Scrambling for the Light
Christian Depression and the Use of Medication

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An acquaintance of mine, Becky, is a grandmother who cites her chief joy in life as "pleasing the Lord and walking faithfully with him." She delves into Scripture daily, and for decades has shepherded others through Bible studies. Christ has claimed her heart, and daily stirs her mind. Yet seasons of guilt and uncertainty have punctuated Becky's walk with her Lord, because while she remains steadfastly devoted to Christ, she also struggles with clinical depression. To maintain her clarity and focus on God's word, she needs help from an antidepressant medication.

As is often the case, depression runs in Becky's family. When despair first gripped her in her twenties, Becky had already watched her mother slide through the deep darkness into a mental breakdown. She'd witnessed firsthand how depression can ravage a life, as well as the critical roles that medication and counseling can play in drawing sufferers back into the world again.

But even these experiences didn't banish Becky's concerns about taking antidepressants herself. She wondered if she were right to take medication for an issue that seemed spiritual. Her guilt only deepened when someone in authority at church claimed, "It's rare for someone to really need antidepressants, because usually things can be solved biblically."

"Hearing that from the pulpit sent me into the depths of guilt," she relates. "I feel so guilty that I must take this medication that has kept me well for years."

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A TROUBLING SUBJECT

The doubts swamping Becky trouble so many of us who suffer from depression. Some of us worry that reliance upon medications implies a paltry faith. Others confuse antidepressants with opioids, and fear addiction. In an opposing scenario, our pain-averse culture, which prioritizes comfort and instant gratification, can mislead us toward chemical prescriptions for normal, refining grief. Throughout, questions churn: Are antidepressants permissible? Or sufficient? Does our need for them reflect a deficit in faith? How do they factor into other means of grace with which God has blessed us, such as prayer, study of the word, and counseling?

After a careful exploration of depression, its treatment, and how the Bible guides us in suffering, these questions should give way to discernment and gratitude. No medication can sponge away the blackness in our hearts. But in his steadfast love and mercy toward us, God has gifted us with medical science as a means of common kindness. In the right circumstances, when carefully combined with counseling and spiritual disciplines, antidepressants can ease some of us back into daylight. While we should never rely on medication exclusively, neither should we demonize those who use it as part of a comprehensive approach.

MORE THAN SADNESS

At this point in the discussion, we need to define terms. In the undulating course of life, seasons of grief, tears, and bleakness can trouble all of us. In most cases, these valleys have limits. We may sink low, but we retain our capacity to climb, and eventually we crest into the bright air again.

Clinical depression, also called *major depressive disorder*, falls outside these usual variations in emotion. The fact that depression increases the suicide rate by *27 times* that of the general population should alert us to something gone terribly awry.[1] In major depression, hopelessness, despair, and lack of motivation persist long after wounds have healed, for reasons even the victim can't always pinpoint.

1 F. Angst et al., "Mortality of Patients with Mood Disorders: Follow-Up Over 34–38 Years," *Journal of Affective Disorders* 68, nos. 2–3 (April 2002): 167–81, https://doi.org/10.1016/S0165-0327(01)00377-9.

Sufferers can't control their descent into darkness, nor can they wrench themselves from its clutches by sheer will, because the social, spiritual, and practical factors we can easily see interact with changes deep in the brain, hidden from view. The ramifications are not only spiritual, but also physical (see the table below), hampering engagement in even the most basic stuff of living. Laughter, conversation, and interaction feel impossible, even with those we love.[2] Routine self-care overwhelms, and some of us find ourselves bed-bound, too bereft of joy to drag ourselves into the world. In many ways, living through depression resembles dying.

Diagnostic Criteria for Major Depressive Disorder[3]

Diagnosis requires at least five of the following symptoms, nearly every day, for at least two weeks. One symptom must be depressed mood or anhedonia.
Depressed mood (hopelessness, despair)
Anhedonia (loss of pleasure in usual passions and activities)
Weight loss/weight gain or change in appetite
Insomnia/hypersomnia
Psychomotor agitation/retardation (can't sit still, or can't get moving)
Fatigue/loss of energy
Feelings of worthlessness or guilt
Inability to concentrate
Recurrent thoughts of death or suicide

2 Ronald C. Kessler et al., "The Epidemiology of Major Depressive Disorder: Results from the National Comorbidity Survey Replication (NCS-R)," *Journal of the American Medical Association* 289, no. 23 (June 2003): 3095–105, https://doi.org/10.1001/jama.289.23.3095.

3 American Psychiatric Association, "Depressive Disorders," in *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. (Arlington, VA: American Psychiatric Publishing, 2013), https://doi.org/10.1176/appi.books.9780890425596.

It's crucial to distinguish this affliction from appropriate sadness or grief, because God works through our suffering to refine us (Gen. 50:20; Jonah 2; Rom. 5:2–5). We should never seek chemical means to buttress ourselves through the *typical* peaks and valleys of our emotions. Not only can melancholy and anguish be worthy responses to the travails of a sinful world, but God also disciplines us, shapes us, and draws us closer to himself through our ordeals. Even Jesus wept in the face of loss (John 11:34–36).

Depression, however, isn't typical grief. It can persist even when our days unfold free from catastrophe. It's a complex beast, whose sufferers desperately need prayer, Christian love, and professional help.

A COMPLICATED PROBLEM

Too few sufferers of major depression actually receive the help they need. Guilt—which is a *feature* of the disorder (see the table)—and stigma discourage many with depression from seeking assistance.[4] In a survey of 5.4 million adults in the US reporting an unmet need for mental-health services, 8.2% did not seek mental-health treatment because they did not want others to find out, 9.5% because "it might cause neighbors/community to have a negative opinion," and 9.6% due to concerns about confidentiality. Some 28% believed that they could handle the problem without treatment, and 22.8% did not know where to go to receive treatment.[5] Such statistics reveal that the road to healing slouches uphill. Many tread it alone.

Yet even those who seek help embark upon a tortuous path, without easy remedies. We have no quick-fix cures for depression, because the neurobiological underpinnings that fuel our despondency are much more elaborate than a simple chemical imbalance. Regions of the brain responsible for memory and

4 Graham Thornicroft et al., "Undertreatment of People with Major Depressive Disorder in 21 Countries," *The British Journal of Psychiatry* 210, no. 2 (February 2017), 119–24, https://doi.org/10.1192/bjp.bp.116.188078.

5 Substance Abuse and Mental Health Services Administration, *Results from the 2012 National Survey on Drug Use and Health: Mental Health Findings*, December 2013, https://www.samhsa.gov/data/sites/default/files/NSDUHmhfr2012/NSDUHmhfr2012.pdf.

executive function shrink in depression, as do the pathways connecting these areas to sites controlling mood, fear, and drives.[6] Brain cell loss is accelerated among the depressed.[7] The actions of chemical signals between nerve cells are disrupted, especially serotonin, a neurotransmitter that helps regulate mood, sleep, appetite, and pain.[8] While we don't know in all cases whether these chang-

6 P. Cédric M.P. Koolschijn et al., "Brain Volume Abnormalities in Major Depressive Disorder: A Meta-Analysis of Magnetic Resonance Imaging Studies," *Human Brain Mapping* 30, no. 11 (November 2009): 3719–35, https://doi.org/10.1002/hbm.20801; Uma Rao et al., "Hippocampal Changes Associated with Early-Life Adversity and Vulnerability to Depression," *Biological Psychiatry* 67, no. 4 (February 2010): 357–64, https://doi.org/10.1016/j.biopsych.2009.10.017; M.C. Chen, J.P. Hamilton, and I.H. Gotlib, "Decreased Hippocampal Volume in Healthy Girls at Risk of Depression," *Archives of General Psychiatry* 67, no. 3 (March 2010): 216–311, https://doi.org/10.1001/archgenpsychiatry.2009.202; Madeleine Goodkind et al., "Identification of a Common Neurobiological Substrate for Mental Illness," *Journal of the American Medical Association: Psychiatry* 72, no. 4 (April 2015): 305–15, https://doi.org/10.1001/jamapsychiatry.2014.2206; Joseph L. Price and Wayne C. Drevets, "Neurocircuitry of Mood Disorders," *Neuropsychopharmacology* 35, no. 1 (August 2009): 192–216, https://doi.org/10.1038/npp.2009.104; Roselinde H. Kaiser et al., "Large-Scale Network Dysfunction in Major Depressive Disorder: A Meta-Analysis of Resting-State Functional Connectivity," *Journal of the American Medical Association: Psychiatry* 72, no. 6 (June 2015): 603–11, https://doi.org/10.1001/jamapsychiatry.2015.0071.

7 Jennifer L. Phillips et al., "Brian-Volume Increase with Sustained Remission in Patients with Treatment-Resistant Unipolar Depression," *Journal of Clinical Psychiatry* 73, no. 5 (February 2012): 625–31, https://doi.org/10.4088/JCP.11m06865; Nikolaos Koutsouleris et al., "Accelerated Brain Aging in Schizophrenia and Beyond: A Neuroanatomical Marker of Psychiatric Disorders," *Schizophrenia Bulletin* 40, no. 5 (September 2014): 1140–53, https://doi.org/10.1093/schbul/sbt142; L. Schmaal et al., "Subcortical Brain Alterations in Major Depressive Disorder: Findings from the ENIGMA Major Depressive Disorder Working Group," *Molecular Psychiatry* 21, no. 6 (June 2015): 806–12, https://doi.org/10.1038/mp.2015.69; Y.J. Zhao et al., "Brain Grey Matter Abnormalities in Medication-Free Patients with Major Depressive Disorder: A Meta-Analysis," *Psychological Medicine* 44, no. 14 (October 14): 2927–37, https://doi.org/10.1017/S0033291714000518; Joan L. Luby et al., "Early Childhood Depression and Alterations in the Trajectory of Gray Matter Maturation in Middle Childhood and Early Adolescence," *Journal of the American Medical Association: Psychiatry* 73, no. 1 (January 2016): 31–38, https://doi.org/10.1001/jamapsychiatry.2015.2356.

8 Shintaro Ogawa et al., "Plasma L-Tryptophan Concentration in Major Depressive Disorder: New Data and Meta-Analysis," *Journal of Clinical Psychiatry* 75,

es *cause* depression or arise as a *result* of the disorder, they hint at why sufferers struggle to recover. In depression, the architecture of our own brains traps us in the dark.

And yet, while neurological changes abound in depression, even biology doesn't tell the entire story. While some individuals are genetically prone to major depression,[9] a first episode requires the intermingling of this risk with social, psychological, and spiritual triggers. Medical illnesses contribute in up to 15% of cases, and depression increases the risk of a future heart attack by two to threefold among people with heart disease.[10] People with seasonal affective disorder, who struggle with depression during the winter months, respond well to bright-light therapy, while others without this temporal pattern don't. Some sufferers struggle with anxiety in depression, others with melancholy, and still others with catatonia or psychosis. This variability hints that the current diagnosis we call *major depression* is probably an umbrella term, a catchall phrase encompassing multiple related syndromes with similar effects, but distinct causative mechanisms.

This diversity in depression creates treatment challenges, as one person's struggle doesn't resemble another's. Promising research suggests that MRI scans of the brain may differentiate between depressive subtypes and allow for more

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no. 9 (September 2014): 906–15, https://doi.org/10.4088/JCP.13r08908; F.M. Werner and R. Coveñas, "Short Communication Open Access Classical Neurotransmitters and Neuropeptides Involved in Major Depression: A Multi-Neurotransmitter System," *Journal of Cytology & Histology* 20, no. 38 (June 2014): 4853–58, https://doi.org/10.4172/2157-7099.1000253; Pierre Blier, "Neurotransmitter Targeting in the Treatment of Depression," *Journal of Clinical Psychiatry* 74, no. 2 (2013): 19–24, https://doi.org/10.4088/JCP.12084su1c.04.

9 Patrick F. Sullivan; Michael C. Neale, and Kenneth S. Kendler, "Genetic Epidemiology of Major Depression: Review and Meta-Analysis," *American Journal of Psychiatry* 157, no. 10 (October 2000): 1552–62, https://doi.org/10.1176/appi.ajp.157.10.1552; Kenneth S. Kendler et al., "A Swedish National Twin Study of Lifetime Major Depression," *American Journal of Psychiatry* 163, no. 1 (January 2006): 109–14, https://doi.org/10.1176/appi.ajp.163.1.109.

10 Bruce Rudisch and Charles B. Nemeroff, "Epidemiology of Comorbid Coronary Artery Disease and Depression," *Biological Psychiatry* 54, no. 3 (August 2003): 227–40, https://doi.org/10.1016/S0006-3223(03)00587-0.

precise, targeted treatments.[11] But this research is preliminary. In the meantime, depression continues to wreak havoc upon its victims, earning the eleventh spot on the World Health Organization's list of conditions causing the greatest disability and mortality.[12] Treatment of such a highly convoluted, variable, and debilitating disorder doesn't proceed simply.

IMPERFECT OPTIONS

The two mainstays of treatment for clinical depression are antidepressant medications and psychotherapy or counseling. While both these avenues can provide life-giving support, neither offers a quick fix. And while both play vital roles in recovery, neither diminishes the importance of spiritual disciplines as we strive to reclaim our joy.

Most antidepressants work by increasing the concentration of serotonin in the brain. Given strong evidence for reduced serotonin transmission in depression, for decades we hoped that replenishing serotonin would reverse the disorder. Given what we now know about brain structure and circuitry in depression, it's no surprise that antidepressants produce modest effects. Although these medications can promote crucial *improvements* in symptoms, when used alone they facilitate *full remission* in only about 50% of cases.[13] While this effect

11 Boadie W. Dunlop et al., "Functional Connectivity of the Subcallosal Cingulate Cortex and Differential Outcomes to Treatment with Cognitive-Behavioral Therapy or Antidepressant Medication for Major Depressive Disorder," *American Journal of Psychiatry* 174, no. 6 (June 2017): 533–45, https://doi.org/10.1176/appi.ajp.2016.16050518; Mary L. Phillips et al., "Identifying Predictors, Moderators, and Mediators of Antidepressant Response in Major Depressive Disorder: Neuroimaging Approaches," *American Journal of Psychiatry* 172, no. 2 (February 2015): 124–38, https://doi.org/10.1176/appi.ajp.2014.14010076; Andrew T. Drysdale et al., "Resting-State Connectivity Biomarkers Define Neurophysiological Subtypes of Depression," *Nature Medicine* 23, no. 1 (January 2017): 28–38, https://doi.org/10.1038/nm.4246.

12 C.J. Murray et al., "Disability-Adjusted Life Years (DALYs) for 291 Diseases and Injuries in 21 Regions, 1990–2010: A Systematic Analysis for the Global Burden of Disease Study 2010," *The Lancet* 380, no. 9859 (December 2012): 2197–223, https://doi.org/10.1016/S0140-6736(12)61689-4.

13 George I. Papakostas and Fava Maurizio, "Does the Probability of Receiving Placebo Influence Clinical Trial Outcome? A Meta-Regression of Double-Blind, Random-

can be life-giving for half of sufferers, it's disappointing for a class of medications we hoped would definitively treat the illness. (Imagine our predicament if insulin reduced blood sugar in only half of diabetics, or if antibiotics eradicated the most common bacterial infections only half the time.) Research also reveals only a small benefit of antidepressant therapy over a placebo pill. Just meeting with a health care provider to receive a placebo constitutes personal connection and care, and ameliorates symptoms in up to 35% of cases.[14]

Such research, coupled with criticism that studies supporting antidepressants often suffer from publication bias, has sparked debate about whether antidepressants work at all. Last year, a research group attempted to put the issue to rest by conducting a large meta-analysis of FDA data on antidepressants, and found that all twenty-one agents studied were more effective than placebo. The study garnered significant media attention, with exuberant headlines proclaiming, "The Debate Is Over!" But the data warrant a more restrained response. We can confidently glean from the review that antidepressants can *lessen* symptoms of depression after eight weeks of therapy. That's good news for those clambering in the gloom, for whom even a minor improvement can provide stability to engage with the world. But it still doesn't mean antidepressants have earned a reputation as a miracle cure.[15]

Taken in total, research on antidepressants supports their use as *one component* of a comprehensive approach. Antidepressants are often *necessary* to equip

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ized Clinical Trials in MDD," *European Neuropsychopharmacology* 19, no. 1 (January 2009): 34–40, https://doi.org/10.1016/j.euroneuro.2008.08.009; Robert D. Gibbons et al., "Benefits from Antidepressants: Synthesis of 6-Week Patient-Level Outcomes from Double-Blind Placebo-Controlled Randomized Trials of Fluoxetine and Venlafaxine," *Archives of General Psychiatry* 60, no. 6 (June 2012): 572–79, https://doi.org/10.1001/archgenpsychiatry.2011.2044; Gerald Gartlehner et al., "Comparative Benefits and Harms of Second-Generation Antidepressants for Treating Major Depressive Disorder: An Updated Meta-Analysis," *Annals of Internal Medicine* 155, no. 11 (December 2011): 772–85, https://doi.org/10.7326/0003-4819-155-11-201112060-00009.

14 Gibbons, "Benefits from Antidepressants."

15 Andrea Cipriani et al., "Comparative Efficacy and Acceptability of 21 Antidepressant Drugs for the Acute Treatment of Adults with Major Depressive Disorder: A Sys-

us for the hard work of recovery, but they are not typically *sufficient*. While antidepressants can lift our darkened mood, full recovery also requires attention to elements that pharmacology cannot penetrate: our social support, our patterns of thinking, our habits and histories, and especially our walk with Christ. While antidepressants improve serotonin signaling, psychotherapy and counseling can help us navigate the social and cognitive barriers to recovery. And a rich life of prayer and Bible intake, with support from the body of Christ, is essential to usher us through the storm.

NON-PHARMACOLOGICAL SUPPORT

The term *psychotherapy* often scares Christians, as they automatically associate it with the atheist Sigmund Freud. The term, however, refers to multiple approaches in clinical psychology, many quite different from Freudian psychodynamics. According to the medical literature, cognitive-behavioral therapy and interpersonal therapy are most effective in depression, but other methods also garner favor.[16]

Psychotherapy and counseling can be crucial to keeping depression at bay. Studies show that antidepressants and psychotherapy have similar efficacy in treating acute depression, but after treatment *ends*, those who discontinue antidepressants commonly relapse.[17] By contrast, the benefits of psychotherapy persist long after treatment stops. Dr. Karen Mason, associate professor of counseling and psychology at Gordon-Conwell Theological Seminary, has witnessed this phenomenon firsthand. "There's a biological vulnerability that antidepressants address, but people are also dealing with social and behavioral issues that reinforce their depression," she relates in personal correspondence. "You might

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tematic Review and Network Meta-Analysis," *The Lancet* 391, no. 10128 (April 2018): 1357–66, https://doi.org/10.1016/S0140-6736(17)32802-7.

16 Alan J. Gelenberg et al., *Practice Guideline for the Treatment of Patients with Major Depressive Disorder*, 3rd ed. (Washington, DC: American Psychiatric Association, 2010), 47–49.

17 Gelenberg, *Practice Guideline,* 19; Zac E. Imel et al., "A Meta-Analysis of Psychotherapy and Medication in Unipolar Depression and Dysthymia," *Journal of Affective Disorders* 110, no. 3 (October 2008): 197–206, https://doi.org/10.1016/j.jad.2008.03.018.

be on antidepressants alone for six months, and they help, but as soon as you stop them you become depressed again because patterns of thinking are still there."

In Dr. Mason's experience, spiritual support can also be crucial to recovery. "People struggle through the lens of their faith," she remarks. "In depression, usually the person has a low sense of self-worth, and faith can influence this." For the believer, our value in Christ, and as God's image-bearers, helps us sift past the shadows and cling to life. Whether we enroll in psychotherapy or use an antidepressant, our identity in Christ, and what God has done for us through the cross, remain central.

A MULTIFACETED APPROACH

For those of us with mild cases of major depression (as determined by a professional using validated instruments), it's reasonable to begin with a trial of therapy or counseling alone, and to consider an antidepressant after several months if there's no improvement. But those with severe cases are at high risk for suicide. In such harrowing circumstances, the precaution of an antidepressant in addition to counseling can be lifesaving. Indeed, given the benefits of psychotherapy and antidepressants together, the American Psychiatric Association (APA) recommends combination therapy in moderate to severe cases of major depression.[18]

The APA further recommends that sufferers who improve with antidepressants continue these medications for four to nine months after a first episode, as the risk of recurrence is high before this period. For those who have endured three or more major depressive episodes, the APA recommends continuing an antidepressant *for life*. Such recommendations can unnerve us. We might worry about addiction, and question the strength of our faith. We read headlines announcing that primary care physicians now prescribe 40% of antidepressants,

18 Gelenberg, *Practice Guideline*, 18.

often without documenting a psychiatric diagnosis, and we wonder if we're aiding an epidemic of self-medication to numb the ordinary ripples of life.[19]

Before we chastise one another, consider that while half of people recover from a first episode of depression without further issues, after three episodes the risk of recurrence approaches 100%.[20] In chronic and recurrent depression, maintenance antidepressants don't imply addiction, but rather a vital precaution to safeguard against future episodes. Addictive drugs produce euphoria, sedation, or other states that veer from reality and dishonor God (1 Cor. 6:19–20). Our craving for such substances never abates as long as we continue taking them. Few people, by contrast, covet antidepressants. About 60% of people who take an antidepressant complain of uncomfortable side effects, including diarrhea, nausea, vomiting, insomnia, drowsiness, weight gain, sexual dysfunction, and anxiety.[21] Given these unpleasant effects, the dropout rate for antidepressant therapy is high, with many stopping the medications before their depressive symptoms resolve.[22] Addiction isn't even an appropriate consideration.

When used wisely in severe depression, antidepressants don't offer an escape from suffering, but rather equip us to contend with it. When used with discernment, these medications can root us in reality, and help us to focus with clarity on our risen Lord. Becky, who shared her experiences at the start of this article, emphasizes their role with this point: "This issue has kept a short tether between the Lord and me as I seek him and stay in his word—I know I must!"

DEPRESSION AND CHRISTIAN SUFFERING

Even when we grasp that major depression isn't normal sadness, we can still struggle with misconceptions that depression is somehow "un-Christian." "How can a believer like me struggle with depression when I have the gospel?" one

19 Ryan A. Crowley et al., "The Integration of Care for Mental Health, Substance Abuse, and Other Behavioral Health Conditions into Primary Care: Executive Summary of an American College of Physicians Position Paper," *Annals of Internal Medicine* 163, no. 4 (August 2015), https://doi.org/10.7326/M15-0510.

20 Gelenberg, *Practice Guideline*, 57.

21 Gartlehner, "Comparative Benefits and Harms."

22 Gartlehner, "Comparative Benefits and Harms."

sufferer asked me. Another admitted, "I feel like there must be something wrong with me and my alleged 'faith.' I end up chastising myself for not having the kind of faith that would lead me out of this depression." Such comments echo those of Dr. Beverly Yahnke, executive director of The Lutheran Center for Spiritual Care and Counsel:

> Far too many well-intentioned Christians are imbued with the conviction that strong people of faith simply don't become depressed. Some have come to believe that by virtue of one's baptism, one ought to be insulated from perils of mind and mood. Others whisper unkindly that those who cast their cares upon the Lord simply wouldn't fall prey to a disease that leaves its victims emotionally desolate, despairing and regarding suicide as a refuge and comfort—a certain means to stopping relentless pain.[23]

An assumption common to such doubts is that gospel hope should guard us against maladies of the mind. But such assertions lack both empathy and biblical grounding. Christ has triumphed over death (1 Cor. 15:55; 2 Tim. 1:10), and when he returns, all its wretched manifestations will wash away (Isa. 25:7–8; Rev. 21:4). But for *now*, we still live in the wake of the fall. We must never mistake the Christian life for a prance through a garden path. Jesus warns that persecution will follow us into the world that has rejected him (Matt. 16:24–25; John 1:10–11; 15:20). All creation groans (Rom. 8:22–28). Sin still seethes across the globe, stirring up calamity, infiltrating the synapses in our brains to tangle our thoughts and feelings. Our Savior himself was a man of sorrows, acquainted with grief (Isa. 53:3), even though he shared perfect communion with the Father. While sin stains the world, even those most devoted to Christ can sink into despondency.

The gospel doesn't promise us freedom from pain, but an abundantly more precious gift: the assurance of God's love, which *prevails* over sin and *buoys* us

23 Beverly K. Yahnke, introduction to *I Trust When Dark My Road: A Lutheran View of Depression* by Todd. A. Peperkorn (St. Louis: Lutheran Church, Missouri Synod, 2009), 5.

through the tempests. Christ offers us hope that transcends the crooked wantonness of this broken world. Suffering can bear down on us. Depression can crush even the most faithful among us. But in Christ, nothing can separate us from God's love (Rom. 8:38–39).

THE SOURCE OF OUR HOPE

Christians should feel empowered to consider medical treatments—whether antidepressants or otherwise—as blessings, given by God as evidence of his mercy. We clearly see from Jesus's ministry that healing displays the Father's love for us (Mark 1:40–41; 3:1–5; Matt. 8:1–3; John 9:1–7). Prophets and apostles also mention physical means of healing as instruments to nurture the hurting (Isa. 38:21; 1 Tim. 5:23). Perhaps the best example is the parable of the good Samaritan, when the passerby stops to tend to an injured man's wounds with bandages, oil, and wine (Luke 10:25–37). Such passages should chase away our guilt if we require antidepressant medications as part of a multifaceted, prayerful approach to depression.

And yet, while we partake of these ordinary means of grace, they cannot offer us the renewal we find in Christ. We quench our parched souls only from the living water that springs from the gospel. We're right to accept medical advances for what they are—blessings from God, gifts to help us heal and prosper. While we seek treatment, however, we must still turn our eyes toward God (2 Chron. 16:12). The need for a heavenward gaze does not limit itself to depression, but to any ailment of mind, body, or soul. As Christians we cleave to a hope that far exceeds any protocol or prescription.

Whether we use medications or not, a vital response when we sink into despair is to pray and to meditate as best as our clouded minds permit on his living and active word (Phil. 4:6; James 1:5; Heb. 4:12). When we kneel before our Lord in humility and supplication, and with palms open lift our burdens to him, he draws us near (Ps. 34:18), even as we struggle through the avenues of medications and counseling. In the coming age, our Savior will chase away the specters that loom over creation (Rev. 21:4). In the meantime, we take comfort that he

too has walked in darkness. He too has endured deep suffering, not from brain circuitry gone awry, but willingly, for our sake, out of abundant love for us (John 3:16). And to that truth we cling, even when the shadows descend, even as we labor through medications and therapy, and breathlessly scramble for the light.