered that the root of his troubles is really depression. This is called the “somatic mask” because the physical symptoms tend to mask the real underlying depression.

How we have covered a brief overview of depression. Interestingly enough, this may not really explain what the aforementioned TV program was attempting to get at with regard to the issue of depression and Mormon women.

In my experience as a therapist and as an LDS bishop I have observed something that seemed to be a common theme running through many comments on the TV presentation. The Church as an organization and the Gospel as a philosophy of life teaches perfection. An example is often quoted scriptural verse (Matthew 5:48) “Be ye therefore perfect even as your Father which is in
Heaven is perfect”. That is quite a lofty ideal — one that most of us would probably feel worthy of our emulation. I think most active Church members would agree. As a consequence of that type of value and because of our emphasis on education, on achievement and on being "doers of the word, and not hearers only ...” (James 1:22); because of the emphasis we have on succeeding in our business and professional lives, and because of the emphasis we place on rearing strong, healthy, well-adjusted close-knit, clean, neat, well-organized, efficient, cooperative, etc. families, there is a lot of pressure on LDS mothers, and fathers for that matter, to measure up to the ideal.

Certainly it is appropriate and praiseworthy that we promote such ideals and have opportunity to do the best and be the best that we can; however, there is a hazard involved. There is a risk that instead of accepting where we are and recognizing that any progress we can make toward our ideals is evidence of satisfying, ego-enhancing progress, we may simply feel that since we haven’t reached the ideal, we have failed. Then, more than anyone else, we may begin to feel that great burden of worry, guilt, fear, inadequacy and unworthiness that begins to pull one down instead of elevate one up as is intended. We may become depressed.

Perhaps certain persons are particularly vulnerable to this distortion of what could be a noble ideal. Perhaps it may be those genetically predisposed to endogenous depression. Perhaps it may be those who have unresolved neurotic conflicts from the past. Perhaps, in some cases, it may be an accidental consequence of the perfectionistic ideal itself.

Let’s pursue this last possibility. Sometimes persons who emphasize striving for perfection become “perfectionistic” i.e. something clinicians may call the “obsessive personality type”. We could discuss depression and a variety of other personality types, but perfectionism may be a particular hazard of our culture. This type of person tends to have very high and severe superego functional. Some such persons may have very stringent consciences with a high ego-ideal and very lofty values and standards to strive for. This type of individual may be punctilious and rigid, fastidious and formal and mercurial and overinhibited to some degree, and essentially perfectionistic. Maybe sometimes this personality is self-doubting because the standards are so high and he may have feelings of inadequacy, insecurity and may be lacking in capacity to relax or in ability to “use wisdom and moderation in all things,” including duty and obligation and immediate perfection.

This type of person may have failed to develop the capacity to occasionally put things on the shelf, so to speak, and take some needed time to enjoy life. Perhaps their character structure just won’t permit that.

Sometimes this type of attitude and pattern may be evident in the prevailing philosophy with regard to “never turn down a calling from the bishop to serve in the Church”. There is a kind of unwritten standard that one should never say “no!”

This is not intended to imply that Church members should respond to such calls with a negative attitude. It is important to be honest with one’s self. It is appropriate for the Church member to use his own judgment, wisdom and inspiration, and to remember that the family is the most important organization in time and all eternity. Most bishops would probably welcome some honest feedback, from the members being called to serve, with regard to personal pressures, time available and family needs.

On the other hand, sometimes Church members may suffer a form of depression as a consequence of sin and disobedience. Recall the experience of Zeezrom (Book of Mormon, Alma 15:3) who “lay sick...with a burning fever, which was caused by the great tribulations of his mind on account of his wickedness...”. That sounds somewhat like a form of depression — like being overwhelmed with the consciousness of his own guilt. In the case of Zeezrom, this was not neurotic guilt. It is important for the Church therapist to distinguish between the two.

Let’s consider another depressive reaction which may be encountered by Church members. Consider the experience of a 40 year old faithful, female Church member married to an inactive elder who never really paid much attention to the Church in his married life. The couple eventually divorced. He remarries and life seems to go along nicely for him and his new wife. He makes a good salary, and they are very socially active. Meantime the ex-wife left behind has to make it on very meager income. She is responsible for sole care of the children. She has few social outlets. She complains to her bishop about the Church being so “couple oriented”. She feels she doesn’t fit in anymore. In fact, she says, “I’m not sure I believe in God anymore. If he really loved us, I would not be getting the short end of the deal. My husband’s life is going great and my life is a disaster.” She becomes increasingly angry. Soon she cannot approach Diety in prayer. She becomes more alienated and finds fault with neighbors in the ward. And finally her mood has deteriorated to the point that a well-intended basket of Christmas goodies sent to her home becomes interpreted by her as a “dirty trick”, because “they didn’t send these to everyone in the ward. They singled me and a few others out as single persons, ‘special interests’ if you will”. Here is a great challenge for the LDS therapist.

Certainly there are occasions where depression among LDS members is relatively normal. When we experience life’s tragedies, it is a normal thing to feel the hurt and pain and grief. There are numerous examples in the scriptures where even the Diety has wept, mourned and grieved. That type of experience can even make one stronger, more resilient and compassionate.

For an interesting experience sometime, try looking around at fellow ward members while sitting in meeting. You’ll see a number of very fine people there. There will be people who are paying their contributions, attending their meetings, serving their fellowman, rearing their families, being good citizens, honorable business and professional people. As you contemplate their lives, you’ll recall that some of them have lost children to
The greatest preventive device which we have at our disposal is a well-adjusted frame of reference, what greater tool have we than that? President David O. McKay said, "The Gospel of Jesus Christ should make bad men good and good men better".

The real tragedy in human life is not suffering. It is needless suffering. Christ did not come to earth to end all suffering, he came to end needless suffering. "For behold, I, God, have suffered these things for all, that they might not suffer if they would repent; But if they would not repent they must suffer even as I." (Doctrine & Covenants 19:16-17). So we are all subject to the "natural tragedies of mortality". We needn't be subject to the many forms of suffering which are essentially self-inflicted such as alcoholism, venereal disease, pulmonary disease as a consequence of smoking tobacco or bondage to debt as a result of trying to live on credit beyond our means.

The author works in a setting where all varieties of depression seem to appear sooner or later. Based on that experience along with thorough review of the literature, it seems safe to conclude that there is unquestionably such a thing as biological depression. For that type of illness, one may also observe some dramatic remedies in the form of anti-depressant medication and even electro-convulsive therapy (ECT). Some persons have expressed very hesitant feelings about some of those treatments, but when a patient is totally incapacitated, cannot function, cannot enjoy life and becomes an extreme risk of killing themselves and thus incur not only mortal but perhaps eternal consequences, then it would seem to justify some of those proven remedies.

As for depression in Mormons, the key to effective treatment would seem to consist first and foremost, as it really is in any maladjustment or illness, an accurate diagnosis. Hopefully the foregoing statements have made the point that depression may be essentially biological or situational or both. A few special hazards which may be encountered by Mormon patients have been suggested.

Before concluding this report, perhaps a word about good mental health is in order. In some respects, it is ironic that there are some identifiable distortions of LDS ideals which may lead to depression, because most Mormons would agree that the Gospel may well be the greatest preventive device which we have at our disposal. Properly understood and lived, in a well-adjusted frame of reference, what greater tool have we than that? President David O. McKay said, "The Gospel of Jesus Christ should make bad men good and good men better".

The Natural Association of Mental Health has prepared a little brochure that suggests that good mental health is as simple as 1, 2, and 3:

1. The first measure of mental health is: "How well do you get along with yourself?" Can you see the implication of that idea with regard to depression? Generally depressed people, at least those who distort their values, don't get along well with themselves. They don't like themselves. They feel unworthy. They feel that they are not adequate. They feel guilty. They don't feel they can make their own decisions. They feel they don't measure up to their sometimes overly perfectionistic expectations.

2. The second measure of mental health is: "How well do you get along with others?" Depressed people may feel obsessed with a sense of inferiority to others. They may be covertly angry. They may feel jealous or hurt or bitter. They may feel shy, inhibited and insecure. They may feel incompetent, timid, frightened and overwhelmed in relationship to other people.

3. The third measure of mental health is: "How well do you face, adapt to and cope with the demands of everyday living?" Depressed people feel overwhelmed. They have little energy to apply to problem-solving. They develop anhedonia or an inability to find pleasure in things they once enjoyed. The depressed person often carries an abiding sense of failure and futility.

Depressed patients have problems in each of these three areas necessary for mental health. In some cases the depression, a biological illness, may cause the problems in getting along with self, others and in coping with day to day living. In other patients, the inability to get along with one's self, other people and incompetency in coping behaviors may lead the patient to become depressed. The key to understanding and effectively treating depression comes first in understanding its root causes. Let's not be too quick to oversimplify this most complex problem in the lives of our Mormon or other patients. Let's apply appropriate biological, psychological and or spiritual remedies as the specific case may require.

References


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