What Do You Hear?
You’ve been working for six months with a counselee who struggles with serious depression and anxiety. After walking alongside her in her suffering, you have together identified ways in which her perfectionism and her mistrust in the goodness and mercy of the Lord contribute to her anxiety and depression. She is slowly making progress. You see her more consistently using the Psalms to move toward God to voice her fears and disappointments. She is less hypercritical of herself and others. Then, over a one-month period, you see remarkable change. It’s like she’s coming out of hibernation. She shakes off her sluggish spirituality before your eyes. The Word comes alive to her in new and fresh ways. She has a growing excitement to serve others. Her depression and anxiety lessen week by week. You rejoice! And then she tells you that four weeks earlier she saw her primary physician who prescribed Prozac, which she has been taking since.

So, how do you view her change now? Are you disappointed? Thankful? Confused? Do you change your counseling approach? Should you be more proactive in recommending an evaluation for medication, particularly for those counselees who seem “stuck” or are making slow progress? Do you prayerfully consider going to medical school so you, too, can prescribe Prozac?! Another counselee comes to you for help with longstanding obsessions and compulsions. He has been on six different medication combinations in the past, none of which have significantly improved his struggle. He is discouraged about his lack of progress and about the twenty pound weight gain and frequent headaches he has experienced over the last six months on his latest medical regimen. Where do you begin?

A counselee notes on his intake form that he is taking Tegretol, Zoloft, and Abilify for a diagnosis of bipolar disorder. He is interested in coming off these medications and wants your advice before he returns to his psychiatrist. More specifically, he has developed the conviction that he should, with God’s help, be able to live medication-free. How should you proceed? What information would you want to know? Should a life characterized by robust faith and repentance make medication unnecessary?

These vignettes show that familiarity with psychoactive medications is a must for counselors. We live in a time when more and more problems in living are attributed to brain-based dysfunction. Medication is touted as an important (if not the most important) aspect of treatment within the psychiatric community. In popular street-level understanding, it is THE
treatment of choice.

Christians remain divided on this issue. Some would say that medication is usually appropriate, viewing it as a “common-grace” tool to relieve mental suffering. Others are more cautious, recommending medication only in more severe situations. Still others decry the use of psychoactive medication as a “cop-out,” when a basic posture of gospel-centered obedience is all that is really necessary.

As Christians, we can’t just “listen to Prozac”; we need a biblically-based philosophy to guide the use or non-use of medications. We need to know not only the “what” and “how” of psychoactive medication use, but also the “why” or “why not.” And we need strategies. How should we proceed in difficult cases like those mentioned above?

To that end, I have several goals in this article:

- to familiarize you with the basic classes of psychoactive medications,
- to review what we know about the mechanism of action and efficacy of such drugs, and
- to discuss a biblical approach to psychoactive medications.

Classes of Psychoactive Medications

The term “psychoactive” medication refers to those chemical substances that are designed to enter the brain tissue from the bloodstream to cause changes in mood, thoughts, emotions, and behavior. Most any medication, at high enough doses, can have psychoactive (side) effects (e.g., a certain high blood pressure pill may cause drowsiness or impaired ability to concentrate). But my focus is on those classes of medications designed to have effects on the brain.

Let me summarize the various classes here.

Antidepressants – are probably the class of medications we are most familiar with. Early antidepressants, developed in the 1950s and 60s, such as Tofranil (imipramine) and Elavil (amitriptyline), are still used today, but have been overshadowed by the “SSRIs”—selective serotonin reuptake inhibitors—such as Prozac (fluoxetine), Zoloft (sertraline), Paxil (paroxetine), and Celexa (citalopram), which were released in the late 1980s. Other antidepressants with varied chemical compositions include Wellbutrin (bupropion), Effexor (venalafaxine), Remeron (mirtazapine), and Cymbalta (duloxetine). No one sub-class of antidepressants has proved more effective than another and newer antidepressants are not more efficacious than older ones, although they do tend to have less sedative side effects than the older antidepressants.

Mood Stabilizers – are used to treat bipolar disorder. These are also called “anti-mania drugs.” Lithium, discovered in 1949, has been the gold standard within psychiatry for many years. But it is associated with potentially dangerous side effects, so it is less likely to be used as a first-line agent unless the person has a more severe presentation. More likely are medications that initially were used for seizure disorders but were observed to have a mood-leveling effect. These include Tegretol (carbamazepine), Depakote (divalproex) and Lamictal (lamotrigine), to name a few.

Antiobsessionals – are medications used to treat obsessions and compulsions. Many of these are the SSRIs I noted earlier, along with Anafranil (chomipramine). Notice that many medications, particularly the SSRIs, have multiple potential uses authorized by the Food and Drug Administration (FDA). Right away that tells you that these medications are less like “smart bombs” that work with laser precision, and more like conventional bombs with widespread effect on systems of neurotransmitters in the brain. This lack of specificity reminds us just how little we understand the neurobiological component in psychiatric problems.

Psychostimulants – have been used since the 1950s to treat the symptoms of Attention-Deficit Hyperactivity Disorder (ADHD). These include Ritalin (methylphenidate), Concerta (the sustained release version of methylphenidate), Focalin (dexamethylphenidate), Dexedrine...
(dextroamphetamine), and Adderall (mixed amphetamines). Because they are stimulants they have the potential for abuse if not used as prescribed.

Antipsychotics – are used to treat the symptoms of psychosis, including the hallucinations and delusions characteristic of schizophrenia. The older antipsychotics, used since the 1950s, include Thorazine (chlorpromazine), Mellaril (thioridazine), and Haldol (haloperidol). Due to very severe side effects, some of which are permanent, these drugs were limited in their use.

However, the creation of a new generation of antipsychotics has led to more patients being treated, particularly bipolar patients whose mania has features of psychosis. These newer antipsychotics, which are essentially equal in efficacy to the first generation antipsychotics, include Risperdal (risperidone), Zyprexa (olanzapine), Geodon (ziprasidone), and Abilify (aripiprazole). Early research suggested the second-generation antipsychotics had fewer side effects. More recent research suggests the potential for equally serious but different kinds of side effects when compared to the first-generation antipsychotics.4

Anxiolytics (anti-anxiety medications) – are used to treat the symptoms of anxiety. Historically, physicians have used a subclass known as benzodiazepines for treating anxiety and panic. These included drugs such as Valium (diazepam) and Librium (chlordiazepoxide), and more recently, Klonopin (clonazepam), Ativan (lorazepam), and Xanax (alprazolam).

The problem with the benzodiazepines, when used regularly and over the long term, is the potential for tolerance, dependence, and withdrawal. Tolerance means that your body requires more of the drug over time to get the same effect. Dependence is your body saying it needs a certain level of the drug to feel normal and to prevent withdrawal. Withdrawal symptoms, including increased anxiety, rapid heart rate, sweating, and more, occur when the drug is stopped abruptly due to this physical dependence. In some cases this withdrawal (e.g., from Xanax) can be life-threatening. In general, physicians now use benzodiazepines for the short-term treatment of anxiety, and are more likely to prescribe the SSRI class for longer-term treatment.

Hypnotics – are prescribed for insomnia. Older agents were in the benzodiazepine class

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Classes of Psychoactive Medications</th>
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<tr>
<td>Category of Drug</td>
<td>Used to Treat</td>
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<tr>
<td>Anti-depressants</td>
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<td>Mood Stabilizers</td>
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<td>Anxiolytics</td>
<td>Anxiety</td>
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<tr>
<td>Hypnotics</td>
<td>Insomnia</td>
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*Many of these drugs are available as generics. Basic drug information is available at www.PsyD-fx.com
but now physicians choose newer drugs such as Ambien (zolpidem), Sonata (zaleplon), Lunesta (eszopiclone), and others that have less addictive potential.

Although I mentioned some specific concerns above, it is important to note that side effects are common with each of these classes of psychoactive medications. Drowsiness and weight gain are very common. Sexual side effects, such as decreased libido and the inability to experience orgasm, may be as high as 60% in the SSRI sub-class. As we will see later, the potential benefits of using medication might outweigh the costs, including side effects; so simply note at this point that these are not benign agents. They may help, but they can also harm—hence their regulation by the FDA!

Do Medications Treat a “Chemical Imbalance”?

Now that I have familiarized you with the basic categories of psychoactive medications, let’s tackle the question, “How do they work?” Are they treating “chemical imbalances”? This is certainly the lay understanding, as fueled by biologically-oriented psychiatry and pharmacological marketing. But do psychoactive drugs correct imbalances in body chemistry?

To answer that question, I need to give you a crash course in basic neuro-anatomy. Don’t worry, if you were an English major, I’ll make it painless! In the brain there are billions of nerve cells (neurons) that communicate with each other via chemical substances called neurotransmitters. In simple terms, the sending cell releases neurotransmitters into the space between it and the receiving cell. The receiving cell has receptors for the neurotransmitter and is activated when the neurotransmitter binds to it. Following activation, the neurotransmitter is released from the receptor site. Then it either: 1) is taken back up into the sending cell to be repackaged and used again, 2) remains in the space between the neurons, or 3) gets destroyed. Scientists have discovered over 200 neurotransmitters. Some that you may be familiar with are serotonin, dopamine, and norepinephrine. The theory is that psychiatric problems result from an imbalance in, or a dysregulation of, neurotransmitters in certain parts of the brain. For example, some conclude that depression results from a deficiency of serotonin, so treatment involves using psychoactive medications to address this deficiency. The impact of these treatments is often vividly portrayed in pharmaceutical ads in before and after schematics of the patients’ brains. But what do we really know?

First, since we are unable to measure neurotransmitter levels in the brain of a person being treated with these medications, we cannot scientifically prove that these drugs are responsible for any changes in the person’s symptoms. Note that this is very different from other medical diagnoses. For example, for hypothyroidism we can directly measure a low amount of thyroid hormone, or for diabetes we can directly measure a high amount of glucose in the bloodstream. Treatment of both conditions will lead to direct changes in blood measurements. But because we cannot measure neurotransmitters, we cannot make the same kinds of conclusions about the impact of the psychoactive medication on the person’s symptoms.

Second, we do not know exactly how these medications work in humans. What we do know is how these medications work in test tubes with animal brain tissue and this research is then extrapolated to humans. This, in and of itself, is appropriate for testing hypotheses, but it cannot tell you what is actually going on in the human brain. Listen to what even a very biomedically-oriented scientist, pharmacologist Stephen Stahl, has to say:

In general, contemporary knowledge of CNS [Central Nervous System] disorders is in fact largely predicated on knowing how drugs act on disease symptoms, and then inferring pathophysiology [i.e., what’s wrong physically in the brain] by knowing how the drugs act. Thus, pathophysiology is inferred rather than proved [emphasis mine], since we do not yet know the primary enzyme, receptor, or genetic deficiency in any given psychiatric or neurological disorder.5

Here is an example from the description of a specific drug. The PDR (Physician’s Drug Reference) describes Zoloft (sertraline) this way: “the mechanism of action of sertraline is presumed [emphasis mine] to be linked to its inhibition of CNS neuronal uptake of serotonin.”6
In other words, Zoloft *may* impact the neurotransmitter serotonin in the human brain as it does in basic laboratory research, but we’re not certain. Nor are we exactly sure how this might translate to an antidepressant effect.

This is important: if neuroscientific and psychiatric researchers acknowledge the current limitations of biomedical hypotheses regarding the origin of psychiatric symptoms, how much more should we as biblical counselors acknowledge the complex nature of these struggles, taking into account underlying spiritual, biological, relational, situational, and societal-cultural factors! 

So, at best we can say these drugs modulate, or change, neurotransmission in some way, and that seems to be associated with symptom reduction in a statistically significant proportion of those tested in clinical drug trials. But, are these drugs treating a chemical imbalance? We don’t really know—maybe. We know they seem to alleviate symptoms in some people but do not exactly know how. Our knowledge is incomplete. However, by pointing out that the level of actual knowledge we have about how these drugs work in the brain is limited, I’m not saying we should avoid such medications. I’m saying that if we do use them, we should be aware of what we really know. We have much to learn and a cautious optimism is in order, not an unbridled and uncritical enthusiasm.

**How Effective Are Psychoactive Medications?**

Space precludes an analysis of each class of psychoactive medications, so let me focus primarily on the use of antidepressants since it is the class you will encounter the most frequently. First, remember that a drug cannot come to market unless the FDA approves it, based upon the results of clinical drug trials. More specifically, a study medication has to beat a placebo by a statistically significant margin to be considered effective.

So, how well do antidepressants work? Compared to placebo they have been shown in published studies to help in mild, moderate, and severe depression. Realize that the “placebo effect” in clinical studies is not uncommonly 35% and even higher. This shows the power of belief: if I *think* a treatment I’m receiving may be effective (whether it is or is not) it is more likely to have that effect. The higher the placebo effect, the more the active drug must demonstrate its effect in order to be considered superior to the placebo.

Take for example a clinical drug trial of 200 depressed patients, 100 of whom receive a new antidepressant and 100 of whom receive a placebo. The standard protocol for such studies is “double blind”—i.e., neither the patients nor the researchers know who has the active medication vs. the placebo, so as not to bias the results. 

Let’s say 35% of the placebo group responds favorably with reduction of their depression (= the placebo effect) and 70% of the active drug group responds favorably. Looks good, right? But remember a component of that 70% could be the power of belief (a placebo effect of the active drug) and another component could be the actual biochemical effects of the drug itself. So, at the end of the day, of those 100 patients who got the active drug, 30% did not respond, 35% may have responded by virtue of a standard placebo effect, and 35% may have responded due to the actual effects of the drug itself. 

We should conclude that overall there seems to be a modest drug effect, but it’s certainly not a “chemical cure.” And these studies ultimately say nothing about how an individual person will or will not respond when given an antidepressant. At this point there is no way to predict who will respond best to which treatment.

We can also ask if medications are more effective than counseling for depression. Individual studies have revealed that even in moderate to severe depression, although medication might bring more rapid improvement compared with counseling, counseling was equal to medication at four.
months of treatment. Note that the degree of effectiveness of the psychotherapy may well depend on the counselor’s experience/expertise.11 There is also evidence that cognitive therapy is superior to medication in preventing relapse once medication and/or counseling is discontinued.12 Other studies seem to show that the combination of counseling and medication may be superior to counseling or medication alone.

It is important to remember that not all psychiatric symptoms are created equal. I have been highlighting treatment for depression, which is quite variegated in its presentation. Other problems, such as the psychotic symptoms of schizophrenia or, in some cases, the mania of bipolar disorder, definitely respond better to medication than to counseling. However, a multi-faceted approach that includes counseling and other social interventions is still in order once psychosis has stabilized.

So, what should we conclude from all this information, particularly with regard to antidepressants? They do seem to work—that is, improve mood and other symptoms of depression—in some people, some of the time, but they certainly are not the “silver bullet” that some make them out to be.13 Even if we conclude that medications are or might be effective for a particular person, they comprise only a part of the total approach to the person. Secular research shows the critical importance and efficacy of psychotherapy as well.

Medications may well change neurotransmission at microscopic levels; they certainly are associated with change in the pattern of brain activity at “macroscopic” levels on “live action” brain scans such as positron emission tomography (PET scans) and functional MRIs (fMRIs). But then secular forms of counseling such as cognitive behavioral therapy have “proven effective” as well.14 In that sense, both medication and counseling are “biological” treatments—medication directly so, and counseling indirectly so. How much more so should we expect brain activity patterns to change with the embrace and actualization of gospel-centered counsel!

A Biblical Evaluation

We have assessed the secular data on the use of medications, but how should we assess the use of medications from a biblical perspective? First, remember that we exist as body-spirit creatures. We are simultaneously body and soul. There’s never a time we’re not spiritually engaged. And there’s never a time we are not bodily engaged. This means that attention to both physical and spiritual aspects of our personhood is mandatory in ministry. What biblical-theological truths provide guidance? Let me discuss some things I keep in mind as I consider the use of medications.15 You might call this “walking the wisdom tight rope” because you will see that the biblical approach balances different priorities.

It is a kingdom agenda to relieve our suffering; it is a kingdom agenda to redeem us through suffering.

When the kingdom comes in Jesus Christ, you see God’s heart with regard to suffering in two ways. First, it is God’s design to relieve the suffering that arose as a result of the fall. Consider how Mark 1 describes the activities of Jesus’ ministry: teaching, exorcisms, healing those with various diseases, prayer, and cleansing a leper. Peter put it this way to Cornelius:

God anointed Jesus of Nazareth with the Holy Spirit and power, and . . . he went around doing good and healing all those who were under the power of the devil, because God was with him. (Acts 10:38)

Clearly a mark of the in-breaking kingdom is relief of suffering. Relief of suffering is a good thing! As the Puritan Jeremiah Burroughs says, contentment is “not opposed to all lawful seeking for help in different circumstances, nor endeavoring simply to be delivered out of present afflictions by the use of lawful means.”16 I believe medications can certainly be one of those lawful means.

You see a second strand of teaching in the New Testament: God’s design to redeem the experience of suffering for believers because of their union with Jesus, the Suffering Servant. Paul calls this “the fellowship of sharing in [Jesus’] sufferings” (Phil 3:10). By virtue of being in Christ, God is at work in the midst of our suffering, conforming us to the image of Christ. This is the very gateway to experiencing his resurrection power and glory (cf. Phil 3:10-11; Rom 8:17; 2 Cor 4; 2 Cor 1:8-9; 1 Peter 4:12-13; James 1:2-4). So, while relieving suffering is
a kingdom priority, seeking mere relief without a vision for God’s transforming agenda in the midst of suffering may short-circuit all that God wants to do in the person’s life. Another way of saying this is we should be glad for symptom relief but simultaneously look for the variegated fruit of the Spirit: perseverance in the midst of suffering, deeper trust in the Father’s love, more settled hope, love for fellow strugglers, gratitude, and more.

Medications are a gift of God’s grace; medications can be used idolatrously.

I believe it is right to view the development of psychoactive medications as a good gift from God. As such, we should receive them gratefully and humbly, not forgetting who has given the necessary wisdom to scientists and physicians to discover such remedies. He is the One who promises to uphold you with his righteous right hand (Isa 41:10).

Sadly however, I have met people who are better evangelists for Prozac than they are for the living God. Rather than viewing medication as simply one component of a full-orbed God-centered treatment approach, they view it in almost salvific terms. By definition, this is idolatry: investing ultimate power and help in something other than our triune God. If a counselee believes that what really matters is fine-tuning the dose of Paxil, and finds discussion of spiritual things superfluous or irrelevant, that’s a problem. How the person responds when the medication works—or doesn’t work—reveals the basic heart posture before God. Thanksgiving and a more fervent seeking after God in the wake of medication success says one thing; a lack of gratitude and a comfort-driven forgetfulness of God says another. A commitment to trust God’s faithfulness and goodness in the wake of medication failure says one thing; a bitter, complaining distrust of his ways says another.

Too much suffering can be “hazardous” to spiritual growth; too little suffering may be “hazardous” to spiritual growth.

This might be considered a corollary to my first point. What do I mean here? Simply this: in the midst of intense suffering, whether it stems from the body or from other sources (relationships, life circumstances), there tends to be a greater temptation to become embittered and angry. Witness the counsel of Job’s wife, “Curse God and die” (Job 2:9). As we’ve seen, it’s not a bad thing to seek deliverance from intense suffering; the psalmists ask for it all the time in the midst of their grief.

At the same time, a lack of suffering may bring the temptation to simply forget that “in him we live and move and have our being” (Acts 17:28). This was part of the problem God’s people experienced once they entered the Promised Land; their dependence on him waned in the midst of material blessing (Deut 8:10-14; Judg 2:10-12).

Here’s another way of saying this: God-centered contentment is elusive in want or in plenty. Neither situation is the “ideal” for spiritual growth. Paul highlights this in Phil 4:11-13. He learned “the secret of being content in any and every situation, whether well fed or hungry, whether living in plenty or in want.” He looked to the strength of Christ in all situations. So, don’t be too quick to cast off suffering as though immediate relief from trials is the only good God is up to. And don’t think it’s more “spiritual” to refrain from taking medications, as though character refinement through suffering is the only good God is up to. We don’t choose our suffering in some masochistic way; yet we are called to a life of walking in the footsteps of our suffering Savior. Christ teaches us a cruciform and dependent lifestyle.

A person can have wrong motives for wanting to take medication; a person can have wrong motives for not wanting to take medication.

Often, the most important issue in the use of medications is the attitude of the person to whom you are ministering. It’s not that psychoactive medications in themselves are either “good” or “bad.” Rather, it’s how a person views and handles this potential treatment that makes the difference. I’ve had counselees who want a referral for medication immediately without really wanting to examine their hearts and lifestyle. I’ve had counselees who resist the recommendation to consider the use of medications for self-oriented reasons. Let me elaborate on these two scenarios.

What are problematic reasons for wanting to take medication? The first is a demand for immediate relief coupled with doubt about the benefits of looking at potential underlying issues. I remember meeting one time with a
young man who came in with a recent history of anxiety associated with public speaking. Some of the things he said pointed to underlying fear of man/fear of failure—much to work with from a gospel perspective! But he was not interested in counseling. He was not interested in a gospel perspective on his struggle. Rather, he had made an appointment for the sole purpose of obtaining my recommendation for a provider who could prescribe an anti-anxiety medication.

A second questionable motive for wanting to take medication involves caving into the pressures of others. Family and friends (and counselors!) may push for medications due to their own discomfort in seeing the suffering of their loved one. Sometimes the pressure reflects a selfish desire to have their loved one back to normal so that life would be easier for them.

What problematic reasons exist for not wanting to take medication? Resistance to medication can be an issue of pride and self-sufficiency: “I should be able to do this without medication.” Or the more spiritualized version of this: “I should be able, by trusting God more, to do this without medication.” Another reason could be fear of man: “What would people think?” Yet another concern is shame: “There’s something seriously wrong with me if I have to take this medication.”

Many people sincerely want to grow in Christ in the midst of their mental suffering and simply wonder about the pros and cons of medication. Many rightfully wonder about the potential side effects of using medication. These thoughtful counselees remain open to starting—or not starting—medication, which is a wise posture before the Lord.

Using medications may make it more difficult to address moral-spiritual issues; not using medications may make it more difficult to address moral-spiritual issues.

Scripture treats us as unified beings, having both spiritual and bodily aspects. Given that we are fully integrated, body and spirit (heart/soul) creatures, it is not surprising that bodily strength or weakness impact us spiritually and vice versa, but I’ll focus here on the impact of our bodily constitution on our spiritual lives.

Here’s a simple example. Let’s say that for various reasons outside your control you have had poor sleep for the last week. You’re exhausted; you find it difficult to concentrate. You also find that you are more prone to grumbling and impatience. You see life through a grey lens. And then you get two great nights of sleep in a row. Suddenly, your world is sunnier. You have a new vitality, both physically and spiritually. Patience and kindness require far less effort. What just happened? A physical "treatment”—sleep—impacted your spiritual life. The heart issues of grumbling and irritation have become less prominent. That’s not necessarily a bad thing; we are called to be wise stewards of our bodies. But in a time of “plenty” (sleep-wise), we shouldn’t forget our sinful tendencies toward anger and complaining that were revealed in our weakness. At the same time, we don’t “invite” greater bodily stress so as to provoke our own hearts! This is our Father’s business, “mingling toil with peace and rest.”

How does this relate to the use of psychotropic medications? Improving someone’s symptoms (of anxiety, for example) doesn’t necessarily address the underlying fears and desires that may be present. Might one feel better? Yes. Again, this may not be a bad thing in itself, but does the person retain the zeal to address the revealed heart inclinations now that those propensities are less visible in day-to-day life? Is there a commitment to address the situational factors that contribute to the experience of anxiety? In my experience, more mature believers do indeed remember what they saw in the mirror and continue to take their soul to task in thought, word, and deed (James 1:23–25). They do recognize the importance of assessing and changing contextual factors. But I have also had counselees who, after improvement in their symptoms, assume no further work is required.

Conversely, there are situations, albeit more extreme, when a failure to use medication...

Gospel-centered ministry targets both the somatic and moral-spiritual aspects of life.
may make it more difficult to address a person’s spiritual life. I counseled a young woman in a demanding graduate program who presented with insomnia, depression, severe anxiety, and suicidal thoughts. While her suicidal thoughts rapidly waned by simply airing them with me, her other struggles did not. She could affirm intellectually the promises of God, but it was like her soul was coated in Teflon; the truths of Scripture seemed to slide right off. While this disconnect is true for all of us to some degree it seemed particularly prominent for her.

After several weeks, I saw how much her ongoing exhaustion from the insomnia was part of a vicious cycle. On the one hand, you could say that her insomnia, which was anxiety driven, was a fruit of her fear and unbelief and so that should be the primary target of ministry. On the other hand, you could say that her bodily exhaustion was making it much more difficult for her to respond in a faith-filled way. Both are appropriate avenues for ministry. In the end I thought that evaluation for a short-term course of sleeping medication might be beneficial to break the negative cycle she was in. In fact, that was the case. As she slept better, it wasn’t as if her problems magically melted away; she still struggled with anxiety. But she was able to internalize spiritual realities and truly begin to engage with God, addressing issues of perfectionism, legalism, and fear of man, which were root causes of her anxiety and despair.

Think of it this way: using medication in select situations may be analogous to calming the surface waters to allow for deep-sea exploration. You can’t have a diving expedition if there is a gale on the surface of the water. Situations in which such “calming” might be helpful include (but are not necessarily limited to) the hallucinations and delusions of psychosis (whether associated with schizophrenia or mania) and severe or unremitting anxiety or depression, particularly if associated with suicidal thoughts and plans.¹⁹

Can taking a medication actually assist in sanctification? Yes, in the same way that adequate sleep can assist in sanctification! It’s not that you can buy holiness in a pill, but using medication in certain situations may help set bodily conditions that allow for a greater spiritual flourishing.

Putting It All Together

What have we seen? The scientific witness is mixed. While psychoactive medications may help a certain percentage of individuals, the benefits do not rise to the level touted by pharmaceutical companies. In addition, these medications are associated with significant side effects. In depression, working with a trained counselor is at least as effective as medication and may confer a longer-term protection against relapse. Biblically we have seen that gospel-centered ministry targets both the somatic and moral-spiritual aspects of life, and that both relief of suffering and perseverance in the midst of suffering are consistent with God’s design. We also noted the interdependence of body and spirit. Given these scientific and biblical perspectives, what should our practice in counseling be with regard to psychoactive medications?

I hope you have seen there is not a clear-cut “right” or “wrong” answer. There is no universal “rule” we can apply to all people at all times. There is no simple algorithm. Rather, the use of these medications is a wisdom issue, to be addressed individually with counselees. There will always be a mix of pros and cons, costs and benefits to carefully consider. We must ask, “What seems wisest for this particular person with these particular struggles at this particular time?” Most often, addressing the person’s suffering and sin takes place without the use of medication. Yet, in some cases, after asking that question, we will lean toward more directly addressing potential bodily causes and correlates of the person’s struggle by recommending an evaluation to consider the use of medication. Notice how I phrase that—“recommending an evaluation to consider…” I’m not mandating. I’m not making a definitive recommendation. I’m simply suggesting that medication be considered as a part of the holistic approach to the struggle.

I’m most likely to recommend an evaluation for medication when any of the following occur:

- symptoms are severe and unremitting,
- symptoms are not abating despite engagement with the counseling process, or
- there is a high risk of suicide.²⁰
I encourage you to develop a relationship with a trusted and wise psychiatrist who shares your strong biblical convictions and is able to provide consultation for these kinds of decisions. Such a person may or may not exist in your locale. Well-trained, clinically-savvy psychiatrists whose practice is governed by a robust biblical worldview are indeed few and far between! A family physician or internist with extensive experience in the use of psychoactive medications may be another option. The point is that we biblical counselors don’t make these decisions on our own; close communication with medical providers is essential.

Often enough, people come to me already on medications and the choice to start or not start them is a non-issue. Usually they’ve realized that medications do not solve all their problems. They need help to reconcile conflict, or to walk in faith not fear, or to address any of the multitudes of other problems that bring people to counseling. There’s plenty to discuss apart from talking about the utility or non-utility of their medication. Whether on medications or off, the goal is always to help a person grow in love for God and for neighbor.

Let me illustrate with an orthopedic analogy. I liken the use of medications to the use of crutches, and I don’t mean that in a pejorative sense. A person can experience many different injuries to the legs that don’t require a set of crutches. He may have visible pain; he may have a limp initially, but the problem is self-limited with forms of treatment other than the support of crutches. Here I might think of milder experiences of depression, anxiety, and OCD, for example, where medication (like the crutches) might not be needed.

Others require crutches to assist them after experiencing a more significant injury or surgery. They use them for a season while their bodies recover. Here I might envision a fairly severe postpartum depression or severe panic attacks treated by a brief course of medication. Still others have a more significant disability and may need to use crutches for an extended time or perhaps for life, if the disability is permanent. Here I think of problems such as schizophrenia and severe bipolar disorder, which seem to have a more significant brain-based etiology and long-term use of medication seems warranted.22

Then, there are times someone may be relying too much on his crutches and it actually impedes progress. I experienced this as a teenager when I broke my ankle. After the cast was removed I was told to bear weight ‘as tolerated.’ But I didn’t tolerate it very well! I continued to use my crutches for an extended time because putting weight on my ankle caused pain. At my follow-up visit, my orthopedist told me to throw away the crutches and learn to bear weight, despite the pain. It was hard work, but I learned again to walk without the aid of crutches. The bottom line is that all musculoskeletal problems are different and it takes wisdom to know when the additional support of crutches is necessary and, if so, for how long. The same is true of psychoactive medication.

The analogy is imperfect, of course. It’s easier to determine if someone can walk unaided or not. It’s far more challenging to assess what a person can or can’t do in the midst of emotional suffering. We see through a glass far more darkly than we realize. We will always struggle to find a wise balance between attention to the spiritual and physical aspects of our personhood. Sometimes in retrospect we’ll judge that we should have recommended the possibility of medications earlier. Other times we will conclude that we jumped the gun and that medication wasn’t the wisest choice after all. But we can be sure that whether medication is part of the total ministry approach or not, God sovereignly acts, and “is able to do immeasurably more than all we ask or imagine, according to his power that is at work within us” (Eph 3:20). He will accomplish the redemption that he has begun in us.

To conclude, let’s return to the opening examples and see how this “wisdom” framework might look in action. What about the woman experiencing depression and anxiety? Certainly we should rejoice in the remarkable changes in her life! But can we say why she has changed? No doubt the Prozac could be having brain-based biochemical effects that have catalyzed her spiritual growth, given the mysterious interface of body and spirit. Or she could be experiencing a placebo effect from the Prozac. Or the Prozac isn’t really doing much, but God has himself intervened in his providential timing in a new and deeper way. At the end
of the day, I remain unsure about the ultimate cause. But my goals would be the same for her: rooting her security in Christ’s righteousness in a way that pushes against her perfectionism, turning to God as an ever-present help in the midst of anxiety, and moving outward in love toward others. I wouldn’t make a huge issue of the medication right now, although I might inquire about her decision to see her primary physician. Did she feel that progress was too slow? Did family or friends urge her to go? What is her understanding about the utility of the Prozac?

At some point in the future, should her spiritual growth be sustained and her depression and anxiety remain at bay, I would suggest her physician consider discontinuing her medication. It’s not that the ultimate goal is being off medication—conformity to the image of Jesus Christ! But there’s no indication at this point, by virtue of severity or chronicity of her struggle, that she would need to be on medication long-term. In fact, the progress (albeit slow) she was making prior to the medication bolsters that hope.

The second counselee is experiencing the reality that medication is not a panacea for his obsessions and compulsions. For him, not only has medication not helped, its side effects have hurt him. While I’m dubious about the benefit of continuing his medical regimen, I would not recommend that he discontinue the medication(s) on his own. Instead, I would suggest he speak with his physician about suspending the medication temporarily and see how he fares. If I were concerned about the quality and experience of his treating physician, I might recommend a consultation with a trusted psychiatrist. But apart from any decisions about medication, there is much work to be done in addressing his obsessions and compulsions from a gospel-centered framework.

Lastly, how would I approach the man who has the bipolar diagnosis and wants to discontinue his medications? I want to get a better idea about the nature of his struggle over time. When was he diagnosed? How severe were his symptoms? Did he have psychotic features? Has he had recurrences either on medication or off medication in the past? How compliant has he been with his medications? Has he ever been hospitalized? The more severe and recurrent his problem—and here I might get input from his family and friends—the greater the concern I would have about discontinuing medication.

In addition, I want to understand why he believes God wants him to be medication-free. How has he come to that decision? If the man chooses to discontinue his medications he will need close monitoring and follow up. I would want to work closely with his psychiatrist, as well as with other members of his family and church community.

Some Concluding Thoughts

We are body-spirit creatures. We should not be surprised that a physical treatment such as medication may be associated with symptomatic and perhaps more substantial change in people’s lives. Medication can be an appropriate and even necessary part of someone’s care, depending on the specific nature of a person’s struggle.

Yet, we must admit a great deal of remaining mystery about how psychoactive medications actually work in the human brain. We take care to remain balanced in our assessment of the efficacy of medications. We neither exalt them nor disregard them. Even if we do view medication as a potential piece in a comprehensive ministry approach, we always seek to bring the riches of Christ’s redemption to bear upon people’s lives. Sinners will always need mercy, grace, forgiveness, and supernatural power to love God and neighbor. Sufferers will always need comfort, hope, and the will to persevere. Ultimately, these blessings are found not in a pill bottle…but in the person of Jesus Christ.

2 The adjectives “psychotropic” or “psychiatric” are synonyms for psychoactive. These terms can be used interchangeably.
The ongoing disagreement within psychiatry itself regarding how to understand and classify mental disorders shows the insufficiency of a purely biological orientation to causation and treatment of psychiatric symptoms.

8 If I know I am getting a placebo—an inactive substitute—I will be less likely to respond favorably; the placebo effect declines. If I know I am getting the active drug, it is more likely to work; that is, the placebo effect (even for the active drug) is boosted. “Blinding” the study participants seeks to avoid this bias. Of course, if I experience side effects because I am on the active drug, I may conclude that I am taking the study medication, which also biases in favor of the drug.


10 Cognitive or cognitive-behavioral therapy is the most frequently studied method of counseling.


13 As believers we hope not only for symptom reduction but also for tangible growth in love for God and love for people. Improved mood may correlate with these things, but not necessarily!


15 I could look at the places in Scripture where attention to the body is explicitly mentioned as a focus of “treatment”—e.g., passages include 1 Kings 19 (God “prescribed” sleep, food, and water for Elijah) and 1 Timothy 5:23 (Paul urged Timothy to take some wine for his stomach ailment). However, it is my assumption that the doctrines of creation, incarnation, and resurrection (among others) demonstrate the critical value God places upon our bodily constitution. Therefore, my starting presupposition is that the body is an appropriate “target” for ministry, just as our moral-spiritual disposition clearly is. So my focus will lie on other aspects of biblical truth that inform the use or non-use of medications for the Christian.


19 These extreme cases are more clear-cut. But we live a culture that doesn’t tolerate any hint of “rough seas” but yearns for the comfort of glassy calm waters. This contributes to the overuse of psychoactive medication in some who only want a quick fix rather than tasting the fruit of persevering through choppy waters.

20 My goal with a seriously suicidal person is to stabilize the person first, with medications or even with hospitalization if necessary, then begin to work through the particular problems in living.

21 This is generally because they have seen their primary care physician who has prescribed such a medication, but they may have already seen a psychiatrist as well. The majority of psychoactive medications—particularly antidepressants—are prescribed by primary care physicians.

22 Understanding the causes and classification of mental disorders is another topic in itself, although closely related to the subject at hand. The trajectory of modern psychiatry has been toward the biological, fueled in part by the apparent success of psychoactive medications. Thus, diagnosis and treatment go hand-in-hand.

23 Most psychiatrists recommend a 9-12 month course of an antidepressant before discontinuing it.

24 A new onset of “super-spirituality” may in fact be a warning sign of mania!