Building Adolescent Resilience

A NeuroFaith® Model To Empower Teens to Thrive in a Complex World

Jeffrey E. Hansen, PhD

Russell Gombosi, MD

Contents

In Dedication 4

Introduction 6

Part I: Unveiling the Crisis 16

Numbers Don't Lie 17

The Fading Teen ***See the Signs. Step In. Save a Life*** 23

Part II: The Deeper Causes of Adolescent Depression 35

Cause I: ***Replacing Play-Based Childhood with Screen-Based Childhood*** . 36

Cause II: Hijacked Minds: ***How Pornography Is Rewiring the Teenage Brain*** ... 43

Cause III: ***Disconnection and the Descent into Adolescent Despair*** 57

Cause IV: Trauma ***The Hidden Epicenter of Adolescent Despair*** 105

Cause V: Ideologies of Disorientation: ***How Radical Theories Are Rewriting Childhood and Undermining Identity*** 139

Cause VI: When the Family Fractures: ***Attachment, Divorce, and the Erosion of Resilience*** ***149***

Part III: The ***NeuroFaith®*** Model for Healing 158

The Therapeutic Pathway to Healing and Peace 159

Pillar One: ***Polyvagal-Informed Therapy*** 165

Pillar Two: ***HeartMath®*** 183

Pillar Three: ***Internal Family Systems (IFS)*** 200

Pillar Four: ***Spirituality and Faith*** 222

The Honorary Pillar: ***Movement as Medicine*** 250

Part IV: Wise Care and Thoughtful Choices 258

Creating a Safe Place for Teens to Talk.....259
A Few Thoughts on Finding the Right Therapist and Therapy..... 269
Rethinking Medication.....275
Conclusion *A Journey of Hope and Healing*.....290
References.....296
About the Authors.....320

In Dedication

This book is dedicated first to adolescents who are finding their way in a complex and often confusing world.

You are growing up in a time that asks a great deal of you, much of which you did not choose and much of which is not easy to navigate. And yet, day after day, you get up and face what is in front of you. You try, you stretch, you wrestle with who you are and who you are becoming, and you continue to move forward even when the path is not clear. That matters more than you may realize.

We see you. We respect you. We support you. And we hope, in some meaningful way, to do better by you by offering clarity where there is confusion, guidance where there is uncertainty, and encouragement as you move toward maturity, responsibility, and strength.

This book is also dedicated to their parents.

You are raising your children in a time where there is no clear manual, no simple script, and no shortage of competing voices. The decisions are not always obvious, and the pressures are real. And yet, you continue to show up. You continue to care. You continue to do your best to guide and support your children as they grow.

We honor that.

Our hope is that this book offers some measure of encouragement and steadiness as you walk alongside them, helping them move not toward perfection, but toward resilience, wisdom, and the kind of grounded strength that will carry them into adulthood.

Building Adolescent Resilience

A NeuroFaith® Model To Empower Teens to Thrive in a Complex World

Jeffrey E. Hansen, Ph.D. & Russell Gombosi, M.D.

NO MEDICAL ADVICE IS GIVEN NOR PROVIDED IN THIS BOOK. SUCH INFORMATION, WHICH MAY BE MEDICAL IN NATURE, IS INFORMATION ONLY FOR THE USE OF LICENSED AND EXPERIENCED MEDICAL PRACTIONERS. A READER INTERESTED IN MEDICAL ADVICE OR MEDICAL TREATMENT SHOULD CONSULT A MEDICAL PRACTIONER WITH AN APPROPRIATE SPECIALTY WHO IS PROPERLY LICENSED IN THE READER'S JURISDICTION.

Authors' Note on AI Contributions

Limited parts of this book were crafted with the support of ChatGPT, an AI tool that helped refine transitions and assist with research. Every effort has been made to ensure that all sources and information are accurate and reliable. Additionally, some images were created with the help of AI technology. We invite readers to explore the content with an open mind, and where applicable, feel free to consult other sources for further insight.

Copyright © Jeffrey E. Hansen, Ph.D. & Russell Gombosi, M.D.
Published by NeuroFaith® LLC
Prescott Valley, AZ
2026 Jeffrey E. Hansen

Introduction

"He who has a why to live can bear almost any how. But what of the child who has lost the 'why' before they've even begun to live?"

—Inspired by Friedrich Nietzsche

We did not originally set out to write this book together. We come from different disciplines and practice in different parts of the country, yet over time our paths began to converge through a shared concern for what is happening to adolescents. One of us is a clinical psychologist and the other a physician. Our training is different, our daily work looks different, and yet, across those differences, we found ourselves encountering the same patterns with increasing clarity and concern.

That convergence became more intentional through a medical conference series called *Shed Some Light*, an effort founded and led by Russell to create space for clinicians committed to pursuing truth in medicine and mental health with clarity, intellectual honesty, and freedom from ideological distortion. Jeff was invited to speak at the conference, first on adolescent depression, and then invited back the following year to speak on adolescent resilience. What began as a professional invitation quickly developed into an ongoing dialogue, one that extended beyond the conference itself and into a deeper exchange of ideas, observations, and shared concerns.

Through those conversations, it became increasingly evident that we were seeing the same reality from different vantage points. Across clinical settings, we were encountering rising levels of anxiety, depression, fragmentation, and disconnection among adolescents. These were not isolated cases or temporary fluctuations, but part of a broader shift that seemed to be unfolding across families, communities, and systems of care. While there has been no shortage of effort directed toward understanding these trends, much of that effort has focused on identifying what is wrong, naming symptoms, and attempting to manage distress once it has already taken hold.

That work is important, but it is not sufficient on its own. When attention becomes organized primarily around what is broken, there is a subtle but significant risk that our thinking, and ultimately our interventions, begin to orient around the problem itself. We react. We manage. We attempt to stabilize. Yet we may fail to build the internal capacities that would allow adolescents to navigate difficulty with greater resilience, coherence, and direction over time. What became clear to both of us, in our respective fields, is that something essential has been underemphasized—not simply the reduction of distress, but the deliberate cultivation of strength.

This book is an effort to shift that orientation. It reflects a shared conviction that adolescents do not merely need to be protected from what is harmful, but equipped with the internal structure necessary to engage life with stability, meaning, and purpose. The NeuroFaith® model represents one attempt to articulate that process in an integrated way, bringing together an understanding of the nervous system, relational development, and the deeper dimensions of identity and faith. Our aim is not to ignore the seriousness of what is happening, but to widen the lens and redirect attention toward what must be built if adolescents are to navigate this stage of life well.

For one of us, one of the clearest ways to understand how attention shapes direction comes from an unexpected place.

I (Jeff) have always loved motorcycles, in part because riding demands a kind of presence that is increasingly rare. When you are on a bike, there is no distance between you and the experience. You feel the road, the curvature of a turn, the subtle shift in balance as you lean and adjust. It requires attention, not in a forced or anxious way, but in a way that draws you fully into the moment. Over time, as you gain experience, you begin to recognize that riding is not just about mechanics or skill. It teaches you something about how attention works, and how profoundly it shapes direction.

One of the most important lessons comes in a moment that most riders remember clearly. You enter a turn carrying more speed than you intended, or the curve tightens in a way you did not anticipate, and your awareness is suddenly pulled toward the edge of the road. It might be a guardrail, a patch of gravel, or simply the sense of what lies beyond the pavement. Without thinking, your eyes fix on that point of danger, and almost as quickly, the motorcycle begins to drift in that direction. Riders refer to this as target fixation, and it reflects something deeply human. Under stress, the brain narrows its focus to what it perceives

as a threat, and the body follows where the eyes are directed. The more intensely you focus on what you are trying to avoid, the more likely you are to move toward it.

Learning to ride well requires an intentional shift. You have to lift your gaze and look through the turn, orienting yourself toward where the road is actually going rather than where it might end if you lose control. When you do that, something begins to reorganize. Your movements become smoother, your posture steadies, and the motorcycle follows the path your attention has chosen. The danger does not disappear, but it no longer dictates your direction. That distinction matters, and it extends well beyond the road.

It applies, with surprising precision, to how we are currently approaching the well-being of our adolescents. We are living in a time when concern about teenagers has become both widespread and urgent. Rates of depression, anxiety, and self-harm have increased, and suicide remains one of the leading causes of death among young people. These are not abstract statistics. They represent real families, real

children, and a reality that many parents and clinicians are encountering every day. At the same time, our response has increasingly centered on identifying what is wrong. We have become skilled at naming the symptoms, tracking the trends, and pointing to the many forces that appear to be contributing to the problem.

That awareness is important, but it carries a subtle risk. When our focus becomes dominated by what is broken, we can begin to organize our thinking and our interventions around the problem itself. We respond reactively. We define adolescents by their struggles. We work to manage symptoms without always building the internal capacities that would allow them to navigate those struggles more effectively. In doing so, we can unintentionally mirror the very dynamic that creates difficulty on a motorcycle. Our attention narrows, and without realizing it, we begin to move in the direction of what we are most focused on.

This book is an effort to shift that orientation. It does not ignore the seriousness of what is happening, nor does it minimize the risks. Instead, it seeks to widen the lens and redirect attention toward what must be built if adolescents are going to navigate this developmental period well. To do that, we will first take an honest look at the scope of the problem, examining the rise in depression, anxiety, and suicidal behavior, not for the sake of alarm, but for the sake of clarity. From there, we will explore the major forces shaping this generation, including the transition from a play-based childhood to a screen-based childhood, the effects of constant digital stimulation, early exposure to pornography, increasing social disconnection, the fragmentation of families, the influence of cultural and ideological pressures, and the enduring impact of trauma. These factors do not operate

independently. They converge in ways that amplify vulnerability and complicate development.

At the same time, understanding the problem is only part of the task. We will turn our attention to resilience, a concept that is often referenced but not always well understood. Resilience is not the absence of struggle, nor is it simply toughness. It is the capacity to encounter difficulty, regulate internal states, adapt, and continue moving forward with a sense of coherence and identity. It develops over time through experience, through relationships, and through the gradual strengthening of internal systems that allow a person to respond rather than react. In many ways, what we are seeing in the current generation is not simply an increase in distress, but a decrease in the conditions that historically allowed resilience to form.

To understand this more fully, we will examine the adolescent brain, looking at the developmental sequence that gives rise to heightened emotional intensity alongside still maturing systems of regulation and judgment. This is not a flaw in design, but it does create a period of

increased sensitivity to environment, which makes the surrounding context all the more important. From there, we will consider how adults can relate to adolescents in ways that support growth, recognizing that resilience is not built in isolation, but in the context of connection, guidance, and appropriately calibrated challenge.

All of this ultimately leads to the NeuroFaith® model, an integrative approach that brings together an understanding of the nervous system, emotional and relational processes, and the deeper dimensions of identity and spirituality. The aim is not merely to reduce symptoms, but to foster transformation, helping adolescents develop the internal structure needed to engage life with stability, meaning, and purpose.

The curve, in other words, is real, and the risks are real. But the outcome is not determined by the presence of danger alone. It is shaped by where attention is placed and how that attention guides action over time. If we remain focused only on what is going wrong, we will continue to react to the problem. If, however, we can lift our gaze and orient ourselves toward what builds resilience, we create the possibility for a different trajectory, one that moves beyond survival and toward genuine thriving.

There is a quiet wisdom in the reminder that where we look is where we go. It is simple, but it is not easy, especially in moments of uncertainty. Yet it is precisely in those moments that direction is determined. As the Scriptures remind us, ***"Let us fix our eyes not on what is seen, but on what is unseen. For what is seen is temporary, but what is unseen is eternal"*** (2 Corinthians 4:18, NIV). In learning to shift our focus, both as individuals and as those guiding the next generation, we begin to move differently. And perhaps that is where change begins,

not by ignoring the curve, but by learning to see beyond it. But before we move further into the seriousness of this topic, it is worth pausing for a moment to appreciate the wonderfully complex and often perplexing reality of adolescence. It is easy, especially when facing rising rates of anxiety and depression, to begin viewing teenagers primarily through the lens of concern. But doing so can cause us to miss something essential about who they are in this stage of life.

Just what is an adolescent anyway ?

Adolescent (noun):

A rapidly evolving lifeform caught between childhood innocence and adult responsibility, powered by sarcasm, caffeine, and alarming amounts of sugar.

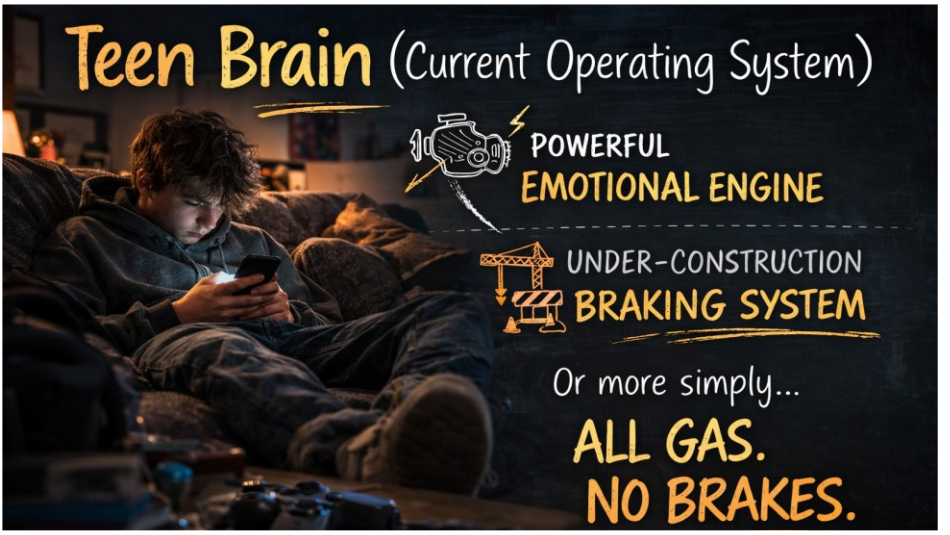
Known for questioning everything except their own questionable decisions, they possess the unique ability to sleep till noon but stay awake worrying about life at 2 a.m.

Proceed with humor and headphones.

Adolescents are not broken adults in smaller bodies. They are developing human beings in the middle of one of the most dynamic and formative periods of growth they will ever experience. At any given moment, they can appear thoughtful and impulsive, insightful and inconsistent, deeply feeling and yet difficult to understand. One minute they may sound like philosophers, wrestling with questions of identity, meaning, and purpose, and the next they may seem completely absorbed in things that leave the adults around them shaking their heads.

Part of what makes this stage so challenging is that their inner world is undergoing rapid change. Their emotional life is intense, their awareness is expanding, and their sense of self is still taking shape. They are learning how to navigate relationships, how to interpret their own thoughts and feelings, and how to find their place in a world that often feels both exciting and overwhelming.

From a developmental standpoint, this is not accidental. The adolescent brain is operating with a powerful emotional and motivational system that is fully online, while the systems responsible for regulation and long-term judgment are still maturing. In simple terms, the engine is strong, but the braking system is still under construction. This helps explain why adolescents can feel things so deeply, react so quickly, and sometimes make decisions that seem confusing or frustrating to the adults in their lives.



But beneath the intensity, the inconsistency, and even the occasional chaos, there is something far more important taking place. There is a young person trying to make sense of who they are, longing for

connection, searching for clarity, and reaching toward a life that feels meaningful and secure.

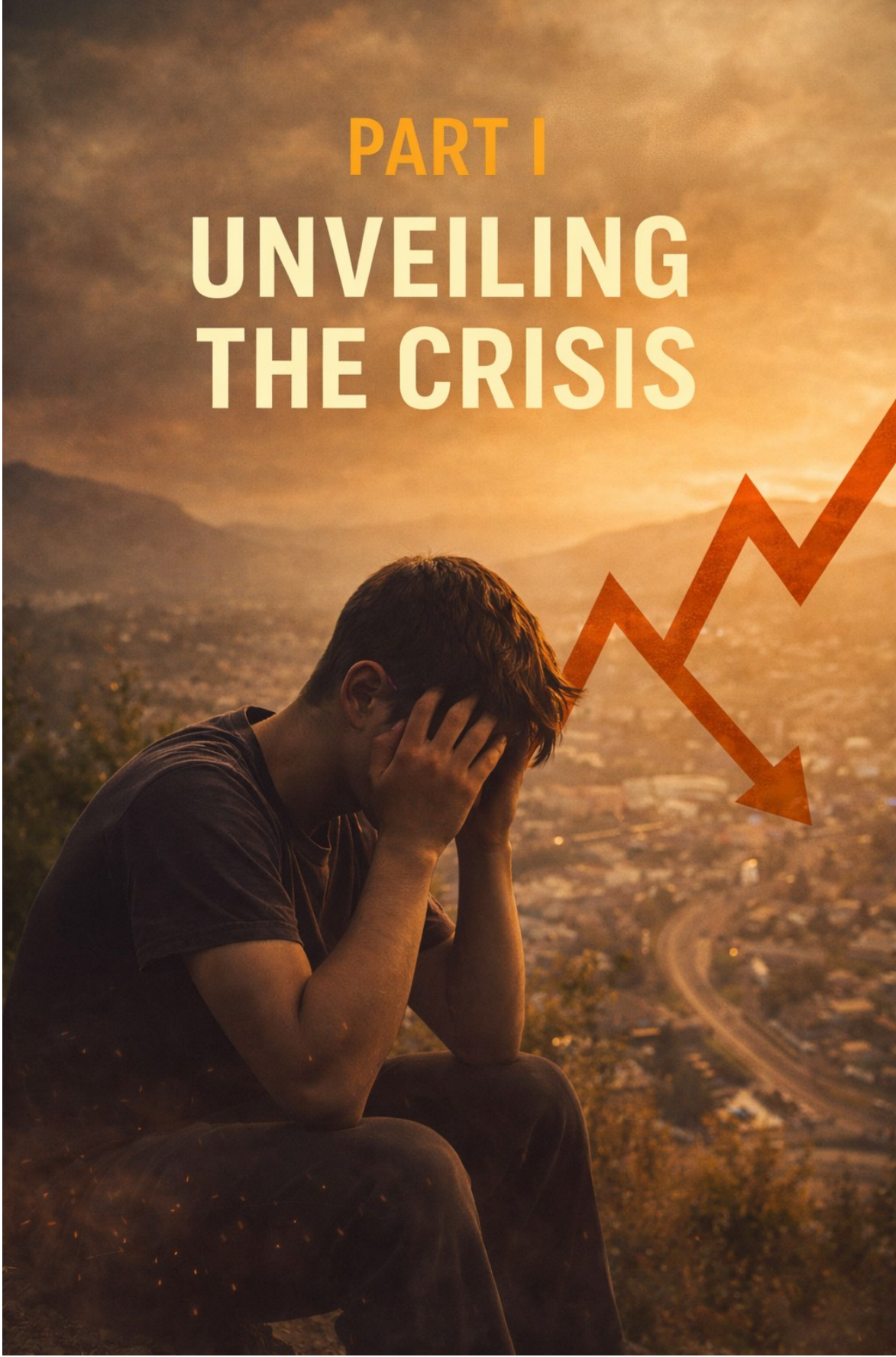
If we can hold onto that perspective, it changes how we approach everything that follows. Instead of seeing adolescents as problems to be fixed, we begin to see them as people to be understood, guided, and strengthened.

And with that foundation in place, we can now turn our attention to the more serious question.

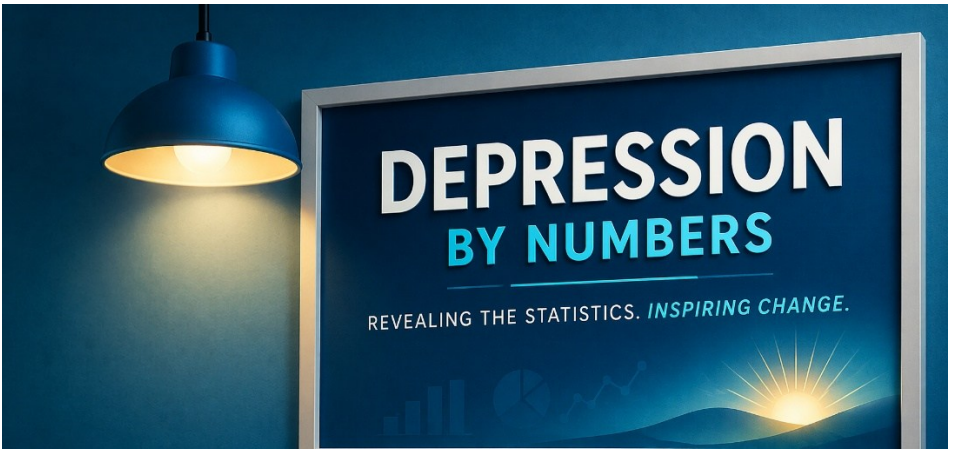
What is happening to this generation, and why does it matter so much?

PART I

UNVEILING THE CRISIS



Numbers Don’t Lie



At some point, we have to stop minimizing what we are seeing. This is not just teenage moodiness. It is not simply stress. It is not a phase that will pass if we wait it out long enough. What is unfolding in this generation is something far more serious, and most of us sense it long before we ever see it in the data. We see it in kids who are exhausted before life has really begun. We hear it in quiet statements like, ***“I don’t know who I am,”*** or ***“I don’t think anything matters.”*** We feel it in families who are trying to hold things together while something underneath is slipping.

And then the numbers confirm what we already know.

Roughly one in five adolescents will experience depression during their teenage years, a statistic consistently supported in large scale national studies (Merikangas et al., 2010). More recent national data continue to

affirm this reality, with the National Institute of Mental Health reporting that 20.1% of U.S. adolescents aged 12 to 17 experienced at least one major depressive episode in the past year (National Institute of Mental Health, 2023), a finding further reinforced by ongoing federal surveillance through the Substance Abuse and Mental Health Services Administration, which places adolescent prevalence rates in the range of approximately 18% to 20% (Substance Abuse and Mental Health Services Administration, 2024). That means in almost every classroom, every youth group, every team, there are teenagers carrying a weight that most adults would struggle to bear.

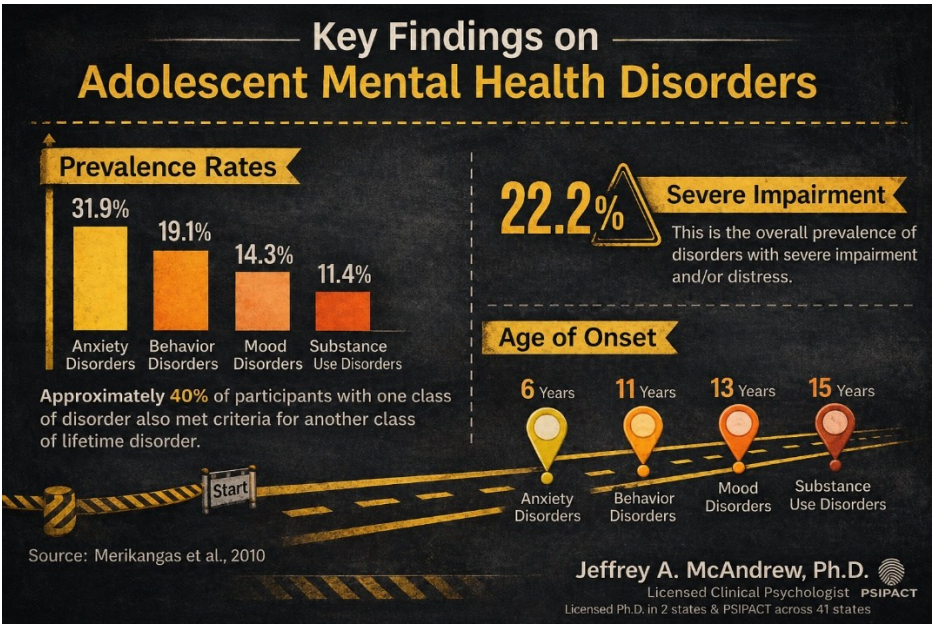
Even more sobering, suicide has become one of the leading causes of death among individuals aged 10 to 24, with rates rising significantly over the past decade (Centers for Disease Control and Prevention [CDC], 2022). This is not a marginal trend. It is a sobering shift in how our young people are experiencing life itself.

Complicating the picture, adolescent depression frequently overlaps with other psychiatric conditions such as generalized anxiety disorder,

ADHD, bipolar spectrum disorders, and PTSD. This comorbidity clouds the clinical picture, resulting in misdiagnosis and treatments that often target symptoms rather than the deeper roots of the pain.

The long-term impact of untreated adolescent depression cannot be overstated. It increases the risk of persistent adult mental illness, poor vocational outcomes, relational instability, and chronic health problems. Most heartbreakingly, untreated depression is the most significant predictor of suicide attempts and completions.

Anxiety, though often less visible, is just as pervasive. National data suggests that nearly one in three adolescents will meet criteria for an anxiety disorder at some point during their development (Merikangas et al., 2010). For many, this is not occasional worry. It is a constant internal pressure, a sense that something is always wrong, even when they cannot name what it is. In clinical settings, it is increasingly common to see anxiety and depression intertwined, each reinforcing the other, creating a cycle that can be exceptionally difficult to interrupt.



Researchers such as Jean Twenge have documented sharp increases in depressive symptoms, loneliness, and psychological distress among adolescents over the past decade, particularly in parallel with the rise of smartphone use and social media (Twenge et al., 2019). While no single factor explains the crisis, the convergence of these trends points to something more than coincidence.

But statistics, as important as they are, can only take us so far.

Numbers can tell us how many are struggling, but they cannot tell us what it feels like to be sixteen years old and lying awake at two in the morning, scrolling endlessly, comparing their life to everyone else's, wondering why they feel so off and whether it will ever change. They cannot capture the quiet shame of believing they are the only one who

feels this way, or the confusion that comes when their internal world feels out of control and they do not have the language to explain it.

Behind every number is a person. A son. A daughter. A child who was once carefree and is now trying to carry something too heavy, too early, and too alone. And this is where we have to be careful.

Because it would be easy to stop here and let the weight of the problem define the entire conversation. But if all we do is fixate on how bad things are, we risk doing exactly what we talked about earlier. We start staring at the guardrail. We organize ourselves around fear. We react instead of guide.

The numbers matter. They wake us up. They remove denial.

But they are not the whole story. Because alongside the rise in depression and anxiety, there is another reality that deserves just as much attention. Many adolescents today are growing up without the conditions that reliably build resilience. They are more connected digitally, but often less connected relationally. They are more stimulated, but less grounded. They are more aware, but often less anchored.

Which means the real question is not simply how many teens are struggling. It is why. And even more importantly, what we are going to do about it.

Because this is not a hopeless situation. It is a serious one, and it demands our attention, but it is not beyond redemption. If we are willing to look honestly at what is happening, and if we are willing to shift our focus from reacting to problems toward building resilience, there is a path forward.

And that is where we are headed next.

The Fading Teen

See the Signs. Step In. Save a Life

What does depression actually look like in the real world? Not in textbooks, not in diagnostic codes, and not in neatly defined categories. It shows up in lived moments, often quietly at first, and often in ways that are easy for us to miss if we are not paying close attention.

It can look like a door that used to stay open, now closed more often than not. A teenager who once lingered in the living room gradually begins to withdraw, spending more time alone. If we are honest, it can be easy to explain this away in the beginning. We tell ourselves it is just a phase, just moodiness, just part of growing up. Sometimes that is true. But sometimes it is not, and the difference is often found in the pattern rather than any single moment.

The shift is usually subtle at first. A little more time alone. A little less engagement. Conversations that feel thinner, less present. It does not demand attention, which is precisely why it can go unnoticed. It does not force us to respond, but it quietly invites us to pay attention.

Over time, it can look like a gradual loss of interest in things that once mattered. Activities begin to fall away. Friendships thin out. Invitations

are declined, and eventually they stop coming altogether. What once brought energy now feels like effort. As parents, as caregivers, or even as the young person themselves, there can be a quiet question in the background about when this changed and why it feels so different now.

These changes often show up in school as well, not always as failure, but as disengagement. Assignments go unfinished, motivation fades, and teachers may describe the student as capable but not applying themselves. From the outside, it can look like a matter of effort or choice. From the inside, it often feels very different, as if something essential has been dulled or drained, making even simple tasks feel disproportionately difficult.

We may also begin to hear the shift in conversation. The tone changes. Hope becomes quieter. Statements about the future carry less expectation and more resignation. It is rarely dramatic. More often, it is a subtle but meaningful change in how a young person speaks about their life and what lies ahead.

In some cases, the struggle becomes more visible. Risk taking behaviors increase, substances may enter the picture, and decisions can become more impulsive or reckless. It is important to understand these behaviors in context. They are not always acts of rebellion or defiance. More often, they are attempts to cope, attempts to escape what feels increasingly heavy, or attempts to feel something different in the midst of emotional numbness.

At times, there are more direct signals that deserve careful attention. A young person may begin giving away meaningful possessions, withdraw even further, or express thoughts that suggest life has begun

to lose its value. These moments are not dramatic gestures. They are communications, and they matter deeply.

This is where our awareness becomes so important, not in a way that creates fear, but in a way that keeps us present, steady, and attentive to what is unfolding. Because many of these signs do not arrive clearly labeled. They come in pieces. They come in patterns that only begin to make sense when we are willing to slow down and see them together. And it is easy to miss them, not because we do not care, but because life is busy and these changes tend to unfold gradually.

It is a little like a fire starting in the kitchen. At first, it is small. Something left on the stove a little too long, a bit of smoke, a small flame. If we are nearby and paying attention, we notice it quickly. We respond simply. A small extinguisher, a quick adjustment, and it is handled. There may be a little damage, something to clean up, something to repair, but it is contained and manageable.

But if it goes unnoticed, or if we convince ourselves it is nothing serious, that same small fire can begin to spread. It reaches beyond where it started. It catches onto something else. What could have been handled in a few moments becomes something much more disruptive. Now there are sirens, fire trucks, urgency, and loss. The kitchen may be destroyed, and in some cases, the damage extends even further.

The difference is not just the size of the fire. It is whether it was seen early and responded to with care.

In the same way, the early signs of depression are often not crises in themselves. They are signals. Small shifts. Changes that may not seem significant on their own but begin to matter when they form a pattern.

When we notice them early, when we stay present and willing to move toward what we are seeing, we create the opportunity to respond while things are still manageable.

The goal is not to live in fear of something going wrong. It is simply to stay close enough, attentive enough, that when something begins to shift, we are there to see it. And when we see it, we can respond with steadiness and care, rather than waiting until the situation has grown into something much harder to contain.

Depression rarely arrives all at once. It unfolds. It accumulates. It reshapes a young person's inner world over time. And this is where it becomes important to pause and consider not only what we are seeing, but what it might mean.

Depression is often described as a disorder, and in many contexts that language is useful. It allows clinicians to communicate clearly and can help guide treatment. But in the lived experience of a young person, it is rarely just a label. More often, it is a signal. It is the mind and body communicating that something is not right.

That signal can arise from many different sources. It may reflect chronic stress, unresolved trauma, relational disconnection, a loss of meaning, or the cumulative effects of a life that has drifted out of alignment with how human beings are designed to function. In some cases, biological and genetic vulnerabilities shape how these pressures are experienced. More often, it is a convergence of influences that gradually begin to weigh on the system over time.

When we focus too narrowly on the label, there is a risk that we begin to treat the name of the problem rather than its underlying meaning.

Symptoms may be managed, but the deeper contributors can remain unaddressed. At the same time, dismissing the seriousness of depression would be a mistake. The experience is real, often deeply painful, and at times dangerous. It requires careful attention.

The task, then, is not to choose between recognizing depression and looking beyond it. It is to do both. We need to be able to see it clearly, recognizing the patterns, the shifts, and the warning signs, while also asking what those signs may be pointing toward beneath the surface.

Because when we are able to recognize it early, and respond with clarity and care, we create the opportunity to step in before it becomes more deeply entrenched. And in doing so, we move beyond simply managing symptoms and begin building something more enduring, restoring connection, meaning, and resilience over time.

Emotionally, teens may express or display persistent sadness, irritability, or anger. At times this can look like a heaviness that seems to linger beneath the surface, even in moments that would normally bring some sense of ease or enjoyment. Other times it shows up as a short fuse, a quickness to frustration, or reactions that feel bigger than the moment itself. What we are often seeing is not simply attitude or defiance, but a young person struggling to carry something internally that they may not fully understand or know how to express.

They may begin to voice feelings of hopelessness or helplessness, sometimes directly and sometimes in more subtle ways. It can come through in how they talk about the future, in a tone that feels flatter, less expectant, or quietly resigned. There may be a sense that things will not get better, or that their efforts will not make much of a difference. For a young person who is still forming their sense of identity and direction, that loss of hope can feel especially heavy.

Alongside this, many teens carry an increasing sense of guilt or self-criticism. They may blame themselves for things that are not fully within their control or hold themselves to standards that feel impossible to meet. Even small setbacks can take on a disproportionate emotional weight, reinforcing a sense of not being good enough or of somehow falling short.

Mood can also become more unpredictable. There may be moments of relative calm followed by sudden shifts into irritability, sadness, or withdrawal. These changes can feel confusing, both for the teen and for those around them, and it is easy to misinterpret them as inconsistency or overreaction. More often, they reflect an internal emotional system that is becoming overwhelmed and less regulated.

When we step back and look at these emotional patterns as a whole, what begins to emerge is not just a collection of symptoms, but a young person who is struggling to find steadiness, meaning, and relief in the midst of something that feels increasingly difficult to carry.

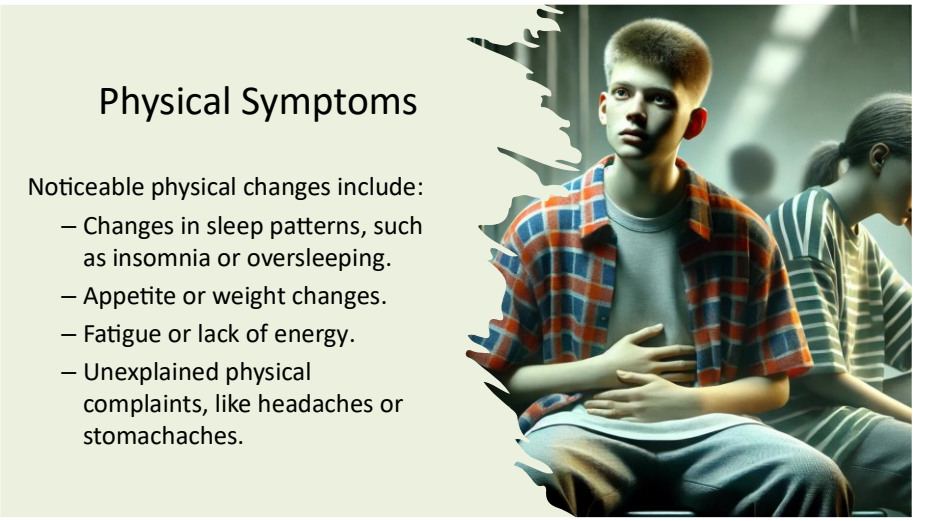
Physically, depression often shows up in ways that can be easy to overlook or misattribute, especially because the body tends to carry what the mind has difficulty expressing. Changes in sleep are common. Some teens struggle to fall asleep or stay asleep, their minds active late into the night, while others seem to sleep far more than usual and still wake feeling unrefreshed. Appetite can shift as well, with some losing interest in food altogether and others turning to eating more frequently, sometimes as a way to soothe or distract them from what they are feeling.

There is often a sense of ongoing fatigue that does not quite make sense on the surface. Even with adequate rest, energy feels low. Simple tasks can feel heavier, and motivation to engage physically or mentally can be hard to access. What might appear from the outside as laziness is more

often a reflection of a system that is depleted, where both mind and body are running low on resources.

Teens may also begin to experience physical complaints that do not have a clear medical explanation. Headaches, stomachaches, muscle tension, or a general sense of discomfort can become more frequent. These are not imagined or exaggerated symptoms. They are real bodily experiences, often reflecting how closely connected emotional and physical systems truly are. When distress builds internally, the body often becomes the place where it is expressed.

When we look at these physical patterns together, they remind us that depression is not just something that exists in thoughts or feelings. It is something that is lived in the body as well, shaping energy, sleep, appetite, and overall sense of well-being.



Cognitively, many teens begin to notice a change in how their mind is working, even if they cannot fully put it into words. Concentration becomes harder to sustain. Tasks that once felt manageable may now

take longer, require more effort, or go unfinished altogether. It can feel as though their thoughts are scattered or slowed, making it difficult to stay engaged in schoolwork, conversations, or even everyday decisions.

Decision-making can also become more challenging. Choices that were once simple may start to feel overwhelming, as if there is too much to sort through or not enough clarity to move forward with confidence. This can lead to hesitation, second guessing, or avoiding decisions altogether, which can then reinforce a sense of being stuck.

Alongside this, many teens find themselves caught in cycles of self-criticism and negative thought patterns. Their internal dialogue can become harsh and unforgiving, focusing on perceived failures, shortcomings, or mistakes. Small setbacks may be interpreted as evidence of something fundamentally wrong with them, and over time, this way of thinking can shape how they see themselves and their place in the world.

For some, these patterns deepen into a preoccupation with death or dying. This does not always present as direct statements of wanting to die. It may appear as a quiet fixation, a sense of curiosity, or a feeling that life has lost some of its meaning or value. At times it may be expressed more clearly, and when it is, it is important that we take it seriously and respond with presence and care.

When we step back and look at these cognitive changes together, we begin to see a mind that is working harder but feeling less effective, more burdened, and increasingly shaped by patterns that pull toward doubt, discouragement, and disconnection.

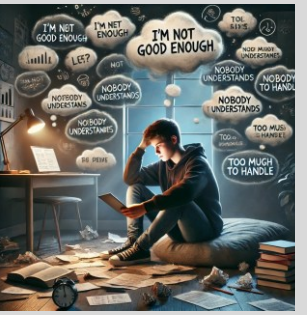
Cognitive and Psychological Indicators

Difficulty concentrating or focusing.

Indecisiveness, even with simple decisions.

Negative thought patterns or self - criticism.

Preoccupation with death or dying.



Socially, they may withdraw from gatherings, pick fights with those closest to them, or engage in concerning online behavior. And in the most serious cases, red flags such as self-harm, suicidal ideation, or giving away prized possessions demand immediate attention. If several of these signs persist for two weeks or longer, or if your gut tells you something is seriously wrong, do not ignore it. The consequences of waiting can be devastating.

Social Signs

Changes in social behavior to watch for include:

- Conflict with friends or family.
- Decline in social engagement or avoidance of gatherings.
- Concerning online behaviors, such as isolation or risky interactions.

What makes this crisis so tragic is not only the level of suffering, but the reality that so much of it is preventable. When we are able to recognize the signs early, when we respond with clarity, compassion, and presence, the trajectory can change. With timely intervention, compassionate understanding, and the right tools, many teens can not only recover, but emerge stronger, more resilient, and more deeply connected to themselves and to others.

This is why learning to recognize these patterns matters. Not so we can become fearful or overly reactive, but so we can become more aware, more attentive, and more willing to lean in when something begins to shift. The goal is not simply to respond when things fall apart, but to notice when something is beginning to move off course and to gently guide it back.

In many ways, this is the foundation of resilience. When resilience is present and actively being built, many of these patterns may never take hold in a lasting way. A young person who is grounded, connected, and supported is far better equipped to navigate stress, disappointment, and emotional pain without becoming overwhelmed by it. At the same time, even in the presence of strong protective factors, there will be moments when struggle emerges. And when it does, these signs are not failures. They are opportunities. They are invitations to lean in, to strengthen what may be underdeveloped, and to build resilience in a deeper and more intentional way.

So, we hold both truths at the same time. We learn to recognize the early signs of distress, the shifts in behavior, mood, and thinking that tell us something is not right. And at the same time, we actively build the kind of resilience that helps prevent those patterns from taking root

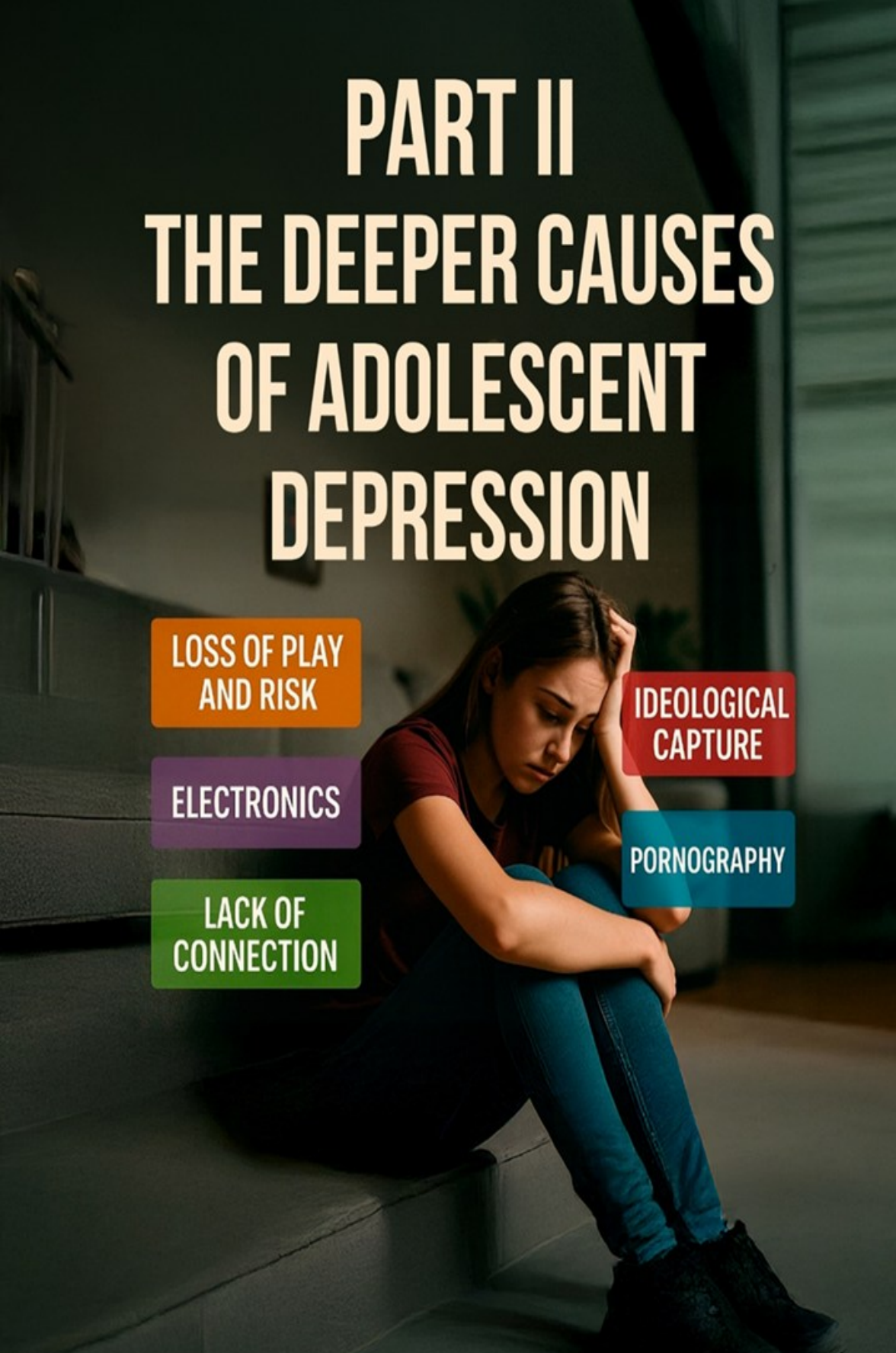
or allows us to respond effectively when they do. So, we hold both truths at the same time. We learn to recognize the early signs of distress, the shifts in behavior, mood, and thinking that tell us something is not right, while also building the resilience that helps a young person respond to those challenges and, in many cases, prevents them from taking root.

In the chapters that follow, we will begin to break the silence and dismantle the shame that so often surrounds depression, anxiety, and other forms of emotional stuggle. We will explore not only the clinical realities, but also the deeper wounds that shape a young person's experience, including the relational, emotional, and spiritual dimensions that are too often overlooked. And we will introduce a path forward that is both grounded and hopeful, one that integrates neuroscience and faith into a holistic model of restoration and renewal through the NeuroFaith® approach.

That is the promise of this work. It is also the invitation. To see more clearly. To understand more deeply. To respond with more than labels or prescriptions. To listen with intention, to act with wisdom, and to trust that healing is not only possible, but already beginning in ways we may not yet fully see.

This is where resilience is built.
This is where healing begins.

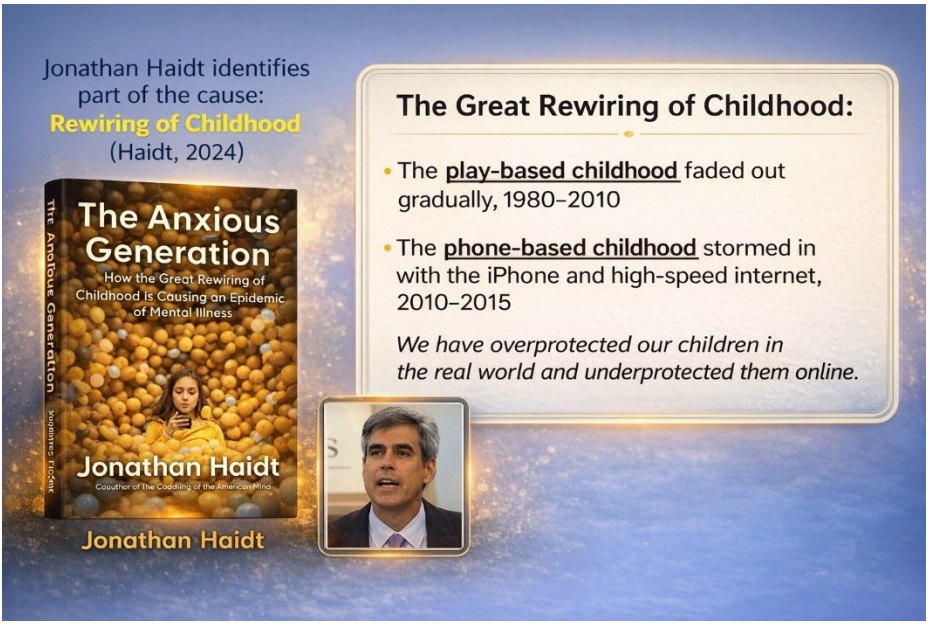
PART II
THE DEEPER CAUSES OF ADOLESCENT DEPRESSION



Cause One

Replacing Play-Based Childhood with Screen-Based Childhood

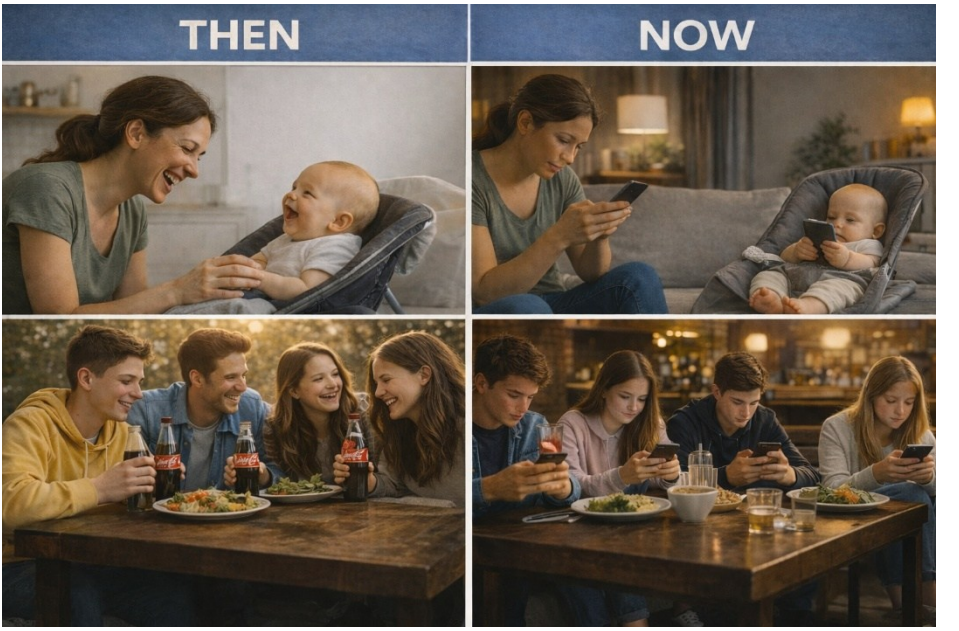
In ***The Anxious Generation***, Jonathan Haidt (2024) describes a profound and culture-wide shift that he calls ***"the great rewiring of childhood."*** This term isn't used metaphorically, Haidt is quite literal. He argues that the rise in mental illness among youth is not coincidental but a direct result of a sudden and dramatic transformation in how children grow up. According to Haidt, we have exchanged a generation raised on outdoor play, real-world risk-taking, and face-to-face socialization for one raised on smartphones, algorithmic feeds, and a sedentary, digitally isolated existence.



The way childhood used to be (play-based) and the way it is now (screen-based)

Between 1980 and 2010, childhood slowly transitioned away from being ***play-based***, filled with unstructured time, outdoor exploration, and face-to-face peer interaction. But around 2010, a pivotal year also noted by CDC data on rising adolescent suicide and anxiety (Centers for Disease Control and Prevention [CDC], 2021), the shift accelerated. The ***phone-based*** childhood took over. This shift was supercharged by the release of the iPhone, the proliferation of high-speed internet, and the mainstream adoption of social media apps designed not for connection, but for compulsion.

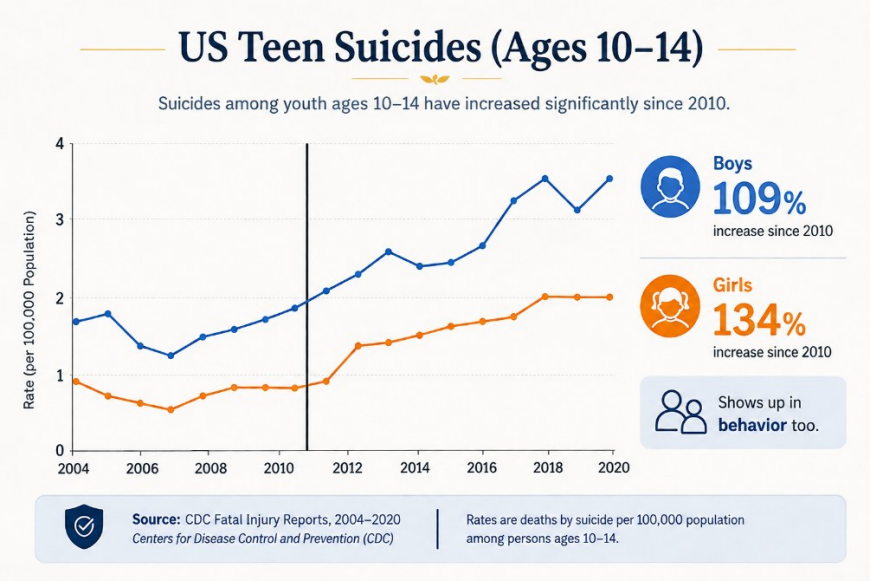
"We overprotected our children in the real world and underprotected them in the online world," Haidt writes (2024, p. 13).

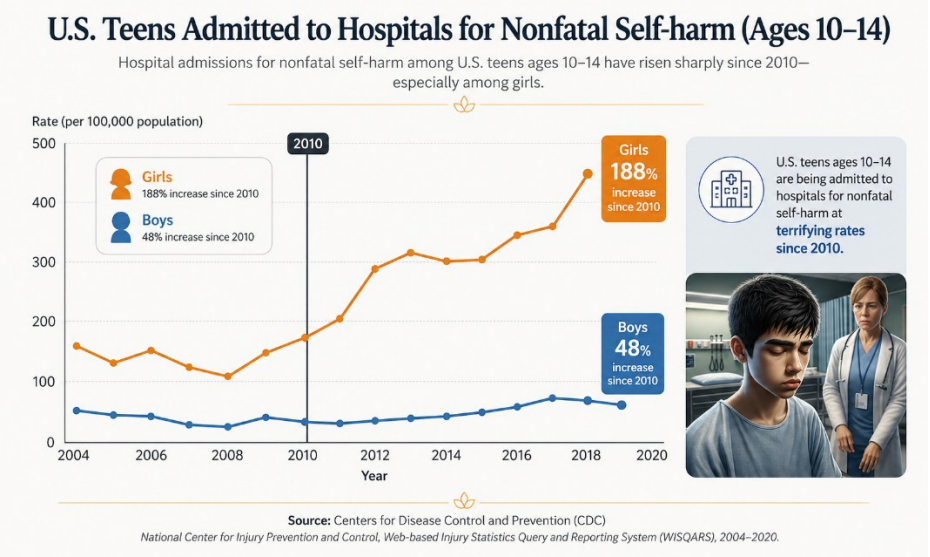


And the cost has been catastrophic.

A Crisis Measured in Mental Illness and Lost Potential

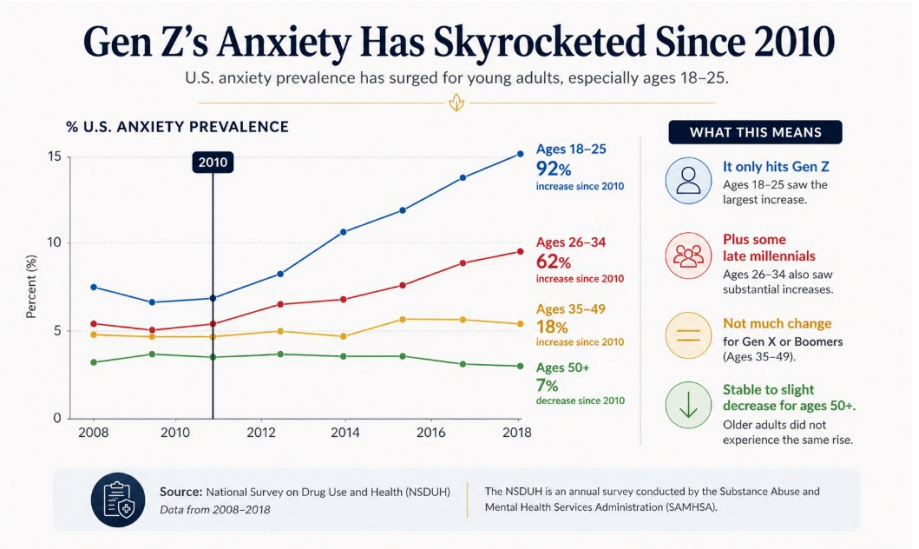
According to Haidt (2024), suicide rates among children ages 10–14 have increased dramatically since 2010—with a 109% increase among boys and a 134% increase among girls. But the tragedy doesn't end there. Nonfatal self-harm, a clinical red flag for unprocessed emotional pain and dysregulation, has skyrocketed: 188% increase among girls, 48% among boys (CDC, 2021). These are not merely numbers—they are cries for help that too often go unheard.





Likewise, anxiety and depression among Gen Z, especially those between ages 10 and 25, have surged at rates unprecedented in previous generations. Haidt (2024) reports a 134% increase in anxiety diagnoses and a 106% increase in depression among undergraduates since 2010. The change is not mirrored among Gen X or Boomers. Something specific is targeting Generation Z—and

it began, as Haidt notes, right around the arrival of smartphone-saturated adolescence.



The Displacement of Developmentally Necessary Risks

What makes this shift particularly dangerous is what it replaced. In normal childhood development, risk is not a hazard, it is a requirement. Children must climb trees, scrape knees, negotiate peer conflicts, and wander just a little too far in order to develop healthy executive functioning, resilience, and social skills.

Instead, in the past 15 years we began insulating our children in the physical world while exposing them, very often completely unsupervised, to the most psychologically destabilizing aspects of the digital one. They are no longer allowed to walk to school or play unsupervised at the park, but they're handed a smartphone, essentially a portable dopamine dispenser, and given access to content that would emotionally devastate most adults.

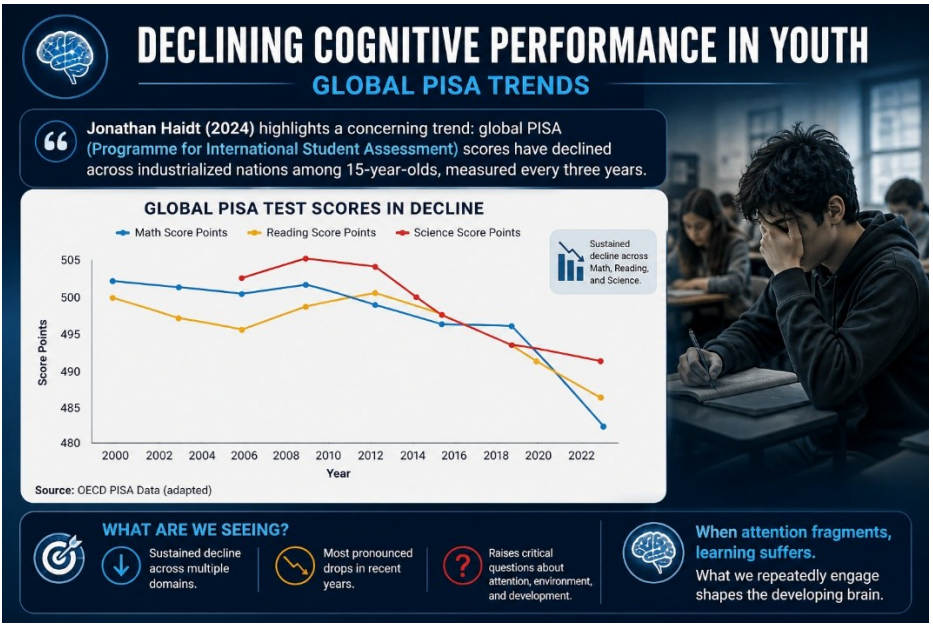
Haidt (2024) calls this ***"a profound developmental mismatch"***: a generation biologically wired for connection, risk, and experiential learning, now

developmentally stunted by isolation, hyper-stimulation, and the absence of embodied life.

The result? Underdeveloped nervous systems, fragile identities, externalized self-worth, and an alarming reliance on digital validation to feel seen and soothed.

A Parallel Crisis in Cognitive Development

The decline is not only emotional, but cognitive. Global PISA (Programme for International Student Assessment) test scores, which track academic performance in reading, math, and science across industrialized nations, have been steadily falling since 2012 (Organization for Economic Cooperation and Development [OECD], 2022). Haidt (2024) identifies this as further evidence that attention, deep focus, and intellectual endurance, core neurological functions, are deteriorating in the screen-based generation.



The shift to screens didn't just displace play; it displaced ***thinking***.

Haidt's Call: Restore the Real World

Jonathan Haidt is not anti-technology and nor are we. He is not nostalgic for some golden age. He is calling for balance. In *The Anxious Generation*, he urges parents, educators, clinicians, and policymakers to restore real-world childhood. That means unstructured play. In-person interaction. Climbing trees. Getting dirty. Navigating conflict without a mute button.

It also means radically limiting smartphone and social media exposure, especially before age 16. His research shows that the sharpest spikes in mental illness occur when smartphones and social media become central to identity formation, a process that is naturally turbulent even without algorithms feeding insecurity and comparison.

Where We Go From Here

We cannot fix what we do not name. The replacement of play-based childhood with screen-based childhood is one of the root causes of the adolescent mental health epidemic. This isn't speculation, it is a pattern that emerges across multiple independent data sets, including suicide rates, ER visits for self-harm, rising anxiety, and declining cognitive performance (Haidt, 2024; CDC, 2021; OECD, 2022).

In the chapters ahead, we will explore how this rewiring of childhood can be gently undone. The NeuroFaith® model integrates developmental neuroscience, attachment theory, polyvagal-informed therapy, and spiritual restoration to help young people reestablish resilience, safety, and purpose.

There is a way out. But first, we must continue to tell the truth.

Cause Two Hijacked Minds

How Pornography Is Rewiring the Teenage Brain

Vice is a monster of so frightful mien
As to be hated needs but to be seen
Yet seen too oft, familiar, with her face,
We first endure, then pity, then embrace.

-Alexander Pope's essay on man

A Quiet Epidemic No One Wants to Name

In the words of Stephen Arterburn, a recognized expert in the field of sexual addiction, ***"I don't know of any plague to ever reach into the homes and families all over the world and create as much damage or heartaches than the struggle of lust, affairs, pornography, perversion, and sexual addiction. It seems that everywhere I look, it gets worse and worse. The Internet exploded the problem, and now cell phones transport pornography more portably than the computer and facilitate affairs with greater accessibility and secrecy"*** (cited in Roberts, 2008, p. 9).

When we first entered our respective fields, one in pediatric psychology and the other in medicine, we never imagined that we would one day be writing a chapter like this. Decades ago, our concerns about adolescents were centered on issues such as bullying, academic struggles, family stress, and the early emergence of anxiety or depression. Those concerns remain, but over time something else has emerged alongside them, something quieter, more pervasive, and far more difficult to address directly.

It is not a topic that is easily discussed, and in many cases, it is avoided altogether. Yet despite the discomfort surrounding it, its influence is both widespread and increasingly normalized within the developmental landscape of adolescents. Pornography now enters the lives of young people not through deliberate seeking alone, but through the devices they carry with them at all times. It bypasses traditional boundaries, appears in private spaces where oversight is limited, and interacts with a stage of development marked by curiosity, vulnerability, and rapid neurological change.

Large-scale surveys, including those by Common Sense Media (2022) and the Children's Commissioner for England (2023), indicate that a meaningful minority of youth encounter explicit material before age 10, with exposure beginning as early as ages 9 to 11 for a growing segment.

In clinical settings, this early exposure can occur even younger. In my own practice as a clinical psychologist, I (Jeff) have encountered cases in which children as young as five have been exposed to explicit material, followed by the emergence of developmentally inappropriate and at times highly concerning sexualized behaviors. These observations do not suggest that the average age has collapsed into early childhood, but rather that the distribution has widened, with the leading edge moving into increasingly earlier developmental periods. The trend is not merely academic. It reflects a digital environment in which access is pervasive, safeguards are inconsistent, and exposure often occurs before children possess the cognitive, emotional, or moral frameworks necessary to process what they are seeing. Taken together, both the research and clinical experience point to a trajectory that is more concerning than many parents realize, with earlier exposure carrying meaningful implications for development, behavior, and relational formation.

Equally concerning is the cultural environment in which this exposure occurs. Many of us have watched this shift happen in real time, even if we have not always had the language to describe it. What once might have been recognized as potentially harmful is now, in many contexts, treated as expected, if not inevitable. Among peers, pornography is often accepted, encouraged, or simply met with indifference, and over time that normalization begins to shape how it is understood and experienced. This is not only about access. It reflects a deeper change

in norms, expectations, and the internal frameworks through which young people come to interpret themselves, their relationships, and the world around them.

For those of us who are parents, this can feel unsettling, even difficult to fully take in. It challenges assumptions we may have held about what our children are exposed to and when. At the same time, for those of you reading this as adolescents or young adults, this may not feel unusual at all. It may simply feel like the world you have grown up in. That difference in perspective matters, because it can create a gap in understanding at precisely the point where clarity and connection are most needed.

What we are facing then is not a simple problem with a single point of intervention. It is a complex reality that touches development at multiple levels. It intersects with the brain's sensitivity to reward and novelty, with the formation of identity, and with the ways we all come to understand relationships, intimacy, and ourselves. Whether we are raising adolescents, working with them, or navigating these experiences personally, we are all moving within the same broader cultural landscape.

It is also important to acknowledge why this subject is so often left unaddressed. Conversations about pornography are uncomfortable for all of us. As parents, we may hesitate to consider the possibility that our child has been exposed at a young age. As adolescents, there can be uncertainty, embarrassment, or reluctance to speak openly about something that is often kept private. Even in professional settings, there can be a lack of clarity about how to approach the topic in a way that is both responsible and helpful.

We understand that hesitation, because in many ways we share it. This is not an easy subject to bring into the open. Yet it is a necessary one. If we are serious about understanding what is shaping adolescent mental health today, and if we are committed to building resilience rather than simply reacting to symptoms, we cannot overlook an influence that is this pervasive, this accessible, and this neurologically significant.

Our aim in this chapter is not to sensationalize the issue or reduce adolescent struggle to a single factor. Rather, it is to bring clarity to something that often remains in the background, and to explore how repeated exposure to this kind of content may interact with development in ways that are both subtle and far-reaching.

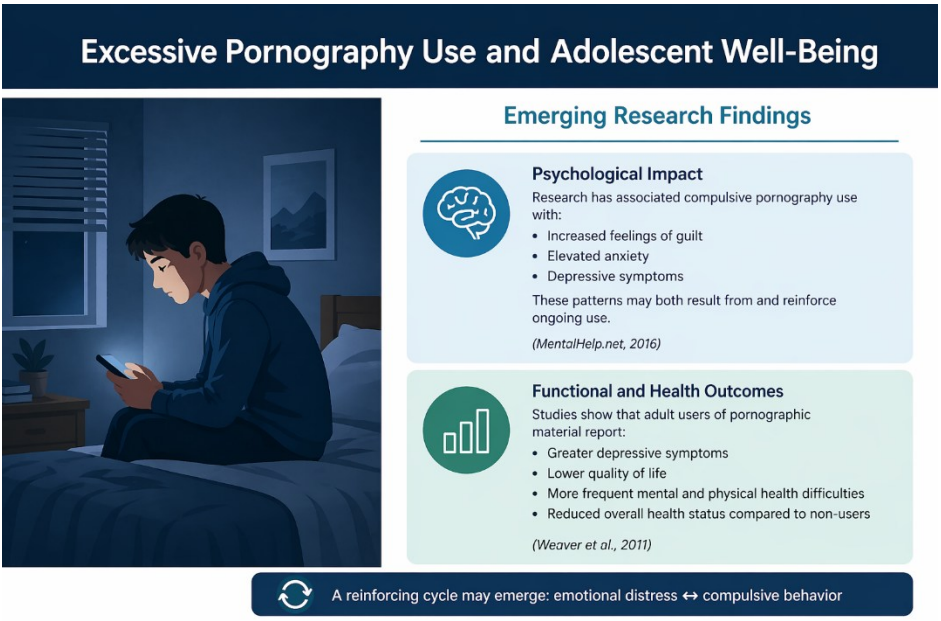
Again, we did not set out to write about this, but we are all living in a world where it must be understood. So, we must write about it, and we pray that you will read it, as hard as that might be.

The result is a generation for whom porn is not just tolerated—it's normalized.

Emotional Impact: Depression, Anxiety, and Disconnection

What we are seeing more clearly in the research is not simply a behavior, but a pattern that often becomes intertwined with emotional struggle over time.

Dr. David Skinner reviewed a study of 450 users and found a meaningful relationship between frequent pornography consumption and depression. Those who reported daily use scored an average of 21 on depression inventories, compared to 6.5 in the general population. That difference reflects a significant gap in emotional well-being (Skinner, 2019).



A 2016 report from MentalHelp.net observed that individuals struggling with compulsive or at-risk use frequently experience guilt, depression,

and anxiety. These emotional states do not just follow the behavior. They can also sustain it, creating a cycle that becomes increasingly difficult to step out of.

In a landmark study, Weaver et al. (2011) found that users of pornographic material reported:

- greater depressive symptoms
- lower overall health
- more days of diminished mental and physical well-being
- poorer quality of life compared to non-users

Dr. Gail Dines, founder of Culture Reframed, adds to this understanding. Her review of the literature suggests that adolescent pornography use is associated with:

- increased depression
- lower emotional bonding with caregivers
- greater conduct issues
- higher delinquency
- significantly lower levels of social integration

(CultureReframed.org)

Other studies reinforce this pattern. Doornwaard et al. (2016) found that compulsive users reported lower self-esteem and higher depressive symptoms. Owens et al. (2012) and Sun et al. (2016) noted increasing concerns around body image and a growing sense of inadequacy in both boys and girls.

Taken together, these findings point to something important. This is not about weakness or moral failure. It is about people who often find

themselves caught in a pattern that affects both how they feel and how they cope.

The Quiet Impact on Sexual Development

This is one of the most difficult parts of the conversation, and perhaps one of the most necessary.

We are speaking about adolescents and young adults at a formative stage of life, a season when they are beginning to understand their bodies, their desires, and what it means to connect with another person in a meaningful and intimate way. It is a tender developmental window where identity, curiosity, and vulnerability come together. When pornography enters that space, especially at an early age, it does not simply add information. It can begin to shape the very template through which sexuality is understood and experienced.

This is not about blame. Most young people do not go looking for something that will disrupt their development. Exposure is often early and uninvited. Curiosity is natural. The pull is powerful. The brain responds to novelty and intensity, reinforcing what is stimulating and immediate. Over time, that pattern can quietly become conditioning, shifting expectations in ways that are not immediately obvious.

Gary Wilson's *Your Brain on Porn* offers a helpful framework for understanding this. Many young men, some first exposed as early as age 8 or 9, describe increasing difficulty with real world intimacy by their early twenties. They report delayed ejaculation, diminished interest in connection, and difficulty maintaining arousal. Historically, erectile dysfunction in men under 40 was relatively rare, occurring in about 2% to 3% (de Boer et al., 2004). More recent data suggest rates ranging

from 14% to 33%, representing a marked increase over a relatively short period of time (Wilson, 2017; Park et al., 2016).

A Canadian study found that 78.6% of males aged 16 to 21 reported at least one sexual difficulty during partnered experiences (O'Sullivan et al., 2016). These included:

- Erectile dysfunction: 45%
- Low sexual desire: 46%
- Difficulty climaxing: 24%

What we are seeing is not only statistical, but deeply personal for those experiencing it. Young men in their late teens and early twenties are describing patterns that feel confusing, even disorienting, given what they expected this stage of life to be.

They report:

- Difficulty maintaining arousal in real world situations
- Delayed or absent climax
- Reduced desire for relational intimacy
- Disconnection from their own bodies and emotional experience

These are not just physical symptoms. They often carry a deeper, quieter emotional weight.

Many begin to feel:

- Confusion about what is happening in their bodies
- Self-doubt and a loss of confidence
- Shame that is rarely spoken but deeply felt
- A growing hesitation around real connection

Left unaddressed, this can begin to shape how a young person sees himself. What started as a neurobiological adaptation can become something more personal, a questioning of adequacy, a retreat from intimacy, and a growing sense of isolation in an area of life closely tied to identity and worth. In some cases, this distress contributes to broader emotional struggles, including depression and anxiety, and at times, impulsive or self-harming behavior when the confusion and discouragement feel overwhelming.

From a neuroscientific perspective, this pattern is understandable. Dopamine, the brain's reward and motivation system, responds strongly to novelty. Internet pornography provides an almost endless stream of new and highly stimulating content. Over time, this can condition the brain in a way that makes real world intimacy feel less engaging by comparison. As Wilson describes, real connection can begin to feel muted, not because it lacks depth, but because the brain has adapted to a different level of stimulation.

This is why the conversation matters. Not to alarm or condemn, but to bring clarity and compassion to something that is unfolding quietly in many lives. Adolescent development is not only about physical maturation. It is about learning connection, attunement, and meaning. When that pathway is shaped primarily by high intensity artificial stimulation, it can distort expectations, even while leaving the deeper longing for connection untouched.

And yet, this is not where the story ends.

The brain is capable of change. Patterns that have been learned can be reshaped. With awareness, support, and intentional steps forward, many young people begin to experience a gradual restoration. Not just

of function, but of presence, confidence, and the capacity for genuine connection.

This is not a lost generation. But it is a generation facing something we can no longer afford to ignore.

And the way forward begins with honest conversation, steady support, and a commitment to helping young people rediscover a healthier, more integrated understanding of themselves and their capacity to connect.

Pornography and Sexual Dysfunction: A New Epidemic

Gary Wilson's *Your Brain on Porn* offers perhaps the clearest neurological lens through which to understand the sexual fallout of this crisis. Young men, often exposed to porn by age 8 or 9, report difficulty with real-world sex by their early 20s. They describe delayed ejaculation, loss of interest in intimacy, and erectile dysfunction.

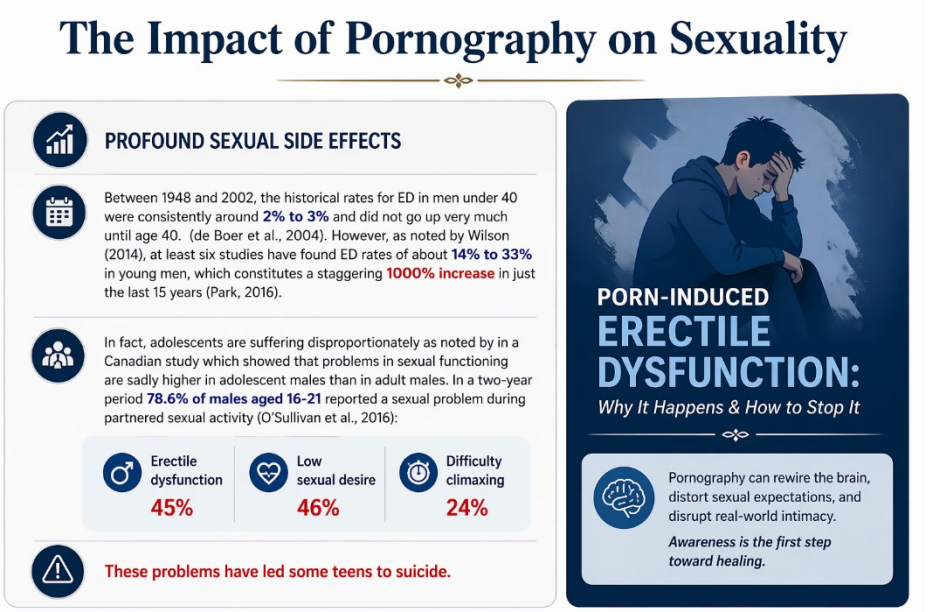
Historically, erectile dysfunction (ED) in men under 40 was rare—about 2% to 3% (de Boer et al., 2004). But today, ED in young men ranges from 14% to 33%, a 1000% increase over just 15 years (Wilson, 2017; Park, 2016).

A Canadian study found that 78.6% of males aged 16–21 experienced at least one sexual problem during partnered sex (O'Sullivan et al., 2016):

- Erectile dysfunction: 45%
- Low sexual desire: 46%
- Difficulty climaxing: 24%

Neuroscientific research explains this well. Dopamine, the brain's pleasure and reward chemical, surges with novelty. Internet porn, with its endless stream of hyperstimulating content, outcompetes the

subtle, nuanced experience of real intimacy. As Wilson explains, real sex becomes neurologically "boring," leading to a drop in dopamine—and arousal.



The Path to Escalation: From Curiosity to Compulsion

Perhaps most troubling is how quickly users escalate to increasingly extreme content. Wilson (2017) documents cases of users shifting from simple searches to material they once found unsettling or even repulsive. The brain, always seeking novelty and intensity, begins to pursue stimulation at levels that no longer align with the individual's values or intentions. What begins as curiosity can, over time, become a pattern that feels increasingly outside of one's control.

Downing et al. (2016) found that nearly 21% of heterosexual men view gay pornography, and over 55% of gay men view heterosexual content. These findings are often less about identity and more about escalation

and novelty seeking, reflecting the brain's adaptation to repeated high intensity stimulation.

Many report feelings of shame, disgust, or anxiety over what they now find arousing. Some spiral into depression, others into despair. A few, tragically, into suicidal ideation.

There Is a Way Forward

This is not the end of the story.

The same brain that was drawn into compulsive patterns retains the capacity to change. Neural pathways can be reshaped. Sensitivity can be restored. Patterns that feel entrenched can loosen over time with the right support and intentional effort. Just as importantly, the adolescent heart that may have been burdened by shame and disconnection is not beyond healing. It remains capable of growth, restoration, and renewed strength.

Part of that restoration involves helping young people develop healthier ways to regulate emotion. When teens are equipped with tools for managing stress, anxiety, and loneliness, the need to turn to artificial forms of relief begins to diminish. Rather than simply being told what to avoid, they are given something meaningful to move toward. They begin to build resilience, learning how to tolerate discomfort, how to seek connection, and how to remain grounded in the midst of emotional intensity.

Equally important is the development of internal strength and clarity. Adolescents can learn to recognize what is being presented to them, to understand how it affects the brain, and to make conscious, values-based decisions in the moment. This is not about fear or avoidance. It

is about agency, awareness, and the growing ability to say no when something does not align with who they are becoming.

This is where the NeuroFaith® model offers a comprehensive path forward. By integrating neuroscience, trauma informed care, and deep spiritual renewal, it addresses both the biological and the personal dimensions of this struggle. It helps individuals understand what has occurred in the brain, process the emotional and relational impact, and reconnect with a sense of identity and purpose.

Healing, in this context, is not merely the absence of a behavior. It is the restoration of the whole person. It is the return of clarity where there was confusion, connection where there was isolation, and hope where there had been discouragement.

As we move forward, the goal is not only to help those who are already struggling, but to equip the next generation before patterns take hold. When young people are given truth, tools, and a framework for understanding themselves, they are far less likely to become trapped in cycles of compulsion. They are better prepared to navigate what they encounter, to remain grounded, and to move toward lives marked by authenticity, resilience, and meaningful connection.

There is a way forward. And it is one marked not by shame, but by understanding, strength, and restoration.

.

Cause Three

Disconnection and the Descent into Adolescent Despair

" *We are not destroyed by suffering; we are destroyed by suffering without meaning."*

– Viktor Frankl

Adolescence is a sacred and sensitive chapter in human development. It is a period rich with questions of identity, belonging, and purpose. But for too many teens today, that journey is not marked by flourishing but by falling—into apathy, anxiety, profound and often paralyzing depression. The numbers are not just statistics; they are alarms. And behind the alarms is a pattern: disconnection.

For far too many of our youth, that ache has a name: depression. For others, it wears the mask of anxiety, insomnia, apathy, irritability, or just a fog that won't lift. But the symptom is never the whole story. It's a signal. A call to attention. A cry from the deeper self that something important has been lost.

That's where Johann Hari comes in.

Hari, one of Jeff's absolute favorite authors and thinkers, wrote a groundbreaking book titled ***Lost Connections: Uncovering the Real Causes of Depression – and the Unexpected Solutions*** (2018). In it, he dares to ask a question that few in psychiatry have had the courage, or humility, to ask: ***What if depression and anxiety aren't simply malfunctions of the brain? What if they are messages from lives gone off track?***

Hari's answer is not only intellectually compelling but emotionally liberating. He argues that depression is not primarily about serotonin deficits or broken synapses. It is about disconnection. Disconnection from meaning, from purpose, from belonging. Disconnection from nature, from others, from community, and ultimately, from the truest

parts of ourselves. When those connections fray, the soul begins to dim. When they rupture, we fall.

And many of our teens are falling.

Modern life, for all its conveniences, is structured for disconnection. We live in crowded cities but feel isolated. We scroll endlessly through curated images but feel unseen. We are more "connected" than ever digitally, yet lonelier, angrier, more exhausted, and more despairing than any generation in recorded history.

This didn't happen all at once. It was a slow erosion. A thousand tiny compromises. A culture that traded purpose for productivity, presence for performance, contemplation for consumption. We were told that if we worked harder, optimized more, stayed busy, and stayed plugged in, we would find happiness.

Hari gives language to what so many teens have felt but didn't know how to articulate. That their suffering is not random. It is rooted. It is rational. It's not a flaw in our chemistry. It's a reflection of a deeper wound in our society, and often, in our story.

This book honors that insight.

We have seen it over and over in the clinical setting. A man in his fifties breaks down and says, "***I don't even know who I am anymore.***" A mother confesses that she feels invisible. A retired veteran says the silence at night feels unbearable. These aren't weak people. These are the strong ones who've carried too much for too long without a place to lay it down. And beneath it all, at the core of the depression or anxiety or

addiction, is a wound of disconnection—sometimes from others, sometimes from self, sometimes from God.

We believe Hari is right. Depression is not nonsense. It makes perfect sense. Anxiety is not irrational. It is often the nervous system responding to a life out of alignment with what matters most. And this same disconnection does not stop there. It spreads. It shows up as despair, as emotional numbness, as a loss of identity and direction. It can take hold in the form of addiction, as people reach for anything that offers even momentary relief from the ache of disconnection.

This chapter will explore these themes of disconnection in depth, not just to name the pain but to begin charting a path back to connection. We will talk about the big ones: disconnection from community, meaningful work, from personal agency, from the natural world, from safe emotional bonds, and from a sense of transcendence.

We'll also be honest. This chapter might stir something in our young people. That's good. That means it's working. It means they're not numb. It means there's still a flicker of desire deep down to reconnect with what matters, to reawaken to the sacredness of their own life.

We are not promising a quick fix. But we are promising this: teens' emotions, whether depression, anxiety, despair, or the pull toward escape, are not signs that you are broken. They may be signs that they are still alive, that some part of them refuses to settle for disconnection. That part of them is not a liability. It's their signal fire. It's their path home.

Let's follow it.

Disconnection from Meaningful Work

Disconnection from Meaningful Effort is Hidden source of adolescent depression, anxiety, and addiction…

When a teen is depressed, the idea of engaging in schoolwork, responsibilities, or even basic daily tasks can feel overwhelming. They often wake up already feeling behind, already tired, carrying a quiet but persistent sense of failure before the day even begins. Motivation is low, energy is low, and even small expectations can feel insurmountable. When anxiety is present, the experience shifts but remains equally distressing. Thoughts race, the body remains in a constant state of tension, and ordinary demands, assignments, social interactions, expectations from parents or teachers, can feel like too much to manage.

So, let's be clear. We are not suggesting that adolescents should simply

push through or "try harder." That kind of thinking misses the complexity of what they are experiencing. We know better

At the same time, there is both a hard truth and a hopeful one that must be held together. Meaningful effort, when approached gently and with appropriate support, can play a critical role in stabilizing and healing the adolescent mind and heart. In psychology, this principle is captured in what we call behavioral activation. The idea is simple but powerful. We do not wait for motivation or emotional readiness before acting. Instead, we begin with small, manageable steps. The adolescent is guided to take the next right action, getting out of bed, completing part of an assignment, helping with a task at home, showing up in some small but intentional way. Over time, something begins to shift. Action starts to influence emotion. The body moves first, and gradually the mind and heart begin to follow. In this sense, action often precedes emotion. The body can lead, and the soul can begin to wake up.

Johann Hari draws attention to what he describes as a worldwide crisis of meaning. In a large Gallup study conducted between 2011 and 2012, millions of workers across 142 countries were surveyed, and the findings were striking. Only 13 percent reported being engaged in their work, while 63 percent were not engaged, and 24 percent were actively disengaged, meaning they were not only disconnected but expressing their dissatisfaction in outward ways. Hari makes the compelling case that this is not simply a matter of productivity. Rather, this widespread disconnection is deeply tied to the rising rates of addiction, depression, and anxiety seen across modern society.

While young poeple are not yet in careers, they are very much in the formative stages of what will become their life's work. Their daily

responsibilities, school, family roles, relationships, skill development, and identity formation, function as their primary arena of meaningful effort. When these domains begin to feel pointless, overwhelming, or disconnected from who they are and who they are becoming, a similar pattern of disengagement begins to take hold. The adolescent may not articulate it in these terms, but the internal experience is unmistakable. Effort begins to feel futile. Motivation declines. Apathy sets in. In some cases, this disengagement remains internal, presenting as withdrawal and quiet despair. In others, it becomes externalized through defiance, irritability, or acting out.

Human beings are not designed to invest their energy into what feels meaningless, and adolescents are particularly sensitive to this reality. Developmentally, they are asking deeper questions about identity and purpose. They are trying to understand whether what they are doing matters, whether their efforts lead anywhere, and who they are becoming in the process. When those questions are met with emptiness, the psychological cost is significant.

This dynamic was clearly illustrated in the Whitehall Study, Marmot et al. (2002), which examined British civil servants and found that a lack of autonomy and a weak connection between effort and reward were strong predictors of poor mental health outcomes. When individuals feel that they have little control over their environment and cannot see how their efforts make a difference, something essential begins to erode. Although this study focused on adults, the underlying principle translates directly to adolescents. When school feels like meaningless busywork, when effort appears disconnected from outcome, and when young people feel they have no voice or agency in their own lives, the

same erosion begins to occur. It takes something out of them, not only psychologically, but at a deeper level as well.

And this is where the conversation moves beyond psychology into the spiritual domain. In Genesis 2:15 (NIV), ***"The Lord God took the man and put him in the Garden of Eden to work it and take care of it."*** Work, in its original design, was never intended as punishment. It was an invitation into meaningful participation, a way of partnering with God in stewarding and cultivating what had been created. Effort, responsibility, and contribution were woven into the fabric of human identity from the very beginning.

Teens need this just as much as adults do. They need to experience themselves not merely as consumers of entertainment or recipients of instruction, but as contributors whose efforts matter. They need responsibility that is real, not artificial. They need to see that what they do has impact, even in small ways. When that connection to meaningful effort is absent, something within them begins to fray.

In many ways, modern life has unintentionally created conditions that make this disconnection more likely. Adolescents today are often surrounded by constant stimulation but limited meaningful engagement. School can feel disconnected from real world purpose. Responsibilities at home may be minimal or inconsistently enforced. Digital environments offer immediate reward without requiring sustained effort. Over time, this combination can lead to what Hari describes as a kind of psychological and spiritual numbness. It is not simply boredom. It is a deeper loss of meaning.

When that sense of meaning is lost, young people respond in predictable ways. Like all human beings, they seek relief from discomfort and emptiness. They turn toward what is readily available and immediately rewarding, social media, gaming, pornography, substances, or immersive fantasy worlds. These behaviors are not random. They are attempts to regulate emotion, to feel something in the face of numbness, or to escape from an internal world that feels heavy and directionless.

Yet this trajectory is not inevitable. It can be disrupted, and one of the most powerful ways to do so is by helping adolescents reconnect to meaningful effort as a central component of resilience.

This does not require dramatic or immediate change. In fact, it is often most effective when it begins gradually. It may involve helping an adolescent reengage with school in manageable steps, shifting from avoidance to participation one assignment at a time. It may include introducing consistent, meaningful responsibilities at home, tasks that contribute to the functioning of the family rather than simply occupying time. It may also involve encouraging involvement in activities that build competence and identity, such as sports, creative pursuits, service opportunities, or the development of practical skills.

As these experiences accumulate, something important begins to take shape. The teen starts to experience a sense of agency, the recognition that their actions have impact. Competence begins to grow, followed by a developing sense of purpose. At a deeper level, they begin to internalize a foundational truth, what I do matters, and therefore, my life has meaning.

When this effort is further grounded in a larger spiritual framework, its significance deepens even more. Colossians 3:23–24 (NIV) tells us, ***"Whatever you do, work at it with all your heart, as working for the Lord, not for human masters. It is the Lord Christ you are serving."*** This perspective elevates even the smallest acts of effort. For the adolescent struggling to complete a school assignment, for the teen learning responsibility at home, or for the young person attempting to rebuild after discouragement or failure, their work is no longer merely about performance or external validation. It becomes an offering, an act of meaning that transcends immediate circumstances.

The implication is both simple and profound. Adolescents do not need to feel motivated in order to begin. They begin, and over time, motivation often follows. The role of the parent, clinician, or mentor is to help them take that first step and then the next, providing structure, encouragement, and meaning along the way.

So, when an adolescent is struggling with depression or anxiety, the path forward often starts small. One assignment completed. One responsibility followed through. One meaningful action aligned with the person they are becoming. These steps may seem insignificant in isolation, but they are not. They are seeds.

And with time, consistency, and God's help, those seeds can grow into resilience, purpose, and ultimately a life that feels worth living. And this is where the conversation moves beyond psychology into the spiritual domain. In Genesis 2:15 (NIV), ***"The Lord God took the man and put him in the Garden of Eden to work it and take care of it."*** Work, in its original design, was never intended as punishment. It was an invitation into meaningful participation, a way of partnering with God in

stewarding and cultivating what had been created. Effort, responsibility, and contribution were woven into the fabric of human identity from the very beginning.

Disconnection from Meaningful People

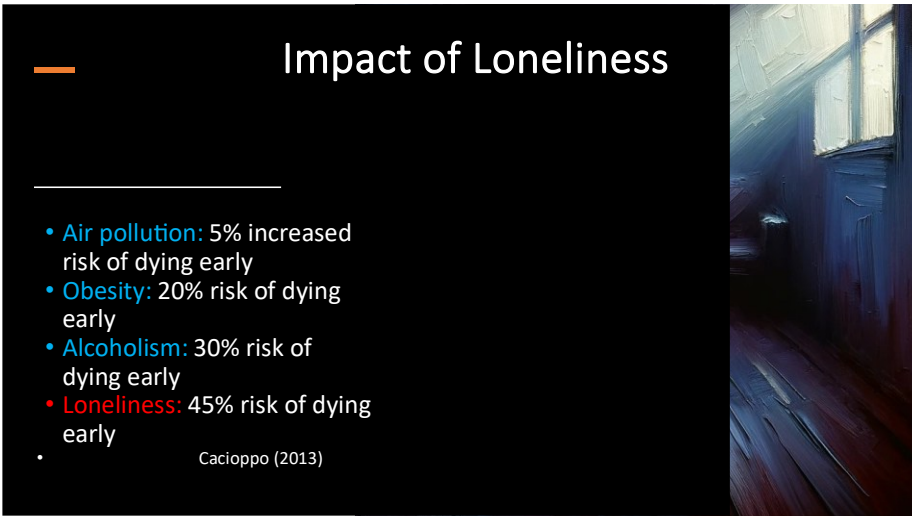
Loneliness is not just an emotion…

It is a physiological and psychological threat. It can break your heart, not just figuratively but literally. It can scramble your brain's ability to regulate emotion, jack up your stress hormones, and slowly dismantle your resilience until you feel hollowed out and exhausted from the inside out.

Dr. John Cacioppo, a pioneer in social neuroscience, studied the impact of loneliness over many years. He and his colleagues found something staggering. When people were placed in an experiment and made to feel acutely alone, their bodies responded with a stress reaction as severe as if they were under physical attack (Cacioppo et al., 2006, 2008, 2010; Hari, 2018). In fact, loneliness drives cortisol levels through the roof. It hits the hypothalamic-pituitary-adrenal (HPA) axis, the very center of

your stress system, and floods the body with the same neurochemical chaos one would experience if they had just jumped you in a dark alley. Only this threat comes from within. And it lingers.

Lisa Bergman's long-term research confirms just how deadly loneliness can be. Over a nine-year period, she found that socially isolated individuals were two to three times more likely to die during lonely periods than their connected counterparts. Heart disease, cancer, respiratory illness—almost everything became more fatal during seasons of social disconnection (Pinker, 2015).



Cacioppo went even further. In a five-year longitudinal study, his team demonstrated that loneliness is not merely a byproduct of depression. It is a direct contributor. He found that when a person moved from moderate loneliness to a slightly higher threshold, from approximately 50 percent to 65 percent on their loneliness scale, the risk of becoming clinically depressed increased eightfold (Cacioppo et al., 2010). Eightfold. Not double. Not triple. Eight times more likely to spiral into depression. That reality alone should stop us in our tracks.

Yet we live in a culture that often glorifies independence while quietly tolerating isolation. We explain it away as busy schedules, personality differences, or simply the rhythm of modern life. But loneliness carries real psychological, physiological, and spiritual consequences. As Cacioppo explained in his TED Talk (2013), a meta-analysis involving more than 100,000 participants found that social isolation increased the risk of early death more than obesity, smoking, or lack of exercise.

This is not merely abstract data. It is lived experience. It is the quiet ache of coming home to an empty house night after night. It is endlessly scrolling through a phone while longing to feel truly known. It is sitting in a church, classroom, or workplace surrounded by people and yet feeling profoundly unseen. A person does not have to be physically alone to experience loneliness. They simply have to believe that no one genuinely sees them, understands them, or cares.

And it is precisely within those hidden places of isolation that despair often grows. The enemy of our souls thrives in secrecy and disconnection, whispering lies into the emptiness, convincing people that they do not matter, that they are forgotten, or that their pain will never change. But Scripture reminds us that we were never designed to carry life alone. Psalm 68:6 (NIV) tells us, "God sets the lonely in families." This is more than poetic imagery. It reflects a profound spiritual and relational truth. Human beings are created for connection, and healthy connection is essential for emotional, physical, and spiritual well-being.

And dear teen, if you are reading this while carrying that ache of loneliness, please hear this clearly: your loneliness is not a reflection of your worth. It is a wound, not a verdict. Wounds can heal. Healing often begins with small but courageous steps, reaching out to another person, joining a group, serving others, asking for help, or simply telling the truth about how you are really doing. Relationship always carries some

degree of risk, but authentic connection also carries the possibility of restoration, belonging, and life itself.

This need for connection becomes especially important during adolescence. Young people need more than entertainment, achievement, or passive consumption. They need to experience themselves as contributors whose lives and actions genuinely matter. They need meaningful responsibility, opportunities to contribute, and experiences that cultivate purpose and agency. When those opportunities are absent, something important within them often begins to erode.

Modern culture has unintentionally created conditions that make this erosion increasingly common. Many adolescents today live surrounded by stimulation yet disconnected from meaningful engagement. School can feel detached from real world purpose. Responsibilities at home may be inconsistent or minimal. Digital environments provide immediate reward without requiring perseverance, sacrifice, or sustained effort. Over time, this can create what Johann Hari and others describe as a deeper sense of disconnection and psychological numbness. It is not merely boredom. It is the gradual loss of meaning itself.

When meaning begins to disappear, adolescents naturally seek relief. Like all human beings, they move toward whatever temporarily reduces discomfort or helps them escape emotional emptiness. Social media, gaming, pornography, substances, compulsive entertainment, and immersive fantasy worlds often become attempts at emotional regulation. These behaviors are rarely random acts of rebellion. More often, they are efforts to soothe distress, feel something in the midst of numbness, or escape an internal world that feels overwhelming and directionless.

Yet this trajectory is not irreversible. One of the most powerful ways to disrupt it is by helping adolescents reconnect with meaningful effort and purposeful engagement. This process does not usually begin with dramatic transformation. More often, it starts gradually and concretely. An adolescent may begin by re engaging with school one assignment at a time. It may involve consistent responsibilities at home that genuinely contribute to family life rather than simply occupying time. It may include involvement in sports, creative pursuits, service opportunities, work, or practical skill development that cultivates competence and identity.

As these experiences accumulate, something important begins to emerge. Adolescents slowly develop a sense of agency, the realization that their choices and actions have impact. Competence grows. Purpose begins to take shape. And eventually a deeper internal truth starts to form: what I do matters, and therefore my life has meaning.

When this process becomes grounded within a larger spiritual framework, its significance deepens even further. Colossians 3:23–24 (NIV) reminds us, ***"Whatever you do, work at it with all your heart, as working for the Lord, not for human masters. It is the Lord Christ you are serving."*** This perspective transforms even ordinary effort into something sacred. For the discouraged teen struggling to finish a school assignment, learning responsibility at home, or rebuilding after failure, their effort is no longer merely about achievement or external approval. It becomes an act of meaning, dignity, and worship that transcends immediate circumstances.

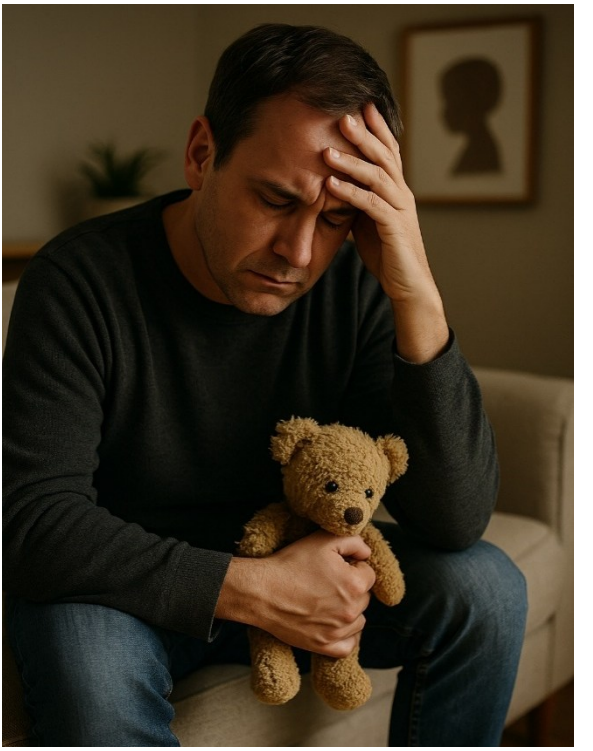
The implication is both simple and deeply hopeful. Adolescents do not need to feel fully motivated before they begin. Often, motivation follows action rather than preceding it. The role of parents, mentors, clinicians, and communities is to help young people take that first step,

then the next, while offering structure, encouragement, accountability, and meaning along the way.

So, when an adolescent struggles with depression or anxiety, the path forward often begins with very small acts of movement toward life. One assignment completed. One responsibility followed through. One meaningful action aligned with the person they are becoming. These moments may appear insignificant in isolation, but they are not. They are seeds.

And with time, consistency, healthy connection, meaningful effort, and God's grace, those seeds can grow into resilience, purpose, healing, and ultimately a life that once again feels worth living.

Disconnection from Childhood Trauma



Unresolved Trauma - the hidden fire in the adolescent soul...

As we will explore deeper in the next chapter, unresolved childhood trauma often lies at the heart of addiction, depression, and anxiety. For adolescents, this reality is especially important to understand, because they are not only carrying what has already happened to them, but they are also still being shaped by it in real time. Even when specific memories fade or are difficult to articulate, the impact remains. It lingers beneath the surface, quietly shaping how they think, feel, and respond to the world around them.

Johann Hari captured this with striking clarity when he wrote in *Lost Connections*, *"There's a house fire inside many of us"* For adolescents, that fire may not yet be fully understood, but it is often deeply felt. It can show up as irritability, withdrawal, anxiety, defiance, or a persistent sense that something is not right. It is not an abstract metaphor. It is a living reality for many young people who are trying to navigate life while carrying an internal sense of distress they cannot fully explain.

And it is not only early childhood trauma. Adolescents can experience layers of trauma as they grow. It may be the instability of family conflict, the pain of rejection or bullying, exposure to inappropriate material, the loss of a relationship, or the quiet accumulation of experiences that leave them feeling unseen, unsafe, or unworthy. Trauma rarely exists in isolation. It compounds. What begins as one wound can lead to others, and when those layers go unrecognized, the internal distress deepens.

This inner fire is often invisible to others. An adolescent may continue to go to school, interact with peers, participate in activities, and appear outwardly functional, while internally feeling overwhelmed or emotionally disconnected. As we will see in the next chapter, trauma, especially when unresolved, does not stay confined to the past. It lives in the nervous system. It alters how the brain processes stress, threat, and connection. It can leave a young person feeling constantly on edge or, at times, emotionally numb. It can shape beliefs about identity, safety, and worth in ways that are subtle but powerful.

Hari's insight remains critical here. You cannot disconnect from or ignore trauma and expect to heal. Attempts to numb it, ignore it, or

push it aside may offer temporary relief, but they do not resolve the underlying pain. Over time, avoidance tends to intensify the distress rather than diminish it. The fire may seem contained for a while, but eventually, it begins to affect more areas of life.

Yet even here, there is profound hope.

Healing is not only possible, but also promised. Jesus consistently moved toward those who were burdened and overwhelmed. He did not ask them to manage their pain alone or to pretend it was not there. Instead, He extended an invitation. ***"Come to me, all you who are weary and burdened, and I will give you rest"*** (Matthew 11:28, NIV). For the adolescent who feels anxious, depressed, or emotionally exhausted, this is not merely comforting language. It is a lifeline. It speaks directly to the reality that they were never meant to carry these burdens in isolation.

Scripture repeatedly affirms God's role as healer. ***"I will heal My people and will let them enjoy abundant peace and security"*** (Jeremiah 33:6 NIV). ***"I am the Lord, who heals you"*** (Exodus 15:26 NIV). These are not distant promises. They speak to the present reality of pain and the possibility of restoration, even in the midst of struggle.

True healing for adolescents goes deeper than managing symptoms or reducing behaviors. It involves helping them gradually face what has been painful, confusing, or overwhelming and bringing those experiences into the light. It means learning, often for the first time, that their feelings can be expressed safely and that their story matters. It involves gently releasing coping strategies that once served a protective purpose but now interfere with growth and connection. It is

an invitation to allow truth to replace the distorted beliefs that trauma often leaves behind.

This process rarely happens in isolation. Young people need safe, attuned relationships where they can be seen, heard, and supported. This may take place in counseling, within the family, in mentoring relationships, or within a healthy faith community. Healing is relational. It unfolds in the presence of others who offer consistency, patience, and care.

At times, the church has struggled to respond well to trauma, particularly in young people. There can be a tendency toward quick solutions or well-intended but insufficient responses that do not fully engage the depth of the pain. Yet the calling of the church is far deeper. It is meant to be a place of refuge, where brokenness is acknowledged rather than hidden, and where healing is approached with patience and grace. *"Therefore, encourage one another and build each other up, just as in fact you are doing*" (1 Thessalonians 5:11, NLT). *"Therefore, confess your sins to each other and pray for each other so that you may be healed"* (James 5:16 NIV). These passages point to a community that walks alongside one another in the process of restoration.

For adolescents, healing often unfolds gradually. It may look like learning how to regulate their breathing when anxiety rises, allowing themselves to express emotions they have long suppressed, or taking the risk to trust someone with their story. It may involve showing up for counseling even when it feels uncomfortable, choosing connection instead of isolation, and learning to receive support rather than managing everything alone. Over time, these small but meaningful steps begin to create space for something new.

That "something new" is not simply the absence of distress. It is the presence of peace. Not emotional numbness or avoidance, but a grounded, steady sense of safety and connection that begins to take root within them.

And at the core of this transformation is a critical truth. **Trauma is not identity.** An adolescent is not defined by what has happened to them, by their symptoms, or by the ways they have struggled to cope. They are, at their core, a child of God, deeply loved and created for restoration. As truth is spoken, as support is provided, and as healing unfolds, that identity becomes clearer and more firmly established.

Scripture captures this restoration beautifully. *"He will give you a crown of beauty for ashes, a joyous blessing instead of mourning, festive praise instead of despair"* (Isaiah 61:3, NLT). This promise speaks directly to the reality of transformation. What has been broken is not discarded. It is redeemed.

Christ is not afraid of their pain. He does not turn away from their wounds. He meets them there and begins the work of restoration.

The fire can be put out.
The walls can be rebuilt.
And the adolescent soul can be restored.

Disconnection from Status and Respect

Belonging, Status, and the Adolescent Need to Be Seen...

These wounds are not hidden in childhood alone. They are alive in the present moment, especially in adolescence, where identity is forming and social belonging carries enormous weight. Young people are shaped not only by what has happened to them in the past, but by the social dynamics they are navigating right now. Peer groups, school environments, social hierarchies, and digital spaces all play a powerful role in shaping how they see themselves and where they believe they stand.

The need for belonging and self-respect is not superficial. It is deeply rooted in human biology. Adolescents are wired to seek connection, to find their place, and to feel that they matter. When that need is met, it fosters confidence, resilience, and growth. When it goes unmet, the nervous system responds with stress, and the emotional world begins

to shift. Anxiety can rise. Mood can drop. A sense of discouragement or invisibility can quietly take hold.

Neuroscientist and Stanford Professor Robert Sapolsky offers one of the clearest windows into this reality. In his decades-long research on baboon social hierarchies, he observed a striking pattern. Low-status baboons, those pushed to the bottom of the social structure, began to display behaviors that closely resemble human depression. They became less active, less socially engaged, lost appetite, and withdrew from interaction. Alongside these behavioral changes, Sapolsky identified significantly elevated levels of cortisol, the body's primary stress hormone, circulating through their systems. Their neurobiology reflected the same stress patterns seen in depressed and anxious humans (Sapolsky, 1992, 2002).

What makes this so important for understanding adolescents is what it reveals about our design. Social position matters, not because adolescents are shallow or overly concerned with popularity, but because they are biologically and relationally wired to live within communities where their presence and contribution have meaning. When a teen feels excluded, overlooked, or diminished, their body can interpret that experience as a form of threat. The result is not simply hurt feelings. It can manifest as anxiety, depression, withdrawal, or attempts to cope through unhealthy behaviors.

This dynamic is especially pronounced during adolescence because social hierarchies are often more visible and more intensely felt. Friend groups, athletic status, academic performance, and social reputation can all contribute to a young person's perceived standing. When adolescents begin to believe that they do not matter, that they are on

the outside looking in, or that they are somehow "less than," the psychological impact can be profound.

Modern life intensifies this challenge. The digital environment has created a world where comparison is constant and often unavoidable. Social media platforms present curated images of success, popularity, and connection, creating what can feel like an ongoing scoreboard. For adolescents who are still forming their identity, this can amplify feelings of inadequacy or exclusion. They may not always articulate it directly, but internally they can begin to absorb a quiet and damaging message that they are falling behind or do not measure up.

This kind of chronic comparison does more than create dissatisfaction. It can contribute to anxiety, depression, and even addictive patterns of behavior, particularly when adolescents lack meaningful avenues to experience competence, contribution, and genuine connection.

Jean Twenge (2006) speaks directly to this issue. She emphasizes that self-esteem is not built through external validation alone, but through real-world mastery. It develops when individuals engage in meaningful effort, overcome challenges, and experience themselves as capable and effective. For adolescents, this is critical. They need opportunities to do hard things, to grow in competence, and to see that their effort leads to real impact.

When those opportunities are limited, whether through overprotection, lack of structure, negative environments, or social exclusion, adolescents may begin to lose not only the respect of others but their internal sense of worth. This is often where anxiety, depression, and maladaptive coping behaviors begin to take root. Not

necessarily from a single traumatic event, but from the gradual erosion of identity, purpose, and belonging.

It is important to be clear about what this is and what it is not. This is not about ego or striving for popularity. It is not about being impressive in the eyes of others. It is about a much deeper and more sacred human need, the need to belong, to contribute, and to be seen. When that need is nurtured in healthy ways, it strengthens the adolescent's capacity for resilience. When it is neglected, the nervous system remains under strain, stress hormones rise, and emotional exhaustion can follow.

Yet even here, there is hope and direction.

Adolescents can be guided toward environments and experiences that foster genuine belonging and healthy identity formation. This includes relationships where they are known and valued, opportunities where they can contribute meaningfully, and challenges that allow them to grow in competence. It also involves helping them interpret their social experiences with greater clarity, recognizing that temporary exclusion or difficulty does not define their worth or their future.

At a deeper level, Scripture speaks directly to the experience of feeling unseen or alone. *"Turn to me and be gracious to me, for I am lonely and afflicted. Relieve the troubles of my heart and free me from my anguish"* (Psalm 25:16–17, NIV). This is not the voice of weakness. It is the honest expression of a human heart longing to be seen, known, and relieved of its burden.

And the response is just as important. God sees. God turns toward the one who feels overlooked. God responds with presence, compassion, and care.

For the adolescent who feels invisible, excluded, or unsure of their place, this truth becomes foundational. Their worth is not determined by shifting social hierarchies or digital comparisons. Their identity is not defined by popularity or status. They are seen fully and known completely by God.

From that foundation, resilience can begin to grow.

Disconnection from Meaningful Values

Rooted or Drifting: Values, Identity, and the Adolescent Search for Meaning…

When a young person becomes unmoored, when their days are filled with motion but empty of meaning, something begins to erode within them. This erosion can begin quietly but does not stay that way for long. It often shows up in restlessness, emotional volatility, a constant search for stimulation, or a growing sense of emptiness that is difficult to name. In today's Western culture, this is no longer a subtle issue. It is widespread and increasingly visible. You see it in the burnout of young people who feel overwhelmed before life has even fully begun, in the anxious pull toward constant entertainment or validation, and in the quiet despair that can take root in habits, distractions, or emotional withdrawal.

Tim Kasser (2002), in his research on values and psychological well-being, found something deeply important for understanding this

generation. When people organize their lives around materialistic and extrinsic goals such as appearance, image, money, social status, or fame, they become significantly more vulnerable to depression, anxiety, and chronic dissatisfaction. These values promise fulfillment, but they consistently fail to deliver it. For adolescents growing up in a world saturated with screens, comparison, and consumer messaging, these false promises are not occasional influences. They are constant. They are told, implicitly and explicitly, that they can construct the perfect life, the perfect image, the perfect identity. Yet the more they chase validation, the more elusive peace becomes.

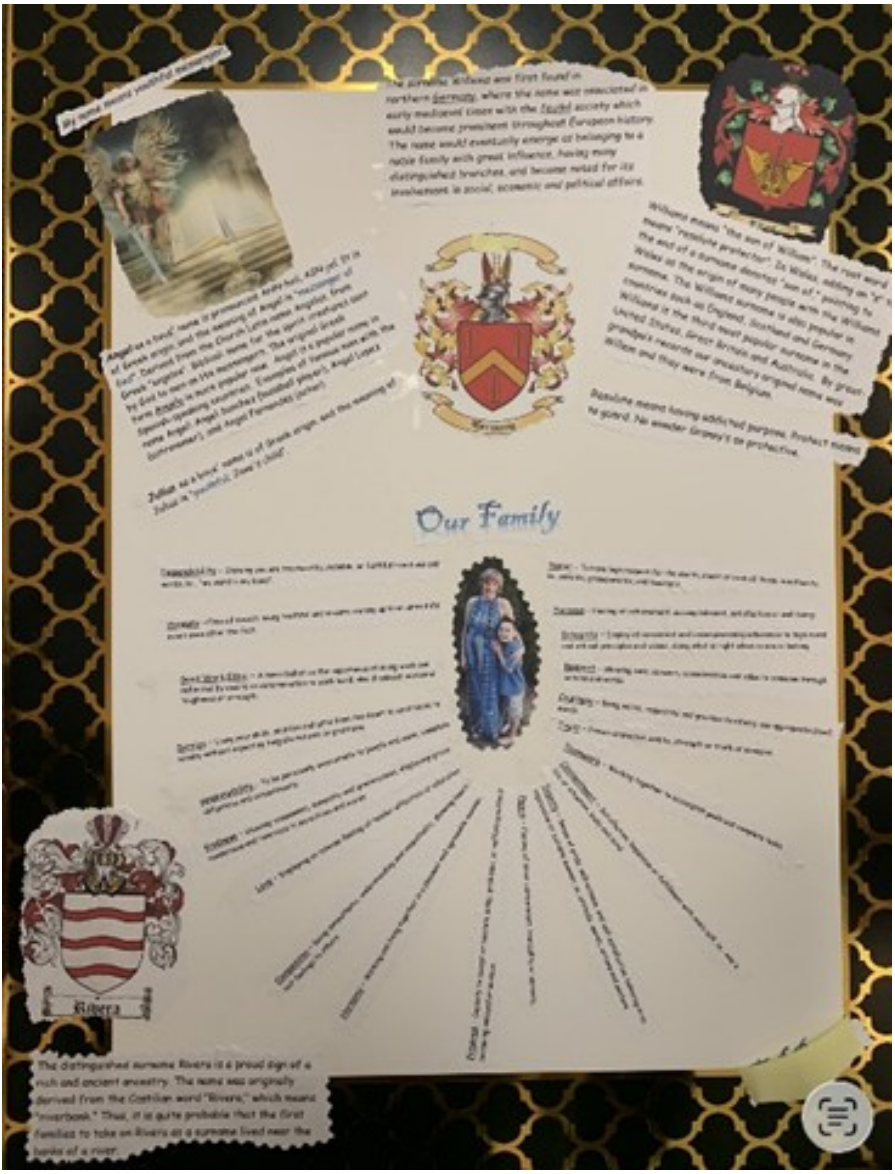
This is particularly significant in adolescence, a developmental stage already marked by a heightened drive for identity, belonging, and novelty. The brain is wired to explore, to seek connection, and to ask fundamental questions about purpose and self. When that natural drive is shaped primarily by external validation and comparison, it can lead to confusion rather than clarity. Instead of forming a stable sense of identity, adolescents may find themselves constantly adjusting to the expectations of others, unsure of who they are or what truly matters.

At the same time, this issue does not begin or end with adolescents. Many adults have never fully moved beyond this stage in the realm of values. They continue to pursue status, appearance, and validation well into adulthood, often without realizing it. Adolescents are not only navigating their own developmental challenges. They are also observing and learning from the adults around them. When they see a world that remains preoccupied with comparison and external success, it reinforces the same patterns they are already struggling to understand.

As a culture, we have drifted. Many of the structures that once provided clarity, identity, and stability have weakened or disappeared. Families are less anchored in shared values. Faith traditions, which once offered a coherent framework for meaning, have often been set aside or approached with uncertainty. Young people are frequently encouraged to find their own truth, yet they are rarely given the tools, guidance, or context to do so. The result is not greater freedom, but greater confusion. Not deeper connection, but increased loneliness. Not clarity, but a growing sense of instability.

In my (Jeff) work as a psychotherapist, particularly with families and adolescents, this theme has emerged repeatedly. When I would ask families a simple question, ***"What are your values?"*** the responses were often well-intentioned but vague. There might be references to kindness or hard work, but when I explored further, asking whether those values were discussed regularly, intentionally taught, or actively practiced within the family, the answer was often no. For adolescents, this absence of clearly defined and consistently lived values creates a kind of vacuum. Without a shared framework, they are left to piece together their identity from a culture that is often fragmented and contradictory.

I am reminded of one of my favorite families I had the privilege of working with years ago. The graphic shown on the next page is shared with permission. AJ was being raised by his grandmother, a woman of remarkable strength and intentionality, who refused to let his circumstances define him. Instead, she helped him discover his value and purpose. Together, they created a family coat of arms, a visual declaration of who they were and what they stood for. It was not just



an art project. It was identity formation. It gave AJ language for his worth, structure for his life, and a sense that he belonged to something meaningful. You could see the shift in him. He stood a little taller. He

spoke with more clarity. He began to live into the very values they had named.

Experiences such as this illustrate something essential. Adolescents do not drift because they lack intelligence or potential. They drift when they lack structure, clarity, and a sense of anchored identity. When values are named, modeled, and lived out consistently, they provide a stabilizing framework. They give direction in moments of uncertainty and meaning in the midst of struggle.

When teens lose sight of meaningful values, they lose their internal compass. Without that compass, decision-making becomes overwhelming. Every choice feels uncertain. Every social interaction carries heightened pressure. Depression can begin to take root when daily life feels disconnected from purpose. Anxiety often grows in the absence of direction, as the mind searches for stability that has not been clearly defined.

The need, then, is not for values shaped by trends or measured through comparison. Adolescents need values that are rooted in something deeper and more enduring than social approval or personal preference. For many, this will involve a return to faith, to a Biblical worldview that provides purpose, moral clarity, and hope. For others, it may begin with rediscovering the importance of community, service, creativity, integrity, responsibility, and stewardship. Regardless of where the starting point is, the underlying truth remains unchanged. Human beings, including adolescents, were never designed to live without roots.

When adolescents are connected to intrinsic values such as love, compassion, purpose, creativity, and responsibility, something shifts. Their experiences begin to make sense within a larger framework. Their efforts take on meaning. Their relationships deepen. And when difficulties arise, as they inevitably will, they are less likely to collapse under the weight of them. Instead, they draw strength from a foundation that is steady and enduring.

The invitation, then, is both simple and deeply important. Help adolescents reconnect with meaningful values. Write them down as a family. Talk about them regularly. Model them consistently. Make them visible within the home. Provide structure where modern life has quietly removed it. In doing so, you offer adolescents something invaluable, a sense of direction, identity, and belonging that cannot be easily shaken.

And at the deepest level, this invitation leads back to God. *"Then you will call upon Me and come and pray to Me, and I will listen to you. You will seek Me and find Me when you seek Me with all your heart"* (Jeremiah 29:12–13 NIV). This is not merely a spiritual concept. It is a relational promise. It speaks to the adolescent who is searching, questioning, and trying to find solid ground. It reminds them that meaning is not something they must construct alone. It is something they can discover in relationship with the One who created them.

When that connection begins to take root, the fog of confusion can start to lift. Anxiety softens. Depression loosens its grip. And in its place, there emerges a growing sense of peace, clarity, and purpose that anchors the heart in something far more lasting than the shifting values of the world.

Disconnection from the Natural World

Our children no longer learn how to read the great Book of Nature from their own direct experience or how to interact creatively with the seasonal transformations of the planet. They seldom learn where their water comes from or where it goes. We no longer coordinate our human celebration with the great liturgy of the heavens.

-Wendell Berry

Reconnecting with Creation: Nature, Movement, and the Adolescent Nervous System…

Sometimes, healing does not begin in a therapist's office or with a new journal or book. Sometimes, it begins with something far more fundamental. It begins with stepping outside and standing still long enough to hear the wind move through the trees or to notice the way light scatters across the surface of water. It begins with returning to the world God made, not the digital one we have constructed, but the

real one we were designed to inhabit. For adolescents, this return is not simply restorative. It is essential.

Many young people today are growing up in environments that are profoundly disconnected from the natural world. They wake to artificial light, move through their day surrounded by screens and structured indoor spaces, and fall asleep to the glow of devices. Their lives are filled with stimulation, but not necessarily nourishment. They move quickly from one demand to the next, yet rarely step outside without a purpose, and even more rarely without distraction. Nature becomes something peripheral rather than something participatory, a backdrop rather than an environment that actively shapes their internal world. Over time, this disconnection begins to take a toll, not only emotionally, but neurologically and physically as well.

Nature is not a luxury. It is a biological necessity.

Research affirms what both experience and intuition have long suggested. Berman et al. (2012) demonstrated that even brief exposure to natural environments, something as simple as a walk among trees or along a river, can significantly improve mood, attention, and cognitive clarity. These effects are particularly pronounced in those struggling with depression, in part because nature quiets the brain's default mode network, the system associated with rumination and anxious self-focus. In practical terms, it reduces the mental noise that so often traps adolescents in cycles of overthinking, self-criticism, and emotional overwhelm.

This is especially relevant given how adolescents are currently living. Many now spend the vast majority of their time indoors, often

exceeding ninety percent, immersed in environments dominated by artificial light, static posture, and constant digital input. The developing brain was never designed for this level of confinement. It was shaped in open environments, through movement, sensory variation, and engagement with the natural rhythms of creation. When those inputs are removed, the system does not simply adapt without consequence. It begins to dysregulate.

Richard Louv (2005) described this as "nature deficit disorder," capturing a cultural reality in which young people are increasingly separated from the environments that support healthy development. When adolescents are cut off from nature, they are not merely missing out on fresh air or recreation. They are losing access to a powerful source of nervous system regulation. They become more anxious, more distracted, and more internally unsettled, not because something is inherently wrong with them, but because something essential is missing from their environment.

At a physiological level, this disconnection contributes to chronic activation of the stress response. The adolescent nervous system, already undergoing significant developmental change, becomes increasingly shaped by patterns of hyperstimulation and sedentary behavior. Cortisol and other stress-related chemicals, which are designed to help us respond to short-term challenges, remain elevated over longer periods. This sustained activation can contribute to anxiety, low mood, irritability, and a sense of internal exhaustion. Over time, it can also affect broader health outcomes (Hansen & Doan, 2024).

In contrast, the natural world provides a powerful and immediate counterbalance. The colors most prevalent in nature, particularly blues

and greens, are inherently calming to the autonomic nervous system. Organic, rounded shapes, found in landscapes, water, and plant life, signal safety to the brain, in contrast to the sharp, angular, and often overstimulating environments of modern design. These sensory inputs support a shift toward parasympathetic regulation, allowing the body to move out of chronic stress and into states of restoration.

Yet it is not only exposure to nature that matters. Movement within that environment is equally critical. Adolescents were not designed to live sedentary lives. Their bodies are built for motion, for exertion, for physical engagement with the world around them. And yet, increasingly, their daily experience is characterized by prolonged sitting, minimal physical activity, and continuous digital engagement. As Hansen and Doan (2024) have noted, this combination of sedentary behavior, excessive screen exposure, and disconnection from natural environments contributes not only to emotional distress but also to the development of metabolic syndrome and related health concerns. What begins as a lifestyle pattern becomes, over time, a physiological burden.

This is where the conversation moves beyond symptom relief and into the domain of resilience.

Learning to step outside, to move the body, to engage physically with the world is not simply a coping strategy for depression or anxiety. It is a foundational skill in building resilience. When adolescents learn to walk, run, hike, play, or simply move their bodies in open space, they are not only improving mood in the moment. They are training their nervous system to regulate. They are increasing their capacity to tolerate stress. They are strengthening the connection between body

and mind. They are, in a very real sense, rebuilding systems that modern life has eroded.

In clinical work, this becomes evident in both subtle and profound ways. Encouraging an adolescent to step outside, to take a walk, to breathe real air, or to sit near water may seem simple, even insignificant. Yet these small acts often become entry points into larger change. Not because nature itself is a cure, but because it restores alignment. It brings the individual back into contact with rhythms that are ordered, predictable, and life-giving. It provides a context in which the nervous system can settle, and the mind can begin to clear.

And over time, as these practices become more consistent, they do more than reduce distress. They begin to build strength. The adolescent who learns to move their body regularly, to seek out natural environments, and to disconnect from constant stimulation develops an internal capacity that extends far beyond the moment. They become more grounded, more regulated, and more capable of navigating the inevitable challenges of life. This is resilience, not as an abstract concept, but as a lived and embodied reality.

This reconnection is also deeply spiritual. Scripture consistently points to the created world as a place of instruction, reflection, and restoration. *"But ask the animals, and they will teach you, or the birds in the sky, and they will tell you... In his hand is the life of every creature and the breath of all mankind"* (Job 12:7–10, NIV). Creation is not incidental. It reflects the order and sustaining presence of God, and to engage with it is to be reminded of that reality.

"Shout for joy, O heavens; rejoice, O earth; burst into song, O mountains! For the Lord comforts His people and will have compassion on His afflicted ones" (Isaiah 49:13, NIV). There is a resonance between creation and comfort, between the external world and the internal experience of peace.

"The Lord is my shepherd; I shall not be in want. He makes me lie down in green pastures, He leads me beside quiet waters, He restores my soul. He guides me in paths of righteousness for His name's sake" (Psalm 23:1–2, NIV). Restoration, as Scripture presents it, is not disconnected from environment. It is tied to place, to movement, to stillness, and to the presence of God within the natural world He created.

For adolescents struggling with depression, anxiety, or patterns of disconnection, the call to step outside, to move, and to reconnect with creation is not simplistic advice. It is an invitation back into alignment. It quiets the overactive mind, lowers physiological stress, and reintroduces a sense of awe and perspective that is often lost in digital environments.

In a culture that pulls them toward stillness of the wrong kind, passive, screen-bound, and disconnected, they must relearn stillness of the right kind, grounded, attentive, and alive within creation. And they must relearn movement, not as obligation, but as part of what it means to be fully human.

So, the invitation remains both simple and profound. Step outside. Move the body. Breathe deeply. Let the nervous system recalibrate in the presence of something real. These are not small acts. They are the building blocks of resilience.

Adolescents were made for this. And creation, in its quiet and steady way, continues to offer what they need.

Disconnection from Hope and the Future

Adolescent Disconnection and the Collapse of Hope...

Hope is not something adolescents can simply will into existence. It is not a switch they flip when life becomes difficult, nor is it sustained by slogans or surface-level encouragement. Hope is formed over time within the context of relationships, stability, meaning, and a believable future. It emerges when a young person begins to sense that their life is moving somewhere, that their effort connects to something real, and that tomorrow holds more than a repetition of today.

Right now, that developmental process is under strain. Young people are growing up in a world that feels increasingly unstable and disorienting. Family structures are more fragmented than in previous generations, cultural messages about identity and purpose are often conflicting, and the digital world exposes them to constant comparison and pressure before they have the internal foundation to process it. They are asked to make sense of a world that often feels chaotic, while

still in the process of forming a sense of self. Over time, this creates not just stress, but a deeper sense of disconnection, from themselves, from others, and from any clear vision of the future.

Hope rarely disappears in dramatic fashion. More often, it erodes quietly. An adolescent may continue to function outwardly, attending school, maintaining friendships, meeting expectations, but internally something begins to shift. The future no longer feels compelling. Motivation becomes harder to access. Effort feels heavier and less meaningful. What was once imagined as possible begins to feel distant or unrealistic. In this state, disengagement is not laziness; it is the natural consequence of a mind that no longer believes its efforts will lead anywhere worth going.

Psychologist C. R. Snyder (1991) described hope as the integration of agency and pathways, the will to move forward and the perceived ability to do so. This model is clinically useful and maps well onto what we see in both depression and anxiety. When teens lose a sense of agency, they begin to feel powerless, as though their actions no longer influence outcomes. When they lose a sense of pathways, they begin to feel trapped, unable to identify a viable way forward. When both collapse, the result is not simply discouragement but a deeper psychological foreclosure in which the future itself begins to close off.

However, what becomes increasingly clear in working with adolescents today is that this framework, while accurate, is incomplete if it is treated as purely internal. Much of modern psychology emphasizes helping young people ***"believe in themselves,"*** to cultivate confidence, resilience, and internal strength. These are essential capacities, but they are not sufficient on their own. For many adolescents, especially those

navigating significant stress, trauma, or instability, the issue is not simply a lack of internal resources. It is the absence of a larger framework that gives their effort meaning.

Hope becomes fragile when it is forced to exist in isolation.

Historically, teens developed a sense of hope within systems that extended beyond themselves. Stable families, consistent communities, shared values, and for many, a faith tradition that provided a coherent understanding of identity, purpose, and suffering. These structures did not eliminate hardship, but they provided a context in which hardship could be understood and endured. They allowed the adolescent to locate their struggle within a larger story, one that extended beyond the immediacy of their current pain.

When these structures weaken, the burden shifts inward. The adolescent is left to generate meaning, direction, and hope largely on their own, often while navigating the emotional volatility and cognitive development of this stage of life. Over time, this becomes an unsustainable demand. Without a stable reference point beyond themselves, many begin to internalize the belief that their efforts are disconnected from any lasting significance. The question that emerges, sometimes consciously, often not, is simple but devastating: ***What is the point?***

Addressing this does not require imposing a specific belief system, but it does require recognizing a fundamental truth about human development. Hope is strengthened when it is anchored in something that does not collapse under pressure. For many young people, this includes a faith-based framework that offers a sense of being known,

valued, and guided by something greater than themselves. Within a Christian context, this is not merely abstract belief, but a relational understanding that their life is held within a larger purpose.

Scripture speaks directly into this need. The Apostle Paul the Apostle writes, ***"May the God of hope fill you with all joy and peace as you trust in Him, so that you may overflow with hope by the power of the Holy Spirit"*** (Romans 15:13, NIV). This is not a call to passive optimism, but an invitation into a source of hope that exists beyond fluctuating circumstances. Similarly, we are reminded, ***"Let us hold unswervingly to the hope we profess, for He who promised is faithful"*** (Hebrews 10:23, NIV). The stability of hope, in this context, is not dependent on the adolescent's internal state alone, but on the reliability of the One in whom that hope is placed.

This does not negate the importance of building internal resilience. Adolescents still need to develop agency, emotional regulation, and the capacity to take meaningful action in their lives. But when these internal capacities are paired with an external anchor, whether through faith, deeply held values, or relationships that provide enduring meaning, hope becomes more sustainable. It is no longer something they must manufacture under pressure, but something they can return to, even when they feel uncertain or overwhelmed.

The clinical task, then, is not simply to help our young people think more positively or try harder. It is to help them reconnect, to themselves, to others, and to a framework of meaning that allows their life to feel coherent and purposeful. When that reconnection begins to take place, hope often returns in ways that are both subtle and profound. The adolescent begins, sometimes tentatively, to imagine a

future again. Effort starts to feel worthwhile. Movement replaces stagnation.

And perhaps most importantly, they begin to sense that their story is not finished.

As Scripture reminds us, "***For I know the plans I have for you," declares the Lord, "plans to prosper you and not to harm you, plans to give you hope and a future"*** (Jeremiah 29:11, NIV). In a world that often feels uncertain and unstable, this assurance offers something adolescents deeply need, not just optimism, but a grounded and enduring reason to move forward.

Disconnection from Faith and Meaning

Johann Hari's work has been deeply meaningful in helping us understand the many forms of disconnection that contribute to modern despair. His articulation of lost connection to meaningful work, to community, to nature, and to purpose has resonated widely because it reflects something people are genuinely experiencing. In many ways, his framework gives language to the quiet suffering that so many adolescents and adults carry.

At the same time, it is important to acknowledge that Johann Hari does not fully explore the dimension of spiritual disconnection. His work is grounded in a largely secular perspective, and while it is thoughtful and compelling, it stops short of addressing what we would argue is the most foundational form of disconnection. This is not a critique of his contribution. It is simply an honest recognition of its limits.

For the sake of completeness, we introduce this here as part of the broader landscape of disconnection. But we do so knowing that it deserves far more than a brief mention. In the chapters ahead,

particularly as we unfold the Fourth Pillar of NeuroFaith®, we will explore this dimension in much greater depth, examining how spiritual reconnection transforms healing at its core

And if we are candid, it is our hope and prayer that one day this dimension might be more fully considered within broader conversations like his. Because clinically, relationally, and spiritually, the absence of this connection is not theoretical. It is something we see lived out in the lives of adolescents every day.

This is particularly critical during adolescence, which is not merely a stage of life but a formative window in which identity, meaning, and direction are being established. What is built, or not built, during this season often becomes the foundation for future stability, resilience, and the capacity to navigate suffering in adulthood. When an adolescent develops within a framework that lacks grounding, coherence, or transcendent meaning, that instability often carries forward. When they are anchored, that strength often carries forward as well.

When a young person is left to construct hope entirely within themselves, without any anchoring in something greater, more stable, and more enduring than their own shifting emotions and circumstances, hope becomes fragile. It may appear for a moment, but it does not hold under pressure. It struggles to survive suffering. Over time, it often begins to collapse.

This is why we must name what has not been named.

Within the NeuroFaith® model, spiritual connection is not an optional addition to the healing process. It is central. Faith speaks to the deep

human need to be known, to be guided, to be loved, and to belong to something that does not fail when life becomes uncertain. For the adolescent, in particular, this becomes a stabilizing force during a time that is otherwise marked by rapid change and internal uncertainty. It restores not only belief, but identity. Not only comfort, but direction.

Scripture captures this grounding with profound clarity. ***"The Lord is my shepherd, I lack nothing... Even though I walk through the darkest valley, I will fear no evil, for you are with me"*** (Psalm 23:1,4 NIV). For the adolescent who feels untethered and uncertain, this is not abstract theology. It is a stabilizing truth. It answers the fear that they are alone in the struggle and reminds them that their life is held within something faithful and enduring.

Because at its heart, this is not simply about adding spirituality to psychology. It is about recognizing that without it, something essential is missing.

And when that missing connection is restored, especially during the formative years of adolescence, hope does not merely return. It becomes anchored, and that anchoring has the power to shape a life for decades to come.

Cause Four
Trauma

The Hidden Epicenter of Adolescent Despair

Of all the drivers of adolescent despair, trauma may be among the most devastating, and at the same time, one of the most overlooked. Trauma exposure, particularly in the form of child maltreatment such as neglect, emotional, physical, and sexual abuse, has been consistently identified as a major contributor to emotional dysregulation and poor mental health outcomes. It stands as one of the most significant risk

factors for both depressive symptoms and post-traumatic stress (McLaughlin et al., 2012, 2013).

What makes this especially concerning in adolescence is that these experiences do not simply pass through a young person and fade with time as noted earlier. They take root. They shape how emotions are processed, how stress is tolerated, and how the self is experienced. Multiple studies confirm that trauma compromises our capacity to regulate emotions, often beginning in early childhood and extending into adolescence and adulthood (Langevin et al., 2016; Shields and Cicchetti, 1997; Briere and Rickards, 2007; Dunn et al., 2018). Trauma is not only about what happens to us. It is about what happens within us when we are left to carry those experiences alone, without support, without understanding, and without a safe place to process what we have endured. As Barta (2018) describes, trauma overwhelms the nervous system and disrupts integration, leaving individuals caught in patterns of hyperarousal or emotional shutdown.

One of the more hidden, yet deeply influential consequences of trauma is the formation of **negative core beliefs**, which we introduce here and will explore more fully later in this book. These are not fleeting thoughts. They are deeply embedded assumptions about the self, such as *"I am not lovable," "I am not worthy," or "I have no value."* Over time, these beliefs become internalized and begin to organize how a young person interprets the world. As clinicians like Tim Fletcher have emphasized, these beliefs do not remain at the level of cognition. They become part of the architecture of identity itself.

From a neurobiological perspective, these patterns are reinforced within implicit memory systems, particularly the default mode

network, which governs self-referential thinking. Over time, this network can become a carrier of a painful and distorted internal narrative. What begins as an adaptive response to overwhelming experiences gradually becomes a persistent lens through which life is viewed.

These are not just painful ideas. They are internalized distortions about identity and worth, what Scripture might describe as the lies of the enemy, who *"was a murderer from the beginning... for there is no truth in him"* (John 8:44, NIV). These beliefs shape how adolescents approach relationships, success, failure, and even the possibility of hope. For a developing brain, this is particularly significant, as these early narratives often become the template for adult functioning if left unaddressed.

As Fletcher and others have noted, trauma is not stored only as narrative memory. It is held in the body. It lives within the nervous system and is expressed through patterns of behavior and relationship. Adolescents carrying trauma may appear avoidant, perfectionistic, overly compliant, or oppositional. These are not signs of defiance or weakness. They are attempts at survival. The world feels unsafe, and their responses reflect an effort to navigate that perceived threat.

Over time, these trauma-driven patterns quietly shape and often disrupt multiple areas of life. Relationships may feel unpredictable or unsafe. Academic challenges may feel overwhelming. Intimacy may feel threatening rather than life-giving. Many adolescents carry an internal script of shame, fear, or inadequacy that influences how they see themselves and how they engage with others. Unless these patterns are brought into the light and addressed through healing relationships and integrative care, they can persist for years, even decades.

The impact of trauma extends beyond emotional and relational functioning. The **Adverse Childhood Experiences (ACE)** study by Felitti et al. (1998, 2009, 2014) demonstrated a strong and consistent relationship between early trauma and increased risk for physical illness, substance use, and premature mortality. Emotional abuse, in particular, has been shown to have a profound association with adult depression, in some cases even more strongly than other forms of abuse. This highlights an important reality. The way a child is treated emotionally, especially in formative years, has lasting implications for both mental and physical health.

The ACE study identifies ten categories of childhood trauma, including various forms of abuse, neglect, and household dysfunction. With each additional category of trauma, the risk for anxiety, despair, substance use, suicide, and chronic illness increases significantly. Individuals with an ACE score of seven or higher have been found to be over 3,000 percent more likely to attempt suicide (Felitti et al., 2009). The cumulative burden of trauma reshapes the brain, the body, and the beliefs individuals carry about themselves and the world.

What we are introducing here is foundational, but not exhaustive. Within the NeuroFaith® model, the deeper work of identifying and healing these trauma-based core beliefs, particularly those embedded at the level of identity, will be addressed more fully in Pillar Four.

For now, it is enough to recognize this. Much of what adolescents struggle with is not random, and it is not simply a matter of willpower. It is rooted in what they have lived through and in how those experiences have shaped their inner world. And when we begin to

understand that, we can begin to respond not with frustration or judgment, but with clarity, compassion, and a pathway toward healing.

Adverse Childhood Experiences

The ten reference categories experienced during childhood or adolescence are listed below, along with their prevalence in parentheses (Felitti and Anda, 2009):

Abuse

- Emotional – recurrent threats, humiliation (11%)
- Physical – beating, not spanking (28%)
- Contact sexual abuse (28% women, 16% men; 22% overall)

Household dysfunction

- Mother treated violently (13%)
- Household member was an alcoholic or drug user (27%)
- Household member was imprisoned (6%)
- Household member was chronically depressed, suicidal, mentally ill, or in psychiatric hospital (17%)
- Not raised by both biological parents (23%)

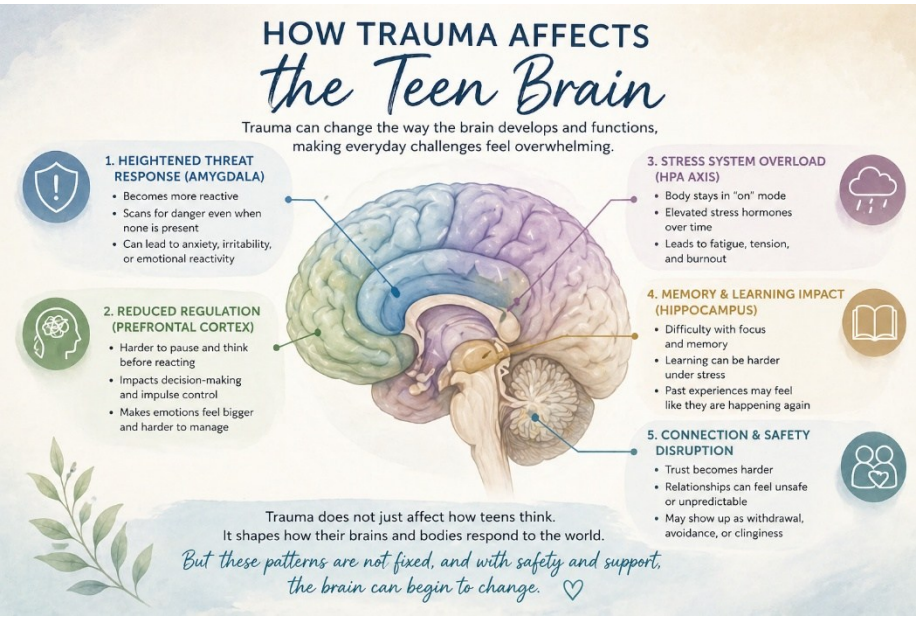
Neglect

- Physical (10%)
- Emotional (15%)

Trauma experts differentiate between **"Big T"** trauma, horrific single events such as violence or disaster, and **"little t"** trauma, repeated

relational wounds such as bullying, chronic criticism, or emotional neglect. However, as many in the trauma field have noted, there is nothing "little" about the impact of little t traumas. They quietly devastate. In my (Jeff) own work as a psychologist, I have seen that consistent absence of attunement, of being truly seen and valued by a parent or adult, is often more damaging than overt acts of aggression.

Barta (2015) noted that trauma is not necessarily caused by bad parents but by emotionally unavailable ones. Many parents do the best they can with the tools they have, but when they fail to respond to the emotional needs of their children, the results can be quietly catastrophic. Children raised without emotional mirroring learn to hide, minimize, or distort their emotional experience, skills that later fuel depression, anxiety, addiction, and relational dysfunction.

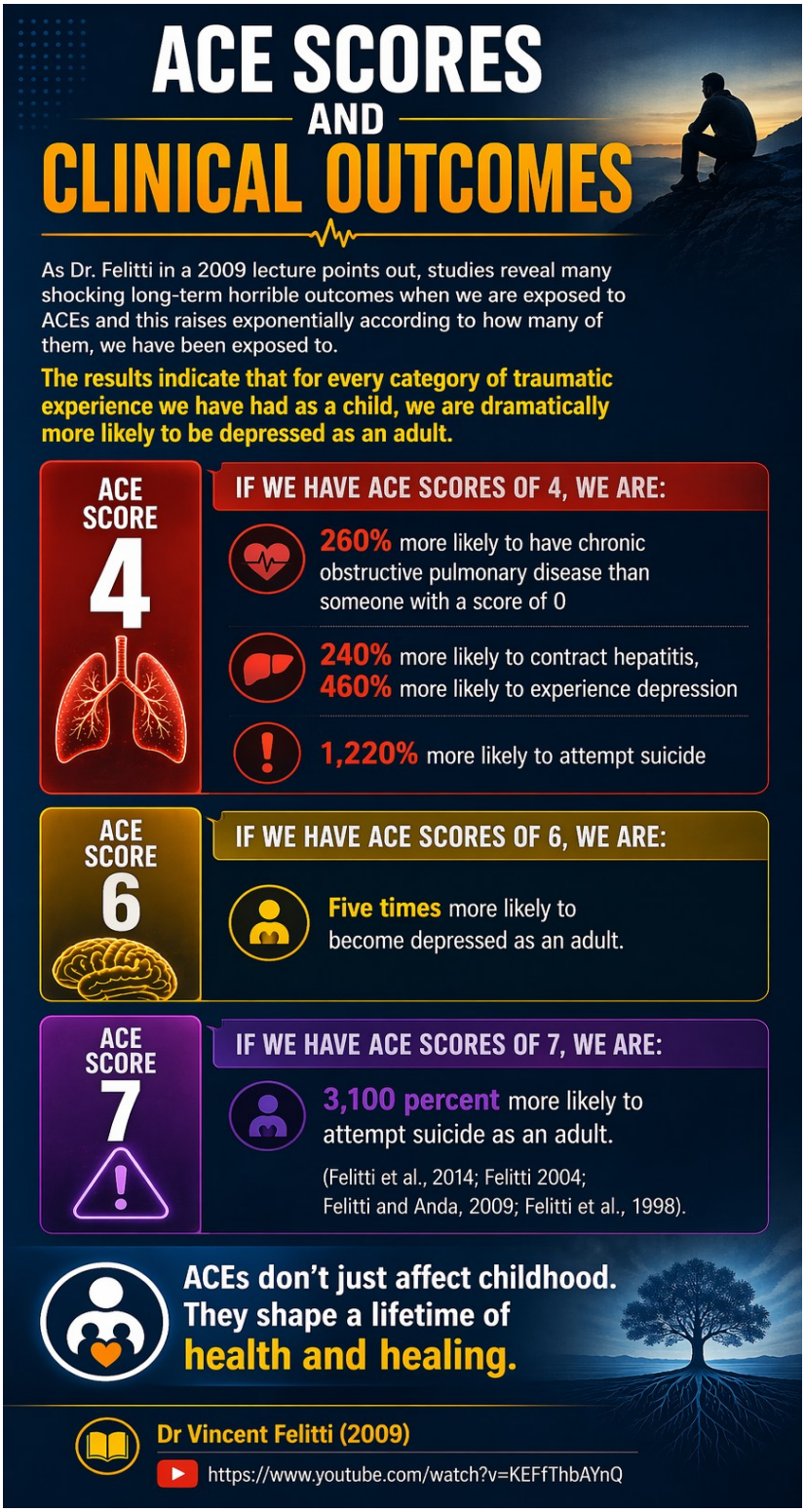


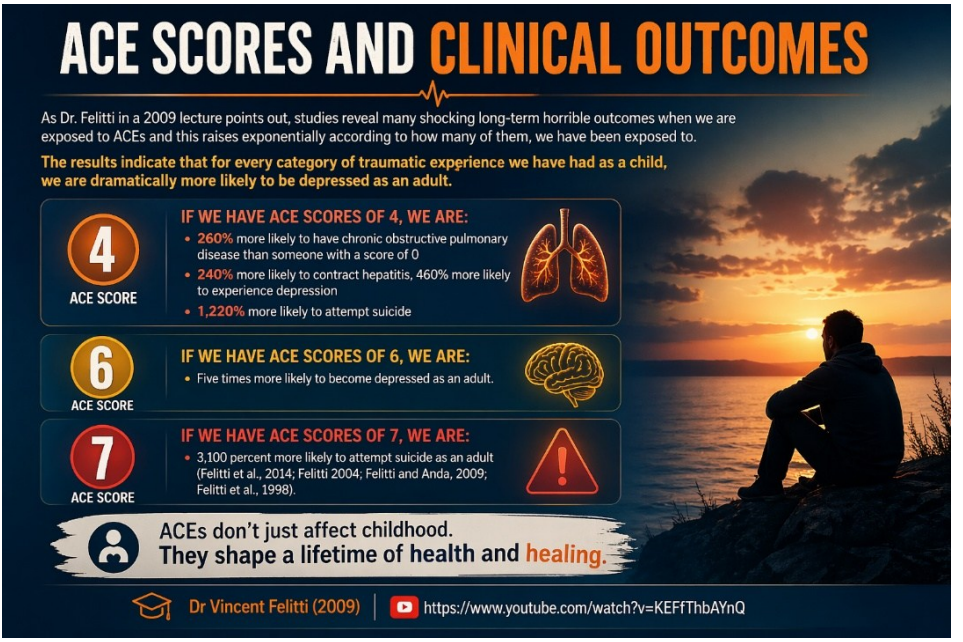
Dr. Peter Levine (2008) writes, ***"Trauma is about loss of connection, to ourselves, our bodies, our families, others, and the world around us."*** That loss of connection often happens subtly over time. People learn to avoid feelings, people, and places that trigger pain. But in doing so, they also lose access to joy, vitality, and the ability to dream.

Most important to normal development is "social engagement," which is the ability to know, understand, regulate, and express emotions in the present moment. Even though everyone is born with a social engagement system (i.e., a neurological system that promotes human connection), we know that early trauma can disrupt normal development. Anda et al. (2018) note, ***"Early adverse experiences may disrupt the ability to form long-term attachments in adulthood. The unsuccessful search for attachment may lead to sexual relations with multiple partners with resultant promiscuity and other issues related to sexuality."*** As a result of adverse developmental trauma, the ensuing

loss of connection with our inner self, our bodies, others, and the world around us, we are predisposed to engage in maladaptive and/or addictive behaviors to relieve the emotional dysregulation that torments us.

As Dr. Felitti highlighted in an outstanding 2009 lecture, studies reveal numerous alarming long-term consequences of being exposed to ACEs, with the severity of these outcomes increasing exponentially with the number of ACEs experienced. The results indicate that for every category of traumatic experience we have had as a child, we are dramatically more likely to be depressed as an adult. If we have ACE scores of four or higher, we are 260% more likely to have chronic obstructive pulmonary disease than someone with a score of zero, 240% more likely to contract hepatitis, 460% more likely to experience depression, and 1,220% more likely to attempt suicide. If we have had six categories of traumatic events as a child, we are five times more likely to become depressed as an adult, and if we have had seven categories, we are a terrifying 3,100 percent more likely to attempt suicide as an adult (Felitti et al., 2014; Felitti 2004; Felitti and Anda, 2009; Felitti et al., 1998).


ACE SCORES
AND
CLINICAL OUTCOMES
As Dr. Felitti in a 2009 lecture points out, studies reveal many shocking long-term horrible outcomes when we are exposed to ACEs and this raises exponentially according to how many of them, we have been exposed to.
The results indicate that for every category of traumatic experience we have had as a child, we are dramatically more likely to be depressed as an adult.
ACE SCORE 4
IF WE HAVE ACE SCORES OF 4, WE ARE:
260% more likely to have chronic obstructive pulmonary disease than someone with a score of 0
240% more likely to contract hepatitis,
460% more likely to experience depression
1,220% more likely to attempt suicide
ACE SCORE 6
IF WE HAVE ACE SCORES OF 6, WE ARE:
Five times more likely to become depressed as an adult.
ACE SCORE 7
IF WE HAVE ACE SCORES OF 7, WE ARE:
3,100 percent more likely to attempt suicide as an adult.
(Felitti et al., 2014; Felitti 2004; Felitti and Anda, 2009; Felitti et al., 1998).
ACEs don't just affect childhood.
They shape a lifetime of
health and healing.
Dr Vincent Felitti (2009)
https://www.youtube.com/watch?v=KEFfThbAYnQ



In the 2009 lecture, Dr. Felitti offered the following data, captured in the graphics below, which shockingly detail the dramatic impact that ACEs have on our society:

So how does trauma take root so deeply within us, and why is it so difficult to let go?

Trauma does not stay contained in one part of our lives. It moves through us. It settles into the ways we see ourselves, the ways we connect with others, and the patterns we find ourselves repeating, often without fully understanding why.

We carry it into our closest relationships, where it shapes how we trust, how we protect ourselves, and how we respond when we feel hurt or afraid. We absorb it through the environments we grow up in, learning from what is modeled around us, even when those patterns are unhealthy or painful. And over time, trauma can reach even deeper, leaving its imprint on our biology, influencing how our bodies respond to stress and how certain tendencies may be passed forward.

In this way, trauma is not just something that happened to us. It becomes something that lives within us.

But if we are going to understand how healing is possible, we must first understand how trauma gains this kind of influence.

There are three primary pathways through which it takes root and continues to shape our lives:

Pathway One: Attachment
How trauma shapes the way we connect and feel safe with others

Pathway Two: Social Learning
How trauma is modeled, learned, and repeated across relationships

Pathway Three: Epigenetics
How trauma leaves its imprint on the body and may be carried forward

Pathway One
Connection Shapes Us: Attachment

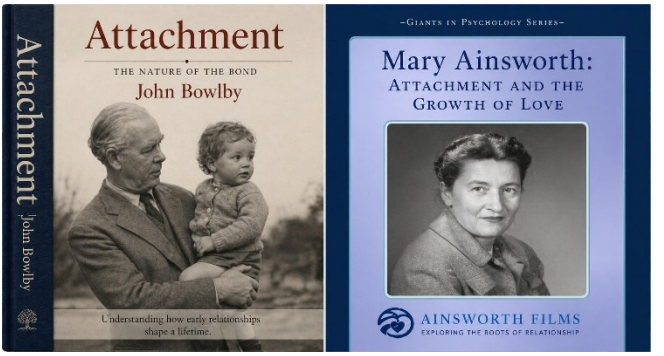
Attachment is not a small thing in our lives. It is one of the most powerful forces shaping who our teens become.

From their earliest moments, they are wired for connection. They come into this world not simply needing food or shelter but needing relationship. They need to be seen, soothed, protected, and known, and when those needs are met consistently, something profound begins to take shape within them: a sense of safety, a sense of worth, and a growing belief that the world, and the people in it, can be trusted.

But when those needs are not met, or are met inconsistently, something else begins to take shape. Our teens adapt. They learn how to survive emotionally, developing patterns of relating that may protect them in the moment but can quietly follow them into adolescence and beyond.

This is what attachment is. It is the deep and enduring emotional bond that forms between a child and those who care for them, and it does not stay confined to early childhood. It becomes the blueprint for how our teens experience relationships, how they regulate their emotions, and how they come to understand themselves.

The groundbreaking work of John Bowlby and Mary Ainsworth helped us begin to understand just how central these early bonds are. Their research showed that attachment is not always mutual. A child may attach deeply to a caregiver even when that care is inconsistent or, at times, absent. What matters is not perfection, but the pattern that forms over time, a pattern that continues to shape how our teens connect, cope, and make sense of the world.



And long before modern psychology articulated these truths, they were already reflected in Scripture. As Proverbs 22:6 reminds us, ***"Start children off on the way they should go, and even when they are old, they will not turn from it."*** The relationships that shape us early do not simply fade. They echo across a lifetime.

When we understand attachment, we begin to understand our children. And when we understand them, we begin to see a path toward healing.

By way of background, John Bowlby did not begin his career intending to study human relationships. He initially pursued medicine, following

a path laid out before him, but found himself increasingly drawn to questions of development and emotional life.

That shift became decisive during a brief six-month experience working with maladjusted children at Priory Gates. What he encountered there would shape the course of his life's work. Reflecting on that time, Bowlby described it as one of the most valuable periods of his life, a place where he began to understand that the struggles we see in the present are deeply rooted in early developmental experiences.

This insight would become foundational. The problems teens face today are not random. They are shaped, in large part, by the relationships and environments that formed them (Kanter, 2007).

As we begin to understand attachment more deeply, we quickly see that John Bowlby was not working alone. His collaboration with Mary Ainsworth helped bring attachment theory into clearer focus, giving us a way not just to describe these bonds, but to actually observe them.

Ainsworth was driven by a simple but profound question. How do we ***see*** attachment? How do we understand what is happening inside a child who cannot yet put their experience into words?

To answer that question, she developed what became known as the **Strange Situation,** a carefully designed observation in which a young child is briefly separated from their caregiver in an unfamiliar setting. What happens next is deeply revealing. When the caregiver leaves, we see how the child responds to distress. And when the caregiver returns, we see something even more important. We see how that child has learned to seek comfort, or not. We see whether connection feels safe, uncertain, or something to be avoided.

What Ainsworth discovered is something we can all recognize, not just in younger children, but clearly in our teens. They are not all the same in how they connect. Some move toward others with trust and openness. Some pull away and keep their distance. Others seem caught in a painful tension, wanting closeness while at the same time fearing it.

From her work, three primary patterns began to emerge: secure attachment, anxious-avoidant attachment, and anxious-resistant attachment. These are not simply categories for early childhood. They are patterns that often carry forward into adolescence, shaping how our teens relate to friends, respond to authority, navigate dating relationships, and manage emotional stress.

These patterns influence how they love, how they protect themselves, and how they respond when relationships feel uncertain. What we often see on the surface—withdrawal, defiance, clinginess, or emotional swings, may, at a deeper level, reflect the attachment patterns that have been forming over time.

And as research continued, it became clear that attachment is not a single moment, but a process that unfolds over time. In a longitudinal study of infants, Rudolph Schaffer and Peggy Emerson observed how attachment develops across the first years of life. Infants were followed closely throughout their first year and again at 18 months, revealing that attachment forms in distinct stages rather than all at once. These findings remind us that connection is built over time, shaped by repeated experiences of care, responsiveness, and presence (Schaffer & Emerson, 1964).

Pre-attachment stage: From birth to three months, infants do not show any particular attachment to a specific caregiver. The infant's signals, such as crying and fussing, naturally attract the attention of the caregiver and the baby's positive responses encourage the caregiver to remain close (Schaffer & Emerson, 1964).

Indiscriminate attachment: From around six weeks of age to seven months, infants begin to show preferences for primary and secondary caregivers. During this phase, infants begin to develop a feeling of trust that the caregiver will respond to their needs. While they will still accept care from other people, they become better at distinguishing between familiar and unfamiliar people as they approach seven months of age. They also respond more positively to the primary caregiver (Schaffer & Emerson, 1964).

Discriminant attachment: At this point, from about seven to eleven months of age, infants show a strong attachment and preference for one specific individual. They will protest when separated from the primary attachment figure (separation anxiety) and begin to display anxiety around strangers (stranger anxiety) (Schaffer & Emerson, 1964).

Multiple attachments: After approximately nine months of age, children begin to form strong emotional bonds with other caregivers beyond the primary attachment figure. This often includes the father, older siblings, and grandparents (Schaffer & Emerson, 1964).

As nicely summarized by Lyons-Ruth (1996), the basic attachment styles culminating from John Bowlby and Mary Ainsworth's research and the fourth by Drs. Mary Main and Judith Solomon's (Main & Solomon, 1986) work include:

Secure attachment: Secure attachment is marked by distress when separated from caregivers and joy when the caregiver returns. Remember, these children feel secure and are able to depend on their adult caregivers. When the adult leaves, the child may be upset, but he or she feels assured that the parent or caregiver will return. When frightened, securely attached children will seek comfort from caregivers. These children know their parent or caregiver will provide comfort and reassurance, so they are comfortable seeking them out in times of need (Lyons-Ruth, 1996).

Ambivalent attachment: Ambivalently attached children usually do not appear too distressed by the separation, and, upon reunion, actively avoid seeking contact with their parent, sometimes turning their attention to play objects on the laboratory floor. This attachment style is considered relatively uncommon, affecting an estimated 7 percent to 15 percent of U.S. children. Ambivalent attachment may be a result of poor parental availability. These children cannot depend on their mother (or caregiver) to be there when the child is in need (Lyons-Ruth, 1996).

Avoidant attachment: Children with an avoidant attachment tend to avoid parents or caregivers. When offered a choice, these children will show no preference between a caregiver and a complete stranger. Research has suggested that this attachment style might be a result of abusive or neglectful caregivers. Children who are punished for relying on a caregiver will learn to avoid seeking help in the future (Lyons-Ruth, 1996).

Disorganized attachment: Children with a disorganized attachment often display a confusing mix of behavior and may seem disoriented, dazed, or confused. Children may both avoid or resist the parent. Some researchers believe that the lack of a clear attachment pattern is likely linked to inconsistent behavior from caregivers. In such cases, parents may serve as both a source of comfort and a source of fear, leading to disorganized behavior (Lyons-Ruth, 1996).

In 1978, Mary Ainsworth and her colleagues reported that studies on the three initial attachment classifications revealed: 70 percent of American infants have been classified as secure, 20 percent as avoidant-insecure, and 10 percent as resistant-insecure (Ainsworth et al., 1978). Kain and Terrell (2018) warn of concerning declines in secure attachment, noting that in more recent research populations, the rates of secure attachment have declined by 10 percent (Andreassen et al., 2007).

Studies reveal that interactions during the first three years of life can affect cognitive development and will impact the physical, emotional, and mental health of children as they age and develop (Colmer et al., 2011). Typically, a parent's emotional response will serve as a template for helping their child learn about emotion. As parents model appropriate emotion regulation through conversations or actions, children learn to control and regulate their emotions.

In contrast, insecurely attached children may learn to mask their emotional distress or exaggerate it to gain their parent's attention, therefore compensating for a parent who is not consistently responsive (Laible, 2010). This type of maladaptive behavior has devastating consequences, resulting in poor social skills, emotional dysregulation, depression, anxiety, peer exclusion, social rejection, and low self-esteem (Lewis et al, 2015; Newman, 2017). So, those of us who are young parents should ensure that we spend lots and lots of time with our infants and children in healthy, safe, and connected ways, particularly early in life, to develop secure attachment so they can have joy, fulfilling relationships, and emotional stability.

Psychiatrist and Internal Family Systems (IFS) leader Dr. Frank Anderson presents a refreshingly new view on attachment as it relates to IFS therapy, which will be explained later in this book in the Therapeutic Pathway to Peace chapter. Anderson (2021) notes that he does not fully subscribe to the concept of attachment styles as such, nor does he believe they are formed solely in the first few years of life. Rather, he posits that different parts of children attach to different parts of caregivers throughout their lives. He contends that most attachment styles, when seen through an IFS lens, are actually wounds or protective parts that develop as a result of difficult or challenging

interactions. They have a tremendous influence on our lives as adults, especially when they are not adequately addressed or healed. Dr. Anderson adds that we each have different parts that relate to different parts of other people. Finally, he posits that we each have experiences with each of these "styles" or "different parts," which connect to the various parts of people with whom we are in connection (Anderson, 2021).

Takeaway: Attachment is one of the most powerful forces that shapes our emotional lives and relationships, influencing how we connect with others from childhood through adulthood. Secure attachment, formed through safe, consistent, and caring relationships, is key to emotional regulation, building trust, and forming healthy, lasting connections. Early pioneers like Dr. John Bowlby and Dr. Mary Ainsworth showed us just how deep this impact runs. Ainsworth's famous research identified different attachment styles, secure, avoidant, and anxious, that play a leading role in how we relate to others, manage stress, and navigate relationships throughout life.

When attachment is insecure, whether due to inconsistent, neglectful, or unavailable caregiving, children can struggle with emotional regulation, anxiety, and difficulties forming healthy relationships. These early interactions profoundly shape mental, emotional, and even physical health, laying the groundwork for how we cope with challenges.

However, recent insights, like those from Dr. Frank Anderson, offer a fresh perspective on attachment. Anderson's work in Internal Family Systems (IFS) therapy suggests that attachment patterns aren't set in stone in early childhood. Instead, he proposes that different parts of

our personality attach to different parts of others and that these attachment styles reflect emotional wounds and protective parts we develop in response to life's difficulties. According to Anderson, healing and growth are possible at any stage of life as we integrate these parts and form healthier connections (Anderson, 2021).

In short, understanding attachment helps us see how our earliest bonds shape our emotional landscape and set the stage for stable, fulfilling relationships. By nurturing secure attachment, especially early in life, we can promote long-lasting emotional health and resilience, not only for ourselves but for future generations. As 1 John 4:18 (NIV) reminds us, ***"There is no fear in love. But perfect love drives out fear, because fear has to do with punishment. The one who fears is not made perfect in love."*** Secure attachment, rooted in love and care, can indeed drive out fear, helping us build trusting and fulfilling relationships that last a lifetime.

Pathway Two
What They See, They Learn: Social Learning

How Do We Absorb Trauma Through Relationship?

Albert Bandura (1977) revolutionized psychology with his theory of social learning. We learn not only through direct experience, but through watching others, especially those closest to us.

Our teens are no different. They are constantly observing, interpreting, and internalizing what they see at home and in their relationships. When they are raised in chaotic or emotionally unsafe environments, they do not just endure trauma. They learn it. They absorb patterns of relating, defensive postures, and ways of handling pain. They watch how shame is hidden, how anger is expressed, how needs are dismissed, and over time, they begin to carry and repeat those same patterns.

These patterns are not just behavioral. They become internalized as normal. And unless they are brought into awareness and intentionally challenged, they can be carried forward into adulthood and passed down to the next generation. This is one of the ways trauma moves through families, not simply through genetics, but through modeling, mimicry, and silence.

And yet, this is not the end of the story.

When these patterns are brought into awareness, they are no longer automatic. They can be named, understood, and gradually changed. This is where resilience begins to take shape, not by erasing the past, but by responding to it differently.

For parents, this means that your presence matters more than your perfection. Even if your teen has absorbed painful patterns, those patterns are not fixed. They can be softened and reshaped through consistent, attuned relationship. When you listen instead of reacting, when you stay engaged instead of withdrawing, when you respond with steadiness in the face of their intensity, you are offering something powerful. You are giving your teen a new relational experience, one that begins to challenge what they have come to expect.

Over time, these repeated moments begin to reshape the internal blueprint. Trust can grow where there was guardedness. Regulation can develop where there was chaos. Connection can deepen where there was distance.

This is how cycles begin to break. Not all at once, and not perfectly, but through small, consistent moments of showing up differently.

HOW DO WE ABSORB TRAUMA *Through Relationship?*

THE POWER OF SOCIAL LEARNING
(BANDURA, 1977)

We learn not only through experience,
but through watching others—**especially** those closest to us.

SOCIAL LEARNING IN ACTION

Children raised in chaotic, emotionally unsafe environments do not just endure trauma; they learn it.

They absorb relational patterns, defensive postures, and ways of handling pain.

1

HOW SHAME IS HIDDEN

They watch how shame is avoided, buried, or denied. They learn to hide, pretend, or disconnect.

2

HOW RAGE IS EXPRESSED

They see how anger shows up—explosive, passive-aggressive, or controlling. They learn to express or suppress in the same way.

3

HOW NEEDS ARE IGNORED

They learn that needs don't matter or won't be met. So they stop asking—or stop believing.

4

AND THEN THEY MIMIC THOSE PATTERNS

These patterns become internalized as normal. They show up in friendships, romantic relationships, and the way they handle stress, conflict, and pain.

5

INTO ADOLESCENCE AND ADULTHOOD

Unless they are brought into awareness and challenged, these patterns get passed down to the next generation.

THIS IS HOW TRAUMA MOVES THROUGH FAMILIES—
NOT THROUGH GENETICS, BUT THROUGH MODELING, MIMICRY, AND SILENCE.

THE CYCLE CAN CHANGE.

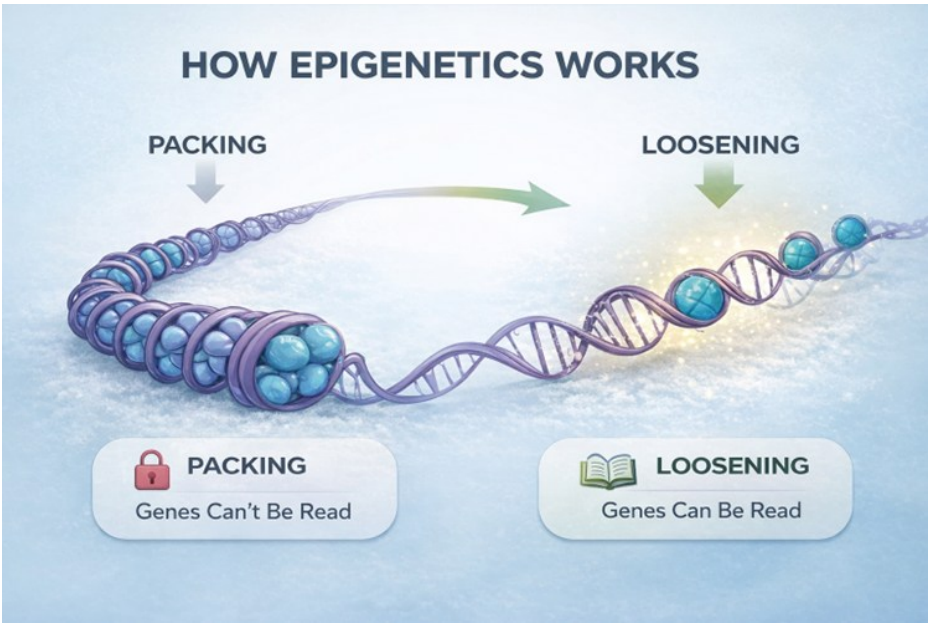
- Awareness interrupts automatic patterns.
- Safe relationships create new experiences.
- New patterns become the new normal.
- Healing breaks the cycle.

WHEN WE MODEL SAFETY, RESPECT, AND EMOTIONAL CONNECTION,
we teach our children a different way to be— AND A DIFFERENT FUTURE IS **POSSIBLE.**

Pathway Three
Biology Speaks: Epigenetics

The third, and perhaps most sobering, pathway is biological. Trauma does not simply shape how our teens think or how they relate to others. It can reach even deeper into the very systems that govern how their bodies function and respond. In ways that are often invisible to us, trauma can influence how their genes express themselves through a process known as epigenetics.

Epigenetics refers to chemical modifications that sit on top of our DNA, influencing whether certain genes are turned on or off, or more simply, whether they are read or not read, without changing the genetic code itself. These changes are not random. They are shaped by experience, especially by chronic stress, adversity, and trauma (Moore et al., 2013). In other words, what our teens live through can leave a biological imprint on how their bodies operate.



To understand this, it can help to think of our genes as a vast library of instructions stored within every cell of our body. These instructions tell our cells how to build proteins, the essential components of nearly everything within us, including our muscles, our hormones, our neurotransmitters, and even the chemistry of our brain. But having the instructions is not the same as using them. Those instructions have to be read.

This is where epigenetics becomes so important. It helps determine which parts of that library are opened and which remain closed, which instructions are read and which are left untouched. Some experiences signal the body toward growth, regulation, and resilience. Others, particularly prolonged stress and trauma, can signal the body toward protection, survival, and heightened reactivity.

For our teens, this matters more than we often realize. The environments they grow up in, the relationships they experience, and

the stress they carry all shape which "books" are pulled from the shelf. Systems designed for protection can become overactive, firing too quickly and too often, while systems that support calming, balancing, and connecting are slower to engage. Over time, this can leave a teen feeling on edge, disconnected, or overwhelmed, not because something is wrong with them, but because their nervous system has adapted to the world as they have experienced it.

Over time, this imbalance manifests across multiple domains, including increased anxiety, emotional volatility, depression, and chronic stress reactivity. These effects extend beyond psychological functioning to include disruptions in sleep, impairments in attention and concentration, and physiological consequences such as obesity, metabolic dysfunction, autoimmune processes, and early cardiovascular risk.

For many adolescents, this means that trauma does not simply live in their memories. It shapes how their bodies respond to the world, how quickly they move into fear or overwhelm, and how difficult it can feel to return to a sense of calm. It is not just something they think about. It is something they carry.

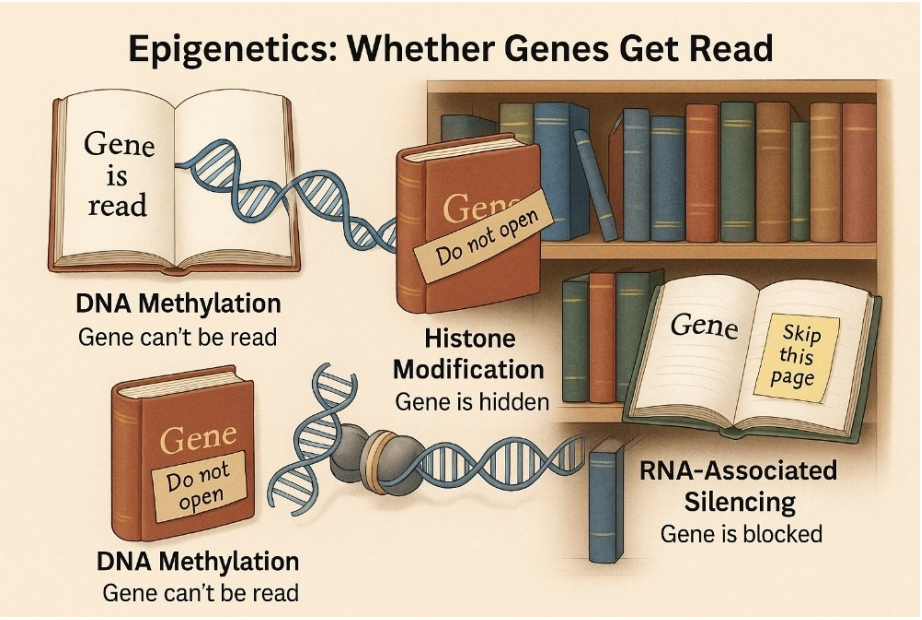
And yet, even here, there is something deeply hopeful. These patterns are not fixed. Just as difficult experiences can influence which genes are expressed, new experiences, especially those grounded in safety, connection, and consistent care, can begin to shift what gets "read" and what does not in a healing direction.

The library is still there. And over time, through relationship, stability, and intentional support, it can be accessed in a different way, one that supports resilience, regulation, and growth.

DNA methylation is like putting tape over a book cover. The book is still in the library, but the tape keeps anyone from opening it. The gene is there, but it can't be read, so its instructions are never used.

Histone modification is about how tightly the DNA is wrapped around its packaging proteins (the histones). If the DNA is wound too tightly, it's like books shoved so hard into the shelf that you can't pull them out, those genes stay hidden and unread. But if the DNA is loosened too much, books can be pulled out that maybe shouldn't be read at that moment, and their instructions get used when they're not supposed to.

RNA-associated silencing is like slipping a sticky note over certain pages that says, "Skip this." The words are still printed, but the cell's machinery moves right past them, leaving the instructions unused.



These processes are vital in early development, but they can also be hijacked by trauma. The impact is not theoretical. It is real, and it is measurable. One of the most sobering examples comes from Holocaust survivors. Dr. Rachel Yehuda and colleagues (1998) found that the children of Holocaust survivors, who never experienced the camps themselves, carried biological imprints of their parents' trauma. Their stress response systems were altered. Their genes carried the memory of fear. The trauma became a biological inheritance.

The Dutch Hunger Winter offers another powerful case. In the winter of 1944 to 1945, the Nazis blockaded food supplies to punish the Dutch resistance, plunging the country into famine. Over 20,000 people starved to death. Pregnant women, in particular, were deeply affected. Their children, still in utero during the famine, were later found to have epigenetic changes in key genes like IGF2, which is linked to growth and metabolism. As adults, these individuals faced higher risks of obesity, heart disease, diabetes, schizophrenia, and even premature death. What they endured in the womb shaped their lifelong health, and remarkably, these changes were also found in their children and grandchildren (Heijmans et al., 2008).

Imagine your teen carrying the biological memory of a winter they never lived through. Imagine them stepping into the world already marked by stress or scarcity, their body tuned to survive something they did not directly experience. That is the power of epigenetics.

These are not just fascinating ideas from research. They point to something deeply human and deeply spiritual. Trauma can write itself into the body. It can embed into the nervous system, the immune system, hormonal pathways, and even influence how genes are expressed. It can shape how our teens perceive danger, how they handle emotion, and how they connect, or disconnect, from others.

And yet, this is not the end of the story.

Just as trauma can influence biology, healing can begin to restore it. Research shows that many epigenetic changes are not permanent. The same nervous system that adapts to survive can also be reshaped

through experiences of safety, connection, and truth. For our teens, this includes consistent, secure relationships, meaningful connection with others and with God, healthy rhythms of sleep and activity, good nutrition, and trauma-informed care when needed.

Over time, these experiences begin to shift what has been written. Patterns can soften. Reactivity can decrease. Capacity for regulation, connection, and resilience can grow. The scars may not fully disappear, but the story does not have to stay the same.

This brings both responsibility and hope. Our teens are not stuck. They are not defined by what came before them. And as parents, we are not powerless in this process. Through steady presence, wise choices, and faithful love, we can help shape a different biological and relational legacy.

As Scripture reminds us in Deuteronomy 30:19, ***"Now choose life, so that you and your children may live."*** And in Exodus 20:5–6, while the impact of sin may reach across generations, so does the promise that God ***"lavishes unfailing love for a thousand generations on those who love Him and keep His commands."***

Trauma may shape a family line, but so can faith. So can love. So can healing. The chain of suffering can be broken, and for our teens, that process can begin right here, in the relationships and choices we make today.

The NeuroFaith® Response: Reversing the Curse

The NeuroFaith® model recognizes that trauma is not simply a psychological wound. It is a neurological, physiological, relational, and spiritual rupture. And healing requires access to all four domains.

Through polyvagal-informed therapy, HeartMath® neurocardiology, Internal Family Systems (IFS), and authentic Christian faith, we offer a path to reconnect body, brain, and soul.

For adolescents living in quiet despair, this matters deeply. Because what they are experiencing is not weakness. It is not failure. It is the natural consequence of carrying more than they were ever meant to carry, often without the support or understanding they needed. Their nervous systems are shaped by what they have lived through. Their beliefs are shaped by what they have come to believe about themselves. And yet, neither is fixed.

This is not about symptom suppression. It is about genuine transformation. It is about helping young people take ownership of their healing while holding onto something even more powerful, the hope that God can restore what was broken, even at the level of biology. Yes, trauma may run in families, but so can healing. Yes, emotional pain may leave its imprint on the nervous system, but those patterns can be rewritten. Through God's grace, power, and intentional therapeutic work, the darkness does not win.

There is always hope. And there is always a way forward. That path is not easy, and it will require courage, especially for adolescents who are just beginning to make sense of their inner world. But they do not walk it alone. We walk it with them, and more importantly, God walks beside them, restoring what was fractured, reconnecting what was severed, and rewriting the story at every level, biological, relational, and spiritual.

"The light shines in the darkness, and the darkness has not overcome it" (John 1:5, NIV).

In a fallen world, trauma is common, but healing is possible. The NeuroFaith® model understands that the path forward is not primarily about reducing symptoms. It is about reconnection, to self, to others, and to God. It is about helping adolescents begin to question the story trauma wrote in them and to replace it with something truer, something stronger. As we ask, ***"Where were you wounded?"*** we must also ask, ***"How can we help you heal and reclaim your story?"***

And we are reminded of the promise in Isaiah, a promise that speaks directly into despair and calls forth resilience. ***"The Spirit of the Sovereign Lord is on me... He has sent me to bind up the brokenhearted... to comfort all who mourn... and to bestow on them a crown of beauty instead of ashes"*** (Isaiah 61:1).

This is our hope. That what trauma tried to destroy, Christ can restore. That the brain, the body, and the soul can be healed. That adolescents who once believed they were invisible, unworthy, or beyond repair may one day say with confidence, ***"I am loved. I belong. I have purpose. And I matter."***

The story is not fixed. What was once shaped by pain and distortion can be reshaped by truth. And as that truth takes root, resilience begins to grow.

And for the adolescent standing in the tension between despair and hope, that freedom is not theoretical. It is the beginning of a new life.

Cause Five Ideologies of Disorientation

How Radical Theories Are Rewriting Childhood and Undermining Identity

"The truth knocks on the door, and you say, 'Go away, I'm looking for the truth,' and so it goes away. Puzzling."

—Robert M. Pirsig

Adolescence has always been a season of searching, a time when young people begin to form a coherent sense of who they are, where they belong, and what their lives mean. This developmental process is not only natural, it is essential. It is how a child grows into a stable, grounded adult. Yet today's adolescents are navigating this critical window in a cultural environment that is markedly different from any generation before them, one that presents an unprecedented volume of competing messages about identity, gender, sexuality, and selfhood. These messages often do more than invite exploration. They challenge the stability of the body, the coherence of identity, and the formative influence of family, faith, and tradition. For a developing mind, this can create not clarity, but fragmentation.

We recognize that thoughtful, well-meaning people may disagree with our perspective. These are complex and deeply personal issues. However, after a deep dive into this topic, including careful study of its historical development, clinical implications, and cultural trajectory, we feel a clear responsibility to present what we believe to be an accurate and necessary understanding of the current landscape. Our intent is not to provoke, but to illuminate. Avoiding these conversations does not protect young people. In many cases, it leaves them without the guidance they need during one of the most vulnerable periods of development.

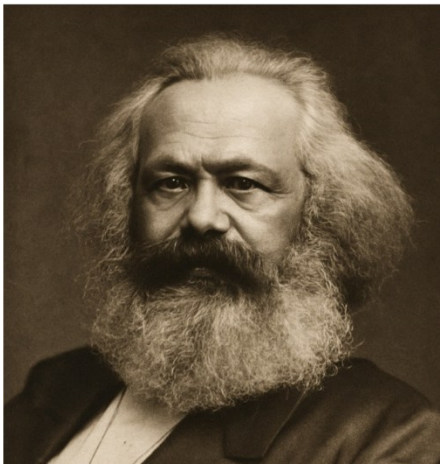
What we are witnessing is not merely a shift in cultural attitudes, but a broader redefinition of how identity itself is understood and formed. Over time, influences from media, education, and digital environments have converged to emphasize self-definition in ways that can become disconnected from biological, relational, and even spiritual foundations. Adolescents, whose brains are still developing the capacity for long-term reasoning and stable self-concept, are particularly susceptible to these pressures. Rather than moving steadily toward an integrated sense of self, many experience confusion, anxiety, and an increasing preoccupation with identity categories, particularly around sexuality and gender. This focus can come at the expense of building resilience, competence, and a deeper, more enduring sense of personhood.

It is important to be clear that adolescents themselves are not the problem. They are responding, often sincerely, to the world they have been given. The responsibility rests with the broader cultural forces that shape that world and with the adults who are called to guide them. As clinicians, parents, and people of faith, we believe it is essential to

engage these realities with both clarity and compassion, holding together truth and care rather than allowing one to eclipse the other.

In the pages that follow, we seek to trace how we arrived at this moment and to examine its impact on the developing adolescent mind. We also aim to offer a path forward that supports identity formation in a way that is grounded, coherent, and life-giving. For those who share a faith perspective, this includes the conviction that identity is not something we must construct in isolation, but something that can be discovered and restored in alignment with what is true and enduring. The stakes are significant. Adolescence is too important a season to leave young people alone in confusion. They need guidance that is thoughtful, courageous, and oriented toward wholeness.

From Oppression to Alienation: The Marxist Foundation



At the foundation lies Karl Marx's belief that the central human struggle was one of oppression and alienation (Tinker, 2020). In Marx's model, the capitalist system dehumanized the worker, estranging him from the fruit of his labor, from his fellow man, and ultimately from himself. This fourfold alienation, ***from the act of production, the product made, other workers, and identity***, was not just an economic condition for Marx but a psychological one. The

remedy, in his view, was radical upheaval: "revolutionary terror" to accelerate the demise of the old order and usher in a classless utopia (Smith, 2020).

But the revolution didn't unfold as Marx predicted. Industrial workers did not rise up in Western Europe or America. Instead, the revolution emerged in Russia and China, driven not by laborers but by intellectuals and students, supported by peasants. This gap between Marx's theory and reality left future thinkers with a question: Why did the West resist the revolution?

Gramsci and the Long March Through Culture

Antonio Gramsci (1891–1937), writing from Mussolini's prisons, provided a critical answer. The West had not succumbed to Marxism because it was still held together by Judeo-Christian values—by a spiritual and moral consensus that resisted ideological subversion. Gramsci concluded that as long as religion, tradition, and family structures held sway, no political revolution could take root. So rather than attack these institutions outright, Gramsci proposed a subtler strategy: infiltration.

This strategy came to be known as ***cultural hegemony***, the slow takeover of society's formative institutions, including schools, churches, media, and civil agencies (Tinker, 2020). The goal was not to

overthrow power but to ***reshape the cultural consciousness itself***, redefining what was considered "normal" and "good." As German student radical Rudi Dutschke would later call it, this was "the long march through the institutions."

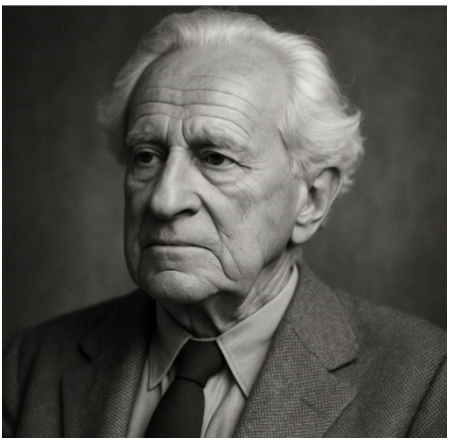
Samuel Kronen (2006, cited in Tinker, 2020) pointed out that this approach reframed Marx's class-based conflict into a broader ideological framework that could be applied across categories—race, gender, sexuality, and beyond. In this model, every power differential was reframed as oppression, and every societal norm became suspect.

The Frankfurt School and the Critical Deconstruction of Norms

In the early 20th century, the Frankfurt School emerged from the Institute for Social Research in Germany, further advancing these ideas. The thinkers of this movement, Horkheimer, Adorno, Marcuse, Fromm, and others, developed what became known as **Critical Theory,** a framework that sought not to understand society but to critique and ultimately transform it.

Herbert Marcuse, perhaps the most influential figure of the group, fused Marxist and Freudian thought into a potent critique of Western society. In his 1965 work ***Repressive Tolerance***, Marcuse argued that the supposed tolerance of liberal democracies was actually a mechanism of control. True liberation, he claimed, required the suppression of dissenting viewpoints, particularly

those that supported traditional norms or conservative beliefs (Marcuse, 1965; Walsh, 2017).



This inversion, where "tolerance" now justified censorship, planted seeds that have flowered in cancel culture, academic intolerance, and the suppression of any narrative not aligned with prevailing progressive ideologies. This has had real consequences in medical and psychological fields, where voices advocating caution in gender transitions for children have often been silenced or defamed.

Michael Walsh (2017) noted that Marcuse's ideas energized the countercultural Left of the 1960s, infusing youth culture with slogans like "make love, not war," and promoting a worldview in which sexual restraint was repressive, and gratification was the new moral compass. These notions, once radical, became mainstream in many corners of education, media, and therapy today.

Queer Theory and the Disassembly of Identity

In the 1990s, these currents coalesced into Queer Theory, which sought to deconstruct all traditional notions of gender and sexuality. Rooted in poststructuralism, it framed identity not as biological or innate, but as performative and malleable (Indiana University Libraries, 2023).

Michel Foucault's *The History of Sexuality* (1976) laid the groundwork by arguing that sexuality was socially constructed, not biologically

fixed. Judith Butler's *Gender Trouble* (1990) built on this, positing that gender is not something we are but something we do - a performance repeated until it becomes internalized (Duignan, 2023).

Yet some proponents of this movement went even further. Dr. Em (2019a), in *The Trojan Unicorn*, exposed how some theorists stretched Foucault's logic to deeply troubling places. Foucault not only questioned age-of-consent laws, he actively advocated for their abolition. He suggested that children might desire sexual contact with adults, and that legal norms around such protections actually constructed the concept of harm itself. These views, though shocking, were not fringe in early Queer Theory discourse.

Judith Butler, too, has argued against legal prohibitions on incest and intrafamilial sexual abuse, claiming such restrictions reinforce oppressive norms (Em, 2019b). Her views, cloaked in academic language, challenge the most basic safeguards we have for children's well-being.

As Edsinger (2023) writes, Queer Theory has framed trans-identification as the highest form of liberation, a mantle of moral heroism. Children, eager to belong, are taught that their most defining truth lies in their gender identity, rather than in their capacity to grow, learn, and love. The result is a psychological landscape of deep confusion.

Confusion and Collapse: What Children Are Losing

The adolescent years are meant to be a season of becoming, of forming an identity rooted in resilience, competence, and authentic connection to others. Instead, young people have been immersed in a world that encourages them to disidentify from their own biology and distrust inherited wisdom.

The exposure of children to sexualized content, whether in curricula, media, or therapy, distorts development in serious ways. It:

1. Distorts perceptions of sexuality, replacing relational bonding with commodified or performative sexuality.
2. Prematurely sexualizes children, which disrupts emotional regulation and developmental sequencing.
3. Diverts attention from academic and relational growth, undermining competence and self-esteem.
4. Leads to addiction and compulsivity, as exposure rewires reward circuits.
5. Exacerbates anxiety, depression, and body image disorders.

6. Undermines the importance of consent, safety, and personal boundaries.
7. Erodes trust between parents and schools, fueling intergenerational tension.
8. Pressures children to conform to hypersexual norms, damaging authenticity.
9. Opens institutions to legal and ethical consequences, particularly when content is developmentally inappropriate.

In bringing this together, we want to again be clear that our aim is not to provoke, but to bring clarity. The ideas we have explored are complex and have developed over time, yet their influence on adolescents today is both real and significant. To understand this moment requires not only sensitivity, but a willingness to look carefully at the broader cultural forces shaping identity during one of the most critical stages of development.

While thoughtful people may see these issues differently, we believe there is a responsibility to engage them honestly. Adolescents are not the problem. They are responding, often sincerely, to a world that is asking them to define themselves in ways that can outpace their developmental readiness and, at times, lead to confusion rather than coherence.

Naming what is happening is not about judgment. It is about guidance. When we understand the landscape more clearly, we are better equipped to walk alongside young people with steadiness, truth, and compassion, helping them move toward a sense of identity that is grounded rather than fragmented.

If we are willing to engage this thoughtfully, we can begin to restore a path where identity is formed through resilience, connection, and a deeper understanding of self. That is the work before us, and it is work that matters deeply for the well-being of the next generation.

"So, God created human beings in His own image. In the image of God he created them: Male and female He created them" (Genesis 1:27).

Cause Six

When the Family Fractures: Attachment, Divorce, and the Erosion of Resilience

Although we have already discussed throughout this book how trauma, attachment disruptions, neglect, emotional dysregulation, technology overexposure, social isolation, spiritual disconnection, and cultural fragmentation can all profoundly affect the developing child, we felt it was important to address one particular issue more directly and intentionally in its own standalone section: the growing fragmentation and breakdown of the family itself.

We do so carefully and with great humility because nearly all of us have been touched by relational pain in some form. Some reading this chapter are divorced. Some grew up in fractured homes. Some are trying heroically to parent alone. Some are navigating blended families, conflict, betrayal, abandonment, addiction, or years of unresolved hurt. This chapter is not written to condemn you, shame you, or reduce extraordinarily painful and complicated situations into simplistic moral slogans.

In fact, many divorced mothers and fathers are loving, sacrificial, deeply devoted parents who are doing everything within their power to provide emotional safety, stability, and love for their children. Some divorces occur in situations involving abuse, addiction, severe conflict, abandonment, or chronic dysfunction where separation may ultimately reduce harm rather than increase it. We recognize that reality fully and compassionately.

At the same time, we also believe we have become increasingly casual about relational fragmentation in modern culture. Divorce, father absence, emotional disengagement, chronic family instability, fractured attachment systems, and the erosion of embodied family and community structures have become so commonplace that we sometimes fail to appreciate the profound emotional burden many children quietly carry within them.

There are moments in every generation when we are forced to stop and honestly ask ourselves difficult questions. Why are so many of our children anxious, depressed, lonely, emotionally overwhelmed, and struggling to find hope? Why do increasing numbers of adolescents battle despair, addiction, self-harm, emotional dysregulation, and a

pervasive sense of emptiness at younger and younger ages? Why do so many young people seem emotionally exhausted before they have even fully entered adulthood?

As we have explored throughout this book, these struggles do not emerge from a vacuum. Trauma matters. Technology matters. Sleep deprivation matters. Social media matters. Meaninglessness matters. Spiritual disconnection matters. Isolation matters.

And we believe the breakdown of stable family attachment systems matters deeply as well.

Children experience family very differently than adults do.

Adults often understand divorce through the lens of conflict resolution, compatibility, betrayal, exhaustion, unhappiness, or emotional survival. Children, however, experience it through the lens of attachment, safety, identity, belonging, predictability, and fear. Their developing nervous systems absorb instability long before they possess the cognitive maturity to explain what they are feeling internally.

The family, ideally, is meant to be the child's first experience of safety, attunement, regulation, belonging, structure, affection, repair, guidance, and love. It is within the family system that children first learn whether the world is safe, whether emotions can be regulated, whether relationships are trustworthy, whether conflict can be repaired, whether people remain emotionally present when life becomes difficult, and whether they themselves are valued and worthy of love.

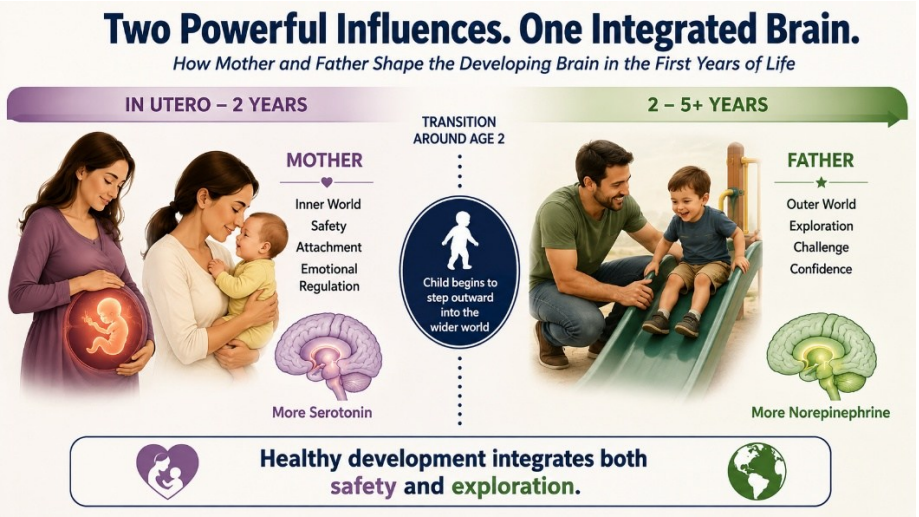
Long before resilience becomes internal, it is first experienced relationally.

As noted earlier, the pioneering work of John Bowlby and Mary Ainsworth transformed our understanding of attachment and emotional development. Building upon their work, Dr. Allan Schore's groundbreaking integration of attachment theory and developmental neuroscience has further demonstrated how profoundly early relational experiences shape the developing brain itself. In his 2017 Oslo lecture on attachment and emotional development, Schore (2017) emphasized that early caregiver attunement plays a central role in shaping the infant's developing right hemisphere, particularly systems involved in emotional regulation, stress modulation, relational safety, and the development of the sense of self.

Schore's work further emphasizes that attachment theory has increasingly evolved into what is now often referred to as regulation theory. In other words, children first learn emotional regulation through emotionally attuned relationships with caregivers. The developing nervous system is literally shaped within the relational environment of the family. During infancy, this attachment process occurs largely through right-brain-to-right-brain communication between the infant and caregiver through facial expression, tone of voice, touch, eye contact, emotional presence, and nonverbal attunement. These thousands upon thousands of moments of co-regulation gradually help the child develop an internal sense of safety, trust, stability, and emotional grounding.

Importantly, Schore (2017) also noted that while maternal attachment experiences are especially dominant during infancy, paternal involvement often becomes increasingly influential during the toddler years, contributing to exploration, symbolic play, confidence, challenge, emotional regulation, and expanding social development.

This does not mean mothers and fathers serve rigid or interchangeable roles, nor does it diminish the remarkable sacrifices made by single parents, grandparents, adoptive parents, or blended families. Rather, the broader developmental point is that children generally benefit from stable, loving, emotionally available, complementary relational influences that help foster both safety and growth.



The growing prevalence of father absence has therefore become an increasingly important area of developmental research. Again, we approach this carefully and compassionately. This is not about idealizing every two-parent home or diminishing the heroic efforts of single parents. Rather, it is about honestly acknowledging what the research increasingly reveals about the importance of healthy paternal involvement in child development.

In their major systematic review of longitudinal studies, Sarkadi, Kristiansson, Oberklaid, and Bremberg (2008) found that positive father involvement was associated with stronger cognitive development, improved academic achievement, healthier behavioral

regulation, greater emotional stability, reduced delinquency, lower rates of psychological distress, and stronger social competence in children and adolescents. Their findings suggested that engaged fathers often play a significant role in helping children develop confidence, self-regulation, resilience, and social functioning over time.

And as we have seen earlier, the landmark Adverse Childhood Experiences (ACE) Study identified parental separation or divorce as one of the major adverse childhood experiences associated with increased long-term risks for emotional, relational, behavioral, and physical health difficulties later in life (Felitti et al., 1998).

One of the heartbreaking realities we often see clinically is that children frequently experience divorce through a profoundly self-referential lens. Developmentally, children are naturally egocentric in the sense that they tend to interpret major events around them in relationship to themselves. Many quietly internalize the belief that they somehow caused the divorce, should have prevented it, or now carry responsibility for fixing the emotional damage surrounding it.

Beneath the surface, many children silently wrestle with questions they rarely articulate aloud: "*If I had behaved differently, would Mom and Dad still be together? If I had been better, quieter, less emotional, less difficult, smarter, or more lovable, would this have happened?*"

For some children, the divorce itself becomes not merely a relational disruption, but a shame wound embedded within the attachment system. The child begins to experience himself or herself not merely as hurt, but somehow fundamentally responsible for the suffering unfolding around them.

And because children instinctively seek attachment security, many begin adapting themselves around the emotional instability of the family rather than simply continuing the ordinary developmental work of childhood and adolescence. Instead of being free to play, explore, mature, develop friendships, discover identity, and gradually move toward healthy independence, some children become emotionally hypervigilant and prematurely burdened with adult emotional responsibilities.

Some become peacemakers. Some become caretakers. Some become emotional referees between parents. Others become excessively responsible, anxiously monitoring the emotional state of struggling mothers or fathers in an attempt to keep the family emotionally intact.

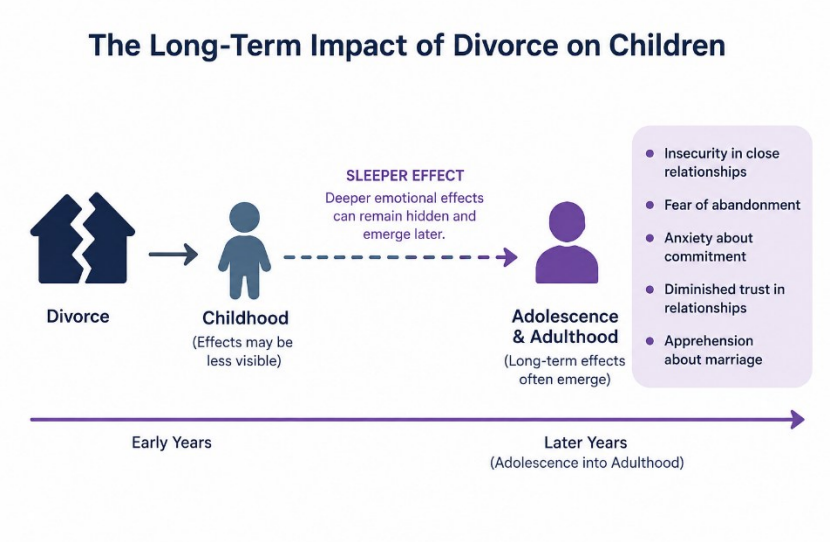
In some cases, children become deeply fearful that a distressed parent may emotionally collapse, abandon them, or even die.

One adolescent I (Jeff) worked with lived in chronic fear that his father, who had previously struggled with suicidality, might take his own life with a shotgun following the divorce. The young man became emotionally consumed with monitoring his father's emotional condition, almost functioning as an ongoing suicide watch despite still being only a child himself. Rather than focusing on his own developmental tasks, friendships, identity formation, academics, and emotional growth, his nervous system became organized around fear, vigilance, responsibility, and the desperate attempt to keep his father alive.

This is what unresolved attachment trauma and chronic relational instability can sometimes do to children. The child stops simply being a child.

Judith Wallerstein's seminal longitudinal research on divorce further challenged the once-common assumption that children simply "bounce back" quickly following parental divorce. In her landmark 25-year longitudinal study, ***The Unexpected Legacy of Divorce***, Wallerstein, Lewis, and Blakeslee (2000) found that many children carried the emotional effects of divorce well into adolescence and adulthood.

A significant number struggled with insecurity in close relationships, fear of abandonment, anxiety regarding commitment, diminished trust in relationships, and apprehension about marriage itself. Wallerstein also described what she termed the "sleeper effect," observing that some of the deeper emotional consequences of divorce often did not fully emerge until adolescence or young adulthood, particularly when individuals themselves began entering serious romantic relationships. The attachment wounds that may have appeared muted during childhood often resurfaced later through fears of betrayal, instability, rejection, abandonment, and relational failure.



Importantly, Wallerstein did not argue that all children of divorce are destined for dysfunction. Far from it. Rather, her work helped remind us that children often experience divorce far more deeply and developmentally than many adults initially recognize.

Again, our goal in discussing these realities is not condemnation. It is awareness.

If we are willing to acknowledge these realities honestly, thoughtfully, and compassionately, we create greater opportunities for healing, emotional repair, healthy co-parenting, emotional attunement, stable connection, healthy boundaries, and emotionally available caregiving. Children are remarkably resilient when surrounded by adults who help them feel safe, seen, emotionally held, and deeply loved even in the midst of family pain.

And this is important: fragmented attachment wounds are not beyond healing.

In the pages ahead, we will discuss many of the ways healing and repair can begin to occur. Secure attachment can be strengthened. Emotional safety can be rebuilt. Shame can be addressed. Trust can slowly be restored. Nervous systems can settle. Families can learn healthier patterns of communication, emotional presence, regulation, and repair. Adolescents can begin rediscovering resilience, meaning, connection, and hope even after significant relational pain.

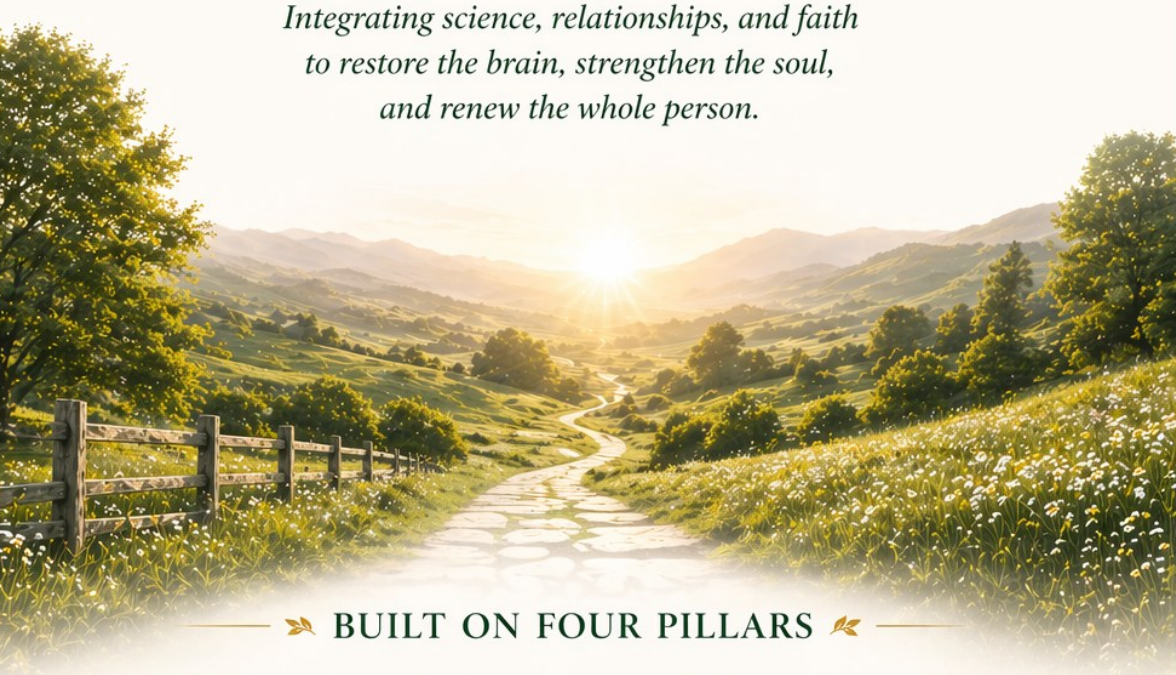
None of this is easy work. But healing is possible.

And perhaps now more than ever, our children desperately need us to believe that

PART III

The NeuroFaith® Model for Healing

Integrating science, relationships, and faith to restore the brain, strengthen the soul, and renew the whole person.



BUILT ON FOUR PILLARS

POLYVAGAL-INFORMED THERAPY

Understanding the nervous system to promote safety, regulation, and healing from the inside out.

HEARTMATH® / NEUROCARDIOLOGY

Using the power of the heart and the science of the heart–brain connection to reduce stress and build resilience.

INTERNAL FAMILY SYSTEMS (IFS)

Healing the inner family, understanding each part, and restoring harmony within.

FAITH AND SPIRITUALITY

Anchoring in truth, finding purpose, and nurturing the soul for lasting hope and direction.

The Four Pillars of Healing

A Restorative Pathway for Addiction, Depression, and Anxiety

"Let all that I am praise the Lord;
may I never forget the good things he does for me. He
forgives all my sins
and heals all my diseases."

- Psalm 103:2-3

As we have established, depression, anxiety, trauma related distress, and other forms of adolescent despair are not simply mental states. They are whole person experiences that touch every part of us, body, brain, soul, and spirit. For many adolescents, what they are carrying is far deeper than what is visible on the surface.

Behind the withdrawal, the irritability, the numbness, or the quiet sadness, there is often a story. A story shaped by experiences they did not choose, emotions they do not yet have language for, and burdens they have been trying to carry largely on their own. What we often label as depression or anxiety is, in many cases, the outward expression of something much deeper. It reflects accumulated stress, unresolved pain, relational wounds, and a growing sense of disconnection from self, from others, and at times, from God.

And all of this is unfolding during one of the most formative seasons of life. Adolescents are still becoming. Their brains are still developing. Their identities are still taking shape. Their understanding of who they are, whether they are valued, and where they belong is still being written. So, when despair enters here, it does not simply affect how they feel in the moment. It begins to shape how they see themselves and their future.

But even here, even in the places that feel the heaviest, light still breaks through. Healing is not only possible, it is real. Not just temporary relief, but meaningful restoration. A return to something grounded, connected, and alive again. There is a way forward. Not a quick fix or a surface level answer, but a thoughtful path that honors both the complexity of the brain and the depth of the human soul. As it is written, ***"The light shines in the darkness, and the darkness has not overcome it"*** (John 1:5, NIV).

Before introducing the **four pillars** of this healing model, it is important to understand the difference between ***incremental*** and ***transformational*** approaches to care. Both matter, especially for adolescents who may feel overwhelmed by the intensity of their internal world.

Approaches such as Cognitive Behavioral Therapy and Dialectical Behavior Therapy can provide important tools. They help adolescents slow things down, regulate emotion, and find their footing in moments that feel overwhelming. In times of acute distress, these approaches can be stabilizing and at times lifesaving.

And yet, over time, something becomes clear. These approaches, while helpful, often address how to cope with distress but do not fully reach the deeper places where that distress was formed. They help adolescents manage what they feel, but they do not always help them understand why it feels so heavy or how it became part of their story.

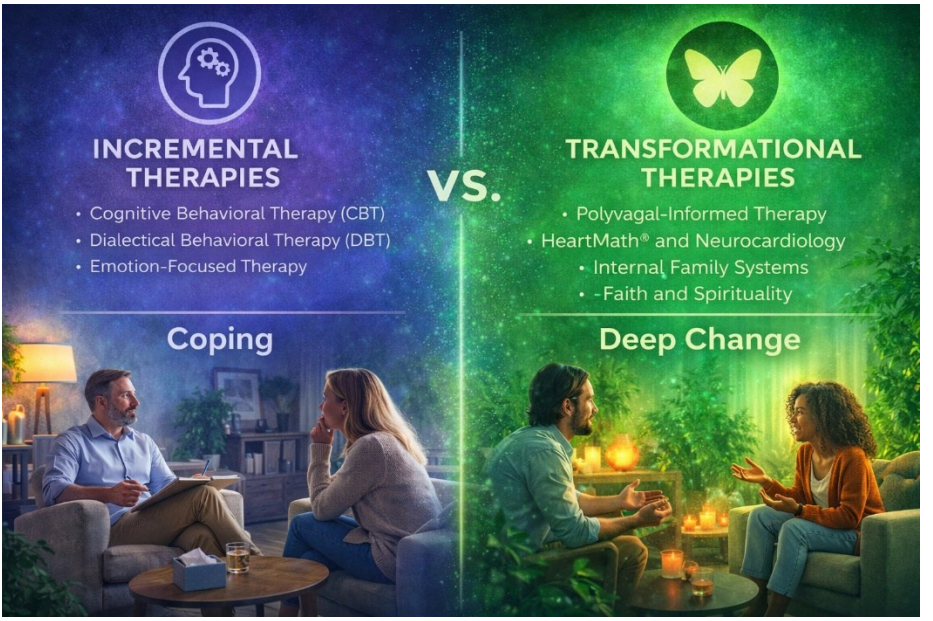
Adolescents are not only trying to get through the day. They are trying to understand who they are. They are asking questions about worth, belonging, identity, and purpose, even if those questions are not spoken out loud. Beneath the surface, there is often a longing to feel known, to feel safe, and to believe that their life has meaning.

What they need is more than symptom management. They need a path toward healing that helps them reconnect with themselves, experience safe and meaningful relationships, and begin to reshape the story they carry about who they are. They need something that not only stabilizes them but strengthens them.

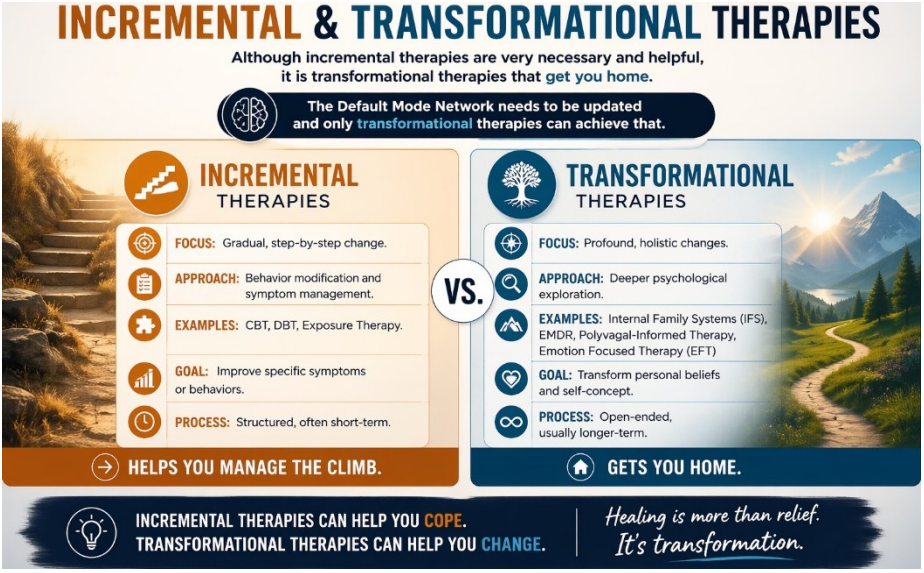
That is the heart of the NeuroFaith® model. Not only to help adolescents feel better, but to help them become whole. To help them move from despair toward resilience, from disconnection toward belonging, and from confusion toward clarity about who they are and why they matter.

Because the goal is not simply to reduce symptoms.

It is to help them rediscover hope.



By contrast, the therapies we present in this chapter, the four pillars of the **NeuroFaith® Model** are ***transformational.*** These are not just symptom-management strategies. They invite deep, systemic change. They help rewire the brain, calm the autonomic nervous system and, critically, transform the default mode network, the network of the brain responsible for self-referential thought, shame-based narratives and internal rumination. Transformational therapies reach the inner core. They do not merely equip you to survive; they offer a path toward wholeness.



The NeuroFaith® Model is not a collection of isolated techniques, but a set of integrated, synergistic pathways designed to realign the nervous system, rewire the brain, reawaken the heart, and restore the soul. For teens and adolescents, this is not simply about managing symptoms of anxiety or depression. It is a guided journey back to who they truly are, their God-given identity, beneath layers of shame, fear, and dysregulation that may have come to define their experience. Through this process, young people begin to experience nervous system healing, the reintegration of fragmented parts of themselves, and the emergence of a deeper, more stable sense of peace, connection, and identity.

In the following sections, we'll walk through these four interlocking pillars:

1. **Polyvagal-Informed Therapy**: Healing through the language of the nervous system, recalibrating the body's threat response and shifting from survival states to safety and connection.
2. **HeartMath® and Neurocardiology**: Reconnecting with the heart as an intelligent center of emotional processing, coherence, and spiritual resonance.
3. **Internal Family Systems (IFS):** Mapping the inner landscape of parts and burdens, welcoming even the exiled and protective aspects of the self into compassionate relationship and healing.
4. **Faith and Spirituality:** Rediscovering a living connection with the Divine, where grace replaces shame and love replaces fear. For many, this includes a return to the God who heals and restores.

Together, these four pillars form a holistic, hope-centered framework for recovery. This is not just about coping. This is about transformation.

Pillar One

Polyvagal-Informed Therapy

Building on what we have already explored about the body, and specifically the autonomic nervous system, Polyvagal-informed therapy invites us to understand something profoundly important. Our emotional world is not just in our thoughts. It is rooted in our body.

For adolescents navigating depression, anxiety, and despair, this is a game changer. Because what they are feeling is not random, and it is not a sign that something is "wrong" with them. It is their nervous system doing its best to respond to a world that has at times felt overwhelming, unpredictable, or unsafe.

Polyvagal-informed therapy helps us understand that a teen's sense of well-being is deeply tied to whether their body feels safe, connected, and calm. When a young person's body begins to experience safety, everything starts to shift. Emotions become more manageable, relationships feel more accessible, and the future begins to feel possible again. Healing, then, does not begin by forcing teens to think differently, but by helping their bodies relearn what it means to feel safe.

Dr. Stephen Porges and his son Seth Porges capture this beautifully in their book *Our Polyvagal World: How Safety and Trauma Change Us*. Unlike earlier, more technical works, this book brings these ideas to life in a way that is both accessible and deeply encouraging. They summarize Polyvagal Theory in one powerful sentence: "How safe we feel is crucial to our physical and mental health and happiness" (Porges & Porges, 2023, p. 13).

Pause on that for a moment. For the adolescent who feels anxious, shut down, overwhelmed, or disconnected, this means something hopeful. It means their struggle is not just about willpower or mindset. It is about safety. And safety can be rebuilt.

Porges and Porges go on to say, *"When we feel safe, our nervous systems and entire bodies undergo a massive physiological shift that primes us to be healthier, happier, and smarter; to be better learners*

and problem-solvers; to have more fun; to heal faster; and generally, to feel more alive" (Porges & Porges, 2023, p. 13).

For adolescents, this is nothing short of transformative. Imagine what it means to move from constantly feeling on edge or shut down to feeling regulated, present, and engaged with life. This is not a small shift. It is a fundamental change in how the body and brain experience the world.

Trauma, as they explain and as we have noted earlier, does not just affect the brain. It extends throughout the entire nervous system. It shapes how we perceive the world, how our body reacts to stress, how our organs function, and how we experience both physical and emotional health. Trauma lives in the body. But here is the hopeful truth. If it can be stored in the body, it can also be healed in the body.

Polyvagal Theory helps us move the conversation beyond simply asking, *"What happened to you?"* and toward understanding, *"What did that experience do inside your body?"* This shift is powerful, especially for adolescents, because it removes shame and replaces it with understanding. It says, your reactions make sense. Your body learned this. And what has been learned can be reshaped.

At the center of this process is the vagus nerve, a remarkable pathway that connects the brain to the body and plays a central role in how we experience safety and connection. Through this pathway, there is not only an explanation for how trauma becomes embedded in us, but also a pathway out. A way toward regulation, toward connection, toward peace.

Porges and Porges describe this as ***"a light at the end of trauma's tunnel, and a pathway toward healing and happiness in a world that seems designed to threaten and traumatize us at every turn"*** (Porges & Porges, 2023, p. 13).

And for adolescents standing in the middle of that tension, this matters deeply. Because it means that what they are feeling is not permanent. It means there is a way forward. It means that their nervous system can learn a new story, one rooted not in fear or disconnection, but in safety, connection, and life.

This is more than theory. This is a powerful resilience skill. Learning to tune into the body, to recognize signals of safety and threat, and to intentionally move toward regulation is one of the most important ways resilience is built in adolescence.

It is not just about managing emotions. It is about reclaiming a sense of control, restoring connection, and building the internal strength that defines resilience.

And this is not only about healing from emotional wounds. It is about developing resilience so that when life brings stress, disappointment, and adversity, an adolescent is better equipped to handle it. Because the reality is, the blows will come. The question is not whether hardship will happen, but whether a young person has the capacity to absorb it, recover from it, and continue moving forward without losing themselves.

Polyvagal-informed therapy helps build that capacity. It strengthens the nervous system so that when stress arises, the body does not immediately move into chaos or shutdown, but instead has the

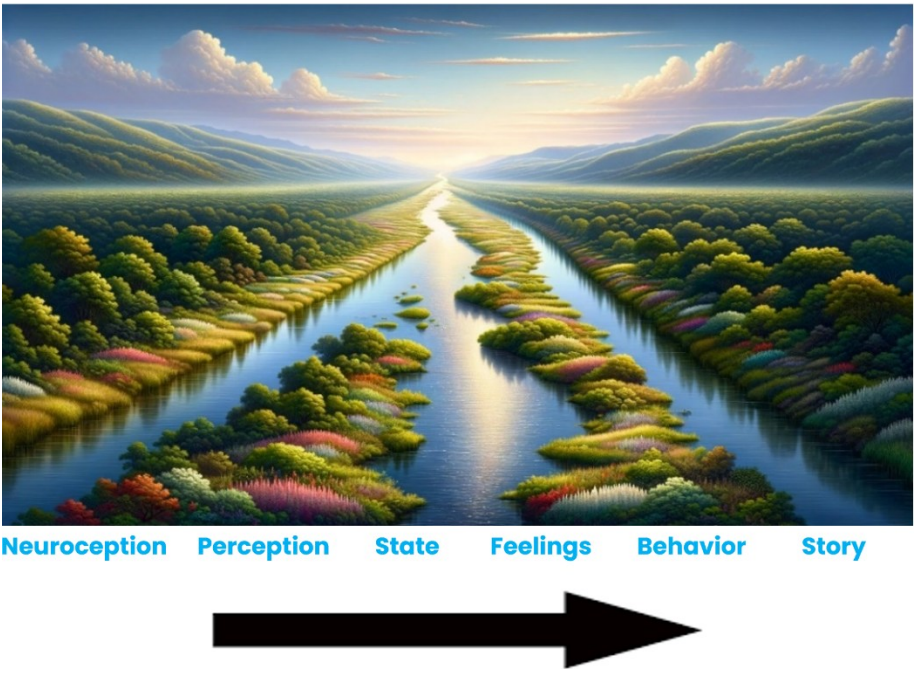
flexibility to return to safety, connection, and regulation. That flexibility is resilience.

Resilience is not the absence of struggle. It is the ability to move through it. It is not perfection. It is recovery. It is not avoiding pain, but having the internal stability to face it, process it, and grow through it.

For adolescents, this is life changing. Because it means they are not just learning how to heal from what has already happened. They are actively building resilience for everything that lies ahead.

And perhaps most importantly, it offers something many adolescents desperately need but rarely feel.

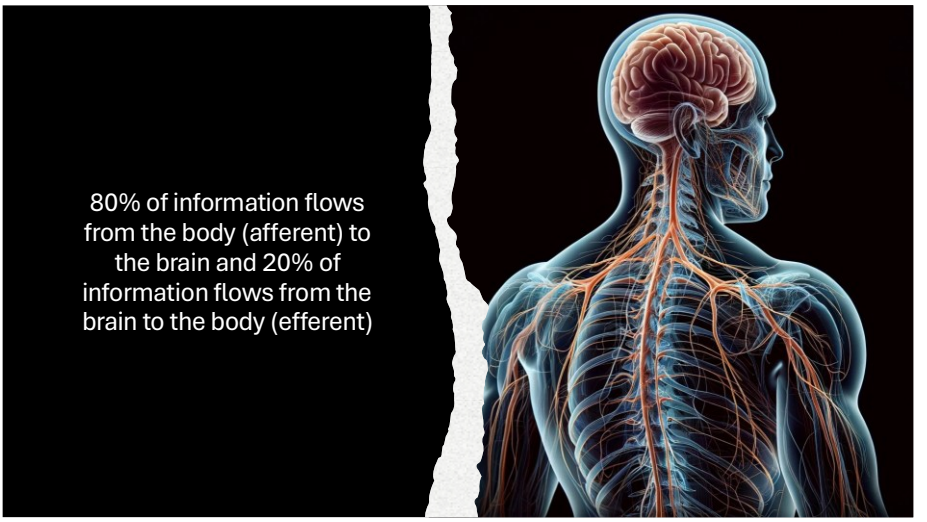
Hope.



Borrowing from a metaphor of flowing down a stream, the first step in healing is to move our neuroception - what our autonomic nervous system is automatically sensing regarding safety and danger without our awareness to awareness of sensing, which is called perception. Flowing downstream, we can then appreciate what our physiological state is causing us to feel emotionally and subsequently change the behaviors that we engage in. The ensuing story or narrative we give to this process to make sense of what we are sensing and feeling, if positive and healthy, helps us correct our autonomic state. On the other hand, if our narrative is false, as it often is (e.g., we often shame and blame ourselves or we catastrophize the situation), then our autonomic state becomes even more activated or shut down, and our subsequent emotions become more anxious or depressed, respectively, and we enter into a negative feedback loop, a process that leads to emotional problems/illness and/or physical problems.

There are two basic approaches to healing: Bottom-up and Top-down.

Bottom-up entails working with the body more directly. It is important to appreciate that, as previously noted, 80 percent of the fibers in the vagus nerve are sensory, carrying signals from the organs to the brain, while 20 percent are motor, transmitting signals from the brain to various body organs. (Porges, 2017). This suggests that what our bodies tell us is indeed very important, and we must make every effort to listen and heal on that level. Top-down strategies, which involve our thinking and hopefully more rational brain, require a certain level of cognitive development and maturity, so very young children will not be able to benefit from this approach (e.g., Cognitive Behavioral Therapy aka CBT).



As previously noted by Deb Dana, a ventral vagal state and a neuroception of safety brings the possibility for connection, curiosity, and change. She nicely presents a polyvagal approach, which she calls the four R's (the first three are bottom-up (body to brain) and the last is top down (brain to body) (Dana, 2018):

The Four R's

- Recognize the autonomic state
- Respect the adaptive survival response
- Regulate or co-regulate in a ventral vagal state
- Re-story

Recognize the autonomic state

I recommend making the Emotion Regulation Chart I developed below as our companion to help us recognize where we are on that continuum of regulation. In doing so, we can make what is implicit (under the table and outside of our awareness) explicit (on the table and in our

awareness). We can use the color codes to describe for ourselves and others where we and others are with just one neutral and non-judgmental word. This is also particularly helpful for children as it helps give them a physical and emotional language that connects the mind with the body.

Dimension	Lethargic	Calm	Active/Alert	Fight/Flight	Hyper Freeze	Hypo Freeze
Primary Experience	Shutdown, Depression	Safety, Social engaged	Ready to act	React to danger	Overloaded	Collapse, Numb
Body Response	Low energy, slowed body	Relaxed, steady rhythm	Energized, focused	High arousal, tense body	Rigid, panicked	Flaccid, shutdown
Emotional Tone	Numb, sad, withdrawn	Clear, connected, at peace	Interested, engaged, curious	Fear, anger, urgency	Terror, frozen in fear	Empty, detached, despair
Therapeutic Focus	Gently activate energy	Maintain connection	Channel energy	Ground, create safety	Contain, stabilize	Emergency support

Emotion Regulation Chart

If we find ourselves in the Orange Zone to the Red Zone, we are overly activated and prone to experience:

- Rapid heartrate
- Hyperventilation
- Panic attacks
- Inability to focus or follow through
- Distress in relationships
- Emotions of fear, terror, rage, anger
- Possible health consequences, including heart disease, high cholesterol, high blood pressure, weight gain, memory impairment, headaches, chronic neck shoulder and back tension,

stomach problems, and increased vulnerability to illness (lower immune response) (Dana, 2018).

If we find ourselves in the Yellow Zone, we are under activated or shutdown and prone to experience:

- Slow heart rate
- Shallow breathing
- Withdrawal from others
- Emotions of sadness, depression, shame, disgust
- Possible health consequences, including chronic fatigue, fibromyalgia, stomach problems, low blood pressure, type 2 diabetes, and weight gain (Dana, 2018)

If we find ourselves in the Green Zone, we experience safety and connection and are prone to experience:

- Regulated heart rate (the vagal brake, the body's built-in calming system that slows the heart by about 20 beats per minute, helps us stay regulated and socially engaged when we feel safe)
- Breath is full
- Feeling regulated
- We take in the faces of others
- We can "tune in" to conversations and "tune out" distractions
- We can see the "big picture"
- We can connect with the world and the people in it
- We are able to reach out to others
- We are able to play and take time to enjoy life and others
- We are able to be productive in work

- We are able to organize and follow-through
- We are able to heal emotionally and physically
- We experience emotions of happiness, joy, love, peace, calm
- Possible health consequences include a healthy heart, regulated blood pressure, a healthy immune system, decreased vulnerability to illness, good digestion, quality sleep, and an overall sense of well-being (Dana, 2018)

Respect the adaptive survival response

One of the beautiful aspects of Polyvagal Theory is that it helps to remove shame from the equation. Dr. Porges kindly states in reference to clients, ***"I was going to say that depending on the age of my client, but actually, regardless of age, the first thing to convey to the client is that they did not do anything wrong... If we want individuals to feel safe, we do not accuse them of doing something wrong or bad. We explain to them how their body responded, how their responses are adaptive, how we need to appreciate this adaptive feature and how the client needs to understand that this adaptive feature is flexible and can change in different contexts."*** (Porges, 2017, p. 121 - 122). So, rather than shaming a woman for shutting down in dorsal vagal freeze when being molested or raped, which will only fuel her shame, guilt, and emotional pain, we must compassionately inform her that her autonomic nervous system acted brilliantly, interpreting the signals and immobilizing her in a situation where fighting or fleeing might have cost her life. Many a court judge have literally ruined survivors of abuse by blaming them for not running or fighting and invalidated their trauma.

Regulate or co-regulate in a ventral vagal state

Once we recognize that we are dysregulated and have pinpointed which defensive physiological state we are in, and where we are on the emotional regulation continuum (see emotional regulation chart above) i.e., activation or slowing/shutting down, we can act by using bottom-up self-regulation strategies and co-regulation strategies.

As Herman Melville once wrote, "***We cannot live for ourselves, a thousand fibers connect us."*** Connection is a biological imperative, according to Porges (2015). Our autonomic nervous system longs for connection, and it is through our biology that we are wired to connect. Co-regulation, as described by Dr. Porges, is the mutual regulation of physiological states between individuals. In life, it occurs first between mother and infant but later extends to friends, partners, co-workers, and groups such as families, to name a few (Porges, 2017).

We humans are social creatures, and "our nature is to recognize, interact, and form relationships" with others (Cacioppo & Cacioppo, 2014, p. 1). As we know, low birthweight babies need to connect for survival and positive co-regulation and connection. When connected, these babies experience improved heart rate and temperature, breathing stabilization, more organized sleep, rapid improvement in state regulation, and reduced mortality, severe illness, and infection (Jefferies, 2012).

Connection is a wired-in biological necessity, and isolation or even the perception of social isolation can lead to a compromised ability to regulate our autonomic state, which diminishes our physical and emotional well-being (Porges & Furman, 2011). We can all appreciate that when we feel alone, we suffer. In a Ted Talk presentation,

Cacioppo (2013) reported a rather shocking meta-analysis study of over 100,000 participants, which found an increased risk of dying early due to the following:

- Air pollution: 5% increased risk of dying early
- Obesity: 20% risk of dying early
- Alcoholism: 30% risk of dying early
- Loneliness: 45% risk of dying early

Deb Dana notes that when there is ongoing misattunement, when ruptures in a teen's relationships are not recognized and repaired, the autonomic experience of persistent danger moves the system away from connection and into patterns of protection, with loneliness becoming the subjective experience (Dana, 2018).

So, when teens are suffering and dysregulated, it is very helpful and sometimes lifesaving for them to seek safe refuge in others, especially in their parents or other trusted adults.

Conversely, when parents are emotionally regulated themselves, they can offer that sense of safety to their teens. This is a particularly important and essential component of effective parenting. Parents can extend this safe regulation to themselves and to their adolescents by intentionally practicing the strategies below. Remember, through the process of neuroception, teens are constantly reading their parents' cues of safety, just as parents read theirs. In many ways, what is offered is often what is returned. We would do well to practice these strategies, so they become automatic whenever a teen moves out of the green zone and needs support returning to it.

Here are some interpersonal behavioral cues for parents to be mindful of, as they directly influence how teens co-regulate with them. While these may come naturally to some, for others they must be learned. When they are practiced consistently and become a natural part of a parent's relational style, the impact on a teen can be profound. Please do not underestimate the difference they can make in your life and in the life of your child.

Kind eyes: As they say, the eyes are the window to the soul.

Melodious voice: Speak with a more melodious voice, full of prosody and life.

Smiling mouth and eyes: Smile not only with your mouth but with your eyes. Whether or not we are aware, our neuroception scans for congruence between the smiling mouth and smiling eyes. Crow's feet wrinkles are testament to someone who lives a more joyful life. So maybe reconsider that Botox.

Avoid leaning in: Leaning in can be perceived as very threatening. Most of us don't like it when others enter our personal space uninvited, particularly in western cultures, and the result is typically defensive activation moving us toward fight or flight or less typically, occasional freeze responses.

Slow and low Breathing: Our lungs are the only internal body organ we can directly control, and proper breathing has a huge impact on our health. Breathe slowly with exhalations longer than inhalations – breathing out slowly accentuates relaxation and can slow our heart rate by 20 beats per minute (vagal brake).

Re-story

Now that teens, or those we care about, are in a more regulated state by using the bottom-up strategies discussed earlier, they should feel more settled and better able to use top-down strategies to correct the narrative or re-story the situation, whether it is a current event or something from the distant past. As humans, we naturally seek meaning in our experiences, often creating stories to make sense of our pain (Dana, 2018, 2020; Kain, 2018). Unfortunately, these narratives often skew negative due to the brain's bias toward negativity, a survival mechanism that kept us vigilant for danger (Hanson & Mendius, 2009). While this served us well in the wild, it works against us when the threat is no longer present. Adolescents who have experienced trauma are particularly prone to constructing false narratives about themselves and the world around them (Porges, 2017; Dana, 2018; Kain & Terrell, 2018).

In a more regulated state, however, teens can begin to rewrite a new narrative that better reflects their healing journey and the heroic efforts of their nervous systems to protect them through their pain. This new story allows them to embrace both the lessons of the past and the bright possibilities of the future.

As the Bible reminds us, ***"Do not conform to the pattern of this world, but be transformed by the renewing of your mind"*** (Romans 12:2, NIV). As adolescents begin to renew their narratives, they transform their minds and start to see themselves and their stories in a new light, one marked by resilience, hope, and purpose.

Drs. Kain and Terrell describe this beautifully*: "As our capacity increases, our narratives are likely to change, including the sense of success at meeting challenges, developing curiosity, or a willingness to explore. Eventually, our narratives may also include access to a sense of safety and connection. Rather than 'I am constantly afraid and unhappy,' a client will begin telling himself a different story: 'I am stronger than I thought and able to meet challenges with greater balance and success'"* (Kain & Terrell, 2018, pp. 101-192). They add, *"At the same time, our somatic narratives will begin to change. We may literally experience changes in our symptoms—decreased inflammation, less pain, fewer migraines. Our illness narratives may alter to include the possibility of being free of pain, free of symptoms that have beleaguered us for most of our lives"* (Kain & Terrell, 2018, p. 192).

In this process of re-storying, teens not only begin to reinterpret their past, but also open themselves to a future marked by greater peace and wholeness.

What makes polyvagal work so remarkable is not only that it helps heal what has been wounded, but that it actively builds resilience in the very adolescents who have carried those wounds. As they learn to settle their bodies, to recognize their internal states, and to return to safety and connection, they are not just recovering from the past. They are becoming stronger, more stable, and more grounded in the present. The same nervous system that once carried the imprint of fear begins to carry the imprint of safety. The same body that once braced for threat begins to rest, connect, and engage with life again. This is the quiet miracle of this work. Trauma may live in the body, but so does healing. And as regulation becomes more consistent, resilience begins to take root, giving adolescents the capacity not only to endure life's

challenges, but to move through them with increasing strength, flexibility, and hope.

And yet, as powerful as this is, it is only the beginning. Because as teens continue this journey, we discover that the body does not heal in isolation. It heals through connection, rhythm, and coherence. In the next pillar, we turn our attention to the heart, not only as an organ, but as a central player in regulation, integration, and human connection. What we will see is nothing short of remarkable. The heart becomes a bridge between the body and the brain, between physiology and emotion, and ultimately between the human experience and something greater than ourselves. It is here that the science of healing begins to touch something even deeper, pointing us toward the divine.

Pillar Two

HeartMath®

Our heart is an extraordinary organ, and it is far more than a pump. It carries its own form of intelligence and wisdom, working in constant communication with the brain and the body. HeartMath® has helped bring scientific clarity to this connection, translating it into practical tools that can support healing, emotional stability, and resilience.

For adolescents, this is especially powerful. Because as we have just seen through Polyvagal-informed therapy, the body plays a central role in how we experience safety, connection, and regulation. Now we begin to see that the heart is not separate from that process. It is deeply involved in it. The heart helps shape how we feel, how we respond, and how we return to a place of calm and clarity.

In a season of life where emotions can feel intense, unpredictable, and at times overwhelming, learning to work with the heart becomes a critical resilience skill. It offers adolescents a way to steady themselves from within, to move from chaos toward coherence, and to experience a sense of inner stability even when life around them feels uncertain.

The wisdom of the heart is not new. It has been recognized throughout history and expressed beautifully in Scripture. ***"Above all else, guard your heart, for everything you do flows from it"*** (Proverbs 4:23, NIV). This is not simply poetic language. It is a profound truth. The heart sits at the center of our emotional and relational life, shaping not only how we feel, but how we interpret the world, how we make decisions, and how we engage with others.

For many adolescents, the heart has been wounded. Trust has been shaken. Emotions may feel confusing or even overwhelming. But this is where hope begins to rise again. Because just as the nervous system can be retrained toward safety, the heart can be guided toward coherence, connection, and strength.

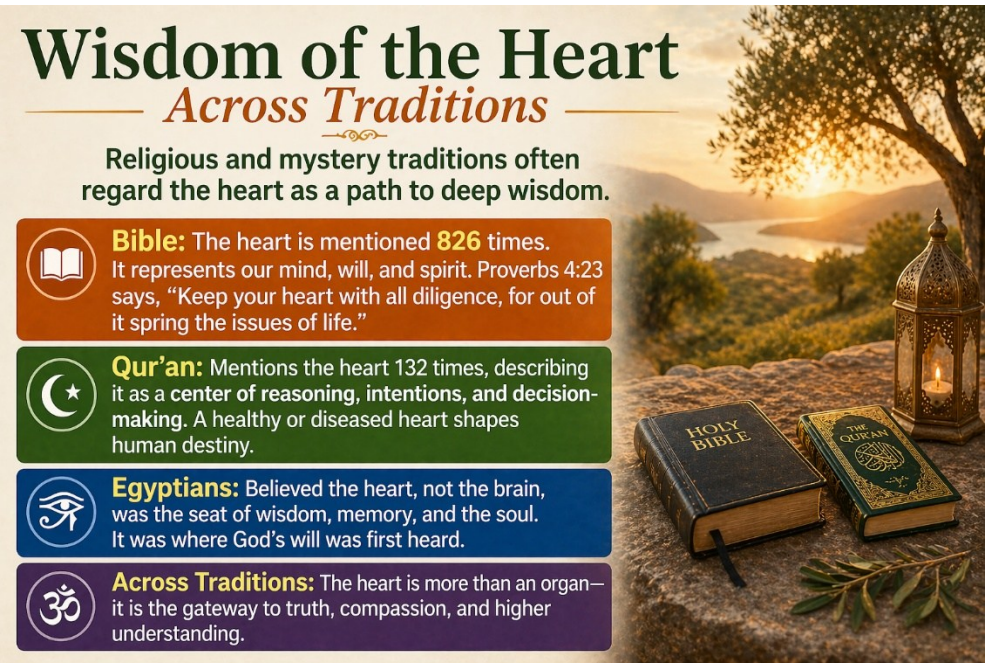
What was once dismissed as abstract or purely spiritual is now being rediscovered through both science and faith. The heart is not only responsive, it is influential. It plays a central role in integrating our emotional, physiological, and relational experiences. And as we learn to

engage it intentionally, something begins to shift. We do not just calm down. We become more connected, more present, and more capable of navigating life with resilience.

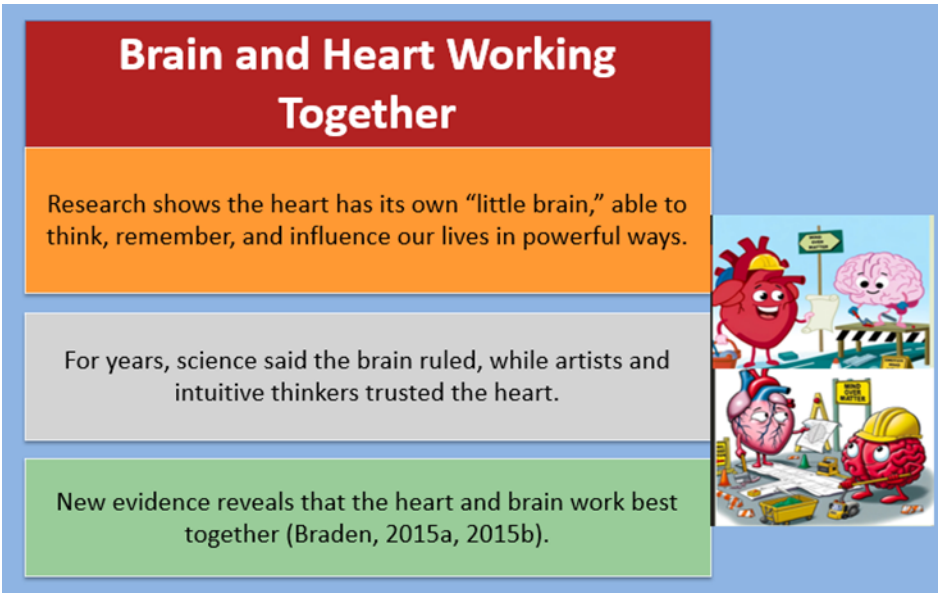
This is where Polyvagal-informed therapy and HeartMath® begin to work together in a powerful way. One helps us understand and regulate the nervous system through safety. The other helps us cultivate coherence through the heart, bringing rhythm, alignment, and stability to the entire system. Together, they create a pathway not only for healing past wounds, but for building a resilient, grounded, and hopeful future.

And for adolescents, that may be one of the most important gifts we can offer. Not just relief from what hurts, but the tools to live with strength, clarity, and a deep sense of connection moving forward.

Again, the ancients knew of the importance of the heart, but that wisdom was lost with time. Happily, this knowledge is coming back to us and can lead us to fuller and more meaningful lives.



One of Jeff's heroes who advocates new and innovative ways to promote mental health is Gregg Braden. He is an author and speaker who has actively bridged science and spirituality. He has a background in earth sciences and worked in the aerospace and defense industries during the 1980s. Braden is also widely known for his work in popularizing the concept of HeartMath®. Although not a founder of the HeartMath® Institute, he has been a strong proponent of its work, particularly in the areas of emotional self-regulation and the connection between the heart and brain.

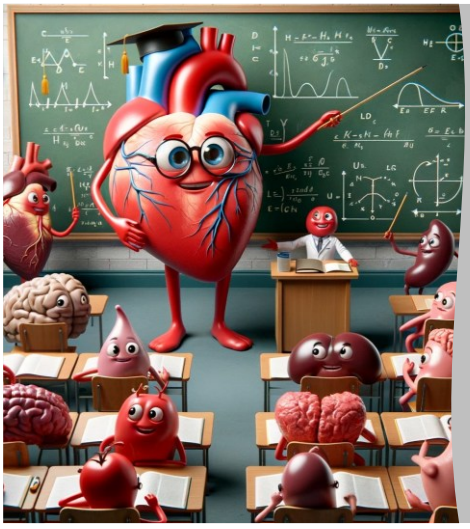


Braden's work often explores the role of human emotion in physical health, healing, and the interconnectedness of all life. Braden's approach combines science with spirituality to offer perspectives on personal and collective wellness, emphasizing the importance of harmony within oneself, others, and with the environment. He is a brilliant, sincere, and inspirational speaker, and We encourage you to search out some of his YouTube presentations on HeartMath®. His one entitled "***Practice this Technique to Relieve Daily Stress... Three Keys to Heart - Brain - Earth Harmony"*** is one of our favorites. Give it a try, you will love it.

Braden (2015a, 2015b) eloquently describes the research that supports the concept of heart intelligence, suggesting that when we are in a calm and positive autonomic state, we can access it much more easily.

What – Heart Intelligence?

- Dr. Armour, MD, PhD., at the University of Montreal in 1991, discovered that the heart has its own "little brain" or "intrinsic cardiac nervous system" (cited in Braden, 2015).
- This "heart brain" is composed of approximately 40,000 neurons, called sensory neurites that are similar to neurons in the brain, meaning that the heart has its own nervous system.
- In addition, the heart communicates with the brain in many methods: neurologically, biochemically, biophysically, and energetically.
- The vagus nerve, which is 80% afferent, carries information from the heart and other internal organs to the brain.
- Signals from the "heart brain" redirect to the medulla, hypothalamus, thalamus, and amygdala and the cerebral cortex (Braden , 2015a, 2015b).

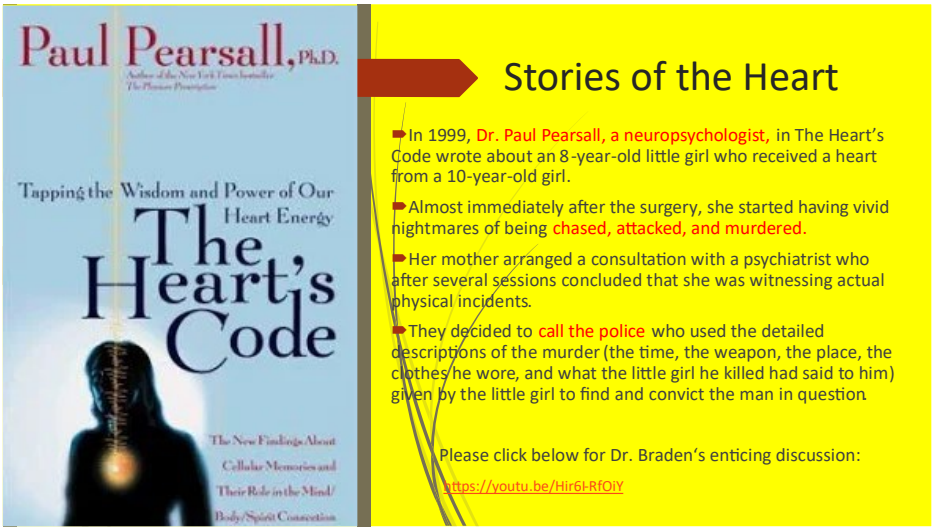


What – Heart Intelligence?

- Braden notes that a key role of the heart brain is to detect changes in the body such as hormone levels and other chemicals and to communicate this information to the brain so it can meet our needs accordingly.
- The heart brain achieves this by converting the language of the body, chemistry, to the electrical language of the nervous system so it makes sense to the brain.
- For example, the heart's encoded messages to the brain informs it as to when we need adrenalin for danger or when we need less in times of safety so the immune system can be turned on (Braden, 2015a, 2015b).

Braden (2020) notes that the heart has over 40,000 cells called sensory neurites, very similar to the cells in the brain, and there is evidence that the heart has a certain capacity for some types of memory as well as a gut level wisdom that guides us (Dispenza & Braden, 2019).

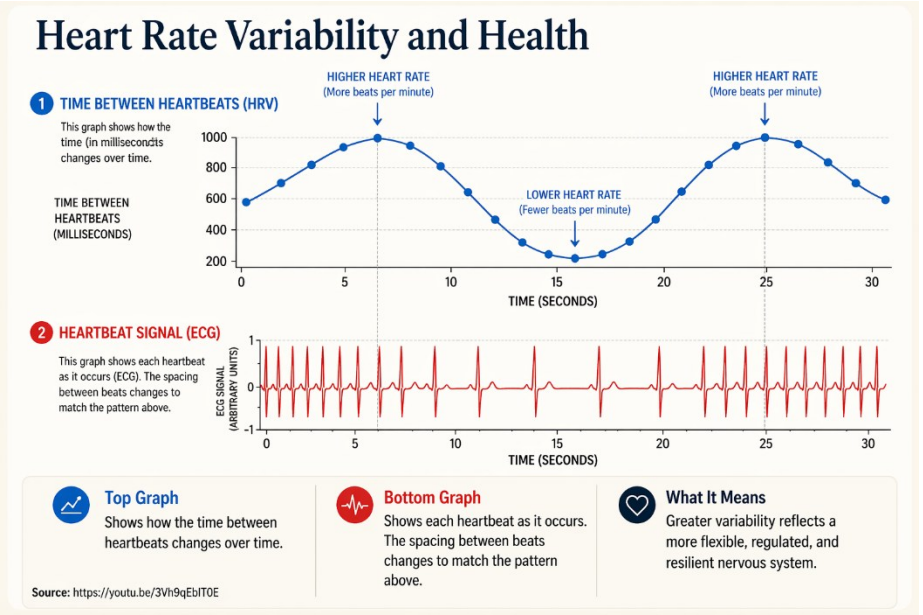
Braden nicely narrates two stories detailed in the graphics below about how memories stored in the neural networks in the heart can be transferred to the heart recipients following heart transplant surgeries.



HeartMath® is a magnificent therapy that uses techniques that focus on heart rate variability and the heart's influence on emotional well-being and stress management. By learning to regulate our heart rhythm,

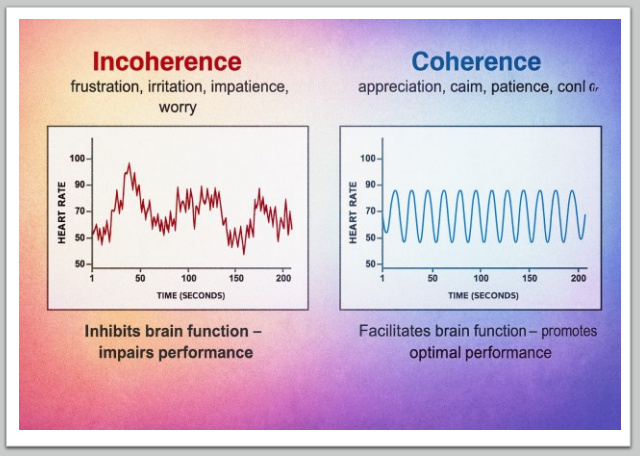
we can achieve a more coherent state, where emotions, mind, and body are in sync. This approach helps reduce stress, enhance emotional regulation, and improve overall health. In therapy, HeartMath® tools teach us how to access our heart's intelligence to foster resilience, improve decision-making, and deepen personal connections. Learning to live more from the heart is a gamechanger, allowing you to relate to others in safer, more profound ways, bringing much more groundedness and stability to your life.

HeartMath® defines heart rate variability (HRV) as the measure of the beat-to-beat changes in heart rate, which reflects the heart's ability to adapt to stress, environmental, and physiological changes. HRV is a key indicator of the autonomic nervous system's efficiency and balance, particularly the interaction between the sympathetic (stress response) and the parasympathetic (relaxation response) branches (McCraty, 2023).



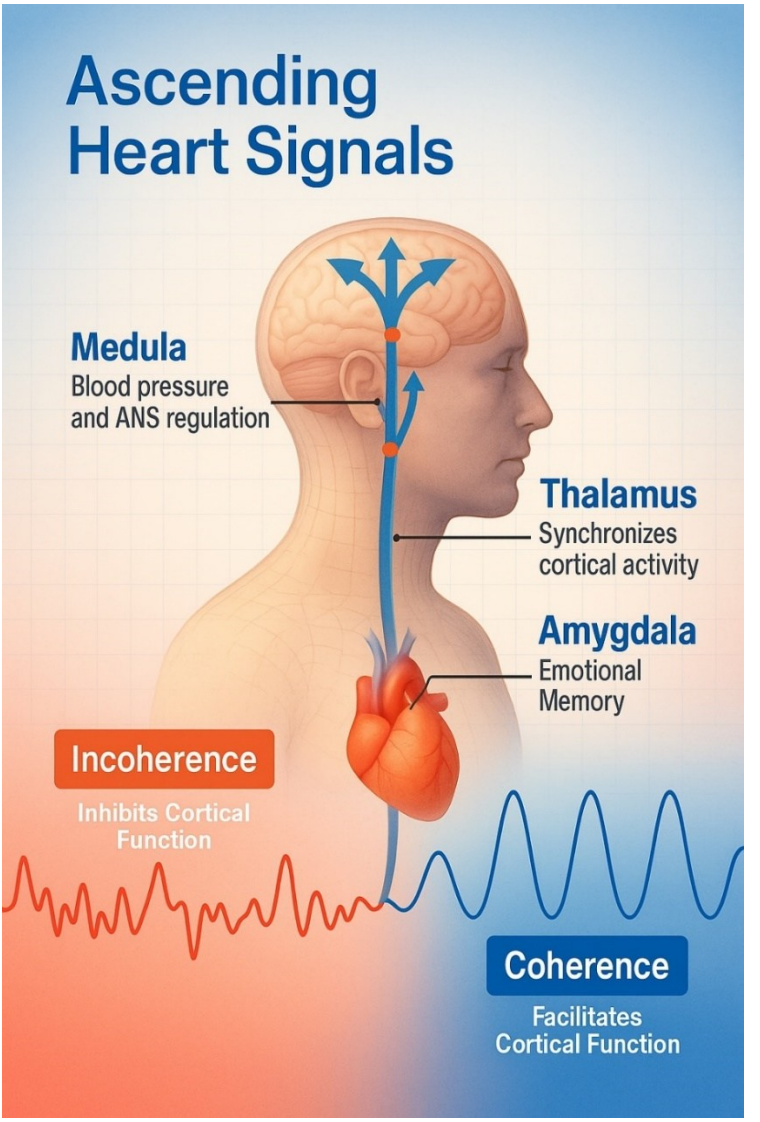
In practice, HeartMath® uses HRV to assess an individual's level of coherence, a state where the heart, mind, and emotions are in energetic alignment and cooperation. This state is characterized by a smooth, wave-like pattern in the heart rhythm, indicating emotional balance and mental clarity. HeartMath® techniques involve specific breathing practices and the cultivation of positive emotional states to increase coherence, thereby improving HRV. This approach is used to help adolescents reduce stress, enhance decision-making, and boost overall well-being (McCraty, 2023). The graphic below shows how the heart can shift from a negative and dysregulated state on the left to a more positive and coherent state.

Emotions and Heart Rhythms



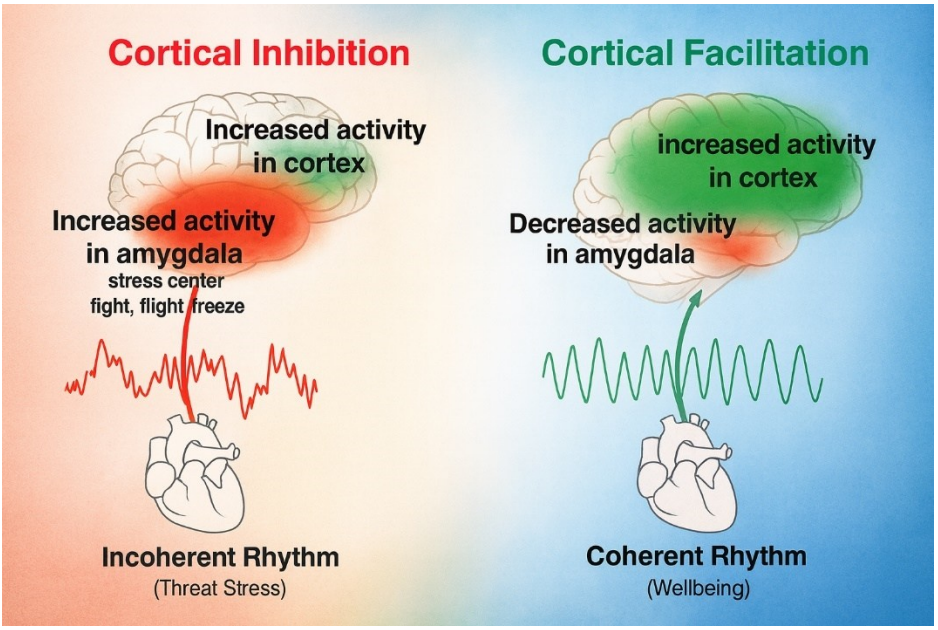
Once we attain coherence in the heart, the coherent heart then communicates in four distinct ways to the brain, enabling it to achieve coherence: (1) nerves connecting the heart to the brain, particularly the vagus nerve, (2) hormones, (3) blood pressure shifts, and (4) electromatic waves (McCraty 2023). This allows the brain to be more integrated and efficient, while an incoherent heart inhibits cortical

function. Note that 80% of information flows from body to brain (efferent).



This following graphic nicely illustrates how an incoherent heart increases the activity of the amygdala and diminishes the activity of the prefrontal cortex (thinking brain/executive functioning). In this state,

our thinking is governed by lower brain centers, and we thus make impulsive, emotionally driven decisions. On the other hand, the right side of the graphic demonstrates how a coherent heart signals the amygdala to quiet down, allowing the higher order processes of the prefrontal cortex to reign so great decisions can be thereby authored.



One very attractive element of HeartMath® is the concept of one person's heart coherence helping another person achieve coherence, which is grounded in the understanding of interconnectedness and the physiological phenomenon known as entrainment. Here is a brief description of how it works, broken down into key points (McCraty et al., 2009; McCraty er al.; McCraty, 2023; Tiller et al., 1996):

1. **Heart Coherence:** As previously noted, heart coherence refers to a harmonious, ordered pattern in the heart rhythms, characterized by a stable, sine-wave-like pattern in the heart rate variability (HRV). This state is associated with positive

emotions, physiological efficiency, and a sense of well-being. It is achieved when the heart, mind, and emotions are in energetic alignment and cooperation.

2. **Interconnectedness and Energy Fields:** The HeartMath® Institute suggests that the heart emits an electromagnetic field of up to a radius of 10 to 15 feet that can affect the people, animals, and environment around us. This field can be detected by others unconsciously. In a coherent state, the heart's electromagnetic field is more ordered and coherent. If ordered or coherent, the effect on others is positive and if disordered or incoherent, the effect on others is negative.

3. **Entrainment and Resonance:** Entrainment is a physics principle where two oscillating systems assume the same frequency. When applied to heart coherence, entrainment suggests that the coherent heart rhythm of one person can influence and synchronize with the heart rhythm of another person when they are in close proximity, leading to mutual coherence. This is a beautiful form of energetic communication, where the heart's electromagnetic field of one person can influence the heart rhythm of another person.

4. **Emotional Contagion:** On a psychological level, this concept mirrors the idea of emotional contagion, where one person's mood and behaviors can lead to the synchronization of feelings and behaviors in another person. In a positive sense, a person in a state of heart coherence can, through their calm and positive emotional state, help induce a similar state in others, promoting emotional stability and coherence. Thus, this has great

implications in helping another person reach the aforementioned autonomic green state when the ventral vagus nerve is active, which promotes social engagement (Hansen, 2021).

5. Improved Group Dynamics: When applied in groups, this phenomenon can lead to improved cooperation, understanding, and a collective increase in coherence among individuals. This not only benefits emotional and mental health but can also enhance group performance, creativity, and problem-solving abilities.

The HeartMath® research supports the idea that practicing heart coherence techniques can not only improve one's own health and well-being but also positively influence the people around us, effectively creating a more harmonious environment and thus making the world a better place to live in.

Heart Lock-In® Technique:

The Heart Lock-In® Technique is a practice developed by the HeartMath® Institute, designed to help individuals enter a state of heart coherence, where the heart, mind, and emotions are aligned. This technique is beneficial for reducing stress, enhancing emotional stability, and fostering a sense of inner peace and well-being. Here is a step-by-step guide we expanded for clarity on how to perform the Heart Lock-In® Technique:

Step 1: Center and Breathe

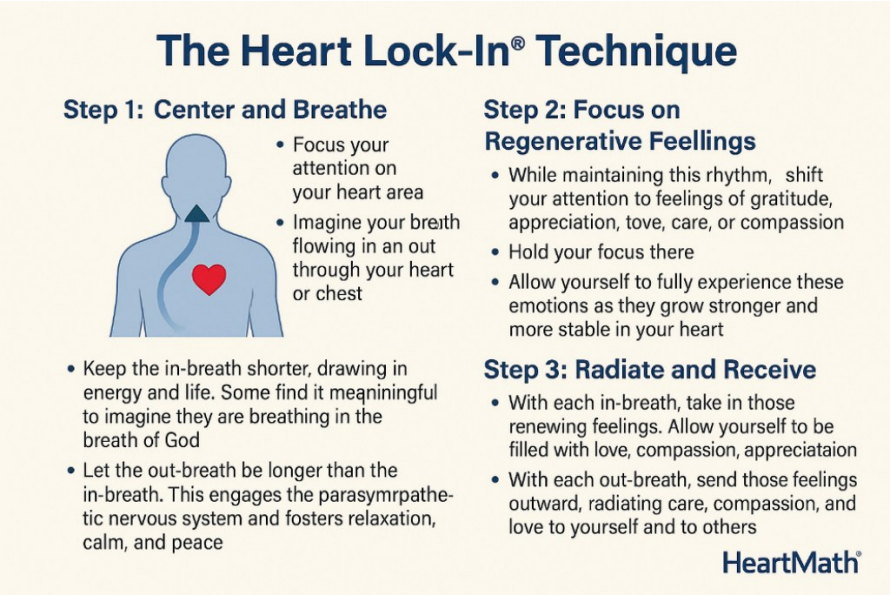
- Focus your attention on your heart area
- Imagine your breath flowing in and out through your heart or chest
- Breathe slowly and deeply from the abdomen, letting your belly rise with each inhale
- Keep the in-breath shorter, drawing in energy and life. Some find it meaningful to imagine they are breathing in the breath of God
- Let the out-breath be longer than the in-breath. This engages the parasympathetic nervous system and fosters relaxation, calm, and peace

Step 2: Focus on Regenerative Feelings

- While maintaining this rhythm, shift your attention to feelings of gratitude, appreciation, love, care, or compassion
- Hold your focus there
- Allow yourself to fully experience these emotions as they grow stronger and more stable in your heart

Step 3: Radiate and Receive

- With each in-breath, take in those renewing feelings. Allow yourself to be filled with love, compassion, and appreciation
- With each out-breath, send those feelings outward, radiating care, compassion, and love to yourself and to others
- Continue this cycle of receiving on the inhale and radiating on the exhale
- Sustain the flow of coherence for several minutes



As we bring these two pillars together, something powerful begins to emerge. Polyvagal-informed therapy helps adolescents understand and settle what is happening in the body. It teaches them how to recognize when they are activated, overwhelmed, or shut down, and more importantly, how to return to a place of safety and connection. It lays the groundwork for regulation.

HeartMath® then builds on that foundation. It helps bring the body into coherence, a state where the heart, the nervous system, and the brain begin to work in harmony rather than in conflict. As the heart

becomes more regulated and rhythmic, the entire system follows. Emotions stabilize. Attention improves. The brain begins to function with greater clarity, flexibility, and integration.

This is where resilience deepens. Not just the ability for adolescents to calm down in the moment, but the capacity for them to live from a more steady, grounded place over time. Teens begin to experience what it feels like to be anchored rather than reactive, connected rather than isolated, and capable rather than overwhelmed.

And as coherence grows in the body and in the heart, something else becomes possible. The brain becomes more available. The higher centers of thinking, reflection, and meaning-making come back online. Instead of being driven by survival patterns alone, adolescents gain access to curiosity, insight, and choice.

This prepares parents and teens for the next step in the journey. Because once a teen's body is more regulated and the heart more coherent, they are better equipped to explore the inner world of thoughts, beliefs, and identity. They can begin to gently examine the stories they carry, the parts of themselves that have been shaped by pain, and the ways those parts have tried to protect them.

In the next pillar, we will move into Internal Family Systems, a powerful approach that helps adolescents understand and work with these internal parts in a compassionate and transformative way. It is here that the psychological dimension comes more fully into view. But it is important for parents to recognize that this work becomes far more effective when the teen's body and heart are already settled and aligned.

For adolescents, this sequence matters. We are not asking them to think their way out of distress. We are helping them build a foundation of safety, coherence, and connection so that when they do begin to reflect and process, they can do so from a place of strength.

And that is where real transformation begins.

Pillar Three

Internal Family Systems (IFS)

There are few discoveries in modern psychology as breathtaking as Internal Family Systems (IFS), developed by family therapist Dr. Richard C. Schwartz, Ph.D. It is as though someone has finally handed us a map of the inner world, revealing that what once felt confusing, overwhelming, or even chaotic within adolescents is in fact deeply organized and profoundly meaningful. For parents, providers, and those who care for young people, this

understanding can be both relieving and empowering as they help teens make sense of their emotions, reactions, and emerging identity.

Throughout this book, we have taken a careful and intentional path toward healing. We began with the body, recognizing that trauma is not simply something adolescents think about, but something they feel and carry. Through polyvagal-informed therapy, we learned how the nervous system responds to safety and threat, and how adolescents can begin to recognize and regulate those responses. We then turned to the heart, exploring through HeartMath® and neurocardiology how coherence within the heart helps bring stability to the entire system. As the body settles and the heart becomes more regulated, the adolescent brain begins to function more clearly, more flexibly, and more in partnership with them rather than against them.

This progression matters. Because once a teen's body feels safer and the heart is more coherent, they are no longer operating purely from survival. They are no longer overwhelmed, shut down, or reactive in the same way. Instead, they begin to have access to something incredibly important during adolescence: the ability to reflect, to understand, and to make sense of what is happening inside.

And this is where we now turn our attention.

IFS invites adolescents, along with the parents and providers who support them, into the inner landscape of the mind, helping them understand that their thoughts, emotions, and reactions are not random or broken, but organized into different "parts," each with a purpose. When teens feel pulled in different directions—part of them wanting to succeed, part of them wanting to withdraw, part of them feeling anxious, and another part feeling angry or overwhelmed—it can

feel confusing or even discouraging. But IFS reframes this experience in a powerful way. It shows us that these parts are not problems to eliminate, but protective responses that developed to help them navigate pain, stress, and uncertainty.

In many ways, what we are doing now is shifting from the bottom-up work of the body and heart to a more top-down understanding of the mind. We are building on the foundation of regulation and safety to explore the psychological strategies that have helped adolescents survive. This allows them not only to make sense of their struggles, but also to engage with them in a more compassionate and intentional way, with the guidance of supportive adults.

This is not just about addressing problems. It is about building resilience. When adolescents learn to recognize their internal parts, to understand their roles, and to respond with curiosity rather than judgment, they develop a deeper sense of stability and self-awareness. They are better equipped not only to heal from past wounds, but to navigate future challenges with strength, flexibility, and confidence.

What once felt like chaos begins to feel understandable. What once felt overwhelming becomes manageable. And what once felt broken begins to reveal itself as something far more hopeful: a system that has been trying, all along, to protect and preserve them.

And as we will see, at the center of this system is not disorder, but something deeply steady and good. A core within each adolescent that is capable of leading with calm, compassion, clarity, and courage.

This is where the journey becomes not only about healing, but about becoming whole. So, that said, let's explore what the primary parts are:

Exiles (Wounded Parts)
Carry deep pain, shame, fear, or grief from past experiences.

Managers (Protective Parts - Proactive)
Try to prevent pain from being triggered through control, perfectionism, or avoidance.

Firefighters (Protective Parts - Reactive)
Act quickly when pain breaks through, using distraction, numbing, anger, or impulsive behaviors to shut it down.

Inner Critic (Protective Voice - Feedback)
Evaluates, judges, or criticizes in an effort to prevent failure, rejection, or harm, though it can feel harsh or discouraging.

Self (Core of Who You Are)
The steady center within, marked by calm, curiosity, compassion, clarity, and courage.

The Parts Within Us

Exiles

Carry deep pain, shame, fear, or grief.

Managers

Work to prevent pain through control, perfectionism, or avoidance.

Firefighters

Act quickly when pain breaks through, using distraction, anger, or numbing.

Inner Critic

Evaluates and judges in an effort to protect, though often harshly.

Self

The core within, marked by calm, curiosity, compassion, clarity, and courage.

When we understand our parts with compassion, healing becomes possible. Wholeness becomes our path.

Exiles: Exiles are the vulnerable, wounded parts that carry deep emotional pain such as fear, shame, grief, abandonment, or trauma. These parts often hold memories or emotions that were too overwhelming to process at the time they occurred. Because their pain is intense, they are frequently pushed out of conscious awareness.
When exiles become activated, the nervous system can flood with distress. For this reason, other parts work tirelessly to keep them contained. In addiction and depression, exiles often drive the emotional pain the system is desperately trying to escape.

Managers: Managers are proactive protective parts responsible for maintaining order, control, and stability. Their role is to prevent the activation of exiled pain by anticipating problems and regulating emotion.

Managers often operate through strategies such as perfectionism, overachievement, people-pleasing, rigidity, intellectualization, or spiritual performance. They are deeply invested in appearing competent and composed. Many managers are highly functional and socially rewarded, yet they operate from fear rather than freedom.

Managers are all about performance—being the best student, clinician, teacher, leader, employee, spouse, or even the most disciplined or religious person—in order to prevent pain from surfacing.

Firefighters: Firefighters are reactive protective parts that emerge when exiled pain breaks through despite managerial control. Their role is immediate relief.

Unlike managers, firefighters do not plan. They react. They seek to extinguish emotional fire as quickly as possible through impulsive or numbing behaviors such as anger, dissociation, bingeing, substance use, sexual acting out, or other addictive patterns.

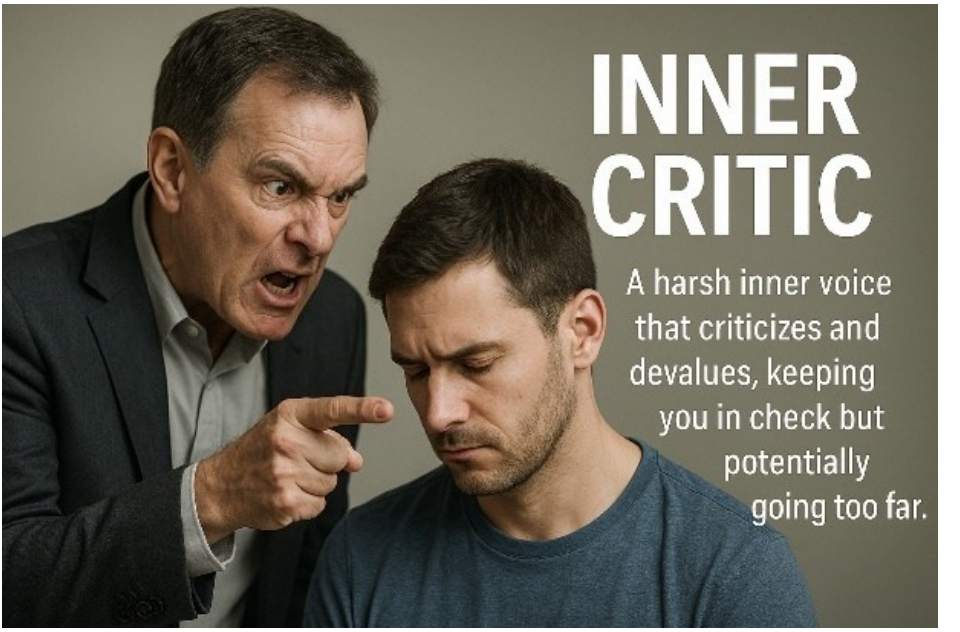
Firefighters are not concerned with long-term consequences. Their sole priority is stopping pain in the present moment. In extreme cases, firefighter activity can include self-injury or suicidal behavior. Though their methods may be destructive, their intent remains protective.

The Inner Critic: The inner critic is a powerful and often misunderstood part of the internal system. It commonly develops in response to environments where mistakes, vulnerability, or failure felt dangerous.

At its healthiest, the inner critic can provide feedback, promote accountability, and guide behavior in alignment with values. When distorted by fear, however, it becomes harsh, condemning, and relentless.

Spiritually, this distinction matters. Condemnation does not come from God. Learning to place the critic under appropriate authority allows its feedback to be received without being crushed by shame.

As Revelation 12:10 (NIV) reminds us, the enemy is ***"the accuser of our brothers and sisters, who accuses them before our God day and night."*** Learning to discern the critic's proper role, and to place it under the authority of Christ, allows us to benefit from its guidance without being crushed by its condemnation.



Understanding Addiction Through the Lens of Parts

For individuals struggling with addiction, this framework often brings profound clarity and relief. Many have spent years believing they lack willpower, discipline, or moral strength. Internal Family Systems offers a very different understanding. Long before substances or compulsive behaviors enter the picture, the internal system is already working tirelessly to manage pain.

Managers often take the lead early in life. These parts attempt to control emotional distress by being good, responsible, dutiful, or

excellent. They strive to earn safety through performance. They may push you to be the perfect student, the reliable employee, the strong provider, the compliant child, or the spiritually disciplined believer. Their message is often, "If we do everything right, the pain will stay buried." For a time, this strategy can appear successful. Life may look functional on the outside, even admirable. Yet the pain carried by exiled parts does not disappear. It waits.

As stress increases, loss occurs, trauma resurfaces, or emotional demands exceed the capacity of the managing system, that buried pain begins to leak through. In those moments, managers no longer know what to do. Control fails. Meaning collapses. The system becomes overwhelmed. This is when firefighters rush in.

Firefighters are not concerned with insight or long-term consequences. Their sole task is immediate relief. When emotional distress becomes intolerable, they seek the fastest way to shut it down. For many, this is where substances enter the story. Alcohol, drugs, pornography, or other forms of acting out become powerful firefighter strategies. In those moments, the behavior is not chosen because it is healthy or wise, but because it works. It numbs pain. It quiets chaos. It brings temporary relief when nothing else can. From the inside, addiction rarely feels like rebellion. It feels like survival.

As you, our friend, begin to understand this dynamic, something important often happens. Shame begins to soften. When you recognize that your behavior has functioned as a defensive response rather than a moral defect, the harsh self-judgment that has fueled despair can begin to loosen its grip. This understanding does not excuse harmful behavior, nor does it deny responsibility. Rather, it brings clarity. You are no

longer left asking, "What is wrong with me?" but are invited instead to ask, "What has my system been trying to protect me from?"

When shame decreases, something else begins to emerge — agency. With understanding comes the ability to respond more neutrally and less emotionally. Instead of being swept along by defenses that feel out of control, you can begin to observe them. You can notice when managers tighten their grip or when firefighters are preparing to act. Awareness creates space, and in that space a different kind of relationship becomes possible.

Rather than fighting your defenses or trying to eliminate them, you can begin to engage them. You can listen to what they fear, understand what they are protecting, and gently negotiate new roles. These parts no longer need to run the system unchecked. They can be brought into dialogue under Self-leadership. In this way, knowledge truly becomes power — not power over yourself, but power with yourself. As insight increases, you are no longer passively controlled by defensive parts reacting in fear. You begin to participate actively in your own healing.

From a NeuroFaith® perspective, this restoration of agency is deeply healing. As understanding replaces judgment and curiosity replaces condemnation, the heart becomes safer. When the heart feels safer, change becomes possible. Defenses no longer need to dominate. They can finally begin to rest.

Self: Self (Who We Were Created to Be)

The Self is not another part competing for influence within the internal system. Rather, it represents what we are ultimately seeking to restore. From a NeuroFaith® perspective, the Self reflects the essence of who

God created us to be — a centered, connected, and relational being designed to live in safety, truth, and love.

Scripture teaches that humanity was created good, bearing the image of God. In that original design, the self functioned in harmony, internally aligned, relationally connected, and securely grounded in God's presence. However, through original sin, that connection was fractured. The self did not cease to exist, but it became wounded, distorted, and disconnected from its true source.

Trauma further compounds this fracture. Pain, fear, and loss obscure access to the self God intended, giving rise to protective parts that attempt to survive in the absence of safety. Over time, individuals lose touch with their true self, not because it is gone, but because it has been overshadowed by fear-driven defenses.

Internal Family Systems helps individuals begin to reconnect with this deeper center. It teaches that beneath layers of protection lies a capacity for calm, compassion, clarity, and courage. Yet NeuroFaith® affirms that full restoration of the self does not occur through psychological insight alone.

Restoration comes through our new identity in Christ, replacing the SELF damaged by sin with the new self, the new creation Christ gives to each of us. This is not just the redemption of the old SELF but replacing it with the new SELF, that is completely aligned with Christ.

" *Throw off your old sinful nature and your former way of life, which is corrupted by lust and deception. Instead, let the Spirit renew your thoughts and attitudes. Put on your new nature, created to be like God—truly righteous and holy."* Ephesians 4:22-24 (NLT)

"*This means that anyone who belongs to Christ has become a new person. The old life is gone; a new life has begun!* (2 Corinthians 5:17 NLT). We will explore this process and these passages in more detail in the next section on spirituality.

Through our new relationship with Christ, the SELF God intended us to be have full access to Him, His Spirit, His Kingdom, and our entire inner world. IFS works best when the SELF is aligned with Christ and empowered by His Spirit to bring healing and restoration to all the fractured parts of our inner world. Therapy can help remove obstacles; grace brings transformation.

IFS identifies this centered presence through what it calls the Eight Cs:

When individuals begin to operate from this restored center, they are more regulated than reactive, more grounded than defensive, and more capable of leading their internal system with wisdom and care.

From a faith perspective, these qualities closely parallel the Fruit of the Spirit described in Galatians 5:22, 23, "***Love, joy, peace, patience, kindness, goodness, faithfulness, gentleness, and self-control.***" When the SELF has been renewed under Christ's leadership, Behavior increasingly reflects these qualities, not through effortful striving, but through inner transformation and alignment with God's design.

How the Parts Work Together

In a traumatized system, exiles carry pain, managers attempt to prevent pain, and firefighters attempt to escape pain. The system is not broken, it is overworked.

As Self-leadership increases, protectors no longer need to remain extreme. Exiles can be approached with care. Internal conflict gives way to cooperation. This shift occurs not through force, but through safety and relationship.

In order to access and heal pain that has been largely exiled from conscious awareness, protective parts must first feel safe enough to soften their roles. Attempting to confront trauma directly often overwhelms the nervous system and strengthens defensive responses. Healing requires that protectors be approached with respect rather than resistance.

Internal Family Systems provides a compassionate and structured pathway for this work through six essential steps, often referred to as the Six Fs.

1. Find

The first step involves identifying the part that is activated in the present moment. Rather than analyzing or judging the experience, the individual is encouraged simply to notice what is arising internally. This may appear as an emotion, bodily sensation, image, impulse, or internal voice. The goal is awareness, not change.

2. Focus

Once a part has been identified, attention is gently directed toward it. The individual remains grounded and differentiated from the part, observing rather than becoming overwhelmed or blended. This step strengthens Self-leadership and promotes regulation.

3. Flesh Out

In this phase, curiosity is used to learn more about the part. Questions may include when it first appeared, what it fears, what it is trying to protect against, and how it has helped in the past. Understanding replaces judgment, and internal trust begins to develop.

4. Feel

Here, the emotions carried by the part are allowed to be experienced in a regulated and supported manner. Rather than avoiding pain, the individual learns to remain present with it, trusting that the nervous system can tolerate emotion when safety is established.

5. Befriend

This step marks a significant shift in the internal system. The part is approached with compassion and appreciation for its protective intent, even if its strategies have been harmful. Internal hostility softens, and cooperation begins to replace conflict.

6. Fear

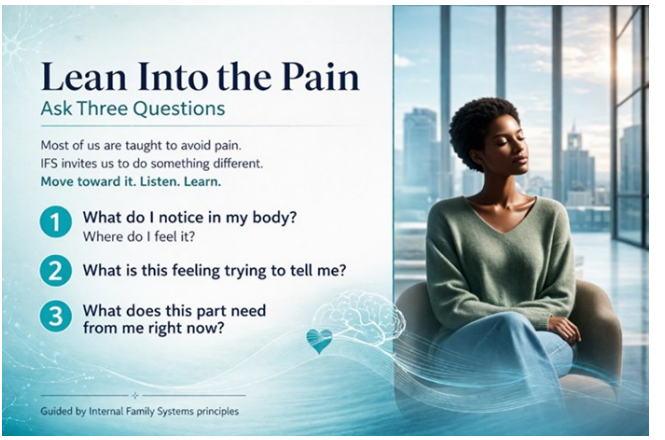
Protective parts often carry fears about what will happen if they release control. They may fear emotional flooding, vulnerability, or further harm. Naming and addressing these fears helps protectors gradually relax their extreme roles and trust the healing process.

Throughout this process, healing unfolds at the pace of the nervous system. Trauma cannot be rushed, and restoration cannot be forced. When approached with patience, curiosity, and compassion, even the most burdened parts can begin to experience relief.

Engaging Emotions Rather Than Avoiding Them

One of the more influential voices helping Christians engage Internal Family Systems with confidence and discernment is Jenna Riemersma. Her book, ***Altogether You***, has become one of the most accessible and readable introductions to IFS for Christian audiences.

Riemersma emphasizes that emotions are not problems to be eliminated, but meaningful signals that deserve attention. She challenges a cultural and spiritual tendency to pursue positive emotions such as happiness and joy while suppressing or avoiding emotions such as sadness, fear, grief, anger, and anxiety. When difficult emotions are dismissed or spiritualized prematurely, individuals often become disconnected from vital internal information.



She teaches that emotions function as important messengers. It has often been said that words are the language of the mind, while emotions are the language of the body and heart. When emotional signals are ignored or numbed, the body continues to communicate distress through symptoms, behaviors, or relational struggles.

A central theme in Riemersma's work is the invitation to move toward pain rather than away from it. She encourages individuals to approach emotional discomfort with curiosity and compassion, trusting that pain often carries insight about unmet needs, violated boundaries, or unresolved grief. In this way, emotions function much like a canary in the coal mine, alerting the system to danger long before collapse occurs.

Many individuals find this perspective liberating, particularly when pain is reframed not as failure, but as feedback. When emotional experience

is met with safety rather than resistance, intensity often decreases and regulation increases.

From a NeuroFaith® perspective, this emphasis aligns closely with trauma-informed care. When pain is acknowledged with compassion, the nervous system begins to settle and defensive parts soften. Emotional awareness becomes a doorway to healing rather than something to fear.

A Necessary Theological Clarification

While Jenna Riemersma's work provides an important bridge for Christians engaging IFS, NeuroFaith® offers a necessary theological clarification regarding the nature of the Self.

Internal Family Systems tends to describe the Self in largely humanistic terms, viewing it as inherently good and simply hidden beneath layers of pain and protection. In this framework, healing occurs primarily through uncovering what was already whole.

While this perspective contains important truth, it remains incomplete.

Scripture teaches that human beings were indeed created good in the image of God. However, it also affirms that the Fall introduced deep fracture into the human interior world. Sin did not affect behavior alone; it wounded identity, desire, and relational capacity. As a result, the self is not merely obscured by trauma but also damaged by original sin.

Healing, therefore, cannot be understood as self-discovery alone. It is also a redemptive process.

NeuroFaith® understands the self as created, fallen, wounded, and unredeemable. Trauma fragments the nervous system and internal

experience, while sin destroyed the self's orientation toward God, self, and others. Both realities must be addressed with humility and grace. Therapeutic work can bring awareness, regulation, and emotional integration. Yet Scripture teaches that true renewal emerges through transformation in Christ. In Him, believers are described as a new creation. The old self is not merely repaired but is being made new.

From this perspective, the Self described in IFS cannot find its fullest expression unless it has been replaced by new SELF, imparted to us through Christ's redemptive work on the cross. New SELF-leadership is Spirit-led leadership. Compassion is grounded in grace. Courage is strengthened by truth. Connectedness flows not only internally, but relationally with God.

This distinction does not reject IFS. Rather, it grounds it within a redemptive framework that honors both psychological insight and spiritual truth.

Integration Rather Than Opposition

NeuroFaith® does not place psychology and faith in competition. Instead, it recognizes that they address different dimensions of the same human experience.

> Psychology helps explain how wounds form.
> Neuroscience reveals how the body responds.
> IFS offers language for the internal system.
> Faith reveals the source of redemption.

When these domains are integrated rather than opposed, healing becomes both compassionate and anchored. As the nervous system stabilizes and internal conflict softens, individuals often find

themselves more able to receive God's presence rather than defend against it.

Therapy, in this sense, does not replace faith. It prepares the soil in which spiritual formation can take root.

Conclusion: Toward a Restored Self

For many adolescents struggling today, the deepest fear is not just the pain they feel, but the quiet belief that something inside them is fundamentally wrong. They may not always say it out loud, but it shows up in how they withdraw, how they overcompensate, how they criticize themselves, or how they try to escape what feels overwhelming. Trauma and stress have a way of shaping that inner narrative early, convincing them that their confusion, intensity, or emotional swings mean they are broken.

But both science and faith offer a very different story.

Internal Family Systems helps adolescents understand that what feels chaotic inside is often deeply organized. The different thoughts, emotions, and reactions they experience are not random or defective. They are parts of a system that learned to survive. The part that shuts down. The part that tries to be perfect. The part that gets angry. The part that numbs out. Even the inner critic that feels so harsh. Each one developed for a reason, often in response to stress, pain, or unmet needs.

When adolescents begin to see this, something important shifts. Instead of fighting themselves, they begin to understand themselves. Instead of shame, there is curiosity. Instead of feeling out of control,

there is a growing sense that their inner world can be known and even guided.

Within the NeuroFaith® model, this understanding does not stand alone. It builds on the work we have already done. As adolescents learn to regulate their nervous system and settle their body through polyvagal-informed approaches, and as they begin to develop coherence through the heart, their capacity to think clearly and reflect increases. They are no longer operating only from survival. They have more space inside. More awareness. More choice.

And this is where real resilience begins to take shape.

Because now, instead of being driven by automatic reactions, adolescents can begin to recognize their internal parts and respond to them with intention. They can notice when a protective part is taking over. They can begin to understand what that part is trying to do. And over time, they can learn to respond not with judgment, but with steadiness and care. This is not just healing from past wounds. This is building the capacity to navigate future challenges with strength and flexibility.

But even this is not the end of the story.

Because adolescents are not only biological and psychological beings. They are spiritual beings as well.

As safety increases in the body, coherence develops in the heart, and understanding grows in the mind, something deeper begins to emerge. Adolescents begin to ask bigger questions. Who am I, really? Why do I matter? Is there purpose to my life? Is there something beyond the pain I feel right now?

And this is where the spiritual dimension becomes essential.

In Christ, adolescents are not defined by their wounds, their struggles, or their past. They are invited into a deeper identity. An identity rooted not in fear, but in love. Not in shame, but in belonging. Not in fragmentation, but in wholeness. As they begin to encounter this truth, the work of healing moves beyond technique and into transformation.

The body learns safety.
The heart learns trust.
The mind gains understanding.
And the spirit awakens to truth.

"May the God of peace himself sanctify you completely. May your whole spirit, soul, and body be kept blameless at the coming of our Lord Jesus Christ." (1 Thessalonians 5:23)

This is the invitation before them. Not just to get through adolescence, but to grow through it. Not just to manage pain, but to become resilient, grounded, and alive. And as we move into the next chapter, we will explore more deeply how this spiritual dimension is not separate from the work we have been doing, but woven through it, shaping and sustaining true and lasting transformation.

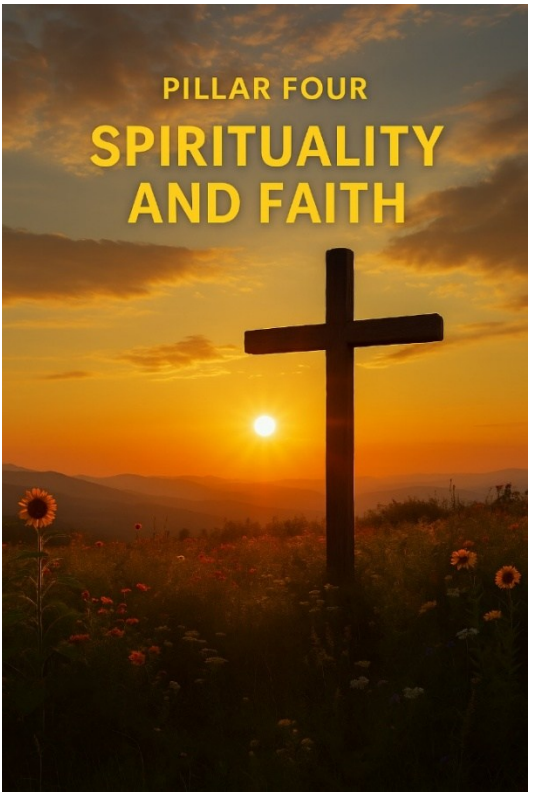
They are not alone in this journey. And neither are you

Pillar Four

Spirituality and Faith

Transformational Healing Through Faith, Neuroscience, and the Rewriting of the Soul

---



Of all the pillars within the NeuroFaith® model, this one stands apart. Not because it is less grounded in science, but because it reaches into a dimension of human experience that science alone cannot fully explain. Polyvagal-informed therapy, neurocardiology, and Internal Family Systems offer powerful and necessary tools for calming the nervous system, restoring physiological balance, and helping us understand the inner architecture of our emotional lives. These approaches matter deeply, especially for adolescents. They help young people regulate their bodies, steady their hearts, and begin to make sense of the internal parts that respond to stress, pain, and uncertainty during one of the most formative seasons of life.

And yet, even as this work begins to take hold, even as the body finds greater safety, the heart moves toward coherence, and the mind gains clarity, something deeper often begins to surface. For teens, this is not optional. It is part of the developmental task of becoming. Because adolescence is not only a time of emotional intensity, it is a time of identity formation. It is a season marked by deeper questions, questions that cannot be quieted by regulation alone. What restores a sense of worth when shame has taken root? What gives meaning to suffering? What anchors hope when life feels unstable or overwhelming? And perhaps most quietly, yet most powerfully, who am I, really?

These are not questions that technique alone can answer.

They lead us into a deeper territory, one that science can illuminate but cannot fully occupy. They lead us into the realm of spirituality.

Within the NeuroFaith® model, spirituality is not treated as a vague abstraction or a sentimental addition to clinical work. It is understood

as a foundational dimension of healing, one that interacts dynamically with the brain, the body, the heart, and the internal emotional world. This is not a separate step or a final layer. It is a permeating force, present within every aspect of the healing process. Faith is not something adolescents arrive at after they have figured everything else out. It is something that shapes, sustains, and deepens their growth from the inside out.

For adolescents, this becomes profoundly practical. Faith begins to shape how they interpret what they feel in their bodies. It reframes emotional pain so that it is no longer experienced solely as failure or deficiency, but as something that can be understood, held, and ultimately redeemed. It changes how they relate to their internal parts, not as enemies to suppress, but as experiences to approach with compassion and guide with wisdom.

And slowly, something begins to shift within them.

Shame, which once felt defining, begins to loosen its grip. Identity, once fragile and uncertain, begins to feel more grounded and secure.
There is a growing sense, often subtle at first, that they are not facing life alone, but are held within something greater than themselves.

Hope begins to return, not as something they must manufacture through effort, but as something they can receive, something anchored beyond their immediate circumstances.

This is where the NeuroFaith® model moves beyond the traditional biopsychosocial framework into a more complete understanding of the person. Adolescents are not simply biological and psychological beings

shaped by their environment. They are spiritual beings as well. And the deeper we explore trauma and recovery during these formative years, the more evident this becomes. The soul is not an abstract concept. It is present within every layer of their experience, shaping how they understand themselves, their pain, and their future. Spirituality, then, is not an escape from science. It is the completion of it.

It allows adolescents to move beyond symptom reduction and even beyond psychological insight into something more enduring. It speaks to the restoration of identity, the healing of shame, and the renewal of hope at a stage of life where those elements are still being formed. It provides a framework through which suffering can be understood, not as meaningless, but as something that can be held within a larger story.

And perhaps most importantly, it reminds them that they are not alone.

Faith becomes the process through which adolescents learn to live, grow, and remain anchored in the midst of uncertainty. It becomes the lens through which they interpret their experiences and the foundation upon which true resilience is built. It offers a strength beyond their own, a perspective beyond their limitations, and a hope that does not rise and fall with circumstance. It connects them not only to meaning, but to a relationship, to a presence that is steady, personal, and grounded in love.

As Scripture reminds us, ***"May the God of peace himself sanctify you completely. May your whole spirit, soul, and body be kept blameless at the coming of our Lord Jesus Christ."*** (1 Thessalonians 5:23, NIV)

This is the invitation before them. Not simply to heal, but to become whole. Not merely to survive adolescence, but to grow through it with strength, clarity, and purpose.

And as we now move more fully into this fourth pillar, we are not leaving behind the work of the body, the heart, or the mind. We are deepening it. Because true healing is not linear. It is multidimensional, multidirectional, and deeply relational. The body learns safety. The heart learns coherence. The mind gains understanding. And through it all, the spirit awakens to truth.

This is the place where healing becomes more than recovery.

It becomes transformation.

Lisa Miller's Research: A New Science of Spirituality

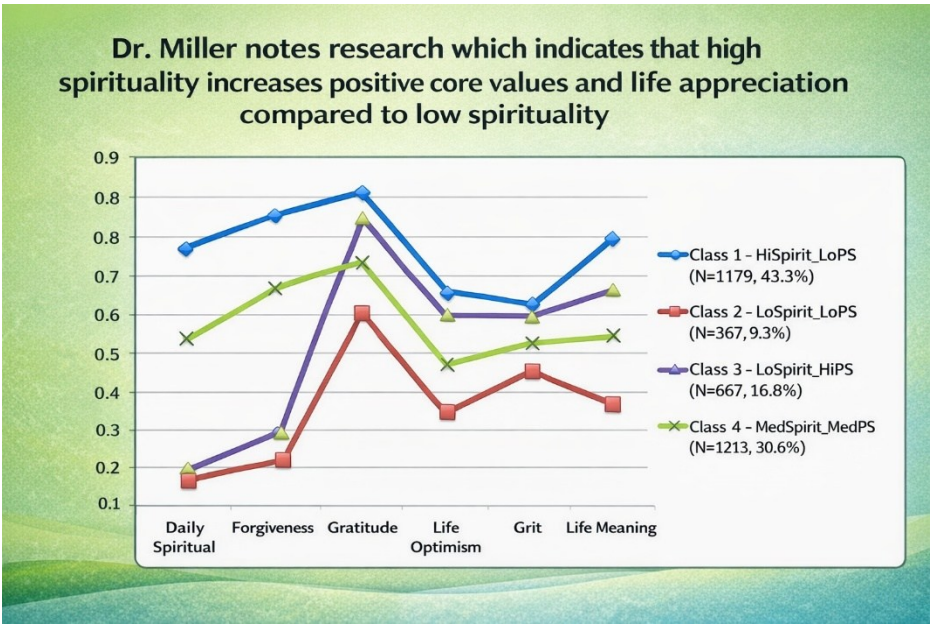
Dr. Lisa Miller, psychologist at Columbia University, has become one of the most respected voices bridging spirituality and neuroscience. In her groundbreaking book *The Awakened Brain* (2021), Miller outlines the robust, peer-reviewed evidence that spirituality is not merely beneficial—it is neuroprotective. Her findings, drawn from over two decades of research and multiple longitudinal and twin studies, include the following:

- Adolescents raised in a spiritual environment were 80% less likely to experience substance dependence or addiction.
- They were 60% less likely to develop Major Depressive Disorder.
- Girls were 70% less likely to engage in sexual risk-taking.
- Spiritual adolescents were 50% less likely to experience suicidality.
- Most powerfully, children whose mothers were also highly spiritual showed an 80% reduction in depression risk.

PROTECTIVE FACTORS OF SPIRITUALITY
Adolescents raised in a spiritual environment were 80% less likely to experience substence dependence or addiction.
They were 60% less likely to develop Major Depressive Disorder.
Girls were 70% less likely to engage in sexual risk taking.
Spiritual adolescents were 50% less likely to experience suicidality.
Most powerfully, children whose mothers were also highly spiritual showed an 80% reduction in depression risk.

These numbers are astonishing. They rival or exceed the protective benefits of medication or therapy alone. And the mechanism is now visible through MRI imaging.

Miller's research shows that individuals with an awakened, spiritually engaged brain exhibit greater cortical thickness, especially in areas responsible for self-regulation, reflection, and resilience. These areas are significantly compromised in those with depression, anxiety, and trauma histories. When activated through spiritual engagement, they buffer the effects of adversity and provide a foundation for moral discernment, emotional regulation, and hope.



The Biopsychosocial-Spiritual Model

The old "biopsychosocial" model is no longer enough. We now recognize that the soul is not an abstraction. It is integrated in every

layer of the human experience—biological, psychological, relational, and existential. The biopsychosocial-spiritual model is not an invention of religion. It is a recognition of human wholeness.

In *The Effect of Spirituality on Health and Healing*, Brian Udermann (2000) concluded from an extensive literature review that spiritual involvement correlates positively with reduced incidence of stroke, cardiovascular disease, cancer, suicide, substance abuse, and general mortality. These outcomes remained significant even after controlling for variables like socioeconomic status and physical health behaviors.

Udermann writes: *"Strong scientific evidence suggests that individuals who regularly participate in spiritual worship services or related activities and who feel strongly that spirituality or the presence of a higher being or power are sources of strength and comfort to them are healthier and possess greater healing capabilities"* (p. 194).

When spirituality is integrated with clinical wisdom, it activates latent neuroplasticity, regulates the nervous system, restores fractured identity, and reshapes the narrative through which individuals understand their lives. The NeuroFaith® model therefore approaches spirituality with both reverence and scientific curiosity. It recognizes that spiritual experience has measurable effects on the brain, the heart, and emotional regulation. At the same time, it acknowledges that the deepest form of healing involves more than physiological regulation or psychological insight. It involves restoration of the soul.

Yet before we can understand how spirituality heals, we must confront the force that most profoundly wounds the human interior world. At the center of trauma and addiction lies a destructive power that is

psychological, physiological, relational, and spiritual all at once. That force is shame.

In parallel, we must address what spirituality is up against: shame. Developmental trauma writes shame into the narrative code of the soul, unlike guilt, which says "I did something wrong," shame says ***"I am wrong."*** It is totalizing, isolating, and destructive. It creates an existential rupture that is resistant to reason and immune to self-help.

Dr. David Hawkins (2014, 2020), though controversial, offers a powerful framework for understanding emotional energy states. Using kinesiology, Hawkins mapped shame at the lowest energetic frequency of all measurable states—a level of 20 on a scale from 0 to 1,000. According to his data, shame produces a cascade of demoralization, physiological breakdown, and soul despair.

Though Hawkins' methodology has been criticized, many clinicians and spiritual leaders have found his conclusions experientially valid. Shame constricts the nervous system, suppresses immune function, and

disrupts the default mode network. It leads to addictive behavior, relational sabotage, and hopelessness. It is, in every sense, anti-life.

The Neurobiology of Shame

If shame were only a belief, it might be easier to overcome. Unfortunately, shame embeds itself far deeper than thought. It becomes encoded in the body, the nervous system, and the physiological systems that govern survival.

The body is often the first place where shame is felt. Before the mind has time to interpret what is happening, the nervous system reacts as though a threat has appeared. The hypothalamic-pituitary-adrenal (HPA) axis, the primary stress response system of the body, activates rapidly. As previously discussed, the hypothalamus signals the pituitary gland, which in turn stimulates the adrenal glands to release cortisol and other stress hormones into the bloodstream (Porges & Porges, 2023).

This response is designed to protect life during genuine danger. In situations of trauma or chronic emotional threat, however, the system becomes repeatedly activated. Over time the body learns to anticipate rejection and humiliation in the same way it would anticipate physical harm. The result is a nervous system that lives in a nearly constant state of vigilance.

Individuals who carry toxic shame frequently describe a persistent sense of tension in their bodies. Muscles remain tight. Breathing becomes shallow. Sleep is often disrupted. The heart races in response to even minor interpersonal stress. These responses are not signs of weakness

or lack of willpower. They are the physiological echoes of repeated emotional injury.

The Polyvagal system provides an especially helpful framework for understanding these responses. In review, according to Polyvagal Theory, the autonomic nervous system contains specialized pathways that continuously scan the environment for cues of safety or danger. When the system detects safety, the ventral vagal pathway supports calmness, connection, and social engagement. When danger is perceived, the system shifts toward sympathetic activation or dorsal shutdown (Porges & Porges, 2023).

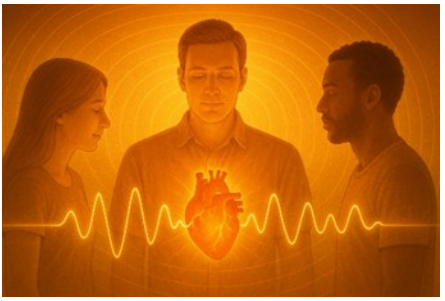
Shame disrupts this system profoundly. Because shame is often experienced in the context of relationships, the nervous system begins to associate social exposure with threat. Eye contact becomes difficult. Voice tone becomes restricted. Facial expression loses animation. The person withdraws emotionally in an attempt to avoid further injury.

In sympathetic activation the individual may appear restless, anxious, perfectionistic, or driven. They work harder, speak faster, and attempt to control their environment in order to prevent rejection. In dorsal shutdown the opposite pattern appears. The person becomes numb, exhausted, disconnected, and emotionally withdrawn. Although these patterns appear very different, they arise from the same underlying problem. The nervous system has lost its sense of safety.

Healing therefore requires more than intellectual understanding. The nervous system itself must learn that connection is no longer dangerous.

The Heart Dimension

The storm of shame does not stop at the nervous system. It also affects the heart. As previously discussed, research in neurocardiology has shown that the heart is not merely a mechanical pump. It generates a powerful electromagnetic field that interacts continuously with the brain and the rest of the body. Emotional states influence the rhythm of the heart, and those rhythms in turn influence neurological and physiological regulation (McCraty, 2023).



When individuals experience emotional coherence, the rhythm of the heart becomes smooth and organized. This state is associated with improved emotional regulation, clearer thinking, and greater resilience. When individuals experience fear, anger, or shame, however, heart rhythms become chaotic and irregular.

Shame produces some of the most disruptive patterns in heart rhythm. The individual feels exposed and unsafe. Emotional tension increases. Heart-rate variability decreases. The communication between heart and brain becomes strained. Over time this pattern contributes to chronic stress and emotional instability.

Yet the heart also plays an important role in healing. Practices that cultivate gratitude, compassion, and reverence can restore coherence to heart rhythms. As the heart becomes more regulated, the brain receives signals of safety and calmness. Emotional stability gradually increases. For many individuals, spiritual practices become a powerful

pathway to restoring this coherence. Prayer, worship, reflection, and gratitude can calm the nervous system and restore harmony between heart and brain (McCraty, 2023). In this sense spirituality does not exist apart from physiology. It participates in the regulation of the body itself.

The heart, quite literally, begins to remember peace.

Psychology can name shame, and at times buffer its effects. But it cannot redeem the soul. Only a transformative encounter with grace can do that.

The Eye of the Storm

Shame is often misunderstood as a simple emotion. In reality, it behaves more like a storm that sweeps through the entire human system. It moves through the nervous system, the body, the heart, the inner

emotional world, and the story a person tells about themselves. It does not merely produce discomfort. It reshapes identity.

Shame whispers a devastating lie. It tells the individual that the problem is not simply what they have done but who they are. It convinces them that they are fundamentally defective, unworthy of love, and unsafe to reveal. This lie is ancient. The earliest description of shame appears in the opening chapters of Scripture. After Adam and Eve disobeyed God, their immediate response was not merely guilt but hiding. Adam explains his reaction with heartbreaking simplicity: ***"I heard you in the garden, and I was afraid because I was naked; so I hid"*** (Genesis 3:10, NIV).

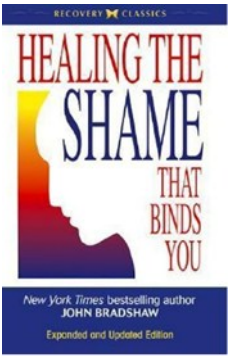
In that moment fear and shame became intertwined. Humanity stepped away from safety and belonging and entered a long history of hiding. The story of trauma and addiction often reflects that same movement. The wounded person withdraws into secrecy, convinced that exposure would lead only to rejection.

Modern neuroscience confirms what Scripture recognized thousands of years ago. Shame is not only emotional or spiritual. It is physiological. When shame is triggered, the hypothalamic-pituitary-adrenal axis activates as though the individual were facing physical danger. Stress hormones flood the bloodstream. The nervous system shifts into survival mode. The body prepares for threat even when no immediate threat is present (Porges & Porges, 2023). The result is a state of chronic vigilance. Muscles tighten. Breathing becomes shallow. The heart races. The nervous system learns to interpret ordinary human interaction as potential danger. Over time shame becomes embodied. It is not simply remembered. It is carried.

As noted earlier, the Polyvagal system, which helps the body detect safety through tone of voice, facial expression, and relational presence, begins to malfunction under the weight of chronic and toxic shame. The ventral vagal pathways that normally support connection and calmness withdraw. The sympathetic nervous system pushes the individual toward constant alertness. Some individuals move into relentless activity and anxiety. Others collapse into emotional numbness and withdrawal. Both patterns reflect the same underlying disruption of safety (Porges & Porges, 2023). Shame therefore becomes more than a psychological experience. It becomes a physiological environment. The person learns to live as though love itself were dangerous.

To understand how deeply this storm affects human identity, it is helpful to listen to several voices that have helped shape our understanding of shame in modern psychology and trauma recovery. Three such voices are John Bradshaw, Tim Fletcher, and Curt Thompson. Each approaches the subject from a different perspective. Yet together they reveal a common truth. Shame is not merely an emotional state. It is an identity wound.

John Bradshaw: The Wounded Healer and the Language of Shame



John Bradshaw's life story reflects the very struggle he would later help thousands of others understand. Born in Houston in 1933, Bradshaw grew up in a family shaped by alcoholism and emotional instability. His father's absence left a profound wound of abandonment that followed him into adulthood.

Bradshaw initially pursued the priesthood, studying philosophy and theology at the University of Toronto. Like many who are drawn toward spiritual vocation, he hoped that intellectual and theological understanding might quiet the deeper ache within the human heart. Yet beneath his studies remained a persistent sense that something was fundamentally wrong with him.

After leaving the priesthood, Bradshaw battled alcoholism and despair before eventually entering recovery. Through that process he discovered the insight that would define his life's work. The deepest pain of many individuals was not guilt about their actions but shame about their identity. In his influential book ***Healing the Shame That Binds You***, Bradshaw described the distinction between healthy shame and toxic shame. Healthy shame reminds human beings of their limitations and encourages humility and dependence on others. Toxic shame, however, operates very differently. It convinces individuals that they themselves are defective. It transforms shame from a feeling into an identity (Bradshaw, 2005).

Bradshaw referred to this condition as "soul murder."

When toxic shame takes root, authenticity begins to disappear. The individual learns to hide not only their mistakes but their needs, emotions, and desires. They become increasingly disconnected from their true selves. Instead of living from a place of authenticity, they begin performing roles designed to gain approval or avoid rejection.

Bradshaw also recognized that shame is often transmitted across generations. In families where love is conditional, where affection is withheld, or where perfection is demanded, children quickly learn that their worth depends on performance. Over time they internalize the

belief that their deepest longings are somehow wrong. The spontaneous joy and curiosity of childhood slowly give way to caution and self-protection (Bradshaw, 2005).

Yet Bradshaw's work also pointed toward hope. He recognized that healing shame requires more than intellectual insight. It requires community, honesty, and grace. Through confession, acceptance, and spiritual restoration, individuals can begin rediscovering the truth that their worth was never lost. In this way Bradshaw laid the conceptual foundation for understanding shame as an identity wound rather than simply a moral failure.

Tim Fletcher: Shame and the Narrative of the Mind

Tim Fletcher extends Bradshaw's insights by exploring how shame becomes embedded in the nervous system and in the narrative structure of the brain itself. Fletcher is a Canadian counselor and the founder of RE/ACT Recovery Education for Addictions and Complex Trauma. His work focuses on the relationship between developmental trauma, addiction, and negative core beliefs.

Fletcher often explains that trauma does not only create painful memories. It reshapes the beliefs individuals hold about themselves. When children grow up in environments where their emotional needs

are repeatedly ignored, criticized, or invalidated, they eventually arrive at a devastating conclusion: the problem must be me.

From that conclusion emerges a set of core beliefs that become the operating system of the wounded mind. Fletcher frequently describes four of the most common beliefs that appear in individuals who have experienced developmental trauma:

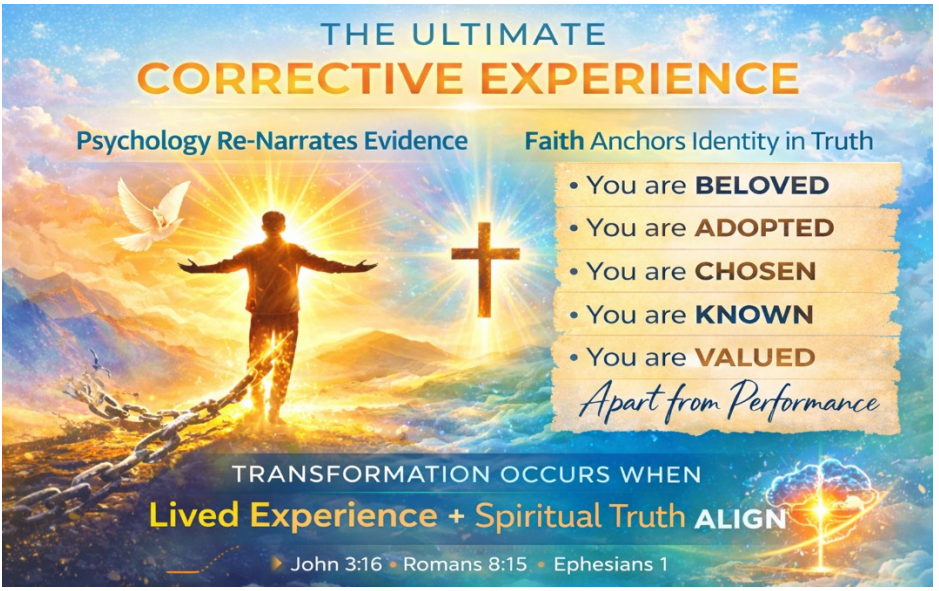
"I am not lovable."
"I am not safe."
"I do not matter."
"I am bad."

These beliefs become deeply embedded in the brain's Default Mode Network, the neural system responsible for self-referential thinking and autobiographical identity. Over time they become the lens through which the individual interprets every relationship and every experience (Fletcher, 2022; Fletcher, 2023; Fletcher, 2025).

When trauma occurs repeatedly during development, the Default Mode Network becomes organized around negative self-referential beliefs. These beliefs shape the ongoing narrative of the self. The individual begins to interpret life through a lens of defectiveness and insecurity (Thompson, 2023). This is why shame can feel so permanent. It is not simply an emotion that appears occasionally. It becomes part of the brain's background activity. Every experience is filtered through the same internal story. Positive events are minimized. Criticism is magnified. Ambiguous interactions are interpreted as rejection. The mind quietly rehearses the same painful narrative over and over.

The tragic result is that even positive experiences may fail to penetrate the internal narrative. Compliments feel suspicious. Love feels temporary. Acceptance feels fragile. Addiction often emerges as an attempt to escape the relentless pressure of this internal story.

Fletcher's work highlights an important truth for trauma treatment. Recovery cannot stop at behavioral change alone. A person may achieve sobriety and still feel worthless. Until the underlying identity narrative is addressed, the deeper wound of shame remains intact. Healing therefore requires something more powerful than willpower or self-improvement. It requires transformation of the story the mind tells about the self.



Curt Thompson: Being Seen and Known

Psychiatrist Curt Thompson brings another important dimension to the conversation by integrating neuroscience, attachment theory, and Christian spirituality. In his book ***The Soul of Shame***, Thompson explains that shame disrupts the neural pathways that allow human beings to experience belonging (Thompson & Seybeth, 2018).

Human beings are created for connection. The brain develops within relational environments that shape its ability to regulate emotion and interpret social cues. When individuals experience consistent love, presence, and safety, their nervous systems learn that relationships are trustworthy. When those experiences are absent or distorted, the brain adapts by preparing for rejection. Shame therefore becomes a relational injury. It teaches the individual that being seen is dangerous.

Thompson describes how this dynamic disrupts integration within the brain itself. The prefrontal cortex, responsible for reflection and self-

regulation, becomes less coordinated with emotional and relational circuits in the limbic system. The Default Mode Network begins reinforcing narratives of defectiveness and isolation (Thompson, 2023). Yet Thompson also emphasizes that healing occurs through relational presence. When individuals are seen, heard, and accepted without condemnation, the brain begins to reorganize. Neural pathways associated with safety and connection grow stronger.

This insight aligns beautifully with the spiritual vision of Scripture. Healing occurs not through isolation but through love. ***"There is no fear in love. But perfect love drives out fear"*** (1 John 4:18, NIV). Thompson's work reminds us that grace is not merely a theological concept. It has measurable biological effects. When love replaces condemnation, the brain itself begins to change (Thompson, 2025).

The Internal World: Fragmentation and the Inner Family

Shame does not only affect our body and our heart. It also reorganizes our internal emotional world.

As we have previously discussed, Internal Family Systems offers a helpful framework for understanding how this occurs. According to IFS theory, the human psyche is composed of multiple internal parts that interact with one another. These parts include exiles, managers, and firefighters. Each of them develops in response to emotional experience and plays a role in protecting the individual from pain (Schwartz, 2023).

Exiles are the parts of the Self that carry the deepest wounds. They often hold memories of rejection, humiliation, fear, and abandonment. Because these emotions are overwhelming, other parts of the psyche work hard to keep the exiles hidden from awareness. Managers attempt to maintain order and control. They often manifest as perfectionism, hyper-responsibility, emotional restraint, or people-pleasing behavior. Their goal is to prevent situations that might expose the vulnerable exiled parts. Firefighters emerge when the pain of exile becomes unbearable. They attempt to extinguish emotional distress through impulsive behaviors such as addiction, anger, or dissociation.

Shame intensifies these dynamics dramatically. The exiled parts become saturated with the belief that they themselves are defective. Managers become increasingly rigid in their efforts to prevent exposure. Firefighters become more extreme as they attempt to silence overwhelming emotional pain.

One of the most painful consequences of shame within the internal system is the emergence of the Inner Critic. This voice often begins as an attempt to protect the individual from external criticism. Over time, however, it becomes relentless and destructive. The critic accuses, condemns, and shames the individual repeatedly. Instead of guiding behavior toward growth, it begins attacking identity itself.

This dynamic erodes the qualities that IFS identifies as the Eight C's of Self as noted previously. In review these qualities include calm, clarity, curiosity, compassion, confidence, courage, creativity, and connectedness (Schwartz, 2023). Under the weight of shame these qualities fade. We begin living primarily from our defensive parts rather than from the grounded center of out Self. Yet these qualities are not truly lost. They remain present beneath our layers of protection and fear. Healing involves helping our internal system rediscover these qualities and allowing our wounded parts to experience compassion rather than condemnation.

The Science of Spirituality and the Healing of Shame

As we have seen throughout this chapter, shame moves through every dimension of the human person. It affects our nervous system, our heart, our internal emotional world, and the narrative structures of our mind. It teaches our body to brace, our heart to constrict, and our mind to repeat a painful story about our identity. If healing is to occur, something powerful enough to reach each of these layers must enter the process. Increasingly, research suggests that spirituality is one of the most powerful forces capable of doing precisely that.

Psychology can help us understand shame and reduce its impact, but it often struggles to fully dismantle our deeper narrative that shame creates. Our wounds need more than coping strategies. They need a

new verdict about our identity. This is precisely where the Christian story enters the conversation.

The Redemptive Work of Christ

The NeuroFaith® model ultimately points toward a spiritual truth that lies at the heart of Christian faith. According to the New Testament, the central act of redemption occurred through the life, death, and resurrection of Jesus Christ. In the language of the Apostle Paul, this event was not merely symbolic but transformative.

"He was delivered over to death for our sins and was raised to life for our justification" (Romans 4:25, NIV).

In this declaration our narrative of shame is directly confronted. We are no longer defined by our past failures or by the wounds inflicted through trauma. Instead, our identity becomes rooted in reconciliation with God.

The transformation described in Christian Scripture is not superficial. It involves the renewal of our mind itself. Paul writes, *"Do not conform to the pattern of this world, but be transformed by the renewing of your mind"* (Romans 12:2, NIV). The Greek word translated as "transformed" in this passage refers to a profound change in form or nature. It suggests something closer to metamorphosis than gradual improvement. Our old narrative shaped by shame begins to dissolve, and a new narrative grounded in grace begins to emerge.

Paul summarizes this transformation with extraordinary clarity: *"Therefore, if anyone is in Christ, the new creation has come: The old has gone, the new is here!"* (2 Corinthians 5:17, NIV). For those of us whose lives have been shaped by shame, these words carry immense

significance. They declare that our identity is not determined by trauma, addiction, or failure. Through Christ, the deepest accusation against our soul loses its authority.

Grace interrupts shame's narrative.

Soul Rebirth: From Shame to Restoration

Healing from trauma, addiction, despair, and depression is not merely the reduction of symptoms. It is the restoration of the whole person. It is the rediscovery of the Self that existed before shame rewrote the story of identity.

Throughout this journey, we have seen how trauma does not affect just one part of us. It wounds the nervous system, teaching the body to live in vigilance. It disrupts the rhythms of the heart, creating instability where there was meant to be coherence. It reshapes the mind, embedding narratives of fear, defect, and unworthiness. And over time, these wounds reach even deeper, settling into the very core of identity as wounds of the psyche and wounds of the soul.

For adolescents, this is especially profound. The very years meant for forming identity, building resilience, and discovering purpose can instead become years where shame quietly takes root. What should have been a season of becoming can begin to feel like a season of unraveling. And yet, this is precisely where hope begins.

Because each of the pillars we have explored is not isolated but deeply connected. When the body learns safety, the heart begins to settle. As the heart becomes more coherent, the mind gains the capacity to reflect and understand. And as the mind begins to make sense of its internal world, it can respond with wisdom rather than reactivity. As these

systems begin to align, something deeper opens—something that cannot be manufactured through technique alone.

The soul awakens.

This is why the fourth pillar is not simply another component of healing, but the dimension that gives meaning to all the others. It is the force that quietly permeates the entire process. Without it, we can regulate, understand, and even improve, but something essential remains unresolved. With it, healing moves beyond management into transformation.

Spirituality speaks directly to the questions that linger beneath the surface. It addresses identity where shame has distorted it. It restores worth where it has been diminished. It brings meaning to suffering and anchors hope beyond circumstance. Where shame isolates and condemns, faith reconnects and restores, gently but persistently reminding us that we are known, loved, and not alone.

And as this truth begins to take root, something within the adolescent begins to change. The nervous system finds a deeper sense of safety. The heart begins to move toward coherence with greater ease. The mind loosens its grip on distorted narratives, and the inner critic slowly loses its authority. What once felt overwhelming becomes more navigable, and what once felt defining begins to release its hold. Resilience is no longer something forced through effort alone, but something formed through connection, meaning, and truth.

"For you created my inmost being; you knit me together in my mother's womb" (Psalm 139:13, NIV).

This is the truth that shame could never erase.

Recovery, then, is not the reconstruction of a broken self. It is the rediscovery of the person God designed from the beginning. As the storm of shame begins to quiet, the body breathes more freely, the heart steadies, and the mind begins to tell a different story. And in that quiet space, the soul begins to recognize a familiar voice—not a voice of condemnation, but a voice of invitation, calling gently and persistently, Come home.

This is the movement from fragmentation to integration, from isolation to connection, from despair to hope, and from shame to restoration. It is the journey from soul-wounding to soul-renewal. And in that renewal, adolescents do not simply recover from what has happened to them. They become stronger because of it, developing a resilience that is not rooted in self-reliance alone, but in connection to something greater than themselves—a strength that endures, a hope that holds, and a life that is deeply anchored.

This is the gift of the fourth pillar. Not merely symptom relief or psychological insight, but the restoration of identity, the healing of shame, and the awakening of a living relationship with God. It is the dimension that brings direction to the body, coherence to the heart, clarity to the mind, and life to the soul.

And it reminds us, with quiet authority and enduring truth, that the final word over our lives is not trauma, not addiction, not despair, and not shame, but restoration—steady, redemptive, and complete.

Peace.

The Honorary Pillar

Movement as Medicine

Although not formally listed among the four foundational pillars of the NeuroFaith® model, physical exercise deserves a prominent place in any serious conversation about the mental, emotional, and spiritual health of adolescents. For parents navigating the challenges of raising teens in today's world, it is important to understand that movement is not simply a lifestyle preference. It is a powerful and often underutilized intervention for anxiety, depression, trauma, and even early addictive patterns. To leave it out would be a

disservice not only to the science, but to the lived experience of countless young people whose lives have been meaningfully changed through consistent physical activity. For this reason, we offer it here as an honorary pillar, a steady companion to the spiritual, neurological, and emotional work of healing.

To be clear, if the effects of exercise could be distilled into a pill, it would likely be considered one of the most effective interventions available for adolescent mental health. Regular movement improves mood, stabilizes sleep, increases energy, sharpens cognitive clarity, and reduces inflammation. It also supports the release of **brain-derived neurotrophic factor, or BDNF**, which plays a critical role in neuroplasticity and the developing adolescent brain. During a season of life when the brain is rapidly changing and highly sensitive to both stress and input, these effects are not minor. They are foundational.

For teens, movement does more than change the brain. It helps regulate emotion, builds confidence, channels stress, and reconnects them to their bodies in a healthy and grounding way. In a culture that often pulls young people into screens, comparison, and internal rumination, physical activity provides an essential counterbalance. It draws them outward, engages their strengths, and reinforces a sense of capability and resilience.

For parents, the implication is both simple and profound. Encouraging regular physical activity is not just about health or fitness. It is an investment in your child's emotional stability, mental clarity, and long-term capacity to cope with stress and adversity. Whether through sports, strength training, hiking, or simply consistent daily movement,

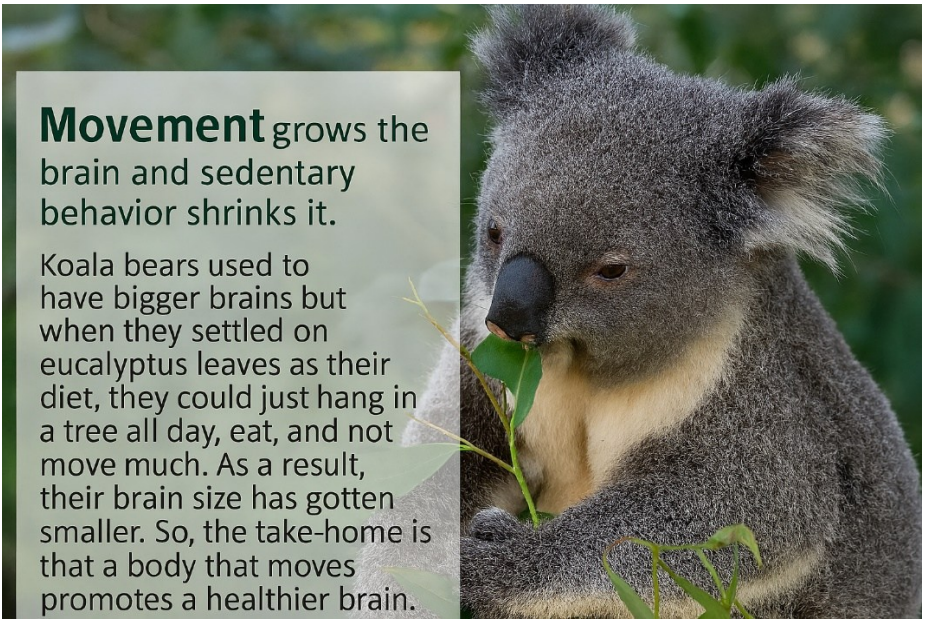
helping adolescents build this habit can be one of the most practical and impactful ways to support their development.

Scripture reminds us of this integrated vision of health: ***"Dear friend, I hope all is well with you and that you are as healthy in body as you are strong in spirit"*** (3 John 2 NLT). The body and the spirit are not separate domains. They are deeply connected. When we care for one, we often strengthen the other.

In the broader work of guiding adolescents toward wholeness, physical movement is not optional. It is essential.

Movement as Sacred Participation

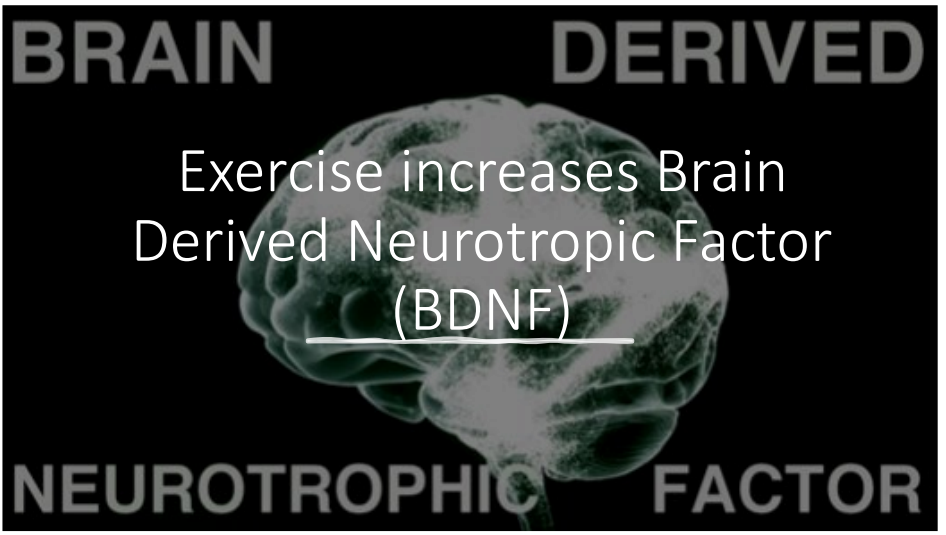
Exercise is not merely a physical task. It is an embodied prayer, a declaration of hope, and a direct act of resistance against the immobilizing weight of depression. When someone battling depressive symptoms chooses to get up and move, they are sending a powerful signal to their brain and body that life still matters. In that moment, they are reclaiming agency and affirming their commitment to healing, to becoming, and to living.



In Scripture, the body is not a shell to be escaped but a temple to be honored. Paul writes, *"Do you not know that your bodies are temples of the Holy Spirit, who is in you, whom you have received from God?"* (1 Corinthians 6:19, NIV). Movement, then, is not only therapeutic but sacred. It is a return to the rhythms of life and an invitation for the Holy Spirit to inhabit us more fully.

BDNF: The Miracle Molecule

Brain-derived neurotrophic factor, or BDNF, plays a critical role in neural resilience and regeneration. Often dubbed "Miracle-Gro for the brain," BDNF supports the growth of new neurons, protects existing ones, and fosters the synaptic connections necessary for learning and memory. Individuals with depression often show reduced levels of BDNF, which may contribute to cognitive fog, low mood, and difficulty experiencing pleasure (Duman & Monteggia, 2006).



Exercise, particularly aerobic activity such as brisk walking, cycling, or swimming, reliably increases BDNF levels. In one landmark study, Erickson and colleagues (2011) found that one year of moderate aerobic exercise increased hippocampal volume and BDNF levels in older adults. These findings suggest that movement is not simply helpful but essential to reversing the cognitive and emotional shrinkage that often accompanies chronic stress and depression.

Anti-Inflammatory Effects

Emerging research shows that depression is not merely a neurochemical imbalance but also a neuroinflammatory condition. Inflammatory markers such as C-reactive protein (CRP), interleukin-6 (IL-6), and tumor necrosis factor-alpha (TNF-α) are often elevated in individuals with major depressive disorder (MDD) (Miller & Raison, 2016). Chronic low-grade inflammation affects neurotransmitter availability, reduces BDNF, and disrupts the HPA axis; all of which exacerbate depressive symptoms.

Exercise helps reduce systemic inflammation by downregulating these inflammatory cytokines, enhancing antioxidant defenses, and improving immune regulation. The effects are particularly strong with consistent, moderate-intensity movement. In a world where pharmaceuticals dominate the conversation, we must remember that movement is one of the most powerful anti-inflammatory agents known to man.

Restoring Autonomic Balance

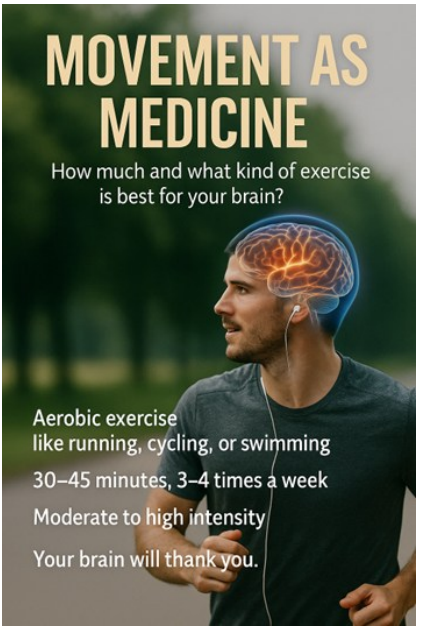
As discussed in our chapter on polyvagal theory, the autonomic nervous system (ANS) plays a pivotal role in mood regulation. Depression often correlates with a shutdown of the ventral vagal system and a dominance of dorsal vagal responses—marked by lethargy, immobilization, and despair. Exercise activates the sympathetic nervous system in a healthy way and promotes rebound engagement of the ventral vagus, helping to restore autonomic flexibility (Porges, 2011).

Activities like yoga, tai chi, and mindful walking not only engage the body but also soothe the mind, fostering a sense of embodied safety. When combined with breathwork and intention, movement becomes a powerful gateway to regulation and spiritual attunement.

The Evidence is Overwhelming

Meta-analyses have confirmed that exercise is as effective, and in some cases more effective, than pharmacotherapy for mild to moderate depression (Blumenthal et al., 2007; Cooney et al., 2013). Unlike medication, which often comes with side effects and long-term

dependency risks, exercise builds capacity, not dependency. It fosters agency, not passivity.



In fact, the most robust outcomes are found when exercise is integrated into a multi-modal treatment approach. This is the very premise of NeuroFaith®, that no single intervention is enough, but when layered together, each strand forms a cord of healing that is not easily broken.

Hope with Sweat Equity

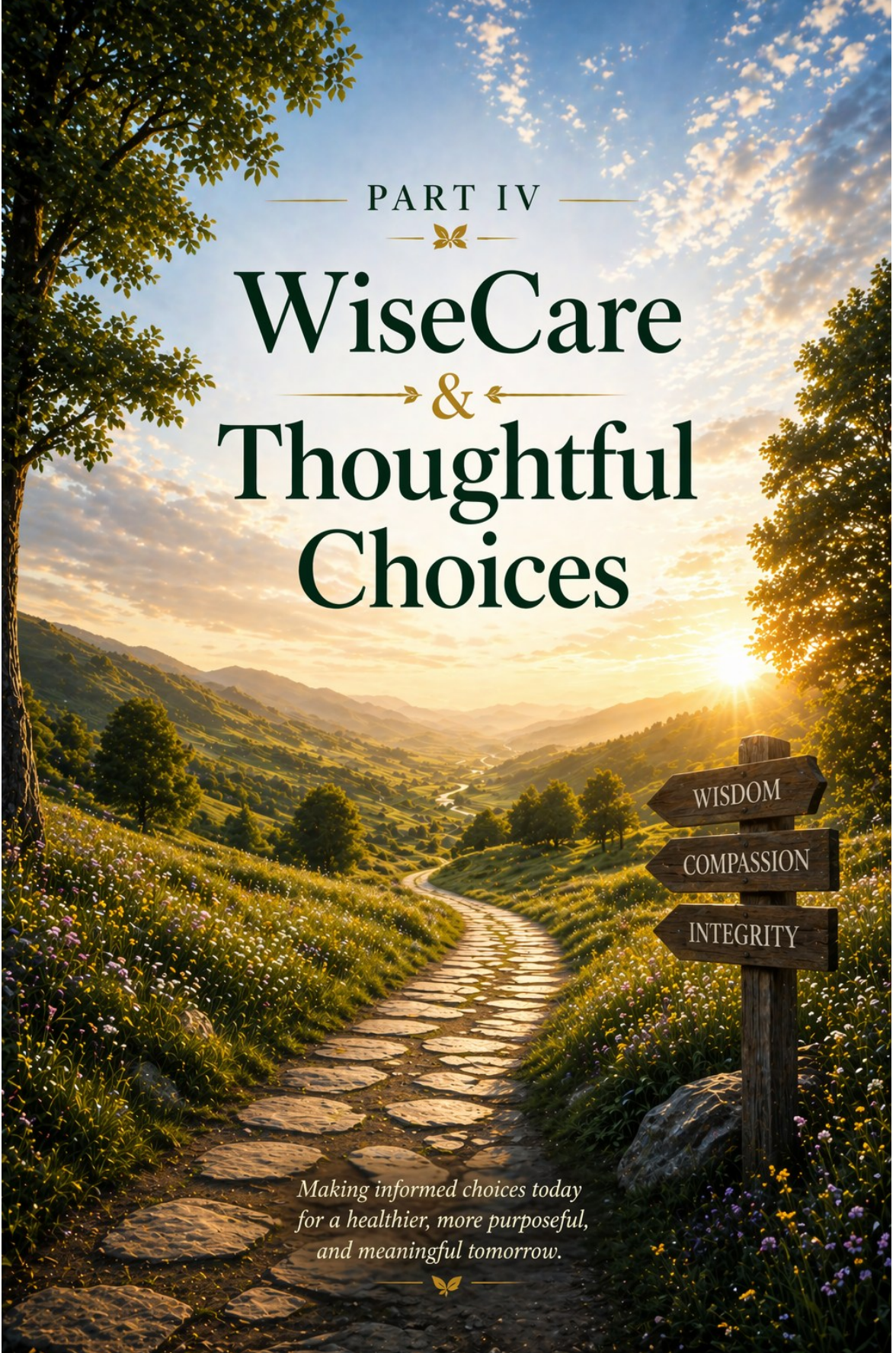
In the end, what we are highlighting here is both simple and profound. Movement is not just helpful. It is essential. In a season of life where adolescents are developing rapidly and often struggling under the weight of anxiety, depression, and disconnection, physical activity provides a stabilizing force that strengthens the mind, regulates the body, and supports the spirit in ways few interventions can.

As we noted earlier, if the effects of exercise could be captured in a pill, it would likely be considered one of the most powerful treatments available. But it is more than that. It builds capacity rather than dependency. It restores agency. It invites young people back into their bodies and into the real world, breaking the quiet drift toward isolation that so often takes hold in screen saturated environments and spaces of withdrawal. It reminds them, at a very real level, that they are capable of movement, growth, and change.

For we parents, this is not a small lever. It is a decisive one. Encouraging consistent movement is one of the most practical and impactful ways to support your child's resilience, emotional stability, and long-term well-being. It does not require perfection. It requires consistency, encouragement, and a willingness to draw them out of isolation and into engagement with life.

As we consider the broader work of guiding adolescents toward wholeness, this honorary pillar stands firmly alongside the others. When practiced consistently, it reinforces everything we are trying to build. Strength. Clarity. Regulation. Hope.

This is not optional. It is part of the pathway forward.


PART IV
WiseCare
&
Thoughtful
Choices
WISDOM
COMPASSION
INTEGRITY
Making informed choices today
for a healthier, more purposeful,
and meaningful tomorrow.

Creating a Safe Place for Teens to Talk

The doorway to an adolescent's heart is narrow, and fragile. Step toward it with grace, and it may open. Push too hard, and it slams shut.

This chapter is about helping create that doorway - a safe space where depressed and hurting teens can feel secure enough to speak. We cannot overstate this: the wrong approach will shut them down. One careless

remark, one dismissive glance, one moment of mis-attunement can cause a teen to retreat into silence. Our posture, tone, and facial expressions must be one of care, humility, and sacred attentiveness.

Adolescence is not merely a stage to endure, it's a sacred window of becoming. It's a time of dramatic neurological development, emotional intensity, and identity exploration. For parents, providers, and mentors, walking alongside teens can feel daunting, even overwhelming. But with insight and intentional care, this journey can also be one of the most rewarding. This chapter offers both practical strategies and deep encouragement for those walking with adolescents through depression, confusion, or emotional pain.

We offer this with humility and hope, recognizing that there are no perfect formulas when working with teens, only postures of presence, patience, and persistent grace.

Listen more, talk less

One of the first and most essential postures we can adopt is learning to listen more and speak less. In our eagerness to help, we may be tempted to lecture or preach, thinking our wisdom will pull them out of their despair. But for many teens, those well-intended monologues land with a thud or even worse. They don't need our sermons—they need our presence. We must resist the urge to correct and instead learn to co-regulate. A teen doesn't want to be told how to fix their feelings; they want to know someone is strong enough to sit with them in and through the storm.

Many of us fall into the trap of over-talking. Yet the 80/20 rule is a simple and powerful corrective: listen 80% of the time and speak only

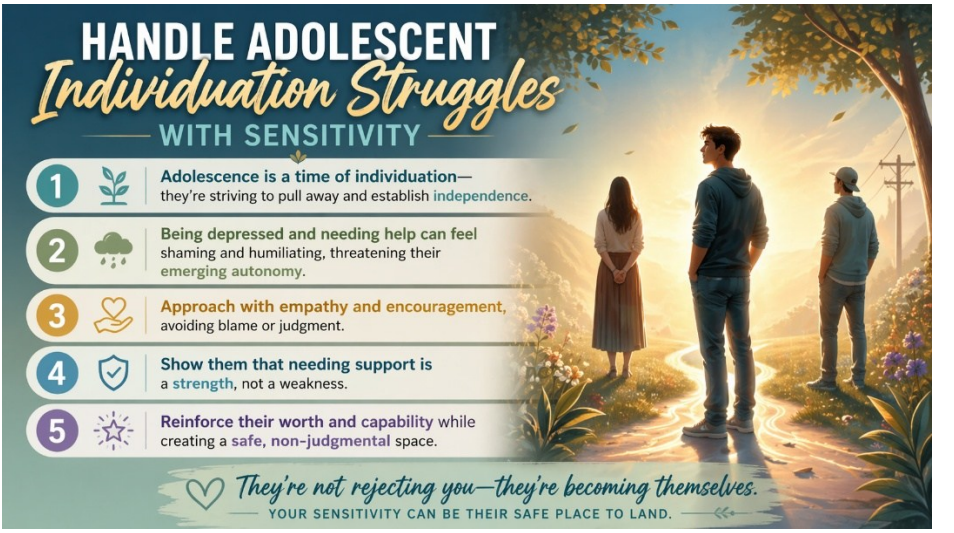
20%. If we fill every pause with our own fears or advice, we rob them of the space they need to hear their own voice. Even silence can be healing when held with compassion. The goal isn't to fill the air with solutions but to offer a safe space where teens can begin to hear and accept themselves again. When the emotional stakes are high—and they often are—a teenager needs to feel that they can share without judgment or interruption. The wrong approach can shut them down in an instant. One wrong word, one critical look, and the opportunity for honest dialogue may vanish. The aim, always, is to create a sacred and secure space that invites openness rather than demands it.

Of course, this means managing our own anxiety. Adolescents are profoundly sensitive to emotional tone. If we bring stress into the conversation, they'll pick it up before we say a word. Think of anxiety as emotional poison ivy—it spreads fast and leaves everyone irritated. When we lead with calm assurance and grounded love, we offer something their nervous systems can mirror. In essence, we become the

thermostat for the emotional climate. If we are regulated, we invite regulation. If we are panicked, they absorb it and escalate.

This capacity to stay steady becomes even more important when we understand the adolescent brain. It's undergoing a radical neurological renovation. The limbic system, which processes emotion, matures early, while the prefrontal cortex, responsible for judgment and self-regulation, comes online much later. This imbalance leaves teens with intense emotions and underdeveloped brakes. They are, quite literally, "all gas, no brakes." That's not a character flaw—it's biology. But it does mean they need adults who can lend them their prefrontal cortex in moments of overwhelm. We do this not by controlling them but by containing the chaos with wisdom and warmth.

When a teen is depressed, their emerging independence can feel especially fragile. They may interpret offers of help as threats to their autonomy. What they often need is not intervention but invitation. We can affirm their autonomy even as we extend support. Let them know that needing help is not weakness but wisdom. We must meet their despair not with directives but with dignity. Often, this means being quietly and compassionately available, ready to walk beside them rather than push them forward or hold them back.



Motivational Interviewing

Motivational Interviewing (MI) is one of the most effective ways to support hurting teens while respecting their independence. Instead of pushing or correcting, MI helps us guide with empathy. Rather than saying, "Here's what you need to do," we begin with, "Can we talk about what's been hard lately?" That simple shift opens doors instead of closing them.

At its core, MI is about partnership, not pressure. Teens are far more likely to engage when they feel heard, respected, and not controlled. This approach lowers defensiveness and builds trust, which is the foundation for any meaningful change.

One of the most powerful (and often overlooked) skills in MI is asking permission. It sounds simple, but it changes everything:

- "Would it be okay if I shared an observation?"
- "Can I ask you something about that?"

- "Do you want my thoughts, or do you just want me to listen?"

When teens are given a choice, they feel a sense of ownership and safety, rather than resistance.

From there, we keep it simple:

- Listen more than you speak
- Reflect what you hear ("It sounds like you've been really overwhelmed lately.")
- Validate their experience ("That makes sense—you've had a lot on your plate.")
- Explore gently ("What do you think might help, even a little?")

The goal is not to force change, but to help them discover it. Even small steps matter. When teens feel understood rather than judged, they are far more willing to consider new directions.

MI reminds us of something essential:
Connection creates change, not control.

Humor

Sometimes, what is needed most in these moments is not more intensity, but a gentle lightness. When used wisely, humor can soften tension and create space where connection can breathe again. It is not about making fun of the situation or minimizing pain, but about reminding one another that we are still human in the middle of it.

As the illustration below suggests, trying to force a teen to open up in the wrong way can feel like poking a bear and hoping for a hug. At best, the teen pulls away. At worst, the moment escalates. The point is not to criticize the effort, but to recognize how easily pressure can backfire, even when our intentions are good.

A small, well-timed moment of levity can shift the tone. It can lower defenses, ease anxiety, and quietly communicate, "We're okay. We can figure this out together." For adolescents especially, humor can feel safer than intensity, more inviting than pressure.

When offered with sensitivity and care, humor becomes more than a coping tool. It becomes a bridge. A way of restoring connection when fear, frustration, or discouragement have begun to pull people apart.

In the end, it is not about saying the perfect thing. It is about staying connected. And sometimes, a shared smile is the first step back toward one another.

Be present

Ultimately, none of this is about being perfect. It's about being present. It's about learning to sit with discomfort without rushing to fix it. To hold a space where teens can breathe again, believe again, and begin, slowly and with support, to hope again. Our words may fade, but our presence lingers. When we stay, when we soften, when we believe in them even when they cannot believe in themselves, we plant seeds that may not bloom for years—but bloom they will.

The path is narrow and steep, but it is holy ground. And the impact of showing up well for an adolescent? It can echo for generations. You

don't have to be a perfect parent or provider to make a profound difference. You only have to be a faithful one—compassionate, patient, and willing to walk the path with love.

Take heart: every small act of presence, every moment of understanding, is shaping a future adult who knows they are not alone.

A Few Thoughts on Finding the Right Therapist and Therapy

Before we leave this chapter, we would like to say a few words about the importance of finding the right therapy and therapist to meet your teenager's needs. This can be difficult as the psychotherapeutic community can be confusing, especially for the first time consumer.

It is unfortunate that there is much to criticize about the current state of psychotherapy. To begin with, psychotherapy's outcomes can be

hard to measure, with variable effectiveness across different types of therapy and individual therapists. In some cases, it is reasonable to be concerned about potential harm, including dependency on the therapist, misdiagnosis, or worsening of symptoms.

Abigail Schrier (2024), in her new book, ***Bad Therapy: Why the Kids Aren't Growing Up,*** expresses her concern about too many bad therapies. In fact, Abigail devotes an entire chapter to iatrogenesis, which refers to any condition, symptom, or complication caused directly by medical treatment, intervention, or advice rather than by the underlying disease or condition itself. She specifically comments on how psychotherapy can be harmful and notes that therapists often do not want to acknowledge that the "medicine" is not working because the therapist is "the medicine." Moreover, she notes that it is often in the therapist's best interest to treat the ***least sick for the longest period of time*** and, on the other hand, many therapists shy away from more complex clinical presentations, such as complex trauma, bipolar disorder, and borderline personality disorder, to name a few (Schrier, 2024).

Finding the right therapist for your teenager is one of the most important decisions you can make, and one of the most difficult. The world of psychotherapy can be confusing, especially for parents trying to help a young person who may already be hesitant, guarded, or unsure about the process.

This is not simply about finding a qualified professional. It is about finding the right fit for your adolescent.

Teenagers are not small adults. They are in a unique developmental window, often highly sensitive to tone, trust, and authenticity. A therapist who is technically skilled but unable to connect relationally with your teen may have limited impact. In contrast, a therapist who builds trust, demonstrates respect, and creates a sense of safety can become a powerful catalyst for healing.

For adolescents, the therapeutic relationship is often the intervention.

With that in mind, here are several considerations that are especially important when seeking a therapist for a young person:

Relational fit matters most
More than credentials alone, ask whether your teen feels comfortable with the therapist. Do they feel heard, respected, and safe. If a teen does not feel a connection, they will disengage, sometimes subtly, sometimes completely.

Respect for autonomy
Adolescents are highly attuned to control. A good therapist will not overpower, lecture, or impose, but will instead invite, collaborate, and guide. Your teen should feel like a participant in the process, not a subject of it.

Ability to work with the adolescent brain
Teens are navigating intense emotions with still developing regulation systems. A skilled therapist understands this and works not just cognitively, but physiologically, helping regulate the nervous system, not just talk about problems.

Clinical competence with teen specific issues
Look for a therapist who understands anxiety, depression, trauma, and identity development within the context of adolescence, not just in adults. Depth matters.

Willingness to stay current

The field is constantly evolving. A good therapist continues to learn, refine, and apply what is supported by research and real-world outcomes.

Freedom from ideological pressure
Your teen deserves a space where they can explore their experience without being shaped or directed toward a predetermined outcome. Therapy should be about discovery, not persuasion.

You and your teen have a voice
You are not passive participants in this process. You have the right to ask questions, express concerns, and seek clarity. A good therapist will welcome this.

Trust your instincts
If something feels off, it probably is. If it feels right, that matters. Fit is not everything, but it is a great deal.

At the end of the day, you are not simply choosing a therapist. You are choosing a relationship that has the potential to influence how your teen understands themselves, their struggles, and their path forward.

As you navigate the process of finding the right therapist for your teenager, it is important to approach it with both care and confidence. This is not a passive decision. It is an active and meaningful step in supporting your child's well-being.

You have the right to ask thoughtful, even difficult questions. You have the right to understand how your teen will be treated, what approach will be used, and whether that approach aligns with your values and your child's needs. A good therapist will welcome those questions, not resist them.

At the same time, give space for the most important factor to emerge, the relationship. Watch how your child responds. Do they feel safe. Do they feel respected. Do they feel understood. These signals matter more than any list of credentials or techniques.

If the fit is not right, it is okay to keep looking. Finding the right therapist can take time, but when that connection is present, it can make a profound difference in your teen's willingness to engage and in the overall trajectory of their healing.

There is real hope in this process. With the right support, guidance, and relational connection, your teenager can begin to make sense of what they are feeling, develop greater stability, and move toward a healthier and more grounded sense of self.

Stay engaged. Stay thoughtful. Stay encouraged. Your involvement matters more than you may realize, and your willingness to walk this road with your teen is already a powerful part of their healing.

Rethinking Medication

Are We Reaching Too Quickly?

A this chapter, we thoughtfully explore how cultural trends, institutional practices, and broader belief systems may, at times, contribute to an increasing reliance on psychotropic medications in the treatment of adolescents. We offer these reflections not as an attack on medicine, psychiatry, or those who prescribe these medications, but rather as an invitation to consider a broader and more compassionate lens, one that honors the profound complexity of adolescence itself.

We believe that each young person is far more than a diagnosis or a cluster of symptoms. Every adolescent carries a unique story, a developing nervous system, relational experiences, emotional wounds,

hopes, fears, and a deep need for connection, safety, meaning, and belonging. Our hope is to encourage thoughtful, balanced conversations that carefully consider the whole person rather than reducing suffering solely to a biochemical framework.

With that spirit in mind, we encourage parents, clinicians, and young people themselves to become as informed as possible about the full range of treatment options available, including the research surrounding both the potential benefits and the possible risks associated with psychotropic medications. Thoughtful care requires humility, discernment, informed consent, and an openness to exploring multiple pathways toward healing and resilience.

For the purposes of this discussion, we will focus specifically on antidepressants. These medications are among the most commonly prescribed medications in the United States and, at various times, have ranked among the highest prescribed medication classes nationally.

According to data cited by the Mayo Clinic (Salmassi, 2013), the top three categories by prescription volume have included:

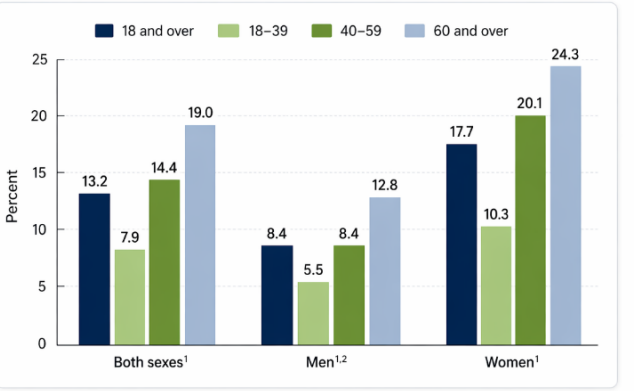
1. Antibiotics
2. Antidepressants
3. Opioid pain medications

It has been said that as a culture, we are too quick to run from pain, and part of that process involves an overreliance on psychotropic medications. Robert Whitaker (2023) notes that in 1987, we spent about 80 million dollars on psychotropics, and in 2007, that figure rose to 40 billion dollars, an astounding 50 fold increase in just 20 years.

The data from the CDC indicates that an alarming percentage of people in the US are taking antidepressant medication.

SOURCE:
National Center for Health Statistics, National Health and Nutrition Examination Survey, 2015–2018.
(CDC, 2020)

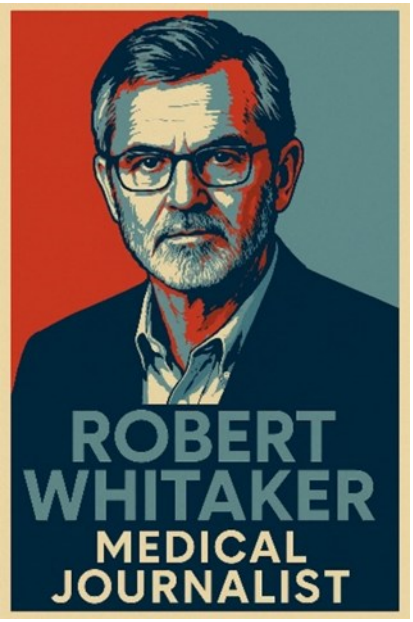
Figure 1. Percentage of adults aged 18 and over who used antidepressant medication over past 30 days, by age and sex: United States, 2015–2018



[1]Significant linear trend by age group ($p < 0.05$).
[2]Significant linear trend by age group within sex ($p < 0.05$).

Robert Whitaker Speaks Out

One of Jeff's literary heroes, Robert Whitaker, is an American journalist and author. He has been a prominent critic of the psychiatric medication paradigm, including antidepressants (Whitaker, 2010). Through his investigative work, Whitaker has raised significant concerns about the efficacy, safety, and long-term impacts of antidepressants, drawing attention to what he perceives, and we agree, as the over-medication of society and the influence of the pharmaceutical industry on psychiatric treatment.



One of Whitaker's main criticisms regarding antidepressants is their efficacy and the quality of the evidence supporting their use. In his ground-breaking book, ***Anatomy of an Epidemic*** (2010), he examines the scientific literature and argues that while antidepressants may offer short-term relief, their long-term efficacy is questionable. He cites studies that suggest the possibility of antidepressants worsening long-term outcomes for many patients. Whitaker addresses the issue of publication bias, where studies showing positive outcomes are more likely to be published than those showing negative or inconclusive results, potentially skewing the perceived effectiveness of these medications.

Whitaker also addresses the issue of dependence and withdrawal from antidepressants. He argues that the long-term use of antidepressants can lead to a physical dependence, making it difficult for patients to stop taking them due to severe withdrawal symptoms. This dependence is often not adequately discussed with patients prior to starting medication, according to Whitaker's findings. We are amazed that many of patients have not been sufficiently counseled about the side effects of psychotropics such as Post SSRI (Selective Serotonin Reuptake Inhibitors) Sexual Dysfunction (PSSD).

A significant part of Whitaker's critique focuses on the role of the pharmaceutical industry in promoting the use of antidepressants. He accuses the industry of exaggerating the benefits and underplaying the risks of antidepressants and intentionally misrepresenting and influencing both prescribers and patients. Whitaker's investigative work argues that marketing strategies and financial incentives have contributed to the widespread use of these medications, often at the expense of more comprehensive approaches to mental health care.

The pharmaceutical industry knew early on that the low serotonin model of depression was not valid, yet they propagated the myth, along with either mis-informed, naïve, or patently unethical and/or incompetent prescribers, that SSRIs corrected an imbalance.

Moreover, in an extensive metanalytic study, psychiatrists Joanna Moncrieff and Mark Horowitz (3023) critically examined and challenged the serotonin hypothesis of depression. The serotonin hypothesis posits that depression is caused by an imbalance of serotonin levels in the brain and that increasing serotonin activity through antidepressants can correct this imbalance. However, Moncrieff, Horowitz, and other researchers have presented unquestionable evidence that the low serotonin hypothesis is dead (Moncrieff & Horowitz, 2023).

The deception that depression is an imbalance in serotonin promotes a disease model of depression and can lead one down the wrong path of healing. Moncrieff (2023), in a brilliant podcast interview, notes that Horowitz's research, along with her own, alternatively revealed that most depression stems from past trauma and/or difficult life circumstances and, moreover, that negative feelings serve as signals that something is wrong and needs to be addressed. While antidepressants might offer some initial relief, namely, "If I just fix my brain with this medicine, my depression will remit," this reasoning comes at a steep price in that it takes away any sense of agency and reduces the likelihood that we can take responsibility for our lives and heal the pain rather than masking that pain.

Whitaker advocates, and we fully agree, for a broader approach to treating depression and other mental health issues, beyond the medical model. He highlights the importance of psychotherapy, lifestyle changes, social support, and addressing the underlying causes of mental health conditions as critical components of treatment that are often overshadowed by the focus on medication.

Robert Whitaker's criticism of antidepressant medications is part of a broader challenge to the conventional psychiatric treatment model. His work encourages a more nuanced conversation about mental health care, urging a reevaluation of the reliance on medication as the primary form of treatment. Whitaker's contributions have spurred an important and essential debate within the medical community and among the public, highlighting the dire need for a more holistic and informed approach to mental health treatment (Whitaker, 2010; Whitaker & Cosgrove, 2015).

Antidepressant Side Effects

Although many good prescribers competently review side effects with their patients, far too many do not. Dr. Mark Horowitz is a psychiatrist, clinical researcher, and one of my heroes, and is known for his critical examination of antidepressant medications, particularly focusing on their efficacy, side effects, and the challenges associated with discontinuing their use. He has a background in psychiatry and neuroscience and has been involved in research and advocacy related to the careful use of psychiatric drugs, the importance of evidence-based

approaches to medication tapering, and the reconsideration of how mental health conditions are understood and treated. Mark Horowitz has openly discussed his personal struggles with antidepressants, providing a unique perspective that blends professional expertise with personal experience. His journey with antidepressant withdrawal has informed his research interests and advocacy for better understanding and management of antidepressant discontinuation syndrome.

Horowitz has shared how his own attempt to taper off antidepressants led to severe withdrawal symptoms, underscoring the lack of guidance and support available for individuals trying to reduce or stop their medication. This experience highlighted the gap between clinical practice, and the real-world challenges patients face when discontinuing antidepressants. It spurred him to focus on researching the mechanisms of withdrawal and advocate for the development of evidence-based tapering protocols to help patients safely discontinue these medications.

His personal encounter with the difficulties of antidepressant withdrawal has made him a vocal advocate for greater awareness of these issues within the medical community. He emphasizes the importance of prescribing clinicians being well-informed about the potential for withdrawal symptoms and developing personalized tapering schedules that account for each patient's response to medication reduction. Horowitz's work aims to bridge the gap between clinical research and practice, ensuring that patients receive care that supports both the initiation and discontinuation of antidepressant therapy in a way that minimizes harm and maximizes well-being. In his excellent and just published book, ***Deprescribing Guidelines for Psychiatric Medications***, he details, along with his co-author, Dr. David

Taylor, the all-too-frequent mismanagement of these medications and how to safely taper off them. Specific to this discussion, he does a superlative job of bringing together the most recent research on antidepressant side effects, many of which are not shared with patients before they take them.

Emotional Numbing and Other Effects

- Emotional numbness – 71%
- Feeling foggy or detached – 70%
- Feeling not like me – 66%
- Drowsiness – 63%
- Reduction in positive feelings – 60%

Horowitz and Taylor (2024) note that emotional blunting appears to be a rather common and dependent consequence of antidepressant use. This is to say that you may feel the lows less, but you also feel the highs less.

Weight Gain:
It appears that long-term use of antidepressants may result in more weight gain than suggested in short-term trials. Specifically, studies suggest that there is a 30% risk of normal weight people becoming obese after 10 years of common antidepressant use than those not taking antidepressants.

Cognitive Effects:
Metanalytic Studies have found that some antidepressants can produce cognitive impairment in otherwise healthy controls – specifically on tests of information processing, memory, eye-hand coordination, and concentration. This finding might be particularly troubling for children and teens who may be struggling with academics.

Potential Increase in Dementia:

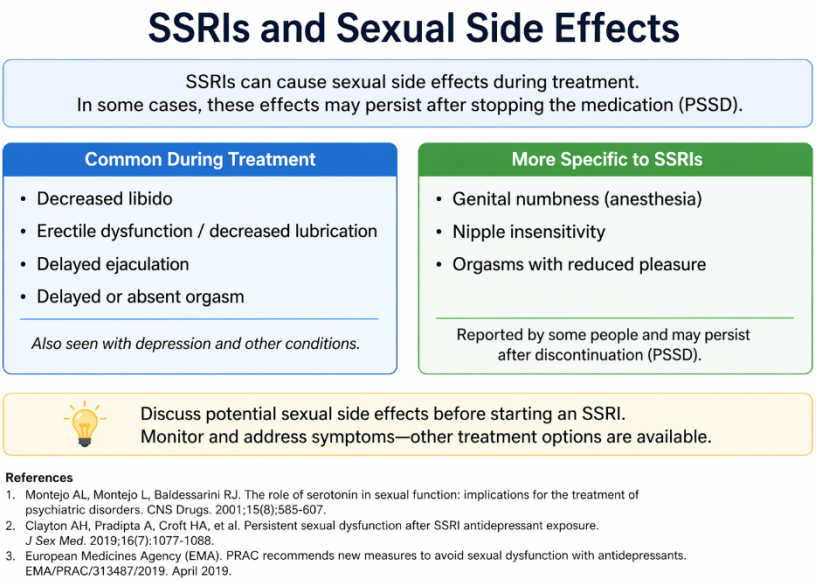
Horowitz and Taylor (2024) report that the research suggests that there is a dose-dependent relationship between total exposure to antidepressants and risk for eventual diagnosis of dementia. Quite alarmingly, patients with the highest exposure to more antidepressants – more than three years of daily use of standard antidepressants – had a 34% chance of dementia than patients who had no exposure to antidepressants at all.

Bleeding:

Horowitz and Taylor (2024) note that SSRIs (Selective Serotonin Reuptake Inhibitors) and SNRIs (Serotonin-Norepinephrine Reuptake Inhibitors) inhibit the uptake of serotonin into platelets. Depletion of platelet serotonin reduces the body's ability to form clots and hence increases the risk of bleeding. This can, of course, have profoundly serious consequences. For example, in coronary bypass procedures, they note research, which indicates a 50% increased risk of mortality in serotonergic antidepressants than non-users.

Sexual Effects:

And then there's the elephant in the room that far too many do not want to talk about. Horowitz and Taylor report that sexual adverse effects include a lack of desire, as well as reduced sexual sensation, and failure to reach orgasm in both sexes and, genuinely concerning, this occurs in 25% to 80% of patients, depending on the study. Moreover, and even more alarming, is that these sexual effects can persist even after cessation of antidepressants in a minority of patients. This condition is now called Post-SSRI Sexual Dysfunction (PSSD) and has been formally recognized by the European Medicines Agency. This is a devastating condition, and patients deserve to be warned about it, especially adolescents just beginning to explore their sexuality.



Black Box Warning - Increased Suicide Risk

Surprisingly not summarized by Horowitz and Taylor (2024), suicide risk needs to be mentioned. Black Box Warnings are the most stringent

labeling requirements that the U.S. Food and Drug Administration (FDA) can mandate for prescription drugs. They signify that medical studies have shown that the drug carries a significant risk of serious or even life-threatening adverse effects.

The warning about Selective Serotonin Reuptake Inhibitors (SSRIs), a class of drugs commonly prescribed for depression and anxiety disorders, is a notable example. In 2004, the FDA issued a Black Box Warning for all antidepressants, including SSRIs, highlighting the increased risk of suicidal thinking and behavior in children, adolescents, and young adults up to the age of 24, especially during the initial treatment phases (FDA, 2004). This decision was based on a comprehensive review of clinical trials that showed a higher rate of suicidal ideation and behavior in individuals within these age groups when taking antidepressants than those receiving a placebo. It is crucial for healthcare providers to closely monitor patients for worsening depression or emergent suicidality, especially during the first few months of treatment or when changing doses. The FDA's action underscores the importance of cautious use and vigilant monitoring of these medications in vulnerable populations (U.S. Food and Drug Administration, 2004).

A final word – in summary:

As we bring this chapter to a close, we want to return to a place of clarity and care.

We are not opposed to psychiatry. We are not opposed to psychotropic medications. And we are certainly not opposed to the many thoughtful, compassionate clinicians who prescribe them with wisdom and integrity. These treatments have helped many people, and in some

cases, they can be stabilizing, even lifesaving. That matters, and it deserves to be honored.

Our concern is not with their existence, but with their position.

Too often, medication has come to occupy the role of a first response rather than a considered one. It can be introduced quickly, sometimes before a deeper understanding of the individual's experience has had time to unfold. In that process, something essential can be missed. Emotional pain, especially in adolescents, is rarely simple. It is often layered, shaped by relationships, identity, stress, trauma, and the quiet struggles that are not always visible on the surface. When we move too quickly to intervene at the level of symptoms, we may unintentionally bypass the story that those symptoms are trying to tell.

Equally important is the issue of informed consent. Individuals deserve to understand not only the potential benefits of treatment, but also the risks, the uncertainties, and the alternatives. This is especially true for adolescents, who are still coming into themselves, still learning how to think, feel, decide, and endure. They are not simply patients to be managed; they are young people in the process of becoming.

As previously noted in earlier chapters, between the ages of roughly fifteen and twenty-five, the brain is undergoing profound development. Neural pathways are being refined, executive functions are strengthening, and the capacity for judgment, impulse control, and long-term thinking is taking shape. These years are not only about symptom reduction, but they are also about formation. They are about learning how to navigate difficulty, how to tolerate discomfort, how to find one's footing in the midst of uncertainty.

Resilience grows in that space.

It is not the absence of struggle, but the capacity to move through it. It is the ability to bend without breaking, to feel pressure and, over time, to rise again. And that kind of resilience cannot be given. It must be developed. It requires support, guidance, and often the presence of others who are willing to sit with someone in their difficulty rather than immediately trying to remove it.

This does not mean that suffering should be ignored, nor that all distress is meant to be endured without intervention. There are moments when symptoms become overwhelming, when functioning is significantly impaired, when safety is at risk. In those moments, medication may play an important and appropriate role. But even then, it is best understood as one part of a broader approach, not a replacement for the deeper work of understanding, connection, and growth.

So, our invitation is not to reject medication, but to reconsider how and when it is used. To approach it with thoughtfulness rather than urgency. To ensure that it follows careful listening rather than precedes it. To make space for the full complexity of a person's experience before narrowing the focus to a single form of intervention.

In the end, our aim is not simply to alleviate symptoms, but to support the development of whole, resilient, and grounded individuals. That kind of healing takes time. It requires patience, humility, and a willingness to engage with what is difficult rather than immediately moving past it.

If we can slow down, listen more deeply, and act with greater intention, we may find that we are not only helping people feel better in the

moment, but equipping them to live more fully over the course of their lives.

Conclusion

A Journey of Hope and Healing

If you have journeyed with us to this final chapter, then you already sense the weight of what we are facing. A generation in pain, not just struggling but often unraveling, not simply sad but disoriented, fragmented, and disconnected from the truth of who they are.

We have not written these pages to provoke controversy, but to awaken compassion and a steady, thoughtful urgency. What we are witnessing

is not simply a rise in symptoms, but a disruption in formation. Adolescents are moving through one of the most neurologically sensitive and developmentally critical seasons of life, yet they are doing so within a cultural landscape marked by uncertainty, fragmentation of family, and competing narratives about identity, meaning, and truth. At the very stage when their brains are still developing and their sense of self is still forming, they are being asked to make sense of pressures that often exceed their capacity to process them.

When we understand the neuroscience of the adolescent brain, this begins to make sense. Their emotional systems are highly activated, their drive for intensity and novelty is strong, and their capacity for regulation is still maturing. In many4

ways, the system is powerful but not yet balanced. What can appear as instability is often development in progress. Yet in the midst of this vulnerability, many adolescents are given explanations about themselves that are too narrow. Systems of care, often with good intentions, can move quickly toward labeling and intervention before the deeper story has been fully understood. Medication has an important role, particularly in acute situations, but when it becomes the primary lens, we risk missing the broader context of a young person's life and experience.

In doing so, we can unintentionally offer a story that is incomplete. A story that centers symptoms more than meaning and that can be internalized as identity. Adolescents are listening closely as they try to answer the most important questions of their lives. Who am I? What is happening to me? Why do I feel this way? The answers they receive shape not only how they understand their struggles, but how they come

to understand themselves. When the narrative is too small, their sense of self becomes small with it. When the narrative is fragmented, they begin to feel fragmented.

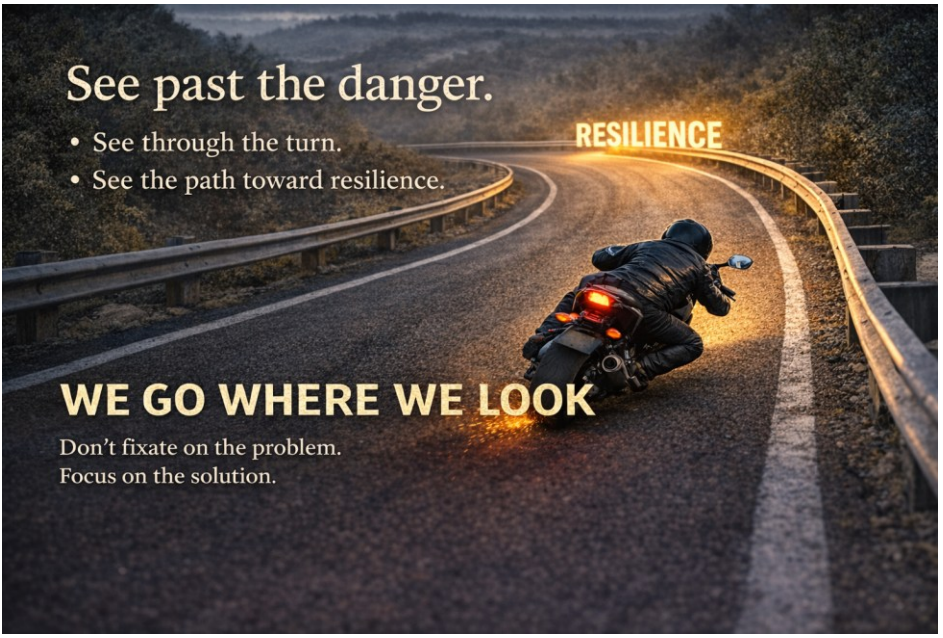
The work before us, then, is not simply to reduce symptoms, but to restore a coherent and truthful understanding of the whole person. This is where resilience is formed. Not through pressure or performance, but through repeated experiences of safety, attunement, and presence. Resilience grows when adolescents are helped to regulate their bodies, to understand their internal world, and to make meaning of their experiences in ways that are grounded and life giving.

The body is central in this process because it holds what the mind cannot yet fully organize. Stress, fear, and unprocessed experience are carried not only in thought, but in physiology. When adolescents learn to return to their bodies through breath, awareness, and regulation, they begin to develop an internal stability that cannot be achieved through external control alone. At the same time, when they are guided to understand the different parts of their inner experience, the protective, reactive, and striving aspects of themselves, they begin to replace shame with curiosity and fragmentation with integration.

And yet resilience is not sustained by technique alone. It is strengthened by meaning and anchored in identity. This is where the integration of faith becomes essential, not as pressure, but as invitation. An invitation to understand that they are not accidents, but purposeful and known. That their worth is not defined by their struggles. That they are seen and loved in a way that no diagnosis, symptom, or cultural message can fully capture. Faith does not narrow the story. It expands it, grounding identity in something stable, enduring, and true.

This is the heart of NeuroFaith®. It is not simply a framework for treatment, but a reorientation of how we understand suffering and how we respond to it. It brings together the insights of neuroscience with the depth of faith, honoring the reality of the brain while refusing to reduce the person to biology alone. It recognizes that adolescents do not need to be fixed as much as they need to be understood, guided, and anchored in something true and enduring.

As we discussed before, the mind tends to move in the direction of its focus. Like a motorcycle rider who drifts toward whatever holds their gaze, adolescents will begin to move toward the story they are fixated on, whether that story is true or not.



Resilience requires helping them lift their gaze toward where they are going, toward truth, toward connection, toward purpose, and toward who they are becoming. It means teaching them to remain aware of

difficulty without being defined by it, to regulate their bodies, to understand their minds, and to anchor their identity in something deeper than the instability around them. It also means that we do not send them into this process alone. We walk with them as steady, attuned presences, offering the co regulation, guidance, and consistency that their developing systems require until they are able to internalize that steadiness for themselves.

Adolescent depression is not a passing phase. It is a signal, a call for grounding in a world that often feels unsteady, a longing for authentic connection in the midst of noise, and a search for truth in a time of confusion. Our response must be thoughtful, measured, and deeply human, rooted in both wisdom and humility.

And yet, even in the face of this complexity, we do not lose hope. Healing is possible. Resilience can be built. Lives can be restored when we take the time to understand the full story of the adolescent mind, body, and soul, and when we respond in ways that honor all three.

There is a better way forward, one that does not reduce, rush, or fragment, but instead restores, integrates, and guides.

That way is NeuroFaith®.

And in that, there is real and enduring hope.

References

Ainsworth, M. D. S. (1973). The development of infant-mother attachment. In B. Cardwell & H. Ricciuti (Eds.), ***Review of child development research*** (pp. 1–94). University of Chicago Press.

Ainsworth, M. D., Belhar, M. C., Waters, E., & Wall, S. (1978). ***Patterns of attachment: A psychological study of the strange situation.*** Lawrence Erlbaum Associates.

Alcoholics Anonymous World Services. (2001). ***Alcoholics Anonymous: The story of how many thousands of men and women have recovered from alcoholism*** (4th ed.). Alcoholics Anonymous World Services, Inc.

Anderson, F. (2021). ***Transcending trauma: Healing complex PTSD with internal family systems.*** PESI Publishing.

Andreassen, C., & Fletcher, P. (2007). ***Early childhood longitudinal study, birth cohort (ECLS–B) psychometric report for the 2-year data collection (NCES 2007–084).*** National Center for Education Statistics, Institute of Education Sciences, U.S. Department of Education.

American Society of Addiction Medicine. (2011). Definition of addiction. https://www.asam.org/definition_of_addiction_long_4-11.pdf (accessed October 9, 2024).

Ballantyne, J. C., & LaForge, K. S. (2007). Opioid dependence and addiction during opioid treatment of chronic pain. ***Pain, 129***(3), 235-255. https://doi.org/10.1016/j.pain.2007.03.028

(accessed October 13, 2024).

Barta, M. (2018). ***TINSA: Trauma induced sexual addiction.*** CreateSpace Independent Publishing Platform.

Bechtold, J., Simpson, T., White, H. R., & Pardini, D. (2015). Chronic adolescent marijuana use as a risk factor for physical and mental health problems in young adult men. ***Psychology of Addictive Behaviors***, ***29***(3), 552-563. https://doi.org/10.1037/adb0000103 (accessed October 18, 2024).

Berman, M. G., Jonides, J., & Kaplan, S. (2012). Interacting with nature improves cognition and affect for individuals with depression. ***Journal of Affective Disorders, 140***(3), 300–305.

Betkowski, B. "1 in 3 boys heavy porn users, study shows," Eurekalert.org, Feb. 23, 2007. http://www.eurekalert.org/pub_ releases/2007-02/uoa-oit022307.php (accessed June 7, 2018).

Bowlby, J. (1960). ***Attachment*** (Vol. 1 of ***Attachment and loss***). Basic Books.

Braden, G. (2020, March 10). ***The science of heart-brain harmony with Gregg Braden.*** https://www.youtube.com/watch?v=2nsm8SCWjic (accessed March 10, 2024).

Braden, G. (2015a). Practice this technique to relieve daily stress. ***Three keys to heart-brain-earth harmony.*** https://www.youtube.com/watch?v=znOZ-peRiYo (accessed March 10, 2024).

Braden, G. (2015b). ***Resilience from the heart.*** Hay House.

Briere, J., & Rickards, S. (2007). Self-awareness, affect regulation, and relatedness: Differential sequelae of childhood versus adult victimization experiences. ***Journal of Nervous and Mental Disease, 195***(6), 497–503. https://doi.org/10.1097/NMD.0b013e31803044e2

Brownstein, M. J. (1993). A brief history of opiates, opioid peptides, and opioid receptors. Proceedings of the National Academy of Sciences, 90(12), 5391–5393. A brief history of opiates, opioid peptides, and opioid receptors. - PMC (nih.gov) (accessed October 13, 2024).

Butler, J. (1990). ***Gender trouble: Feminism and the subversion of identity***. Routledge.

Cacioppo, J. T., & Cacioppo, S. (2014). Social relationships and health: The toxic effects of perceived social isolation. ***Social and Personality Psychological Compass, 8***(2), 58–72. https://doi.org/10.1111/spc3.12087 (accessed October 13, 2024).

Cacioppo, J. T., Hughes, M. E., Waite, L. J., Hawkley, L. C., & Thisted, R. A. (2014). Perceived social isolation makes me sad: 5-year cross-lagged analyses of loneliness and depressive symptomatology in the Chicago health, aging, and social relations study. ***Psychology and Aging, 25***(2), 453–463. https://doi.org/10.1037/a0017216

Cacioppo, J. T. (2013). The lethality of loneliness. TED Talk. https://www.youtube.com/watch?v=_ohxlo3JoAo

Cacioppo, J. T., Hughes, M. E., Waite, L. J., Hawkley, L. C., & Thisted, R. A. (2010). Loneliness as a specific risk factor for depressive symptoms: Cross-sectional and longitudinal analyses. *Psychology and Aging, 25*(2), 453–465.

Cacioppo, J. T., & Patrick, W. (2008). ***Loneliness: Human nature and the need for social connection.*** W. W. Norton & Company.

Cacioppo, J. T., Sander, T., Nusbaum, H., & Bernston, G. (2006). Day-to-day dynamics of experience-cortisol associations in a population-based sample. *Proceedings of the National Academy of Sciences, 103*(45), 17058–17063. https://doi.org/10.1073/pnas.0605053103

Centers for Disease Control and Prevention. (2021). ***Youth Risk Behavior Surveillance System (YRBSS)***.

Centers for Disease Control and Prevention (CDC). (2023). Provisional drug overdose death counts. https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm (accessed October 13, 2024).

Centers for Disease Control and Prevention (CDC) (2022). Overdose Prevention. Stimulant Overdose Stimulant Overdose | Overdose Prevention | CDC (accessed October, 13, 2024).

Centers for Disease Control and Prevention (CDC). (2021). Drug overdose deaths in the U.S. top 100,000 annually. https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm (accessed October 13, 2024).

Centers for Disease Control and Prevention. (2020). Antidepressant use among adults: United States, 2015–2018. https://www.cdc.gov/nchs/products/databriefs/db377.htm (accessed March 7, 2024).

Centers for Disease Control and Prevention (CDC). (2010). Prescription painkiller overdoses: Use and abuse of methadone as a painkiller. Morbidity and Mortality Weekly Report, 59(30), 951-956.

Children's Commissioner for England. (2023). ***A lot of it is actually just abuse: Young people and pornography***. Children's Commissioner for England. https://www.childrenscommissioner.gov.uk/resource/a-lot-of-it-is-actually-just-abuse-young-people-and-pornography/Cigna. (2018). ***U.S. Loneliness Index: Survey of 20,000 Americans Examining Behaviors Driving Loneliness***.

Cohen, S. R., Mount, B. M., Strobel, M. G., & Bui, F. (1995). The McGill quality of life questionnaire: A measure of quality of life appropriate for people with advanced disease. ***Palliative Medicine, 9***(3), 207–219. https://doi.org/10.1177/026921639500900306

Common Sense Media. (2022). ***Teens and pornography: Today's digital reality***. Common Sense Media. https://www.commonsensemedia.org/research/teens-and-pornography

Cosgrove, L., & Krimsky, S. (2012). A comparison of DSM-IV and DSM-5 panel members' financial associations with industry: A pernicious problem persists. ***PLOS Medicine, 9***(3), e1001190. https://doi.org/10.1371/journal.pmed.1001190

Dana, D. (2018). ***The polyvagal theory in therapy: Engaging the rhythm of regulation.*** W. W. Norton & Company.

Dana, D. (2020). ***Polyvagal exercises for safety and connection.*** W. W. Norton & Company.

Davies, J. (2019). ***Sedated: How modern capitalism created our mental health crisis***. Atlantic Books.

Davies, J. (2016). Dr. James Davies: The origins of the DSM. https://www.youtube.com/watch?v=6JPgpasgueQ (accessed March 6, 2024).

Davies, J. (2013). ***Cracked: The unhappy truth about psychiatry***. Icon Books.

Delahooke, M. (2019). ***Beyond behaviors: Using brain science and compassion to understand and solve children's behavioral challenges.*** PESI Publishing.

Di Forti, M., Quattrone, D., Freeman, T. P., Tripoli, G., Gayer-Anderson, C., Quigley, H., ... & Murray, R. M. (2019). The contribution of cannabis use to variation in the incidence of psychotic disorder across Europe (EU-GEI): a multicentre case-control study. ***The Lancet Psychiatry***, ***6***(5), 427-436. https://doi.org/10.1016/S2215-0366(19)30048-3 (accessed October 18, 2024).

Dispenza, J., & Braden, G. (2019). Brain and heart gratitude. https://www.youtube.com/watch?v=znOZ-peRiY0 (accessed June 6, 2020).

Doan, A. (2012). ***Hooked on games.*** F.E.P. International.

Donevan, M., & Mattebo, M. (2017). The Relationship between FrequentPornography Consumption, Behaviors, and Sexual Preoccupancy among Male Adolescents in Sweden, ***Sexual & Reproductive.***

Duignan, B. (2023). Judith Butler. In ***Encyclopedia Britannica***. https://www.britannica.com/biography/Judith-Butler (accessed April 22, 2025).

Dunn, E. C., Nishimi, K., Powers, A., & Bradley, B. (2018). Developmental timing of trauma exposure and emotion dysregulation in adulthood: Are there sensitive periods when trauma is most harmful? ***Journal of Affective Disorders, 227,*** 869–877. https://doi.org/10.1016/j.jad.2017.10.045

Em, Dr. (2019a). ***The Trojan unicorn: Queer theory and paedophilia*** (Vol. 1). Self-published.

Em, Dr. (2019b). ***The Trojan unicorn: Queer theory and paedophilia*** (Vol. 2). Self-published.

Edsinger, K. (2023). ***The cult of gender ideology: How critical theories captured institutions and confused a generation***. Veritas Press.

Felitti, V. J., & Anda, R. F. (2009). The hidden epidemic: The impact of early life trauma on health and disease. https://www.theannainstitute.org/LV%20FINAL%202-7-09.pdf (accessed August 3, 2019).

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. ***American Journal of Preventive Medicine, 14***(4), 245–258. https://doi.org/10.1016/S0749-3797(98)00017-8

Filipowicz, W., Bhattacharyya, S. N., & Sonenberg, N. (2008). Mechanisms of post-transcriptional regulation by microRNAs: Are the answers in sight? ***Nature Reviews Genetics, 9***(2), 102–114. https://doi.org/10.1038/nrg2290 (accessed October 19,2024).

Foubert, J. (2017). ***How Pornography Harms: What Today's Teens, Young Adults, Parents, and Pastors Need to Know***. Bloomington, IN: LifeRich Publishing.

Foucault, M. (1976). ***The history of sexuality, Volume I: An introduction*** (R. Hurley, Trans.). Pantheon Books.

Fradd, M. (2017). ***The Porn Myth: Exposing the Reality Behind the Fantasy of Pornography.*** San Francisco, CA: Ignatius Press.

Fraga, M. F., Ballestar, E., Paz, M. F., Ropero, S., Setien, F., Ballestar, M. L., ... & Esteller, M. (2005). Epigenetic differences arise during the lifetime of

monozygotic twins. ***Proceedings of the National Academy of Sciences, 102***(30), 10604–10609. https://doi.org/10.1073/pnas.0500398102

Frances, A. (2013). ***Essentials of psychiatric diagnosis: Responding to the challenge of DSM-5.*** Guilford Press.

Goldman, H. (2014). Regular exercise changes the brain to improve memory and thinking skills. https://www.health.harvard.edu/exercise-and-fitness/exercise-can-boost-your-memory-and-thinking-skills (accessed March 14, 2024).

Grisel, J. (2022). https://www.youtube.com/watch?v=GtosSWrYAHM (assessed October 16, 2024.

Grisel, J. (2019). ***Never enough: The neuroscience and experience of addiction.*** Anchor Books.

Haidt, J. (2024). ***The Anxious Generation: How the Great Rewiring of Childhood Is Causing an Epidemic of Mental Illness***. Penguin Press.

Hall, W., Stjepanović, D., Caulkins, J., Lynskey, M., Leung, J., Campbell, G., & Degenhardt, L. (2019). Public health implications of legalising the production and sale of cannabis for medicinal and recreational use. ***The Lancet***, ***394***(10208), 1580-1590. https://doi.org/10.1016/S0140-6736(19)31789-1 (accessed October 18, 2024).

Hansen, J. E. (2021). ***The storm within us and the pathway to peace.*** Center for Connected Living, LLC.

Hansen, J. E., & Doan, A. P. (2023). ***Digital drugs and the search for connection.*** Center for Connected Living, LLC.

Hari, J. (2015, June). Everything you think you know about addiction is wrong. TED Talk.

https://www.ted.com/talks/johann_hari_everything_you_think_you_know_about_addiction_is_wrong

Hari, J. (2018). ***Lost connections: Uncovering the real causes of depression—and the unexpected solutions.*** Berryville Graphics.

Hawkins, D. R. (2020). ***The map of consciousness explained: A proven energy scale to actualize your ultimate potential***. Hay House Inc.

Hawkins, D. R. (2014). ***Letting go: The pathway of surrender***. Hay House Inc.

Healey, D. (2021). ISSM webinar on post-SSRI sexual dysfunction. https://www.youtube.com/watch?v=yFxMeoa1c3c (accessed March 8, 2024).

Hedegaard, H., Miniño, A. M., Spencer, M. R., & Warner, M. (2021). Drug overdose deaths in the United States, 1999–2020. ***NCHS Data Brief, 428,*** 1–8.

Hedegaard, H., Miniño, A. M., Spencer, M. R., & Warner, M. (2022). Drug overdose deaths in the United States, 2001–2021. ***NCHS Data Brief, 457,*** 1–8. https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates

Hedegaard, H., Miniño, A. M., & Warner, M. (2021). Drug overdose deaths in the United States, 1999–2020. National Center for Health Statistics. https://doi.org/10.15620/cdc:112340 (accessed October 13, 2024).

Heijmans, B. T., Tobi, E. W., Putter, H., Blauw, G. J., Susser, E. S., Slagboom, P. E., & Lumey, L. H. (2008). Persistent epigenetic differences associated with prenatal exposure to famine in humans. ***Proceedings of the National Academy of Sciences, 105***(44), 17046–17049. https://doi.org/10.1073/pnas.0806560105

HeartMath® Institute. (2020). About us. https://www.heartmath.org/about-us/ (accessed June 6, 2020).

Heverly, E. (2024). 12 Step with Christian Focus. Shared with permission by personal communication.

Horowitz, M., & Taylor, D. (2024). ***Deprescribing guidelines for psychiatric medications.*** John Wiley & Sons.

Huberman, A. (2022). Understanding dopamine and motivation. https://www.youtube.com/watch?v=DkS1pkKpILY (accessed October 12, 2022).

Huberman, A. (2021). The effects of cannabis on the brain and body. Retrieved from https://www.youtube.com/watch?v=UCbqfBAhmPY (accessed October 18, 2024).

ISAA Counseling. (2024). Breaking down the 6 Fs of IFS. https://issacounseling.com/breaking-down-the-6-fs-of-ifs (accessed March 2, 2024).

Jefferies, A. L. (2012). Canadian Paediatric Society, Fetus and Newborn Committee. Kangaroo care for the preterm infant and family. ***Paediatrics & Child Health, 17***(3), 141–146. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3287094/ (accessed June 3, 2020).

Indiana University Bloomington Libraries. (2023). ***Queer Theory***. https://libraries.indiana.edu/queer-theory

Jenuwein, T., & Allis, C. D. (2001). Translating the histone code. ***Science, 293***(5532), 1074–1080. https://doi.org/10.1126/science.1063127 (accessed March 16, 2024).

Kain, K. L., & Terrell, S. J. (2018). ***Nurturing resilience: Helping clients move forward from developmental trauma.*** North Atlantic Press.

Kaiser Family Foundation (2001). Generation Rx.com: How Young People Use the Internet.

https://www.kff.org/wp-content/uploads/2001/11/3202-genrx-report.pdf

Kanter, J. (2007). John Bowlby, interview with Dr. Milton Senn. ***Beyond the Couch: The Online Journal of the American Association for Psychoanalysis in Clinical Social Work,*** 2. http://www.beyondthecouch.org/1207/bowlby_int.htm (accessed May 5, 2020).

Kasser, T. (2003). ***The high price of materialism.*** MIT Press.

Kendell, R. E., & Jablensky, A. (2003). Distinguishing between the validity and utility of psychiatric diagnoses. ***American Journal of Psychiatry, 160***(1), 4–12. https://doi.org/10.1176/appi.ajp.160.1.4 (accessed October 19, 2024).

Kingston, D. A., Malamuth, N. M., Fedoroff, P., & Marshall, W. L. (2009).

Koenig, H. G., McCullough, M. E., & Larson, D. B. (1997). Attendance at religious services, interleukin-6, and other biological parameters of immune function in older adults. ***International Journal of Psychiatry in Medicine, 27***(3), 233–250. https://doi.org/10.2190/40NF-Q9Y2-0GG7-4WH6

Kolodny, A., Courtwright, D. T., Hwang, C. S., Kreiner, P., Eadie, J. L., Clark, T. W., & Alexander, G. C. (2015). The prescription opioid and heroin crisis: A public health approach to an epidemic of addiction. Annual Review of Public Health, 36, 559-574. The Prescription Opioid and Heroin Crisis: A Public Health Approach to an Epidemic of Addiction | Annual Reviews (accessed October 13, 2024).

Koob, G. F., & Volkow, N. D. (2016). Neurobiology of addiction: A neurocircuitry analysis. ***The Lancet Psychiatry, 3***(8), 760-773. https://doi.org/10.1016/S2215-0366(16)00104-8 (accessed October 13, 2024).

Kosten, T. R., & George, T. P. (2002). The neurobiology of opioid dependence: Implications for treatment. ***Science & Practice Perspectives, 1***(1), 13–20. Neurobiology of Opioid Dependence: Implications for Treatment | Office of Justice Programs (ojp.gov) (accessed October 13, 2024).

Kronen, S. (2006). [Commentary cited in Tinker, 2020].Kurtz, E. (1979). ***Not-God: A history of Alcoholics Anonymous.*** Hazelden Publishing.

Laible, D. (2011). Does it matter if preschool children and mothers discuss positive versus negative events during reminiscing? Links with mother-reported attachment, family emotional climate, and socioemotional development. ***Social Development, 20***(2), 394–411. https://doi.org/10.1111/j.1467-9507.2010.00598.x. (accessed October, 19, 2024).

Lambert, N., Negash, S., et al. "A Love That Doesn't Last: Pornography Consumption and Weakened Commitment to One's Romantic Partner."

Langevin, R., Hebert, M., Allard-Dansereau, C., & Bernard-Bonnin, A. C. (2016). Emotion regulation in sexually abused preschoolers: The contribution of parental factors. ***Journal of Traumatic Stress, 29***(2), 180–184. https://doi.org/10.1002/jts.22082

Laura, B. (2008). Epigenomics: The new tool in studying complex diseases. ***Nature Education, 1***(1), 178. https://www.nature.com/scitable/topicpage/epigenomics-the-new-tool-in-studying-complex-694/ (accessed June 11, 2020).

Lev-Ran, S., Roerecke, M., Le Foll, B., George, T. P., McKenzie, K., & Rehm, J. (2014). The association between cannabis use and depression: A systematic review and meta-analysis of longitudinal studies. ***Psychological Medicine***, ***44***(4), 797-810. https://doi.org/10.1017/S0033291713001438 (accessed October 18, 2024).

Levine, P. A. (2008). ***Healing trauma: A pioneering program for restoring the wisdom of your body.*** Sounds True.

Lewis, M. (2015). ***The biology of desire: Why addiction is not a disease.*** Public Affairs.

Lewis-Fernández, R., & Aggarwal, N. K. (2013). ***Culture and psychiatric diagnosis: A DSM-5 perspective.*** American Psychiatric Publishing.

Lewis-Morrarty, E., Degnan, K. A., Chronis-Tuscano, A., Henderson, H. A., Pine, D. S., & Fox, N. A. (2015). Infant attachment security and early childhood behavioral inhibition interact to predict adolescent social anxiety symptoms. ***Child Development, 86***(2), 598–613. https://doi.org/10.1111/cdev.12336

Louv, R. (2005). ***Last child in the woods: Saving our children from nature-deficit disorder.*** Workman Publishing.

Lyons-Ruth, K. (1996). Attachment relationships among children with aggressive behavior problems: The role of disorganized early attachment patterns. ***Journal of Consulting and Clinical Psychology, 64***(1), 64–73. https://doi.org/10.1037/0022-006X.64.1.64

MacLean, P. D. (1990). ***The triune brain in evolution: Role in paleocerebral functions.*** Plenum Press.

Main, M., & Solomon, J. (1986). Discovery of an insecure-disorganized/disoriented attachment pattern. In T. B. Brazelton & M. W. Yogman (Eds.), ***Affective development in infancy*** (pp. 95–124). Ablex Publishing.

Malamuth, N., Addison, T. & Kross, M. (2000). Pornography and sexual aggression: Are there reliable effects and can we understand them? ***Annual Review of Sex Research,*** 11, 267-91

Marcuse, H. (1965). ***Repressive tolerance***. In R. P. Wolff, B. Moore Jr., & H. Marcuse (Eds.), ***A critique of pure tolerance*** (pp. 81–117). Beacon Press.

Marmot, M., Stansfeld, S., Patel, C., North, F., Head, J., White, I., ... & Smith, G. D. (1991). Health inequalities among British civil servants: The Whitehall II study. ***The Lancet, 337***(8754), 1387–1393.

McCraty, R. (2023). The science of HeartMath® . https://www.heartmath.org/research/science-of-the-heart (accessed March 10, 2024).

McCraty, R., Atkinson, M., Tomasino, D., & Bradley, R. T. (2009). The coherent heart: Heart-brain interactions, psychophysiological coherence, and the emergence of system-wide order. ***Integral Review, 5***(2), 10–115.

McCraty, R., & Childre, D. (2010). Coherence: Bridging personal, social, and global health. ***Alternative Therapies in Health and Medicine, 16***(4), 10–24.

Merikangas, K. R., et al. (2010). ***Lifetime prevalence of mental disorders in U.S. adolescents.*** Journal of the American Academy of Child & Adolescent Psychiatry.

Merck Manual. (2019). Overview of the autonomic nervous system. https://www.merckmanuals.com/home/brain,-spinal-cord,-and-nerve-disorders/autonomic-nervous-system-disorders/overview-of-the-autonomic-nervous-system (accessed August 20, 2019).

Miller, L. (2021). ***The Awakened Brain: The New Science of Spirituality and Our Quest for an Inspired Life***. Random House.

Monbiot, G. (2014, October 14). The age of loneliness is killing us. ***The Guardian.*** https://www.theguardian.com/commentisfree/2014/oct/14/age-of-loneliness-killing-us (accessed September 8, 2019).

Moncrieff, J. (2023). Dr. Joanna Moncrieff: Chemical imbalance—Truth or myth? MH360°. https://www.youtube.com/watch?v=FdbX5JstwgA (accessed March 8, 2024).

Moncrieff, J., Cooper, R. E., Stockmann, T., Amendola, S., Hengartner, M. P., & Horowitz, M. A. (2023). The serotonin theory of depression: A systematic umbrella review of the evidence. ***Molecular Psychiatry, 28***(8), 3243–3256. https://doi.org/10.1038/s41380-022-01661-0

Moore, L. D., Le, T., & Fan, G. (2013). DNA methylation and its basic function. ***Neuropsychopharmacology, 38***(1), 23–38. https://doi.org/10.1038/npp.2012.112 (accessed March 16, 2024).

National Coalition for the Protection of Children & Families (2010). http://en.wikipedia.org/wiki/Internet_pornography_statistics#cite_note-Internet_Usage_bsecure-4 (accessed October 19, 2024),

NIH Record. (2021). Meth overdose deaths surge. https://nihrecord.nih.gov (accessed October 13, 2024.

National Institute on Alcohol Abuse and Alcoholism. (2024). Drinking levels and patterns defined. https://www.niaaa.nih.gov/alcohol-health/overview-alcohol-consumption/moderate-binge-drinking (accessed October 9, 2024).

National Institute on Drug Abuse. (2022). Trends & statistics. https://nida.nih.gov/research-topics/trends-statistics

New York Times. (2018, January 31). The Dutch famine: How starvation scarred genes and babies. ***The New York Times.*** https://www.nytimes.com/2018/01/31/science/dutch-famine-genes.html (accessed June 9, 2020).

Newman, A. E. (2017). Poor attachment and the socioemotional effects during early childhood (master's thesis, California State University, San

Bernardino). https://scholarworks.lib.csusb.edu/etd/554 (accessed October 19, 2024).

National Institute of Mental Health. (2023). ***Major depression***. U.S. Department of Health and Human Services, National Institutes of Health. https://www.nimh.nih.gov/health/statistics/major-depression

NIH Genetics Home Reference. (2020). How genes work: Proteins. https://ghr.nlm.nih.gov/primer/howgeneswork/protein (accessed June 10, 2020).

NIV: The Holy Bible, New International Version, Copyright 1973, 1978, 1984, 2011 by Biblica, Inc. Used by permission. All rights reserved worldwide.

NLT: New Living Translation, Tyndale House, 2006

Ogasa, O. and Goddam, S. (2011). A Billion Wicked Thoughts: What the World's Largest Experiment Reveals about Human Desire*.* New York, NY.

O'Sullivan, L., Byers, E., Brotto, L., Majerovich, J., & Fletcher, J. (2016) Longitudinal Study of Problems in Sexual Functioning and Related Sexual Distress among Middle to Late Adolescents. ***Journal of Adolescent Medicine and Health.*** https://pubmed.ncbi.nlm.nih.gov/27320034/ (accessed October 19, 2024).

Owens, E. W., Behun, R. J., Manning, J. C., & Reid, R. C. (2012). The impact of internet pornography on adolescents: A review of the research. ***Sexual Addiction & Compulsivity, 19***(1–2), 99–122. https://doi.org/10.1080/10720162.2012.660431

Paris, J., & Phillips, J. (Eds.). (2013). ***Making the DSM-5: Concepts and controversies.*** Springer.

Peter, J & Valkenburg, P. (2009). Adolescents' exposure to sexually explicit Internet material and notations of women as sex objects: Assessing causality

and underlying processes. ***Journal of Communication, 59,*** 4-7-433. DOI:10.1111/j1460-2466.2009.01422.x

Peter, J. & Valkenburg, P. (2016). Adolescents and pornography: A review of 20 years of research, ***The Journal of Sex Research***, DOI: 10.1080/0022449.2016.1143441

Peter, J & Valkenburg, P. (2009). Adolescents' exposure to sexually explicit Internet material and notations of women as sex objects: Assessing causality and underlying processes. ***Journal of Communication, 59,*** 4-7-433. https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1460-2466.2009.01422.x (accessed October 19, 2024).

Pizzol, D., Bertoldo, A., & Foresta, C. (2016). Adolescents and web porn: A new era of sexuality. ***International Journal of Adolescent Medicine and Health***, 28(2), 169-173. DOI: 10.1515/ijamh-2015-0003

Porges, S. W. (2017). ***The pocket guide to polyvagal theory: The transformative power of feeling safe.*** W. W. Norton & Company.

Porges, S. W., & Furman, S. A. (2011). The early development of the autonomic nervous system provides a neural platform for social behavior: A polyvagal perspective. ***Infant and Child Development, 20***(1), 106–118. https://doi.org/10.1002/icd.688.

Porter, K. (2019). Cannabis, It's Complicated. Retrieved from https://www.youtube.com/watch?v=fdguiE_dTuo (accessed October 18, 2024).

Proven Men Ministries. Pornography Survey and Statistics. 2014. http://www.provenmen.org/2014pornsurvey/ (accessed July 28, 2019).

Reich, W. (1945). ***The sexual revolution: Toward a self-governing character structure***. Farrar, Straus and Giroux.

Riemersma, J. (2024). Move toward healing with IFS. https://jennariemersma.com/move-toward/ (accessed March 3, 2024).

Riemersma, J. (2020). ***Altogether you: Experiencing personal and spiritual transformation with internal family systems therapy.*** Pivotal Press.

Roberts, T. (2008). Pure Desire. Bloomington, MN: Bethany House Publishers.

Ropelato, J. (n.d.) "Internet Pornography Statistics" Retrieved July 27, 2019, from Top Ten Reviews, TechMediaNetwork: https://www.ministryoftruth.me.uk/wp-content/uploads/2014/03/IFR2013.pdf (accessed October 19, 2024).

Rothschild, B. (2017). ***Autonomic nervous system: Precision regulation chart.*** Amazon.

Rudd, R. A., Aleshire, N., Zibbell, J. E., & Gladden, R. M. (2016). Increases in drug and opioid overdose deaths—United States, 2000–2014. MMWR Morbidity and Mortality Weekly Report, 64(50-51), 1378-1382. https://doi.org/10.15585/mmwr.mm6450a3 (accessed October 13, 2024).

Salmassi, M. (2013, June 19). Almost 70 percent of Americans take at least one prescription medication, study finds. ***Partnership to End Addiction.*** https://drugfree.org/drug-and-alcohol-news/almost-70-percent-of-americans-take-at-least-one-prescription-medication-study-finds

Sapolsky, R. M. (2002). ***A Primate's Memoir: A Neuroscientist's Unconventional Life Among the Baboons***. Scribner.

Sapolsky, R. M. (1992). ***Stress, the Aging Brain, and the Mechanisms of Neuron Death***. MIT Press.

Sarkadi, A., Kristiansson, R., Oberklaid, F., & Bremberg, S. (2008). Fathers' involvement and children's developmental outcomes: A systematic review of longitudinal studies. ***Acta Paediatrica, 97***(2), 153–158.

Schaffer, H. R., & Emerson, P. E. (1964). The development of social attachments in infancy. ***Monographs of the Society for Research in Child Development, 29***(3), 1–77.

Schore, A. N. (2017). ***The first 1000 days of life: A critical period for shaping our emotional selves and social brains*** [Lecture]. Oslo, Norway.

SCRIBD "The Digital Divide: How the Online Behavior of Teens is Getting Past Parents," McAfee.com. June 2012. http:// www.cil.cnrs.fr/CIL/IMG/pdf/digital-divide-study.pdf (accessed July 28, 2019).

Shields, A., & Cicchetti, D. (1997). Emotion regulation among school-age children: The development and validation of a new criterion Q-sort scale. ***Developmental Psychology, 33***(6), 906–916. https://doi.org/10.1037/0012-1649.33.6.906 (accessed October 19, 2024).

Smith, D. (2020). ***Marx's revolutionary legacy***. In Tinker, T. (2020). ***Ideological origins of identity politics***. Theopolis Institute Press

Soeters & van Schaik (2006). Children's experiences on the internet. ***Semantic Scholar.*** https://www.semanticscholar.org/paper/Children%27s-experiences-on-the-internet-Soeters-Schaik/b00082d66e8f4ed167c1c772b91ba50e86e3cb3c (accessed October 19, 2024).

Shonkoff, J. P. (2015, May 5). Take the ACE quiz and learn what it does and doesn't mean. ***Harvard University Center on the Developing Child.*** https://developingchild.harvard.edu/media-coverage/take-the-ace-quiz-and-learn-what-it-does-and-doesnt-mean

Simonetto, D. A., Oxentenko, A. S., Herman, M. L., & Szostek, J. H. (2012). Cannabinoid hyperemesis: A case series of 98 patients. ***Mayo Clinic Proceedings***, ***87***(2), 114-119. https://doi.org/10.1016/j.mayocp.2011.10.005, (accessed October 18, 2024).

Skinner, K. (2011). https://www.psychologytoday.com/us/blog/inside-porn-addiction/201111/can-pornography-trigger-depression. (accessed September 11, 2019).

Snyder, C. R. (1991). The will and the ways: Development and validation of an individual-differences measure of hope. ***Journal of Personality and Social Psychology, 60***(4), 570–585. https://doi.org/10.1037/0022-3514.60.4.570

Snyder, C. R. (Ed.). (2000). ***Handbook of hope: Theory, measures, and applications.*** Academic Press.

Snyder, C. R., Harris, C., Anderson, J. R., Holleran, S. A., Irving, L. M., Sigmon, S. T., ... & Harney, P. (1991). The will and the ways: Development and validation of an individual-differences measure of hope. ***Journal of Personality and Social Psychology, 60***(4), 570–585.

Spencer, M. R., Miniño, A. M., & Warner, M. (2022). Drug overdose deaths in the United States, 2001–2021. ***NCHS Data Brief, 457,*** 1–8. https://dx.doi.org/10.15620/cdc:122556

Stanley, T. H. (1992). The fentanyl story. Journal of Pain and Symptom Management, 7(3), 146-149. The Fentanyl Story (jpain.org) (accessed October 13, 2024).

Strawbridge, W. J., Shema, S. J., Cohen, R. D., & Kaplan, G. A. (1997). Frequent attendance at religious services and mortality over 28 years. ***American Journal of Public Health, 87***(6), 957–961. https://doi.org/10.2105/AJPH.87.6.957

Strahl, B. D., & Allis, C. D. (2000). The language of covalent histone modifications. ***Nature, 403***(6765), 41–45. https://doi.org/10.1038/47412

Strohle, A. (2009). Physical activity, exercise, depression and anxiety disorders. ***Journal of Neural Transmission, 116***(6), 777–784.

Substance Abuse and Mental Health Services Administration. (2024). ***Key substance use and mental health indicators in the United States: Results from the 2023 National Survey on Drug Use and Health*** (NSDUH Series H-58, HHS Publication No. PEP24-07-021). U.S. Department of Health and Human Services. https://www.samhsa.gov/data/report/2023-nsduh-annual-national-report

Suitable My Nature. (2014). Epigenomics: The new tool in studying complex diseases. ***Nature.*** https://www.nature.com/scitable/topicpage/epigenomics-the-new-tool-in-studying-complex-694/ (accessed July 11, 2020).

Sun, C., Bridges, A., Johnson, J., & Ezzell, M. (2016). Pornography and the male sexual script: An analysis of consumption and sexual relations.

The neurobiology of romantic love (2018).

https://sexinfo.soc.ucsb.edu/article/neurobiology-romantic-love

(accessed October 2, 2019).

Thompson, K. L., & Hannan, S. M. (2014). Fight, flight, and freeze: Threat sensitivity and emotion dysregulation in survivors of chronic childhood maltreatment. ***Personality and Individual Differences, 69***, 28–32. https://doi.org/10.1016/j.paid.2014.05.005

Tiller, W. A., McCraty, R., & Atkinson, M. (1996). Cardiac coherence: A new, noninvasive measure of autonomic nervous system order. ***Alternative Therapies in Health and Medicine, 2***(1), 52–65.

Tinker, T. (2020). ***Ideological origins of identity politics***. Theopolis Institute Press.

University of Lancaster. (2020). Ethics of epigenetics. https://www2.le.ac.uk/projects/vgec/highereducation/epigenetics_ethics/introduction (accessed June 9, 2020).

U.S. Food and Drug Administration. (2004). FDA MedWatch - Antidepressant drugs: Updated labeling includes warnings about increased risks of suicidal thinking and behavior in young adults ages 18 to 24. https://www.fda.gov/Drugs/DrugSafety/InformationbyDrugClass/UCM096273

Van der Kolk, B. A. (2014). ***The body keeps the score: Brain, mind, and body in the healing of trauma.*** Viking.

Verywell Mind. (2019). What is attachment theory? https://www.verywellmind.com/what-is-attachment-theory-2795337 (accessed May 2, 2020).

Vettese, L. C., Dyer, C. E., Li, W. L., & Wekerle, C. (2011). Does self-compassion mitigate the association between childhood maltreatment and later emotion regulation difficulties? ***International Journal of Mental Health and Addiction, 9***(5), 480–491. https://doi.org/10.1007/s11469-011-9340-7

Wallerstein, J. S., Lewis, J. M., & Blakeslee, S. (2000). ***The unexpected legacy of divorce: A 25-year landmark study***. Hyperion.

Walsh, M. (2017). ***The devil's pleasure palace: The cult of critical theory and the subversion of the West***. Encounter Books.

Wolff, V., Armspach, J. P., Lauer, V., Rouyer, O., Bataillard, M., Marescaux, C., & Geny, B. (2013). Cannabis-related stroke: Myth or reality? ***Stroke***, ***44***(2), 558-563. https://doi.org/10.1161/STROKEAHA.112.671347 (accessed October 18, 2024).

Volkow, N. D., Baler, R. D., Compton, W. M., & Weiss, S. R. (2014). Adverse health effects of marijuana use. ***The New England Journal of Medicine***, ***370***(23), 2219-2227. https://doi.org/10.1056/NEJMra1402309 (accessed October 18, 2024).

Volkow, N. D., & McLellan, A. T. (2016). Opioid abuse in chronic pain—misconceptions and mitigation strategies. The New England Journal of Medici***ne***, 374(13), 1253-1263. Opioid abuse in chronic pain—misconceptions and mitigation strategies. | PSNet (ahrq.gov) (accessed October 13. 2024).

Watkins, P. C., Woodward, K., Stone, T., & Kolts, R. L. (2003). Gratitude and happiness: Development of a measure of gratitude, and relationships with subjective well-being. ***Social Behavior and Personality***, 31(5), 431–451. https://doi.org/10.2224/sbp.2003.31.5.431

Weebroot (2019). Internet Pornography by the Numbers; A significant Threat to Society. https://www.webroot.com/us/en/resources/tips-articles/internet-pornography-by-the-numbers?srsltid=AfmBOopAbfOBv-3X7vJvHX45SY6MKVwy4zjQLaHHn5fy46jzwY8m9_SE (accessed October 19, 2024).

Whitaker, R. (2010). ***Anatomy of an epidemic: Magic bullets, psychiatric drugs, and the astonishing rise of mental illness in America.*** Crown.

Whitaker, R., & Cosgrove, L. (2015). ***Psychiatry under the influence: Institutional corruption, social injury, and prescriptions for reform.*** Palgrave Macmillan.

Whitaker, R. (2023). Long-term effects of antidepressant medication. https://www.youtube.com/watch?v=FY-5npruTGc (accessed March 6, 2024).

Wilson, G. (2014). ***Your Brain on Porn***. UK: Commonwealth Publishing.

Wolff, V., Armspach, J. P., Lauer, V., Rouyer, O., Bataillard, M., Marescaux, C., & Geny, B. (2013). Cannabis-related stroke: Myth or reality? ***Stroke***,

44(2), 558-563. https://doi.org/10.1161/STROKEAHA.112.671347 (accessed October 18, 2024).

Wright, P. J., Tokunaga, R. S., & Bae, S. (2021). More than a dalliance? Pornography consumption and extramarital sex attitudes among married U.S. adults. *Psychology of Popular Media, 10*(2), 199–206. https://doi.org/10.1037/ppm0000281

Yehuda, R., Schmeidler, J., Wainberg, M., Binder-Brynes, K., & Duvdevani, T. (1998). Vulnerability to posttraumatic stress disorder in adult offspring of Holocaust survivors. *American Journal of Psychiatry, 155*(9), 1163–1171. https://doi.org/10.1176/ajp.155.9.1163

About the Authors

Jeffrey E. Hansen, Ph.D. is a clinical psychologist specializing in addiction and trauma, with degrees from the University of California, Berkeley and the University of Arkansas. He brings over four decades of clinical experience, including service as an active-duty psychologist in the U.S. Army and later with the Defense Health Agency. He previously served as Clinical Director of Holdfast Recovery and AnchorPoint, faith-centered treatment programs for addiction and trauma recovery.

Dr. Hansen is the founder of NeuroFaith®, an integrative model combining neuroscience, trauma-informed care, and Christian spirituality. He now focuses on writing, training, and consulting with organizations and providers nationwide to advance the NeuroFaith® approach. He is the author of nine books and is active in national conversations on protecting children and adolescents from overly reductive and prematurely medicalized approaches to care.

He lives in Arizona with his wife, their three dogs, stays closely connected with his children and granddaughter, and enjoys time on the open road riding his BMW R1250RS.

Dr. Russell Gombosi is a highly respected physician and community leader, triple board-certified in internal medicine, pediatrics, and sleep medicine, allowing him to provide comprehensive, lifespan-oriented care. Known for his thoughtful, patient-centered approach, he is deeply committed to practicing medicine with integrity, seeing each individual as more than a diagnosis. Dr. Gombosi is a strong advocate for responsible, evidence-informed care and the importance of clinical discernment in an increasingly protocol-driven system. He is also widely recognized for his leadership in fostering open dialogue within the medical community, encouraging physicians to think critically, engage honestly, and remain grounded in both science and compassion.

Outside of his professional work, when time allows, Dr. Gombosi enjoys biking and hunting, finding both to be grounding, restorative, and a welcome balance to the demands of medicine.