A Phenomenological Exploration of the Experience ad Understanding of Depression within a Sample of Young, Single, Latter-Day Saint Women

CHAPTER ONE: INTRODUCTION

Problem and Setting

I hadn't known Jamie* very long before she started opening up to me. I distinctly remember a discussion we had in her car as she was dropping me off after having lunch one day. We didn't go in my apartment because the conversation was too private, or perhaps we felt the need to keep it a secret because it would be too shameful if anyone else knew—they wouldn't understand—they would be judgmental instead of compassionate. She began by telling me how stressful it was searching for a job, that she wasn't where she had expected she would be at this point in her life, how lately it seemed like a big wall had been placed between her and God. Tears welled up in her eyes as she spoke of the heavy sadness, overwhelming isolation, intense confusion, and angry self-hatred. Her voice wavered, straining to convey the emotional pain she was experiencing, expressing how hopeless and helpless she felt. Jamie didn't know where to turn for help—she lived far away from her family, was not in a significant romantic relationship, and had not found it helpful talking with her church leaders. "And really," Jamie stated as a kind of parenthetical remark, "if I was a righteous Mormon woman I wouldn't be unhappy." And then, as the sobs came more violently, she cried out, "It just doesn't make sense why I'm experiencing this!"

It was clear to me that Jamie was struggling with depression, an insidious epidemic that has spread across all cultures, ethnicities, and socio-economic classes

(McGrath, Keita, Strickland, & Russo, 1990). Among 107 disorders studied for their degree of global mortality and disability, including heart disease, tuberculosis, measles, and HIV, this illness ranked fourth for its disease burden (Freres, Gillham, Reivich, & Shatte, 2002). This epidemic is predicted to become the number two health problem, following heart disease, for people in the United States (Schrof & Schultz, 1999). Depression is the black plague of the twenty-first century and it manifests itself as more than just the blues; it is a persistent feeling of sadness, hopelessness, worthlessness and despair that rears its ugly head when someone with a vulnerability to depression experiences a stressful event. In Jamie's case, she was involved in a job-search, found herself alone at a time in her life when she thought she would have a companion, and felt distanced from her familial and spiritual resources. Peter Whybrow, UCLA neuropsychiatrist coined the term "neurobiological Achilles heel" to illustrate this concept of some people being vulnerable to depression (Schrof & Schultz, 1999). He explained that stressful events can trigger depression, but only in someone whose brain is susceptible to the illness.

Although this disease is in no way gender specific, it appears that women are more likely to have this "neurobiological Achilles heel" than men. U.S. News and World Report declared depression as the number one health problem for women (Schrof & Schultz, 1999). It afflicts two to three times as many women as men, hospitalizing one out of every seven women at least once in her lifetime (Wetzel, 1994). Currently at least seven million women in the United States are struggling with diagnosable depression (McGrath et al., 1990).

In response to this epidemic, the American Psychological Association formed a multidisciplinary National Task Force on Women and Depression. The goal of the Task Force was to "identify risk factors for and treatment needs of women with depression" (McGrath et al., 1990, p. xi). In their final report, a summary of existing literature and theory on women and depression, they listed personality traits, other psychological factors, and women's roles and status as factors that contribute to women's vulnerability to depression. They reported that some personality traits of women who are more susceptible to depression are perfectionism, being overly demanding or too hard on themselves, and/or feeling responsible for others' reactions. Psychological factors such as rumination (becoming stuck on what should have, could have, would have been) and a negative explanatory style (explaining life events to oneself in a pessimistic way that is universal, personal, and permanent) also increase a women's vulnerability towards depression. In addition, the American Psychological Association's National Task Force on Women and Depression emphasized the fact that women who feel their roles are complete (i.e. wife, parents, employee) have fewer depressive symptoms than women "who do not participate in marriage, parenthood, or employment" (p.22). Knowing Jamie the little bit that I did, I could see she possessed a "neurobiological Achilles heel". She was not only overly critical of herself, but she also ruminated about many situations. In addition, she felt very incomplete in her roles in life and was unsure where she fit as a young, single woman.

Studies in the past have examined older women with depression (Haug & Folmar, 1986; Himmelfarb, 1984) and depressed married women with young children (Fergusson, Horwood, & Shannon, 1984; Weismman & Paykel, 1974; Weismman, Paykel, &

Klerman, 1972); however, little research has been conducted looking at single, young adults with depression. The prevalence of depression among young adults has increased (Klerman & Weissman, 1989) as have the suicide rates among young adults (McGrath et al., 1990), which indicates to me that this is a group that must be examined more closely in order to understand their experience of depression and prevent suicide. As each stage of life brings different excitements and challenges, it stands to reason that women in different developmental phases will experience depression differently (Culbertson, 1997). Women in their older years, dealing with the death of loved ones and loss of health and vitality, experience depression differently and have different resources to help in their struggle with depression than young adult women who, like Jamie, are struggling with not being in a serious romantic relationship or starting their life's career. What is it that defines what a woman's role should be in her various stages of life? Who decides what the expectations are? I think these answers lie in the cultures to which women subscribe.

Culture encompasses the beliefs and social norms of a racial, religious, or social group. One's belief system structures attitudes, values, and goals. The norms of one's culture structure behavior and an understanding of expectations. The culture to which a woman subscribes not only outlines what her roles should be at different developmental stages, but also provides guidance on how to make sense of her experiences. Arthur Kleinman, one of the world's leading researchers in cross-cultural psychiatry and the chair of Anthropology at Harvard University, and Byron Good, chair of Medical Anthropology at Harvard and involved in NIMH funded culture and mental health research, edited a book on culture and depression (1985). In their introduction they define culture "as the intersection of meaning and experience" (p.8). Kleinman and Good

point out that symptoms of depression (i.e. sadness, helplessness, unworthiness, and unhappiness) are expressed differently and have different meanings in different cultures. They explained:

> "For Buddhists, taking pleasure from things of the world and social relationships is the basis of all suffering; a willful dysphoria is thus the first step on the road to salvation. For Shi'ite Muslims in Iran, grief is a religious experience, associated with recognition of the tragic consequences of living justly in an unjust world; the ability to experience dysphoria fully is thus a marker of depth of a person and understanding." (p.3)

I think it is through a woman's cultural lens that she views, struggles through, and understands her experience with depression. In essence, as she views life through her cultural lens, the ways in which she approaches, lives through, and reflects upon life become tinged with her culture. In this postmodern age it is an accepted fact that one's culture influences one's experiences; thus, research has looked at how depression differs among various racial groups (Jones & Gray, 1984; Salgado de Snyder, 1987) and how religiosity affects depression (Bishop, Larson, & Wilson, 1987; Genia & Shaw, 1991; Maltby & Day, 2000). However, little has been studied about women in specific religious groups and their experience with depression.

As the fifth largest religious group in the United States, members of the Church of Jesus Christ of Latter-day Saints (LDS; Moore, 2002), also known as the Mormons, need more research attention. When the doctrines and practices of the LDS church are lived out in day-to-day life, a distinct culture is created. Just as the Buddhists and Shi'ite Muslims made meaning out of their experience with depression through their cultural

lens, LDS women also understand their experience with depression through their cultural lens. LDS theology (Ulrich, RIchards, & Bergin, 1999) teaches that God is the Father of our spirits and, therefore, we are His children. Furthermore, He has a plan for His children which includes (1) living with Him before this life, (2) mortal life, and (3) living with Him after this life. Members of the LDS church view mortal life as a test wherein there are challenges and experiences, which bring both joy and pain, and through which we become refined and sanctified—closer to our potential. The doctrine also states that men and women have been given the freedom to choose—when they choose to turn to God they are blessed both in this life and in the life to come. Therefore, when LDS women view their experience with depression through their cultural lens, they may focus on the fact that there is a Divinely organized plan and that life's experiences fit into that plan, that God loves every man and woman and that He does not do anything unless it is for their benefit, and that they are free to choose and are accountable for their choices. Within the LDS culture, as these doctrines are interpreted and applied by different people, there emerges an emphasis (oftentimes an intense emphasis) on being obedient and perfect, grateful and happy, and reaping what is sown; hence, Jamie's comment—that if she was a righteous Mormon woman she would not be depressed—was based on this idea that if she was following the teachings of the church and doing what she needed to be doing, she would be happy, peaceful, and full of joy. After hearing Jamie's story, I was left with the question: How do single, young, practicing LDS women understand their experience with depression when they are being good Mormon women?

The LDS church is organized in such a way that there are some congregations made up entirely of young, single, adults ages 18-30 (i.e. the single's ward). Some of

these young adults live at home with their families while most of them live on their own attending school or working in their professions—either way, all share in common the life stage of young adulthood. This group of LDS members becomes, in some ways, a distinct sub-culture with an intense emphasis on dating and marriage. It would be helpful for clergy and mental health workers working with this particular group of LDS people, as well as the single's ward as a whole, to be more aware of what it is like to struggle with depression as a young, single, practicing LDS woman.

Theory

Marie* and I had known one another for over twelve years when we finally talked about the depression she had struggled with. Prompted by my inquisitive, somewhat probing, "therapist" questions, she laid before me her story. The first several minutes of our conversation were spent discussing the intense emotional pain and anguish she had experienced after the devastating break-up with her boyfriend, her undiagnosed health problems, and the spiritual distance she felt as she tried to look to God for strength. "At first, I was so sad and angry it was all I could do to get out of bed and go to my college classes". But then, Marie explained, when the initial shock of the depression subsided somewhat, she began to search for meaning within her experience. By drawing upon spiritual truths she believed, she made sense of her experience; thus, when her first bout with depression drew to a close, she emerged a stronger, more confident women, filled with more compassion and empathy for others. "In the end, I could honestly say I was grateful for the experience. Not that I would have wished it upon myself, but I have been refined and changed for the better."

Even after talking with Marie, I still felt very far removed from her experience of struggling with depression. It was difficult in our brief conversation to understand her reality—what the experience had been like and how she viewed the experience. I found myself wanting to know how Marie perceived, understood, and dealt with her struggle with depression. I wanted to know what it meant to her, how it affected her, what she thought about it, and what she had done/ was doing about it. The theoretical framework of phenomenology guided this thesis and helped me ask questions designed to understand the experience of the participants in my study.

The foundational question phenomenology is concerned with is what the meaning and essence of experiencing a certain phenomenon is for a certain person or group of people (Patton, 2002). "Phenomenology aims at gaining a deeper understanding of the nature or meaning of our everyday experiences" (Van Manen, 1990, p.10). Essentially, phenomenology focuses on the lived experience of people and how they make sense of that experience. Guided by this theory, my study focused on the descriptions of these women's struggle with depression and how they understand their struggle with depression. It was important for me to remember, when conducting this phenomenological research, that their stories and their interpretations of their experience are so intertwined and often indistinguishable from one another; thus, reality is subjective and cannot be seen through any lens except that of one's worldview. Therefore, my study sought to describe how these women experienced their lived experience and, using their own words, sought to help us understand their world. Another important tenet of phenomenology is that it is not concerned with explaining the experience, but rather

describing and exploring people's experience and the meaning they make from their experience (Giorgi, 1985).

Guided by phenomenology, this study explored how a sample of young, single, practicing LDS women perceive, describe, feel about, make sense of, and talk with others about their struggle with depression. According to phenomenology, this kind of detailed data can only be gathered from those persons who have directly experienced the phenomenon in question. Phenomenology also emphasizes the fact that the only way to truly understand the lived experiences of others is to "experience the phenomenon as directly as possible" (Patton, 2002, p.106). Thus, although my close proximity to the sample (myself being a young, single, practicing LDS woman) may have slightly hindered my ability to see some patterns within the data, it also allowed me to be that much closer to experiencing the phenomenon under study.

Phenomenology is less interested in the occurrence, prevalence, or correlates of a phenomenon and more interested in the nature of an experience and "meaning making as the essence of human experience" (Patton, 2002, p.106). Not only did I focus on these women's stories of their lived experience, but I specifically explored how they experienced what they experienced and how they view it. The goal in phenomenological research "is to determine what an experience means for the persons who have had the experience and are able to provide a comprehensive description of it. From the individual descriptions, general or universal meanings are derived, or, in other words, the essences or structures of the experience" (Schwandt, 1997, p.13). Phenomenology presupposes there is an essence to a shared experience—that commonalities in meaning making do exist. These essences are essentially how human beings make sense of their

experience and they are transformed into consciousness both individually and as a shared meaning (Patton, 2002). I believe it is these essences that are beneficial for mental health and clergy to better understand so that they might be more helpful to young, single, practicing LDS women experiencing depression.

Purpose

The purpose of this study was to explore how young, single, practicing LDS women experience and understand their struggle with depression. I was interested in how these women "experience their everyday worlds and how their perceptions of what they experience lead to different meanings" (Boss, Dahl, & Kaplan, 1996). I wanted to hear, in their own words, the story of their struggle with depression, including how they view depression, what factors they see having contributed to the depression, and what has hindered and what has helped in their struggle with depression. Because these women are part of the LDS culture, I specifically explored what they think and how they feel about the fit between LDS cultural views and their own views on their struggle with depression. In addition, I also explored what has been done in their single's ward to help or hinder their struggle (i.e. counsel from church leaders). Essentially, I tried to remain open to explore how these women have experienced and understood their struggle with depression, so that I could discover what will help mental health professionals and clergy be more helpful.

I used a qualitative research method, interviewing young, single, practicing LDS women to hear their stories in their own words and collect data that is rich and descriptive. Guided by phenomenology, I sought to understand these women's realities.

This study is essentially a collection of resources/ thoughts and ideas these women found helpful in their struggle with depression.

Significance

Jamie and Marie are hardly alone in their struggle with depression. There are millions of women experiencing the agony of depression, feeling swallowed up in the "dark mist that seems to rob life of all joy and purpose" (Decker & Chatlin, 2000). U.S. News and World Report declared depression as the number one health problem for women (Schrof & Schultz, 1999). Up until the late eighties, depression was considered a disorder that affected only middle-aged and elderly individuals; however, in the last two decades, there has been an increase in the number of young adults diagnosed with and seeking treatment for depression (Klerman & Weissman, 1989). In addition to the prevalence of depression increasing among young adults, the American Psychological Association found that suicide rates have changed in the last few decades (McGrath et al., 1990). Young adults are attempting suicide more often than they did before and women, in particular, are using more violent and lethal methods to attempt suicide than before. In order to curb the increase in suicide rates and the far-reaching prevalence of depression, there must be more research focusing specifically on young adults and their experience with depression. This study will add to the research by attempting to understand what it is like for a particular sample of young adults to be depressed.

Lately, particular attention has been given to diversity and cross-cultural research in the social sciences. In this postmodern age it is an accepted fact that our belief systems influence our experiences (Nichols & Schwartz, 2001); thus, studies have begun to examine depression within religious cultural contexts. A sociology professor at the

University of Washington, Rodney Stark, predicted that the LDS religion will become the next major world religion during the twenty-first century (Barlow & Bergin, 1998). Although Starks' statistics are just a prediction, the reality is that right now there are over five million members of the LDS church in America (over 12 million worldwide) and it is the fifth-largest denomination in the U.S. (Moore, 2002). As the depression rates increase and the membership of the LDS church increases, it stands to reason that the number of LDS women who are struggling with depression will also continue to increase. Several studies conducted with LDS women and depression have looked at the prevalence rates (Maxwell, 1992) and risk factors (Spendlove, 1982; Spendlove, West, & Stanish, 1984; Williams, 1999) involved, but no research has been done examining the experience and understanding of depression within an LDS culture. With this in mind, it is important to explore in-depth how LDS women like Jamie and Marie experience and view depression. This study will begin to fill in the research gap by attempting to understand what it is like for single, young, practicing LDS women to be depressed.

Since the population of the LDS church is steadily increasing and the rates of depression are on the rise, mental health professionals will most likely encounter LDS clients struggling with depression at some point in their human service profession. It will be helpful for them to read the experiences of women like Jamie and Marie to begin to understand more what it is like for a young, single, practicing LDS woman to struggle with depression. Likewise, it is important that others within the LDS church, particularly church leaders in single's wards who counsel and comfort members of their congregation, to begin to understand more about what it is like to be a woman with depression in a single's ward.

Rationale

The vignettes related earlier in this paper about Jamie and Marie are not entirely fictitious, although some creative license was used. Both characters' characteristics and situations were based on combinations of several young, single, practicing LDS women I have interacted with in the last few years.— friends, roommates, neighbors, etc. I found myself pondering these women's situations: one whose mother and father were depressed and from whom she learned a negative explanatory style and extreme perfectionism; another who had been struggling with low levels of sadness and anger until she encountered an intense experience and found herself in the depths of despair; and yet another who ruminated about every minute detail in every aspect of her life and never let herself feel successful. Although each woman's story was unique in some aspects, they all had in common three things that were immediately obvious—they were young (in their twenties or early thirties), single (and attending a single's ward), and a practicing member of the LDS church (i.e. they believed in the doctrines and upheld the standards). I began to wonder what played a part in these women's experience with depression.

Furthermore, I recognized that young, single adults in the LDS culture in many ways become part of a sub-culture in which dating and marriage is intensely emphasized—they very much become a special population. As these women attend single's wards they become, in some ways, separated from the general population of the church, particularly in that they have clergy specifically designated to work with them. I found myself wondering, "Do these church leaders know how to deal with depression, specifically among young, single adults?"

As I questioned the capabilities of church leaders to counsel and comfort those around me struggling with depression, I was privy to information regarding the experiences of friends, roommates, and neighbors who sought guidance from church leaders. Not all, but most of the stories related to me, were filled with discouragement and increased hopelessness as these women sought help—their church leaders had not only been unhelpful as far as the depression was concerned, but they also conveyed a lack of understanding about what it was to be a young, single woman in the LDS church. Thus, feeling disappointed and isolated, most of these women went back to their church leaders for a second, third, and fourth time seeking guidance that might prove to be more helpful, some of the women sought help from mental health professionals and received talk-therapy and drug treatments, and most of the women continued to seek comfort and strength from religious worship with an increased level of intensity and need. The aim of this study was to understand more about the experience of single, young, practicing LDS women struggling with depression so that mental health professionals, church leaders, and other single's ward members can be helpful.

Research Question

As I have become familiar with the literature on depression, and interacted personally and professionally with numerous women of all ages who are depressed, I have come to view depression much like Peter Whybrow, UCLA neuropsychiatrist who coined the term "neurobiological Achilles heel" (Schrof & Schultz, 1999). I believe that when certain people who have biological and cognitive vulnerabilities towards depression are faced with stressful life experiences, they become depressed. In other words, the chemical pathways in their brains and their learned thought patterns create a vulnerability

towards depression when they encounter experiences in life that are challenging or adverse. As a therapist, my understanding of depression influences how helpful I can be towards my clients and dictates what resources I will draw upon as I help them. I was interested in exploring how young, single, LDS women view depression because their understanding of this phenomenon will influence what and who they seek help from and how they will receive this help.

There is a stigma that exists within the LDS culture, which has been alluded to previously but not explicitly stated. Because the LDS theology teaches that God loves us and has given us so much and that those who are obedient will be blessed, which often gets interpreted as happy, there are negative connotations attached to unhappiness and feelings of worthlessness and negativity. "If you are unhappy you are ungrateful and do not fully appreciate all that God has given us" or "If you are unhappy you must have done something wrong, otherwise you would be blessed and happy" are two statements that exemplify the stigma attached to being depressed in the LDS culture. As a young, single, LDS woman experiencing depression, there are additional perceptions others may have. For example, others may assume that these women are depressed because they put too much time into other things rather than pursuing marriage and are now still single at a time when they "should" be married. I was interested in exploring how young, single, LDS women experience and understand the interplay between depression, gender, their life-cycle stage, and LDS culture.

CHAPTER TWO: LITERATURE REVIEW

Introduction

This phenomenological exploration into the experience and understanding of depression in a sample of young, single, LDS women is much like the peeling away of layers of an onion. Guided by phenomenology, I sought out to discover what makes this phenomenon what it is—the essence of the experience (Patton, 2002). In this chapter, I will basically attempt to peel away four layers: (1) depression in general; (2) women with depression; (3) young, single women with depression; and (4) young, single, LDS women with depression. On the surface we see depression and all of its symptoms. Then, one layer beneath the surface is a woman with depression and all of the contributing factors that influence that phenomenon. Next lies the layer of being a single, young woman who is experiencing different stressors and reacting to those stresses differently than a teenage girl or an older woman; thus creating a different phenomenon of depression. Lastly, there is a layer steeped in religious beliefs and practices, internalized and acted out—influencing and contributing differently to each individual young, single, LDS woman's experience with depression. At least, this is what I initially thought would happen as we peeled away each of these layers.

While writing this section, I was aware that this review of the literature presumptuously sets forth the onion's layers. I realized that, in fact, it might be that being a woman, or being single, or being LDS, were not the essence of how my participants viewed their struggle with depression. Perhaps one participant experienced and understood depression more from the layer of being a woman rather than being LDS. It is also likely the opposite is true, and the order of the layers is different with different

women. However, whether these layers I set forth are, in fact, part of this phenomenon or not, it is important to remember that "Every human being has some perspective and understanding of meaning for their lives…for some people it is a little vague, for other people they know exactly what they are living for. Everyone has some perspective on what gives their lives meaning and what they are living for." (Aponte, 2004). The purpose of this study is to explore how young, single, LDS women experience and understand depression; thus, although this literature review sets forth certain ideas about how I initially thought they might do that, it was in no way limiting or comprehensive. My intent was to get to the heart of this phenomenon and I started with the basic layers that were obvious to me.

The Outer Layer: Depression in General

All human beings know what it feels like to be sad, helpless, and irritable. In the work place, at a school, or at home, people can often be heard exclaiming that they feel "depressed". It is unlikely, however, that they really are clinically depressed since the prevalence of clinical depression is about 2-4% in the general population (Robins, Helzer, & Weissman, 1984). To be clinically depressed is distinctly different from just feeling the normal blues we all feel from time to time. According to the Diagnostic and Statistical Manual IV-TR (APA, 2000), wherein the standardized criteria for a major depressive episode exist, five or more of the following symptoms must all be present during a two-week period for a diagnoses to be made. At least one of the five symptoms must be the first or second factor in the list below:

(1) reported (e.g., feels sad or empty) or observed (e.g., tearful) depressed mood most of the day, nearly every day

(2) reported or observed significant loss of interest or pleasure in all, or most, activities most of the day nearly every day

(3) decreases or increases in weight in a short amount of time/ decreases or increases in appetite nearly every day

(4) decreases or increases in sleep nearly every day

(5) observed psychomotor agitation (restlessness) or retardation (slowed down)

(6) decrease in energy/ fatigue nearly every day

(7) feelings of worthlessness or exaggerated guilt

(8) indecisiveness, lack of concentration and ability to focus nearly every day

(9) repeated thoughts of death, thoughts of wanting to die, specific suicide plan, or suicide attempt

The person's ability to function must be markedly different from normal, meaning that the above symptoms must cause significant distress in important areas of life, such as social or occupational. In addition the symptoms must not be reactions to a substance or medical condition. The symptoms must also not be better explained by the normal process of bereavement. With these specific criteria, the phenomenon of clinical depression varies markedly from the every day sad feelings one might experience. The World Health Organization declared depression as the leading cause of disability worldwide because of the impairment of functioning which accompanies its symptoms (Goldman, Nielson, & Champion, 1999).

It is often the case that a stressful life event (e.g. death of a loved one, relationship conflict, debilitating illness) is the precipitant to a depressive episode; however, obviously not every person who experiences stressful life events becomes depressed. If

that were the case, all human kind would be diagnosed with depression! Historically depression has been viewed as a combination of biological, psychological, and sociological factors (McGrath et al., 1990). Therefore, the current theory on the origins of depression are that persons who become depressed after stressful life events are those persons who may have various chemical imbalances in their brains and/ or have certain patterns of thinking that make them more vulnerable to depression when stressful life events do occur. The term "neurobiological Achilles heel" was used by Peter Whybrow, UCLA neuropsychiatrist, to illustrate this concept of some people being more vulnerable to depression (Schrof & Schultz, 1999). Stressful events can trigger depression, he explained, but only in someone who has a biological, psychological, or sociological vulnerability. Although depression inflicts men, women, and children, women have been found to be more vulnerable to depression.

The Second Layer: Women Struggling with Depression

Much of the literature written about women struggling with depression agrees that "Throughout the world today, women are two to three times more likely to experience depression" than are men (Wetzel, 1994, p.86). Kessler and Colleagues (1993) reported data from the National Comorbidity Survey (NCS), a structured psychiatric interview designed "to foster epidemiologic and cross-cultural" research (p.85), which revealed that the female to male relative risk of depression is 1:7. Kessler et al. (1993) also found reports of first onset as early as 10 years old among female respondents, corroborating other research that found the sex difference in depression to become pronounced during adolescence. Results from the NCS, however, suggest that there is no major sex difference in the chronicity or acute recurrence of depression; therefore an understanding

of the sex difference in depression "hinges largely on understanding why women are more likely than men to become depressed initially and why sex difference is confined to a particular part of the life cycle" (p.93). Other researchers like Kessler et al. (e.g. Culbertson, 1997) also emphasized the need for research to include in-depth exploration into women with depression at different stages of the life cycle. My study adds to this need for life cycle stage research on women with depression by looking specifically at young, single women.

Numerous theories have been used to explain why women are more likely than men to experience depression. Wetzel (1994) outlines several of the theoretical perspectives researches have taken to make sense of depression. For example, from a psychoanalytic perspective it has been explained that as women come face to face with the anger they have been taught to repress, they experience a disconnect between their true self and the unrealistic representation of the self. In other words: "Depression is the price (woman) pays for the subterfuge pressed on her by society" (p.91). Although these women will suffer from symptoms including sadness, anxiety, irritability, hopelessness, worthlessness, helplessness, inappropriate guilt, problems with concentrating and decision-making, rumination about the self, future, and current situations, lack of interest, withdrawal, and thoughts of death or suicide, often they will mask their depressive symptoms behind a cheerful face because they have been socialized to "smile at all costs" (p.87). Biochemical factors on their own as precipitants to depression are still unsupported; however, it is accepted that once depressive symptoms are severe, "they become biologically autonomous" (p.103). In cases of severe depression, pharmacotherapy has been found initially to be the most effective in relieving individuals

of this disabling, “biologically autonomous” depression, which then allows them to be in the position to focus their energies on changing their thought patterns and solving other problems in psychotherapy (Friedman, 1975). The Life Events Models emphasize the stress response that stems from various environmental situations. It pinpoints the fact that how a person interprets and defines an event, rather than the event itself, is related to depression. Within this model exists the social role theory which describes depression in women as being directly related to their roles in life, especially when their identity is meshed with their roles. They experience strain and conflict as they strive to balance and do it all.

There are certain characteristics and thought patterns that increase a woman’s likelihood of becoming depressed. Women are more likely to engage in ruminative responses (Nolen-Hoeksema, 1991) which lengthens and exacerbates depressive symptoms. In an NIMH funded study (Nolen-Hoeksema, Morrow, & Fredrickson, 1993) women kept track of their depressed moods and responses to their moods for a month. Researchers concluded that women experienced longer and more severe depressed moods because they dwell on how they feel and analyze it over and over, whereas men are more likely to engage in distracting behaviors. Ingram, Cruet, Johnson, and Wisnicki (1988) also found that women who were more feminine sex-typed were more likely to blame themselves when a negative event occurred.

Research done by Nolen-Hoeksema and Colleagues (1999) concluded that women do have more vulnerabilities to depression than men, including experiencing a chronic lack of control over their environment, leading to learned helplessness, low self-efficacy, and low mastery. In a sample of 1,100 adults from 25-75 years old, Nolen-Hoeksema

and Colleagues (1999) examined the relationship between depression and chronic strain, mastery, and rumination by administering several tests at the beginning of the study and then again one year later. Each of the factors were more common in women than men. The authors suggested the existence of a negative cyclical pattern wherein rumination amplifies the effects of chronic strain and mastery, which leads to depressive symptoms, which leads to more rumination, chronic strain, and mastery, which leads to increased depressive symptoms, etc. Nolen-Hoeksema (1990) suggested that although most of the proposed explanations for the differences in depression between women and men have some empirical support, none of them adequately account for the significant sex difference in depression.

One of the constructs Nolen-Hoeksema et al. (1999) measured in the previously discussed study was mastery. The antithesis of mastery is learned helplessness, of which women appear to be more susceptible than men (Seligman, 1990; Wortman & Brehm, 1975). This concept is included in the Cognitive Behavioral perspective which focuses on the connections between events that occur and one's thoughts about those events. From a series of animal experiments, it was concluded that when one repeatedly feels helpless, one learns one has no control over one's situation and ceases from trying to change (Maier & Seligman, 1976). Furthermore, learned helplessness occurs when individuals are "unable to exert control over their environment…unable to have options or reach goals that are important to them, or when they are forced to endure outcomes they wouldn't voluntarily choose" (Wortman & Brehm, 1975). It has been concluded that helplessness can generalize to situations different from those in which it was learned. For example, a single woman, despite her best efforts, who has experienced many failures

in dating, may be very successful in her career; however, the helplessness she feels in her social roles may begin to affect her professional roles as well.

The Third Layer: Women Throughout the Life Cycle

One way researchers have tried to study depression in women more thoroughly is by focusing on women at different phases of the life cycle. In a review on gender and depression, Culbertson (1997) suggested that future research look at women's developmental stages and the influence these stages have on depression. She wondered if different treatment approaches would work better to address different psychological stresses that come at different ages. Throughout the last few decades, research has focused on three groups of women: adolescents, older women, and mothers of young children.

Adolescent girls

In the APA final report from the National Task Force on Women and Depression (McGrath et al., 1990), studies of women in various phases of the life cycle are summarized. Their literature review begins with adolescence because this is when the sex difference in depression first occurs. Beginning in middle to late adolescence (throughout the rest of the life cycle), teenage girls are twice as likely as men to be depressed and more likely (although not more successful) to attempt suicide than teenage boys (Kandel & Davies, 1982). Numerous research studies have been conducted to examine the factors that correlate with depression among adolescents. Simons and Miller (1987) found a significant predictor of depression in adolescent girls to be low parental support while Kandel and Davies (1982) found low self-esteem, low levels of attachment

to parent/ peers, depressed parents, and authoritarian families to be factors associated with depressed mood in adolescents.

The National Task Force on Women and Depression also found studies which suggested that female adolescents experience more depressive symptoms because during puberty their satisfaction with their bodies decreases more than male adolescents' satisfaction with their bodies (Dornbusch et al., 1984; Lerner & Karabenick, 1974; Gilligan et al., 1989). In addition, female adolescents' self-esteem and well-being are more closely tied to their satisfaction with their body. Another phenomenon associated with depression in female adolescents is that of intelligence and competence. A positive relationship has been found between intelligence and depression in female adolescents (Block & Gjerde, in press). In the past, teenage girls have not wanted to be recognized for being intelligent because they feared being rejected for acting outside of the normal female role by being competent and assertive (Coleman, 1961). However, teenage girls who do engage in more feminine-typed behaviors are also more depressed. Thus, it appears that female adolescents are in a double bind—they are more at risk for depression if they take on the stereotyped female role and they are also more at risk for depression if they go outside that role. Interestingly, while instrumentality and competence increase the risk for depression during adolescence, they actually lower the risk for depression over the life cycle. Thus, at different stages of the life cycle, depression is experienced differently.

Older Women

At the opposite end of the life cycle from adolescence is that of old age, another age cohort researchers of women and depression have focused on. There are increasingly

more women over 65 years old in the general population; thus, women are overrepresented in the aging population and have become of special concern (McGrath et al., 1990). Research about depression in this population is complicated "by the fact that depression is often concurrent with or caused by a variety of medications and physical illnesses" (McGrath, et al., p.85). For example, due to the complexity of depression in older women, estimates about the prevalence of depression in this sample range from 2-50% (Formanek & Gurian). Some studies (e.g. Haug, Ford, & Sheafor, 1985) have suggested that the likelihood of serious depression occurring is reduced after the age of 65 while other studies (e.g. Katona, 1994) show that the duration of episodes and possibility of relapse is worse as one ages.

In two reviews of empirical studies examining the relationship between age and depression (Ernst & Angst, 1995; Newmann, 1989), it is pointed out that the standard measures of depression, such as the Beck Depression Inventory, assess for depressive symptoms which are similar to symptoms of deteriorating physical health (e.g. difficulty sleeping and appetite disturbances). In a more recent study, Newmann and Colleagues (Newmann, Klein, Jensen, & Essex, 1996) compared the measurement outcomes of several different measures to investigate further this age-depression relationship. All three measures produced different results. Newmann et al. concluded that the standard way of researching depression is not effective when applied to older women because it fails to take into account specific age-related symptoms and distress. "Depression in older women may be related to different factors from those seen for younger women" such as isolation from adult children as they move away and isolation from friends and family as they die, role changes with retirement or deaths in the family, changes in

physical health, and increasing poverty (McGrath et al., 1990, p.85). Therefore, women at different ages have different stressors which contribute to depression and experience different symptoms of depression.

Mothers of Young Children

Besides the groups of women at the beginning and end of the life cycle, there has been much focus on one of the "middle" stages: motherhood. In particular, mothers of young children are at risk for depressive symptoms because of the role strain associated with this stage of the life cycle (McGrath et al., 1990). Previous studies have linked depression in mothers of young children with maladaptive parenting behaviors (Weismman & Paykel, 1974; Weismman et al., 1972), describing them as distant, irritable, punitive, controlling, resentful, and less responsive. Maternal depression was also found to be linked with childhood behavioral problems, meaning that mothers of children who acted out more were more often depressed (Fergusson et al., 1984). "Although relationships can bring great satisfaction to women, problems and strains in such relationships constitute a greater risk for depression than problems or strains in other realms of life" (Kandel, Davies, & Ravels, 1985, p.22). When difficulties arise within relationships with children or spouses, women are affected more than men (McGrath et al., 1990). What about women who lack those relationships with a spouse and children? What is the effect of the absence of those relationships on women's experience with depression?

Single Women

For years it has been thought that the risk of depression increased with age: "depression was regarded as a disorder of the middle-aged and elderly persons; now,

adolescents and young adults are increasingly depressed and seeking treatment" (Klerman & Weissman, 1989, p.2229). In a survey of 2500 people ages 15-80 (Klerman & Weissman, 1989), participants were asked whether they had ever experienced a depressive episode meeting the DSM criteria. The lifetime prevalence rates reported by young adults were higher than those reported by elderly persons. In fact, the highest prevalence rate reported was among women ages 25-35, the ages of women I interviewed in my study. Is there something different about this stage of the life cycle that would explain the increased prevalence of depression? Some researchers claim that a lack of the social support spouses/ significant others can provide effects depression among young, single, women.

For example, a random sample of adolescents and young adults were assessed for depression using a structured interview format (Haarasilta, Marttunen, Kaprio, & Aro, 2004). Among young adults, not being married nor cohabiting was one of the factors associated with depression. Haarasilta and Colleagues suggest that the relationship between depression and not being married nor cohabiting may be indicative of a lack of social support or trouble with interpersonal relationships. Lamb, Lee, and Demaris (2003) used data from the National Surveys of Families and Households to track young adults who had never been married nor cohabited. They followed about 920 individuals ages 18-35 as they transitioned into cohabitation, marriage, or neither. They stated: "Marriage appears to have significant and meaningful negative effects on depression that emanates from the relationship itself" (p.960), referring to the support an individual with depression derives from their marital relationship. Furthermore, Burns, Sayers, and Moras (1994) examined the interaction of relationship satisfaction and depression in 115

patients with mood disorders receiving CBT. At intake and at 12 weeks, the data showed that those who were satisfied with their relationship were also less depressed. In addition, those patients who were involved in a satisfying marital relationship were more likely to improve significantly within the 12 week time frame of the study. Burns et al. suggest that the presence of a supportive, caring, empathic spouse is a powerful resource when one is healing from a depressive episode.

It stands to reason that the lack of a supportive spouse is not the only factor contributing to the increase in prevalence of depression among this age cohort; yet, the literature focusing on this stage of the life cycle is so scant there really is not another empirically supported explanation that has surfaced. For example, in the comprehensive review published by APA, McGrath et al. much attention was given to adolescents, older women, and married women with depression, but little attention was given to young, single, women without children. However, they did include a study by Kandel and Colleagues (1985) which found that "Women who have the most complete role configurations (i.e. wife, parent, and worker) experience fewer depressive symptoms than those who do not participate in marriage, parenthood, or employment" (p.22). Women at different stages of the life cycle experience life stressors differently; thus, it appears that young, single women experience depression differently than teenage girls, older women, or women with young children and deserve more research attention. In order to ascertain what the contributing factors are for depression in young, single women, my study explored the experience and understanding of depression from the point of view of single, young women. I think the answer as to whether not being married or not having a

significant other is actually a major contributing factor for depression in young, single women lies in the next layer of the onion.

The Inner Layer: Culture and Depression

Not only is depression experienced and affected differently at every stage of life, but it is also experienced differently across various cultures. Lewis-Fernandez and Kleinman, well known researchers of cultural psychology, stated in 1994: "In a world in which ethnic and cultural pluralism is daily becoming more politically salient, it is striking that North American professional constructs of personality and psychopathology are mostly culture bound, selectively reflecting the experiences of…White, male, Anglo-Germanic, Protestants, formally educated and who share a middle-and upper-middle-class cultural orientation" (p.67). In a review article of depressive disorders and gender, Culbertson (1997) emphasizes that one of the additional issues researchers on depression and women needs to consider is that of culture**.** There is evidence to support the fact that depressed symptoms of sadness, unhappiness, and lack of pleasure with social relationships and things of the world have "dramatically different meaning and form of expression in different societies" (Kleinman & Good, 1985, p.2). For example, societies like the Kaluli in Papua New Guinea look highly upon dramatic portrayals of sadness and grieving while Balinese down-play emotional ups and downs, desiring above all else to convey a smooth, pure, and refined inner-self (Kleinman & Good, 1985).

Race and Ethnicity

The American Psychological Association's National Task Force on Women and Depression final report summarized the literature on, what they term, "ethnic minority

women". Studies of African American, Hispanic, and Native American women were reviewed in an attempt to examine cultural influences on depression.

"African American women face a number of mental-health related issues based on their experience with racism and on the historical, cultural, and structural position of black people in American society" (McGrath et al., 1990, p.76). Steele (1978) examined the relationship between depression and race, gender, social class, and social mobility in black and white women and men. The results showed that female status, lower social class, and downward social mobility were related to depression. Misdiagnoses has been a concern for ethnic minority groups. Jones and Gray (1984) conducted a survey among therapists working with black patients and discovered that black women were most frequently diagnosed with affective non-psychotic disorders. Russo and Olmedo (1983) conducted a study to examine the use of outpatient psychiatric services and found the rate of depression for black women to be 42% higher than that of white women. In addition, more black women were likely to receive drug therapy and family therapy than white women; thus, the phenomenon of depression in black women is different from that of white women.

The APA report also cited studies about Hispanic women and depression. Risk factors for women's depression that exist in the Hispanic culture include lower SES classes, being a mother at a young age, and often being divorced or single mothers. Salgado de Snyder (1987) examined depressive symptoms among married Mexican immigrant women. These women identified discrimination, gender role conflicts, and concern about raising a family in the US as contributing factors to their depression. Hernandez (1986, September September September September) suggested that traditional

cultural expectations, such as passivity, sole responsibility for the outcome of the marriage and family, and cultural intolerance for differences, contributes to a "psychocultural vulnerability to depression" (p.77). Hispanic culture places great emphasis on being part of an extended family network, thus, although marital status was not related to depression in Hispanic women, social alienation was a good predictor of depression (Quesada, Spears, & Ramos, 1978). In addition, the stress of acculturation (i.e. disintegration of family values, poverty, discrimination) may be a risk factor in depression in Hispanic women because it contributes to feelings of powerlessness, loss of identity, and depression.

McGrath et al. (1990) concluded the APA's final report about ethnic minority women and depression with a discussion of Native American women. They stated that there is a dearth of research on this population of women and depression and that the research that has been conducted was done by agencies based in the government that were not necessarily doing research with a culturally-sensitive approach. The suicide rate is twice as high among Native Americans than among the general population. Risk factors associated with depression and Native American women include poverty, little education, large numbers of children, single-mother families, and teenage-births. The US Department of Health and Human Services (1988) reported low rates of psychiatric services for Native American women. In addition, the majority of those who did seek treatment for depressive symptoms had also often experienced some type of abuse and were involved with alcohol and drugs. Therefore, women suffering from depression from different cultural backgrounds may be in need of different services since different factors may have contributed to the depression.

Just as Hispanic women experience a psychocultural vulnerability to depression (Hernandez, 1986), Lewis- Fernandez and Kleinman (1994) found cultural beliefs in China to affect the management of emotion and subsequently the presentation and experience of depression among the Chinese. For example, Chinese communities, differing across age and class, emphasize the importance of "the subtle expression of affect" (p.69). This type of management of emotion is a hallmark of health in Chinese communities; whereas, if one were to express strong emotions one would be shunned and demoralized. This behavior is thought to contribute to psychopathology. In addition, any personality problems or psychopathology are "expressed as resentment toward family, as loss of face and favor, and as powerlessness of self and network" (p.69). Therefore, within various ethnic cultures, beliefs and behaviors of that culture contribute to and influence the presentation and experience of depression.

Religion

Just a few decades ago, mental health professionals began to recognize the importance of religion as a cultural influence in people's lives. Before that time, there had been a history of animosity between psychology and religion— a war led by researchers like Ellis who claimed that "the less religious…the more emotionally healthy" (1980, p.637). Thus, mental health research steered clear of delving into the religious lives of individuals because Ellis's claim was a widely held belief: religious beliefs and motivations are unhealthy and dysfunctional. Period. End of discussion. And yet, according to a Gallup study spanning fifty years of religion in America, a large majority of Americans believe in God, go to services, and pray (Ellis, 1980). Thus, in light of the majority of Americans having some religious affiliation, the question among

mental health researchers began to emerge: How long should we believe that religion is unhealthy and how long can we avoid these cultural religious overtones?

In 1983 at the American Psychological Association's convention, Michael Donahue presented his doctoral dissertation meta-analytic research about religion and depression. The presentation was novel because of the way he divided religiosity into intrinsic and extrinsic orientations, thus making conclusions drawn from studies of religion and mental health more meaningful (Bergin, Masters, & Richards, 1987). His results showed that persons who go through the motions of a particular religion without truly believing (extrinsically religious) have more negatively evaluated characteristics (i.e. prejudiced, defensive, dependant, immature); whereas, persons who truly believe and have internalized their religious beliefs (intrinsically religious) have positively evaluated characteristics (i.e. tolerant, unifying, mature, meaning-endowing). This separation of religiosity into extrinsic and intrinsic orientations has continued to be a popular way of researching the effects of religion on mental health (Genia & Shaw, 1991; Maltby & Day, 2000). In light of this new way to research the relationship between religion and mental health without having to be so cut and dry, researchers have been free to explore; however, their explorations have been slow in coming and limited mostly to studies of how religiosity (the degree to which a person is religious) affects mental health rather than trying to understand how persons' religious perspectives influence how they experience life.

In a review of religion and mental health done in the '80's, Dr. Allen Bergin stated, "Race, gender, and ethnic origin now receive deserved attention, but religion is still an orphan in academia" (1983, p.171). Bergin went on to emphasize the need for

clinicians to “understand the cultural content of their client’s religious world views” (p.180) since religious thoughts, behaviors, and emotions are so widespread. In more recent research, it has been emphasized that there is a need for studies to examine the effects of religious beliefs and behaviors for persons diagnosed specifically with depression (Murphy et al., 2000).

Some research in the mental health arena has focused specifically on types of psychopathology and the influence of particular religious affiliations (McCullough & Larson, 1999; Meador et al., 1992). For example, Ross (1990) found that persons with strong religious beliefs had lower levels of anxiety and depression than persons with weak religious beliefs. She also found that persons with no religious beliefs also had lower levels of psychological distress than persons with weak religious beliefs. Breaking the results down into subgroups of Protestants, Catholics, and Jews, and analyzing the relation of these particular religions to depression, no difference was found. Ross concluded that it is the strength of a person’s beliefs, and not the specific content, that has a positive effect on psychological distress. Thus, it appears that when religious beliefs are strongly held to, they serve as a person’s worldview as they approach life—providing meaning to experience. Murphy et al. (2000) stated: “studies are needed that examine specific religious beliefs” (p.1104). My study sought to add to the scarcity of research on specific religious world-views and depression in a way that will help us understand these single, young, women’s experience with depression.

LDS Women and Depression

The Church of Jesus Christ of Latter-day Saints (LDS or Mormons) is the fifth largest denomination in the United States (Moore, 2002) and is predicted to become the

next major world religion in the twenty-first century (Barlow & Bergin, 1998). Thus, it is increasingly more likely that mental health professionals will be called upon to help LDS clients. Because working with persons from other cultures requires some understanding "of different ways of being a person in radically different worlds" (Kleinman & Good, 1985, p.3), there is a great need for research involving this large, distinct cultural group. In one study of Mormon psychotherapy clients, Richards et al. (Richards, Smith, & Davis, 1989) concluded that "despite their problems, the clients felt that their relationship with God gives them strength, helps them cope, and contributes to their well-being" (p.517). They suggested that clinicians should be willing and open to "enter into their client's religious world view" in order to tap into the therapeutic resource of religious beliefs.

Much of the research examining depression in LDS women has focused on disproving the stigma that Mormon women are more depressed than other women (Bergin, Payne, Jenkins, & Cornwall, 1994; Jensen, Jensen, & Wiederhold, 1993; Johnson, 2004; Spendlove, 1982; Spendlove et al., 1984; Williams, 1999). This thought essentially stemmed from a documentary entitled "Mormon Women and Depression" (Degn, Yeates, Greenwell, & Fiddler, 1985) that aired on a popular television channel in 1979 in Salt Lake City, Utah. The program featured many different vignettes of interviews with various mental health professionals (LDS and non-LDS), LDS church leaders, and LDS women (both practicing and not-practicing). The documentary explores what characteristics, if any, of LDS women put them at risk for depression, if LDS women are more prone to depression than other women, and if there are aspects of Mormonism that help in the struggle with depression. Although the content of the

documentary did not portray Mormon women as more depressed, the mere fact that a documentary focused on depression and Mormon women produced a ripple effect that can still be seen in present studies.

For example, in direct response to the documentary on Mormon women and depression, Spendlove, West, and Stanish (1984) conducted a study comparing the prevalence of depression between LDS women and non-LDS women. The random sample of women were selected from the Salt Lake City, UT metropolitan area and were all white, Caucasian, English-speaking, and had children under fourteen years of age. Using the Beck Depression Inventory, no difference in the prevalence of depression was detected between the LDS and the non-LDS women.

Even in one of the most recent studies on depression and LDS women (Johnson, 2004), the ripples of the aforementioned documentary (Degn et al, 1985) are evident. Johnson, however, clarifies Degn's intentions stating that the documentary had been meant to portray Mormon women's experience of depression. Furthermore, it was meant to serve as an educational tool to encourage women suffering with depression to seek professional help. In Johnson's study (2004), she examined the difference between a group of women from a national survey and two groups of LDS women (ages 24-44), those who had served missions and those who had not. On measures of depression she found the two LDS groups to be significantly lower than the national group of women, but not to differ significantly from each other. The question was also asked as to whether these women had received professional counseling or prescribed medication for any emotional problems "such as depression, anxiety, or an eating disorder". Responses from the two groups of LDS women were below the national average of women receiving help

for depression, anxiety, and eating disorders in the United States. Johnson does not offer an interpretation of this statistic. I think it could be interpreted two different ways: (1) because the two groups of LDS women in Johnson's study reported lower depression, they might seek mental health help less because they are in less in need of the help, or (2) taking into account the LDS cultural undertones of feeling shame and increased helplessness when seeking help apart from God and family, it might not be that the LDS women in Johnson's study needed less help, they just simply sought it out less. Degn and Colleagues' documentary (1985) encouraged LDS women suffering from depression to seek help because there is a cultural stigma which affects how LDS women with depression and their friends, family, and church leaders, respond to depression. These cultural stigmas are difficult to understand if one is not part of the culture and if one is not personally affected by the stigma. Because most of us will not be a depressed woman in the LDS culture, a phenomenological study of this phenomenon is the next best way to understand what that experience is like. Phenomenology emphasizes the fact that the only way to truly understand the lived experiences of others is to "experience the phenomenon as directly as possible" (Patton, 2002, p.106); thus, my study explored the experience and understanding of depression in a sample of young, single, LDS women.

There has been very little qualitative research done examining the phenomenon of depression in a sample of LDS women. Bergin (1994) conducted one of the few qualitative studies because he was unsatisfied by the ambiguity and inconclusiveness of previous research. He advocated for "a deeper, more naturalistic, and more descriptive immersion in the phenomena" (Bergin, 1999, p.2). He interviewed 60 men and women when they were undergraduates and then again three years later to determine how

religiousness operated in their lives. In addition, he studied four persons more intensely after the three-year follow-up interview and published his observations from those case studies. For example, observations made of one young woman who was interviewed when she was nineteen, and then again when she was twenty-two, were that "she had drawn upon spiritual resources to manage difficulties and to reconstruct her experiences in a broader context. Her religious values anchored her responses in ways she felt could maintain a life-style that would provide optimal rewards over the long-term" (Bergin, 1999, p.18).

Marleen Williams (1999), assistant clinical professor at the counseling center at Brigham Young University, examined the relationship of religious orientation, traditional family role values, and perfectionism to depression for both a LDS group and a mainline Protestant group of women, incorporating both quantitative and qualitative measures. No significant differences existed in the level of depression in the LDS or Protestant groups; however, perfectionism was related to depression in both groups. A semi-structured interview was given to some of the sample. The qualitative piece of this study was included to gather other possible religious influences on depression. The interviews began with the question: "How do you feel your religion affects your happiness and mental well-being?" The interviews offered insight into the internal dynamics of this sample: "religious issues appeared to play a more prominent role for Mormon women than for Protestants who are mildly depressed. This was particularly true in areas of support and judgment from others, ability to set priorities and make decisions when value conflicts exist, need for approval and to "look good", self-blame, and in taking responsibility for others' behavior" (as quoted in Judd, 1999, p. 57).

An important contribution from this study is the fact that the personal interview data showed that mildly depressed Mormon women have characteristics similar to other depression-prone women. Williams pointed out that the Mormon women with depression from Spendlove and Colleagues' study (1984) exhibited learned helplessness, perfectionism, difficulty prioritizing based on internalized values rather than external expectations, lack of differentiation, and difficulty receiving constructive criticism especially from authority figures. Thus, although these characteristics were often specifically related to LDS cultural practices and beliefs, they are also similar to the dynamics of depression in the population at large.

Other studies, however, have shown that Mormon women do have characteristics or responses that affect how they experience depression. The purpose of the study by Richards, Smith, and Davis (1989) was to further investigate the interaction between religiousness, personality, and mental health. By administering several different tests measuring religiosity, shame and guilt, moral reasoning, and spiritual well-being to 49 Mormon psychotherapy clients and 51 Mormon non-clients, the researchers sought to determine if religious psychotherapy clients have religious beliefs that are a source emotional distress. They also sought to determine if they have personality characteristics or psychological issues that interact in dysfunctional ways with their beliefs. The results of this study showed that religious psychotherapy clients do not have religious beliefs which are a source of emotional distress. The group of Mormon psychotherapy clients did report higher shame scores than the non-clients, which Richards and Colleagues surmised indicates they are more prone to feeling discouraged or depressed when not meeting expectations. In addition, female clients scored much higher on shame and guilt

than male clients. It was suggested by the researchers that the Mormon cultural emphasis on striving for perfection causes those women who are high in shame and guilt to feel inadequate and unworthy, which may lead to depression. Therefore, although there are characteristics of Mormon women who are depressed that are similar to women who are depressed in the population at large, there is also a unique interaction of those characteristics and the LDS culture.

This phenomenon of being a young, single, LDS women struggling with depression is deserving of more research attention. Although research has shown that Mormon women are not more depressed than other women, and that Mormon women who are depressed often have similar characteristics to other women who are depressed, we still know few details about the experience of being a depressed Mormon woman. Furthermore, although there have been studies which examined depression in samples of young, LDS women, there have not been any studies which have focused on the understanding of depression from the point of view of a young, single, LDS woman.

Conclusion

In the final report from the National Task Force on Women and Depression McGrath et al. (1990), suggested that future research on women and depression be culturally sensitive in order to identify "shared and unique experiences among women of diverse groups" (p.95). Through in-depth, personal interviews, my study identified shared and unique experiences of young, single, LDS women struggling with depression. McGrath et al. further emphasized that cultural context needs to be considered and that therapists need to be culturally grounded in order to be effective. Nolen-Hoeksema (1991) suggested that because most people who are depressed do not seek treatment, it is

more important for future research to focus on what people actually do: seek answers to their questions about why they are depressed. Thus, this study also sought to understand the participants' understanding of their experience with depression in the hopes of increasing the knowledge and awareness of clergy and mental health professionals of the phenomenon of depression in young, single, LDS women.

CHAPTER THREE: METHODS

Introduction and Study Design

Although research has begun to emphasize the influence of culture on women struggling with depression, no study has focused specifically on young, single, practicing LDS women and their experience in struggling with depression. This exploratory, phenomenological study was designed to collect data that will add information and depth to the existing research recognizing that, essentially, "meaning becomes the major source of data" (Boss et al., 1996). The goal of this study was to attempt to understand the participants' reality by focusing on how these young, single, practicing LDS women experience and understand their struggle with depression. In order to get data that is rich and descriptive, I used a qualitative research method because there is a "growing awareness of the need to study women in their own right and through their own voices" (Elder, 1993, p.xiv). I have given voice to each woman to tell the story about her experience and understanding of her struggle with depression.

Women who met the criteria and participated in this study engaged in an open-ended interview. The interview was more like an informal discussion wherein the participants were asked questions about what it was like to be a young, single, practicing LDS women struggling with depression and about how they made sense of their experience. Using a qualitative research approach produced a vivid picture of the experience of these young, single, practicing LDS women struggling with depression that is personal and intimate, full of variety, and alive with patterns and themes.

Recruitment and Participants

A snowball method was used to recruit participants. The LDS church is organized in a way that lends itself to positive networking opportunities (e.g. a friend of a friend, etc.). I emailed a flier (See Appendix I) to several friends who attend and are acquainted with different single's wards than I am. I asked them to send this flier to all of the young, single adults who subscribe to the DC area single's ward's listserves. This mode of recruitment was far-reaching because subscribers to these listserves live anywhere from Chevy Chase, MD, to inside the District of Columbia, to Alexandria, VA. This mode of recruitment also added a personal touch because my flier was sent to potential participants from people they were acquainted with, rather than from me who was an unknown person to them. The respondents then contacted me via email at thesisresearch@vt.edu providing some basic contact information, and I responded to them to set up a time and date for the interview.

I interviewed six participants, which is an appropriate sample size given the qualitative method and purpose of my study (i.e. to provide an in-depth picture of my participants' experience). The flier used to recruit participants asked if they have struggled with depression. I interviewed both women who have been depressed, because they were able to view their experience in retrospect, and women who are currently depressed, because I believe "we interpret our experiences as we chug through them" (Higgins, 1994).

Participants were not screened prior to conducting the interview; however, the flier used to recruit participants asked if they were single, between 25-35 years old, and a practicing LDS woman. I decided not to ask any screening questions via email or over

the phone because it felt too impersonal and I thought it was more appropriate to meet with the participants face-to-face and ask the demographic questions (See Appendix III). They were asked about their age, if they were dating anyone seriously, and if they were a practicing member of the LDS church. This criterion was defined as being both extrinsically and intrinsically religious (Bergin et al., 1987; Donahue, 1985; Johnson, 2004). In LDS theology being intrinsically religious is associated with belief in the basic tenets of the faith (Smith, 1842) and by participation in personal religious study (i.e. scripture reading) and worship (i.e. daily prayer, church and temple attendance). An LDS person would be extrinsically religious if they were, what is called, "temple worthy" which means they uphold all of the standards of the church (i.e. do not drink alcohol, do not engage in pre-marital sex, pay 10% of their income to the LDS church, etc.). Having participants define themselves as a practicing member of the LDS church could have produced a wide range of religiosity amongst the participants; however, all but one participant identified themselves as both intrinsically and extrinsically religious.

I did not administer any formal depression assessment. Having participants self-diagnose themselves with depression produced a sample of women who had/ were experiencing varying degrees of depressive symptoms, but I felt it was important to honor their perception of what they had/were experiencing since the aim of my study was to understand their reality. In the course of the interview, I asked questions about how they first became aware they were depressed and if they experienced any of the DSM-IV criteria for depression; thus, I gathered information about their symptoms and level of depression.

Data Collection and Analysis

Boss and Colleagues (1996), in a chapter on phenomenology, stated that, "All data are words about experiences and meanings" (p.95); therefore, I conducted semi-structured interviews with the participants to elicit the story about their struggle with depression and how they viewed their experience. Before beginning each interview, I presented the participants with an informed consent form, which explained the nature of qualitative research and the efforts that were made to maintain anonymity in the reporting of my findings. Each interview then began with me asking the participant to "tell me when/ how you first realized you were depressed". I engaged in reflexive listening to elicit the most detailed account of their experience, allowing each participant to "define the phenomenon in question rather than defining it for them" (Boss et al., 1996). Although the sample questions (see Appendix IV) were influenced by my pre-existing hypotheses, I remained open to the fact that what I thought was part of their experience may not have taken place. Because there may have been trepidation in voicing any negative experiences these women may have had seeking help from church leaders or doctrinal beliefs, I specifically asked about whether they felt the LDS doctrines or church leaders had not been helpful.

The interviews were audio recorded and then I transcribed them soon after the interview took place. By transcribing the interviews myself, I became more intimately acquainted with the data and gained a better sense of the whole of the interview (Boss et al., 1996). After the transcription process was complete I emailed the participants the transcribed interview to allow them to read through it and add to any of their responses or remove anything they felt jeopardized their anonymity; however, most of the participants

did not respond to this email and none of them changed anything in their transcribed interview. I read through the interview and pondered over the participant's words and then started from the beginning of the interview and read through the text categorizing phrases and statements. I used a software package called Atlas.ti to help with the coding process. Initially, the first few interviews were coded using an open-coding process. Then, as themes and patterns emerged, a selective coding process was used. The back and forth nature of data collection and analysis encouraged the use of emerging themes and patterns to guide subsequent interviews. Starting the transcription and data analysis processes soon after the actual interview helped to ensure that I had some patterns and themes to guide the subsequent interviews. As the data informed the interview process, the interview questions were continually adjusted in order to accurately capture these women's reality. This iterative process of analysis produced patterns that reflected both the variability and the commonalities in how these women have/were struggling with depression. According to Boss and Colleagues (1996) I did "not need to 'smooth out' discrepancies or inconsistencies but rather look for the meaning within them" (p.91).

Because I am a single, young, practicing LDS woman, I acknowledge the fact that I embarked upon this study with biases. I think being a single, 25-35 year old member of the LDS church is a stressful experience, which may be a contributing factor to depression. As much as we want to find a companion to share our lives with, there is only so much in our control. The LDS culture focuses intensely on marriage and family sometimes to the point where those without a spouse or children feel excluded and out of place. Therefore, I think being a single, young, practicing LDS woman is an experience which may lead to feeling powerless, hopeless, and undervalued— all symptoms of

depression. Going into this study I was also aware of my belief that the LDS doctrines are a support as we struggle through life. Although I think most LDS women struggling with depression draw strength from their spiritual resources and find that helpful, I remained open to the possibility that this might not have been the case. By checking in with my thesis chair, dialoguing about my reactions with a fellow student, and discussing my thoughts with various friends and colleagues, I tried to recognize when my biases were obstructing my view of the data. I also engaged in cross-coding with my thesis chair, the director of the Marriage and Family Therapy Master's program at Virginia Tech, to provide a perspective outside of the LDS frame of mind. Taking these precautions to be open and aware of myself in the research process aided in the purpose of this study: To explore how young, single, practicing LDS women struggle with depression.

CHAPTER FOUR: FINDINGS

Introduction

The purpose of this study was to explore how young, single, practicing LDS women experience and understand their struggles with depression. I wanted to gain insights into what it was like for them to be depressed, what helped and hindered in their struggles with depression (i.e. what (if any) resources they had used, how people in The Church, therapists, family/ friends had responded to their struggle with depression), how they understood their experience with depression from an LDS perspective, and what advice they would give to others struggling through a similar experience.

I interviewed six young, single, LDS women and then coded their interviews as the study progressed. All of their names have been changed to protect their confidentiality. The themes I will present in this chapter emerged during this iterative coding process. To help the reader understand my participants' world, I use their own words in presenting these themes. The purpose of the study is not to explain their experience, but to describe and explore it (Giorgi, 1985). Essentially, this chapter lays forth the results from my exploration into the experience and understanding of six young, single, LDS women's struggles with depression.

Terminology

I think it would be appropriate here for me to explain some other LDS terms. There are two different organizations in The Church that are designed specifically for men and women: Elders Quorum (men) and Relief Society (women), respectively. All of the leaders in The Church are "lay clergy". Bishops, the leader of the ward (or congregation) is always a man. He, along with several male counselors, oversees the

physical and spiritual functioning of the ward. The Relief Society is headed by a president, who is always a woman. She, along with several female counselors, leads the woman's organization. Each man in The Church is also a "hometeacher" and each woman a "visiting teacher". In these roles, they are assigned to visit, teach, and watch over certain members of their ward. The Spirit, also known as the Holy Ghost or Holy Spirit, is the third member of the Godhead. When each person is baptized a member of the LDS Church, they are blessed with the ability to have the Spirit with them always if they are doing what is right. The Spirit is associated with feelings of peace, love, joy, and patience. Hopefully, these definitions will make the following findings clearer.

Participants

My participants were all Caucasian women who had grown up in various parts of America and had moved to the DC metropolitan area for schooling, work, or to be closer to family. These women were between 24-31 years old. Every woman has, at least, some college-level education: one has her master's degree, two are pursuing masters degrees, two have bachelors degrees, and one is pursuing her bachelors degree. They are all employed in full-time white-collar jobs, except for one woman who is working part-time. None of them are dating anyone seriously. They all defined themselves as extrinsically religious (i.e. they are temple worthy, a.k.a. follow the standards of The Church) and all, but one participant, also identified herself as intrinsically religious (i.e. they have a testimony, read their scriptures, and have personal prayer). Four out of the six women served full-time missions for The Church and all but one attended a Church

Sponsored School[1] for their bachelor's degree. Names and other identifying information have been changed to protect the anonymity of the participants (see Table1).

Although these six women came from different parts of the United States, were raised in different home environments, were trained in a variety of disciplines, and were of various ages, there were similarities throughout their responses. Several spoke of the challenges of being a young adult female in The Church and in the 21st Century at large, many discussed the challenge of struggling with depression in a culture (LDS) that emphasizes happiness, all mentioned a friend, family member, Church leader, therapist, and/ or doctor they had reached out to and how that person had responded. Their responses portrayed a picture painted with words from their collective experiences—a picture I hope will not only inspire further understanding and a general awareness of this experience, but I hope will also be used as an impetus to enhance resources and increase empathic response for this difficult and pervasive struggle.

I found myself continually impressed by these young women who truly have struggled through this experience. To me, the word struggle in this instance connotes a pro-active, powerful battle for understanding, peace, and happiness. My participants

[1] The phrase "Church Sponsored School" is used throughout this paper to substitute for the name of the actual school the participants attended. There are several universities sponsored by the LDS Church.

Table 1

Name	Age	Schooling		Attended Church Sponsored School	Served a Mission	Intrinsically Religious
Amy	31	Masters		Yes	Yes	Yes
Samantha	30	Pursuing Masters		Yes	Yes	Yes
Jessica	24	Bachelors		Yes	No	Yes
Kathy	26	Pursuing Bachelors		No	Yes	Yes
Leslie	25	Pursuing Masters		Yes	No	No
Mary	30	Bachelors		Yes	Yes	Yes

have discovered what it is they are struggling with (depression), reached out to various resources along the way, and are stepping forward to share their stories in an attempt to help others. In this chapter you will see, through the words of these women, their faith, insight, courage, and endurance as they describe their experience and understanding of their struggle with depression.

Participants' Timelines

Before outlining the major themes and in order for the reader to have a more complete picture of their experience, I want to provide a brief description of each young woman's timeline. The following vignettes include at what point in their life they were struggling with depression, how long they struggled, and who they reached out to.

Amy

Amy is a thirty-one year old, masters graduate who is both extrinsically and intrinsically religious. Even dating back to Junior High and High School, Amy described feeling depressed. During those times of feeling low, she would read her scriptures and pray, and she would feel better. In college she had times she felt down, but having good friends around her helped her feel better. Near the end of her college education she decided to serve a mission for The Church, deferred from school, and moved back home. It was then that she began experiencing a depression that would not go away when she prayed, read her scriptures, or talked with friends. Throughout her mission and afterwards she continued to struggle with depression, crying a lot, feeling unmotivated, isolating herself, and internalizing everything that happened. Amy sought counseling first at a Church Sponsored School through the free counseling services they offered to students; however, she didn't feel that it was beneficial and stopped going. Then, when

she moved to DC, still struggling with depressive symptoms, she started taking an antidepressant and seeing a therapist again. Along the way, some church leaders have been aware of her struggle. She describes her current state of depression as being "up and down".

Samantha

Samantha is a thirty year old single woman who is currently pursuing her masters degree. She identifies herself as one who is temple worthy and participates in personal religious worship. Samantha was attending a Church Sponsored School at the time when she began experiencing symptoms of depression. She lost a lot of weight, was not sleeping very well, was unmotivated, felt numb to spiritual feelings, and was extremely sad and hopeless. A good friend noticed the drastic weight loss Samantha was experiencing and suggested she talk with the bishop. Her bishop referred her to the counseling services at a Church Sponsored School and she began seeing a therapist. This therapist then referred her to a general physician because of the physical symptoms she was having who then put her on antidepressants. Samantha continued to see a therapist and attend therapy groups for her last two years at a Church Sponsored School. She stopped taking antidepressants and moved to DC. Once there she continued to experience mild depressive symptoms, continued to seek therapy, and was able to keep herself from becoming depressed. She was eating right, walking almost every day, and learning more about her depressive thinking. More recently she experienced a major depressive episode and was unable to pull herself out. Both friends and Church leaders were aware of her struggle. She hesitated to go back on antidepressants, but eventually hit rock bottom and started taking them again. Samantha recognizes that she will have

ups and downs with depression throughout her life and feels more confident in her abilities to reach out to the appropriate resources in a timely manner in the future.

Jessica

Jessica is a twenty-four year old college graduate who identities herself as one who follows the standards of The Church and has a testimony of its truthfulness. She also experienced her first depressive episode while attending a Church Sponsored School. Jessica describes experiencing changes in her eating and sleeping patterns, having low energy and motivation, feeling very sad and hopeless, and not wanting to socialize with others. After six months of intensely relying on the spiritual resources she had always found comfort from (i.e. scripture study, prayer, fasting, attending the temple, serving others, getting blessings), she talked with a friend who suggested Jessica seek therapy. This friend had experienced depression and was very attuned to Jessica's experience. Jessica also counseled with her bishop during the process of figuring out why she was not receiving relief from all of the spiritual resources she was using. For her last two months at a Church Sponsored School, Jessica saw a therapist and gained more understanding of what depression was. She also saw a general physician who started her on antidepressants. At the end of that college semester, Jessica moved to DC. Just four or five months ago, Jessica began to see a therapist again because she felt like she had just gotten started in her work in therapy. She hates taking the medication and, because she has been feeling so good lately, she has decided to stop taking it. The next time she experiences depression, instead of exhausting her spiritual energies and then turning towards medication and therapy, Jessica is now adamant about using both the spiritual

and secular resources together. She is convinced that the best process to recovery is to combine the spiritual and secular resources.

Kathy

Kathy is a twenty-six year old single woman pursuing her bachelors degree. She identifies herself as one who is both extrinsically and intrinsically religious. A few years ago Kathy returned home from her mission, moved out of her parents' house, and started college again. She found herself very lonely and out of sync with the expectations she had had for herself; thus, despite all of her efforts to be a faithful Latter-day Saint, she was very unhappy and discontent. Several years before Kathy experienced depression she had been very involved in helping a friend who was struggling with depression. This past experience allowed Kathy to recognize early on that the feelings of sadness and loss of motivation she was feeling were depression. During the three months of her "period of darkness" as she referred to it, she was in contact with a good friend who was a social worker. The support of her friend in validating and normalizing how Kathy felt, plus the hope Kathy had that if she kept doing what was right she would eventually feel happy again, helped her to keep going and emerge from the darkness. Kathy explained that even though her family was close by she did not reach out to them because her mom was struggling with depression herself and Kathy did not want to be a burden at all. She says that after her own experience in struggling with depression, she is able to be more compassionate and empathic to others.

Leslie

Leslie is a twenty-five year old, single woman pursuing her masters degree. She identifies herself as one who follows the standards of The Church, but who does not

participate in personal forms of worship. Leslie first experienced depression when she was in her last year at a Church Sponsored School, following a break-up with a boy she had been dating. For six to eight months she cried and slept and ate all the time. Even though she did not live close by her family, her mom was her biggest support during this time. She received counseling from the services at a Church Sponsored School, graduated, moved home to work for a few years, and then transferred with her employer to a job out in DC. A year and a half ago she experienced a traumatic event regarding the boy she was in love with, which triggered another serious depressive episode. During the more recent bout with depression just knowing her family members loved her, even if they did not understand the depression, sustained and comforted her. Leslie tried to reach out to church leaders, but felt misunderstood and pushed aside. She started taking antidepressants so she could function and is now considering seeing a therapist again.

Mary

Mary is a thirty year old college graduate who identifies herself as one who is temple worthy and has personal prayer and scripture study. Growing up, Mary witnessed her mom's depression and resistance to taking medication and had also seen a sister-in-law who had experienced depression. Recently she had broken up with a boyfriend who had struggled with depression. Thus, when Mary felt very unhappy, experienced changes in her eating and sleeping habits, and was crying all of the time, both she and her sister-in-law recognized that Mary was struggling with depression. The most disturbing impact of the depression to Mary was that she could not feel the Spirit like she used to. She consulted her doctor and started taking antidepressants. Then she moved to DC, found a new job, and settled into her new home. Several months passed and Mary began to

realize that she still was not all the way out of the hole of depression. She went back on antidepressants, tried seeing a therapist, read several psycho-educational books, and talked with various friends and family members. Mary now feels like she is back to where she wants to be, she is able to feel the Spirit and receive the comfort, peace, and happiness associated with it, and she is in a place where she wants to reach out and help others who are struggling with depression.

Major Themes

As I pondered the responses from these six women, the picture painted before my view was one of a process of the experience of depression for young, single, LDS women. At the core of this process, and at each layer, is the struggle to make sense of the experience. This process is interwoven with culture at every stage—the expectations, the stigma, and the "contradiction" (i.e. how can a righteous LDS person be unhappy?). Although the following short descriptions of each stage in this process are presented in a step-by-step manner, I want to be clear about the fact that this is not a linear process where one stage inevitably and always follows the previous stage, and only one stage happens at time. However, for the purposes of presenting the process to the reader, it will be laid out as a step-by-step progression.

Essentially, the overall message that was conveyed painted the following picture of what an episode of depression is like for, and how it is understood by, young, single, LDS women. First, there emerged the sense that something was not quite right/that something was going wrong. Next, these women made initial attempts to right this wrong using resources they had used in the past when going through difficult experiences. When these attempts did not produce the results they had in the past, these

women internalized everything, blaming themselves for the unhappiness they were feeling. Then, they, and often others around them, had an epiphany identifying that they were depressed. With this awareness of what was going on, these women chose whether or not to reach out to family, friends, church leaders, the Gospel, medication, and therapists. Most then experienced some relief and the depressive symptoms subsided. Subsequently, some had a second epiphany, sought the same or different resources than the first time, and then experienced more complete recovery. All of these women mentioned the fact that they wanted to share their story with others; hence, they participated in this study. Some also spoke about lessons they had learned through their experience. As I stated before, throughout this process was interwoven the thread of culture which colored the way these women explained their experience to themselves and others at each stage.

Something Is Not Quite Right/Something Is Going Wrong

Descriptions of Depression

To begin each interview, I asked each woman how she had realized she was depressed and, almost inevitably, every woman's response included detailed descriptions of what it felt like to be struggling with depression and how that was a marked difference from how they usually felt.

Physical, emotional, and social symptoms. The women's responses often included descriptions of feeling numb, devastated or empty, not feeling happy, crying a lot, and not being able to move on from past/ present life events. They also often described their experience saying they felt like they did not have control over their

bodies, they felt heavy, and that everything was darkness. A common metaphor for depression that several of the women alluded to was that of being stuck in a hole.

> Mary: "I just wasn't happy. Everything was dark…I definitely had different sleep patterns. It was hard for me to fall asleep…just not excited to face a new day, crying a lot, and just not getting over some things in the past in my life. So, just heavy, is the way I can describe it. My body feeling heavy…just kind of on a sub-level of living…just down in this hole you can't get yourself out of all by yourself."
>
> Jessica: "Your mood can affect you so much to the point where you just don't have the energy to do the things you're supposed to do throughout your day. I guess I wish that people understood that it's not just that you feel blue. You don't feel like you have control over your body because you don't feel like you have control over anything. You just feel like all of the forces of nature are keeping your mood and body down and separated from everything else."

These women described hopelessness as one of the more prominent feelings involved in depression—a sense that there is no end, no way out, that life will always be this hard and this awful.

> Leslie: "That's another thing about depression—you keep thinking, 'I've hit rock bottom. This has to be the bottom. I can't imagine being any lower.' And the next day, you're lower, and the next day you're lower, and the next day you're lower…there's no end to it…there's no end to the unhappiness and the despair and this emptiness…there's no end to it, no bottom you can hit and bounce back from."

These women also often experienced a loss of motivation and interest in things that used to make them happy. They described not being able to feel happy when normally they would have been happy and feeling lower than usual when bad things happened in life.

> Amy: "Things weren't going right. I was losing lots of weight…not eating and not being able to sleep…just knowing there was something wrong…nothing was going right…not expecting anything to go right in my life…a hopeless feeling…There was a sadness, the hopelessness, and not wanting to do anything—just giving up on things. Not going to class, sleeping in because I couldn't sleep at night so I would sleep in the morning. Just not doing the things I normally did."
>
> Jessica: "It's not being resilient to the things that happen in your life. The good things that happen don't make you happy—the things that normally make you happy…I just was kind of numb…things that should have been slightly upsetting were devastating. And I didn't enjoy things…There was the sleeping thing and the change in my behavior from things I enjoyed to not being able to do that and mostly just feeling completely hopeless and not feeling any sort of relief from anything."

Cognitive symptoms. Not only did these women describe the emotional pains of depression, but they also discussed the way their minds functioned differently when they were experiencing depression.

> Samantha: "I had a roommate I didn't get along with very well and we ended up going to live in different places after some big blow-outs. One of the things she said before we split ways was that she didn't understand me at all and that 'maybe

you're just depressed'. I didn't, at that time, feel depressed. I felt normal, I guess, but it made me think as I did get seriously depressed that maybe some of my reactions to people, my thought processes, are self-defeating even if I don't really feel down. I guess it's made me come to think that depression isn't always feeling depressed, it's how you view the world."

Leslie: "It's like this cloud and you only see that part of your life. When I'm not depressed I can see beginning to end and everything is clear: 'This may be a rough patch, but I can definitely see the end of it'. But, when I'm depressed I can't. I only see the darkness around me and that's completely normal to me. My life sucks and that's the way it's always been and the way it's always going to be."

Spiritual symptoms. Interwoven in all of the women's descriptions of the emotional, physical, and cognitive signs and symptoms of depression were descriptions about how the depression had affected them spiritually. Most often, these women talked about not feeling the Spirit (a.k.a. the Holy Spirit/ Holy Ghost) and how awful it had been to not receive the guidance and comfort they associated with feeling the Spirit.

Jessica: "I (usually) have that peaceful feeling-but I wasn't feeling it. I wasn't feeling that peace I normally felt knowing that my life was in accordance to God's laws…it's like that peace was gone."

Leslie: "I'm just hanging on until that day when I'm not depressed and things do make sense again and when I can feel the spirit touching me because right now I can't. I cannot feel God's presence in my life. I know it's there-I know up here in my head, but I don't feel it."

Amy: “There are a lot of spiritual things when you’re depressed…I just don’t, I can’t, feel the Spirit when I’m depressed which is frustrating because then you don’t know if what you’re doing is right...a lot of people tell me, ‘Just pray and read your scriptures.’ Usually, when most people do that, they do feel the Spirit, but when you’re depressed you just don’t. You might be doing all of the things that are right, but you still feel nothing.”

Above everything else, as Mary struggled with depression she wanted to have the spiritual part of her life back on track.

“The most important thing to me was feeling the spirit again in my life, and I’ve definitely felt it again. That has been huge to me. It has come and gone, and hasn’t come back the way I wanted it to, but I think that’s a whole other ballpark…but, that was the key thing to me that I wanted back…that I could feel the Spirit again and feel good when I was reading my scriptures or going to church.”

Initial Attempts to Deal with the Depressive Symptoms

As each woman described the ways they felt physically, emotionally, socially, cognitively, and spiritually, they also described what they did to cope and deal with the situation. Most first turned to religious activities that had brought peace and happiness in the past. When that failed to work, they blamed themselves for their unhappy state and the failure of their faith attempts. Some became exhausted spiritually, while others continued to engage in religious activities even though they were not feeling the peace and happiness they were seeking.

Do More of What Has Worked in the Past: Faith Attempts

These women described the steps they took to try and feel the Spirit and restore the peace and happiness they had previously felt in their lives. Leslie describes everything she was doing in order to feel the Spirit and climb out of the hole of depression.

> "I'd go to the temple every week and read scriptures for an hour a day. I fasted at least twice a week…I was so focused…I checked off every single box you can possibly think of! I was praying all of the time."

In the following quote from Mary, the reader can imagine the exasperated tone with which she described doing things she thought would make her happy, but still not achieving the desired results.

> "Going back to the things I had been taught that would help make you happy weren't making me happy. I was going to church anyway, even though I wasn't excited to be there. I was going because I knew it was the right place to be, but I really didn't enjoy it. Scripture reading, I was doing…like I said, I was doing all of the things I had been told—scripture reading, prayer—all of those things and those weren't snapping me out of the mood like I think they would have normally."

Blaming Self for the Depression and Failed Attempts

In the LDS Church, the belief is that if one is living in accordance with God's laws, one will have the companionship of the Holy Ghost with them always (and, consequently, they will feel peace, happiness, love, joy); thus, if one does not feel the Spirit, it is natural to go through a period of self-introspection in order to examine if there

is anything in one's life not in accordance with God's laws. Upon finding themselves in this circumstance where they were not feeling the Spirit even after doing more of those things that normally helped them feel an increase of the Spirit, these women looked inward thinking that it was something they were doing wrong that was causing them to feel unhappy, hopeless, and separated from their God.

> Amy: "there are a lot of spiritual things when you're depressed. I mean, you worry about a lot of things…you don't think you're as good as you should be, you're not doing the things you're supposed to."
>
> Samantha: "Throughout my mission…my mission was hard because I struggled with companions and I struggled with how I felt, but I never really identified it as being depression. I just thought I was doing something wrong, or that I had done something wrong, or that I shouldn't have gone on a mission."

Jessica and Mary both described the frustrating and confusing experience of (1) having learned in The Church that if you cannot feel the Spirit it must be something you are doing wrong and (2) not being able to find anything in their lives that would be a wrong big enough to prevent them from having access to the Spirit.

> Jessica: "I didn't think that the reason I was so down was a separate issue [apart from being a spiritual issue]. With my experience in The Church, they teach you to pray and to study and all of these things, and I was feeling so low that I was constantly praying and constantly studying and doing supplemental studying and I still was not feeling any relief or comfort or anything like that. I started thinking that maybe I had too many negative influences in my life…Because of what we're taught in The Church—that if you're doing the things you know you should be

doing, then you'll be happy—I thought, 'What is wrong with me? What am I doing wrong?' And I didn't understand it."

Mary: "I'm righteous, I'm doing all the things I'm supposed to and I can't feel the way I've been told I should be able to feel…because you're told that if you can't feel the spirit that you have some things you have to repent of. And I'm sitting here going, okay, there are the little daily things a person has to repent of, but not any of the big sins that you are told of that you need to repent for. And, um, just really freaking out, actually because every time you listen in conference you hear, 'if you can't feel the spirit you need to repent.'"

Spiritually Spent

A few women spoke not only about the frustration they felt as a result of these vain attempts to address the depression through increased involvement in their faith, but also a negative, adverse response to the spiritual resources they had turned to.

Jessica: "I've been doing this for months and months and it had just gotten worse and worse and worse. I felt like the more I put my heart into it and do the right things and be close to the Spirit-I don't know-I was just getting more and more depressed.… I was just spiritually spent…I guess I had a negative feeling about all of the effort I'd put in that felt so fruitless…And I would still pray and I had faith-it's not like it shook my testimony at all. It was just my effort-I just didn't have the energy to do that. I thought, "I know I should be doing this and I know that it would help, I just can't right now" is how I felt. …it was almost more depressing, pushing me further and further down because I felt like I was just so far away from that and that no matter how hard I tried there was no way I could

become this person that they teach us in the Church that we can become. There's no effect and it makes you even more depressed."

Endure

Some women described how they had continued on in doing those things they knew were right, even though they were not achieving the desired effects, because they knew at some point they would feel the Spirit like they used to. Amy describes why she kept drawing upon those spiritual resources even when they were not working like they had before.

Amy: "I think a lot of it has just been some really good experiences I've had with the Spirit teaching me things-things I know are true, some base things. And those have been strong enough that even when I'm really depressed, and I question them somewhat, they're strong enough experiences that I know they're true and I figure out what's going on… And I think a lot of time to pull me out of it, what's helped is feeling the Savior's love…Just keep going and doing it and eventually you'll feel something sometime."

Kathy explained that she was able to continue to use the Gospel as a support because she drew upon the feelings she had felt in the past and the hope she had that she would feel them again.

Kathy: "Just knowing the fact that everything was going to be okay in the long run because of my faith in Jesus Christ and everything He has done in the terms of all Christianity, that I was okay because my sins were taken care of-so, I was going to be fine in that sense. I wasn't this horrible sinner…And the Spirit-having peace within myself, peace in my heart that everything is going to be

fine…it was the knowledge and the past feelings I'd had-those past feelings of peace that I knew I'd felt before…Even though you don't feel them I think you will eventually…Sometimes you just have to hold on-you have to hold on tight-and kind of keep going."

The "Contradiction"

Somewhere amidst this process of these young, single, LDS women's experiences with depression, they come face to face with a very blatant "contradiction": the doctrine of The Church teaches that if you are doing the things you need to be doing (e.g. reading your scriptures, praying, going to church, keeping the standards of The Church) you are going to be happy and that you are going to have peace; yet, these women found themselves in a situation where this was not true (i.e. they were not feeling those feelings anymore even though they were still doing the things they needed to be doing). After I presented this "contradiction" to each of the women, I asked what their thoughts were. Most said, "This is something I've thought about a lot." In response to this interview question, I received some of the most insightful, articulate, and faithful answers; in addition, interestingly enough, interwoven throughout their responses are also the hints of many still lingering questions, confusions, and wonderings.

Jessica: I mean, obviously depression exists and, to me, obviously the Church is true. Those two facts can co-exist…I've been on both sides-I know that the Church is true, and I know how I felt. So, I know they co-exist. I don't know why or what it means or what the purpose is. I just know that it's possible."

Samantha found some comfort in relating her experience to the experiences of ancient and modern-day leaders in The Church:

> "I guess that's one thing I'm still waiting for an answer on…cognitively it doesn't really make sense. At the same time I can see that the Lord is blessing me. For a while it's not very clear. I guess we have to go through trials in this life. It (the Gospel) doesn't say we'll be happy all the time. Even Joseph Smith, like in the scripture at the end of Doctrine and Covenants, "The Son of Man hath descended below all this; art thou greater than he?" You have to understand that Joseph Smith must have gone pretty low and we can go pretty low and it wasn't because he was doing anything wrong. And even as you read Job and I was reading Jeremiah…I guess it's a different kind of peace. It's not like you'll be happy all the time. You have to go through your trials and maybe this is just a trial for a lot of people."

Mary's response provides us an inside glance into her internal dialogue regarding this "contradiction":

> "I don't' know if I've made sense of it yet. Umm, definitely gone through some very angry phases of-'I'm righteous, I'm doing all the things I'm supposed to and I can't feel the way I've been told I should be able to feel'…And, I think maybe coming to terms in a sense and realizing that depression affects the ability of your emotions-how you feel and how you act and stuff like that…that's the reconciliation, that it had nothing to do with sinning…and knowing that it had everything to do with how I felt…of course, I still have questions of, "Okay, this doesn't quite seem to jive with some promises we've been given". And so, I'm still working with that-still trying to reconcile that."

Kathy's words are filled with encouragement, hope, and the wisdom of retrospection:

"Sometimes you're going to have times in your life when you're weaker than other times…I just think that even though sometimes you're doing the things you know are right and you're supposed to-you're going to the temple, you're going to church every Sunday, you're reading your scriptures and you're praying even though you're not feeling it…even though you don't feel them I think you will eventually. There are blank times in our lives when we just have to go through these little channels of nothingness so we can appreciate the other times, the good times, the feelings of peace and satisfaction. I think it happens to everyone. I don't really know why it happens. It's a challenge, it's another trial we face in our lives. But I think they're important-they test you-to see if you're going to continue to move forward and keep going to church and keep reading your scriptures even though you're not getting the results you would want."

Epiphany: Awareness and Discovery

All of the women commented on some instances of "ah-ha" moments that began to shed a little light into the darkness of the depression. Whether they talked to a friend, saw a therapist, read some books, had a better understanding of some Gospel principles, noticed the effects of medication, and/or related to an experience of a family member or friend struggling with depression, each women came to a point when they realized, "This is not a spiritual problem, and it is not my fault—there is something else at work here."

Having a mom, sister, and ex-boyfriend who had all struggled with depression helped Mary to recognize the signs and symptoms of depression in herself.

Mary: "I was a dating a guy who was struggling with depression and so I learned a lot of the symptoms of depression because of him. And I learned through

family members—for example, my mom and my sister-in-law who had struggled with depression themselves…I self-diagnosed myself…Because of my previous experience in seeing it in somebody else, I was able to see it more clearly…I had recognized some symptoms in myself that I had seen in my ex-boyfriend and knew that it needed to be taken care of and that there had been a history of it in my family."

Amy discovered that her sad, hopeless feelings were not a result of some sin when she started taking antidepressants. She noticed a big difference in her mood even though she continued to do the same things she had been doing prior to taking medication.

Amy: "I went on medicine again and within just a couple of weeks I was feeling better. I think it was because it was such a marked difference between trying really hard and not getting anywhere and then having the medicine and doing the same things and getting somewhere that made the difference and helped me realize that it's not necessarily me that's doing it. There's something else there…I did the same things on both sides of the medication, but it (scripture study, prayer, etc) wasn't working before, and after the medication it was."

A moment of increased awareness for Jessica came during a church meeting when she realized she had been doing the same things others were doing, but not achieving similar results.

Jessica: "One of the turning points for me in starting to explore that maybe there was something else wrong with me [other than a spiritual problem]—I remember sitting in a Sacrament meeting, a fast and testimony meeting, and everybody got up and talked about how they had this trial in their life or that trial in their life, but

> they felt comforted and they felt the power of the Atonement in their life and they said a prayer and did this or that. I kept thinking about how much effort I was putting into being a better person and I went in the bathroom and cried for the next two hours of church."

As she continued to explore what might be contributing to the depression, she sought help from a therapist and discovered more about what had been affected her mood.

> Jessica: "I guess the way I explained it to myself…there's a disconnect in your brain from being able to feel the correct emotion, from being able to experience reality and what's in your heart, in your brain…Whatever happens in your brain just makes you numb to everything and more susceptible to pain. It was the numbness that made me think, 'Okay, there's a reason I'm not feeling the spirit. It's because I'm numb to everything good, everything happy.'…Realizing that there was something that wasn't just emotional, that it was something I didn't have control over, that it was an actual medical condition-that has to do with emotion, which still kind of blows my mind that that exists. It was a relief, I guess."

Reaching Out

Who They Reach Out to and Why

After realizing that it was depression they were struggling with, these women reached out to various resources: family and friends, doctors and medication, therapists, church leaders, and Gospel doctrines. They had both positive and negative experiences as they went to people for comfort, advice, and counsel. Most of the women talked about

why they chose to reach out to one person and not another. They explained to me the delicacy of discussing their experience of struggling with depression with someone.

> Mary: "I've been careful about who I've told and most everybody I've told have there own stories, even, of struggling with it, and so it's been positive in that way…you just don't want to randomly…you just don't know who's going to accept or reject the information you give them. So, umm, there's some people I felt like I could help them out if I told them and others because they've become my really good friends and I've felt comfortable telling them about it. You never know—not everyone has experience with depression and they don't all know how to handle it necessarily."

Leslie described the qualities and responses of someone she would want to reach out to:

> Leslie: "I want people to say, 'I don't understand what you're feeling, but I know it's real and it's very real to you and it's okay to feel that way. It's not going to last forever. We don't want you to feel that way forever, but we love you even though you are feeling that way. Just know that there's a light at the end of the tunnel. I can see it even though you can't see it. I know that there is.' (Cries) That's what would be helpful, rather than the, 'Don't feel that way' or 'You shouldn't feel that way' or 'Can't you see your blessings.'"

Kathy discussed some of the unhelpful ways people she had reached to had responded:

> "I never called up my friends and said, 'I'm depressed.' But, if I said something like, 'Oh, I'm depressed' they would say, 'You're okay.

> Everybody gets depressed and wants to eat chocolate and then you get over it.' But, no one picked up the other hints I was signaling out, like: 'I don't want to do anything. I'm bored, I'm sad.' They would just think of it as, 'You're just feeling sad right now. Tomorrow you'll be fine because you're such a happy person, you're fine.' But, really, I was really sad."

The stigma. Once again, interwoven in their experiences of reaching out are the threads of culture. In particular, they spoke of feeling the effects of a stigma attached to depression. Jessica asserts that she did not want to be "one of those people".

> Jessica: "And I'd had several friends who had been through it [depression] before and I am still surprised that I hadn't considered it earlier on. I think probably one of the reasons I hadn't considered it earlier on is because I do have so many friends [with depression]. And I'd thought what are the odds that everyone I know-and myself-have this pre-disposition, or you know, to depression. It just seemed too uncanny or just over-prescribed. You here all of these things in the news: Does everybody really need Prozac or is it just the quick fix to life's day-to-day problems? I thought, there's so many people that have it that I don't want to consider that as an option because I don't want to be one of those people who can't handle her own problems-that doesn't know how to deal with life. I didn't want to be that side of the Prozac spectrum."

Mary speaks to part of the stigma associated with depression: that a depressed person is a particular type of person who looks and acts a certain way. Mary's bishop

seemed to think that a person who seemed fine at church and was participating in the meetings would not be someone who was depressed.

> Mary: "I did go to the bishop here for a list of therapists and he had a list ready for me and was quite surprised that I was a person that would ask for it. I think that's another thing-depression strikes everyone and it's not obvious who's struggling with it...it didn't offend me at that time, but maybe it could have…I don't know…he was surprised…he felt like I was doing well enough at church…he was surprised I was struggling with depression. Just because somebody is coming to church every week or doing all of their callings, doesn't mean they're not struggling with depression."

Samantha describes not wanting to be treated differently by friends and family.

> Samantha: "People don't know how to treat some one who's depressed…I think it's kind of that you want to be able to help them…you're always trying to help them and you can't be a normal friend with them. I guess in some ways I just didn't want to have that. I'd rather isolate myself, which I guess really isn't the best thing, than have people treat me like a burden and someone they don't understand."

Amy identified shame as one of the parts of the stigma.

> Amy: "I think there's lots of shame with depression…I think it's because you're seen as a weakness and most people who see symptoms of depression see it as weakness and not doing Church well enough or not

being spiritual enough…so you're ashamed because people don't like to be seen as not being good."

Reaching Out to Family and Friends

Most of the women first reached out to family members or friends; however, they did not just blindly ask for help from any family member or friend. The experiences these women shared varied greatly about calling upon family and friends for help and support and teach a myriad of lessons about how to be a family member or friend to someone struggling with depression. Samantha succinctly describes her experience:

> "I tried talking to my dad, but he got frustrated and didn't know what was wrong."

Jessica explains that she chose to talk with her close friends instead of her family:

> "I didn't ever want to talk to my parents about it because-I don't know how your parents are, but my parents know that their kids have weaknesses and they feel that it's their job to encourage them to do better, which it is, but my parents' view of encouragement-they give healthy encouragement, but they also set their expectations really high. I know what their expectations are and I know what they're like when they're disappointed in me and I just didn't want to deal with it. So I didn't want to tell them I was sleeping for 15 hours out of every day."

Leslie received her biggest support from her family, even though they were across the country.

> "My mom would have to call me every morning to get me out of bed…My mom was great-just helping me function…I told my mom— and I was

away living at college at the time, so she didn't know I didn't get up in the morning—I told her, "I can't get out of bed today; I don't know what's wrong." And I'd be crying and no matter how much I knew I needed to get out of bed, I couldn't make myself do it-I couldn't face the day…I have a great support system at home with my family...and gradually I've told my brothers and sisters I'm depressed. And they're really supportive and call me or talk to me when I call them. They're all younger than me, so it's not like they really understand what I'm going through, but I know they love me, so… (cries)"

Jessica describes what it was about her friend that allowed her to open up about how she had been feeling:

"She's just a very close friend-the type that wouldn't think any less of me and she knows me for who I am, what my potential is. You know, just a real…the best kind of friend."

Kathy also reached out to a good friend who had some knowledge about mental health issues. She described how this friend's responses were much different than other friends' responses.

Kathy: "It got to the point that I turned a lot to a friend I have who is a social worker. I talked to her a lot and she really helped me through. Just having someone to talk to and tell me it was okay I was feeling these things, that it didn't mean I was a bad person or worthless, because I was a good person. Having someone I could vent all of the feelings I was feeling-that really helped me…and she's one of my best friends so I could

> just talk to her as a friend, but she had that background, so that helped…I think that helped a bit because I have other really good friends who I didn't talk to about it because they don't understand. It really helped that she had that background. It made me better able to talk to her and open up because I knew that she wouldn't think that I'm "psycho" or wouldn't tell me, 'It's okay' and 'Just move on'. She really understood that I was feeling these things and she understood that people do feel these things."

Samantha had a negative experience in reaching out to her home teacher and his roommate, who she had identified as friends. After she had shared with them that she was struggling with depression, they responded in ways that caused her to close off from opening up to them any further.

> Samantha: "In the case of my home teacher it [the stigma] proved to be somewhat founded because after that both he and his roommate who were my friends they, just in the things they would say showed, just didn't understand depression at all. My home teacher just tried and he was shy…his roommate would say, he must have told his roommate because his roommate would say things like, "Are you finding more friends now?" As if it was because I didn't have friends before that I was depressed…"I have friends, that's not why…" It just showed they didn't understand. And, when I'd talk about things my home teacher would just make these faces like he didn't understand. They would think it had to do with other things rather than an actual depression."

Reaching Out to Doctors and Medication

All but one participant consulted with her primary care physician and started taking an antidepressant. They described feeling initially nervous and unsure to share what they were feeling with their doctor. Mary was hesitant to go see her doctor, but after talking with family members and having good experiences in receiving support from them, she decided to go and seek his help.

> Mary: "I was very afraid of the doctor saying, 'No, you don't need anything, go home.' But, I felt lucky I burst into tears because in some days I felt no emotion and dead-pan and other days I was crying too much about dumb little things. I burst into tears while talking to him and he was very understanding and was willing to help me out, which I was really appreciative of."

The majority of the participants found medication to be helpful in relieving them of some depressive symptoms. Despite any cultural discouragement to depend on medication, as stated earlier, all but one participant received a course of antidepressants. Some spoke about side effects they did not like (e.g. lack of an interest in dating). Jessica spoke to the cultural influences that affected her desire to be on medication and seek that out as an option.

> Jessica: "I think in our church there's so much focus on being able to have control over our bodies. That's why we don't' drink alcohol, that's why we don't' drink coffee or use tobacco. You want to have control over our emotions and over your mind and so it's just a part of that. I want to have control over myself and that included control over my happiness and I

> don't want to have to take a pill to be able to get up in the morning to get up in the morning and take a shower and go to work. And then be able to come home, go to the gym, and still be pleasant. I'd like to be able to do that by myself."

Reaching Out to Therapists

All but one of the women sought help from a therapist at some point during their struggle with depression. Many have had interaction with more than one therapist and some who ended therapy at one point have recently started it again. They talked about what was helpful about therapy, the experience of reaching out to and LDS therapist, a Non-LDS therapist, and why they did not seek therapy.

In general what was helpful. Several of the women mentioned how helpful it was to talk with their therapist about the distorted thoughts they had when struggling with depression. Leslie commented that she liked to have her therapist point out unreasonable thoughts she expressed rather than dismissing them.

> Leslie: "…because sometimes when I'm depressed I am unreasonable. What's an example…Everything sucks and…and no one loves me. That's how I feel and I know those thought processes are wrong. Sometimes it's helpful to have that pointed out to me. 'Okay, you know that's really not…' and that helps me see that's not really the true thing."

Several of the women also mentioned the relief they felt when therapists helped them embrace their emotions. Amy asserted that one of the most important realizations she has received through therapy was that of being okay with a wide range of emotions, particularly anger.

> Amy: "It's [therapy] helping me acknowledge I have this wide range of emotions. I can't just be happy all of the time…It was more validation that it was okay for me to feel some of the things that I was feeling and that you can overcome them. That it's okay to feel angry sometimes-that maybe you're justified at being angry at some things, and being able to talk it out and express it because I'd kept so much inside and hadn't told anyone."

Reaching out to LDS therapists. For most of the women, it was important to them to have a therapist who was LDS so they would understand the cultural terminology. Repeatedly these women also brought up the point that an LDS therapist would encourage a healthy balance within the bounds of The Church rather than suggesting that The Church is the problem. Samantha describes this well when she said:

> Samantha: "Well, my life is The Church and I would worry if they [the therapist] weren't a member—that they would think…would try to discourage me from some practices and be thinking, 'Maybe some of your activities in The Church are doing this.' Whereas if they are LDS then they can help you find more balance within your beliefs…And as I have had an LDS therapist I've noticed it's good because my whole life is LDS. If they weren't I would feel like I was always having to explain to them, 'Well, I do this because of this and this means this'. If they are LDS they understand the lingo and what things mean. Like what's a visiting teacher or a home teacher?"

Jessica felt similarly and described more in detail the balance she felt her LDS therapists have helped her to find between being a faithful Latter-day Saint and setting realistic expectations for herself.

> Jessica: "It was important to me to have somebody who recognized the validity of the spiritual component in a person's life. I didn't want a person to respond, 'Don't you think you're being really hard on yourself. I mean, a Church that teaches you that you can be perfect. I'd be depressed too if I expected perfection out of myself!' It's been important for me to talk with somebody who understands what sort of feelings can cause depression, but also understands the expectations we put on ourselves through the Gospel should be realistic-and that there needs to be a balance between the two. How to not overwhelm ourselves with expectations of perfection, but also how to believe in our potential and our mission to come to the earth and experience life and to grow and develop and harness our natural man and all of those things."

Reaching out to non-LDS therapists. As stated earlier, most of the women talked about their experiences with LDS therapists; however, one of the women talked about some interactions she had with a therapist who was not a member of the LDS faith and how she wished her therapist had refrained from making hasty assumptions.

> Amy: "There was just a feeling near the end that she would have preferred me not to be so involved in the Church and that I needed to branch out from it. I mean, there are some valid points that I tend to serve too much and do too much for other people…there was an issue…she, instead of

> listening to me, jumped to the conclusion that I was just following something without thinking about myself. That I was just blindly kind of following the dictates of what was being dictated to me…I mean, yeah maybe it did create some of the depression, but understanding…just not jumping to conclusions."

Why one did not reach out. All but one of the women chose to see a therapist. Kathy explained why it was she did not reach out to a therapist when she said the following:

> Kathy: "I didn't want to go see somebody about it, a professional, either because I didn't think I needed to even though it never hurts to talk to somebody about your problems-someone who knows something about these things. But I just didn't want to. I thought, 'No, I'm not a depressed person, I'm a happy person so I'm not going to talk to anyone.' I guess my pride wouldn't let me, I mean, I thought, 'I don't need a therapist! Only weak people need therapists!' So, it was that kind of attitude that kept me from expressing…from showing the world that I was depressed. I just wanted to get through it and move forward. That was my attitude."

Reaching Out to Church Resources

As was pointed out earlier, most of these women initially reached out to the spiritual resources they had always found comfort, guidance, and peace from; however, as they struggled through the darkness of depression they could not feel the Spirit. Some, as was also mentioned previously, found themselves "spiritually spent" and were unable to continue to draw upon these spiritual resources until after their struggle with

depression was over, while others continued to call upon the support of church leaders and the gospel (aka beliefs) throughout their struggle.

The gospel. The majority of the women talked about turning to their beliefs for support; they described the gospel as their strength and stability during a time of feeling tossed about and weak. Kathy simply said that the Gospel had been her foundation through this hard time:

> Kathy: "Even though I wasn't really feeling anything, it was my foundation that helped me overcome it…I had grown up all of my life knowing I was a child of God and that I was worth something and that helps a lot. And, knowing that this life isn't everything and even how people say this life is a test and the things you go through are there to make you stronger and build you up. Just having that perspective…All of these Gospel principles…knowing that there is opposition in all things. And just because you're feeling opposition doesn't mean you're bad, it just means you're going through this so you can be prepared for something bigger…so you can become stronger, and just a better person, and become more refined. Those things really helped me."

A few of the women explained their experience of feeling both helped and hindered by the Gospel. Jessica stated:

> Jessica: "It's sort of a double-edged sword when you feel that low because you think, 'Exaltation, I can't even imagine.' It sort of gives you such a large spectrum that it's almost intimidating and can make you feel lower. But, like I said before, if you're trying to work through it and it's not that

> you're just sitting there with depression, then it can be part of the healing. Otherwise, like it was for me, it was almost more depressing, pushing me further and further down because I felt like I was just so far away from that and that no matter how hard I tried there was no way I could become this person that they teach us in the Church that we can become."

Going to church leaders. These women described experiences they had had in going to their church leaders for support and they explained how it would be most helpful for church leaders to respond. Samantha describes her experience in going to meet with her bishop about her struggle with depression. She found this interaction helpful because he realized he was not knowledgeable enough to counsel her and referred her to a therapist.

> Samantha: "When I was talking to my current bishop about counseling, he was at least knowledgeable enough to know, that even though he would love to counsel, he's been 'blown out of the water', is the phrase he used, that he would rather just refer us to counselors (laughs)…I think there's a lot of ignorance…not in a bad way, but they just don't know…They ask worthiness questions and try to figure out…and they say, 'It doesn't look like you've done anything really horrible'. And they give the basic answers: 'It sounds like you're doing everything you need to be doing.'"

Mary explained her fear of going to talk to her bishop and what she thinks would be most helpful:

> "I was afraid of them laughing me out of the office and saying, 'You're fine.' So, if I were to go to a bishop I would want that bishop to listen and

> say, ‘This is a real thing and you can go to a doctor and get help.’ I guess, for the bishop to be open to the fact that it’s something that’s a real struggle and that it isn’t something I can just read my scriptures and get over it kind of a thing-and have compassion for that, maybe. Sometimes it’s hard to have compassion for that when you don’t’ have the understanding.”

Kathy expressed some suggestions for how church leaders could respond in the most helpful way:

> Kathy: “I think the most important thing for bishops and RS presidents to know is that they need to be able to listen and not so ready to give advice, but just listen and support. I think those are the main things that can help people and that would help me. Because sometimes you don’t want to hear advice, and people can tell you you’re going to be fine and life is good and you’re just going through a phase. But, you don’t want to hear it because you’re not feeling that way. You feel sad and you feel like nothing is going to work out for you. You just want to talk about it and get it out there. So, I think people just need to be able to listen.”

The power of validating the experience repeatedly came up as a way specifically for church leaders, but also people in general, to be most helpful.

> Amy: “That’s the biggest one-not jumping to the conclusion that they can pull themselves out of it or that if they thought more positive they would feel better because it doesn’t work that way. Validation that they can feel depressed and not be a bad person.”

Several of the women expressed a desire to not only be validated, but to also have church leaders hold out hope for them that tomorrow is a brighter day.

> Kathy: "I think by expressing to the people that it's going to end-that's it's not a forever thing-you will feel good again. And to just keep doing all of the things you know to be right. Do all of those things that would help keep your testimony strong-read your scriptures, pray, go to church-keep doing all of those things…And let them know that it's okay to feel down every once in a while and it's okay to feel sad. But there's hope-there's always hope. I think to express the fact that there is hope is important because when you're depressed you feel pretty hopeless. Tomorrow is a brighter day-it's cliché, but that's important."

Leslie expressed her frustration and disappointment regarding the way she has had church leaders respond when she has reached out to them for help:

> Leslie: "They're just not very responsive…They think all depression stems from the fact that the Elders' Quorum isn't asking enough girls out. That's how it seems like they take it. You say, 'hey, I'm depressed' and they think, 'that's because you're single, you're not dating anyone, and you just have a negative attitude', or something like that, 'and maybe if you made yourself more available or more pretty or lost weight or something, the boys would pay attention to you. You need to be proactive about making yourself not depressed. Put yourself out there and I'm sure everything will solve itself.'"

She went on to describe a very helpful way her church leaders had tried to increase awareness about depression:

> "We had a lesson in Relief Society one time and…they had a girl who… had a masters in clinical psychology and she have a talk on depression…I enjoyed hearing that people understand it goes on more commonly than I think we'd all like to admit and it was an eye opener for those who don't think about depression because they don't have it. They realized it's out there and it's not just 'I'm down in the dumps because Johnny dumped me' or 'didn't ask me out last weekend'."

Amy agreed that increasing others' awareness about depression is very helpful.

> Amy: "I think more openness in the Church about it. I think the reason my ward is doing better at it is that my RS had a lesson about it, and how to get help, and where to go, because they felt it was something they needed to know about. Being open and direct that there is this issue will help."

Second Awareness

After reaching out, and continuing to draw upon those supports, and feeling better than they had, several women talked about a time when they experienced a second epiphany. At some point in their process of struggling with depression, even after having chased away some of the darkness, they realized they could be doing even better than they were doing—that full recovery still alluded them.

Mary says it took her a year or so before she was aware of the fact that she still had some steps to climb in order to get herself all the way out of the hole of depression.

> Mary: “Just a year ago I really decided I was going to get myself out of this all the way… And I thought I was doing better for a while, but I really wasn’t all the way back up and that’s when really said to myself, “I’m going to get all the way out”… I’m much better than I was (laugh). Uh, my experience has been-the first antidepressant I was on got me 80% out. I was better than I was and, at a point, I didn’t realize I could still be better.”

After discovering there was still more light ahead, these women kept doing more of what had been working (i.e. talking with friends, taking antidepressants, seeing therapists, etc.). Jessica explained why it was she started seeing a therapist again and how she is continuing to work on some beliefs and expectations that contributed to her struggle with depression.

> Jessica: “And when I left [a Church Sponsored School] I felt like I’d just skimmed the surface and uncovered all of these wounds, sort of, and I thought, ‘Now I need to work through them’. But I was moving and I really didn’t want to be in [city of a Church Sponsored School], so I went ahead and came out here and let them sit. And now I’ve started talking to a psychologist…I feel like I’m just starting now to go back and readdress some of those issues and see if I can’t change opinions or views or beliefs or expectations I should have of myself. And, expectations I should have from other people.”

Off-Time Transitions

I wondered how the LDS cultural emphasis on marriage was affecting these young, single women, so I asked how they viewed the interplay between being a young, single, LDS woman and struggling with depression. Some responded by talking about the larger culture and expectations for women these days. Some mentioned the disappointment they felt in not being where they thought they would be at a certain age. A few women spoke specifically about the emphasis placed on marriage in the LDS culture and how that had contributed to their depression. However, it was not the highlight of anyone's story. In fact, one woman, as quoted earlier, found it offensive when church leaders assumed this was a big factor in the depression.

Kathy talked at length about the expectations and perceptions 21st century society has about women and depression.

> Kathy: "I think in society, too, today's women are strong women. Even though depression is on the rise in women these days, I think a lot of women don't want to be stereotyped as the "depressed woman". No one wants to be the woman who's depressed all the time, so they'll try and cover it up even if they are depressed-they'll put on a smiling face and move forward even though they don't feel like they're meeting up to all of the expectations that are placed upon women these days because there are so many."

Kathy went on to talk about what she had anticipated her life would be like as she moved through her twenties.

> "I always thought when I was in high school that I'd graduate high school, go to school and be married before I got done with my bachelor's degree. You know, be married by 21. I wasn't even thinking of going on a mission when you're 21-that wasn't in my plans, it just kind of happened later when I decided to go. I always thought I'd be married by 25 because my mom was married by 25 and I always thought I was pretty liberal in my thinking. The fact that I was like, "Oh, yeah, I'll get married when I'm 25 and I'll be cool." But, then all of your friends are getting married…I guess there was that expectation and the fact that I wasn't dating anyone either and no one seemed to be interested in me-I just didn't feel like I was getting anywhere."

Mary explained how the expectations of The Church fit in with her experience in struggling with depression:

> Mary: "We have such an expectancy of certain things to happen in our lives in the LDS church and that I think is definitely geared toward marriage-I mean, as a single person geared toward marriage. There's other things different people face in the church at different stages in our lives. As a single person you're told-you can't progress any further because you're not married and therefore you're trying to find this perfect person-a companion who can match you and wants to be with you and you're continually trying to put yourself out there and when that doesn't

work, um, you yourself feel like you're a failure somehow. That's definitely where my depression has tied in."

Amy agreed that the expectations that exist within LDS culture contributed to her struggle with depression:

> Amy: "I can see some of the problems at work are being single and my age in the Church can lead to depression because of so much of what people think you should be doing at that age…Expectations…There have been times when it's really bothered me, but now I'm okay with it. It just depends on where I'm at. But, when I'm in the depression thinking, it will come to me, " Oh, you're just not good enough to get married. Heavenly Father isn't going to bless you with that. You must be doing something bad because you haven't been blessed with that." And, I start going on those lines and I can get really depressed. So, I think it contributes to it."

Spread the Word

Although each of the women seemed to be at their own point along this process of struggling with depression, in a sense they had all moved past the stigma enough to step forward and share their experience with others. Amy explained this in the following words:

> Amy: "Recently, in the last couple of years, I've really gotten to the point where I like to be very up front with everybody. And if people don't like it then it's a good weeding out factor for me to be able to say, 'I don't want to know you better'. I don't know where this has come from, but I'm a much more open person than I was before. Ten years ago I wouldn't

> have talked to anybody about anything…confident in myself and also this desire to want other people to know about it…That's my biggest thing-I think I'm kind of on this crusade now to let everyone know that it's okay…It's amazing-sometimes I'll just say it and all of a sudden people will talk to me about things they never would have. But, because I was willing to say it first…"

Samantha explained that she was now making a conscious effort to increase others' awareness of depression.

> Samantha: "With my counselor I list goals and one of the things I want to do is help people…I guess it's a natural thing where you want to help people once you've understand something yourself you want to go out and help other people overcome all of the stigmas because you understand them yourself…rather than perpetuate them.

I asked several of the women what words of advice or inspiration they would give to a room full of young, single, LDS women struggling with depression.

Kathy gave the following words of comfort and motivation:

> "I would just tell them to hold on-hold on with everything you have because it's hard and some days it feels like it's never going to end. It just feels like you're being beat up left and right, but just hold on as hard as you can even if you feel like you're being pulled-literally. Just keep holding on and that's the most important thing you can do. And it's okay. It will end, even if you don't see an end in sight. Keep holding on and eventually you will be all right. That's what I would say."

Samantha responded with a list of things that came to her mind:

> "The first things that come to my mind are patience and prayer. Some re-thinking. Going to see counselors and understanding your background. Not being hard on yourself and finding things to be grateful for. Understanding they're not the only ones and trying to see the whole picture. Just patience."

Lessons Learned

Several of the women described lessons they had learned through struggle with depression.

> Jessica: "…there's a purpose to being here and a purpose to all of these trials and you learn things-how to be compassionate. You learn a lot-you know what it feels like to feel so down. I feel much more open to other people's problems whatever they may be because people don't understand what I felt like and I don't understand what people feel like."

Likewise, Kathy talked about the fact that although the experience had been awful, there was good that came out of it too.

> Kathy: "Yeah, I mean, it really was darkness and it was horrible, and I wish that I wouldn't have had to have felt those feelings because it does set you back, you know? But, I am able to have a different perspective because I got through it. I guess that's the thing-I got through it, I'm fine, and when it happens again, if it happens again, I know what to do and I know who I can call. I mean, there are positive things that come out of every negative situation-I really believe that. Yeah, good things come out

of negative things all the time. We just have to have the perspective we need to see them."

CHAPTER FIVE: DISCUSSION

Overview

The purpose of this study was to explore how young, single, practicing LDS women experience and understand their struggle with depression. I interviewed six single LDS women between the ages of 24 and 31 about what the experience of struggling with depression had been like and how they viewed that experience. Through this phenomenological exploration, I sought to know how these women perceived, understood, and dealt with their struggle with depression— what it meant to them, how it affected them, what they thought about it, and what they had done/ were doing about it. Guided by phenomenology, this study uncovered how a sample of young, single, practicing LDS women perceive, describe, feel about, make sense of, and talk with others about their struggle with depression.

In chapter two I reviewed the current literature regarding women and depression, attempting to, like an onion, peel away the layers of this phenomenon: depression in general, being a woman struggling with depression, being a young adult struggling with depression, and depression within the LDS culture. In chapter four my findings were presented, rich with the scent of all of the layers of the onion. Most poignant, and I think the essence of this phenomenon of depression within a sample of young, single, LDS women, is the innermost layer of culture. Like the Balinese, Kaluli in Papua New Guinea, or the Chinese whose experience and expression of depression are influenced by their culture, the LDS culture appears to be the overriding influence for these young, single, LDS women in their experience in struggling with depression. In this chapter, I will present some highlights of the process I identified in chapter four and discuss both

those findings that corroborate with the current literature and those that are unique, so as to enable clinicians and clergy to be more helpful to young, single, LDS women struggling with depression. I will also attempt to describe these women's experience through the cultural lens of the LDS Church.

The Outer Layer

Depression in General

As was expected, one part of this phenomenon of depression in young, single, LDS women was the cognitive, emotional, and physical depressive symptoms. Each of the women's descriptions of their symptoms when they were struggling with depression was included in the DSM-IV criteria for depression, including sadness, tearfulness, loss of interest, motivation, and energy, changes in eating/ sleeping patterns, and increased feelings of guilt and worthlessness. Several of the women, like most of the literature on depression, pointed out that being clinically depressed is distinctly different from just feeling the normal blues we all feel from time to time. As in the DSM-IV, these women experienced a marked difference from their normal way of being, including physical, emotional, cognitive, and social functioning.

Several of the women talked about depression in terms that resonated with the psychoanalytic perspective of depression: that it is anger turned inward (Wetzel, 1994). All of them described a family member, mother, sister, cousins, or aunts who had struggled with depression and all identified some unhealthy thought patterns they felt like they had learned. This familial link and these learned thought patterns support Peter Whybrow's concept of the "neurobiological Achilles heel" (Schrof & Schultz, 1999):

some people are more vulnerable to depression when stressful life events occur because of a biological/cognitive predisposition.

A Spiritual Component

Not only did every woman's description of depression meet the DSM-IV criteria for depression, but their descriptions also included a spiritual component. Like the evidence Kleinman and Good (1985) found to support the fact that depressive symptoms have "dramatically different meaning and form of expression in different societies" (p.2) these LDS women often described experiencing depression as a spiritual deprivation. LDS doctrine teaches that each worthy member of The Church has access to the power of the Holy Ghost (a.k.a. the Spirit) which brings Divine guidance, light, peace, affirmations, love, and joy among other things (LDS, 1997). These women identified a stark contrast between having felt the Spirit pre-depression, and then becoming numb and void of all spiritual feelings while struggling with depression. Several of the women tearfully talked about the dark depths of depression, wherein they had not been able to feel or see the peace and light of the Spirit. Implications for clinicians and clergy include recognizing how depression affects LDS clients' spiritual functioning and the importance they place upon feeling the Spirit.

The Layers In-between

Young and Single in The Church

I had originally thought that a big contributing factor to these young, single, LDS women's struggle with depression was the fact that they were not married. Although this did surface as a stressor, it was not the focal point of any woman's story. As it turns out,

this is only one of many pieces involved in these women's experience. They each acknowledged this was a part, some saying they had thoughts about not being good enough to get married, etc., but almost dismissed it as if every young, single, woman in The Church was dealing with that stressor so it was not unique to their situation. In fact, as mentioned in chapter four, one woman found it insulting when people assumed she was depressed because she was single and not dating anyone. It appears important to be aware of the LDS cultural expectations regarding marriage and family, but to not assume that a young, single, LDS woman is depressed because she is single.

Interestingly, it seemed that the sample of young, single, LDS women in this study relied upon their friends and family members for the support some researchers concluded came from a spouse (Burns, Sayers, and Moras, 1994; Haarasilta et al., 2004). Burns et al. suggest the presence of a supportive, caring, empathic spouse is a powerful resource when one is healing from a depressive episode. Despite the lack of a spousal relationship, all of the women in this study benefited from relationships that offered support, caring, and empathy in the absence of a spouse.

A 21st Century Woman

The expectations participants discussed were not only those associated with The Church, but also included societal expectations of American women in the 21st century. As Wetzel (1994) described it, many women suffer from symptoms including sadness, anxiety, irritability, hopelessness, worthlessness, helplessness, inappropriate guilt, problems with concentrating and decision-making, rumination about the self, future, and current situations, lack of interest, withdrawal, and thoughts of death or suicide, but often they will mask their depressive symptoms behind a cheerful face because they have been

socialized to “smile at all costs” (p.87). This socialization is complicated even further for these young, single, LDS women struggling with depression because their culture expects that they will be happy, peaceful, and calm.

The Inner Layer: LDS Culture

As mentioned earlier, the women in this study made sense of their experience namely through the lens of the LDS culture. There appears to be a complicated interplay between depression and the LDS culture. Despite this complexity, or I should say because of it, these women portrayed considerable resilience. Their stories conveyed a humble strength void of any bravado or self-righteousness, faith interlaced with questions, patience and insight forged out of experience, compassion and empathy for others who might be struggling with depression, and a vision for how they will approach depression in the future. I believe that, as Kleinman and Good (1985) defined it, culture is “the intersection of meaning and experience” (p.8). Phenomenologically speaking, this sample of young, single, LDS women, lived their experience and essentially made sense of it by examining how it fit with truths they believed in; and, when it did not instantly fit or make sense, they decided to have faith, be patient, and continue on obediently until a day when it would.

The idea surfaced that it would have been difficult for me if my participants had not identified themselves as intrinsically religious—essentially, if my participants had not been the type of person who chugs through life with faith. In other words, if the six women I interviewed had described their experience and understanding of that experience in a tone that was more negative, blaming, and antagonistic towards The Church and doctrines therein, I would have been faced with the challenge of understanding their

worldview when it was so different, and maybe even offensive, to mine. This is only a hypothetical musing since this situation did not occur, but one that is interesting to consider, especially because my study is guided by phenomenology.

In this section I will present themes that emerged as a result of the interaction between depression and the LDS culture. First I will discuss two patterns of thought characteristic of both depression and the LDS culture. Then, I will present the effects the LDS culture has on the management and expression of emotion in The Church. Lastly, I will discuss resilience from an LDS perspective.

Self-Introspection

On their journey towards understanding their experience, participants noticed they were not feeling the spirit, turned towards religious practices that had worked for them in the past, and, not receiving any relief from their unhappiness, began to look at their daily thoughts and actions to see what they could change. This process of self-introspection is common for members of the LDS Church (a.k.a. repentance); however, this practice of examining, judging, and teasing out one's strengths and weaknesses takes on a new flavor when it is seasoned with depression.

As was determined by the American Psychological Association National Task Force on Women and Depression (McGrath et al., 1990), factors that contribute to women's vulnerability to depression include perfectionism, being overly demanding or too hard on themselves, and thought patterns such as rumination (becoming stuck on what should have, could have, would have been) and a negative explanatory style (explaining life events to oneself in a pessimistic way that is universal, personal, and

permanent). Thus the practice of periodically examining oneself to determine if one's life is in accordance with God's laws, when mixed with rumination and a negative explanatory style, can be a detrimental combination. It is easy to see how, when viewed and understood through the eyes and mind of depression, this experience of being part of a culture that has high expectations of obedience and worthiness perhaps adds another dimension in the struggle of depression.

All or Nothing Thinking

Another pattern of thought common among those struggling with depression is that of all or nothing thinking—you are right or wrong, good or bad, etc. I came to discover through this exploration into the experience of these women's struggle with depression, that pattern of thought also exists in LDS culture to some degree. The interaction of one's physical, emotional, cognitive, social, and spiritual selves is not linear; there is a complex interplay of the layers of this phenomenon unique for each woman in this study. It is not as clear and simple as: "This woman is not feeling the spirit, therefore she must be sinning and the solution is to pray more, etc." It is important that anyone working with those struggling with depression remember there is an in-between.

In fact, this all or nothing thinking pattern was pointed out by one of the women regarding the usage of spiritual and therapeutic resources. She passionately emphasized the need to couple these resources together to avoid maxing out on one of the other. It appear it is important for Church leaders and therapists alike to be cognizant of the benefit these women can receive when coupling the spiritual and therapeutic resources.

Management and Expression of Emotions

Doctrine in the LDS church states that we are commanded to be perfect (Matthew 5:48) and have joy (2 Nephi 2:25) and peace (John 14:27) and be of good cheer (John 16:33). As these doctrines are applied in the lives of church members, these commandments to be perfect and feel certain feelings are misconstrued and translated into cultural expectations to be happy and not sad, calm and not angry.

As mentioned earlier in the discussion about feeling the Spirit, if one is not feeling what one is expected to feel (e.g. joy and peace), it is assumed that one is doing something wrong (LDS, 1997). Kleinman and Good (1985) stated that depressive symptoms have different forms of expression and meaning in different societies. It is clear that this is the case in the LDS culture. When assessing for depression in an LDS woman and helping in the healing process, it is important to be aware of the impact the LDS culture has on the expression and management of emotions.

Richards, Smith, and Davis (1989) conducted a study with Mormon psychotherapy clients and concluded that they felt a high degree of shame. Because of the erroneous beliefs some in the LDS culture have of depression, the women in my study sometimes felt ashamed for feeling the way they did. At some point in their process of experiencing an episode of depression however, these women each talked about casting aside the shame and speaking out about their experience. Several women mentioned wanting to participate in this study so they could help others by sharing what they had been through.

Resilience in LDS Terms

In chapter one I presented two vignettes about Jamie and Marie. Although neither one exists as they were described, they are a compilation of real people I have been in contact with. Like Marie's comments at the end of the vignette about becoming more compassionate through her experience, the women in this study also talked about emerging from the depths of depression a different person. In Froma Walsh's writings (1998) on resilience she captures the experience these women had of growing through their struggle:

> "Resilience can be defined as the capacity to rebound from adversity strengthened and more resourceful…resilience involves struggling well: experiencing both suffering and courage, effectively working through difficulties both internally and interpersonally. In building resilience, we strive to integrate the fullness of a crisis experience into the fabric of our individual and collective identity, influencing how we go on to live our lives…resilience is forged through adversity, not despite it." (p.4-6)

Likewise, from an LDS perspective, these women spoke of resilience. They viewed the depression as a trial and challenge, an experience that was part of the plan their Heavenly Father had for them, to test and try them in this life so they could come forth refined and sanctified. Resilience seen through an LDS lens can be described as follows in the words of one of the worldwide leaders of the church, Dallin H. Oaks (2000):

> "Most of us experience some measure of what the scriptures call "the furnace of affliction" (Isaiah 48:10; 1 Nephi 20:10). Some are submerged in service to a disadvantaged family member. Others suffer the death of a

> loved one or the loss or postponement of a righteous goal like marriage or childbearing. Still others struggle with personal impairments or with feelings of rejection, inadequacy, or depression. Through the justice and mercy of a loving Father in Heaven, the refinement and sanctification possible through such experiences can help us achieve what God desires us to become."

Implications

Throughout this chapter I have offered suggestions for therapists and clergy in working with young, single, LDS women struggling with depression. In this section I will list the implications that have been woven throughout this chapter so as to help clinicians and clergy be most helpful.

In General

An important theme that emerged in this study was the coupling of therapeutic and spiritual resources. As discussed in Chapter Two, there has long been a rift between religion and psychotherapy (Ellis, 1980); however, in this post-modern age, it is an accepted fact that one's worldview guides one's reactions and experiences to life (Nichols & Schwartz, 2001). Thus, clinicians and clergy must work together drawing upon each others' expertise and influence in helping those struggling with depression. Coupling spiritual and therapeutic resources will lead to the fastest road to recovery.

Another important theme that has implications for therapists and Church leaders was that of the influence of cultural and societal expectations. As clinicians and clergy alike are more aware of the impact these expectations have on women who have a vulnerability to depression, they can begin to tease out how to use these expectations in a

way that is motivating and provides direction rather than discouraging and hindering progress.

Church Leaders

First and foremost it is crucial that clergy have a basic understanding of the symptoms of depression. They will then be able to recognize it and distinguish it from unworthiness, helping their congregants see that they are not feeling the spirit because of depression and not because of sin. It is also important to keep in mind that things are not always right or wrong, black or white, but that there is an in-between. They should emphasize the fact that one can be depressed and not be a "bad" person. Having an understanding of the basics of depression will also help Church leaders to avoid assuming that young, single women are struggling with depression because they are unmarried and not dating anyone. It is important that clergy not attempt to be therapists, or be quick or glib in offering advice/ solutions. It also appears to be important for Church leaders to recognize the influence their own situation (i.e. gender, stage of life, etc.) may have on their ability to connect and empathize with young, single, LDS women struggling with depression. It is most helpful when Church leaders validate the experience, are supportive and compassionate, and make appropriate referrals to mental health professionals.

The women also talked about how much it meant when Church leaders held hope for them and their future that they had momentarily lost. In a book written to LDS women struggling with depression, co-authors Meghan Decker, a journalist, and Betsy Chatlin, a therapist, preface their book (2000) by holding that hope for their readers:

> "…a victim of clinical depression…in a deep pit of hopelessness and despair…the agony of depression, a dark mist that seems to rob life of all joy and purpose. And out of that darkness, we come as messengers to tell you that there is hope. You can recover, and you will again love life and feel joy. The primary purpose of this book is to inspire hope in women who are somewhere in their own passage through depression…Looking out the window…we see trees that have weathered a difficult winter beginning to put forth the first young leaves of spring. You will be like these trees. Though you may now, in the darkness and chill of your depression, feel that hope is gone, you will again feel warmth and light. As you leave your winter of depression behind you and begin to reach for hope, you will one day return to joy, richness, and light." (p.xiii)

Furthermore, the ward as a whole may benefit from lessons/ presentations about depression to increase awareness and dispel any myths associated with the disorder (e.g. that depression is the result of sin).

Clinicians

Clinicians working with active members of The Church who are not familiar with the LDS culture/ worldview would benefit from a deeper exploration into the basic doctrines and beliefs. As Kleinman and Good (1985) explained, working with persons from other cultures requires some understanding "of different ways of being a person in radically different worlds" (p.3). Therapists will then be able to recognize the importance of feeling the spirit and the difficulty in expressing/ feeling different emotions (i.e. being in the depths of sorrow, angry, etc.) in the lives of their LDS clients. This study supports

the work of Aponte (2002a, 2002b) about the importance of considering clients' spirituality in treatment.

Most of the sample of young, single, LDS women in this study talked about using their beliefs in much the same way as Richards et al. (1989) concluded from their study of Mormon psychotherapy clients: "despite their problems, the clients felt that their relationship with God gives them strength, helps them cope, and contributes to their well-being" (p.517). Richards et al. suggested that clinicians should be willing and open to "enter into their client's religious world view" in order to tap into the therapeutic resource of religious beliefs. As was discussed previously, these women want therapists who will help them see the expectations and doctrines of The Church in a realistic light so they can feel comforted, buoyed up, and inspired by their beliefs instead of overwhelmed, frustrated, and like a failure.

Almost every participant mentioned how helpful it had been to receive some psycho-education about depression: cognitive distortions, management of emotions, biopsychosocial components of depression, and the course of a depressive episode. Understanding what contributed to the depression, that some symptoms will linger longer than others, that medication should be taken for a certain length of time in order for a depressive episode to completely subside (Bailey, 2005), and that it is healthy to have a wide range of emotions will help in the healing process.

Study Limitations and Need for Further Study

This study is an exploration into the experience and understanding of depression of six young, single, white, LDS women from the Washington DC metropolitan area. Besides the limitations in my sample, there were also two limitations regarding how I

measured depression and intrinsic religiosity. I did not administer any depression assessment in order to honor my participants' perception of their experience; however, although this may be limiting, there was evidence in my participants' words that they were struggling with depression. For instance, they described symptoms the DSM-IV outlines as criteria for depression and all but one participant saw a therapist and used antidepressants. This indicates to me that others (i.e. doctors) also identified these women as depressed. As far as the measurement for intrinsic religiosity, it might have been the case that my participants felt pressure to identify themselves as taking part in personal religious worship because I am an active member of The Church. I tried to lessen this pressure by asking this question on a piece of paper and then not looking at their response until after I had left the interview. Their stories are a good beginning and provide impetus to further explore the experience and understanding of depression in other young, single, LDS women, especially as the prevalence of depression and the membership of the LDS church both continue to increase.

It would be interesting to explore the experience and understanding of older single women who are active in the LDS church; perhaps a sample a decade older (35-45) would reveal a much different phenomenon. Future research could focus on following samples of LDS women over-time, further exploring how the stage of life influences the struggle with depression. Specifically, it would be interesting to hear the stories of young, married, LDS women's struggle with depression to explore more in-depth the impact the spousal relationship has on the experience of struggling with depression. I also think any of these suggested studies should also be replicated using samples of men—young, single men, a longitudinal study of men struggling with depression, and

married men struggling with depression. Another fascinating study would include exploring the experiences of therapists/ Church leaders in working with LDS women struggling with depression. More qualitative research also needs to be done exploring how depression affects other intrinsically religious women. Indeed, much more research needs to be done in this area in order to continue to increase awareness and determine ways mental health professionals and clergy can be most helpful to LDS women struggling with depression.

References

APA. (2000). *DSM-IV- TR*. Washington, DC: American Psychological Association.

Aponte, H. (2004). Spirituality and Family Therapy Conference, Falls Church, VA.

Aponte, H. (2002a). Spirituality: The heart of of therapy. *Journal of Family and Psychotherapy. 13(1-2), 2002, 13-27*

Aponte, H. (2002b). Spiritually-sensitive psychotherapy. In Florence W. *Kaslow (Ed). (2002). Comprehensive handbook of psychotherapy: Interpersonal/humanistic/existential, vol. 3, New York, NY, John Wiley & Sons, 279-302.*

Bailey, G. (2005, February 15). *Psychopharmacology.* Paper presented at the INOVA Kellar Center Staff Development, February, Fairfax, VA.

Barlow, S. H., & Bergin, A. E. (1998). Religion and mental health from the Mormon perspective. In H. G. Koenig (Ed.), *Handbook of Religion and Mental Health* (pp. 225-243). San Diego: Academic Press.

Bergin, A. (1994). Religious life-styles and mental health. *Religion, Personality, and Mental Health*, 70-93.

Bergin, A. (1999). Religious life-styles and mental health. In D. K. Judd (Ed.), *Religion, Mental Health, and the Latter-day Saints*. Salt Lake City: Bookcraft Publishers.

Bergin, A., Masters, K., & Richards, P. (1987). Religiousness and mental health reconsidered: A study of an instrinsically religious sample. *Journal of Counseling and Psychology, 34*(2), 197-204.

Bergin, A., Payne, I. R., Jenkins, P. H., & Cornwall, M. (1994). Religion and mental health: Mormons and Other Groups. In M. Cornwall, T. B. Heaton & L. A. Young

(Eds.), *Contemporary Mormonism: Social Science Perspectives*. Urbana, IL: University of Illinois Press.

Bishop, L. C., Larson, D. B., & Wilson, W. P. (1987). Religious life of individuals with affective disorders. *Southern Medical Journal, 80,* 1083-1086.

Block, J., & Gjerde, P. F. (in press). Depressive symptomatology in late adolescence: A longitudinal perspective on personality antecedents. In J. E. Rolf, A. Masten, D. Cicchetti, K. Neuchterlein & S. Weintraub (Eds.), *Risk and protective factors in the development of psychopathology*. New York: Cambridge University Press.

Boss, P., Dahl, C., & Kaplan, L. (1996). The use of phenomenology for the family therapy research: The search for meaning. In D. H. Sprenkle & S. M. Moon (Eds.), *Research Methods in Family Therapy*. New York: Guilford Press.

Burns, D., Sayers, S., & Moras, K. (1994). Intimate relationships and depression: Is there a causal connection. *Journal of Consulting and Clinical Psychology, 62*(5), 1033-1043.

Culbertson, F. M. (1997). Depression and gender: An international review. *American Psychologist, 52*(1), 25-31.

Decker, M., & Chatlin, B. (2000). *Reaching for hope: An LDS perspective on recovering from depression*. Salt Lake City, UT: Bookcraft.

Degn, L., Yeates, E., Greenwell, B., & Fiddler, L. (1985). Mormon women and depression. *Sunstone, 10,* 19-27.

Donahue, M. J. (1985). Intrinsic and extrinsic religiousness: Review and meta-analysis. *Journal of Personality and Social Psychology, 48,* 400-419.

Elder, G. H. (1993). Foreword. In K. D. Hulbert & D. T. Schuster (Eds.), *Women's lives through time: Educated American women of the twentieth century*. San Francisco: Jossey-Bass.

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

Ernst, C., & Angst, J. (1995). Depression in old age: Is there a real decrease in prevalence? A review. *European Archives of Psychiatry and Clinical Neuroscience, 245,* 272-287.

Fergusson, D. M., Horwood, L. J., & Shannon, F. T. (1984). Relationship of family life events, maternal depression, and child-rearing problems. *Pediatrics, 73,* 773-776.

Freres, D. R., Gillham, J. E., Reivich, K. J., & Shatte, A. J. (2002). Preventing depressive symptoms in middle school students: The Penn Resiliency Program. *International Journal of Emergency Mental Health, 4*(1), 31-40.

Friedman, A. S. (1975). Interaction of drug therapy with marital therapy in depressive patients. *Archives of General Psychiatry, 32,* 619-637.

Genia, V., & Shaw, D. (1991). Religion, intrinsic-extrinsic orientation, and depression. *Review of Religious Research, 32,* 274-283.

Giorgi, A. (1985). Introduction. In A. Giorgi (Ed.), *Phenomenology and Psychological Research*. Pittsburgh: Duquesne University Press.

Goldman, L. S., Nielson, N. H., & Champion, H. C. (1999). Awareness, diagnosis, and treatment of depression. *Journal of General Internal Medicine, 14,* 569-580.

Haarasilta, L. M., Marttunen, M. J., Kaprio, J. A., & Aro, H. M. (2004). Correlates of depression in a representative sample of adolescents (15-19 years) and young adults (20-24 years). *European Journal of Public Health, 14*, 280-285.

Haug, M. R., & Folmar, S. J. (1986). Longevity, gender, and life quality. *Journal of Health and Social Behavior, 27*, 332-345.

Haug, M. R., Ford, A. B., & Sheafor, M. (1985). *The phsycial and mental health of aged women*. New York: Springer.

Hernandez, M. (1986, September). *Depression among Mexican Women: A transgenerational perspective.* Paper presented at the biannual meeting of the National Coalition of Hispanic Health and Human Serivices Organization, New York.

Higgins, G. O. (1994). *Resilient adults: Overcoming a cruel past*. San Francisco: Jossey-Bass.

Himmelfarb, S. (1984). Age and sex differences in the mental health of older persons. *Journal of Consulting and Clinical Psychology, 52*, 844-856.

Ingram, R. E., Cruet, D., Johnson, B. R., & Wisnicki, K. S. (1988). Self-focused attention, gender, gender role, and vulnerability to negative affect. *Journal of Personality and Social Psychology, 55*, 967-978.

Jensen, L. C., Jensen, J., & Wiederhold, T. (1993). Religiosity, denomination, and mental health among young men and women. *Psychological Reports, 72*, 1157-1158.

Johnson, S. (2004). *Religiosity and life satisfaction among LDS women.* Paper presented at the Association of Mormon Counselors and Psychotherapists, Brigham Young University: Provo, UT.

Jones, B. E., & Gray, B. A. (1984). Similarities and differences in Black men and women in psychotherapy. *Journal of the National Medical Association, 76,* 21-27.

Judd, D. K. (Ed.). (1999). *Religion, Mental Health, and the Latter-day Saints*. Salt Lake City, UT: Bookcraft, Inc.

Kandel, D. B., Davies, M., & Ravels, V. (1985). The stressfulness of daily social roles for women: Marital, occupational, and household roles. *Journal of Health and Social Behavior, 26*, 64-78.

Katona, C. L. E. (1994). *Depression in old age*. Chichester: Wiley.

Kessler, R., McGonagle, K., Swartz, M., Blazer, G., & Nelson, C. (1993). Sex and depression in the National Comorbidity Survey I: Lifetime prevalence, chronicity and recurrence. *Journal of Affective Disorders, 29*(2-3), 85-96.

Kleinman, A., & Good, B. (1985). Introduction: Culture and depression. In A. Kleinman & B. Good (Eds.), *Culture and Depression: Studies in the Anthropology and Cross-Cultural Psychiatry of Affect and Disorder* (pp. 1-33). Berkeley, CA: University of California Press.

Klerman, G. L., & Weissman, M. M. (1989). Increasing rates of depression. *Journal of the American Medical Association, 261,* 2229-2235.

Lamb, K. A., Lee, G. R., & Demaris, A. (2003). Union formation and depression: Selection and relationship effects. *Journal of Marriag and Family, 65*(November), 953-962.

LDS. (1997). *Gospel Principles*. Salt Lake City, UT: The Church of Jesus Christ of Latter-day Saints.

Lewis-Fernandez, R., & Kleinman, A. (1994). Culture, personality, and psychopathology. *Journal of Abnormal Psychology, 103*(1), 67-71.

Maier, S. F., & Seligman, M. E. (1976). Learned helplessness: Theory and evidence. *Journal of Experimental Psychology: General, 105*, 3-46.

Maltby, J., & Day, L. (2000). Depressive symptoms and religious orientation: Examining the relationship between religiosity and depression within the context of other correlates of depression. *Pesonality and Individual Differences, 28*, 383-393.

Maxwell, J. (1992). *Mormon women and depression.* University of Nevada, Las Vegas.

McCullough, M., & Larson, D. (1999). Religion and depression: A review of the literature. *Twin Research: The official Journal of the International Society for Twin Studies, 2*, 126-136.

McGrath, E., Keita, G. P., Strickland, B. R., & Russo, N. F. (Eds.). (1990). *Women and Depression: Risk Factors and Treatment Issues*. Washington, DC: American Psychological Association.

Meador, K., Koenig, H., Hughes, D., Balzer, D., Tumbull, J., & George, L. (1992). Religious affiliation and major depression. *Hospital and Community Psychiatry, 43*, 1204-1208.

Moore, C. A. (2002). *LDS Church now 5th largest in U.S.* Retrieved September 2, 2004, from deseretnews.com

Newmann, J. P. (1989). Aging and depression. *Psychology and Aging, 4*, 150-165.

Newmann, J. P., Klein, M. H., Jensen, J., & Essex, M. J. (1996). Depressive symptom experiences among older women: A comparison of alternative measurement approaches. *Psychology and Aging, 11*(1), 112-126.

Nichols, M. P., & Schwartz, R. C. (2001). Family therapy enters the twenty-first century: Collaborative, conversational approaches. In *Family Therapy: Concepts and Methods*. Boston: Allyn and Bacon.

Nolen-Hoeksema, S. (1990). *Sex differences in depression*. Stanford: Stanford University Press.

Nolen-Hoeksema, S. (1991). Responses to depression and their effects on the duration of depressive episodes. *Journal of Abnormal Psychology, 100*, 569-582.

Nolen-Hoeksema, S., Larson, J., & Grayson, C. (1999). Explaining the gender difference in depressive symptoms. *Journal of Personality and Social Psychology, 77*(5), 1061-1072.

Nolen-Hoeksema, S., Morrow, J., & Fredrickson, B. L. (1993). Response styles and the duration of episodes of depressed mood. *Journal of Abnormal Psychology, 102*(1), 20-28.

Oaks, D. H. (2000). The challenge to become. *Ensign*(November), 32.

Patton, M. Q. (2002). *Qualitative research & evaluation methods* (3 ed.). Thousand Oaks, CA: Sage.

Quesada, G. M., Spears, W., & Ramos, P. (1978). Interracial depressive epidemiology in the Southwest. *Journal of Health and Social Behavior, 19*(1), 77-85.

Richards, P., Smith, S., & Davis, L. (1989). Health and unhealthy forms of religiousness manifested by psychotherapy clients: An empirical investigation. *Journal of Research in Personality, 23*, 506-524.

Robins, L. W., Helzer, J. E., & Weissman, M. M. (1984). Lifetime prevalence of specific psychiatric disorders in three cites. *Archives of General Psychiatry, 41*, 949-958.

Russo, N. F., & Olmedo, E. L. (1983). Women's utilization of outpatient psychiatric services: Some emerging priorities for rehabilitation psychologists. *Rehabilitation Psychology, 28*, 141-155.

Salgado de Snyder, V. N. (1987). Factors associated with acculturative stress and depressive symptomology among married Mexican immigrant women. *Psychology of Women Quarterly, 11*, 475-488.

Schrof, J. M., & Schultz, S. (1999, March 8). Melancholy Nation. *U.S. News and World Report,* 57.

Schwandt, T. A. (1997). *Qualitative inquiry: A dictionary of terms*. Thousand Oaks, CA: Sage Publications, Inc.

Seligman, M. E. (1990). *Learned optimism: How to change your mind and your life*. New York: Pocket Books.

Smith, J. (1842, March 1). The Articles of Faith of The Church of Jesus Christ of Latter-day Saints. *Times and Seasons*.

Spendlove, D. (1982). *Depression in Mormon women.* Unpublished dissertation, University of Utah, Salt Lake City.

Spendlove, D., West, D., & Stanish, W. (1984). Risk factors in the prevalence of depression in Mormon women. *Social Science and Medicine, 18*(6), 491-495.

Steele, R. E. (1978). The relationship of race, sex, social class, and social mobility to depression in normal adults. *Journal of Social Psychology, 104*, 34-47.

Ulrich, W. L., RIchards, P. S., & Bergin, A. E. (1999). Psychotherapy with Latter-day Saints. In P. S. Richards & A. E. Bergin (Eds.), *The Handbook of Psychotherapy*

and Religious Diversity (pp. 185-210). Washington, D.C.: American Psychological Association.

Van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy*. NY: State University of New York.

Walsh, F. (1998). *Strengthening Family Resilience*. New York: Guilford Press.

Weismman, M. M., & Paykel, E. (1974). *The depressed woman*. Chicago: University of Chicago Press.

Weismman, M. M., Paykel, E., & Klerman, G. L. (1972). The depressed womna as a mother. *Social Psychiatry, 7*, 98-108.

Wetzel, J. W. (1994). Depression: Women-at-risk. *Social Work- Health Care, 19*, 85-108.

Williams, M. (1999). Family attitudes and perfectionism as related to depression in Latter-day Saint and Protestant women. In D. K. Judd (Ed.), *Religion, Mental Health, and the Latter-day Saints*. Provo, UT: Brigham Young University.

Wortman, C. B., & Brehm, J. W. (1975). Responses to uncontrollable outcomes: An integration of reactance theory and the learned helplessness model. *Advances in experimental social psychology*, 277-335.

Are you single, between 25-35 years old, and a practicing LDS woman?

Have you struggled with depression?

Would you like to help church leaders and mental health professionals become more helpful to others by sharing your experience?

If you fit the above criteria and are interested in participating in an interview for master's thesis research about your struggle with depression, email me at thesisresearch@vt.edu. Please provide your email address/ phone number so I can contact you to answer any questions you may have and schedule a time to hold the interview.

Virginia Tech
VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY
Northern Virginia Center

Appendix II
Informed Consent Form

Project Title: A Phenomenological Exploration of the Experience of Depression within a Sample of Young, Single, Latter-Day Saint Women
Researchers: Jennifer M. Harris, M.S. Candidate, Department of Human Development, Virginia Polytechnic Institute and State University
Sandra M. Stith, Ph.D., Professor, Department of Human Development, Virginia Polytechnic Institute and State University

What is the purpose of this study? The purpose of this study will be to understand how young, single, LDS women experience and understand depression.

What will I be asked to do? You will be asked to participate in a 1-1.5 hour interview. During this interview you will be asked about your experience with depression, including but not limited to the contributing factors and resources that were helpful/not helpful. The interview will be scheduled at your convenience at a mutually agreed upon location. The face-to-face interview will be audio-taped to make sure we understand exactly what was said. After completing your interview you will be contacted and given the option to read through the transcript of your interview and make any corrections necessary.

Are there any risks to me? There are minimal risks associated with participation in this project. Minimal risks include that you may feel some discomfort when you discuss your experience of struggling with depression. You may decline to answer any question at any time. Please be assured that the interviewer is sensitized to issues about depression. The interviewer is trained and experienced and is able to refer you to any services that might be helpful to you. You are free to withdraw from the study at any time. Please be reassured that your participation is totally voluntary and confidential.

Termination of Study by Investigator

Under certain circumstances, your participation in this research study may be ended without your consent. We are also bound to break confidentiality in these instances and inform the appropriate authorities. This might happen because you tell the researcher information that would put yourself, family members, or the interviewer at risk such as information about the intent to harm oneself or others.

Are there benefits to me? As a result of participating in this study you may feel empowered and satisfied because you have contributed to an important research study that may benefit other women struggling with depression, clergy working with young, single adults in the LDS Church, and mental health professionals.

Are my responses confidential? Every effort will be made to keep all information you provide in the strictest confidence to the extent permitted by law. Any specific identifying information will be omitted from your transcript (e.g. name changes). Your responses will be kept locked for the duration of the project and access will only be

allowed to the researcher. Your name and any other identifying information will not be reported in any publications or presentations, and audiotapes will be destroyed. Once the data collection is complete and interviews are transcribed, a copy of your interview transcription will be sent to you via email. If there are any portions of the interview you wish to change in order to protect your confidentiality, you may do so and send it back to the researcher by the date designated in the email. You may also highlight any portion of your transcription that you do not wish to be quoted later when the research project data analysis is reported. These highlights can be sent back to the researcher via email as well. If you do not respond to the interview transcription email by the designated date, the researcher will assume that you do not wish to make any changes.

Will I be compensated for my participation? Your participation is completely voluntary and there will be no compensation other than the researcher's appreciation for your time and participation.

Do I have the freedom to withdraw? You have the right to refuse to participate in this study. You also have the right to refuse to answer any questions and you may drop out at anytime.

Approval of Research: This project has been approved, as required, by the Institutional Review Board Involving Human Subjects at Virginia Polytechnic Institute and State University.

If you have any questions about this research project, please feel free to contact:

Jennifer M. Harris, Principal Researcher
703-538-8355, jeharri1@vt.edu

Sandra M. Stith, Ph.D., Committee Chair
703-538-8362, sstith@vt.edu

Dr. David Moore, IRB Chair
540-231-4991, moored@vt.edu

Participant's Permission

I voluntarily agree to participate in this research project. I have read and understood the Informed Consent ad the conditions of this project. I hereby acknowledge the above and give my voluntary consent for participation in this project by signing my name on the line below. I realize that although I choose to participate right now, I have the right to withdraw from this study at any time without any penalty.

Printed Name: _____

Signature: _____

Appendix III

Demographic Questions

1. How old are you?

2. Are you dating anyone seriously? Yes or No

3. Are you temple worthy? Yes or No

4. Do you have a testimony, and do you have personal scripture study and prayer? Yes or No

Appendix IV

Sample Questions

(1) Tell me the story of your struggle with depression. (If there is a need to follow-up more in-depth I will ask the following questions.)

(2) What factors do you think contributed to the depression? Is there one thing you can pinpoint as the major trigger?

(3) What has been helpful in your struggle with depression?

   a. Has the Gospel (e.g. LDS beliefs)?

   b. Have church leaders?

   c. Have mental health professionals?

   d. Have antidepressants?

   e. Other?

(4) What has been unhelpful?

   a. Has the Gospel (e.g. LDS beliefs)?

   b. Have church leaders?

   c. Have mental health professionals?

   d. Have antidepressants?

   e. Other?

(5) What is something you wish would have happened that would be helpful in your struggle with depression (i.e. what someone could say or do)?

(6) I've talked with a handful of women like yourself who are struggling with depression and it seems many of them have a hard time making sense of the fact that even though they are righteous, they are unhappy. What do you make of that contradiction?

(7) I'm interested in your response to the following statement:

Many LDS people look to God and try to make sense of challenges and trials. By viewing their experiences from an eternal perspective, they receive comfort, strength, and hope.

Does that fit for you in your experience of struggling with depression?

If it doesn't fit, how would you change it so that it would be true for you?