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Depression and anxiety are part of the human experience. As a vocation director, it's critical to know when a candidate is presenting a problem that is potentially debilitating or talking about a transitory low period.

What to know about candidates with a history of depression or anxiety

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IN OUR 21ST CENTURY CULTURE, anxiety and depression are common words. People say, "I am depressed today," or "I am anxious today," in everyday conversations, especially among younger people, that is, the Millennials (born between 1981-1996) and Gen Z (born after 1996). When are these phrases to be taken lightly, and at what point are they a concern? If an individual is discerning religious life, we want to take into account their mental and spiritual well-being.

Vocation directors may encounter a variety of individuals who express interest and desire to enter their community. It falls to them to gather all the pertinent information, assist with a prayerful discernment, see to a psychological assessment, and recommend an individual to their congregation's leadership. Vocation directors may interview individuals who express anxiety, depression, or both in their conversations. At what point could anxiety or depression hinder the individual's participation in the dis-

cernment process, participation in community life, and move deeper into the person's spiritual life? There are no simple answers, but knowing more about these two mental health conditions and considering some case studies can provide a nuanced framework from which vocation directors can make more confident decisions.

Depression comes in different forms

Everyone, from time to time, feels sad. However, unlike sadness, time cannot heal major depressive disorder (clinical depression), a serious and persistent form of depression, which can wax and wane over a lifetime. It causes severe symptoms that affect how one feels, thinks, and copes with daily activities such as community interaction and ministry. Symptoms may include persistent sadness, anxiety, hopelessness, feelings of guilt, loss of interest in pleasurable activities, fatigue, difficulty concentrating and making decisions, insomnia, excessive sleep, changes in appetite or weight (gain or loss), and thoughts of suicide. A diagnosis of clinical depression takes these symptoms, their duration, and more into account. The National Institute of Mental Health reports that major depressive disorder is one of the most common mental disorders in the United States.

Certain circumstances put individuals at higher risk for major depressive disorder. For instance childhood trauma (sexual, emotional, or verbal abuse, etc.) increases risk, but no one knows for sure what causes clinical depression. Many times you hear that depression is the result of a chemical imbalance (having too little or too much of a certain brain chemical). However, there are many other possibilities, including genetic vulnerability, medical issues, medications, and major life events that can trigger someone who is genetically predisposed. Clinicians recognize that several of these dynamics can interact, triggering clinical depression. It is highly likely that if an individual has experienced one major depressive episode, they will eventually experience another.

The Diagnostic and Statistical Manual of Mental Disorders 5th Edition (DSM-5) rates for major depressive disorder among males and females are about equal before puberty, but starting in early adolescence, the rates for females is 1.5 to 3 times that of males. The peak age of initial diagnosis is around mid-20s, but the course, number of episodes, and likelihood of full recovery vary. Initial episodes are usually triggered by exposure to a stressful life event; but, as the number of previous episodes increases, the recurrence of additional episodes is related more to the number of prior episodes than to the presence of a life stressor.

On the other hand adjustment disorder with anxiety and depressed mood (situational depression) follows a significant and unwanted change in an individual's life, such as a serious accident, ministry loss, or some other life change. Adjustment disorder often resolves in time. Participating in didactic (talk) therapy with a professional, with or without medication, can help facilitate the recovery process. Recovery is likely once the individual accepts the new situation.

It is important to understand that depressive disorders can be active, or the disorder can be recurrent or in remission. Symptoms related to the disorder can be mild, moderate, or severe. These differences are critically important. For instance, if an individual is experiencing a major depressive disorder with severe and recurrent symptoms, they most likely will have difficulty keeping up with the daily demands of community life and ministry. However, someone else who experienced a loss or transition and is diagnosed with an adjustment disorder with depressed mood with mild to moderate symptoms, may be able to deal sufficiently with the daily demands of community life and ministry.

As noted above, depression is characterized by a core set of symptoms, including low mood, lack of motivation, lack of interest in things once enjoyed, sleep disturbances, and changes in appetite. Most people with depression experience some of these symptoms but may

VOCATION DIRECTOR MUST-KNOWS

- Do not disregard mental health as outside your expertise as a vocation director. You are not a clinician and cannot diagnose, but you should observe and gather information.
- Once your relationship with a candidate has developed to the point where it is appropriate, ask about episodes of depression and anxiety, whether or not there is evidence of them now.
- If the candidate has had experiences of depression or anxiety, ask about the circumstances, duration, frequency, and treatment.
- It is crucial to share information you gather (with the candidate's knowledge) with the professional who conducts a psychological evaluation. You are not creating bias; you are helping the psychologist fine-tune the assessment in order to provide you with the highest quality information.

not have them all. Gender can be a contributing factor. It has long been thought that men and women experience and express depression differently. Men are more likely to misuse alcohol, have frequent outbursts or "explosive" anger, engage in risk-taking behavior, or play video games for hours. On the other hand, women are likely to have difficulty concentrating or making decisions, feelings of worthlessness, chronic pain, or episodes of excessive crying. These different forms of expression do not mean the disorder can be separated into two distinct types of depression (one for men and one for women). There are no clear differences between genders in symptoms, course of illness, and treatment.

While not classified in the DSM-5 as a depressive disorder, bipolar disorder is worth a brief mention. There are two types of bipolar disorder, I and II, with I being more severe. Heredity is the primary contributor to bipolar disorder, and a family history of either form of bipolar is one of the strongest predictors of risk, with the level of risk increasing with the degree of relationship. Bipolar disorder is characterized by extreme mood swings, from symptoms of depression to symptoms of mania. Mania involves a distinct period of abnormally

CASE STUDY: SISTER M

SISTER M is a Millennial who is now in temporary profession. She, like other case studies here, is a composite, based on many years of experience in treating newer members of religious communities. During her initial discernment phase, she shared with the vocation director that she was often tearful but was not sure what brought on the tears. She did not have friends with whom she felt comfortable sharing intimate thoughts and feelings and never dated in high school or college. In the vocation director's behavioral assessment the director wrote that Sister M was bullied and teased in school for being too sensitive, but Sister M's lack of intimate relationships wasn't noted. Sister M has been associated with the community for a number of years, starting from her discernment phase to what is now her second year of temporary profession. These last two years have been very stressful for her. Sister M felt she was given too many community responsibilities on top of a demanding ministry. She found it too stressful for her, especially during temporary profession.

During her initial psychological evaluation, Sister M reported a number of personal strengths but also reported what she considers personal limitations such as being shy, too sensitive, too easily stressed, and neglecting her prayer life when she has too much to do. Her psychological testing indicated that she tends to be vulnerable to episodes of depression and anxious rumination over her lack of self-confidence and inability to meet her own expectations, causing a vicious cycle of self-criticism and anxiety. This cycling appears to be significantly problematic for her, causing emotional pain. Her stress paralyzes her ability to make decisions. Given that she sets high standards for herself and has a strong need to achieve, she likely feels she falls short of her own expectations. The assessment also indicated that Sister M lacks self-confidence, feels insecure, and overall feels dissatisfied with her life.

The vocation director and the congregational leadership reviewed the relevant material, and all agreed to accept Sister M into initial formation with the understanding that she would have a growth plan that would include working on assertiveness. During her postulancy, Sister M completed all the tasks asked of her, such as household responsibilities, part-time ministry, and faithfulness to her prayer life. However, she seldom came to the community room, except when required to do so. She spent much of her spare time on the computer, which she reported was related to candidacy classes. She had few connections with the other sisters even within her cohort.

Looking back to Sister M's discernment phase and initial formation, there were warning signs. Remember, in Sister M's background she herself noted having few friends and being very shy. Was Sister M depressed prior to entering initial formation? Most likely, yes, and her psychological evaluation indicated that she was vulnerable to depressive episodes. Her discernment phase would have been a good time to inquire about her lack of friends and why she felt shy. These areas raise concerns that warrant further investigation. Counseling would have been appropriate during her discernment and novitiate to flush out any other issues.

Sister M was given permission to enter into temporary vows. She complied with all community responsibilities, but again was only present for community events that were required and nothing more. During temporary vows, she became more withdrawn and anxious and less self-confident. She exhibited signs of depression. Counseling during her earlier years in formation likely would have helped her understand the connection between her lack of self-confidence, anxiety, and depression. It could have helped her and her community have a better experience.

and persistently elevated, expansive, or irritable mood and persistently increased activity or energy. These symptoms can impair function and even require hospitalization to prevent harm to self or others.

Variations on anxiety

Anxiety is a normal reaction to a stressful event, and in many cases anxiety is useful in motivating an individual to make a necessary decision and act. However, when symptoms become persistent and debilitating to the point where they disrupt an individual's life, it is time to seek help, as the symptoms likely indicate an anxiety disorder with underlying depression.

It is not uncommon for someone to have both depression and anxiety. Usually the two go hand-in-hand. The DSM-5 lists six different anxiety disorders: generalized anxiety disorder, panic disorder, phobias, agoraphobia, social anxiety disorder, and separation anxiety disorder. For the purpose of this article, I will focus on general anxiety disorder.

As defined in the DSM-5, generalized anxiety disorder is excessive anxiety and worry about a number of events or activities. The intensity, duration, or frequency of the anxiety and worry is out of proportion to the actual likelihood or impact of the anticipated event. The person finds it difficult to control the worry and to keep worrisome thoughts from interfering with concentrating on the tasks at hand. Similar to rates of depression, women are twice as likely to have an anxiety disorder as men. While some symptoms of anxiety between genders may differ slightly, for the most part men and women share the same symptoms of anxiety.

According to the 2020 Deloitte Global Millennial Survey, a surprising 44 percent of Millennials and 48 percent of Gen Zs reported feeling anxious and stressed more times than not. In terms of gender breakdown, women experienced more stress than men. Among the different age groupings, some 47 percent of females to 40 percent of males among Millennials and 53 percent of females to 42 percent of males among Gen Zs felt anxious and stressed.

In the same survey, half of the Millennials and Gen Zs surveyed believed stress was a valid reason to take time off from work. Of interest, one in three of the young people surveyed took time off from work this past year because of stress. The physical and emotional burden of anxiety not only affects time away from ministry but also ministry performance.

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Sometimes therapy and medication can bring about a new day for individuals with depression and anxiety. But each case is unique, and not everyone with these conditions can be in a religious community.

Seeking help, determining readiness

Generally speaking, a counselor provides advice for clients after evaluating them over time. Counselors may refer clients to psychologists for more in-depth, insight-oriented psychotherapy, which was likely needed in Sister M's case, [see "Case Study: Sister M" on page 12.] However, such insight-oriented psychotherapy can be a distraction in formation, drawing the applicant away from community activities and prayer. Thus issues of depression and anxiety are best addressed in counseling and psychotherapy prior to formation.

So what is the next step in examining readiness for formation? How does a vocation director determine who should be recommended to leadership to move forward in formation—especially if there are warning signs in the discernment phase and in the recommendations of the psychological assessment? What is the comfort level of the community in receiving an applicant into formation who has experienced anxiety or depression or both?

A number of issues need to be taken into consideration. For instance, does the applicant have a history of depression? If so, what type of depression, and who did the diagnosis? Is the person currently on medication, and if not, was he or she on medication in the past? Was the person in counseling or psychotherapy or only on medication?

Here is a plausible scenario. An applicant appears ready to move forward into candidacy, and the vocation director schedules the psychological assessment. The ap-

CASE STUDY: BROTHER Z

BROTHER Z, AGE 23, discloses he had an abusive childhood. Three years prior to entering into discernment with the community, he was diagnosed with depression. He shared with his primary care physician that he was experiencing frequent outbursts and "explosive" anger and lost interest in many things he used to enjoy. His doctor prescribed an antidepressant and suggested counseling. After about four weeks, Brother Z started feeling better, thus he did not believe he needed counseling or therapy. He remained on the medication for approximately one year. During the discernment phase applicant Brother Z shared his history with the vocation director that he had taken an antidepressant for about one year and has not had a recurrence of symptoms.

The community decided to allow him to enter. He was fine for three years, but after temporary vows he started having outbursts in community and lost interest in his prayer life, community life, and ministry. Subsequently, the community asked him to seek out insight-oriented psychotherapy, which he eventually did. An important lesson learned here is that the information concerning his depressive episode should have been shared with the testing psychologist so that it could have been ascertained whether the depression was situational or genetic.

plicant then tells the vocation director she was depressed during high school and again in her first two years of college. She reports that she is currently on medication. First this information needs to be shared with the testing psychologist. It is valuable for the clinical interview and will help the psychologist determine what additional testing is needed to assess her current emotional well-being. The vocation director needs to know what type of depression the applicant experienced. Was it situational depression, or does the applicant currently have a diagnosis of bipolar disorder or major depressive disorder? If the clinical interview and the testing indicate bipolar disorder or major depressive disorder, the vocation director needs to know if the applicant is taking medication as prescribed.

Research by the National Institutes of Health indicates that upward of 60 percent of individuals diagnosed with bipolar do not take their medication as prescribed. Medication non-adherence can lead to negative outcomes such as hospitalization, relapse, functional impairment, or suicide. Similar research indicated that individuals diagnosed with major depression were 10 to 60 percent medication non-adherent, also with similar negative outcomes. While an applicant believes he or she has a calling to the charism of the community, the vocation director and the community need to assess the liability. Additionally, they need to determine whether the applicant can keep up with the demands of ministry and community life as stress and anxiety are known triggers for bipolar episodes.

Let's consider another scenario. An applicant preparing to enter candidacy or postulancy shares with the vocation director that during his freshman year he was diagnosed with "adjustment disorder with anxiety and depressed mood." He reported that social media bullying led to his depression and anxiety. He was on medication for a brief period and sought out counseling at the college counseling center. He denies having suicidal thoughts at the time of the bullying. Again, this is vital information to share with the testing psychologist. The psychologist can assess whether or not the applicant has dealt with the issues that led to the situational depression and if there are any residual side effects. If the applicant's issues have been resolved, it is likely that he could be accepted into candidacy or postulancy.

Looking at the overall picture of depression and anxiety among the young people who seek out religious life, a number of different diagnoses might be involved. A vocation director, in discernment with the applicant and in the behavioral assessment, needs to assess if an applicant has experienced either one or both of these common mental health concerns, either in the past or currently. Depression and anxiety can be debilitating. Both of these mental health concerns are no fault of the individual as they are genetic and/or situational and often triggered by environmental events. But religious communities need and want individuals who can be in ministry to others and not have an individual who becomes a ministry for the community. Certainly the vocation director's analytical and pastoral skills will be put to the test when good candidates who suffer from depression and anxiety present themselves. Compassion and prudence must both be at play as the vocation director proceeds with caution and understanding. ■

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