The book cover is composed of six panels arranged in a 2x3 grid. The top row consists of three panels with a blue, a maroon, and a brown background, each featuring a stylized rose pattern. The bottom row consists of three panels with a brown, a dark brown, and a dark maroon background, also featuring stylized rose patterns. Scattered across these panels are various pills and capsules in white, blue, green, and brown. A large, dark green rectangular area on the right side of the cover contains the title text in white.

On a PILL and a PRAYER

MEDICATIONS FOR DEPRESSION

by David F. Colvard and William P. Wilson



They said he should have been in the hospital yesterday.” The seminarian’s young wife was desperate as she called on a Friday afternoon from an emergency room. Her husband had very high blood pressure and sharp chest, abdominal, and back pain. He was convinced he was dying from cancer or a heart attack and was threatening suicide. During the preceding months he had seen several physicians in their offices and emergency rooms. They had tried mild sedatives and blood pressure medications, but nothing had helped.

Along with his physical complaints, the young man suffered crying spells, ruminative worrying, low energy, a loss of appetite, and a 12-pound weight loss. Sometimes he awoke at 3 a.m. in a panic, and he had lost interest in everything, including sex. He heard Satan telling him to curse the Holy Spirit and believed he had committed the unpardonable sin. He was overwhelmed with guilt over his prior indulgence in pornography.

Because the man’s finances were limited, and he refused to go to the state hospital, he was treated as an outpatient. His wife was asked to give him a combination of antidepressant and antipsychotic medications. Three days later he was eating and sleeping better. His auditory hallucinations had ceased and he no longer had thoughts of suicide. Over the ensuing months his medications were adjusted and he began effective Christian psychotherapy. He recovered fully, graduated from seminary on schedule, and has become a very usable, highly effective pastor who ministers to unchurched baby boomers. He has lived out Psalm 42.

Somewhat different is the story of a middle-aged church secretary who had been depressed most of her adult life. As a child she had been verbally abused by her mother and did not receive affirmation from her emotionally distant father. After finishing college she married a devoted and loving man and had three children. When these children started school, she worked as a bookkeeper in a large metropolitan church. Yet she was always depressed, and endured, but never enjoyed, life. Although she had a strong faith and an encyclopedic knowledge of the Bible, she never conquered her depression. Psychotherapy produced little symptom relief. She developed good insight, restructured her thinking, and developed good self-esteem, but the depres-

sion persisted. After starting on antidepressant medication, however, her symptoms were relieved. Her spirits rose, she had greater zest for living, and she related to her husband, children, and friends with greater affection.

Another recurrently depressed Christian woman had a different outcome to her depression. She stopped her antidepressant medication, canceled her psychotherapy appointments, and went to a televangelist’s retreat center to use their prayer closets. But God did not heal her depression. A few weeks later she committed suicide in her bathroom after taking the children to her parents’ house.

IS MEDICATION CHRISTIAN?



These three cases illustrate the contention that medication is one of God’s instruments for healing. The controversy among some Christian counselors about the use of antidepressant medications and the reluctance of some Christians to take medication for depression is unnecessary. Failure to use antidepressant medications can lead to prolonged suffering or suicide for the depressed. The severe disruption of their lives does nothing to further the cause of Christ. Satan is an opportunist, and few diseases afford him more opportunities to destroy than major depression.

Many Spirit-filled, Bible-believing Christians who would not hesitate to permit a non-Christian surgeon to perform a coronary bypass operation or a pediatrician to inject an antibiotic, perceive taking an antidepressant medication as lack of faith in God’s ability to heal them. Some believe that depression is demonic or a punishment sent by the Lord or caused by some other spiritual problem. Some mistakenly believe that a good Christian cannot suffer depression, adding a layer of false guilt and shame to the depression. Mental illness or “madness” apart from demon possession or punishment for sin appears to have been recognized even in biblical times.¹

Depression usually has multiple causes: physical, emotional, spiritual, and situational. Some depressed patients have described it as a living death. Bible translator J.B. Phillips felt God did not hear his prayers and Scripture brought him no comfort or hope in the midst of his episodes of depression.² On occasion God does intervene directly to heal depression, but he also uses Christian counseling, medica-

tion, and the passage of time to heal, even as he comforts the depressed in their suffering.

Why would a loving and just God not use medications for the benefit of his suffering children? "Is there no balm in Gilead? Is there no physician there? Why then is there no healing for the wound of my people?" wrote Jeremiah (8:22). Balm, olive oil, frankincense, myrrh, aloes, honey, lint, animal grease, and other substances were known and used medicinally by physicians and lay people in biblical times.³

God now has given us many nonaddicting modern medications with few side effects. They usually result in a marked reduction or removal of symptoms, shortened duration of symptoms, rapid restoration of occupational and social functioning, and increased effectiveness of Christian psychotherapy aimed at preventing relapse and recurrence.⁴

TYPES OF DEPRESSION RESPONSIVE TO MEDICATIONS

Major depressive disorder and bipolar disorder are particularly responsive to antidepressant medications and to electroconvulsive therapy (ECT). Seasonal affective disorder usually responds to antidepressant medications and light therapy administered from late fall to early spring. Dysthymic disorder, adjustment disorders, atypical depression, complicated grief reactions, and some anxiety disorders may respond partially to antidepressants, making psychotherapy easier and more effective. With limited insurance reimbursement and emphasis on brief, focused therapy, anything that hastens recovery is welcome.

PHARMACOLOGICAL OPTIONS

In the past, physicians used spinning chairs, dunking in ice water, insulin-shock treatment, amphetamines, and long-term psychotherapy and residential hospitalization because few other options were available. The development of safe and humane techniques for ECT increased clinical efficacy to 90 percent for major depression - still superior to all current antidepressant medications. More than 20 antidepressant medications have been approved by the FDA and are available in the United States. Even more are at various stages of development and clinical trials. (See chart for a break-

down of antidepressant types and side effects.)

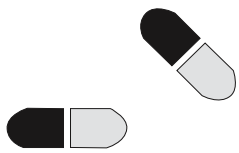
MAOIs. Antidepressant medications are classified by their presumed mechanisms of action. First developed were the monoamine oxidase inhibitors (MAOIs), such as phenelzine (Nardil) and tranylcypromine (Parnate), with their diet restrictions, dangerous side effects, and potential for fatal overdose. Even so, the MAOIs are particularly useful with atypical depressions characterized by sensitivity to rejection, emotional reactivity, excessive sleep, and excessive appetite.

CYCLICS. In the 1960s the tricyclic antidepressants (TCAs) became available and found wide acceptance because of reduced side effects. They act by reducing the reuptake of the neurotransmitters norepinephrine and serotonin (see sidebar). Their clinical effectiveness has been less than 70 percent in double-blind, placebo-controlled clinical trials. No antidepressant medication developed since has shown greater effectiveness.

Side effects have been a problem with TCAs and tetracyclics. While not life-threatening, weight gains of more than 20-pounds have been common, as have dry mouth, constipation, urinary hesitancy, memory disturbance, delayed orgasm, light-headedness upon arising, and drowsiness. Excessive doses and over-doses can cause confusion, disorientation, delusions, and hallucinations. Overdoses are particularly lethal due to interference with electrical conduction in the heart.

Tricyclic and tetracyclic antidepressants have been found to be more effective when augmented with low doses of antipsychotic medications, such as Trilafon, especially with severe, psychotic, or delusional depressions. Combination pills are available containing both medications, such as Triavil, which is a combination of Trilafon and Elavil. Other medications used to enhance effectiveness of TCAs are lithium (used for recurrent and manic-depression), thyroid hormone, and antidepressants known to elevate blood levels of TCAs. Although blood levels for most TCAs can be measured in the lab, they are usually only clinically useful with drugs that have well-established therapeutic windows.

LITHIUM. Lithium, the lightest known metal, occurs as a salt and has been used in medicine since the 1850s. It is not normally found in the body. Lithium was first used to



treat mania in 1949 in Australia; however, it was not widely used before 1970. Since that time, lithium has been used to treat and prevent manic and depressive episodes in individuals with bipolar disorder. The mechanism of action of lithium is unclear. Blood levels are monitored in patients to maintain a therapeutic range and to avoid toxicity. The most common side effects are nausea, vomiting, diarrhea, weight gain, edema, tremor, fatigue, and mild cognitive impairment. Many patients have now taken lithium for decades without difficulties.

SSRIs. In December 1987, the selective serotonin reuptake inhibitor (SSRI) fluoxetine (Prozac) became available in the United States. It quickly became a best seller because of fewer side effects and greater safety in overdose compared to MAOIs and TCAs, though it is considerably more expensive. Its clinical effectiveness in treating depression is equal to TCAs, but it is better tolerated by patients who had complained of side effects of TCAs. Better acceptance by patients translated into better compliance in taking the medicine as prescribed. Accusations implicating Prozac in increased suicide risks and aggression are unfounded.

Other SSRIs have followed Prozac. Additional SSRIs available outside the United States likely will win FDA approval soon.

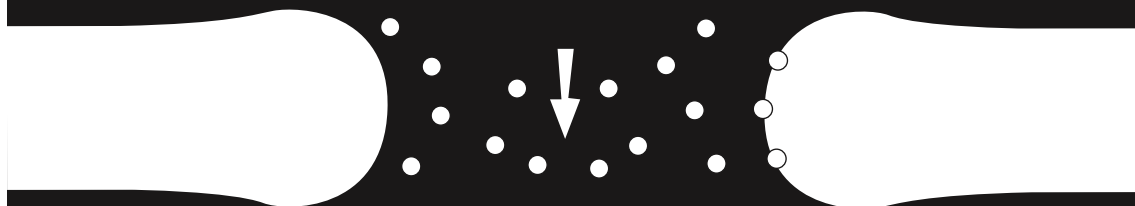
The most common side effects of the SSRIs include agitation, insomnia, nausea/vomiting, and diarrhea. Unlike the MAOIs and the TCAs, the SSRIs are relatively safe in

overdose when taken alone. Most can be taken in a single daily dose, thus improving patient compliance. They also have been found to be useful in treating obsessive-compulsive disorder, panic disorder, generalized anxiety disorder, paraphilias, and premature ejaculation. Their use in personality enhancement has not been well established in clinical trials, despite considerable favorable publicity in 1994.

OTHER ANTIDEPRESSANTS. The antidepressant trazodone also inhibits the reuptake of serotonin and became available several years before Prozac, but frequently causes sedation in therapeutic doses. It improves sleep quality without decreasing stage four sleep and has been used to counteract the insomnia accompanying some of the SSRIs. It has been associated with the occurrence of priapism (prolonged, painful erections that require emergency surgery).

Bupropion (Wellbutrin) was approved by the FDA for the treatment of depression about the same time as Prozac, but was held back by the manufacturer due to concerns over a risk of seizures. Wellbutrin then went through several years of exhaustive clinical trials, which found the seizure incidence to be only four out of 1,000 patients, or about four-fold that for other antidepressants. Wellbutrin is not an MAOI and is a weak serotonin and norepinephrine reuptake inhibitor, but it does somewhat inhibit the reuptake of dopamine. Its more common side effects include agitation, dry mouth, headache, constipation, excessive sweating, nausea/vomiting, dizziness, and

Neuronal



Normally, Neuron A releases a neurotransmitter, such as serotonin or norepinephrine, Neuron B receives it and Neuron A reabsorbs any of the neurotransmitter that remains in the cleft. In depression, too little transmitter may be produced by Neuron A, lessening the amount available to Neuron B. Antidepressants prevent Neuron A from reabsorbing the neurotransmitter, making more of it available to Neuron B.

insomnia, but it is not known to interfere with sexual functioning. Wellbutrin has been rumored to enhance sexual responsiveness and lead to weight loss, a seemingly unbeatable combination. Like the SSRIs, Wellbutrin is relatively safe in overdose when taken alone. A sustained release form is currently in clinical trials, which will allow for once-daily dosage.

Other medications used to treat depression include psychostimulants, carbamazepine, valproic acid, buspirone, alprazolam (used when the patient also suffers anxiety), bromocriptine, T3 thyroid hormone augmentation, and L-tryptophan (currently banned by the FDA). The anticonvulsants carbamazepine and valproic acid are used to treat bipolar disorder, frequently in combination with antidepressants. Valproic acid has become the drug of choice of some psychiatrists for treating bipolar disorder because it has fewer side effects than lithium and carbamazepine and is more effective with rapid-cycling patients. Careful blood-level monitoring is required for carbamazepine, valproic acid, and lithium to assure a therapeutic level and to avoid toxicity.

CHOOSING ANTIDEPRESSANT MEDICATIONS

Currently, there are no reliable biological tests to pinpoint the cause of depression or to predict which antidepressant medication will be most effective for a given patient. No antidepressant currently available has been demonstrated in controlled studies to be more effective than another, although some claim faster onset. Any patient taking an antidepressant should have a physical examination and blood tests to rule out non-psychiatric causes of depression, such as hypothyroidism, anemia, diabetes, cancer, or HIV.

The choice of an antidepressant for the acute treatment phase is then based on side effects, the patient's history and family history, type of depression, presence of other medical or psychiatric illnesses, concurrently prescribed medications, availability, and cost. Cost varies greatly between older antidepressants available in generic form and newer ones still under patent protection. Some managed care companies now restrict the choice of antidepressants to those on their approved list for reimbursement. Although a medical license is required to prescribe antidepressants, counselors would find the PDR

(Physicians Desk Reference) a helpful book to look up medications and possible side effects clients taking antidepressants may report.

Once an antidepressant medication has been chosen, significant symptom improvement typically takes several weeks, with greatest improvement within four to six weeks. After six to twelve months of effective treatment, 90 percent of patients can stop the medication if it is their first episode of depression. Longer treatment is recommended if the depression has been chronic or recurrent or is treatment-resistant. Long-term side effects have proven to be minimal for most of these medications, and the benefits usually far outweigh the risks.

For many depressed patients, antidepressant medications are truly heaven sent. The combination of Christian counseling, medication, and prayer is a powerful tool in our battle against depression.

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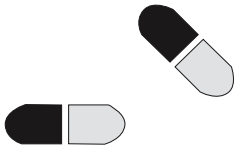
Footnotes

1. See, for example, Matthew 4:24 In the King James Version "sick people" includes people "taken with diverse diseases and torments, and those which were possessed with devils, and those which were lunatic, and those that had the palsy."

2. J.B. Phillips, *The Price of Success* (Wheaton, IL: Harold Shaw Publishers, 1984).

3. S. Madeline and J. L. Miller, *Harper's Encyclopedia of Bible Life, Third Revised Edition*, B. M. Bennett, Jr. and D. H. Scott (Eds.) (San Francisco, CA: Harper & Row, 1978).

4. W. Backus, *Telling the Truth to Troubled People* (Minneapolis, MN: Bethany House, 1985).



COMMON ANTIDEPRESSANTS AND THEIR SIDE EFFECTS

GENERIC NAME	BRAND NAME	MAJOR SIDE EFFECTS
• MONOAMINE OXIDASE INHIBITORS • MONOAMINE OXIDASE INHIBITORS • MONOAMINE OXIDASE • INHIBITORS •		
Isocarboxazid	Marplan	Dietary restrictions to avoid risk
Phenelzine	Nardil	of high blood pressure, sedation,
Tranlycypromine	Parnate	dizziness upon standing
• TRICYCLICS AND TETRACYCLICS • TRICYCLICS AND TETRACYCLICS • TRICYCLICS AND TETRACYCLICS •		
Amitriptyline	Elavil, Endep	Sedation, weight gain, dry
Amoxapine	Asendin	mouth, constipation, urinary
Clomipramine	Anafranil	hesitation, blurred vision
Desipramine	Norpramin, Petrofrane	decreased memory and poor
Doxepin	Sinequan, Adapin	concentration in elderly patients,
Imipramine	Tofranil	dizziness upon standing, sexual
Nortriptyline	Aventyl, Pamelor	dysfunction
Protriptyline	Vivactil	
Trimipramine	Surmontil	
• HETEROCYCLICS • HETEROCYCLICS • HETEROCYCLICS • HETEROCYCLICS • HETEROCYCLICS •		
Trazodone	DesyreL	Sedation, prolonged erections
Nefazodone	Serzone	Slight risk of seizures, dry
Bupropion	Wellbutrin	mouth, headache, constipation,
		sweating, nausea, dizziness,
		insomnia
• SELECTIVE SEROTONIN REUPTAKE INHIBITORS • SELECTIVE SEROTONIN REUPTAKE INHIBITORS •		
Fluoxetine	Prozac	Agitation, insomnia,
Fluvamine	Luvox	nausea, vomiting, diarrhea,
Sertraline	Zoloft	headaches, sexual dysfunction
Venlafaxine	Effexor	
Paroxetine	Paxil	