WHEN TREATMENT HARMS:
Antidepressant-Induced Suicidality and Implications for Biblical Counseling

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More than 720,000 people die by suicide every year.[2] As of 2024, over 60 million people received therapy for some form of mental health condition, and around 35% of the US population was prescribed psychotherapeutic medication.[3] These numbers are greater than ever, and yet, within the past 40 years, there has been a general increase in suicide rates.[4] Several proposed ideas have been put forward to explain this phenomenon. Mental health conditions such as mood disorders, opioid use and overdose, alcohol related deaths, and greater access to firearms are said to be among the contributing factors.[5] For numerous reasons, the iatrogenic effects of antidepressant medication are rarely mentioned as a contributing factor to these rates.

Antidepressant usage can increase the risk of suicidality through adverse

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[2] "Suicide," World Health Organization, accessed July 2, 2025, https://www.who.int/health-topics/suicide.

[3] "Mental Health Treatment or Therapy among U.S. Adults 2024," Statista, accessed August 20, 2025, https://www.statista.com/statistics/794027/mental-health-treatment-counseling-past-year-us-adults/; "Results from the 2024 National Survey on Drug Use and Health: Detailed Tables Prevalence Estimates, Standard Errors, P Values, and Sample Sizes," SAMSHA, 2025, https://www.samhsa.gov/data/sites/default/files/reports/rpt56484/NSDUHDetailedTabs2024/NSDUHDetailedTabs2024/2024-nsduh-detailed-tables.htm?

[4] "Suicide Data and Statistics," CDC, Suicide Prevention, published March 26, 2025, https://www.cdc.gov/suicide/facts/data.html.

[5] Gonzalo Martinez-Ales et al., "Why Are Suicide Rates Increasing in the United States? Towards a Multilevel Reimagination of Suicide Prevention," in Behavioral Neurobiology of Suicide and Self Harm, ed. Enrique Baca-Garcia, vol. 46 (Springer International Publishing, 2020), https://doi.org/10.1007/7854_2020_158.

drug reactions such as akathisia; therefore, counselors and family members need to be aware and able to respond with creative care when someone in their life experiences the iatrogenic effects of this medication. In this paper, I give a brief history of antidepressant medication. Then, I examine the research on the efficacy of antidepressant medication, financial conflicts of interest and publication bias in the literature, and the evidence for antidepressant medication inducing suicidality. I will also review empirical research on toxicology reports of completed suicides. Finally, I will establish how Christians can biblically understand akathisia and the implications of this phenomenon for counselors and family members in a counseling context.

DEFINITION OF KEY TERMS

Iatrogenesis – Any injury or illness that occurs as a result of medical care.[6]

Suicidality - The term suicidality is an umbrella term that includes increases in suicidal thoughts, behaviors, attempts, plans, gestures, and completed suicides.[7]

Akathisia – A movement disorder caused by an adverse drug reaction to different types of medication, though it could occur naturally in some neurologic disorders like Huntington Disease.[8] Akathisia from an adverse drug reaction is a neurological condition where the chemical action in the body attacks healthy functions of the nervous system and diminishes a person's control over their mental and emotional processes.[9] This is the movement disorder that occurs from antidepressant usage and antidepressant withdrawal that can induce suicidality.[10]

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[6] According to ScienceDirect, "Iatrogenesis is defined as any injury or illness that occurs as a result of medical care." See "Iatrogenesis - an Overview | ScienceDirect Topics,"ScienceDirect, accessed August 23, 2025, https://www.sciencedirect.com/topics/medicine-and-dentistry/iatrogenesis.
[7] "Suicidality," Anderson University, July 29, 2020, https://anderson.edu/student-life/counseling/suicidality/
[8] This adverse drug reaction is not limited to psychotropic drugs, but also has been experienced with channel blockers, anti-vertigo, and sedatives used in anesthesia, etc.
[9] Daniel Berger, Suicidal Ideation: A Biblical Perspective for Counselors (Alethia International Publications, 2021), 39.
[10] "Akathisia: What It Is, Symptoms, Causes & Treatment," Cleveland Clinic, accessed July 1, 2025, https://my.clevelandclinic.org/health/diseases/23954-akathisia.

Cohort Study – Researchers who are conducting a cohort study typically follow a specific group or groups of people over an extended period of time to measure the effects of specific environments, therapies, medications, etc. This can be achieved by studying them in their future endeavors, but it can also be accomplished by examining their past to gain insight into why they are experiencing what they are currently experiencing.

Population Study – Researchers who conduct a population study track statistics and trends of a large sample of a population over time to understand trends within their behavior.

Systematic Review – Researchers who conduct a systematic review are attempting to summarize all the individual research studies on a given topic to synthesize and understand trends across data.

Systematic Umbrella Review – Researchers who are conducting a systematic umbrella review are attempting to synthesize all the individual systematic reviews that have been done.

Meta-Analysis – Researchers who are conducting a meta-analysis draw research from multiple independent studies, where the researcher uses various statistical techniques to understand the specific mathematical outcomes of those studies. This helps researchers have greater precision in understanding the statistics of the research conducted so they can know if there was a significant effect or not. Alongside systematic reviews, meta-analyses are generally considered the gold standard of research.

A BRIEF HISTORY OF ANTIDEPRESSANT MEDICATION

Before looking at the evidence of antidepressants increasing the risk of suicide, it is essential to understand how psychiatrists and the culture at large think about antidepressants and how they work within the brain. In the 1950s, Swiss Psychiatrist Roland Kuhn advertised the notion that an antidepressant drug called Imipramine had antidepressant effects due to targeting the underlying

biological mechanism of depression.[11] This was done despite the lack of evidence for Imipramine treating a verifiable biological disease, yet psychiatrists took the opportunity to capitalize on this notion.

From this point forward, the discipline of psychiatry shifted from a drug-centered model of psychotropic medication to a disease-centered model of psychotropic medication. That is, before Imipramine, drugs were advertised by the effect they had on a person. Under the disease-centered approach, drugs began to be advertised by suggesting they help treat an underlying biological condition. This shift occurred in the larger context of psychiatry losing its credibility as a legitimate medical science, and this strategic move (among other new methods of treatment like Electroconvulsive Therapy) placed the profession back into the medical conversation.[12] On this topic, prominent psychiatrist Joanna Moncrieff asserts:

> A crude and often implicit drug-centred model of drug action that existed up until that time—the idea that drugs cause general changes in arousal, emotion and mental activity—was supplanted by the disease-centred model—the idea that drugs target underlying disease or symptom mechanisms. This transformation did not occur because there was evidence to support the truth of the disease-centred view. It came about because psychiatrists wanted the disease-centred model to be true, and that coloured the way they interpreted what they were seeing when they gave their patients the new drugs. The disease-centred model was established so quickly and so comprehensively that people soon forgot there was any other way to think about psychiatric drugs.[13]

The disease-centered model made way for the chemical imbalance theory of depression to begin formulation in the 1960s, which, over time, led to the hypothesis that an imbalance in serotonin levels in the brain can cause depression. Moncrieff states, "By the 1970s, the idea that depression could be the manifest

[11] Joanna Moncrieff and Chris van Tulleken, *Chemically Imbalanced: The Making and Unmaking of the Serotonin Myth* (Flint, 2025), 76–77.
[12] Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (Hoboken, NJ: John Wiley & Sons, Inc., 1997), 260–261.
[13] Shorter, *A History of Psychiatry,* 88.

result of an imbalance of brain chemicals was firmly established."[14] The Selective Serotonin Reuptake Inhibitor (SSRI) called Prozac exploded onto the scene in 1988 with the wholesale promotion to the general public that this drug treats a chemical imbalance.

Pharmaceutical companies received great help from Robert Spitzer, who, in 1980 changed the criteria for mental health diagnoses to reflect that of a disease-centered approach to mental health disorders in the third edition of *The Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) original hypothesis that antidepressant medication treats an underlying illness was never verified biologically.[15] The current edition of the DSM (called the DSM-5-TR) was published in 2022, and the authors do not give a clear biological etiology for any depressive disorder listed.[16] In fact, they write: "No laboratory test has yielded results of sufficient sensitivity and specificity to be used as a diagnostic tool for [Major Depressive Disorder]."[17] Yet, antidepressant medication is still heavily funded by pharmaceutical companies via advertisements directly to consumers, physicians, and lobbying organizations. Antidepressant medication revenue has only increased since the creation of Prozac in the 1980s, and the industry is estimated to make 22.13 billion dollars in revenue in 2025 alone.[18]

The chemical imbalance theory is estimated to be believed by more than 80% of the general public today, yet psychiatrists have only understood their effects (and the effects of psychotropic medication in general) on suicidal behavior for the past 20 years.[19] Written in 2010 in *Pharmaceuticals*, medical doctors write, "Research on the possible relationship between pharmacotherapy and suicidal behavior was virtually unknown until a decade ago."[20] This is problematic given the

[14] Shorter, *A History of Psychiatry*, 97.
[15] Daniel Berger, *Mental Illness: The Necessity for Faith and Authority*, vol. 1 (Alethia International Publications, 2016), 73–84.
[16] The "TR" stands for "Text Revision"; Diagnostic and Statistical Manual of Mental Disorders Text Revision, fifth edition (American Psychiatric Association, 2022), 187.
[17] Diagnostic and Statistical Manual of Mental Disorders, 187.
[18] "Antidepressant Market Size, Forecast, Trends Report & Share 2030," June 30, 2025, https://www.mordorintelligence.com/industry-reports/antidepressants-market.
[19] Joanna Moncrieff et al., "The Serotonin Theory of Depression: A Systematic Umbrella Review of the Evidence," *Molecular Psychiatry* 28, no. 8 (2023): 3243–56, https://doi.org/10.1038/s41380-022-01661-0.
[20] Maurizio Pompili et al., "Antidepressants and Suicide Risk: A Comprehensive Overview," *Pharmaceuticals* 3, no. 9 (2010): 2861–83, https://doi.org/10.3390/ph3092861.

wholesale adoption of this theory and the administration of antidepressant drugs to millions of people over the years. Moncrieff argues, "[Psychiatrists] convinced themselves the drugs were effective long before there were proper clinical trials to test this supposition."[21] Typically, medical professionals attempt to find a verifiable pathology first, and once a known disease is identified, medication is then created to combat the disease. In the case of antidepressants, medication was developed and promoted before understanding an objective way to test for pathology, let alone an understanding of actual pathology itself. This rush and lack of detailed care from psychiatrists has led to the overprescribing of a medication that has a low efficacy rate and increases the risk of suicidality.

THE EFFICACY OF ANTIDEPRESSANTS

The most extensive study ever done on the effectiveness of antidepressants was conducted in 2022. In this systematic umbrella review published in *World Psychiatry*, researchers studied over 650,000 people from 2014 to 2021 and found that antidepressants were effective for about 50% of people. This is about 10–15% higher than the efficacy rate for a placebo. The researchers state:

> After more than half a century of research, thousands of RCTs [randomized control trials] and millions of invested funds, the effect sizes of psychotherapies and pharmacotherapies for mental disorders are limited, suggesting a ceiling effect for treatment research as presently conducted. A paradigm shift in research seems to be required to achieve further progress.[22]

The literature is clear that antidepressants are only slightly more effective than a placebo, but they carry side effects such as sexual dysfunction, emotional blunting, and akathisia, which outweigh the side effects of placebos. Given this data, the disadvantages seem to outweigh the advantages for some medical professionals to prescribe them with confidence.[23] However, medical professionals should

[21] Moncrieff, *Chemically Imbalanced*, 80.
[22] Falk Leichsenring et al., "The Efficacy of Psychotherapies and Pharmacotherapies for Mental Disorders in Adults: An Umbrella Review and Meta-analytic Evaluation of Recent Meta-analyses," *World Psychiatry* 21, no. 1 (2022): 133–45, https://doi.org/10.1002/wps.20941.
[23] Irving Kirsch, *The Emperor's New Drugs: Exploding the Antidepressant Myth* (Basic Books, 2010), 7–22.

expect that antidepressant medication has a limited effect, given that the drug is not treating any clear biological disease or chemical imbalance. Joana Moncrieff conducted what is arguably the most viewed psychiatric journal in history, which examined over 160,000 people across 17 different studies. The evidence from her article demonstrates that the chemical imbalance theory of serotonin is unfounded scientifically. She writes in *Molecular Psychiatry*:

> The main areas of serotonin research provide no consistent evidence of there being an association between serotonin and depression, and no support for the hypothesis that depression is caused by lowered serotonin activity or concentrations. Some evidence was consistent with the possibility that long-term antidepressant use reduces serotonin concentration.[24]

The chemical imbalance theory is a predominant example of secularists conflating the inner man and the outer man and treating them as if they were the same entity. The results are low efficacy rates and iatrogenesis.

LIMITATIONS IN RESEARCH, FINANCIAL CONFLICTS OF INTEREST, AND PUBLICATION BIAS

The current assumption among medical professionals is that antidepressants rarely induce suicidality.[25] However, the data is likely not entirely accurate, given that people who are overtly suicidal are not included in empirical research. On the difficulty of obtaining accurate statistics in studies pertaining to people who are suicidal, researchers in *The British Medical Journal* write:

> Drug safety can be assessed through meta-analyses of trials reporting adverse outcomes, but in the case of antidepressants and suicide or attempted suicide these trials tend to be short term and generally exclude patients with any major suicide risk or with physical or psychiatric comorbidity [multiple physical or mental health diagnoses]. Indication bias is the main concern with observational

[24] Moncrieff, "The Serotonin Theory of Depression."
[25] Moncrieff, *Chemically Imbalanced*, 185.

> studies assessing drug safety, which occurs when patients are prescribed drugs for a condition that is itself associated with the risk of the adverse outcome.[26]

If this is true, then medical professionals do not have a clear understanding of how antidepressants relate to suicidality, and it can be assumed that the data is more troubling than what is portrayed.

The research also consistently demonstrates publication bias and financial conflicts of interest in studies on antidepressants. Meaning, published studies conducted by researchers receiving financial compensation from pharmaceutical companies generally report more positive findings (fewer side effects, more efficacious) than those of researchers who do not have financial ties to pharmaceutical companies. This is evident, for example, when Robert F. Kennedy Jr. called for an investigation and review in 2025 regarding the usage of antidepressants in America after sharing his concerns that SSRIs are dangerous to use long-term and carry significant side effects.[27] In response, six of the most well-respected organizations in psychiatry came together and published a statement defending antidepressant medication as safe to use, carrying minimal side effects.[28]

This article is dangerously deceptive for numerous reasons. First, the only studies that the organizations cite are short-term clinical studies. The real-world median usage of SSRI medication in 5 years, yet, according to Michael Hengartner, there are only 6 studies ever conducted that examined the efficacy of SSRIs past 6 months.[29] There are very few long-term studies for antidepressant usage past 12 weeks because pharmaceutical companies are generally sponsoring the studies, and they have no interest in conducting long-term studies.[30] Therefore, telling the

[26] C. Coupland et al., "Antidepressant Use and Risk of Suicide and Attempted Suicide or Self Harm in People Aged 20 to 64: Cohort Study Using a Primary Care Database," *British Medical Journal*, 350, no. 32 (February 18, 2015): h517–h517, https://doi.org/10.1136/bmj.h517.

[27] Nathan Howard, "RFK Jr. Thrusts Antidepressants into the Spotlight — Unnecessarily, Advocates Say," NBC News, February 21, 2025, https://www.nbcnews.com/health/health-news/rfk-jr-ssri-antidepressants-children-doctors-risks-studies-rcna192722.

[28] https://www.psychiatry.org/news-room/news-releases/joint-statement-on-federal-concerns-about-psychotr

[29] Michale P. Hengartner, *Evidence-Based Antidepressant Prescription, Overmedicalisation, Flawed Research, and Conflicts of Interest* (Cham, CH: Palgrave Macmillan, 2022), 30-31.

[30] Andrea Fagiolini, Professor of Psychiatry at the University of Siena School of Medicine, Chairman of the Department of Mental Health at the University of Siena, interview by author,

general public that antidepressants are safe and pointing to literature that does not reflect real-world usage is invalid at best and deceptive at worst. Second, the six organizations reference a 1995 article asserting that antidepressants are rarely found in toxicology reports of suicide victims. Yet, since 1995, multiple high-quality studies have shown that antidepressants are among the medications most frequently associated with completed suicide, as will be discussed later in this paper. Additionally, all 6 of the organizations that created the statement assuring antidepressants are safe and effective have direct ties to the pharmaceutical industry.[31]

The relationship between the pharmaceutical industry and the mental health industry at large is alarming. Nearly sixty percent of the physicians involved in the DSM-5-TR task force have ties to the pharmaceutical industry.[32] On this topic, psychiatrist Giovanni Fava asserts, "The increasing influence of the pharmaceutical industry on psychiatric research and practice is leading to an intellectual and clinical crisis."[33] Fava wrote these words in 2009, yet this crisis has not been resolved since then. A meta-analysis published in 2021 in *The Journal*

Riverside video software, November 20, 2025.

[31] On financial conflicts of interest (fCOI) with The American Psychiatric Association, see Lauren C Davis et al., "Undisclosed Financial Conflicts of Interest in DSM-5-TR: Cross Sectional Analysis," *British Medical Journal*, January 10, 2024, e076902, https://doi.a org/10.1136/bmj-2023-076902. On fCOI with The American Academy of Child and Adolescent Psychiatry, see the sponsors of their annual report in which they acknowledge their ongoing supporters, many of whom are companies that create SSRI medication: "AACAP Research Committee Annual Report," American Academy of Child and Adolescent Psychiatry, 2025, https://www.aacap.org/App_Themes/AACAP/Docs/research/2025_AACAP_Research_Cmte_AR.pdf. On fCOI with American Society for Clinical Psychopharmacology, see "ASCP Annual Meeting - American Society of Clinical Psychopharmacology," American Society of Clinical Psychopharmacology, 2025, https://ascpp.org/ascp-meetings/ascp-annual-meeting/. On fCOI with American College of Neuropsychopharmacology, see "Financial Disclosures," American College of Neuropsychopharmacology, accessed March 21, 2026, https://acnp.org/about-us/financial-disclosures/. On fCOI with Society of Biological Psychiatry, see "An Ethical and Financially Transparent Framework for Sponsors and Exhibitors," Society of Biological Psychiatry, accessed March 21, 2026, https://sobp.org/wp-content/uploads/2025/04/Ethical-and-Transparent-Framework-for-Industrial-Sponsors-and-Exhibitors.pdf. On FCOI with National Network of Depression Centers, see "NNDC Annual Conference," National Network of Depression Centers (blog), accessed March 21, 2026, https://nndc.org/nndc-annual-conference/.

[32] Lauren C Davis et al., "Undisclosed Financial Conflicts of Interest in DSM-5-TR: Cross Sectional Analysis," *British Medical Journal*, January 10, 2024, https://doi.org/10.1136/bmj-2023-076902.

[33] Giovanni A. Fava, "The Decline of Pharmaceutical Psychiatry and the Increasing Role of Psychological Medicine," *Psychotherapy and Psychosomatics* 78, no. 4 (2009): 220–27, https://doi.org/10.1159/000214443.

of Epidemiology and Community Health examined 27 separate studies totaling 1.45 million people and found that published studies that had a financial conflict of interest reported significantly lower rates of correlation with antidepressant medication and suicide.[34]

The most extensive and most rigorous study on this issue was published in 2016 in *The Journal of Clinical Epidemiology*. In this comprehensive analysis of over 185 meta-analyses, the researchers examined the connections between antidepressant researchers and the pharmaceutical industries. They assert:

> Fifty-four meta-analyses (29%) had authors who were employees of the assessed drug manufacturer, and 147 (79%) had some industry link (sponsorship or authors who were industry employees and/or had conflicts of interest). Only 58 meta-analyses (31%) had negative statements in the concluding statement of the abstract. Meta-analyses including an author who were employees of the manufacturer of the assessed drug were 22-fold less likely to have negative statements about the drug than other meta-analyses . . . There is a massive production of meta-analyses of antidepressants for depression authored by or linked to the industry, and they almost never report any caveats about antidepressants in their abstracts. Our findings add a note of caution for meta-analyses with ties to the manufacturers of the assessed products.[35]

Given our culture's naturalistic worldview, scientific literature is often regarded as the ultimate authority on matters of health. After all, it has brought profound benefits to modern society. Scientific studies can be valuable tools for understanding the effects of medications. However, the corruption of the human heart can distort findings that might otherwise improve lives, turning valuable research into a means of exploiting suffering for financial gain. Antidepressant research is one way in which corrupt human nature and the deceit of the human

[34] For more on understanding meta-analyses, see Christian Basile et al., "When a Meta-Analysis Can Be Really Useful?," *International Journal of Cardiology* 436 (October 2025): 133423, https://doi.org/10.1016/j.ijcard.2025.133423; Hengartner, *Evidence-Based Antidepressant Prescription*.
[35] Shanil Ebrahim et al., "Meta-Analyses with Industry Involvement Are Massively Published and Report No Caveats for Antidepressants," *Journal of Clinical Epidemiology* 70 (February 2016): 155–63, https://doi.org/10.1016/j.jclinepi.2015.08.021.

heart is on display, as side effects are underreported, and positive effects are exaggerated.

Another study in 2019 in *The Journal of Psychiatric Research* reviewed 18 years of research (2000–2017) and found there is a financial interest and publication bias in reporting findings from antidepressant trials, meaning that those who report positive findings (increased efficacy rate, decreased side effects) receive compensation from pharmaceutical industries.[36] Given these findings, one should not assume the scientific literature is neutral and objective, or that pharmaceutical companies have clients' best interests in mind.

EVIDENCE OF ANTIDEPRESSANT-INDUCED SUICIDALITY

Empirical research on antidepressants inducing suicidality is compelling.[37] Examining the data throughout the years shows a clear trend in increased suicidality. For example, in 2005 a systematic review was conducted in *The British Medical Journal* where researchers sought to examine all randomized controlled trials of SSRIs between 1967 and June 2003.[38] After analyzing the data of 87,650 patients, the researchers reported that there was nearly a two-fold increase in suicide when the patients were prescribed antidepressants.[39]

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[36] Ahmed Waqas et al., "Conflicts of Interest and Outcomes of Clinical Trials of Antidepressants: An 18-Year Retrospective Study," Journal of Psychiatric Research 116 (September 2019): 83–87, https://doi.org/10.1016/j.jpsychires.2019.05.029.

[37] Antidepressants are not the only drug to increase suicidality. For example, the largest study ever conducted on the correlation between sedative use and suicide can be accessed in a journal titled *European Psychiatry.* In this cohort study, researchers examined nearly 6.5 million individuals in Denmark from 1995 to 2018 and found that benzodiazepine use (as well as non-benzodiazepine sedatives) correlated with a 140% increase in suicide risk for men and a 320% increase in suicide risk for women. See, N. Høier et al., "The Association between Benzodiazepine and Non-Benzodiazepine and Suicide: A Nationwide Cohort Study," *European Psychiatry* 65, no. S1 (2022): S181–S181, https://doi.org/10.1192/j.eurpsy.2022.478.

[38] For more on understanding systematic reviews, see EunJin Ahn and Hyun Kang, "Introduction to Systematic Review and Meta-Analysis," *Korean Journal of Anesthesiology* 71, no. 2 (2018): 103–12, https://doi.org/10.4097/kjae.2018.71.2.103.

[39] Dean Fergusson et al., "Association between Suicide Attempts and Selective Serotonin Reuptake Inhibitors: Systematic Review of Randomised Controlled Trials," *British Medical Journal*, 330, no. 7488 (February 19, 2005): 396, https://doi.org/10.1136/bmj.330.7488.396.

In 2006, a population study conducted in Ontario was published in *The American Journal of Psychiatry*, where researchers examined over 1,300 suicides of people aged 66 and older and found a nearly five-fold increased risk of suicide within the first month of SSRI therapy in comparison to other antidepressant types, and violent suicides were consistently more common with SSRI therapy.[40]

In 2015, a cohort study was published in *The British Medical Journal*, where researchers sought to examine over 87,000 people in the United Kingdom diagnosed with depression from ages 20–64.[41] They found a nearly twofold increase in suicide when the patient was given antidepressant medication in comparison to a placebo.[42]

In 2021, a meta-analysis was published in *The Journal of Epidemiology and Community Health*, where researchers examined 27 separate studies totaling 1.45 million people. The authors of the study conclude that antidepressants correlate with higher levels of suicide. Specifically, they write, "Exposure to new-generation antidepressants is associated with higher suicide risk in adult routine-care patients with depression and other treatment indications. Publication bias and [financial conflicts of interest] likely contribute to systematic underestimation of risk in the published literature."[43] Again, the literature suggests that bias and financial gain have led to the silencing of accurate data regarding antidepressants and suicidality.

In 2022, a systematic review was published in *Frontiers in Psychiatry*, where researchers sought to examine 17 different studies from 1990 to 2021. They concluded that there was a significant increase in suicide in children and adults aged 5–21 when taking antidepressants compared to no antidepressant use.[44] In

[40] For more on understanding population studies, see "Population-based Study," National Cancer Institute, nciAppModulePage, February 2, 2011. https://www.cancer.gov/publications/dictionaries/cancer-terms/def/population-based-study; David N. Juurlink et al., "The Risk of Suicide With Selective Serotonin Reuptake Inhibitors in the Elderly," *American Journal of Psychiatry* 163, no. 5 (May 2006): 813–21, https://doi.org/10.1176/ajp.2006.163.5.813.

[41] For more on understanding cohort studies, see David Barrett and Helen Noble, "What Are Cohort Studies?" *Evidence-Based Nursing* 22, no. 4 (2019): 95–96, https://doi.org/10.1136/ebnurs-2019-103183.

[42] Coupland, "Antidepressant Use."

[43] Hengartner, *Evidence-Based Antidepressant Prescription.*

[44] Kuan Li et al., "Risk of Suicidal Behaviors and Antidepressant Exposure Among Children and Adolescents: A Meta-Analysis of Observational Studies," *Frontiers in Psychiatry* 13 (May 26, 2022): 880496, https://doi.org/10.3389/fpsyt.2022.880496.

2021, an umbrella review was published in *The Journal of Youth and Adolescence*, where researchers examined 1,149 different studies in New Zealand. They found there was a significant correlation between antidepressants and an increased risk of suicide in children and teenagers.[45] According to the Center for Disease Control and Prevention (CDC) and the data from 2023, one in five high school students has strongly considered attempting suicide.[46]

In response to the literature that suggests antidepressants increase suicidality, the FDA has issued a black box warning, which is a serious label that alerts users of the risk of suicidal thoughts when taking the drug. The FDA's black box warning accompanying prescription antidepressants states:

> Antidepressants increased the risk of suicidal thinking and behavior (suicidality) in short-term studies in children and adolescents with Major Depressive Disorder (MDD) and other psychiatric disorders. Anyone considering the use of [Drug Name] or any other antidepressant in a child or adolescent must balance this risk with the clinical need. Patients who are started on therapy should be observed closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber. [Drug Name] is not approved for use in pediatric patients. The average risk of such events in patients receiving antidepressants was 4%, twice the placebo risk of 2%. No suicides occurred in these trials.[47]

The FDA's data is consistent with that of the other literature, which suggests that antidepressants at least double the risk of suicide. However, as noted previously, the findings are suppressed, and those percentages are likely higher than reported.

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[45] Rebecca Richardson et al., "Risk and Protective Factors of Self-Harm and Suicidality in Adolescents: An Umbrella Review with Meta-Analysis," *Journal of Youth and Adolescence* 53, no. 6 (June 1, 2024): 1301–22, https://doi.org/10.1007/s10964-024-01969-w.

[46] "Suicidal Thoughts & Behavior," CDC, Mental Health, July 16, 2025, https://www.cdc.gov/mental-health/about-data/suicidal-thoughts-and-behavior.html.

[47] Khadijah Booth Watkins, "Illuminating the Black Box: Antidepressants, Youth, and Suicide," Massachusetts General Hospital, October 2024, https://mghcme.org/app/uploads/2024/09/Watkins-Illuminating-the-Black-Box_kbw_2024.pdf.

TOXICOLOGICAL FINDINGS

An important area of research involves toxicological studies of individuals who have completed suicide, examining whether there is a correlation between specific medications and completed suicide. The literature suggests the number one drug associated with suicide is antidepressants themselves. According to researchers in *BMC Pharmacology and Toxicology* and their study of over 100,000 people who committed suicide, antidepressants are one of the top types of drugs found in people's systems after suicide:

> We conducted a pharmacovigilance analysis utilizing real-world data from the FAERS database employing the disproportionality method to analyze the 20 drugs exhibiting the highest reported rates of suicidal ideation or self-injurious behavior. Our findings indicate that antidepressants constitute the most reported medication type for adverse effects associated with suicidal ideation or self-injurious behavior.[48]

This is a remarkable statement that brings into question the efficacy of antidepressant medication in general. Other toxicological studies show with accuracy when people are most at risk of exhibiting suicidal tendencies when using antidepressants. For example, a Swedish nationwide study in *The European Journal of Clinical Pharmacology*, which examined almost 10,000 people postmortem, concluded a nearly fourfold risk of violent suicide in the early stages of antidepressant treatment.[49]

Peter Breggin is a well-known psychiatrist and former consultant of the National Institute of Mental Health (NIMH). On the reality of antidepressants inducing suicide, he writes, "Since antidepressants are now the drugs most commonly implicated in successful suicides, it would seem far more appropriate

[48] Wen-long Xie et al., "An Exploratory Study Evaluating the 20 Medications Most Commonly Associated with Suicidal Ideation and Self-Injurious Behavior in the FAERS Database," *BMC Pharmacology and Toxicology* 26, no. 1 (January, 2025): 24, https://doi.org/10.1186/s40360-025-00858-7.

[49] Jonas Forsman et al., "Selective Serotonin Re-Uptake Inhibitors and the Risk of Violent Suicide: A Nationwide Postmortem Study," *European Journal of Clinical Pharmacology* 75, no. 3 (March, 2019): 393–400, https://doi.org/10.1007/s00228-018-2586-2.

to designate them as 'suicide drugs' rather than anti-suicide drugs. Yet psychiatrists persist in giving them to depressed patients who are suicidal."[50] Breggin said this in 1991. One might think there may have been advancements in the drug side effects since then; after all, that was three decades ago. However, *The Journal of Clinical Toxicology* shows us that there hasn't been an improvement. Here is what researchers conclude regarding the prevalence of antidepressants found in the body after successful suicide attempts from 2000 to 2020 in the US:

> Among individuals 13 years and older, there were 744,853 suspected suicides and nonfatal suicide attempts involving antidepressants as a first-ranked substance reported to PCCs from 2000 through 2020, averaging 35,469 cases annually . . . Regardless of causality, which this study cannot assess because of its design, our findings clearly show that antidepressants are commonly involved in suspected suicides and nonfatal suicide attempts.[51]

Breggin's statement in 1991 was issued after reflecting on antidepressant medication since the first wave of antidepressants in the 1950s and the availability of the first SSRI (Prozac) in 1988. His conclusion in 1991, after reflecting on 30 years of history, is that antidepressants can induce suicide. From 1991 to the present day, decades of toxicological reports, meta-analyses, and systematic reviews conclude the same reality. *The Journal of Clinical Toxicology* is accurate in stating that these findings do not indicate causality; however, these findings show a correlation between antidepressant medication and suicide and reveal that antidepressants increase rather than lower the risk of suicide.

To summarize:

1) The most extensive research available shows that antidepressant medications do not balance a chemical imbalance in the brain or treat any pathological disease.

2) The FDA has issued a black-box warning for antidepressants that alerts patients of the risk of serious side effects such as suicidal ideation.

[50] Peter Breggin, *Toxic Psychiatry* (New York, NY: St Martin's Press, 1991), 158.
[51] Matilda Francis et al., "Suspected Suicides and Nonfatal Suicide Attempts Involving Antidepressants Reported to United States Poison Control Centers, 2000–2020," *Clinical Toxicology* 60, no. 7 (July, 2022): 818–26, https://doi.org/10.1080/15563650.2022.2041202.

3) Leading medical journals have published numerous meta-analyses and systematic reviews that span decades, and they consistently show an increased risk of suicide associated with antidepressant use.

4) Decades of empirical research reveal that positive antidepressant findings (higher efficacy rates, lower side effects) have been influenced by publication bias and financial conflicts of interest.

5) Toxicological studies have repeatedly shown that antidepressants are the most common class of drugs found in the systems of individuals who have completed suicide.

In general, medication can be a valuable tool in alleviating suffering. However, practicing biblical counselors need to think carefully about whether antidepressant medication is a common grace. Given the research not only on antidepressants and their relationship to suicidality, but also aggression and agitation, sexual dysfunction, brain fog, mania, insomnia, pregnancy complications, emotional blunting, memory issues, significant withdrawal effects, and more, it would be wise for biblical counselors to rethink their position on this matter.[52] While antidepressants may reduce symptoms for some, the research demonstrates that it is common for antidepressants to have adverse effects, sometimes even producing the very symptoms they were meant to prevent.

UNDERSTANDING ANTIDEPRESSANT-INDUCED SUICIDALITY BIBLICALLY

A Christian approach to helping someone who is suicidal should differ significantly from the way the culture addresses suicide. It may be argued that the predominant secular approach—administering antidepressant medication under the assumption that it addresses an underlying biological condition—has contributed to the increase in suicide rates. Biblically, this should be expected.

[52] For more on common side effects of antidepressant medications, see Moncrieff, *Chemically Imbalanced*, 178–196. There is also a significant correlation between antidepressant usage and homicidal behavior. For more information on this, see A Midwestern Doctor, "The Decades of Evidence SSRI Antidepressants Cause Mass Shootings," The Forgotten Side of Medicine, September 4, 2024, https://www.midwesterndoctor.com/p/the-evidence-ssri-antidepressants.

Secularists are conflating the inner man and the outer man and attempting to treat the inner man with medication. Scripture provides the lens through which Christians are called to view the world, and its testimony is clear: human beings consist of both a soul and a body. While the body and soul are deeply intertwined, they are not the same entity. In other words, the brain and the mind are not the same thing. According to Scripture, they are distinct, and it is the inner man that ultimately drives our behavior (2 Corinthians 4:16; 5:8, James 4:1–3, Proverbs 4:23–27, Luke 6:45). The body can increase pressure on the soul, tempting it toward deep despair and anguish (Job 7:4–5, Lamentations 3:16–18, Psalm 38:3–8). At the same time, the body can help relieve the soul's suffering, providing support that allows the mind to think with greater clarity. (Acts 9:18–19; 37:33–36, Judges 15:18–19, 1 Kings 19:3–8, Luke 8:54–55, Psalm 23:1–3).

From an evaluation of Elijah's story, for example, it is evident that circumstantial pressure (such as being hunted for one's life) and physical suffering (like running for miles without food, water, or rest) can create the perfect recipe for hopelessness, which can lead to suicidal thoughts (1 Kings 19:1–4). It is also evident that when physical strain is relieved and the body is given rest, the inner person faces less temptation toward despair and gains renewed strength for daily life (1 Kings 19:5–8). Scripture is dynamic in this way and avoids giving a monocausal approach to despair. Yet, under the dominant evolutionary model of psychiatry, doctors often equate the mind with the brain, treating the inner person as though it were merely the outer person. Beliefs shape practice, and since SSRI's hit the market, this belief system has led to the overmedication of suffering people in an effort to reduce depression and suicide.[53]

AKATHISIA

Akathisia is a movement disorder caused by an adverse drug reaction to different types of medication.[54] It is a neurological condition caused by side effects of various kinds of medications, where the chemical action in the body attacks healthy functions of the nervous system and diminishes a person's control

[53] Vita Brisnik et al., "Depriscribing of antidepressants: development of indicators of high-risk and overprescribing using RAND/UCLA Appropriateness Method", *BMC Medicine* 22, no. 193 (May, 2024), https://doi.org/10.1186/s12916-024-03397-w.

[54] This adverse drug reaction is not limited to psychotropic drugs, but also has been experienced with channel blockers, anti-vertigo, sedatives used in anesthesia, etc.

over their mental and emotional processes.[55] This is the movement disorder that occurs from antidepressant usage and antidepressant withdrawal that can induce suicidality.[56]

In Greek, the word akathisia literally means "inability to sit" or "not to sit". Symptoms of akathisia include restlessness, impulsivity, cognitive impairment, lack of self-control, panic attacks, terror, aggression, agitation, hopelessness, despair, insomnia, and more.[57] Those who experience this side effect often describe sensations such as airplane crashes going off in their heads, uncontrollable urges to jump or pace, feeling repeatedly as if they are being set on fire, and chronic insomnia.[58] A common testimony among patients is an overwhelming feeling of inner agony. While the severity of akathisia varies from person to person, people have reported that in severe cases, enduring the drug-induced torment sounds more agonizing than death itself.[59]

Suicide induced by antidepressants is often more violent, where those under distress resort to hanging, drowning, shooting, jumping from high heights, and other highly lethal means.[60] Sadly, akathisia is a condition that is often misclassified or underreported in scientific literature.[61] One study in *Behavioural Pharmacology* found that akathisia was a side effect in about 25% of the patients studied who were prescribed antidepressant medication, suggesting that akathisia is not a rare side effect as some explain it to be.[62]

How should biblical counselors and counselees understand akathisia biblically? The body cannot cause someone to commit suicide. According to

[55] Berger, *Suicidal Ideation*, 39.
[56] "Akathisia: What It Is, Symptoms, Causes & Treatment," Cleveland Clinic, accessed July 1, 2025, https://my.clevelandclinic.org/health/diseases/23954-akathisia.
[57] "Akathisia: What It Is," Cleveland Clinic.
[58] "Patient Experiences – Akathisia Alliance," Akathisia Alliance, accessed June 23, 2025, https://akathisiaalliance.org/patient-experiences/.
[59] There are numerous Facebook groups where people share their difficulties and bizarre side effects from SSRI medication. For example, see the Facebook group titled "Managing SSRI Withdrawal."
[60] Forsman et al., "Selective Serotonin Re-Uptake Inhibitors."
[61] Tarang Sharma et al., "Suicidality and Aggression during Antidepressant Treatment: Systematic Review and Meta-Analyses Based on Clinical Study Reports," *British Medical Journal*, January 27, 2016, i65, https://doi.org/10.1136/bmj.i65.
[62] Ismail Akgoz et al., "Evaluation of Akathisia in Patients Receiving Selective Serotonin Reuptake Inhibitors/Serotonin and Noradrenaline Reuptake Inhibitors," *Behavioural Pharmacology* 35, no. 8 (December 2024): 460–63, https://doi.org/10.1097/FBP.0000000000000797.

Scripture, the will belongs to the domain of the inner person—not the outer (Proverbs 16:9; Psalm 119:112, Romans 7:18–22). Though the body and the soul are intertwined in a complex way, Christians must not treat as one what God has clearly distinguished as separate entities. In cases such as akathisia, the body creates an agonizing environment for the soul to inhabit. This physical distress can make the soul more vulnerable and prone to despair, where the one suffering desires in their heart to escape through death.

People act according to their desires, and tragically, antidepressants can produce such severe effects in the body that the sufferer may genuinely desire to end their life rather than endure the intense physical torment. The same principle applies to the cancer patient tempted toward depression. Chemotherapy and prolonged physical suffering may pressure the soul toward despair, but the cancer itself does not cause someone to despair in their heart. This is why one person can endure the suffering of cancer while rejoicing in God, while another may long for life to end. Each person is unique with their own combination of heart themes. The condition of akathisia reveals outwardly the deceit and despair that are already manifested in their inner man. In this way, counselors gain a glimpse of someone's heart in its raw condition, without the body's help to filter and restrain their fallen desires and hopes.

Though akathisia is not seen explicitly in the Bible, there are various instances of people in Scripture experiencing severe physical symptoms that make them loathe their own lives (2 Corinthians 1:8–9, Lamentations 3:1–16, Jonah 4:5–8). From a simple observation of Scripture, it is clear that intense physical suffering can lead to deep inner agony and even suicidal thoughts. Yet, it is also clear from Scripture that people can have a wide range of responses to physical suffering. Jonah wanted his life to end (Jonah 4:5–8) while Jeremiah turned his mind toward the attributes of God and found relief in the midst of distress (Lamentations 3:22–24). This contrast demonstrates that, contrary to the biological reductionism that is evident in psychiatry, the body does not determine whether someone chooses to end their life. Instead, physical suffering powerfully influences the soul, drawing it toward agony—just as we see in cases of akathisia. Ultimately, the body reveals what is already present in the heart, whether that be despair and deception or hope and trust in God.

When a person takes antidepressant medication and they begin to experience profound side effects, the predominant narrative is that the person's mental illness is worsening when, in reality, the drug action in the body creates physical suffering and influences the person toward thoughts of hopelessness, despair, and inner turmoil. Unfortunately, the common result is an increase in dosage to help reduce the symptoms of the so-called mental illness, which in some instances can lead to the strengthening of the effects of akathisia that induce suicidality.[63]

IMPLICATIONS FOR BIBLICAL COUNSELING

Biblical counseling literature is lacking on the topic of akathisia and antidepressant-induced suicide. For example, out of more than 1,100 journal articles in the *Journal of Biblical Counseling*, only two articles mention this phenomenon.[64] Biblical counselors are not legally authorized to provide medical advice regarding starting or stopping antidepressant medication. However, numerous measures can be taken to help family members understand how to properly help a loved one who is dealing with physical suffering that might be contributing to suicidality.

Be Gentle, Gracious, and Patient

Counselors and family members who have a loved one suffering from suicidal thinking and behavior need to be gentle, gracious, and patient. Unless it is an extreme situation, it can be difficult to tell if someone is suffering from the side effects of antidepressant medication simply by observation.[65] Therefore, the natural posture of the counselor and the family should be to assume this is a suffering issue stemming from someone who is faint-hearted and weak; thus, they

[63] Lindsey P. Koliscak and Eugene H. Makela, "Selective Serotonin Reuptake Inhibitor-Induced Akathisia," *Journal of the American Pharmacists Association* 49, no. 2 (2009): 28–38, https://doi.org/10.1331/JAPhA.2009.08083.

[64] For the two articles that mention akathisia, see Ed Welch, "Medical Treatments for Depressive Symptoms," *Journal of Biblical Counseling* 18, no. 3 (2000); and Benjamin Crawford, "How to Help Counselees with Psychoactive Medications," The Journal of Biblical Counseling 28, no. 2 (2014). Though both of these articles mention akathisia, they do not give a full treatment on how to handle this phenomenon. For a biblical counseling resource that does deal with the topic, see Elyse M. Fitzpatrick et al., *Will Medicine Stop the Pain?: Finding God's Healing for Depression, Anxiety, and Other Troubling Emotions* (Chicago, IL: Moody Publishers, 2006).

[65] "For Clinicians," Akathisia Alliance, n.d., accessed August 25, 2025, https://akathisiaalliance.org/for-clinicians/.https://akathisiaalliance.org/for-clinicians/*For Clinicians – Akathisia Alliance.*

should encourage and help where needed with much patience (1 Thessalonians 5:14). Counselors need to understand that akathisia is a neurological disorder, therefore, they are counseling someone who is weak in body. If there is evidence of sin, the counselor and family member should gently admonish by speaking the truth in love and walking alongside them (Ephesians 4:15, Galatians 6:1–2, 1 Thessalonians 5:14). Counselors and family members should reject biological reductionism while still affirming the biblical reality that the body has a real influence on behavior.

Be Proactive

Counselors and family members must also take seriously any accusations or statements of self-harm or suicidal plans. Neglecting to do so sends a message that the counselor or family member does not take them seriously; taking them at their word actually gives them hope.[66] Robert Jones helpfully asserts, "The life-threatening nature of suicidality calls you to amplify your normal attending and relational skills. Don't minimize the impact of your caring, compassionate presence."[67] If a counselee is overtly suicidal, it is best to call 911 so that they might be admitted into a psychiatric hospital. While the environment of a psychiatric hospital is not ideal, the top priority is that the counselee is kept alive. If they are not overtly suicidal, but there is some risk, then the church, while partnering with the family, should create a safety plan to care for the counselee.[68]

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[66] Jay Adams, "Editorial: A Reminder on Suicide," *The Journal of Biblical Counseling* 5, no. 2 (1981): 1–2.

[67] Robert Jones, "Biblical Counseling Coalition | Nine Guidelines for Counseling Suicidal People," Biblical Counseling Coalition, September 9, 2019, https://www.biblicalcounselingcoalition.org/2019/09/09/nine-guidelines-for-counseling-suicidal-people/

[68] Determining the risk of a counselee ending their life can be difficult. If a counselor uses a risk assessment, they should use it with discernment knowing this is a tool that can be helpful but that it is not determinative. For a helpful article on assessing someone who has suicidal desires, see: Aaron Sironi and Mike Emlet, "Evaluating a Person with Suicidal Desires," *The Journal of Biblical Counseling* 26, no. 2 (2012). For a safety plan that can be implemented in the context of the church, see Kendra Fabel, "A Suicide Care Plan: One Church's Model," *The Journal of Biblical Counseling* 36, no. 3 (2022). I do not recommend taking Fabel's advice in sending the person who is suicidal to a "professional" given that the "professional" is likely counseling out of philosophies that encourage despair. Still, this journal is a helpful tool to see the structures that can be set in place in a church context to help care for someone who is suicidal, and it can be used to stimulate thoughts regarding how to best care for people.

Combine Medication Lists

Counselors need to encourage the counselee to compile a list of every medication they are taking so they can share the list with all doctors involved in their treatment. The counselor or family can even help the counselee do this. The literature suggests that one drug interacting with another drug in the body can create side effects such as akathisia and suicidality. For example, researchers in *The Journal of Internal Medicine* examined over 150,000 middle-aged and older women and found that women taking three or more psychotropic medications at once had over a two-fold increased risk of suicide and unintended overdose death.[69] It is wise to gather a complete medication list to give to all doctors involved so that they might identify potential drug-drug interactions that contribute to suicidal thoughts. Taking this simple step can bring the person closer to ruling out physical factors that influence suicidal thinking.

Be Aware of Side Effects

In general, counselors and family members need to be aware of common side effects of psychotropic medications. According to *The International Journal of Neuropsychopharmacology* and their data across 81 European psychiatric hospitals from 1993–2014, restlessness, impulsivity, and thoughts and attitudes that are not typically displayed by a person may be warning signs for the onset of suicidal behavior.[70] Among other questions, some of the first questions a counselor should ask the counselee are whether they are taking medication, what kind of medication they are taking, and the dosage they are taking. Ruling out physical symptoms first before counseling the heart will enable the counselor to give more accurate counsel (Proverbs 18:13). Failure to do this might lead a counselor to be too quick to give admonishment for issues that have been aggravated or escalated by medication.

In cases of counseling, it might be beneficial for the counselor to lessen the load of homework, knowing that the person they are counseling may be suffering

[69] Carolyn J. Gibson et al., "Long-Term Psychoactive Medications, Polypharmacy, and Risk of Suicide and Unintended Overdose Death Among Midlife and Older Women Veterans," Journal of General Internal Medicine 37, no. 3 (2022): 770–77, https://doi.org/10.1007/s11606-022-07592-4.
[70] Susanne Stübner et al., "Suicidal Ideation and Suicidal Behavior as Rare Adverse Events of Antidepressant Medication: Current Report from the AMSP Multicenter Drug Safety Surveillance Project," *International Journal of Neuropsychopharmacology* 21, no. 9 (September 1, 2018): 814–21, https://doi.org/10.1093/ijnp/pyy048.

from the side effects of medication. Focusing intently on one or two counseling issues can go a long way rather than trying to cover many things that might overwhelm a counselee. During the counseling session, the counselor needs to display compassion, gentleness, and patience, knowing that they may be suffering from cognitive impairment and other adverse reactions to medication.

Go to the Doctor with Them

Counselees who are suicidal might not want to see their general practitioner or their psychiatrist. If a counselor or family member suspects the counselee is suffering from side effects from antidepressant medication, they should be urged to tell their doctor immediately. One way a counselor can gain involvement in the counselee's life and demonstrate advocacy is by accompanying them to the doctor. From there, the counselor can help make the doctor aware of potential adverse drug reactions.

Medication Changes and Proper Tapering

The majority of the literature points to adverse effects like suicidal behavior happening shortly after a medication change, especially regarding antidepressants. The beginning stages of taking an antidepressant come with a lot of physiological changes, as do the beginning stages of discontinuation. The counselor and family must be aware and lovingly monitor the counselee for the first few months on the medication and for the time period after discontinuation. If a counselee's behavior has seemingly worsened shortly after starting the medication, they should consult a medical doctor immediately. Note the words of medical doctors writing in *The Journal of Neuropsychopharmacology* on adverse drug reactions and suicidal thoughts shortly after starting antidepressants. Their study involved nearly 220,000 people across 81 European psychiatric hospitals from 1993–2014. They assert:

> It is important to note that the suicidal adverse drug reactions occurred within the first week (in 71% of the cases) or the first 2 weeks (93%) after onset or dosage increase of the imputed antidepressant. This indicates that attention should be paid to possible suicidal ideation and behavior especially at the beginning of antidepressant therapy. . . Most suicidal adverse drug reactions occurred shortly after beginning

> antidepressant medication or increasing the dosage. Fifty-nine of the 83 adverse drug reaction cases occurred within the first 7 days (71%), 18 cases between day 7 and 14 (22%), and only 6 afterwards (7%).[71]

While it is essential to monitor them if they have started a new medication, it is equally important to keep a close eye on them if they have stopped taking their medication. Tapering quickly off certain medications is dangerous, so they should be encouraged to taper slowly under the direct supervision of a medical doctor who understands how to taper patients off psychotropic medication properly. The withdrawal symptoms will be worse if the counselee has been taking antidepressants for an extended period of time, and the literature suggests slowly tapering over a 12–18 month period.[72]

Encourage Care for the Body

Vitamin intake, consistent quality sleep, and exercise can help those suffering from depressive and/or suicidal thoughts. Studies show an increase in mood with vitamins like D3 taken at high dosages.[73] Unlike antidepressant medication, vitamins have fewer side effects. While this should not be the primary focus of counseling (1 Timothy 4:8), the counselor can encourage the family and the counselee to hold each other accountable in simple ways, such as taking vitamins, which may help them have more energy and a brighter mood.

One systematic review that studied over 128,000 people in *The British Journal of Medicine* shows that exercise over an extended period is 1.5 times more effective than medication in treating depression.[74] The counselor can encourage the counselee and the family to start small by taking a walk outside once a week, to the glory of God. As this happens, the pressure the body puts on the soul may

[71] Stübner, "Suicidal Ideation and Suicidal Behavior."
[72] National Guideline Centre (UK), *Evidence Review: Safe Withdrawal: Medicines Associated with Dependence or Withdrawal Symptoms: Safe Prescribing and Withdrawal Management for Adults: Evidence Review* C, NICE Evidence Reviews Collection, National Institute for Health and Care Excellence, (NICE), (2022), http://www.ncbi.nlm.nih.gov/books/NBK580676/
[73] Shadi Ghaemi et al., "The Effect of Vitamin D Supplementation on Depression: A Systematic Review and Dose–Response Meta-Analysis of Randomized Controlled Trials," *Psychological Medicine* 54, no. 15 (November 2024): 3999–4008, https://doi.org/10.1017/S0033291724001697.
[74] Ben Singh et al., "Effectiveness of Physical Activity Interventions for Improving Depression, Anxiety and Distress: An Overview of Systematic Reviews," British Journal of Sports Medicine 57, no. 18 (September, 2023): 1203–9, https://doi.org/10.1136/bjsports-2022-106195.

lift, which may help suicidal thinking go away. As any positive bodily habits are encouraged, they should be done under the premise that the body is complexly intertwined with the heart, but that the heart is the ultimate driving force for human behavior, not the body (Proverbs 4:20–27).

Counsel the Soul

The biblical counselor has the unique ability to give what no other secular discipline has been able to provide them with: eternal hope through Jesus Christ. They have a significant opportunity to provide specific hope that leads to joy (Proverbs 12:25; 15:22; 16:24). The counselor should teach biblical anthropology and the truth that, though their body may suffer, their mind can be renewed and transformed (2 Corinthians 3:18, 4:6; Ephesians 4:23; Romans 12:2). The counselor should teach about the reality that even small amounts of faith glorify God, and glorifying Him is the ultimate goal of the Christian life, not symptom-reduction (Matthew 17:20, Mark 9:14–29).[75] The counselor should teach about the hope that comes from renewed, glorified bodies and a joyful eternity spent with Jesus Christ (1 Corinthians 15:42–44, Isaiah 40:29–31, Romans 8:11, Revelation 21:1–5). The counselor should teach on the attributes and promises of God, which were more than enough for authors of Scripture who endured extreme bodily affliction and inner distress (Psalm 13; 42; 88; 2 Corinthians 4; Lamentations 3).

The counselor should teach on biblical lament and communion with God through prayer which leads to joy, peace, and renewed strength (Philippians 4:4–7, Psalm 13; 34:17–18). The counselor should teach on the bodily suffering of the Lord Jesus Christ, who endured severe physical torment that their sin debt might be wiped away (Isaiah 53:4–5). Through faith in the death of Christ, the counselee has complete access to the grace of God in their trial (Romans 8:32). Counselors must implore the counselee to go to Him in confident prayer for this grace in their weakness (2 Corinthians 12:9, Hebrews 4:15–16). Though there is temptation to make the primary focus the body, regarding antidepressant-induced suicidality, biblical counselors must focus on ministering specific hope to

[75] For an excellent sermon that deals with the necessity of faith while suicidal, see Nicolas Ellen, "Understanding and Dealing with Suicide," Association of Certified Biblical Counselors, July 15, 2020, accessed August 25, 2025, https://biblicalcounseling.com/resource-library/conference-messages/understanding-and-dealing-with-suicide/.

the particular trial the counselee is enduring, knowing that heart transformation happens through trust in Christ.

CONCLUSION

In this paper, I gave a brief history of antidepressant medication. Then, I examined the research on the efficacy of antidepressant medication, financial conflicts of interest and publication bias in the literature, and the evidence for antidepressant medication inducing suicidality. I also reviewed empirical research on toxicology reports of completed suicides and sought to establish how Christians can biblically understand akathisia. Finally, I gave implications for counselors and family members in a counseling context. After a thorough study of the literature, it is evident that antidepressant usage can increase the risk of suicidality through adverse drug reactions such as akathisia; therefore, counselors and family members need to be aware and able to respond with creative care when someone in their life experiences the iatrogenic effects of this medication