Medical Treatments for Depressive Symptoms

by Edward Welch

When you talk about medication and other somatic treatments for depression, you often encounter strong opinions. For those who have been dramatically helped by medication, these treatments are *the* answer. For those who believe that medication masks sin, these treatments are, at best, considered to be ill-advised. They have even been interpreted as a modern expression of pagan sorcery.

Those who opt for these more extreme positions tend to either ignore Scripture or use Scripture legalistically, asking it to speak more precisely than it intends. This brief, practical review will attempt to steer a course between those who put their hope in medication, and those who believe that Scripture prohibits any pharmacological treatment.[1]

What We Know

From a medical perspective, all we really know is that "more research is needed." Although there has been extensive research over the last twenty years, no biological theory has clear empirical support. There are two propositions, however, on which there is broad agreement.

First, the best known proposition is that *physical treatments, most notably antidepressant medication, can lighten depression in some people*. In fact, there are times when the reduction in depressive symptoms can be dramatic. This is undeniable. Even those who oppose medication would agree that depressive symptoms can be affected by physical treatments. They themselves often recommend various physical treatments. For example, although they might oppose medication, they might suggest more consistent sleep patterns, physical exercise, or a balanced nutritional program. These are all physical treatments that, for some people, might carry a benefit.

We would expect physical treatments to affect some symptoms of depression. If depression had no accompanying physical complaints, then physical treatments would be irrelevant. For example, if someone struggles with guilt from sexual sin, a physical treatment cannot alleviate the guilt unless it erases past memories. Only confession of sin to someone who forgives can quiet the conscience. But depression includes physical symptoms. Similar to fear, it usually has spiritual roots, but its physical manifestations include sleep problems, change in appetite,

[1] For further discussion of psychiatric treatments, see Welch, *Blame It on the Brain* (Phillipsburg, NJ: P&R, 1998), and David Powlison, "Biological Psychiatry," *The Journal of Biblical Counseling*, 17:3 (Spring 1999), pp. 2–8.

lethargy, poor concentration, and even the actual *feeling* of depression. Physical treatments can impact these physical symptoms.

The physical treatment that has received the most attention is psychiatric medication. The present-day assumption, in both lay and professional circles, is that such medication is the most helpful form of treatment, especially when depression is severe. The evidence for this assumption, however, is lacking. Perhaps the assumption is fueled by our admiration of science and technology more than by reliable observations. That is, we are prone to believe that a chemically sophisticated drug is much more effective than a friend who loves in word and deed.

Recognizing that talk therapies and even ordinary relationships may help as much as medication, the mental health community has proposed that for more severe, "clinical" depression, medication has a distinct advantage. Yet even this supposed advantage for medication is questionable.

One reason that medication may be, at times, more effective than non-medical approaches is that medication is *perceived* to be highly effective by most people; therefore, it oftentimes *will* be highly effective. In other words, even if medication is not truly superior to other treatments, its placebo effect tends to inflate its claims. When you are given psychiatric medication, it must first be prescribed by physicians who have significant prestige in this culture. Furthermore, when you consult with them, they will speak with great confidence that medication is *the* treatment and it *will* alleviate depression. Given this introduction, our expectations are very high, and results are likely to be exaggerated. Would psychiatric drugs be as effective if they were sold over-the-counter, without any prescription, and therefore without the accoutrements of medical prestige? Probably not. Without the hype, they would likely be similar to zinc lozenges for the common cold in that they might help some people, but results would vary, and many people wouldn't bother taking them when they had symptoms.

Researchers, of course, try to account for and minimize this placebo effect. But even the double-blind studies of modern pharmacology are not enough to neutralize expectations. Too often, participants in drug studies can detect, by way of certain side effects, whether or not they are being given the active drug or the inert substance of the control group. Their expectations of a beneficial response then rise, enhancing the effect of the drug.

Of particular relevance to counselors is how medical treatments compare to secular counseling. Even in cases of severe depression, careful analysis of the evidence does not demonstrate the superior effectiveness of medication over counseling.[2] Why is this relevant to Chris-

[2] Robert J. DeRubeis, Lois A. Gelfand, Tony Z. Tang, and Anne D. Simons, "Medications Versus Cognitive Behavior Therapy for Severely Depressed Outpatients: Mega-Analysis of Four Randomized Comparisons," *American Journal of Psychiatry*, 156 (1999), pp. 1007–1013.

tian counselors? Too often, Christian counselors have a vague suspicion that there is a magic, awe-inspiring medical treatment for depression, and they become less confident in Scripture's ability to speak deeply to the heart of depression. The reality is that medication, on the average, does not surpass the benefit of psychological (non-medical) approaches, with which biblical counseling could be loosely clustered. Furthermore, neither medical *nor* psychological treatments provide the benefit of dealing with the deep issues of the heart.

Assuming that psychiatric medications can bring some alleviation of symptoms in some depressed people, another question is, "Why?" In short, even though the serotonin hypothesis is widely accepted, we do not know why psychiatric medications alleviate symptoms in some people. The brain is simply too complex and our knowledge of its mechanics is too primitive. This year, serotonin is the favored neurotransmitter. In previous years it was dopamine. In future years it will be another brain chemical.

Most researchers acknowledge that we simply don't know why psychiatric medications work. And since we don't know why medication alleviates symptoms in some people,

- we don't know why it *doesn't* help some people;
- we don't know why, for any individual person, some medications are more effective than others;
- we don't know why medications that are chemically different have a similar effectiveness;
- we don't know why antidepressants seem to be equally effective with seemingly unrelated problems such as obsessive thoughts and compulsive behavior; and
- we don't know why the antidepressants so often lose their effectiveness over time.

At this point, aspirin is an apt analogy for psychiatric medication in that it can alleviate symptoms, but it doesn't treat an underlying cause.

One argument for psychiatric medication that has emerged in the culture of managed care is that medication is simply more efficient than talking and persevering with someone. With insurance companies looking for a cost-effective treatment, medication seems to be the likely candidate. This perceived cost-effectiveness, however, is not as clear as it appears. Those who have taken psychiatric medications know that trying to find a helpful medication is a trial-and-error process. For example, you try a medication for two to six weeks, and, if it doesn't work, you switch to another. Or, perhaps you will add a medication to one that seems only minimally helpful. Then, when you have unwanted side effects, or when the medication is no longer effective, you switch again. In other words, pharmacological treatments only appear to be very simple, as if you just have to take a pill. However, for many people, the drug approach puts a person on a treatment treadmill that is hard to stop.

To summarize, the first proposition is true: ***physical treatments, most notably antidepressant medication, can lighten depression in some people***. However, the claims for some of the

physical treatments tend to be exaggerated.

The second proposition consists of the well-established observation that ***some known medical diseases can have depressing effects***. Table 1 lists some of the more notable ones.

Table 1

Medical Problems with Known Depressing Effects

Parkinson's disease
Strokes
Multiple Sclerosis
Epilepsy
Head trauma
Lupus (SLE)
Vitamin deficiencies
Post-surgical changes
AIDS
Hepatitis
Hyperthyroidism
Hypothyroidism
Cushing's disease
Premenstrual depression
Viral or bacterial Infections
Certain types of headaches
Heart disease
Side effects of medication
Chronic Fatigue

Depressions from known diseases tend to differ from the ones we have been addressing in both this and the past issue of the *Journal of Biblical Counseling* in two ways. First, they have a clear medical cause, in contrast to the more common depression that has no distinguishing characteristics on medical diagnostic tests. Second, they can usually be distinguished on the basis of the depressive experience. For example, depression from a definite medical condition tends to be more simple. It rarely includes the hopelessness, suicidal thinking, or self-loathing that are present when depression is, in some way, an expression of the heart.

Depression that is the result of a definite medical condition is rare when compared to the actual incidence rate of all depression, but counselors should still be alert for it. You need to look for someone who complains about depression but has no previous history of depression, has a known disease, or has been taking medications.

Some Biblical Guidelines

Contained in these two propositions is a world of technical data and new terms. Counselors, however, do not have to be experts on the most current medical treatments for depression. It is enough to know the following.

1. All depression needs more active spiritual attention.

2. Most depression, at the very least, will be lightened as those who are depressed attend to their own hearts, the knowledge of God, trust, and obedience.

3. Dozens of physical treatments have been effective in relieving some of the physical features of depression. The most popular include exercise, antidepressant medication, bright lights for those who have a seasonal rhythm to their depression, and electro-convulsive therapy (ECT). Others that are effective with smaller numbers of people include diet and nutrition, and short-term solutions such as staying up all night in order to try to correct sleep rhythms.

The question for counselors and friends is, When do we encourage others to consider or pursue medical treatments? Do we suggest that they consult with a psychiatrist immediately, while we counsel them? Should we even raise the issue?

The reality is that the question will rarely come up. Medical treatments for depression are so well-known that people will probably be taking medication before they talk to you. Or else their friends or family will quickly suggest antidepressants or another physical treatment.

First, if they are already taking medication, it is not necessary to do anything except be aware. To argue that antidepressants are wrong would be, I believe, legalistic. It would ask Scripture to speak more specifically to the issue than it intends. So it would most likely be outside your ministerial bounds, as well as outside your level of competence to encourage them to stop or change their medication. You have something to offer that is better than medicine, so you should focus on Christ and the encouragement and application of Scripture.

One issue that you will want to address is when you find the depressed person investing salvific hope in medication. This is certainly an issue of the heart. Christians don't put their hope in anything this side of heaven. To do so is idolatry. It is certainly appropriate to be thankful for the alleviation of some difficult symptoms, but there is a deeper thankfulness, embedded in the finished work of Christ, that should shape our emotional lives.

You would do well to consider how depressed people are doing while taking the medication, compared to how they were doing when they were not taking the medication. If they are presently doing worse or having deleterious side effects, you should encourage them to speak to the prescribing physician.

Second, if those who are depressed are not taking medication, it is not necessary to do anything. This doesn't mean that you believe medication is wrong, it simply means that your job is to focus on the heart, on Christ, and on renewal of a person's thinking and lifestyle. That is

the greatest salve that you can offer.

Third, if those who are depressed ask about medication, ask them to consider first a season where they allow their hardship to challenge and increase their faith, in which they say, "Lord, search me," and they meet with a spiritual mentor. The benefit of postponing medication is that it is easier to know what proves helpful if you introduce one "treatment" at a time. For example, if the person immediately began taking medication and, after a few weeks, started to show a lessening of symptoms, you wouldn't know if it was from spiritual changes or medication. If the changes were inaccurately attributed to the medication, then the person could end up taking unhelpful medication for years.

When in doubt about how to manage your counselee with regard to medication, get counsel from other pastors, counselors, physicians, or laypeople who have both biblical wisdom and experience with depression.

The question with medication and other physical treatments is not, "Is this treatment right or wrong?" The question is, "Is this treatment wise?" As such, the guidelines of wisdom apply. These include careful investigation of the treatment, seeking counsel from an experienced, wise group, and, most importantly, walking in the fear of the Lord.

Quick Reference to Psychotropic Medication: Names, Dosages, and Side Effects

The following list includes medications prescribed by psychiatrists and general physicians for anything that would receive a psychiatric label. It is provided only as a source of information, without commentary, and does not represent an endorsement of either the medications or the organizational scheme. It shows what medications are presently being used, and it is organized according to present psychiatric traditions. Especially within the antidepressant class, new drugs are being introduced almost monthly, so there may be one or two new drugs that do not appear. For a more in-depth examination of these drugs, check their sites on the Internet.

Antidepressants

Brand Name	Generic Name	Usual Daily Dosage Range	Sedation	ACH[1]
HETEROCYCLICS				
Asendin	amoxapine	150–400 mg	mid	low
Aventyl, Pamelor	nortriptyline	75–125 mg	mid	mid
Celexa	citalopram	10–60 mg	mid	mid
Desyrel	trazodone	150–400 mg	mid	none
Effexor	venlafaxine	75–375 mg	mid	none

Elavil	amitriptyline	150–300 mg	high	high
Ludiomil	maprotiline	150–225 mg	high	mid
Luvox	fluvoxamine	50–300 mg	low	low
Norpramin	desipramine	150–300 mg	low	low
Paxil	paroxetine	20–50 mg	low	low
Prozac	fluoxetine	20–80 mg	low	none
Remeron	mirtazapine	15–45 mg	mid	low
Serzone	nefazodone	100–500 mg	mid	none
Sinequan, Adapin	doxepin	150–300 mg	high	mid
Surmontil	trimipramine	100–300 mg	high	mid
Tofranil	imipramine	150–300 mg	mid	mid
Vivacil	protriptyline	15–40 mg	mid	mid
Wellbutrin	bupropion	200–450 mg	low	none
Zoloft	sertraline	50–200 mg	low	none
MAO INHIBITORS				
Nardil[2]	phenelzine	30–90 mg	low	none
Parnate[2]	tranylcypromine	20–60 mg	low	none

Anti-obsessionals

Brand	Generic	Dose Range[1]	Sedation	ACH effects
Anafranil	clomipramine	150–250 mg	high	high
Luvox	fluvoxamine	50–300 mg	low	low
Paxil[1]	paroxetine	20–60 mg	low	none
Prozac[1]	fluoxetine	20–80 mg	low	none
Zoloft[1]	sertraline	50–200 mg	low	none

Mood Stabilizers

Brand	Generic	Dose Range	Serum Level
Depakote, Depakene	valproic acid	750–1500 mg	50–100 mcg/ml
Eskalith, Lithonate	lithium carbonate	600–2400 mg	0.6–1.5 mEq/1
Tegretol	carbamazepine	600–1600 mg	4–10+ mcg/ml

Psycho-Stimulants

Brand	Generic	Dose Range[1]

Cylert	pemoline	37.5–112.5 mg
Dexedrine	dextroamphetamine	5–40 mg
Ritalin	methylphenidate	5–50 mg

Antipsychotic

Brand	Generic	Dose Range	Sedation	ESP[1]	ACH effects[2]
Clozaril	clozapine	300–900 mg	high	0	+++++
Compazine[3]	prochlorperazine	15–40 mg	mid	+++	+++
Haldol[4]	haloperidol	2–40 mg	low	+++++	+
Loxitane	loxapine	50–250 mg	low	+++	++
Mellaril	thioridazine	150–800 mg	high	+	+++++
Moban	molindone	20–225 mg	low	+++	+++
Navane	thiothixene	10–60 mg	low	++++	++
Orap	pimozide	1–10 mg	low	+++++	+
Prolixin[4]	fluphenazine	3–45 mg	low	+++++	++
Risperdal	risperidone	4–16 mg	low	+	+
Serentil	mesoridazine	50–500 mg	high	+	+++++
Seroquel	quetiapine fumarate	150–500 mg	mid	0	+
Stelazine	trifluoperazine	10–40 mg	low	++++	++
Thorazine	chlorpromazine	50–1500 mg	high	++	++++
Trilafon	perphenazine	8–60 mg	mid	++++	++
Zyprexa	olanzapine	5–15 mg	mid	+++	+

Anti-Anxiety

Brand	Generic	Single Dosage Dose Range
BENZODIAZEPINES		
Ativan	lorazepam	.5–2 mg
Centraz	prazepam	5–30 mg
Dalmane[1]	flurazepam	15–60 mg
Halcion[1]	triazolam	.25-.5 mg
Klonopin	clonazepam	.5–2.0 mg
Librium	chlordiazepoxide	10–50 mg
Restoril[1]	temazepam	15–30 mg
Serax	oxazepam	10–30 mg

Tranxene	clorazepate	3.75–15 mg
Valium	diazepam	2–10 mg
Xanax	alprazolam	.25–2 mg
ATYPICAL BENZODIAZEPINES		
Ambien[1]	zolpidem	5–10 mg
Doral[1]	quazepam	7.5–30 mg
ProSom[1]	estazolam	1.0–2.0 mg
OTHER ANTI-ANXIETY AGENTS		
Atarax, Vistaril	hydroxyzine	10–50 mg
Benadryl	diphenhydramine	25–100 mg
BuSpar	buspirone	5–20 mg
Catapres	clonidine	.1–3 mg
Inderal	propranolol	10–80 mg
Tenormin	atenolol	25–100 mg

Combination Drugs

Etrafon (Trilafon & Elavil)
Limbitrol (Librium & Elavil)
Triavil (Trilafon & Elavil)