Mental Health Services Awareness Night

Wilkinson Center, Provo, Utah

By Elder Larry Y. Wilson

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Good evening, brothers and sisters. Many of you know that Elder Dale Renlund, now of the Quorum of the Twelve Apostles, was originally scheduled to speak to you. One of the things I have learned through hard experience is that, as a member of the Seventy, it is never good to show up when people were expecting an Apostle.

We all have family members and friends who struggle with mental health challenges. As I think about the major categories of mental health issues--schizophrenia, bipolar disorder, post-traumatic stress disorder, depression, suicide, eating disorders, etc.--I can think of people I have known who have struggled with every one of these challenges. There are also related issues that go hand in hand with mental illness: domestic violence, child maltreatment, addictions, etc. Our immediate and extended family has been touched by suicide and depression. If you spend any time serving as a church leader, you will most likely come face-to-face with nearly all of the challenges I just listed.

It is important to know that mental/behavioral health is the fastest growing disease burden in the U.S. for both male and female populations. And yet, many people have not come to grips with mental illness as an *illness*. Too many still have the attitude that mental illness is a weakness. Too few seek professional help, and too many suffer from a lack of treatment. It is important to know that there is help available if people will seek it and accept it. You play an important role in helping to build understanding of the reality of mental illness, in removing stigmas related to it, and in helping to create an environment in which people can and do seek the resources they need. There is a great need for increased awareness, and we all need to be continually educating ourselves as well as others.

Utah has some particular challenges because of high rates of depression, suicide and prescription drug abuse. We live in what is sometimes referred to as "the suicide belt." These are states in the intermountain west which have higher than average rates of suicide. We don't fully understand the cause. This week I read an article about research into the impact of altitude on mental illness. Let me quote from it: "In a 2011 study published in the American Journal of Psychiatry, a group of researchers…analyzed state suicide rates with respect to gun ownership, population density, poverty, health insurance, quality and availability of psychiatric care…[and other factors.] Altitude had the strongest link to suicide; even the group of states with the least available psychiatric care had fewer suicides than the highest-altitude states, where psychiatric care was easier to find." [1]

An analysis by Perry Renshaw, a neuroscientist at the University of Utah, concluded that the elevation at which people live is a strong predictor of their mental health status. Analysis of suicide rates in South Korea and Austria showed the same thing. There has been some compelling research by the military showing that the mental health of Marines deteriorated when they trained in the mountains of northern California compared to when they trained at sea level.

Dr. Renshaw believes that altitude-induced oxygen depletion is the culprit. People are aware of the physical effects that higher altitude can induce such as nausea, headaches and nosebleeds. However, he believes that oxygen-poor air also tampers with brain chemistry, leading to a drop in serotonin and an uptick in dopamine. These neurotransmitters help stabilize emotions. While this research is still in the early development stages, it demonstrates that we are still learning many things about mental illness, its causes, and its treatment.

Leaving aside the research into the causes, let us turn to the realities of mental illness. We all know those who are struggling with mental health challenges. Let me begin with an example. I have a younger sister who is the mother of 6 children and now the grandmother of 11. She is a highly successful mother and grandmother, happily married to a wonderful man. She is a gifted and accomplished musician and church leader who has served twice as the president of her ward Relief Society. She has also fought her own battle with depression. She believes hers was triggered by sleep deprivation as she raised

small children. Eventually, it reached the point where she found herself crying before she would get out of bed in the morning.

For many years, she was in denial--a common phenomenon with people who experience such challenges. She said to me, that she had a hard time admitting that her reality was something other than what she had hoped it would be. Finally, a friend who was an occasional walking companion of hers, and who knew her well enough to have her confidence, convinced her to seek medical help. She would get the medication to treat the problem and then go home and throw it in the garbage. That happened a couple of times. Eventually, she did take the medication, going through the trial and error process associated with finding the right medication and dosage to help her situation. Eventually, she found something that helped and she benefitted from it for many years. Today, she is at a point where she no longer experiences depression and no longer needs the medication.

In talking with my sister, who has also helped others with these needs in her service as a church leader, she spoke of the difficulty of dealing with something you cannot actually see. If you have a rash or a broken arm, people can observe the problem. With mental health, this is generally more difficult. Mental illness does not present with the same type of physical evidence we see with many other medical problems. That can make it harder to help people come to grips with the reality of their situation.

One of the critical needs we all have is people we can talk to. This is especially true for those battling with mental illness. As a church leader, you can play this critical role--and you can enlist others to do the same. It needs to be a person who is trusted. As my sister put it, it needs to be someone who "can get inside the bubble."

Today, depression is more out in the open as are many other mental health problems. There is less shame and guilt than there used to be. We all play a vital role in continuing to foster understanding of mental illness and the ability to recognize it and help others find the help they need. My sister told me she knew people who were very disabled by their depression and she would tell herself "I'm not one of those people." Finally, she was able to confront her own reality.

There are countless stories like this. Unfortunately, there is still a stigma in the eyes of many people that prevents them from understanding the underlying mental health problem they have and from finding help to treat and resolve it. When my sister was talking to the friend who helped her, she said this woman used basic logic with her. She said, "If you had poor vision, you would go to the eye doctor, wouldn't you?" "If you had appendicitis, wouldn't you seek treatment for it?" Slowly, she convinced my sister of the need to seek help. What a blessing this friend was to my sister. Too many church leaders prescribe *only* spiritual solutions for mental health problems that require professional help. Spiritual solutions are helpful in almost any circumstance but will not be sufficient for those with mental health needs.

In the LDS world, we may encourage people to receive priesthood blessings or to increase their personal worship practices when, as valuable as these things are, the need is for more direct help with the underlying mental health problem. As I have prepared for this meeting tonight, I read through many things including the absolutely wonderful document that was developed here in Utah County entitled "Clergy Bridge: Strengthening the gap between mental health professionals and clergy." It's available to all of you and I would urge you to read it. One of its observations is that in the U.S. about 40 percent of individuals who experience problems in their personal lives go first to clergy for assistance.

According to health care experts at the Advisory Board, almost half of the population in the U.S. will receive a mental health diagnosis in their lifetime and at any given time, 25 percent of the population is diagnosable with a mental condition. Over 60% of the population has experienced adverse childhood events such as abuse, neglect, or serious family dysfunction that results in poor physical, emotional, and behavioral outcomes as adults. We need to help reduce the emotional suffering by effectively utilizing all of the resources at our disposal.

I know that when I served as a bishop, one of my greatest challenges was locating the resources that were needed to address these kinds of problems. Events, such as this, can be a big help to anyone who is seeking

resources to help with mental health challenges. You can also use council meetings of leaders in your congregations to identify resources to help those in need.

As an example, in the LDS community, we have a ward council in each of our congregations. These can be a great place to develop ideas and identify resources to help others. You have both males and females and get the benefit of each of their perspectives. It can provide a good blend of compassion and practical wisdom.

Let me add a word pertaining to mental health matters related to LDS missionaries. Some parents mistakenly believe that such problems will vanish on a mission and that "God will take care of my son or daughter." It is important to understand that a mission is more demanding than what most people were doing prior to their mission and in almost every way. It tends to exacerbate underlying mental health challenges, not alleviate them. It is important to be honest and realistic about such matters and to be sure someone is not being put into a position where they are likely to fail. There is a book that may be helpful to you on this subject by Dr. Marlene Payne entitled *Mission Possible: A Guide for LDS Missionaries and their Mission Presidents, Parents, Bishops and Therapists*. She has a wealth of experience in helping missionaries.

In the remaining time, I thought it might be useful to review some of the important messages that are in the document I referenced earlier entitled *Clergy Bridge*. Accordingly, I am quoting from it liberally and I give full credit to its authors for much of what follows. They note that the vast majority of ecclesiastical leaders interviewed (70 percent) said that their lack of information made it more difficult to help the members of their congregation. All clergy interviewed, reported that they would utilize and refer congregation members to more community resources if they were aware of them.

There are four specific areas of focus in which clergy need assistance to both help alleviate the stress of their responsibilities as well as to better assist those they serve. First, the main problem is to alleviate the complex feelings of stress and the burden of caring which comes with being a church leader. If you feel overwhelmed in your responsibility, realize that you are not alone in feeling that way. However, you should recognize there are specific things each church

leader can do generally and specifically to improve his/her own mental health and preparation. An important step is to seek preparation from the available resources. You can also seek balance in your own life through fostering your own physical, emotional, mental, and spiritual health. This is not an easy thing to do and it may be the most common question I have been asked by people both in employment and church settings: how do you achieve balance in your life?

I remember talking to a friend years ago who was busy with a demanding church calling, a time-consuming and stressful job, and a large family with small and teenage children. He told me he knew he had balance in his life when his church leader, his employer, and his wife were all equally unhappy with him. Hopefully, we can do better than that. We *need* to do better than that if we're going to be effective in helping others.

Some of you may wonder if what you are doing is even considered helpful to those you serve. You should know that your empathy, your kindness, your guidance, and your non-judgmental attitude do make a significant contribution to the well-being of those you are seeking to help. Individuals with problems need support. LDS church president Thomas Monson talks about how much everyone needs an encouraging word from others. You do not have to have all of the answers. Your willingness to listen and to help find other resources can be a major contribution. When you refer individuals to others with additional resources, you give them another link of support and another opportunity for success.

One bit of counsel I received from my sister who both struggled with depression herself and helped others with similar problems was this: Don't be afraid. Too often, we may think we don't have the ability to help when, in fact, we're more capable and have more to offer than we realize. Don't be afraid. You can ask others "How is that counselor working out for you?" Then listen carefully to see what they say. If they're making progress, that's great! If they're not, you might think about encouraging them to consider trying a different counselor or whatever other resource they may be using.

We all need to receive stronger and more extensive training to help others with mental health issues. Your presence here tonight is a testament to your willingness to do so. In the LDS Church, since our leaders are not trained

professionals, we face perhaps an even greater challenge cultivating some understanding of these issues. Each of us should be constantly seeking to know more about various issues (e.g. mental health, domestic violence, addiction, etc.). Finally, we each need to have a better knowledge of community resources. I salute those who have organized this event. Hopefully it can provide significant help to you in that regard.

Let's step back and take a look at the overall statistics for the kinds of mental health problems we're discussing. Statistics on mental health in the U.S. are as follows: 15 million with Social Phobia (about 5 percent of the U.S. population), 14.8 million with Major Depression (also 5 percent), 7.7 million with PTSD (about 2.5%), 6.8 million with General Anxiety, 5.7 million with Bipolar, 2.4 million (just under 1 percent) with Schizophrenia and 2.2 million with OCD. Looking at the treatment side, the statistics indicate that fully half of the mentally ill are not being treated. About 25 per cent are receiving a non-indicated treatment and only 25 percent are receiving appropriate treatment.[2] The World Health Organization has stated, "Barriers to effective treatment of mental illness include lack of recognition of the seriousness of mental illness and lack of understanding about the benefits of services." Those barriers certainly exist in our communities. How do we tear them down and build the solutions that are needed? Today in this country, mental disorders are the fourth costliest health conditions after heart conditions, trauma and cancer. Just to put things in perspective, we spend $58 billion on cancer and the same amount on mental disorders.

There is a wonderful story in the New Testament that captures the spirit of what I am talking about in tearing down the barriers. It is found in Mark 2:1-12. Let me read it to you.

1 And again he [Jesus] entered into Capernaum after some days; and it was noised that he was in the house.

2 And straightway many were gathered together, insomuch that there was no room to receive them, no, not so much as about the door: and he preached the word unto them.

3 And they come unto him, bringing one sick of the palsy, which was borne of four.

4 And when they could not come nigh unto him for the press, they uncovered the roof where he was: and when they had broken it up, they let down the bed wherein the sick of the palsy lay.

5 When Jesus saw their faith, he said unto the sick of the palsy, Son, thy sins be forgiven thee.

6 But there were certain of the scribes sitting there, and reasoning in their hearts,

7 Why doth this man thus speak blasphemies? who can forgive sins but God only?

8 And immediately when Jesus perceived in his spirit that they so reasoned within themselves, he said unto them, Why reason ye these things in your hearts?

9 Whether is it easier to say to the sick of the palsy, Thy sins be forgiven thee; or to say, Arise, and take up thy bed, and walk?

10 But that ye may know that the Son of man hath power on earth to forgive sins, (he saith to the sick of the palsy,)

11 I say unto thee, Arise, and take up thy bed, and go thy way into thine house.

12 And immediately he arose, took up the bed, and went forth before them all; insomuch that they were all amazed, and glorified God, saying, We never saw it on this fashion.

I would hope that our attitude towards finding solutions and resources for the mentally ill would be like the four individuals mentioned in this story who found a way to bring healing to the man with palsy. They were not content to accept the barrier of a room that was too full. They brought creativity and courage to a seemingly impossible situation. They tore off the roof! We should do the same for those who are in need of healing from mental illness.

WHAT IS MENTAL ILLNESS?

Let's talk about this subject in more specificity. Mental illnesses are clinically significant behavioral or psychological syndromes or patterns that occur in an individual and are associated with present distress (e.g., a painful symptom) or

disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. Mental illnesses vary throughout different countries and cultures, although mental illness as we understand it is essentially consistent throughout industrialized countries and cultures. Mental illnesses can generally be grouped into five general categories: anxiety disorders, mood disorders such as depression and bipolar disorders, schizophrenia, dementia and eating disorders.

HOW TO RECOGNIZE MENTAL DISORDERS

It is important to remember that everyone, at some point in their life, experiences some or most of these symptoms. However, it is generally not considered a mental illness unless it is persistent and it somehow negatively affects the individual's life. Also, though these tips may be helpful for identifying those in need, it is important not to jump to conclusions. Mental illness is often associated with a negative stigma, so those of us in a position to help should do what we can to avoid perpetuating this stigma.

Several years ago I read the wonderful memoir written by Katherine Graham, the former publisher of the Washington Post. Entitled *Personal History*, it describes her husband's mental illness. He suffered from manic depression, now called bipolar disorder, and alternated between periods when he functioned brilliantly and when he was morose and erratic. In the end, Phil Graham committed suicide. This occurred just over 50 years ago. As she wrote the memoir, Mrs. Graham noted that, at that time, she did not even know about this type of mental illness and there were no effective treatments for it. We have come a long way since then in our ability to recognize these disorders. And we still have a long way to go to recognize the problems all around us.

WHAT CAN CLERGY DO? COMMUNICATION IN COUNSELING

So, how do we as church leaders help? Listening and allowing people to talk about their problems is an integral part of the helping process and should be at the forefront of applied techniques. We should bring true empathy that is manifested through genuine listening and understanding. This means being able to accurately sense the inner feelings and meanings of the individual's

experience and relate them back in a way that enables the other to know that you do understand. The use of empathy involves such techniques as: (a) listening, (b) verbally communicating empathetic understanding, (c) reflecting feelings, (d) nonverbally communicating empathic understanding, and (e) silence as a way of communicating empathic understanding.

An important piece of counsel is this: Do not "own" the problem. You can invite the individual to change -- and the rest is up to him/her. Not taking others' burdens home with you is a difficult skill to learn. I have struggled with that myself. I am tempted to want to make things all better for someone. Many of us need to learn how to leave some of these problems with the person being counseled and not create unrealistic expectations that we're going to solve everything for them.

DEPRESSION

I just recently reviewed a case where a woman had been subject to such abuse from her husband that the mental health clinician reviewing her situation said it was one of the worst cases of PTSD and depression he had ever seen. We tend to associate this with conditions of war and extreme tragedy. Unfortunately, such conditions also exist in some homes.

The first and most important step is to recognize the symptoms of depression, and help the person get an appropriate diagnosis and treatment. Other suggestions include offering emotional support, understanding, patience and encouragement. While being supportive and understanding, be careful not to do things that suggest you can meet unreasonable or unrealistic needs of the depressed person. There is a very thin line between being supportive and being overly concerned. Too much concern can feed an unrealistic demand for attention. It can also cause dependency and sooner or later feelings of guilt over being indebted to someone else.

Second, engage the individual in conversation, and listen carefully. It is frequently difficult for a depressed person to carry on a conversation. Attempts to help may be met with defensiveness and verbal attacks. Provide constant reassurance that they are really cared about. Finally, never belittle their feelings; rather point out realities and offer hope. Encourage the individual to engage in social activities. Be careful not to push them; too many demands can

frustrate them and cause feelings of failure. Remind them that with time and treatment, the depression will go away.

The *Clergy Bridge* document has wonderful sections on the common myths related to various mental health challenges. Here are a few of the myths related to depression:

- **Depression is hurtful but not a major medical condition.**
- **Only emotionally troubled people get depressed.**
- **Depression does not cause physical pain.**

SUICIDE

There is no one particular method in preventing suicide. Furthermore, nothing can remove an individual's own freedom to choose the path of his/her own life or death, regardless of treatment or intervention. The main key to suicide prevention is awareness on the part of the individual and those who surround them. In order to save the lives of their friends, loved ones, or others, one must *not be afraid of asking the difficult questions and engaging in the hard and often uncomfortable conversations* associated with suicide.

Suicide attempts are a cry for help. Church leaders can offer support. In addition to providing support, leaders can seek out mental health professionals to provide assistance to these individuals. We should not try to handle these issues by ourselves if we are not trained in the appropriate clinical skills. Finally, if someone is talking about suicide and has a plan, do not leave them alone.

Here are a few of the myths about suicide that are outlined in *Clergy Bridge*:

- **Those who talk about suicide won't actually do it.**
- **People will only try to commit suicide once.**
- **If someone is suicidal, there is nothing you can do and they will always be that way.**

CRISIS INTERVENTION

Sometimes, things reach a point of crisis. In certain circumstances, with various types of mental illness, it will be important to consider crisis intervention. This involves techniques used to provide immediate support to individuals who are experiencing or have witnessed events which are causing mental, emotional,

physical, and behavioral distress. A crisis is a situation in which the individual feels they have lost their ability to cope.

What can church leaders do?

1. **Define the problem: empathy, understand, non-judgmental, use "I" statements to reflect back what they are saying to you, genuineness and acceptance.**
2. **Ensure the individual's safety.**
3. **Provide support.**
4. **Examine alternatives.**
5. **Make plans.**
6. **Obtain commitment.**
7. **Follow up.**

Let me add that in conversations with mental health professionals in preparation for this evening, I have heard repeatedly stressed the importance of church leaders *following up* with people. It's great to connect them with the resources they need. However, your ongoing concern for their well-being is powerful. Please don't drop them once they are getting the professional help they need. Continue to follow up. Check on their progress. See if there are other ways to help. Your follow up will make a difference in the lives of those you seek to help.

EATING DISORDERS

Let's shift to another type of mental health challenge: eating disorders. The Diagnostic and Statistical Manual of Mental Disorders outlines the different types of eating disorders. Anorexia Nervosa is a life threatening eating disorder characterized by self-starvation and excessive weight loss. Bulimia Nervosa is a life-threatening eating disorder characterized by a cycle of binging on food and then doing a compensatory behavior such as vomiting or excessive exercising. Binge-eating Disorder is an eating disorder characterized by recurrent bingeing without compensatory behavior.

Because of the secretiveness and shame of eating disorders, many cases are not reported. We do have some statistics from the National Eating Disorders Association (2009). In the United States, as many as 10 million females and 1

million males are struggling with an eating disorder such as Anorexia or Bulimia. Many more are struggling with Binge-eating Disorder. We know that only 33 percent of those with anorexia and only 6 percent of those with bulimia receive mental health care. Anorexia has the highest mortality rate of any mental illness. Studies show that 80 percent of American women do not like their bodies or appearance, which may contribute to the high rate of eating disorders in America.

My daughter-in-law shared some stories with me recently about friends of hers who struggled with difficult challenges related to eating disorders. They were able to get help, work through a challenging recovery process and overcome these disorders. Help is available for those struggling with an eating disorder. If the person struggling is an adult, he or she must choose to get help. In rare circumstances, however, loved ones can take legal guardianship of an adult's treatment if the adult's health is in critical danger. In this case, loved ones would need to consult with a lawyer. If the person struggling is an adolescent that does not want treatment, parents can obtain treatment for the child against his or her will. While these choices are not ideal, they may be necessary for the health of the person.

The causes of eating disorders are many and are not thoroughly researched. What we do know suggests that eating disorders may have biological, genetic, and environmental causes. They are about more than just food and appearance. When you are talking with someone with an eating disorder, it is usually not helpful to focus on their weight or food. It is more helpful to talk about their health and happiness level, and how to help them with these things.

DOMESTIC VIOLENCE

Domestic violence is any form of violence within a relationship or family and is often referred to as intimate partner violence, family violence, or spousal abuse. Domestic violence is not limited to physical violence only; it can also be manifested through spiritual, emotional, psychological, or sexual means. Though women are most commonly discussed in regards to abuse, men and boys are often among abuse victims.

- **In the United States, 33 percent of all women murdered (limited, of course, to murders that have been solved) are murdered by an intimate partner.**

Women make up about 85 percent of the victims of non-lethal domestic violence.

- **One in three American women are victims of sexual or physical abuse from their husband or boyfriend at some point in their lives.**
- **Men are victims of domestic violence only slightly less than women. These numbers may include women physically defending themselves from abuse.**
- **One in five American female high school students report being physically and/or sexually abused by a dating partner.**

HOW CAN ABUSE BE RECOGNIZED?

The following are kinds of abuse and the forms they take:

- **Physical abuse can include pushing, punching, hitting, shoving, shaking, pulling hair, beating, cutting, burning, choking, hitting specific body parts, throwing against walls, hitting with objects, pushing to the ground, damaging teeth, causing internal injuries, and using weapons among others.**
- **Psychological abuse can include demeaning jokes, yelling, insults, strict expectations, ignoring, destroying property, isolating the partner and not letting her be alone, name calling, threats to her or her family, blaming, hurting pets, scaring kids, threatening suicide, and threatening murder.**
- **Sexual abuse can include sexual put-downs, degrading sexual jokes, embarrassing sexual comments, expecting sex as a duty, withholding sex to punish, flirting or acting out sexually with others to hurt partner, forcing unwanted sexual acts, incest, causing extreme pain during sex, raping, and beating after intimacy.**

WHAT CAN CHURCH LEADERS DO?

Helping those caught in domestic violence is possible. The first step in helping is to recognize that not only does the problem exist but that intervention is needed. When an abuse victim comes looking for help, the church leader should take him or her for their word, and worry about evidence later. Only after these artificial walls have been removed can you

begin the helping process. The first and most basic step of the helping process is to remove those abused, the victims, from the abusive environment and to find them a safe place to stay (with other family members, in a safe house or shelter, etc). One of the most important things you will do is to assure the victim that the abuse is not their fault, that they are not alone, and that help is available. It is important to hold the abuser accountable and to not minimize the abuser's behavior. Continue to support and protect the victim while the abuser begins some sort of counseling.

PORNOGRAPHY

There is much to be said on this topic. I would urge you to read two things: the article by Elder Dallin Oaks on *Recovering from the Trap of Pornography* and the section of *Clergy Bridge* on this topic. I will make a couple of points briefly. Some women marry men who have had a pornography problem and think they will stop using porn after they are married. The reality is that pornography use rarely stops after marriage and in many cases escalates. Stopping its use and healing from its effects before marriage is the healthiest choice.

Regarding recovery from the habitual use of pornography, *Clergy Bridge* makes the following statement which has certainly been borne out in my experience: "Habitual pornography use, especially if it started in adolescence, often requires specialized, professional intervention for solid sobriety to occur. A combination of approaches works best: medical (physicians, psychiatrists), therapeutic (addiction counselors, specialized therapists), spiritual supports, and support groups (e.g., 12 step programs). Finally, pornography needs to be recognized as anti-sex and lust-based.

I hope what I have shared with you has helped you in your own efforts to help others. I commend you for seeking to assist those with mental health needs. You can make a difference. I am confident of that.

Let me close with this statement from an early LDS Church welfare pamphlet. It states: "The Church cannot hope to save a man [or woman] on Sunday if during the week it is a complacent witness to the crucifixion of his [or her] soul." This statement was made in the context of unemployment. However, I think it applies every bit as much to those who suffer with mental illness.

We cannot expect to save someone on Sunday if during the week we are complacent to the crucifixion of their soul due to a mental disorder. I pray that we will go to their rescue after the manner set forth in the life of Jesus Christ. We read in Luke that He came "to heal the broken-hearted, to preach deliverance to the captives [think of all the forms that captivity can take including mental illness]… [and] to set at liberty them that are bruised." (Luke 4:18). We can aid others in the process of accomplishing this work of the Savior's. That we may do so is my prayer in the name of Jesus Christ, Amen.

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[1] ***There's a Suicide Epidemic in Utah – and One Neuroscientist Thinks He Knows Why*, by Theresa Fisher, Nov. 18, 2014**
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[2] **The Advisory Board Company, *Behavioral Health Services Strategy,* 2011**

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Research on altitude as a cause of suicide

***Mission Possible: A Guide to Mental Health for LDS Missionaries and their Mission Presidents, Parents, Bishops and Therapists*; book by Marlene Payne**