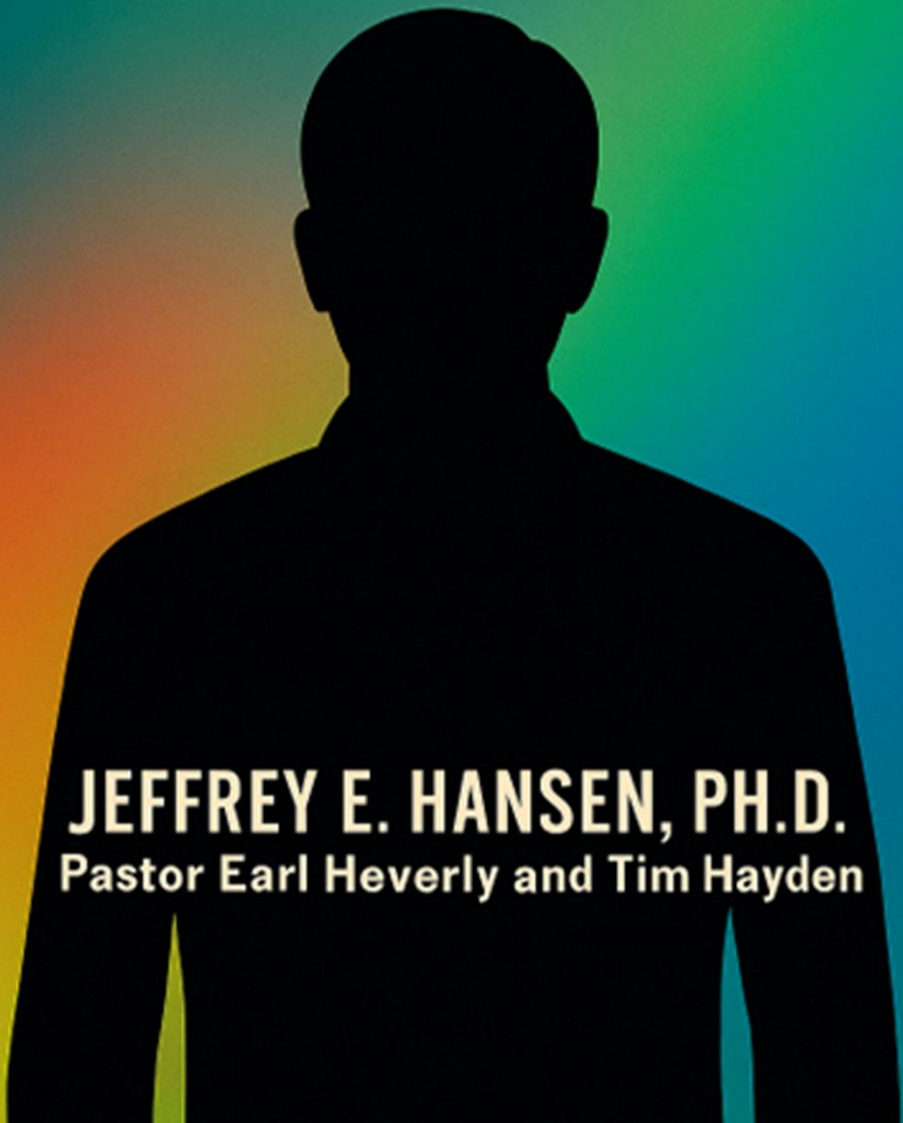
A SACRED PATH TO WHOLENESS

The NeuroFaith™ Approach to Healing Depression and Anxiety



JEFFREY E. HANSEN, PH.D.
Pastor Earl Heverly and Tim Hayden

Table of Contents

Endorsements

for

A Sacred Path to Wholeness: The NeuroFaith™ Approach to Healing Depression and Anxiety

Sacred Path to Wholeness is a groundbreaking book that integrates clinical psychology, neuroscience, and authentic Christian spirituality into a powerful model for healing. Dr. Jeffrey Hansen, a respected thought-leader with over 40 years of clinical experience, brings unmatched wisdom and compassion to every page. Tim Hayden, director of Holdfast Recovery, adds invaluable expertise from the front lines of addiction and trauma recovery. Pastor Earl Heverly offers profound spiritual insight in a field that too often overlooks the soul. The NeuroFaith™ approach combines Polyvagal-Informed Therapy, HeartMath®, Internal Family Systems (IFS), and faith to address the root causes of depression and anxiety. This is not just a book, it's a sacred invitation to wholeness.

Andrew P. Doan, MD, PhD, MPH
Author, Physician, Neuroscientist

In Dedication

At the risk of sounding cliché, we truly mean it when we say this book is dedicated to our wives: Leah, Nancy, and Karen.

We, companions in this sacred calling, want to express our deepest appreciation for the women who have stood by us, loved us, and lifted us through every season of this life. They have patiently put up with our long hours, our striving, and our struggles. They have encouraged us as we pursued our callings, climbed our mountains, and yes, even when we fell off a mountain or two.

They have been there not only to celebrate the victories but to bind up our wounds when we were broken. They have whispered truth when we were discouraged, prayed for us in the dark valleys of depression and anxiety, and reminded us of who we are when we had forgotten. They championed us when we didn't have the strength to move forward, wiped our tears when we had no words, and loved us with a steadfastness that reflects the very heart of Christ.

To Leah, Nancy, and Karen, you are our heroes, our anchors, and the living embodiment of love that heals. This book would not exist without you.

A SACRED PATH TO WHOLENESS

The NeuroFaith™ Approach to Healing Depression and Anxiety

By

Jeffrey E. Hansen, Ph.D.,

Pastor Earl Heverly, and Tim Hayden

Author's Note on AI Collaboration

This book is the product of years of clinical work, research, personal reflection, and prayer. As the primary author, I (Dr. Jeffrey Hansen, Ph.D.) have drawn extensively from my past publications, clinical experience, and therapeutic model development, particularly the NeuroFaith™ model, which integrates neuroscience, trauma-informed therapy, and Christian spirituality.

In preparing this book, I made use of advanced AI tools, including ChatGPT, to assist with brainstorming, drafting, editing, refining structure, and organizing complex ideas. This technology functioned as a supportive collaborator, helping me clarify language, summarize research, and format content. All the clinical insights, theological direction, and original research come from me and my team.

This work reflects my voice, my convictions, and my hard-won experience. The AI never generated original research, therapeutic models, or claims on its own. Rather, it served as a helpful tool under my direct guidance, offering efficiency in the writing process and allowing me to articulate more clearly what has been at the heart of my professional mission for decades.

I believe in transparency and integrity, especially when integrating new technologies. It is my hope that this disclosure affirms the honesty of this process while giving full credit where it is due. The ideas, models, and framework presented in this book are mine, and I stand behind them.

Dr. Jeffrey E. Hansen, Ph.D.

Published by NeuroFaith™, LLC
1579 W Gurley St
Prescott, AZ 86305

Introduction

"Depression and anxiety do not mean you've lost your way; they often mean your soul is signaling for a deeper healing, one that only truth, love, and connection can bring."

– J. Hansen, Ph.D.

Why NeuroFaith™? Why Now?

Depression and anxiety are not just mental health buzzwords. They are the emotional soundtrack of our generation. They affect millions of adults, men and women who look functional on the outside but are quietly unraveling inside. Some are anxious, jittery, sleepless, and overwhelmed. Others are heavy, shut down, numb, and disconnected. And many swing between both, revving with panic one moment, collapsing with hopelessness the next.

These conditions are not random. They are not signs of weakness. They are not just "in your head."

They are the body and soul crying out for safety, meaning, and belonging.

The Problem

Despite decades of awareness, billions of dollars in research, and an endless stream of medication, adult depression and anxiety continue to rise. More people than ever are seeking therapy, taking prescriptions, reading self-help books, and watching TED Talks. And yet, something still isn't working.

The traditional model, rooted in labels and neurotransmitter theories, offers little more than symptom management. It's often a sterile, clinical approach that misses the heart, the story, the soul.

And for the Christian, it can feel even more disjointed. Faith is often left at the door of the therapist's office. Neuroscience is seen as something separate from Scripture. And people are left trying to hold

together two halves of themselves—spiritual and emotional—as if they belong to different worlds.

The NeuroFaith™ Vision
NeuroFaith™ changes that.

This model is a groundbreaking integration of science and faith, one that speaks to the whole person. It bridges the best of modern neuroscience with the ancient truths of Scripture, offering a unified vision of healing for those who feel divided, disoriented, or defeated.

It is built on four transformative pillars:

1. Polyvagal-Informed Therapy
   Understand how your nervous system interprets life as safe or dangerous—and how to come out of chronic fight, flight, or freeze into true relational connection and peace.

2. HeartMath® and Neurocardiology
   Learn to regulate your emotional state by syncing heart and brain. Breath, intention, and coherence are not just techniques—they are portals to transformation.

3. Internal Family Systems (IFS)
   Discover those parts of yourself that carry pain, shame, fear, and the protector parts that try to keep you safe—but leave you stuck. Reconnect with your God-given Self, the part of you that is already calm, compassionate, and Christ-aware.

4. Deep Spirituality Rooted in Christ
   Healing is not complete without returning to the Source. At

the core of the NeuroFaith™ model is the truth that you were created by a loving God, designed for connection, and wired for joy. You are not your diagnosis. You are not your worst moment. You are not too far gone.

Understanding Depression and Anxiety

What neuroscience now confirms is what Scripture has long suggested, your body keeps the score, but it also knows the way home. Depression and anxiety are not just mood disorders. They are nervous system states rooted in lived experience.

- Anxiety is what happens when your system is stuck in survival mode. You scan for threat, brace for impact, and run on adrenaline. It feels like you're always on edge, always trying to manage the next catastrophe.
- Depression sets in when your system shuts down. You stop trying. You stop feeling. You lose the desire to connect. It feels like life is happening around you, not within you.

These states are not moral failings. They are physiological responses to pain, loss, trauma, disconnection, and spiritual fragmentation.

But they are not permanent.

Through the NeuroFaith™ model, we can teach the body to trust again, the heart to open again, and the soul to remember who it is in Christ.

This Book is for You

Whether you are a therapist or a client, a pastor or a parent, a seeker or a sufferer—this book was written for you.

- If you are exhausted from trying to fix yourself, this book is a rest stop.
- If you are overwhelmed by anxiety or crushed by depression, this book is a roadmap.
- If you are caught between faith and science, this book is a bridge.
- If you have been told you are broken, we are here to say—you are not. You are wounded, but you are not beyond healing.

We are not offering a bandage. We are offering a process. A model. A way back into life, back into connection, back into your story.

An Invitation

This is more than a theory. This is a movement. A reimagining of mental health rooted in the belief that faith and neuroscience can work together, and that healing is not only possible; it is promised.

You are not alone.
You are not forgotten.
You are not beyond help.

Welcome to NeuroFaith™.
Where science meets Scripture, the nervous system meets the Spirit, and anxiety and depression meet their match.

Welcome to NeuroFaith™ *where faith meets science, and brokenness meets hope.*

PART 1

THE BACKDROP

Definitions and Incidence

Through the Fog

Defining Depression and Anxiety from the Inside Out

We've sat across from too many souls, men and women who are lost in a fog they can't name, who wake up with a weight they can't explain, and who feel like their bodies are betraying them. One woman told us it felt like her heart was dragging behind her, like a rusted anchor scraping through her chest. A man said the anxiety was like a hundred radio stations playing static at once in his head. These aren't medical metaphors. They are spiritual cries for help, emotional SOS signals from people who know that something is deeply wrong but are told it's "just a chemical imbalance."

We begin this book with a simple question: What are we actually talking about when we say "depression" or "anxiety"?

The Diagnostic Frame

From a psychiatric standpoint, the DSM-5-TR outlines several depressive and anxiety disorders. Here are the most common clinical categories:

Major Depressive Disorder (MDD): Characterized by at least two weeks of persistent low mood, loss of interest or pleasure (anhedonia),

significant weight changes, sleep disturbance, fatigue, feelings of worthlessness or excessive guilt, impaired concentration, and suicidal ideation (APA, 2022). The DSM requires at least five of nine symptoms, with at least one being depressed mood or anhedonia.

Persistent Depressive Disorder (Dysthymia): A more chronic, low-level form of depression lasting two years or more, marked by a depressed mood most of the day, more days than not.

Adjustment Disorder with Depressed Mood: Typically arises in response to a major life change or stressor, often short-lived but emotionally intense.

Generalized Anxiety Disorder (GAD): Defined by excessive worry about a variety of topics, lasting six months or more, with symptoms including restlessness, fatigue, difficulty concentrating, irritability, muscle tension, and sleep disturbance.

Panic Disorder, Social Anxiety Disorder, PTSD, OCD, and others round out the DSM list. Each of these shares a common thread—your nervous system is overwhelmed, dysregulated, and unable to find safe ground.

A Broken System of Classification

Let's pause here. The diagnostic categories above attempt to organize human suffering. But the system they come from—the DSM-5—is itself deeply flawed.

Most people, including many clinicians, assume the DSM-5-TR is scientific. It is not. It looks like science, it uses medical language, and it sells itself as objective, but in truth, many of the categories were determined not by discovery but by consensus. They were created by

vote. As British anthropologist Dr. James Davies pointed out in *Cracked: Why Psychiatry is Doing More Harm Than Good*, most DSM diagnoses were decided in committee rooms by raising hands, not running experiments (Davies, 2013).

The DSM-III, published in 1980, marked a turning point. Prior to this, the psychiatric field still held onto some understanding of the complexities of human experience. But DSM-III signaled a shift. It operationalized distress into symptom checklists. It allied itself with Big Pharma and laid the foundation for decades of overdiagnosis and overprescribing. From a handful of diagnoses in the DSM-I, the list exploded into hundreds by DSM-5.

Worse yet, the DSM imposes arbitrary cutoffs. If you meet five symptoms of MDD, you're depressed. But if you meet four—no matter how severe those symptoms may be—you're not. That means someone can be suicidal, hopeless, insomniac, fatigued, and deeply impaired, but fall one symptom short and be considered not clinically depressed. This "all-or-none" framework is not only unscientific—it's dangerous.

The name "Diagnostic and Statistical Manual" projects authority, but it cloaks what it really is: a political and economic instrument. It has become a tool for categorizing and billing, not for healing.

Labeling and Its Consequences

The problem with this kind of labeling is that it often pathologizes understandable suffering. A person grieving the loss of a child may be given a diagnosis of MDD. A young adult floundering in a chaotic culture may be told they have an anxiety disorder. But perhaps they are

simply responding appropriately to something profoundly wrong in their environment, family, or spiritual story.

And yet the moment the diagnosis is written, a cascade begins: medication, permanent records, lowered expectations, internalized labels. You are no longer a person having a hard time. You are "depressed." You are "anxious." You are disordered.

When a Label Becomes a Life Sentence

Labels can be helpful when they guide care and validate pain. But when paired with the disease model, they can become life sentences. The dominant psychiatric narrative tells people they are broken. Their brains are chemically off. Their serotonin levels are wrong. Only medication can "fix" them.

There is little evidence for this. The chemical imbalance theory has been repeatedly challenged by rigorous research (Moncrieff et al., 2022). And while there are biological correlates of depression, changes in the HPA axis, hippocampal volume loss, disrupted sleep architecture, these are often effects, not causes. The brain changes when the soul is in pain.

It's essential to add here that some true disease states—like hypothyroidism, Cushing's disease, anemia, or certain vitamin deficiencies—can mimic or even cause depressive symptoms. A good medical evaluation is vital. But too often, what passes for a "medical exam" is a 10-minute encounter with a doctor who barely looks up from the EHR, types in a few keywords, and sends you off with a prescription. They document to the record but not to your story.

We do want to acknowledge there are many good, thoughtful psychiatrists, doctors who take the time to listen and collaborate, who understand that life context, trauma history, spiritual wounds, and relationship losses matter. This book is not an attack on the profession of psychiatry. It is a lament about what it has become.

A Personal Reflection from Dr. Jeffrey Hansen
In full transparency, I, (Jeff), went through a crisis nearly two decades ago that almost took my health, my well-being, and my life. As I share in ***The Storm and the Pathway to Peace***, I was hit by a perfect storm of emotional, physical, and spiritual distress.

At first, medication helped. I was grateful for the relief. But I stayed on it too long, and it stripped away my agency. I became a passive consumer of pills. My providers were well-meaning, but they never cautioned me. I became over-sedated. I experienced nighttime incontinence. It was humiliating, soul-crushing.

Benzodiazepines were the worst for me. At first, I improved. Then the floor dropped out. My nervous system began to betray me. I developed akathisia, a condition of unbearable inner restlessness and torment. I could not sit still. I could not rest. I was desperate. Death seemed like a relief, though I never would have taken that route because of my children and my faith.

None of my providers could explain what was happening. That terrified me. So I went back to the books, to the science, to the roots of what I knew. Over the course of a year, I tapered off. I cooled my GABAergic system. I healed. I came back.

That journey led to the birth of the NeuroFaith™ Model. It saved my life. Medication has its place but when prescribed recklessly, it nearly stole the life it claimed to save.

The Right Use of Medication

We want to be clear. In some cases, medication is appropriate and even life-saving. When someone is actively suicidal or so dysregulated that they cannot access therapy, temporary numbing may be necessary. But we must be honest—these medications do not heal. They numb. And the body adapts. The nervous system resists long-term pharmacological manipulation.

SSRI withdrawal can be brutal. Tapering can trigger brain injury symptoms. Akathisia, derealization, cognitive fog—these are real. And the silence around them has harmed too many.

We urge readers to follow the work of Dr. Joseph Witt-Doerring, a former pharmaceutical insider and now one of the world's leading voices on psychiatric drug withdrawal and harm. He stands with Robert Whitaker, Dr. Joanna Moncrieff, Dr. James Davies, Dr. Peter Gøtzsche, Dr. Robert Raffa, and others who are courageously challenging the dominant narrative.

The Neuroplasticity of Suffering

Depression and anxiety change the brain. But healing does too.

Long-term emotional pain affects the limbic system, the hypothalamic-pituitary-adrenal (HPA) axis, and neural connectivity between the amygdala and prefrontal cortex. The result can be disrupted sleep, cognition, memory, and mood regulation.

But this is not the end of the story. The brain is plastic. It can be reshaped through safety, love, challenge, reflection, community, and faith. Every act of courage and kindness remaps the nervous system. Your brain is not your destiny. It is your starting point.

Romans 12:2 reminds us, "Do not conform to the pattern of this world, but be transformed by the renewing of your mind." The Bible spoke of neuroplasticity long before neuroscience did. The act of renewing your mind, when practiced with spiritual truth and loving connection, has the power to literally rewire your internal landscape.

Gratitude, prayer, storytelling, breathwork, forgiveness, compassion—these are not just spiritual practices. They are neurological medicine. Psalm 147:3 says, "He heals the brokenhearted and binds up their wounds." That healing is both symbolic and structural. It's neurobiological and spiritual.

What you feel today is not the final truth. Healing is possible. Your brain is capable of change. And we will walk with you through that process.

We Will Walk With You

This book is an invitation to reject the label of brokenness and reclaim the language of healing. We will walk this journey with you. Yes, it will require ownership. And yes, that will feel uphill at first.

But we promise you this. At the top of that hill is something worth seeing. A vista. A life no longer driven by fear or dependency. A life that emerges from agency, integrity, faith, and hope.

You are not broken. You are wounded. And wounds can heal.

Let's begin.

Numbers Don’t Lie

A Century of Suffering—How Depression and Anxiety Have Surged in the Modern World

It was once rare to speak openly of depression. Anxiety, too, was whispered about in private, if at all. One hundred years ago, most people bore emotional pain silently. The world lacked the clinical vocabulary, let alone the tools, to name, measure, and treat what we now recognize as mood disorders. But something has shifted. Over the past century, and particularly in the last several decades, we have

witnessed a stunning surge in the prevalence of depression and anxiety, conditions that now haunt the lives of millions across the globe.

This chapter explores the data that documents this sharp rise, helping us trace the sociocultural, neurobiological, and spiritual implications of a mental health crisis that is no longer in the shadows. By examining the statistics, we uncover what society has gained in awareness, and what it may have lost in resilience, connection, and soul.

The Hidden Epidemic: A Brief Look Back

In 1900, systematic epidemiological data on mental health did not exist. Depression, if acknowledged at all, was often called "melancholia" or misattributed to character flaws. There were no validated surveys, no community screenings, and certainly no antidepressants. But by the mid-20th century, researchers began tracking symptoms across populations, and the numbers began to rise—steeply.

In a series of well-known Swedish population studies conducted between 1947 and 1972, researchers observed a nearly tenfold increase in depression symptoms over a 25-year period (Hagnell et al., 1989). This startling trend mirrored what was to come in the United States, where rates of major depressive disorder (MDD) more than doubled between 1991 and 2002 (Compton et al., 2006).

Table 1: Long-Term Prevalence Increases in Depression and Anxiety

Time Span	Condition	Prevalence/Incidence Change
1947 → 1972 (Sweden)	Depression	~10x increase in depressive symptoms
1991–92 → 2001–02 (U.S.)	MDD (1-year)	3.3% → 7.1% (Compton et al., 2006)
1990 → 2017 (Global)	Depression	+50% increase (~172M → 258M cases)
1990 → 2021 (Global, Age 10–24)	Anxiety	+52% incidence (GBD, 2023)
2013–14 → 2021–23 (U.S.)	Depression	8.2% → 13.1% point prevalence (CDC, 2024)
2022 → 2024 (U.S.)	Anxiety	32% → 43% report feeling more anxious (APA, 2024)

Modern Day: The Crisis Comes into Focus

Today, the numbers are unambiguous. According to a 2023 Gallup poll, 29% of U.S. adults say they have been clinically diagnosed with depression, with 17.8% currently affected. The CDC's NHANES data show that among both adolescents and adults, depression prevalence rose from 8.2% in 2013–14 to 13.1% by 2023 (CDC, 2024). That's a jump of over 50% in just a decade.

Meanwhile, anxiety has reached new heights. In 2024, the American Psychiatric Association reported that 43% of adults feel more anxious than they did the previous year, up from 32% just two years earlier (APA, 2024). Globally, the World Health Organization documented a 25% increase in anxiety and depression in the wake of the COVID-19 pandemic (WHO, 2022).

These are not small shifts. They represent a massive recalibration in the emotional baseline of modern life.

What's Driving the Increase?

Many theories seek to explain this surge: the erosion of community, the rise of digital overstimulation, chronic stress, and economic pressures. But these alone cannot fully explain the transformation. We must also consider the spiritual dimension—how people have lost a sense of sacred belonging, narrative identity, and existential grounding. Without these anchors, the soul becomes susceptible to despair.

At the NeuroFaith™ level, we also explore how shifts in the autonomic nervous system, neuroinflammatory processes, and heart-brain coherence mirror these cultural changes. Disconnection doesn't just hurt emotionally—it disrupts the nervous system. It alters heart rhythms. It weakens immune resilience. It sets the stage for dysregulation across every domain.

A Sacred Reframe

The statistics are sobering, but they are not the whole story. Behind the rising numbers lies a deeper unraveling, one that cannot be explained by clinical categories alone. Depression and anxiety are not isolated

pathologies. They are symptoms of a larger breakdown in how we live, relate, and believe.

What if the real crisis is not just psychological, but cultural, relational, and spiritual? What if the steady erosion of connection, meaning, and sacred identity has left our nervous systems unmoored and our hearts malnourished? These are not questions of chemistry alone. They are questions of coherence, of story, of soul.

In the chapters ahead, we will explore the hidden architecture of this collapse. From early attachment patterns to digital overstimulation, from trauma and adversity to spiritual dislocation, we will unpack the forces that have silently shaped this epidemic. But more importantly, we will chart a way forward.

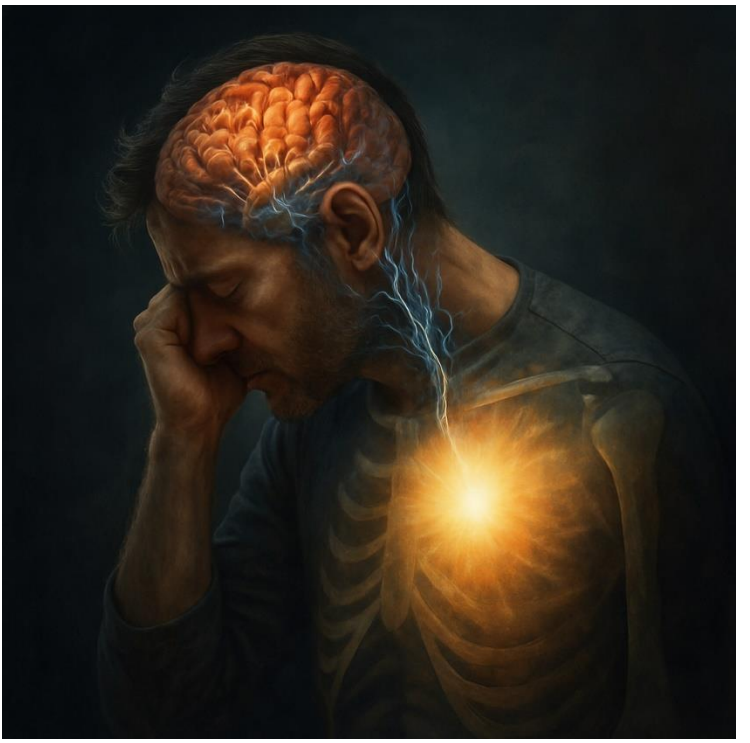
Healing is not found in numbing the pain. It is found in listening to it. It is found in remembering who we are and whose we are.

This is not the end of the story. It is the beginning of a sacred reclamation.

Let's begin.

Neuroscience of Depression and Anxiety States

The Brain, the Body, and the Soul in Chronic Depression and Anxiety



We have sat with countless men and women who weren't just experiencing depression or anxiety. They were living in it. These weren't just episodes. They had become states of being—etched into the brain, imprinted in the body, and echoed in the soul.

Over time, suffering wires itself into us. And it does so at every level. The brain learns it, the body enacts it, and the soul begins to believe it is true. What we once passed through, we now dwell in.

We want you to know this is not just opinion. This is what neuroscience confirms, what trauma research reveals, and what Scripture has always spoken to. The body remembers. The nervous system adapts. And healing must begin at the level of the brain, the body, and the soul.

Depression

Dorsal Vagal Shutdown and the Soul in Collapse

In trauma-informed neuroscience, the term depression can be used to describe not just a mental health diagnosis but a physiological and soul-level state of shutdown. This is what Polyvagal Theory calls dorsal vagal dominance—the biological posture of collapse, withdrawal, and disconnection.

Here, the hypothalamic-pituitary-adrenal (HPA) axis slows but remains off balance. People in this state often feel profound fatigue, emotional deadness, and isolation. Cortisol output may fluctuate. Digestion slows. Movement becomes labored. Even facial expression flattens.

And the soul retreats.

One client said it this way:

"I believe God is good. I just don't believe
He can feel me anymore."

This is the soul in a state of depressive freeze—a spiritual as well as physiological experience. Prayer feels like a whisper into an empty canyon. Scripture doesn't land. Joy feels like something that used to belong to someone else.

And when you are ***in*** that shutdown state, it's nearly impossible to access anything else. Joy feels out of reach. Connection feels dangerous. Even the idea of hope can feel like pressure.

The psalmist gives voice to this soul-state in Psalm 31: ***"I am forgotten as though I were dead. I have become like broken pottery. For I hear many whispering, 'Terror on every side.' They conspire against me and plot to take my life. But I trust in you, Lord. I say, 'You are my God.'"*** (Psalm 31:12–14, NIV)

Even in dorsal vagal shutdown, the soul can reach. And that whisper of trust may be the first sign that regulation is beginning.

Anxiety

Sympathetic Hyperarousal and the Soul in Overdrive

Just as depression symbolizes shutdown, anxiety symbolizes the other extreme: sympathetic hyperarousal. This is the body's fight or flight response in overdrive. It's where the HPA axis is fully activated, dumping cortisol and adrenaline into the system to prepare for threat.

The amygdala becomes hypersensitive. The prefrontal cortex dims. Sleep disappears. Muscles tighten. The body cannot rest because the nervous system has decided that rest equals vulnerability.

And the soul? The soul begins to scramble for control.

Anxiety pulls the spiritual life into overdrive. Worship becomes performance. Prayer becomes frantic repetition. Scripture becomes something to ***grip***, not rest in.

And just as the shutdown of depression makes joy unreachable, the overactivation of anxiety makes peace feel foreign. When you are living in hyperarousal, the calm and safety of connection cannot be accessed easily. This is not moral failure. It is neurological reality.

As one client said:

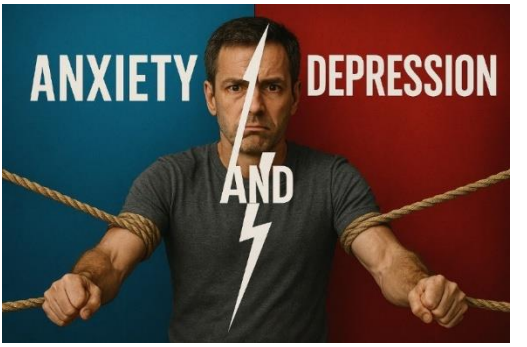
"I know I should relax. But relaxing feels like I'll die."

Scripture speaks directly into this anxious, flooded soul-state:

"Do not be anxious about anything, but in every situation, by prayer and petition, with thanksgiving, present your requests to God. And the peace of God, which transcends all understanding, will guard your hearts and your minds in Christ Jesus." (Philippians 4:6–7, NIV)

This is not a call to try harder. It is an invitation to return to regulation. In Deb Dana's terms, to re-enter the ventral vagal state—the physiological and spiritual posture of safety, openness, and connection.

Trapped States
Why the Other Side Feels Impossible



Here's one of the most important things we've learned in both neuroscience and therapy. When you are in one nervous system state, the other feels unreachable. When you are depressed and shut down, the arousal of sympathetic energy feels terrifying. When you are anxious and hyperaroused, the stillness of ventral vagal safety feels like a trap.

This is why people can live in these states for years. The brain and the body get stuck. And the soul becomes shaped by the same loops of despair or fear.

But healing begins when we recognize these patterns not as permanent identity, but as adaptive survival responses. The body has been trying to protect you. But now it's time to teach it how to return to peace.

The NeuroFaith™ Perspective

We believe that depression and anxiety are more than diagnoses. They are whole-person realities—physiological, psychological, and spiritual. They require a whole-person healing model.

The NeuroFaith™ model integrates brain science, somatic regulation, and biblical truth. It helps people exit dorsal vagal collapse and sympathetic overdrive not just through words but through embodiment. Through breath.

Through connection. Through God's presence made real in the nervous system.

This is not fast work. But it is faithful work.

What comes next is the slow, sacred path of restoration. The next chapter will offer practical steps to exit survival mode and re-enter life. It is called The Pathway to Peace. It begins where the psalms begin. In honesty. In embodiment. In hope.

Let's keep going.

PART II

What's Driving the Collapse?

Understandinging the Deeper Causes of Adult Depression and Anxiety

We cannot heal what we refuse to name.

That's the burden—and the invitation—of this chapter. Before we offer strategies, before we explore paths forward, we must sit with the hard truth: most people struggling with depression and anxiety are not suffering because of a simple chemical imbalance or a random neurobiological misfire. Those narratives are tidy and convenient. But they are not the full story. They are not even the main story.

In our decades of clinical work, we've sat with thousands of people—men and women, young and old—who were struggling to breathe emotionally, desperate for relief. Too often, they had already been given a label. A diagnosis. A prescription. Sometimes multiple ones. But no one had helped them explore the ***why***. No one had helped them slow down, take inventory, and look beneath the surface. And so, the suffering remained.

In this chapter, we want to talk honestly about the real causes—or at least some of the central contributors—to adult depression and anxiety in the modern world. This is not an exhaustive list. There are dozens, maybe hundreds, of contributing factors that can shape a person's mental health. But we believe the following represent a core constellation of root causes, the ones we see again and again in the clinical trenches.

We will talk about disconnection, drawing from the work of Johann Hari and others who've shown how being isolated from meaning, purpose, people, and ourselves is one of the greatest predictors of despair.

We will talk about pornography, and how it rewires the brain, disrupts sexuality, fractures identity, and destroys emotional connection. This is not a fringe issue. It is a silent epidemic that too many men—and women—are suffering through in shame and silence.

We will address media consumption, the endless digital barrage that overwhelms our nervous system and keeps us chronically dysregulated. The world was not designed to be scrolled. We were not built to absorb this much noise.

We will talk about trauma, which, in our view, is the taproot of much of what is called depression. Early attachment wounds, unresolved abuse, developmental neglect—these are not things we "get over." They live in the body. They shape the brain. They distort the narrative we carry about who we are.

We will explore spiritual disconnection—the aching sense that we are not rooted in anything greater than ourselves. When faith disappears, so does ultimate meaning. And when meaning disappears, the human spirit withers.

We will speak to the growing crisis of lost identity, of people living alienated from themselves, drifting in a sea of shoulds and screens and shallow goals. There is no more potent recipe for depression than a life without value or rootedness.

And throughout it all, we will keep returning to one theme: you must go deeper.

This is not a chapter about band-aids. We are not interested in symptom management. We're not going to offer you a slick checklist or

tell you that one breathing technique will change your life. Depression is not solved with platitudes. Anxiety is not calmed with Instagram mantras. These are soul-deep wounds. They demand soul-deep healing.

Too often, modern psychiatry reaches for the fastest solution. Too often, therapists reach for the most comfortable path. But quick fixes are often false fixes. They may numb. They may stabilize. But they rarely transform. And transformation is what you were made for.

If you are suffering right now, we're not going to insult you by pretending this will be easy. It won't be. But it will be worth it. If you're willing to look honestly, to grieve what needs grieving, to face the buried storylines that shaped you, then there is hope. Not just for relief, but for redemption.

This chapter is an invitation to that honest journey. As you read, you may feel uncomfortable. Good. That means we're getting close to something real. Don't turn away. Don't settle for a surface-level explanation when your life is too precious for that.

The roots of depression and anxiety are deeper than most of us were taught. But the healing goes deeper still.

Let's begin.

Cause One
Disconnection and the Descent
into Crippling Depression and Anxiety

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

– Viktor Frankl

Adulthood wasn't supposed to feel like this.

Somewhere along the line, many of us stopped living and started managing. We wake up tired, go through the motions, carry the weight of responsibilities we can't name, and wonder why joy feels like something reserved for someone else's life. We've become experts at showing up, performing, pushing through. But deep inside, there's an ache. A dull, gnawing ache that says, "Something isn't right."

For far too many, 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 us 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, stayed plugged in, starving for something real, we would find happiness.

Hari gives language to what so many of us have felt but didn't know how to articulate. That our 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've 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's often the nervous system responding to a life out of alignment with what matters most.

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, from 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 you. That's good. That means it's working. It means you'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 your own life.

We are not promising a quick fix. But we are promising this: your depression and anxiety are not signs that you are broken. They may be signs that you are still alive—that some part of you refuses to settle for disconnection. That part of you is not a liability. It's your signal fire. It's your path home.

Let's follow it.

Disconnection from Meaningful Work

Disconnection from meaningful work is a Hidden Source of depression and anxiety

Let's talk plainly. When you are depressed, the idea of engaging in work, even simple tasks, can feel crushing. You wake up already behind, already tired, with a fog sitting on your chest. You may feel worthless or defeated before the day even begins. And when you are anxious, your thoughts race, your body hums with tension, and everything feels like too much. So, let's be clear, we are not saying that work is a quick fix or that someone should just "snap out of it." We know better.

But here is the hard truth and the hopeful one: meaningful work, when engaged in gently and with support, can help stabilize and heal you. In psychology, we call this ***behavioral activation***. It means you do not wait until you feel better to start. You start small, you move your body, you do the next right thing, and often, the mind begins to follow. Action precedes emotion. The body can lead, and the soul can begin to wake up.

Johann Hari (2018) draws our attention to a worldwide crisis of meaning. In a massive Gallup study conducted between 2011 and 2012, researchers surveyed millions of workers across 142 countries. Only 13 percent of people reported being "engaged" in their work. Sixty-three percent were "not engaged," and 24 percent were "actively disengaged," meaning they were not only disconnected but acting out their discontent. Hari argues, convincingly, that this disconnection is not just a productivity issue. It is deeply linked to the rise in depression and anxiety.

We are not made to spend our lives doing things that feel pointless. And we are certainly not made to live under the weight of soul-deadening routines that offer no agency, creativity, or purpose. The Whitehall Study (Marmot et al., 2002) of British civil servants confirmed this,

finding that a lack of autonomy and the inability to see a connection between effort and reward were powerful predictors of poor mental health. When your labor does not seem to matter, it takes something essential out of you.

And that is not just psychological. It is spiritual. In Genesis 2:15 (NIV), it says, ***"The Lord God took the man and put him in the Garden of Eden to work it and take care of it."*** Work was part of the original design. It was never meant to be punishment. It was a way to partner with God in caring for the world. When that connection to meaningful labor is lost, something deep within us begins to fray.

For many adults, especially in modern Western life, work has become transactional and empty. People clock in, perform duties that feel disconnected from their values, and clock out. They go home drained, not from effort but from futility. Over time, this leads to what Hari calls a spiritual and psychological numbness. It is not just boredom. It is despair.

And here is the part we sometimes miss. Our children see it. They see us come home weary, bitter, or resigned. They see us sit in front of screens, not from laziness, but from a kind of emotional defeat. Adolescents learn from what we model. When they see adults robbed of purpose, they begin to believe that life itself is just something to survive. And they often turn to numbing behaviors of their own, whether through social media, substances, or fantasy worlds because the real world feels like a dead end.

But we can disrupt that pattern. We can reclaim meaningful work as part of healing.

That does not mean switching careers overnight. It might begin with reframing the work you already do, seeing how your efforts contribute, even in small ways. Or it might mean stepping into a new challenge, volunteering, helping someone else, fixing something, or creating something. These acts begin to stitch purpose back into our lives.

And when we root our labor in something greater, it takes on eternal meaning. 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."*** That reframes everything. Whether you are folding laundry, leading a meeting, or rebuilding your life from the wreckage of depression, your effort matters.

You do not have to feel good to begin. You begin, and over time, the good may come.

So, if you are depressed or anxious right now, start small. Take one action, however simple, that aligns with who you want to be. It might not feel like much today, but it is not nothing. It is a seed. And with time, care, and God's help, it can grow into something beautiful.

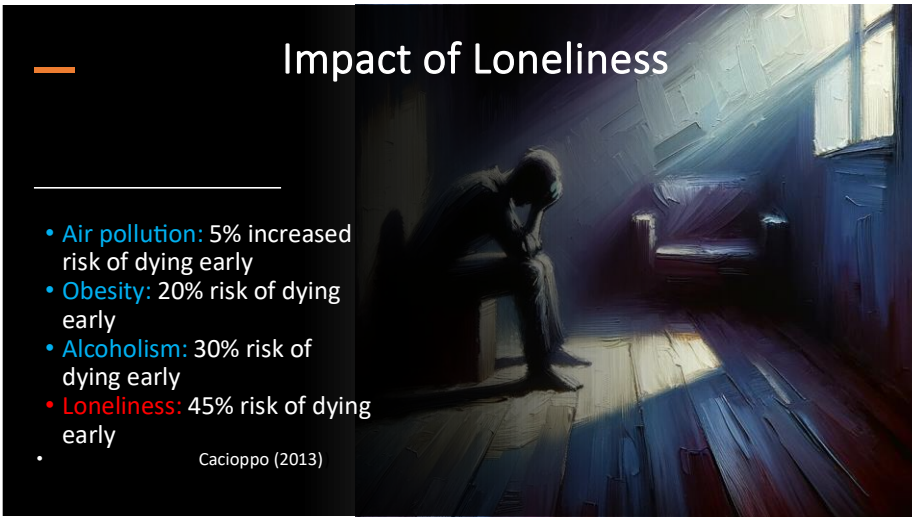
Disconnection from Meaningful People

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 axis, the very center of your stress system, and floods your body with the same neurochemical chaos

you would experience if someone 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 showed 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—say, from 50 percent to 65 percent on their loneliness scale—their 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 should stop us in our tracks.

And yet, we live in a culture that often glamorizes independence. We quietly accept the slow drift into isolation, chalking it up to busy schedules, modern life, or personality. But make no mistake—loneliness kills. As Cacioppo said in his TED Talk (2013), a meta-analysis of over 100,000 participants found that social isolation increased the risk of early death more than obesity, smoking, or lack of exercise.

This is not just data. This is real life. How many people quietly ache every evening when they come home to an empty house, scroll endlessly on their phones, or eat dinner alone in front of the TV? How many sit in church or at work surrounded by people and yet feel invisible? You do not have to be physically alone to be lonely. You just have to feel that no one truly sees you.

And the enemy loves to work in the shadows of loneliness. He whispers lies into that void, telling you that you do not matter, that no one cares, that this ache will never go away. But it can. And it must.

Scripture tells us that we were never meant to do life alone. In Psalm 68:6 (NIV), we read, ***"God sets the lonely in families."*** That is not just poetic. It is a profound spiritual truth. God places us in community for a reason. He knows that connection is not optional—it is vital for the health of our souls, our bodies, and our minds.

And if you are reading this and you feel isolated, please hear this: your loneliness is not a reflection of your worth. It is a wound, not a verdict. And wounds can be healed.

Start small. Reconnect with someone. Join a group. Let someone in. Serve. Show up. Ask for help. Speak the truth about how you are really

doing. The only way out of loneliness is through relationship, and that takes risk. But the reward is life. And life abundantly.

Because at the end of the day, it is not good for man to be alone. We were created for connection. And when we restore that, healing can begin.

Disconnection from Childhood Trauma

As we have explored in earlier chapters, unresolved childhood trauma often lies at the heart of depression and anxiety. Even when the memories fade or the events seem buried, their impact lingers, silently shaping the way we think, feel, and react. Johann Hari (2018) captured

this powerfully when he wrote, "There's a house fire inside many of us." That's not an abstract metaphor. It's a living reality for countless men and women who walk through life with an inner burn, a gnawing ache, a silent alarm that never shuts off.

And it is not only childhood trauma. Many adults carry the layered burden of additional trauma. It may be the slow erosion of dignity from a toxic marriage, the moral injury of betrayal, the loss of a loved one, or the long grind of life that never gave back what it took. Trauma compounds. What begins as one wound often leads to others. And when those layers go unrecognized, the fire spreads deeper.

This inner fire may not be visible to others. You may go to work, raise your children, serve at church, smile at neighbors, and still feel like something inside you is cracking under pressure. Trauma, especially when unresolved, does not stay in the past. It lives in the nervous system. It changes the way the brain processes stress, danger, and even love. It keeps you hyper-alert or emotionally numb. It whispers lies about your worth, your safety, and your ability to be loved.

Hari makes this clear—you cannot disconnect from your trauma and expect to heal. Numbing it, denying it, or burying it only deepens the pain. You might escape the fire for a little while, but eventually, the smoke fills the house.

But there is hope.

Healing is not only possible; it is promised. Jesus did not shy away from the wounded. He moved toward them. He did not tell the weary to tough it out. He invited them to come. ***"Come to me, all you who are weary and burdened, and I will give you rest"*** (Matthew 11:28, NIV).

That is not poetic suggestion. That is lifeline truth for the anxious, the depressed, the overwhelmed, and the soul-weary. You were never meant to carry this alone.

True recovery goes deeper than symptom management. It requires you to stop running from your pain and start bringing it into His light. It means surrendering the survival strategies that no longer serve you and asking Jesus to touch the places in you that have long been locked away. It means letting God speak truth where lies have taken root. And it nearly always requires doing this work in the presence of others, in counseling, in trusted friendships, and within the body of Christ.

Too often, the church has not known what to do with trauma. We have offered quick prayers and surface solutions, sometimes unintentionally shaming those who still struggle. But trauma is not healed by spiritual shortcuts. It is healed by Spirit-empowered presence. The church is called to be a refuge. A place where brokenness is not hidden but embraced, where healing is not rushed but walked out 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).

Healing may not come in a single moment. It looks like learning to breathe again. Letting yourself be seen. Crying tears that you swallowed years ago. Showing up for counseling even when your entire body tells you to stay home. Choosing connection over withdrawal. Opening your heart to receive comfort instead of managing everything alone. And in time, it looks like peace. Not numbness. Not performance. Real, grounded, soul-deep peace.

Because your trauma is not your identity. You are not your symptoms, your past, or your mistakes. You are a child of God, dearly loved, made for restoration. Through faith, through support, and through truth spoken in love, healing can begin. The fire can be put out. The walls rebuilt. The soul restored.

"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).

Christ is not afraid of your ashes. He builds beauty from them.

Disconnection from Status and Respect

Sometimes, the roots of depression and anxiety are not hidden in childhood alone. They are alive in the present moment, shaped by social

dynamics, power structures, and the very human need to feel seen and valued. The need for belonging and self-respect is not shallow. It is built into our biology. When that need goes unmet, the nervous system lights up with stress, and the heart begins to sink.

Neuroscientist Robert Sapolsky offers one of the clearest windows into this reality. In his decades-long research on baboon social hierarchies, he observed a pattern that should give all of us pause. Low-status baboons, those shoved to the bottom of the social ladder, began to behave in ways that uncannily resembled human depression. They hung their heads, moved less, stopped grooming, lost appetite, and isolated themselves. And it was not just behavior. Sapolsky found a dramatic surge in cortisol, the primary stress hormone, coursing through their systems. Their brain chemistry mirrored the patterns we see in depressed and anxious humans (Sapolsky, 1992, 2002).

What makes this so profound is that it reveals something ancient about our wiring. Social rank matters, not because we are obsessed with popularity, but because we are designed to live in communities where our contribution and place have meaning. When we believe we do not matter, when we feel ignored or excluded, our bodies interpret that as a survival threat. The result is often depression, anxiety, or both.

Although this pattern is clearly observable in adolescents, we are not speaking here about teenagers. We are speaking to adults, men and women who may still be carrying the same old wounds, the same silent stories of exclusion and social diminishment that began years ago but never truly healed. These hierarchies do not end after high school. They continue into our adult relationships, our workplaces, our churches, our

families, and our digital lives. The need to be seen, respected, and valued does not evaporate with age. If anything, the stakes grow higher.

Now throw modern life into the mix. What once was a temporary season of status anxiety in youth has, for many adults, become a chronic undercurrent. The digital age has created a world where the scoreboard never turns off. Whether it is social media, professional hierarchies, neighborhood comparisons, or subtle status cues in friend groups, adults are constantly reminded of where they rank. And for those who feel unseen, undervalued, or sidelined, the psychological toll can be profound.

You might never call it by name, but you feel it. That creeping sense of invisibility. The quiet belief that your life does not matter as much as someone else's. You scroll past images of success, beauty, and connection, and silently absorb the message that you are falling behind. This kind of chronic social comparison does not just cause dissatisfaction. It can fuel depression and anxiety, especially when your life lacks meaningful avenues for purpose, contribution, or affirmation.

Jean Twenge (2006) speaks to this deeply. Self-esteem, she writes, is not built through applause or attention. It is formed through real-world mastery, through doing hard things, making a difference, and becoming competent in something that matters. Adults, just like adolescents, need to know that their life has weight, that their effort makes a dent in the world, that they can still grow, contribute, and earn respect in real and lasting ways.

When those opportunities are stripped away, through job loss, toxic workplaces, fractured relationships, or quiet social exclusion, many

adults begin to lose not only the respect of others but their own internal sense of dignity. And that is where depression and anxiety often take root. Not in one traumatic event but in the slow erosion of value, identity, and place.

This is not about ego. It is not about being impressive or achieving status. It is about the sacred human need to belong, contribute, and be seen. Without it, the nervous system stays on high alert. Cortisol rises. The body grows weary. And the soul begins to flicker under the weight of feeling unworthy.

As the psalmist cried out, ***"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). That cry is as ancient as Scripture and as present as this morning. It is the honest voice of a soul that knows isolation, invisibility, and the ache of lost dignity. But it is also a cry that is heard. God sees. He turns. And He answers.

Disconnection from Meaningful Values

When a person feels unmoored, when their days are filled with motion but empty of meaning, the soul begins to erode. For adults today, especially in Western culture, this erosion is no longer subtle. It is widespread and devastating. You see it in the hollow look of burnout, the anxious searching for novelty or pleasure, and the quiet despair that shows up in addictions, disordered habits, or flat-out exhaustion.

Tim Kasser (2002), in his research on values and psychological well-being, found something profoundly sobering. When people organize their lives around materialistic goals such as appearance, image, money, social status, or fame, they become significantly more prone to depression, anxiety, and chronic dissatisfaction. These extrinsic values promise happiness, but they deliver emptiness. And in a culture driven by screens, comparison, and consumerism, these false promises are

everywhere. You are told you can curate your best life, but the more you chase validation, the less peace you seem to have.

This reality is especially concerning in adolescence, where the brain is already wired to seek novelty, identity, and belonging. But the damage does not stop there. Adults, too, are suffering in large numbers. In fact, many adults never moved past adolescence in the realm of values. They continue to chase status, beauty, and validation long after their twenties have ended. It is no surprise, then, that we are seeing record levels of adult depression and anxiety, particularly among those who have become disconnected from anything resembling transcendent purpose.

As a culture, we have drifted. We have moved away from deep-rooted structures that gave people identity and stability. Many have walked away from the church. Others have grown disillusioned with tradition or with organized religion. We have told people to find their own truth, but we have failed to provide the tools or the context for doing so. The result is not more freedom. It is more confusion. More loneliness. More despair.

In my (Jeff) work as a therapist, particularly with families, adolescents, and pediatric populations, this theme has surfaced again and again (Jeff's work). I would often ask families one simple question: "What are your values?" The answers were usually vague. "To be kind," or "To work hard." But when I asked whether those values were ever talked about at the dinner table, written down, taught intentionally, or practiced together, the answer was often no.

One intervention I used with families was to help them create a family coat of arms, an artistic representation of who they were and what they stood for. It became a project in defining identity, and children especially responded to it. They lit up when they realized they could name what they believed. It gave them a sense of pride, direction, and place. That same principle holds true for adults. We are not too old to reclaim clarity about what we believe and why it matters. In fact, it may be one of the most healing things we can do.

When we lose sight of our values, we lose our compass. And when you live without a compass for too long, it becomes easy to drift into despair. Depression creeps in when your days feel meaningless. Anxiety thrives in the absence of direction. If you do not know what you stand for, then every decision becomes overwhelming. Every conflict feels like a threat. Every setback feels like personal failure.

Adults need to reconnect with values that are not imposed by trends or measured by social comparison. They need values that are rooted in something larger than ego or preference. For some, that will mean a return to faith, to a biblical worldview that offers purpose, moral clarity, and hope. For others, it might begin with rediscovering the lost art of community, or committing to service, creativity, hospitality, integrity, or stewardship.

But regardless of where a person starts, the truth remains. We were never meant to live rootless lives. When people are connected to intrinsic values such as love, compassion, purpose, creativity, and responsibility, they thrive. Their suffering has context. Their work has meaning. Their relationships are more resilient. And when suffering

comes, as it always does, they do not collapse. They draw strength from the foundation beneath their feet.

So, the invitation is simple but not easy. Reconnect with your values. Write them down. Talk about them with your children. Display them in your home. Rebuild the structure that modern life has quietly dismantled. In doing so, you might just find that some of the fog begins to lift, and with it, the anxiety and depression that has taken up residence where meaning used to live.

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

Sometimes, healing does not begin in a therapist's office or with a new journal or book. Sometimes, it begins with stepping outside and standing still long enough to hear the wind move through trees or watch the way light scatters on the surface of water. Sometimes, healing begins by coming back to the world God made—not the digital one we created, but the real one we were made for.

Many of us have forgotten this. We wake up to artificial light, move through our day surrounded by screens and concrete, and fall asleep to the low hum of electronics. We move faster, work longer, scroll endlessly. But we rarely step outside without an agenda. We rarely notice the living world beyond our own. Nature becomes a backdrop, not a participant in our lives. And that disconnection comes with a cost.

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

Research affirms what our souls have long known. Berman et al. (2012) demonstrated that even brief walks in natural environments—not hours of hiking, just a stroll through trees or along a riverbank—can lead to marked improvements in mood, concentration, and cognitive clarity. These effects are particularly strong in those struggling with depression. Nature appears to quiet the default mode network; the brain system associated with rumination and anxious self-focus. In other words, it gently lifts the mental fog and eases the internal noise.

And yet, many people, especially teens and young adults, now spend over 90 percent of their time indoors, disconnected from the natural world, immersed in artificial light and curated, filtered realities. The human brain, especially in its formative years, was never designed to be confined within walls and glowing screens.

Richard Louv (2005) called this phenomenon ***"nature deficit disorder,"*** not as a clinical diagnosis but as a cultural wound. When people are severed from wildness, wonder, and the grounding rhythms of God's creation, they become more anxious, more distracted, and more lost. Teens who never touch soil, hear birdsong, or feel the stillness of a forest are not just missing a recreational experience, they are missing neural nourishment. Adults, too, suffer in similar ways. We get stuck inside, physically and emotionally, and our bodies begin to echo that stuckness.

In my own clinical work (Jeff's work), I have seen time and again that the simple act of encouraging someone to walk outdoors, to breathe real air, or to sit near water can serve as a catalyst for change. Not because nature is magic but because it is ***ordered.*** It brings us back into harmony with something deeper than ourselves. It resets the nervous system. It reminds us that we are part of something vast and beautiful and still unfolding.

And it is not just biological. It is spiritual.

The book of Job speaks to this with profound clarity. ***"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). God's creation is not incidental. It is instructional. It is alive with His presence. To be in nature is to return, in some small way, to the garden we lost and to the rhythms that still whisper of Eden.

When we step outside and slow down, we remember who we are. We remember that healing is not always about doing more, fixing faster, or

thinking harder. Sometimes, it is about receiving. Listening. Letting beauty work on us. Letting stillness stretch our breath and open our hearts.

For those who suffer from depression and anxiety, reconnecting with nature is not a silver bullet. But it is one powerful thread in the tapestry of healing. It can quiet the overactive mind. It can lower cortisol. It can invite awe back into a weary spirit. And it can provide something most of us didn't realize we were starving for—real, unscripted, untamed presence.

So, step outside. Step barefoot onto the grass. Sit with the silence. Watch the clouds. Let your soul recalibrate. You were made for this. And creation is waiting.

Disconnection from Hope and the Future

Hope is not wishful thinking. It is not naïve optimism or positive vibes. Hope is oxygen. When it goes missing, we suffocate slowly.

Many adults today are doing just that, suffocating under the weight of hopelessness they cannot always name. Life has become a blur of responsibilities, disruptions, and unanswered questions. People go through the motions, but inside, they are losing connection with something essential. They do not look forward to tomorrow. They have stopped imagining something better. They no longer believe that change is possible. They are alive but not really living.

This quiet erosion of the future is not always loud or dramatic. Sometimes, it shows up as chronic fatigue, irritability, withdrawal, or a gnawing sense of dread. Other times, it looks like perfectionism or overachievement, a frantic attempt to outrun the fear that nothing

they do will matter. Beneath both postures, collapse and overdrive, is the same hollow center, a loss of meaningful hope.

Psychologist C.R. Snyder (1991) described hope as more than just a feeling. He defined it as a combination of agency and pathways, the will and the way. Agency is the belief that you have the power to move toward a goal. Pathways are the strategies and steps that get you there. When both are present, hope thrives. But when either one is missing, despair quietly moves in.

This theory maps perfectly onto the inner world of depression and anxiety. When a person feels powerless and unable to take action, their mind begins to spiral into paralysis. When a person feels there are no paths forward, even their strongest will can collapse. Over time, they stop trying. They stop dreaming. They stop believing anything can change.

This reality is not limited to teenagers. Adults are especially vulnerable to this kind of psychological foreclosure. The longer someone has lived without progress, or with repeated failure, or through seasons of chronic stress or trauma, the easier it is to internalize the message that tomorrow will simply be more of the same. Eventually, the soul begins to shut down.

And let's be honest. We live in a cultural moment that does not help. Institutions have eroded. Public trust is at an all-time low. The future feels uncertain in every direction. People carry silent grief over what the world has become or what their lives have not become. Many are still haunted by wounds that never got time to heal. Some feel stuck in

jobs that deplete them. Others are reeling from lost relationships, financial pressures, or just the sense that they are running out of time.

And all of it adds up to one painful question: What is the point?

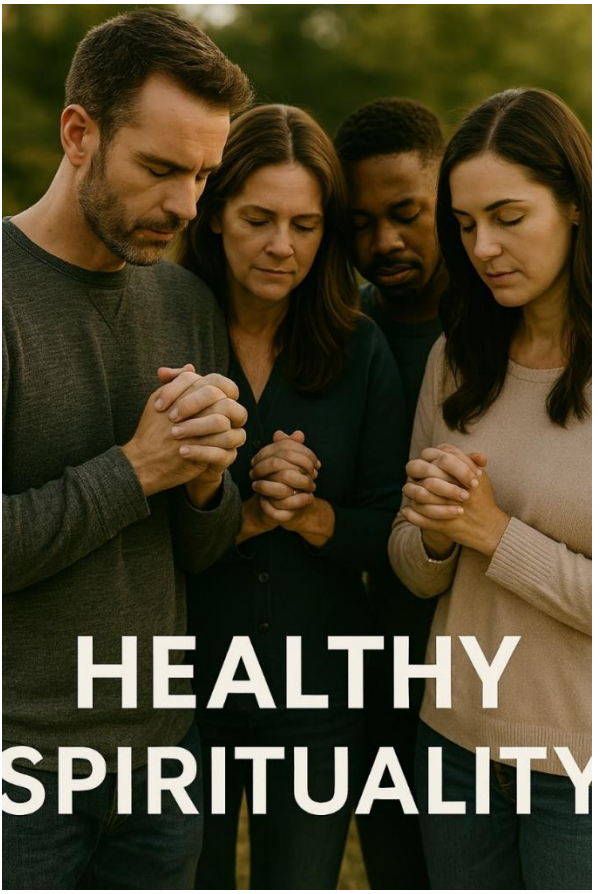
But the truth is, we were never meant to live without hope. We were never meant to white-knuckle our way through life without vision, direction, or a greater purpose.

God designed the human heart to live forward, to aim toward something bigger than the moment we are in. That forward motion is not about chasing success or achievement. It is about knowing that your life still has meaning, that your effort still counts, and that your future is not yet finished.

The Apostle Paul captured this perfectly when he wrote, ***"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).

Even if your hope has gone quiet, it is not gone forever. With the help of God, it can return. You can learn to dream again. You can begin to move again. You can believe, once more, that the story is not over. Because it isn't.

Disconnection from Faith and Meaning



Johann Hari identified many vital forms of disconnection that feed modern despair. He wrote of our loss of meaningful work, community, hope, nature, and purpose. But there is one form of disconnection that, while not explicitly named in his list, we believe deserves to be included. In fact, it may be the most important of all.

We are speaking of the spiritual.

When a person loses connection with the transcendent, when they can no longer sense God's presence, love, or guidance, something vital

inside begins to dim. Adults who once believed they were part of a larger story now find themselves adrift. Others never had that story to begin with and carry a quiet ache that they cannot explain. They live untethered, disconnected not just from people or purpose but from the One who created them.

This spiritual vacuum is not merely philosophical. It is physiological and psychological. As Dr. Lisa Miller (2021) has demonstrated in her groundbreaking research, a strong spiritual life is one of the most robust protective factors against depression. In adolescents and adults alike, spiritual engagement reduces the risk of suicide, increases resilience, and dramatically improves the brain's capacity to process trauma. Spirituality does not bypass suffering. It reframes it. It says, you are not alone, your pain is not pointless, and your story is not over.

And that message matters more than ever.

We live in a time when organized religion is often viewed with suspicion. Church attendance has declined. People claim to be spiritual but not religious. Yet in this individualized spirituality, many find themselves more isolated, not less. The deep communal and theological roots that once grounded generations are now fractured. People are free to choose their path, but many no longer know where to begin.

In my (Jeff) clinical work, it became evident that when spiritual language and relationship with God were removed from the healing process, something essential was missing. People could improve functionally, but their inner world remained dry. The fire of hope never quite returned. But when the soul was given permission to speak again, when we brought Scripture, prayer, and the presence of God into the

therapy room, something shifted. Healing became not just behavioral but redemptive.

Depression and anxiety are often misunderstood as purely chemical problems or purely psychological problems. But many times, they are cries of the soul, silent alarms going off inside us, saying something is wrong. Something is missing. The NeuroFaith™ model recognizes this. It sees healing not just as a clinical process but as a relational, spiritual, and embodied one. We are not brains in jars. We are image-bearers. And we are not meant to heal alone.

All of these disconnections, whether from meaning, people, nature, or God, are invitations. They are not indictments. They are not moral failures. They are the body and the spirit calling us back to what we were made for. Community. Purpose. Stillness. Hope. Eternity. And God Himself.

Spiritual reconnection does not require perfection or ritual. It begins with turning. Turning toward the presence of God, even with doubt. Turning toward Scripture, even with questions. Turning toward love, even when you feel unworthy of it. The invitation is open. And the moment we take even the smallest step; we find that we were never abandoned.

God's words to His people are timeless, and they remain true today:

"Do not fear, for I have redeemed you. I have summoned you by name. You are mine. When you pass through the waters, I will be with you, and when you pass through the rivers, they will not sweep over you. When you walk through the fire, you will not be burned. The flames will not set you ablaze" (Isaiah 43:1–2, NIV).

We will explore the spiritual dimensions of healing more deeply later in this book. But for now, let this truth settle gently in… you are not alone. You are not forgotten. You are not beyond reach. There is a voice that calls you by name. And even in your darkest moments, that voice does not go silent.

Let us never underestimate the power of reconnection. For sometimes, all it takes is one prayer, one verse, one sacred moment of stillness, and the tide begins to turn.

Cause Two

Hijacked Minds

How Pornography is Rewiring the 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.

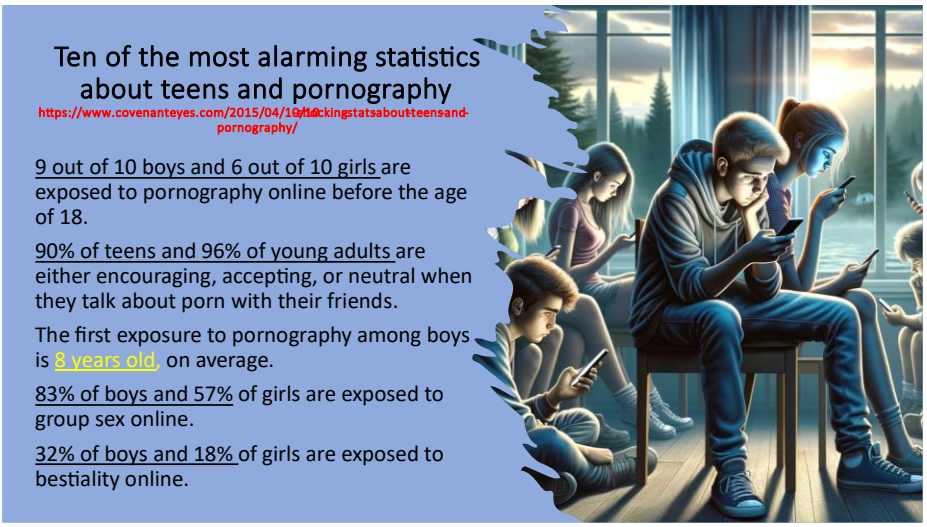
-Alexander Pope's essay on man

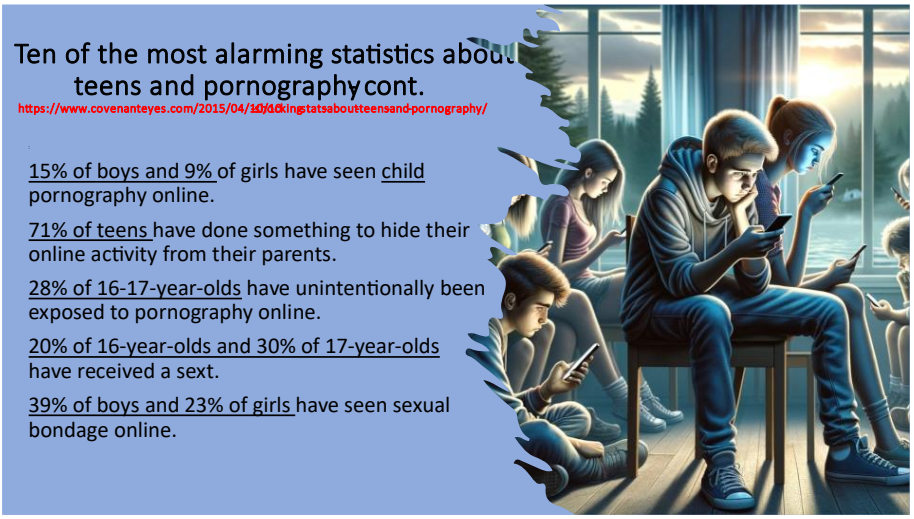
In the words of Stephen Arterburn, world renowned expert on sexual addiction, "***I don't know of any plague to ever reach into the homes and families all over the world and create as much damage or heartaches than the struggle of lust, affairs, pornography, perversion, and sexual addiction. It seems 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 facilitates affairs with greater accessibility and secrecy"*** (cited in Roberts, 2008, p.9).

When I entered the field of psychology over three decades ago, I never imagined that pornography would become one of the most urgent emotional and neurological health crises facing men today. What was once hidden behind seedy bookstores and hushed conversations has become mainstream. Pornography is no longer an uncomfortable sidebar. It is the main event in the collapse of male emotional and relational well-being. We are dealing with a cultural plague that is literally rewiring the brain, hollowing out the soul, and tearing apart marriages, families, and faith.

The Adolescent Hook: When It All Begins

For most men, the story doesn't begin in adulthood. It starts in adolescence. Often before age ten. Covenant Eyes (2015) reports that 9 out of 10 boys are exposed to pornography before the age of 18, and the average age of first exposure is just eight years old. At that stage, the brain is still undergoing massive growth and restructuring. The prefrontal cortex—the part of the brain responsible for decision-making, impulse control, and long-term planning—is still under construction.



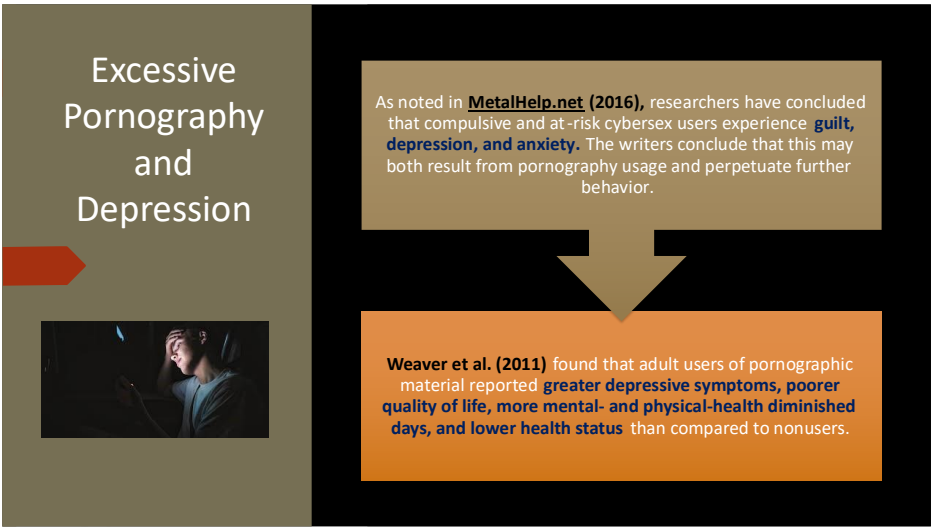


To expose that fragile, rapidly developing brain to high-speed, hyper-stimulating pornography is like lighting a fire in dry brush. It changes everything. What begins as curiosity becomes compulsion. What starts as secret fascination evolves into shameful addiction. And for many boys, this secret struggle follows them into adulthood. They grow up, but the wiring remains. The habits remain. The shame calcifies.

The man becomes a husband or a father, or tries to, while carrying an addiction that has etched itself into his neurochemistry. He may not even see it as an addiction. He may call it stress relief, or "just something I do sometimes." But the emotional toll tells the truth.

The Adult Fallout: Depression, Disconnection, Despair

Study after study confirms what clinicians see every day. Pornography use in men is linked to significantly higher rates of depression, anxiety, guilt, and relational disconnection. Dr. David Skinner's study of 450 adult users found that daily users scored an average of 21 on the Beck Depression Inventory—compared to just 6.5 in the general population.



These aren't isolated findings. They are part of a growing body of evidence. Weaver et al. (2011) found that regular pornography users report greater depressive symptoms, poorer physical health, more days of mental and emotional dysfunction, and lower overall life satisfaction.

Gary Wilson's ***Your Brain on Porn*** dives into the neurobiology of this crisis. Pornography hijacks the reward system of the brain. It floods the system with dopamine, and over time, the brain begins to require more novelty, more shock, more stimulation just to feel arousal. That's why what started with curiosity can end up in darkness—violent porn, fetish material, or content that directly violates a person's moral code.

The Sexual Price: Dysfunction and Deadening

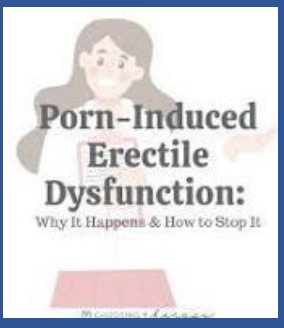
We are facing a new kind of epidemic: men in their twenties and thirties who cannot perform sexually with a real partner. What was once an issue almost exclusively seen in older men has exploded. Rates of erectile dysfunction in men under 40 have gone from 2 to 3 percent (de Boer et al., 2004) to as high as 33 percent (Wilson, 2017; Park, 2016).

A Canadian study (O'Sullivan et al., 2016) found that nearly half of young men aged 16 to 21 report erectile dysfunction. Forty-six percent report low sexual desire. Nearly one-quarter report difficulty climaxing.

The Impact of Pornography on Sexuality

Prfound sexual side effects:

- Between 1948 and 2002, the historical rates for ED in men under 40 were consistently around **2% to 3%** and did not go up very much until age 40. (de Boer et al., 2004). However, as noted by Wilson (2014), at least six studies have found ED rates of about 14% to 35% in young men, which constitutes a staggering **1000% increase** in just the last 15 years (Park, 2016).
- In fact, adolescents are suffering disproportionately as noted by in a Canadian study which showed that problems in sexual functioning are sadly higher in adolescent males than in adult males. In a two-year period **78.6% of males aged 16-21** reported a sexual problem during partnered sexual activity (O'Sullivan et. al., 2016):
  - Erectile dysfunction - 45%
  - Low sexual desire - 46%
  - Difficulty climaxing – 24%
- These problems have led some teens to suicide.



These are not isolated physical issues. These are neurological issues. These are emotional issues. These are soul issues. And many men carry this silently, shamed and confused, believing something is wrong with them without understanding that the damage was being done, slowly and steadily, from the moment they were handed an unfiltered internet connection in adolescence.

Escalation and Identity Disruption

The brain's craving for novelty doesn't stop. Over time, users escalate to content they once found repulsive. Downing et al. (2016) found that 21 percent of heterosexual men view gay porn, and 55 percent of gay men view straight content. This isn't about orientation. It's about novelty addiction. Many men report shock at what they now find arousing. The resulting shame and confusion feed depressive spirals and self-loathing.

Some men begin questioning their masculinity. Others start doubting their own moral compass. Many feel like they've betrayed something sacred inside themselves—and in many cases, they have. That's what we call moral injury. And moral injury is a major driver of depression.

The Spiritual Vacuum

Pornography promises satisfaction but delivers emptiness. It fragments the soul. It numbs the spirit. It hollows out our capacity for real love. For connection. For joy. And it isolates men from their Creator. As one client put it to me, "I used to feel God's presence. Now I just feel static."

Men who once had vision and fire now feel foggy and passive. They struggle to feel deeply. They grow anxious in real intimacy. They feel

dead inside. Pornography is not just lust. It's grief in disguise. It's a counterfeit form of intimacy that leaves a man lonelier than before.

What's at Stake

This isn't about prudishness or shame. It's about war. A war on male identity, mental clarity, sexual integrity, spiritual vitality. Men are losing their marriages, their peace, their purpose, and their minds.

And make no mistake, the enemy doesn't kick the door down anymore. He slips in quietly, silently, through a screen. And once he's in, he starts taking things. One click at a time.

First, he takes your connection. Pornography rewires the brain in such a way that normal, loving intimacy with a real partner becomes foreign, even frustrating. Your partner's touch doesn't excite you anymore. Her realness can't compete with the endless novelty on the screen. Emotional closeness feels less compelling than dopamine-driven arousal. You become disengaged, disinterested, and ultimately disconnected—from her, from yourself, and from God.

Then it takes your sexuality. You may still crave sex, but the drive gets twisted. Your desires become shaped by what you watch, not who you love. Before long, you find yourself aroused by things that once disgusted you. You may feel confused. Ashamed. Isolated. And you probably won't talk to anyone about it, which only deepens the hole.

Next, it takes your potency. Not just sexual potency, though that's often the first thing to go. We're talking about the full force of your masculine presence—your confidence, your energy, your strength of will. Porn deadens a man. It makes him passive, restless, and checked

out. It feeds anxiety. It fuels irritability. It creates a kind of low-grade despair that's hard to shake and even harder to name.

Then it takes your soul. Slowly, silently, it siphons away your passion, your joy, your sense of divine purpose. You begin to feel spiritually numb. You lose clarity about who you are and who you're called to be. Porn doesn't just fracture your attention—it fractures your identity. It is a counterfeit form of intimacy that leaves you hollow, confused, and ashamed.

And ultimately, it takes your mental health. Make no mistake, long-term pornography use is a driver of massive depression. Men caught in its grip report persistent dysphoria, emotional blunting, anxiety, and deep loneliness. You feel disconnected from others, from God, from life. You are no longer authentically related to the people you love. The guilt builds, the anxiety increases, and a slow, gray fog settles in.

That's the path.

It doesn't plateau. It escalates.

And if that's you—if even part of this describes where you are—then this is our plea: get help. Please. Not because we're here to guilt you. Not because we want to heap shame on you. But because we've been there. We've sat with too many men whose lives are quietly imploding under the weight of this silent addiction.

This book isn't about moralizing. It's about saving your life. We are sounding the alarm because we care about your joy, your marriage, your calling, your soul.

There is a way out. It's not easy, but it is possible. With truth, accountability, neuroscience, trauma healing, and the redemptive power of faith, healing can happen. Not just coping—healing. You can be restored. Your mind can be renewed. Your relationships can be rebuilt. Your purpose can come alive again.

But first, you have to be honest. If this has a grip on you, you must confront it. Don't minimize it. Don't rationalize it. Don't let it steal another year of your life.

Freedom begins with truth.

And if you're reading this, maybe that freedom starts today.

This chapter is not about condemnation. It's about clarity. If you are caught in this struggle, know this: you are not alone. And you are not broken beyond repair. There is a way back. The NeuroFaith™ model offers a practical, spiritual, and neuroscience-informed approach to healing the damage that pornography inflicts. It's a path of honesty, humility, and grace. And it works.

We are not here to shame men. We are here to call them back to who they really are. Because you are not what you watch. You are not your past. You are not your lowest moment. You are God's beloved, created for connection, strength, and real joy.

This book will walk you through what it means to reclaim your mind, your body, and your soul. This battle is worth fighting. And you're not fighting alone.

Healing is not only possible. It's already beginning.

Cause Three

Trauma

The Hidden Epicenter of Depression and Anxiety

Of all the causes of depression and anxiety, trauma may be the most devastating and the most overlooked. Trauma, particularly in the form of child maltreatment such as neglect, emotional abuse, physical harm, and sexual violation, has been identified as a major contributor to emotional dysregulation and poor mental health outcomes across the lifespan. It is one of the most

significant risk factors not only for depression but also for post-traumatic stress disorder and a wide array of emotional and relational struggles (McLaughlin et al., 2012, 2013).

Multiple studies confirm that trauma compromises the capacity to regulate emotions, starting in early childhood and continuing well into adolescence and adulthood (Langevin et al., 2016; Shields & Cicchetti, 1997; Briere & Rickards, 2007; Dunn et al., 2018). Trauma occurs not just because from what we go through, but because of the way we are left to carry that experience, isolated, unsupported, unseen. As Barta (2018) explains, trauma overwhelms the nervous system and prevents integration, leaving the body in a perpetual state of hyperarousal or collapse.

Perhaps one of the most insidious effects of unresolved trauma is the formation of negative core beliefs. These deeply ingrained assumptions, such as "I am not lovable," "I am not worthy," or "I have no value," become etched into the brain's implicit memory systems, particularly within the default mode network (DMN), which governs self-referential thought. Over time, the DMN becomes a carrier of a toxic internal narrative. These are not just painful thoughts, they are internalized lies, what Scripture might call the lies of the enemy, who *"was a murderer from the beginning... for there is no truth in him"* (John 8:44, NIV). These distorted beliefs can shape how both adolescents and adults approach life, relationships, success, and failure. For teens, whose brains are still under construction, and for adults whose early injuries were never addressed, these beliefs can become the lens through which all future experiences are filtered.

As Fletcher points out, trauma is not stored as a narrative or memory alone but in the body itself. It is carried in the nervous system and in relational habits. Those who carry trauma may appear avoidant, perfectionistic, overly compliant, or oppositional, not because they are defiant, but because they are trying to survive. The world feels threatening, and their actions are defensive, not disobedient.

These trauma-driven beliefs quietly sabotage every area of life. They distort how people see themselves, how they interpret others' intentions, and how they engage in relationships. Social cues may feel threatening, academic or occupational challenges may seem overwhelming, and intimacy may feel unsafe. These individuals, whether adolescents or adults, often carry invisible scripts of shame and fear that stain their sense of identity for decades, unless they are directly addressed through healing relationships and integrative therapy.

The impact of trauma is not limited to the emotional realm. The Adverse Childhood Experiences (ACE) Study by Felitti et al. (1998, 2009, 2014) revealed that childhood trauma is directly correlated with increased risk for physical illnesses, substance abuse, and early death. Emotional abuse, in particular, was found to be more strongly associated with adult depression than even sexual abuse. This emphasizes that the way a child is emotionally treated by caregivers is a profound predictor of mental health.

The ACE study identifies ten categories of childhood trauma, including various forms of abuse, household dysfunction, and neglect. For each category of trauma experienced, the risk for depression, anxiety, suicide, and chronic illness increased significantly. Those with an ACE

score of 7 or more were found to be over 3,000 percent more likely to attempt suicide (Felitti et al., 2009). The cumulative effect of trauma reshapes the brain, the body, and the belief systems.

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)

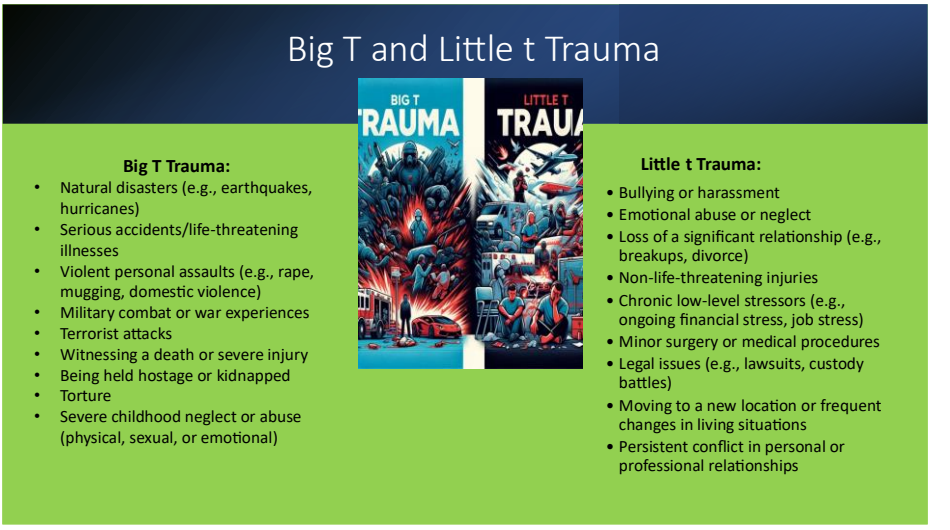
Household dysfunction

- 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%)

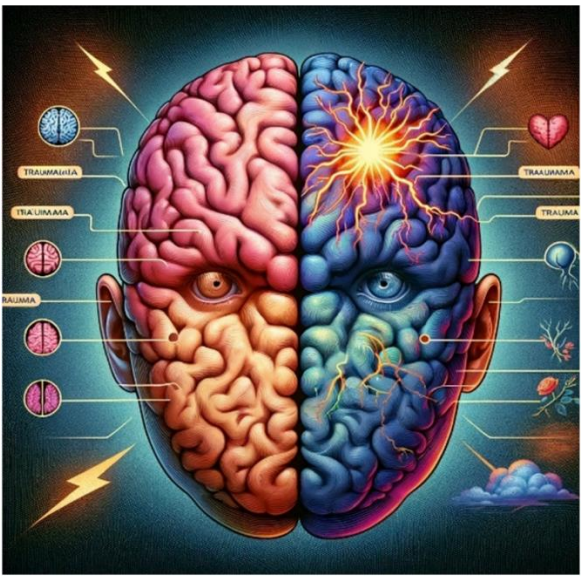
Neglect

- 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.



Trauma changes the brain neurologically

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.

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

If we have ACE scores of 6, we are:

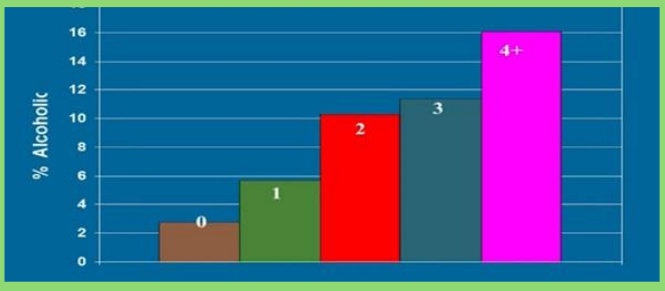
- Five times more likely to become depressed as an adult.

If we have ACE scores of 7, we are :

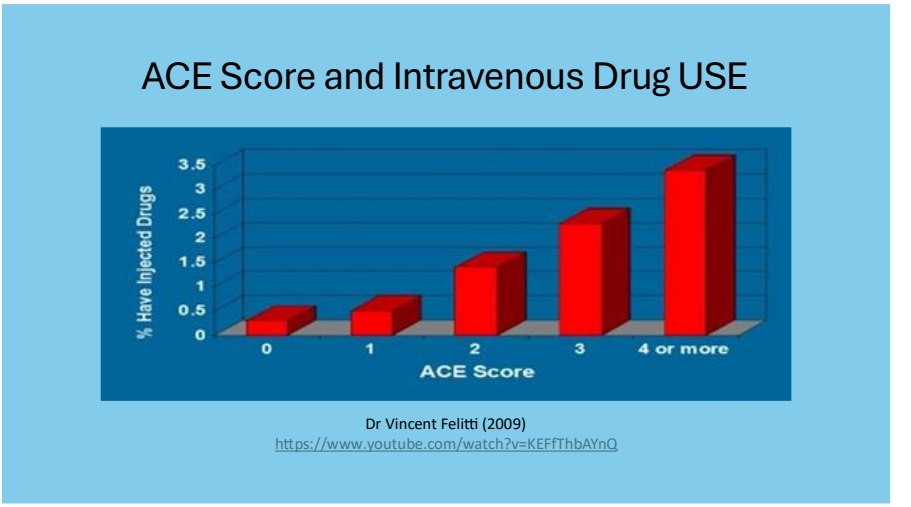
- 3,100 percent more likely to attempt suicide as an adult (Felitti et al., 2014; Felitti 2004; Felitti and Anda, 2009; Felitti et al., 1998).

In the 2009 lecture, Dr. Felitti offered the following graphs, which nicely detail the dramatic impact that ACEs have on our society:

Childhood Experiences vs Adult Alcoholism



Dr Vincent Felitti (2009)
https://www.youtube.com/watch?v=KEFfThbAYnQ



So, how does trauma embed itself so deeply? And why is it so hard to uproot? The answer lies in three powerful pathways that carry trauma forward, one through behavior and relationship, the other through biology and gene expression.

- Attachment
- Social Learning
- Epigenetics

One: Attachment

Attachment is a really big deal and has lifelong implications for all of us. Safe and secure attachment are absolutely necessary for developing healthy and secure relationships, emotional health, and the ability to regulate our emotions. Two early pioneers in this field, Dr. John Bowlby (1969) and Dr. Mary Ainsworth (1973), carved the way to our understanding of attachment and child development theory. They defined attachment as a deep and enduring emotional bond that leads to connections between us across time and space. This attachment is not always mutual and can travel in only one direction. For example, a child can attach to a parent, but the parent does not always attach to the child or vice versa (Kain & Terrell, 2018).

The importance of secure attachment echoes a biblical truth. As ***Proverbs 22:6*** (NIV) says, ***"Start children off on the way they should go, and even when they are old they will not turn from it."*** This verse reflects the profound impact early relationships have on a person's development and well-being throughout their life. When children form

strong, healthy bonds early on, it can set a foundation that lasts into adulthood.

By way of background on Dr. Bowlby, in an interview with Dr. Milton Stenn in 1977, Bowlby explained that his career began in the field of medicine, following in the footsteps of his father, who was a well-known surgeon in London, and John explained that his father encouraged him to study medicine at Cambridge. He followed his father's suggestion but was not terribly interested in anatomy and natural sciences. However, during his time at Trinity College, he became particularly interested in developmental psychology, which led him to give up medicine by his third year. When John left medicine, he accepted a teaching opportunity at a school called Priory Gates for six months, where he worked with maladjusted children. John explained that one of the reasons why he went to work at Priory Gates was because of the influence of an "intelligent" staff member, John Alford. John explained that his experience at Priory Gates had been very influential on him. ***"It suited me very well because I found it interesting.***

And when I was there, I learned everything that I have known; it was the most valuable six months of my life, really. It was analytically oriented." He added that the experience at Priory Gates was extremely important to his career in research as he learned that the problems of today should be understood and dealt with at a developmental level (Kanter, 2007).

Bowlby was not the only act in town as he collaborated extensively with Dr. Mary Ainsworth. Mary was born in Glendale, Ohio. When she was 15, she read William McDougall's book, *Character and the Conduct of Life,* which inspired her to pursue psychology. While teaching at John Hopkins, Mary began working on creating a means to measure attachments between mothers and their children. It was this that led her to develop her famous "Strange Situation" assessment, in which a researcher observes a child's reactions after a mother briefly leaves her child alone in an unfamiliar room. The child's reaction after the separation and upon the mother's return revealed important information about attachment. Based on her observations and research, Mary determined three main styles of attachment: secure, anxious-avoidant, and anxious-resistant. Since these initial findings, her work has spawned numerous studies into the nature of attachment and the different attachment styles that exist between children and their caregivers (VeryWellMind, 2019)

Rudolph Schaffer and Peggy Emerson (1964) analyzed the number of attachment relationships that infants form in a longitudinal study with 60 infants. In their study, infants were observed every four weeks during the first year of life, and then once again at 18 months. Schaffer

and Emerson determined that four distinct phases of attachment emerged:

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).

Discriminate 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.

Two: Social Learning

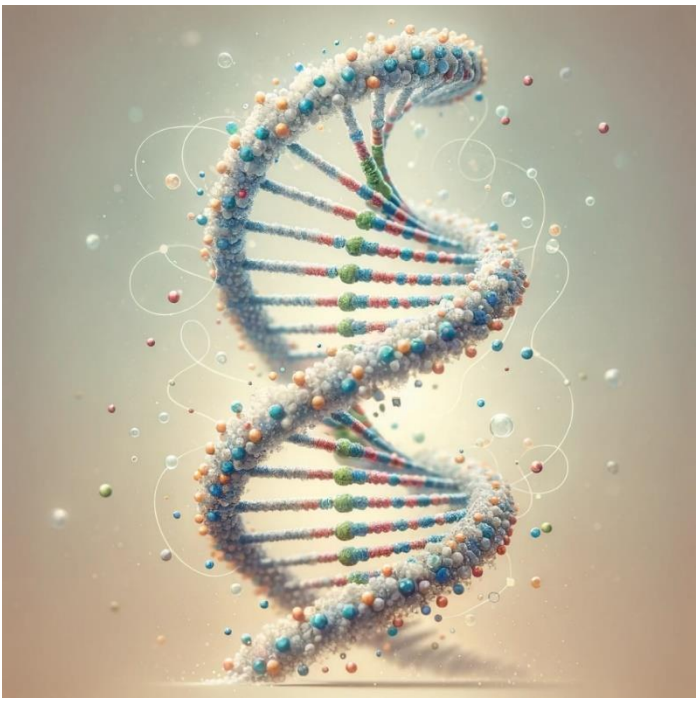
How We Absorb Trauma Through Relationship? Albert Bandura (1977) revolutionized psychology with his theory of social learning. We learn not only through experience but through watching others, especially those closest to us. Children raised in chaotic, emotionally unsafe environments do not just endure trauma; they learn it. They absorb relational patterns, defensive postures, and ways of handling pain. They

watch how shame is hidden, how rage is expressed, how needs are ignored, and then they mimic those patterns in adolescence and adulthood.

These patterns are not just behavioral. They become internalized as ***normal.*** And unless they are brought into awareness and challenged, they get passed down to the next generation. This is one way trauma moves through families, not through genetics but through modeling, mimicry, and silence.

Epigenetics

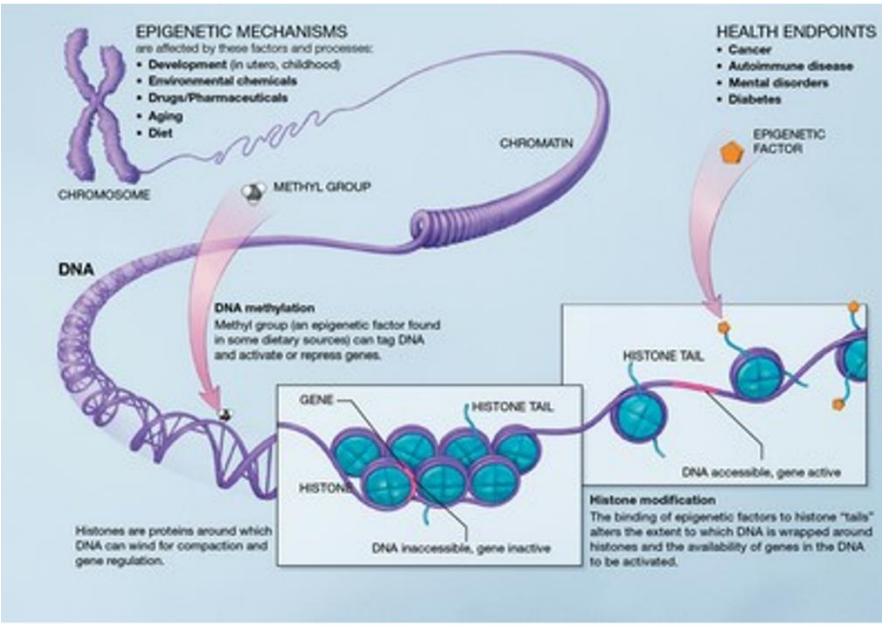
The third, and most sobering, pathway is biological. Trauma does not just shape how we think and relate. It can literally change how our genes express themselves through a process called epigenetics. Epigenetics refers to chemical modifications that sit "on top of" our DNA, switching genes on or off without altering the genetic code itself. These changes are triggered by environmental factors, including chronic stress, adversity, and trauma (Moore et al., 2013).



What makes epigenetics so compelling is that it reveals how our life experiences can physically alter our biology and how those changes can be passed on to our children and grandchildren. In simple terms, epigenetics is like software that tells the DNA hardware what to do. While the genetic code itself remains stable, epigenetic markers determine which genes are turned on and which are silenced. Three main processes are involved in this regulation: DNA methylation, histone modification, and RNA-associated silencing.

DNA methylation is the process by which methyl groups, tiny chemical tags, are added to DNA. This process can silence a gene, meaning that the gene is still present but cannot be expressed. Think of it like covering a light switch with tape. The light is not broken, but it will not turn on. Histone modification involves altering the proteins around

which DNA is coiled. When these histones are tightly packed, the genes are hidden from the cell's machinery and stay inactive. When they loosen, those genes become accessible and can be read and expressed. Lastly, RNA-associated silencing involves small RNA molecules that block messages from being translated into proteins. It is like sticking a "Do Not Read" label on important instructions.



Wikipedia (2023)
https://en.wikipedia.org/wiki/Epigenetics

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.

Barbed Wire Clipart. The Holocaust ...clker.com. Wikipedia

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).

Food rations that were dropped into the Netherlands in 1945.
Credit...Dutch National Archive

Imagine carrying the biological memory of a winter you never lived through. Imagine being born into a world already marked by scarcity and stress, your body tuned to survive a trauma you did not directly endure. That is the power of epigenetics.

These are not just fascinating stories from history. They reveal something deeply human and deeply spiritual. Trauma writes itself into our biology. It embeds into our nervous system, immune system, hormonal pathways, and even our gene expression. It shapes how we see danger, how we handle emotion, how we connect, or disconnect, from others.

And yet, this is not the end of the story. Because just as trauma can alter our biology, healing can begin to restore it. Studies show that many epigenetic changes are not permanent. The same nervous system

that adapts to survive trauma can also be rewired by safety, love, and truth. Practices like regular physical activity, deep restorative sleep, meaningful spiritual connection, secure attachment relationships, healthy nutrition, and trauma-informed therapy can help reverse or soften these harmful patterns. Over time, healing begins to rewrite what trauma once inscribed. The scars may not disappear completely, but the script can change.

This brings both great responsibility and deep hope. We are not stuck. We are not doomed by our lineage. We are not victims of our past. Through deliberate, faithful choices, we can change the biological legacy we pass on. As we heal, our bodies remember. Our cells respond. And so do the lives of those who come after us.

As Scripture says in ***Deuteronomy 30:19***, ***"Now choose life, so that you and your children may live."*** And in ***Exodus 20:5-6***, ***"the sins of the fathers are visited upon the children,"*** but also the promise that God ***"lavishes unfailing love for a thousand generations on those who love [Him] and obey [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 it begins with a choice.

<u>The NeuroFaith™ Response: Reversing the Curse</u>

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.

This is not about symptom suppression. It is about genuine transformation. It is about taking responsibility for our own healing while clinging to 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 mark our nervous systems, but those patterns can be rewritten. Through God's grace and intentional therapeutic work, the darkness does not win.

There is always hope. And there is always a way forward. That way is not easy, and it will require courage. But we walk it together, with God beside us, rewriting the story, biologically, relationally, and spiritually.

"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 recognizes that the path to healing is not primarily about symptom reduction. It is about reconnection, to self, to others, and to God. It involves helping people rewrite the internalized story that trauma told them. As we ask, "Where were you wounded?" we must also ask, "How can we help you heal and reclaim your story?"

And we must remember, in the words of Isaiah 61:1, that *"The Spirit of the Sovereign Lord is on me, because the Lord has anointed me to proclaim good news to the poor. 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."*

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

The story can be rewritten. The lie can be replaced with truth. "***And the light shines in the darkness, and the darkness has not overcome it***" (John 1:5, NIV).

PART III

THE NEUROFAITH™ FRAMEWORK FOR HEALING

The Four Pillars of Healing

A Restorative Pathway for Adult 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 and anxiety are not simply mental states—they are whole-person afflictions that leave deep wounds across the body, brain, and spirit. These conditions are more than biochemical imbalances or fleeting emotional lows. They often represent years, if not decades, of accumulated sorrow, unresolved trauma, autonomic dysregulation, and disconnection from self, others, and God.

Yet, even in the thickest darkness, light still breaks through. Healing is possible. Not just symptom relief but true restoration, a return to wholeness. There is a way forward, a path that is neither simplistic nor

shallow but grounded in both the cutting-edge insights of neuroscience and the timeless truths of Scripture. 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 our healing model, it's important to understand the difference between incremental therapies and transformational therapies. Both have value. Cognitive Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT), and other skill-based interventions can be powerful tools for managing distress. In moments of acute despair, when the weight of depression or anxiety feels crushing, these approaches can help individuals ground themselves, develop emotional regulation, and stay alive. In that sense, incremental therapies can be life-saving.

However, they are often just that—incremental. They offer tools for coping, but they may not reach the root of the pain.

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.

Although incremental therapies are very necessary and helpful, it is transformational therapies that get you home. The Default Mode Network needs to be updated and only transformational therapies can achieve that.

Incremental Therapies	**Transformational Therapies**
Focus: Gradual, step-by-step change.	**Focus**: Profound, holistic changes.
Approach: Behavior modification and symptom management.	**Approach**: Deeper psychological exploration.
Examples: CBT, DBT, Exposure Therapy.	**Examples**: Internal Family Systems (IFS), EMDR, Polyvagal-Informed Therapy, Emotion Focused Therapy (EFT)
Goal: Improve specific symptoms or behaviors.	**Goal**: Transform personal beliefs and self-concept.
Process: Structured, often short-term.	**Process**: Open-ended, usually longer-term.

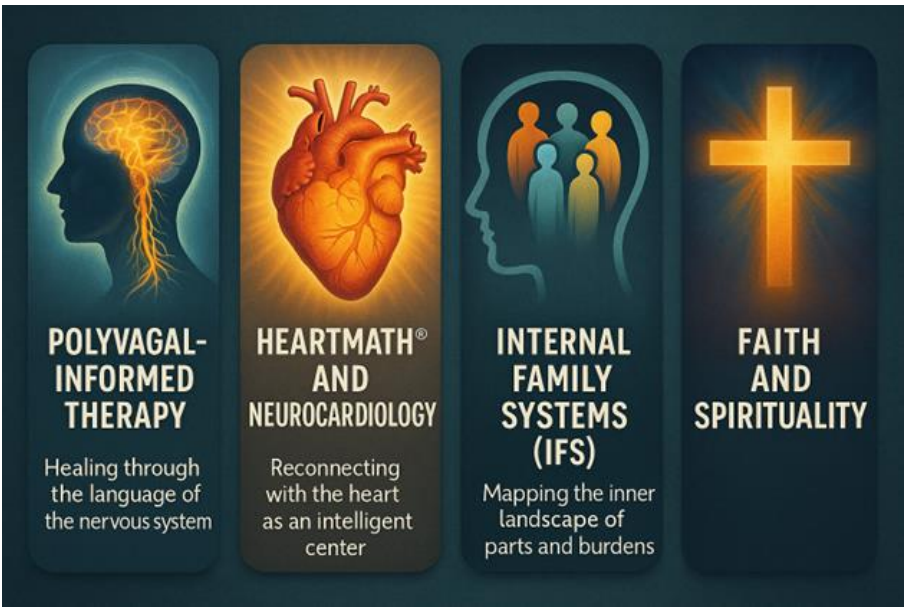
In this chapter, we introduce four central pillars that form the foundation of a truly integrated healing approach—what we call the NeuroFaith™ model. These therapeutic frameworks are not standalone techniques but synergistic pathways that realign the nervous system, rewire the brain, reawaken the heart, and restore the soul.

This is not merely a roadmap to manage symptoms. This is a journey back to yourself—your truest, God-given self—beneath the layers of shame, fear, and dysregulation that have defined your experience of depression and anxiety. These approaches invite you to experience the healing of your nervous system, the reintegration of your fragmented parts, and the restoration of deep inner peace.

As Psalm 34:18 reminds us, ***"The Lord is close to the brokenhearted and saves those who are crushed in spirit."*** The brokenness of depression is not the end of your story. Healing is possible. And the journey begins here.

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

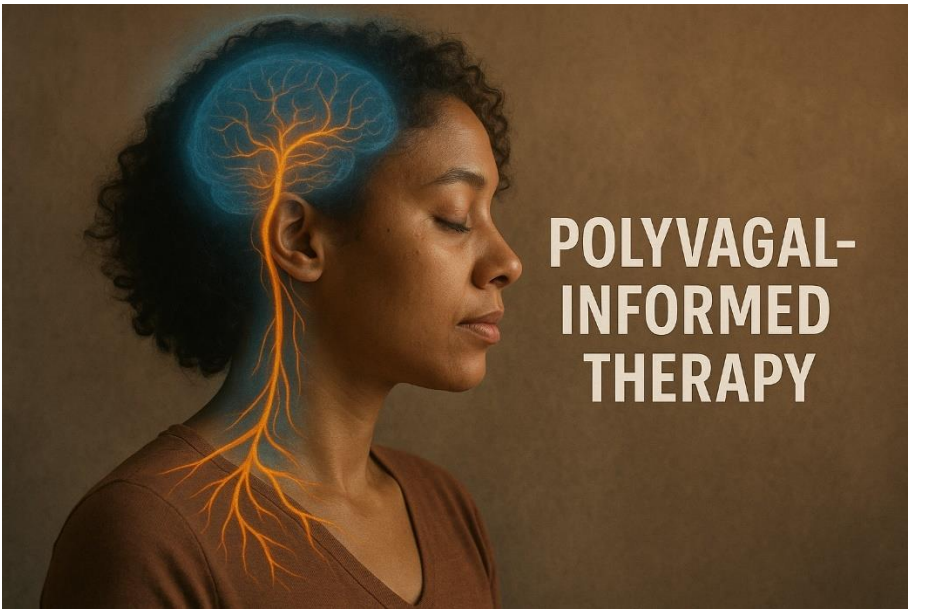
1. Polyvagal-Informed Therapy: Healing through the language of the nervous system, recalibrating the body's threat response and shifting from survival states to safety and connection.
2. HeartMath® and Neurocardiology: Reconnecting with the heart as an intelligent center of emotional processing, coherence, 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. Let's begin.

Pillar One:

Polyvagal-Informed Therapy



Building on what we have previously discussed about the body, specifically the autonomic nervous system, Polyvagal-informed therapy focuses on our body's nervous system and how it responds to stress and safety. It uses the idea that our sense of well-being is closely tied to how our body feels safe, connected, and calm. By understanding and influencing our nervous system's responses, we can

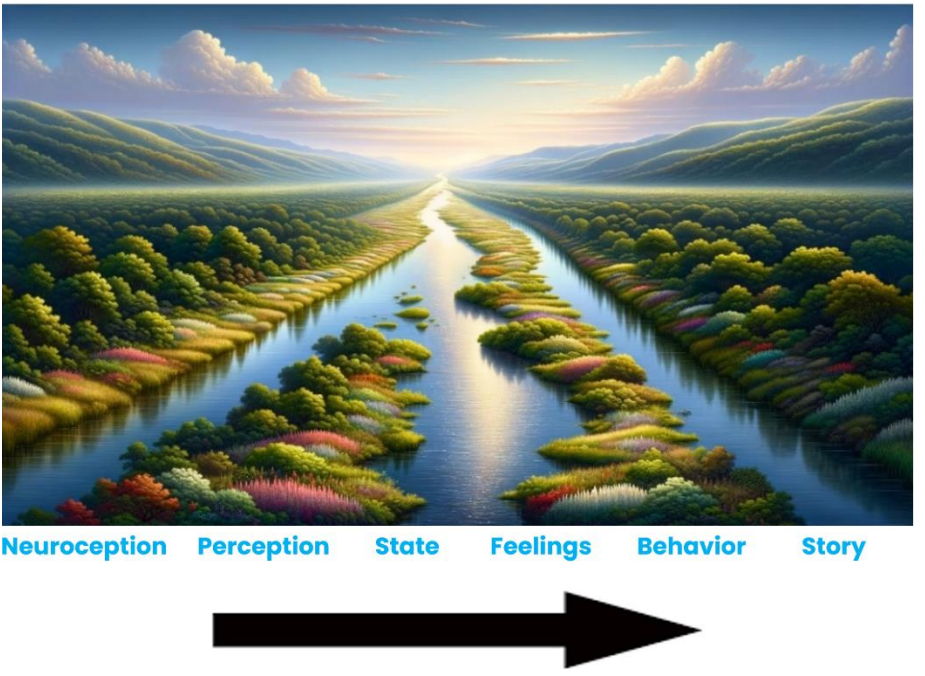
more effectively manage our emotions, feel more connected in relationships, and recover from stress and trauma. In essence, we tune into our body's safety signals to improve our emotional health and resilience.

Dr. Steven Porges and his son, Seth Porges, recently published a marvelous book, ***Our Polyvagal World: How Safety and Trauma Change Us.*** Unlike Dr. Porges' earlier works, this book is free of scientific jargon and is incredibly readable and useful. Bravo Steven and Seth! They start the book by summarizing Polyvagal Theory in one sentence: "How safe we feel is crucial to our physical and mental health and happiness" (Porges & Porges, 2023, p.13).

They later add, "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). Now, how cool is it that - Polyvagal-Informed Therapy can do all of that by helping us achieve regulation through safety! They point out that trauma affects not only our brains but extends throughout our entire nervous system, impacting every part of our body. It alters how our senses perceive, how our organs function, and nearly every aspect of our mental and physical health. As such, trauma changes our bodies in addition to our brains, and Polyvagal Theory gives us an explanation for how specifically these changes occur and, more importantly, how we can deal with them and heal.

Steven and Seth assert that Polyvagal Theory shifts our discussion away from the actual event to how it transforms and becomes embedded in

our bodies, with these changes occurring through the vagus nerve. Therefore, it is through the vagus nerve that we find a way out of neurological disorder and disruption to a pathway to peace and healing. To quote, "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." This is neuroscience poetry to me, and my desire for you is that this neuroscience equally inspires you to feel hope and embark on your own healing journey.

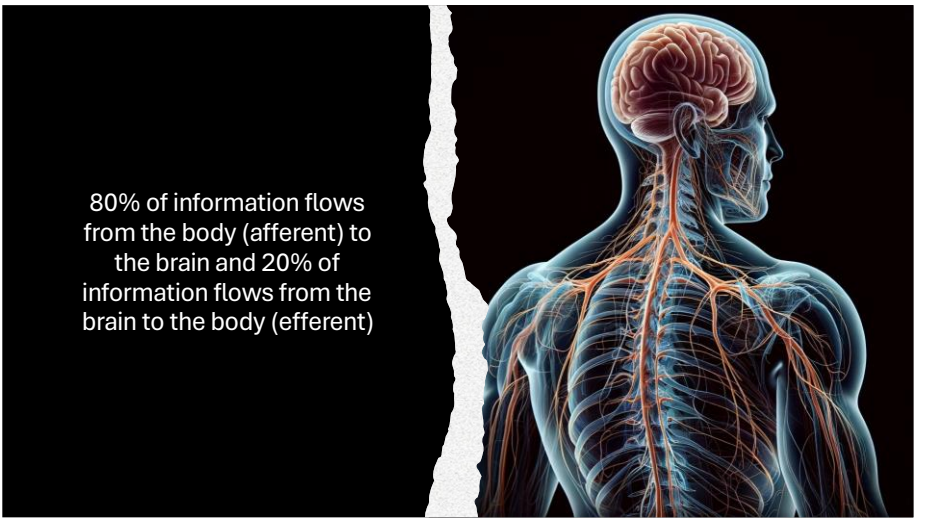


Borrowing from a metaphor of flowing down a stream, the first step in healing is to move our neuroception - what our autonomic nervous system is automatically sensing regarding safety and danger without our awareness to awareness of sensing, which is called perception. Flowing downstream, we can then 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):

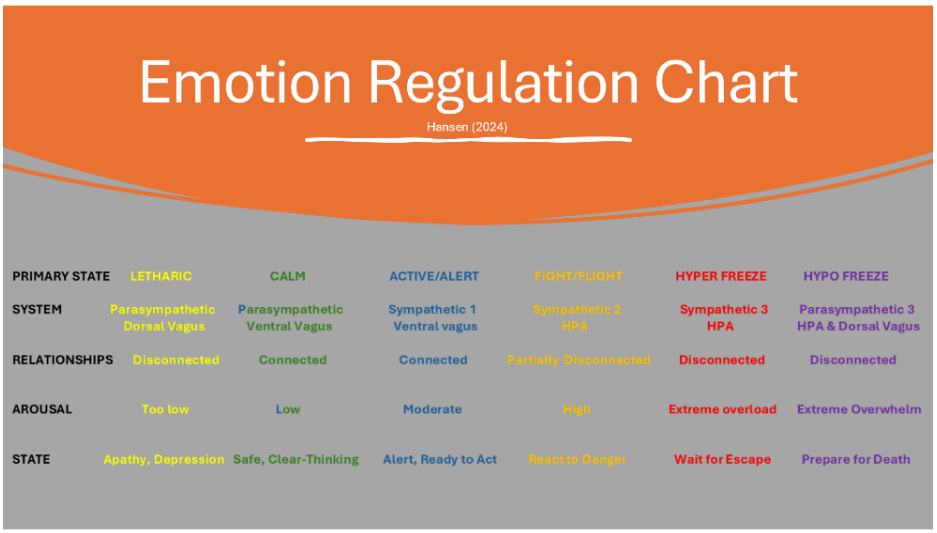
The Four R's

- 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.



Visit Jeffreyhansenphd.com to download a free and more reader-friendly version

If we find ourselves in the Orange Zone (Note: in the graphic, it is actually red 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 prone to experience:

- Regulated heart rate (vagal brake lowers heartrate by 20 beats per minute)
- 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

- Able to reach out to others
- Able to play and take time to enjoy life and others
- Able to be productive in work
- Able to organize and follow-through
- Able to heal emotionally and physically
- 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 removes 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 increased risks 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 mis-attunement, when ruptures are not recognized and repaired, the autonomic experience of persistent danger ends up moving the system away from connection

into patterns of protection, and loneliness is the subjective experience (Dana, 2018).

So, when we recognize that we are suffering and dysregulated, it is very helpful and sometimes lifesaving to seek safe refuge in others. Conversely, when we are emotionally regulated ourselves, we can offer our safe regulation to others, whether they're adults or children. This is a particularly important and essential component of good parenting. We can gift our safe regulation to ourselves and others by choosing the following strategies below. Remember, through the process of neuroception, others read our cues of safety just as we read theirs. Quid pro quo, we receive back what we give and vice versa. We would do well to practice these strategies, so they become automatic whenever we move out of the green zone and want to return.

Here are some interpersonal behavioral cues to be mindful of, as they influence how others co-regulate with you. While they may come naturally to some, for others, they must be learned. When they're done properly and become a natural flow of your interpersonal style, you will be amazed at how others respond to you. Please do not underestimate the blessings they can bring to your life and the lives of people you care about and/or love.

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 end 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 actually can slow our heart rate by 20 beats per minute (vagal brake).

Re-story

Now that we, or our loved ones, are in a more regulated state by using the bottom-up strategies discussed earlier, we should feel more settled and able to use top-down strategies to correct the narrative or re-story the situation—whether it's 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, our 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. Victims of 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, we can rewrite a new narrative that better reflects our healing journey and the heroic efforts of our nervous system to protect us through our pain. This new story allows us 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).

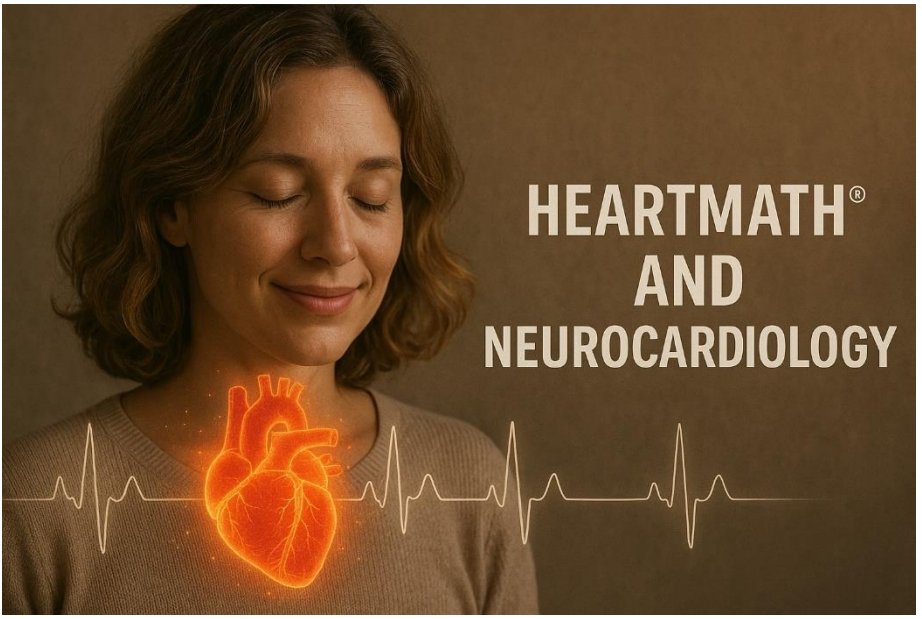
By renewing our narratives, we transform our minds and begin to see ourselves and our stories in a new light—one filled with resilience, hope, and purpose.

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, we not only rewrite our past but also open ourselves to a future of peace and healing.

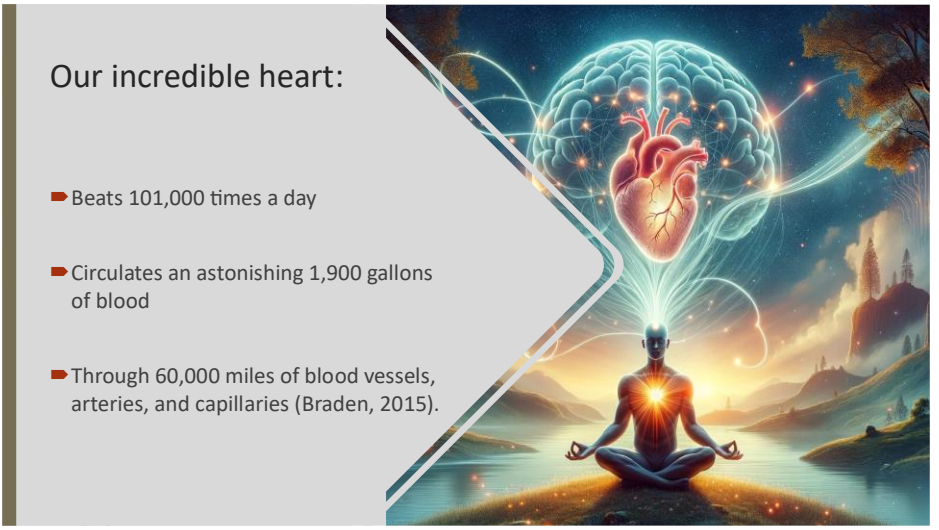
Pillar Two:

HeartMath®



Our heart is an amazing organ and is much more than a pump. It has its own wisdom and intelligence and works cooperatively with the brain. HeartMath® has sought to explore the science of this connection and translate that science into practical ways of healing mental health struggles, thus improving our lives.

The wisdom of the heart is not new—it was known to the ancients and has been referenced throughout Scripture. ***"Above all else, guard your heart, for everything you do flows from it"*** (Proverbs 4:23, NIV). This verse reminds us that our heart is central to the essence of life, influencing not only our emotions but the quality of our decisions and actions. In modern times, much of this wisdom was dismissed and then forgotten, but it is being rediscovered through scientific and spiritual lenses alike, leading us toward fuller, more meaningful lives.



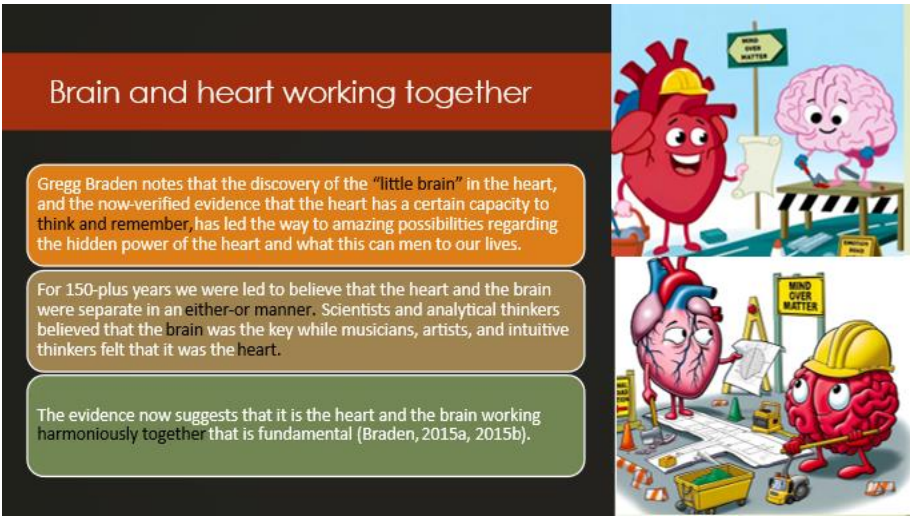
Again, the ancients knew of the importance of the heart, but that wisdom was lost with time. Happily, this knowledge is coming back to us and can lead us to fuller and more meaningful lives.

As some may know, religious and mystery traditions have universally held that the heart has been regarded as a path to deep wisdom in life (Braden 2015b).

In the **Bible** for example, the heart is mentioned **826 times in 59 of 66 books.** The Bible reveals that our heart isn't a separate part of our being. Instead, our heart is a composition of all three components of our soul - our mind, emotion, and will plus the most important part of our spirit, our conscience (Bibles for America, 2021). Solomon wrote in Proverbs 4:23, "Keep your heart with all diligence; for out of it spring the issues of life." The Bible posits that what is in your heart will direct your life (Back to the Bible, 2019).

The **Quran** similarly notes that our heart is a source of wisdom and guidance and mentions the human heart **132 times.** Of the Qur'anic statements, some describe this sentient organ as having the capacity of being a center of reasoning, intentions, and decision-making. Consequently, human hearts can either be healthy or diseased. (Janat Al Quran, 2017).

The **Egyptians** likewise believed that the heart, rather than the brain, was the source of human wisdom, as well as emotions, memory, the soul and the personality itself. Physiology and disease were all connected in concept to the heart, and it was through the heart that God spoke, giving ancient Egyptian's knowledge of God and God's will. As such, the heart was considered the most important of the body's organs (Dunn, 2021).



One of my heroes who advocates for 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

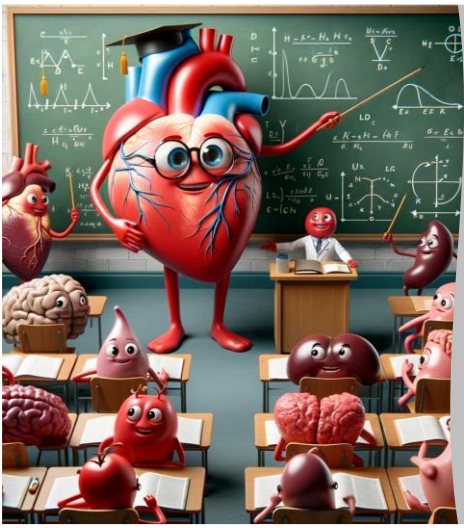
the HeartMath® Institute, he has been a strong proponent of its work, particularly in the areas of emotional self-regulation and the connection between the heart and brain. Braden's work often explores the role of human emotion in physical health, healing, and the interconnectedness of all life. Braden's 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 I 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 my favorites. Give it a try, you will love it.

https://www.youtube.com/watch?v=2nsm8SCWjic&t=1088s&ab_channel=GreggBradenOfficial

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).

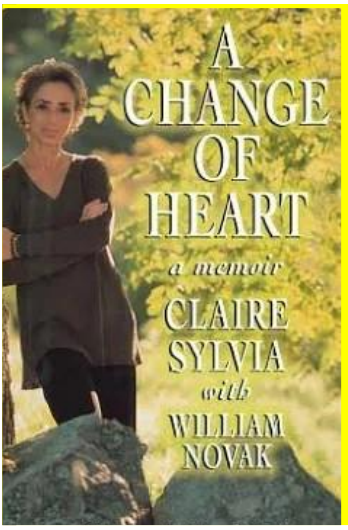


What – Heart Intelligence?

- 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 transplant surgeries.

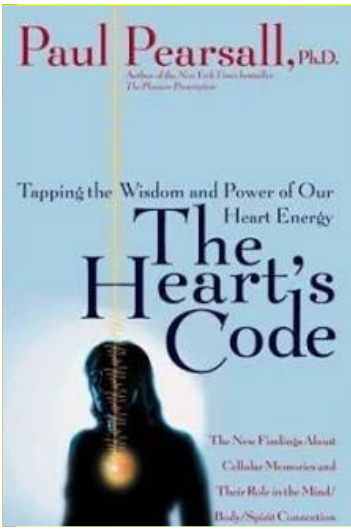


Stories of the Heart:

- Clare Sylva, a professional dancer, in 1998 received the heart and lungs of a young man, Tim, who died in a motorcycle accident.
- Not long after the transplant, she began to crave new foods such as chicken nuggets and green peppers and was specifically drawn to KFC to satisfy her cravings.
- She was able to eventually visit the parents of this young man and discovered that Tim precisely loved the same kinds of foods that she was now craving.
- Clare had acquired her cravings through the phenomenon of memory transference which has become an area of serious study and eventual acceptance.

Please click below for Dr. Braden's enticing discussion:

https://youtu.be/Hir6I-RfOiY



Stories of the Heart

- In 1999, Dr. Paul Pearsall, a neuropsychologist, in The Heart's Code wrote about an 8-year-old little girl who received a heart from a 10-year-old girl.
- Almost immediately after the surgery, she started having vivid nightmares of being chased, attacked, and murdered.
- Her mother arranged a consultation with a psychiatrist who after several sessions concluded that she was witnessing actual physical incidents.
- They decided to call the police who used the detailed descriptions of the murder (the time, the weapon, the place, the clothes he wore, and what the little girl he killed had said to him) given by the little girl to find and convict the man in question.

Please click below for Dr. Braden's enticing discussion:

https://youtu.be/Hir6I-RfOiY

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 game-changer, 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).

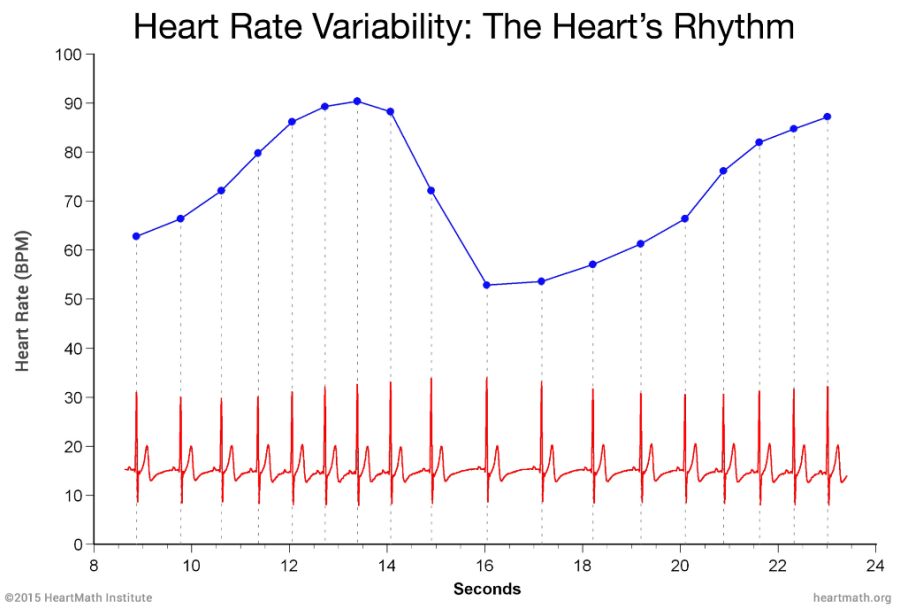


Image courtesy of the HeartMath® Institute – www.heartmath.org.

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 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.

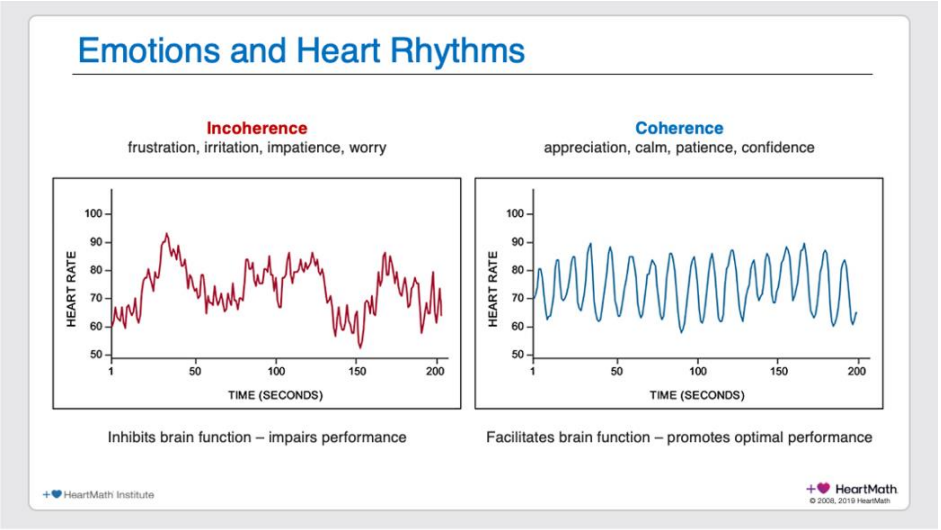


Image courtesy of the HeartMath® Institute – www.heartmath.org.

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).

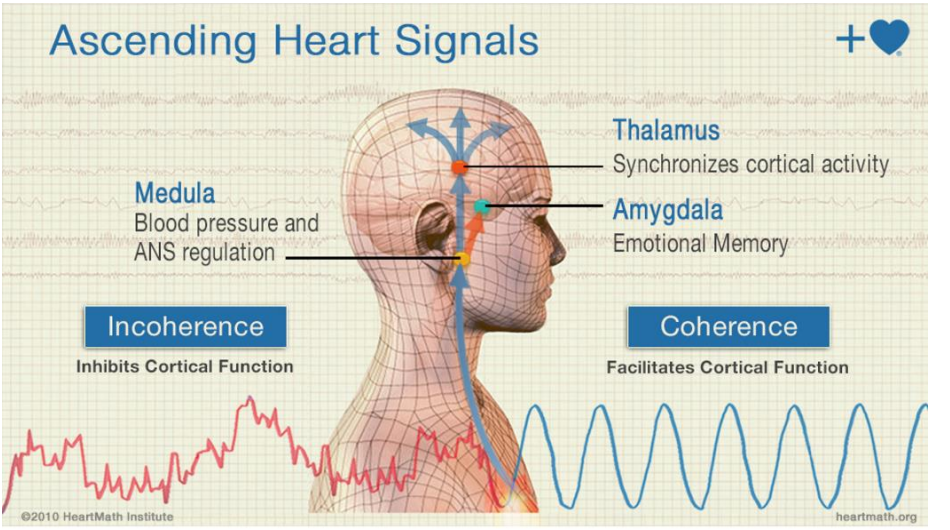


Image courtesy of the HeartMath® Institute – www.heartmath.org.

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.

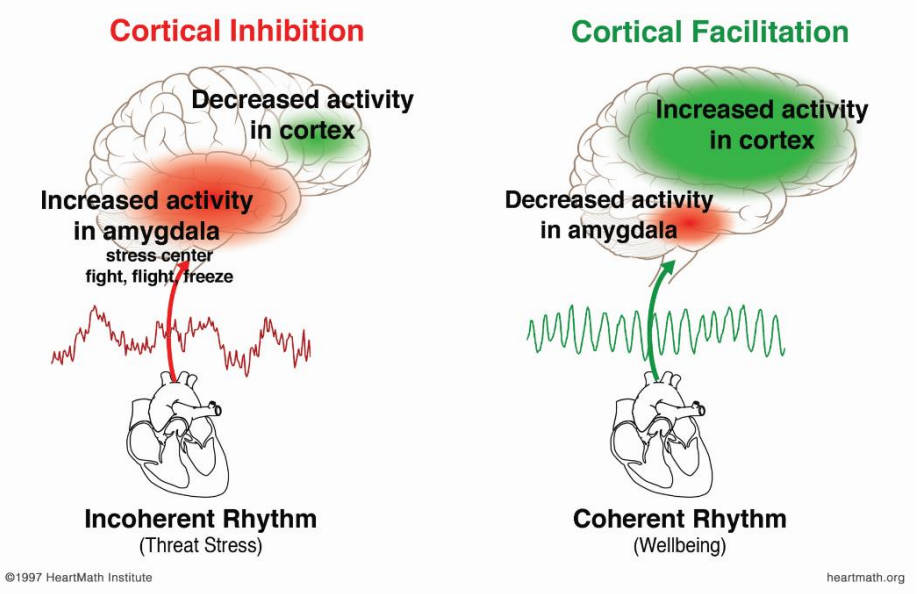


Image courtesy of the HeartMath® Institute – www.heartmath.org.

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).

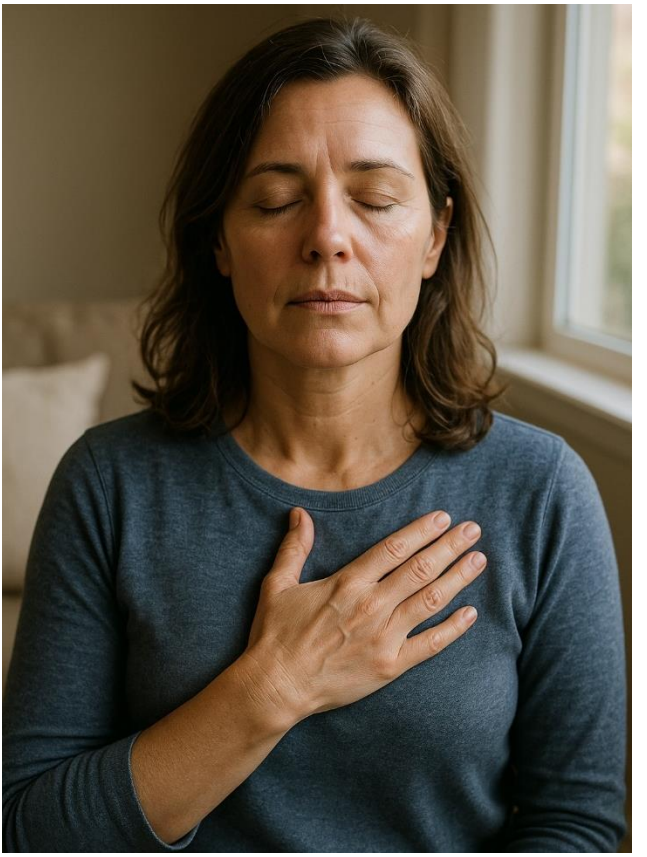
5. Improved Group Dynamics: When applied in groups, this phenomenon can lead to improved cooperation, understanding, and a collective increase in coherence among individuals. This not only benefits emotional and mental health but can also enhance group performance, creativity, and problem-solving abilities.

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.

The coherent HRV of one person positively regulates the other

Heart Lock-In® Technique:

HeartMath® teaches us several different breathing and visualization techniques to help us attain healthy heart rate variability and coherence, each building on the basics of good breathing fundamentals. Below is a description of my favorite, which is called the 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 in alignment. 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 on how to perform the Heart Lock-In® Technique:

1. Focus your attention in the area of the heart. Imagine your breath is flowing in and out of your heart chest area, breathing a little slower and deeper than usual. Find an easy rhythm that's comfortable.

2. Activate and sustain a regenerative feeling such as appreciation, care or compassion.

3. Radiate that renewing feeling to yourself and others.

Pillar Three

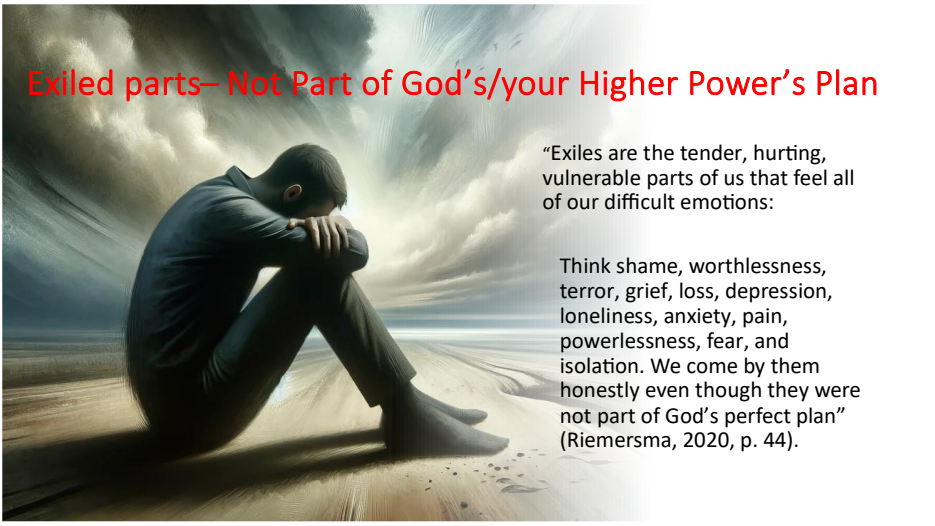
Internal Family Systems (IFS)

Among the best top-down therapies is Internal Family Systems (IFS) Therapy. During early life, we are often faced with pain and/or trauma that can be so extreme that the fragile and poorly developed ego cannot handle it. Unable to be processed, these pains are stored in "implicit" memory, and as such, are often nonverbal. They become part of what is called the "default mode network," which later becomes the substrate for how we think, feel, and behave. Left

unchecked, we must resort to defensive behaviors to keep them from overwhelming us. IFS identifies the pain part as the exiles and the defensive parts as the managers and firefighters.

Internal Family Systems (IFS) is a therapeutic approach that identifies and addresses multiple sub-personalities or parts within each person's mental system.

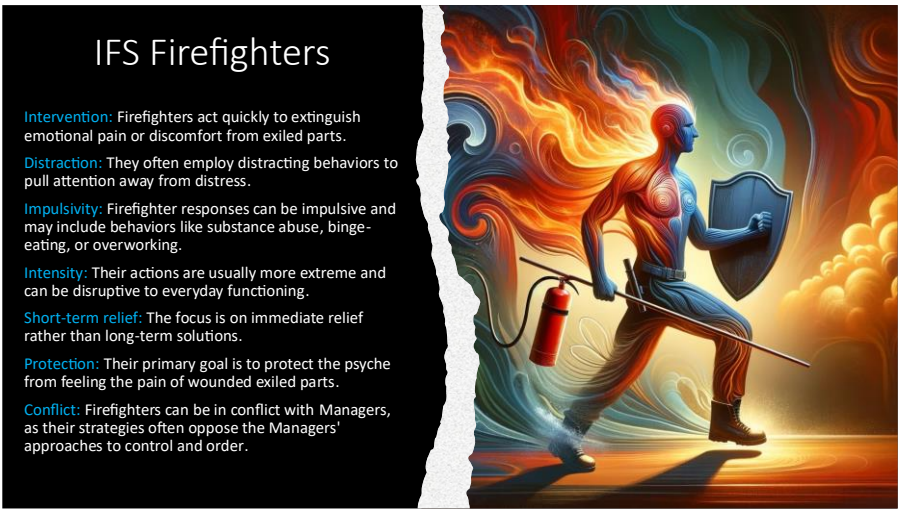
1. Exiles: These are vulnerable, often wounded parts that carry painful memories or emotions such as trauma, fear, or shame. In addition to treatment, these might be parts that are deeply hurt or neglected, driving behaviors as a form of escape or coping mechanism. Exiles are often kept out of conscious awareness by the actions of managers and firefighters.



2. Managers: These parts are responsible for maintaining a sense of order and control in a person's life. They anticipate and address problems proactively to protect the individual from harm or pain. In the context of depression, managers might try to keep depressive behaviors in check by overachieving in order to maintain a semblance of control. Managers are all about

performance – being the best student, doctor, teacher, employer, employee, or even religious person.

3. Firefighters: These parts are more reactive than managers. They emerge when an individual's exiled emotions or experiences become too overwhelming. Their role is to distract and extinguish or numb these distressing feelings, often through impulsive behaviors like substance abuse or other addictive actions. Firefighters serve as a short-term solution to emotional pain but often exacerbate problems in the long run. The ultimate firefighter defenses can be self-injury or even suicide.



4. Self: The Self is seen as the core or center of an individual's being, characterized by qualities such as compassion, courage, confidence, calmness, and clarity. The Self is not another part but rather the person's true, balanced essence. In IFS therapy, strengthening the Self is crucial, so it can lead and bring harmony among the parts. In treatment, this means helping the individual to access their Self to understand and heal the exiles, manage the managers, and redirect the firefighters in healthier ways. The Self is typified by eight qualities called the 8 Cs.

There are many advantages to IFS as an excellent top-down approach, some of which are summarized below (adapted from ChatGPT):

1. Promotes Self-Leadership: IFS encourages individuals to lead themselves with their core Self, which is characterized by qualities such as confidence, calmness, clarity, curiosity, compassion, courage, connectedness, and creativity. This helps make healthier decisions and manage parts that are causing psychological distress.

2. Improves Self-Awareness and Emotional Intelligence: By identifying and understanding the different parts within oneself, individuals become more aware of their inner workings. This heightened self-awareness leads to better emotional intelligence, as individuals learn how to manage their emotions effectively.

3. Encourages Compassion and Understanding: IFS fosters an environment of compassion and understanding, both for oneself

and for others. By recognizing that every part has a positive intent, even if its actions are at times counterproductive or harmful, individuals learn how to approach themselves and their parts with kindness and empathy.

4. Addresses a Wide Range of Psychological Issues: IFS has been applied to a variety of psychological issues, including anxiety, depression, fears, trauma, and relationship problems. Its flexibility and adaptability make it a suitable approach for many different types of individuals and concerns.

5. Facilitates Deep Emotional Healing: IFS therapy goes beyond symptom relief and aims for deep emotional healing. By focusing on the roots of psychological issues, it helps individuals heal the wounds of their parts, leading to lasting changes.

6. Enhances Relationships: By improving self-awareness, emotional intelligence, and communication skills, IFS can help individuals build stronger and healthier relationships. Understanding one's own parts can also lead to a better understanding of others, fostering empathy and connection.

7. Empowers the Individual: IFS empowers individuals by putting them in the driver's seat for their healing process. The model teaches that individuals have the internal resources they need to heal, and the therapist acts as a guide rather than a rescuer.

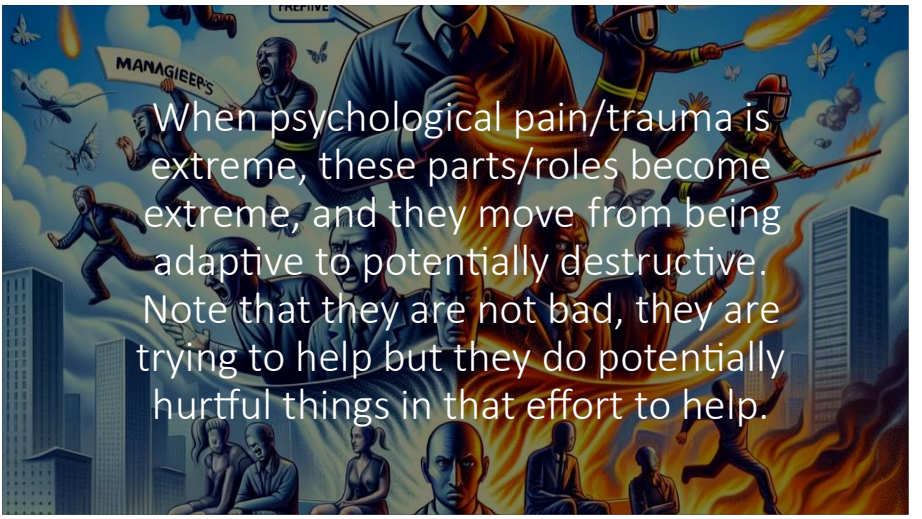
8. Integrates Well with Other Therapeutic Approaches: IFS is a non-pathologizing and hopeful model that can be integrated with other forms of therapy, including cognitive-behavioral therapy (CBT), dialectical behavior therapy (DBT), faith-based

therapies, and more. This makes it a versatile tool in a therapist's toolkit.

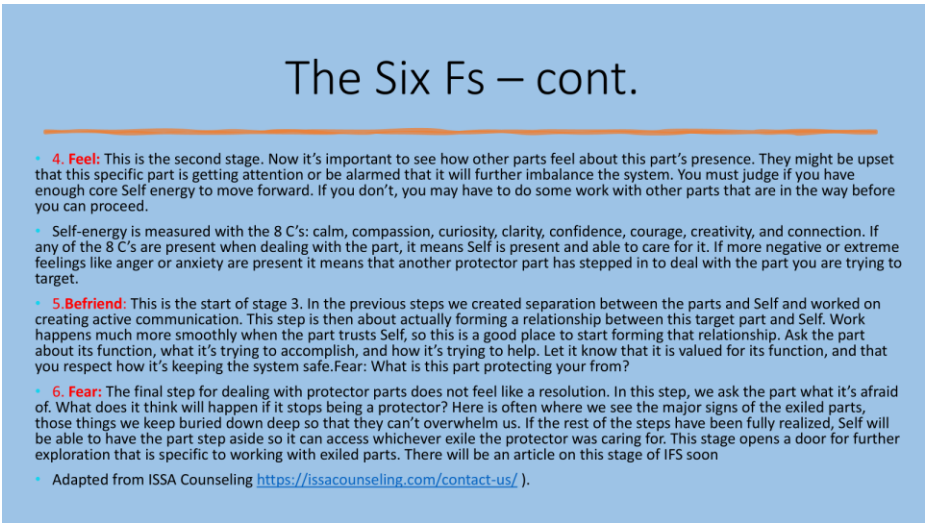
9. Evidence-Based: Research on IFS is growing, and it has been recognized as an evidence-based practice for treating certain conditions, such as PTSD, demonstrating its effectiveness and reliability.
10. Cultivates Mindfulness: The process of identifying and interacting with different parts requires a level of mindfulness, which can improve overall mental health and well-being.

IFS therapy's holistic approach to healing emphasizes understanding and integration of all parts of the Self, including the spirit, leading to profound and lasting psychological change.

In IFS therapy, the goal is to understand the roles of these parts, how they contribute to the problematic behavior, and how to bring them into a harmonious balance under the leadership of the Self. This approach helps individuals address the root causes of their problems and foster a more integrated, healthier state of being (facilitated by ChatGPT).

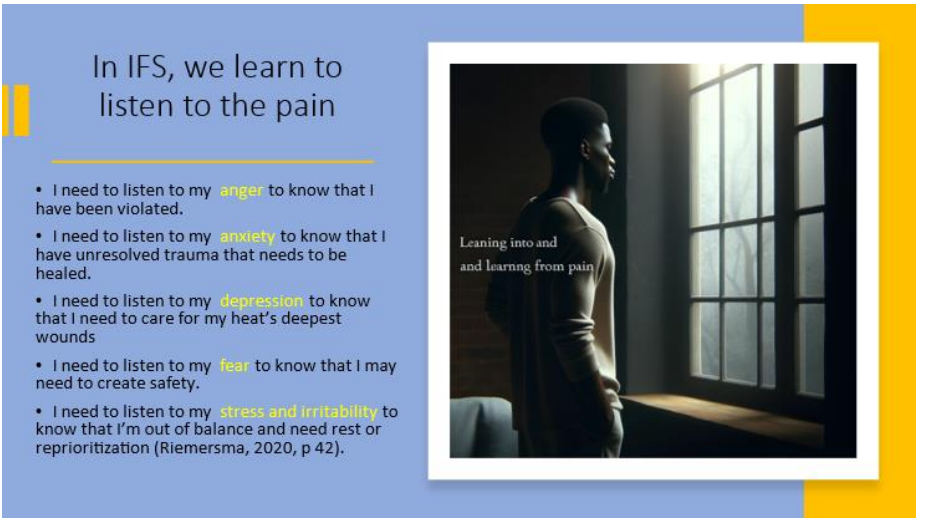


In order to access and resolve the pain that has been largely exiled out of consciousness, we must access the defensive parts and get them to back off from defending as this keeps us distanced from our true self. There are six important steps involved in this process: Find, Focus, Flesh Out, Feel, Befriend, and Fear. This process is described nicely in the two graphics below as adapted from ISAA Counseling (2024):



Jenna Riemersma (2020), who holds a master's degree in psychology from Harvard and integrates IFS with faith, in particular, Christianity, is one of my favorite IFS gurus. Her book, ***Altogether You*** stands among the best and most readable IFS books on the market and is highly recommended. Jenna teaches us that emotions are not to be avoided. Sadly, we live in a culture that teaches us that we should chase the

positive emotions, such as love, joy and happiness, and run from, suppress, medicate away, and avoid the hard emotions, such as sadness, depression, fear, anxiety, grief, and anger. It has been said that words are the language of the mind, and emotions are the language of the body. Jenna encourages us to listen to our emotions as they can guide us. Snuffing them out cuts us off from truths about our lives, whereas tuning into your emotions can lead us to better truths about our lives and point us to a better way of living. Moreover, they are often the canary in the coalmine, and we know how important they were.



In a wonderful exercise, Jenna suggests that we lean into the pain and do three things, as presented in the graphic below. For more detailed information on this process, I suggest you access her website https://jennariemersma.com/move-toward/. It is an amazing resource (Riemersma, 2024). I have used this exercise many times and have found it liberating to re-frame my pain as positive feedback (yes, positive, not negative), as it can lead to vital awareness of what that pain wants us to know and do.

Lean into pain and ask three questions :

Much of medicine and even psychotherapy teaches us the wrong thing, namely, to avoid or mitigate pain which keeps us stuck. IFS teaches us the contrary, that instead we must move toward the pain and listen to its valuable messages.

1. What body or physical sensations do I notice and where do I feel them?
2. What does this pain or emotion want me to know?
3. What does this pain or emotion need me to do?

Click the link below for a wonderful guide on how to do this by Jenna (start at 48:20):
https://www.youtube.com/watch?v=U0C2dLNWgPA&ab_channel=PureDesireMinistries

A few of my favorite speakers on IFS.

Jenna Riersmesma – Faith and IFS
https://www.youtube.com/watch?v=deqxDq9Xw6g&ab_channel=geoffreyholsclaw

Dr. Tori Olds
https://www.youtube.com/watch?v=tNA5qTTxFFA&ab_channel=Dr.ToriOlds

Kenny Dennis – IFS for Kids
https://www.youtube.com/watch?v=Ji7bk3JfEmk&ab_channel=KennyDennis

Courtesy of my rockstar student, Alayna Collins, M.A., Doctoral Candidate

Pillar Four

Spirituality and Faith

Transformational Healing Through Faith, Neuroscience, and the Rewriting of the Soul

Of all the pillars in the NeuroFaith™ model, this one stands apart. Not because it is less scientific but because it addresses what is beyond the reach of science alone. It reaches into the soul. While polyvagal-informed therapy, neurocardiology, and Internal Family Systems (IFS) offer indispensable tools for healing trauma and addiction, they do not answer the question of ultimate meaning. They cannot rewrite a shattered identity or transfigure the human heart. That work belongs to spirituality. More specifically, to a faith-rooted spirituality grounded in the redemptive power of Christ.

Spirituality is not an afterthought or a "nice add-on" in trauma treatment. It is the deep structure beneath every healing process. When integrated into clinical care with clarity and reverence, spirituality activates latent neuroplasticity, regulates the nervous system, restores fractured identity, and reshapes the moral and relational framework of the individual. But not all spirituality is created equal. The NeuroFaith™ model identifies Christ-centered faith as the path of deepest healing—not simply because it is spiritually true but because it aligns with what we now know from neuroscience, developmental psychology, and consciousness studies.

Tim Fletcher and the Default Mode Network: Shame, Narrative, and Inner Healing

To understand the power of spirituality to transform the inner landscape, we must also acknowledge those who are sounding the alarm about trauma's hidden stronghold—the Default Mode Network. One such voice is Tim Fletcher, a Canadian counselor, educator, and founder of RE/ACT, a program dedicated to healing trauma and addiction by focusing on core belief systems and developmental wounding. Fletcher is not a research scientist, but he is a deeply experienced trauma educator whose public lectures, including those on his YouTube channel ***"Tim Fletcher – Trauma and Addiction"***, have reached thousands (Fletcher, 2022).

Fletcher asserts what neuroscience has now confirmed: that trauma wires the Default Mode Network (DMN) with ***negative core beliefs*** that become our operating system. These beliefs often include:

- "I'm not lovable."
- "I'm not safe."
- "I don't matter."
- "I'm bad."

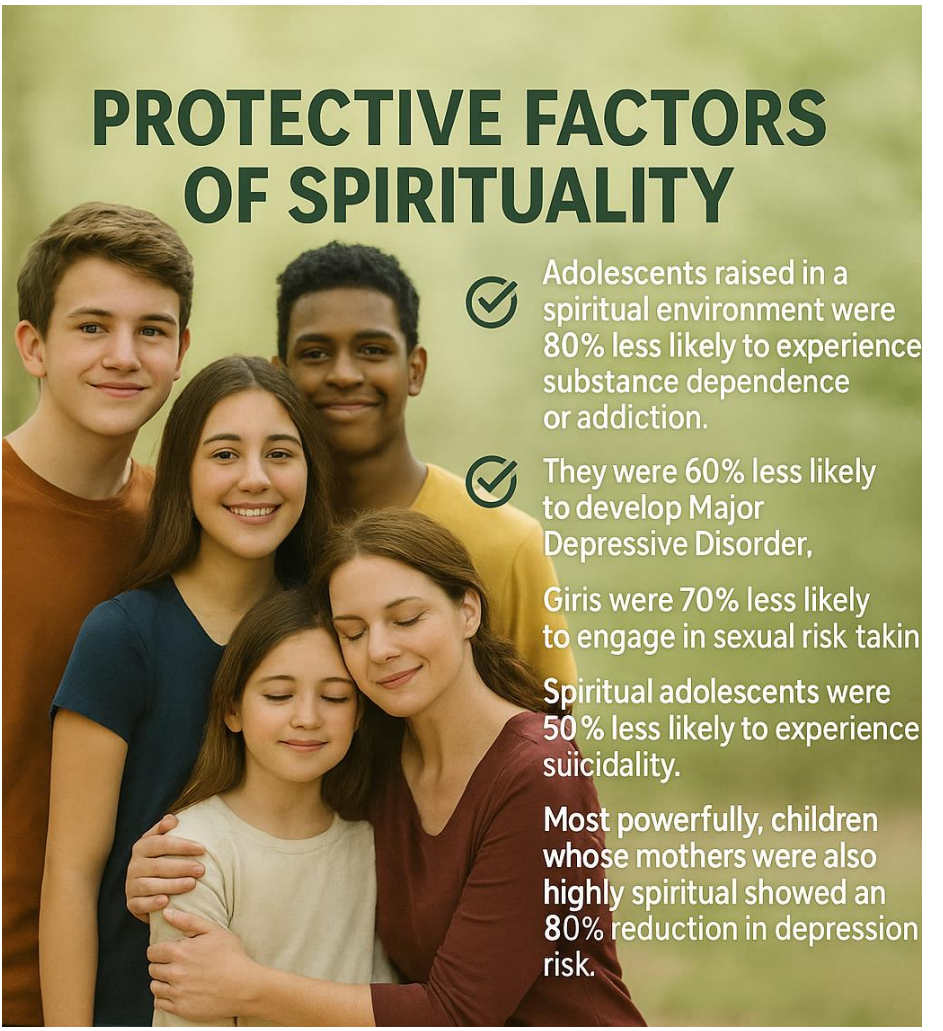
According to Fletcher, these beliefs are not just psychological constructs; they become the emotional and narrative lens through which the traumatized person views all of life. The DMN, which helps us process self-referential thought, becomes hijacked by shame-based scripts that feel permanent, immutable, and unconscious. He emphasizes that until these core beliefs are accessed and replaced, true healing remains incomplete—even if abstinence from substances is achieved.

Fletcher's clinical insight aligns with research by Miller (2021), who found that spiritual experience can shift activity in the DMN and restore meaning, hope, and connection. Fletcher's model integrates well with IFS in that it recognizes exiled parts trapped in shame and fear, as well as protector parts that over-function through perfectionism, anger, or addiction. These parts arise to manage the emotional pain generated by unresolved negative core beliefs.
The NeuroFaith™ model builds on Fletcher's insights by declaring: spirituality is the most effective means to reach, redeem, and restore these inner narratives. Without healing the Default Mode Network, recovery remains superficial. But when the DMN is reoriented through Christ-centered truth—***"You are loved." "You are forgiven." "You are chosen."***—the narrative changes, and with it, the neurobiology of the soul.

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.



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.

Spirituality as a Powerful Protective Factor

Based on Dr. Lisa Miller's research

Children and adolescents raised with meaningful spiritual or religious involvement experience strong mental health protection:

- **80%** less likely to develop substance dependence or abuse
- **70%** less likely to engage in sexual risk-taking (in girls)
- **60%** less likely to develop Major Depressive Disorder
- **50%** less likely to experience suicidality

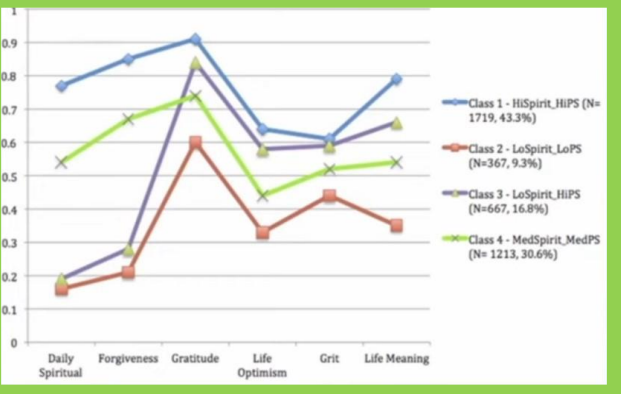
"Spiritual development is not just good for the soul, it's powerfully protective for the mind."

— Dr. Lisa Miller

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.

Dr. Miller notes research which indicates that high spirituality increases positive core values and life appreciation compared to low spirituality



One region of particular interest is the Default Mode Network (DMN), a resting-state network responsible for self-referential thought and autobiographical memory. This is where our identity narrative lives. In trauma survivors, the DMN becomes encoded with scripts of shame: ***"I'm not good enough." "I'm broken." "It's my fault."*** These aren't just cognitive distortions—they are neural grooves carved by years of dysregulation and survival-based meaning-making.

Miller (2021) has shown that spiritual experience can rewire the DMN, introducing new narratives of purpose, connection, and divine value. Experiences of awe, gratitude, prayer, and relational communion with God literally restructure this internal narrator. The result is not just a change in belief but a change in brain structure.

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).

Shame: The Soul Killer

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.

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 Redemptive Work of Christ

This is where the NeuroFaith™ model becomes explicitly Christian. It does not offer vague spirituality or moralistic performance. It offers the death and resurrection of Jesus Christ as the defining moment of healing.

Romans 12:2 commands, ***"Do not conform to the pattern of this world, but be transformed by the renewing of your mind."*** The Greek word for "transformed" is metamorphoo, the same used in Matthew 17:2, where Jesus

is transfigured before the disciples. It is a word of radical change, like the metamorphosis of a caterpillar into a butterfly. The old is not improved, it is left behind.

In Christ, our shame is not managed. It is crucified. Our new life is not rehabilitated. It is resurrected. 2 Corinthians 5:17 tells us, "***If anyone is in Christ, the new creation has come: The old has gone, the new is here!"***

This isn't metaphor. This is ontological shift. When a person places faith in Christ, the soul is regenerated. The mind is renewed. The nervous system calms. The default mode network rewrites its script. The trauma narrative is interrupted by a new story—one not of victimhood or survival but of redemption.

A Theology of Integration

Christian anthropology affirms that the human person is composed of body, soul, and spirit. The soul itself has three parts: intellect, will, and emotions. These faculties work together to form identity, process pain, and express action through the body. When trauma strikes, it often severs the link between these layers. The will collapses. Emotions shut down. Intellect becomes distorted. The body enters chronic dysregulation.

Spirituality reconnects these parts. And Christian spirituality does so uniquely. It does not merely offer insight or ritual. It offers a relationship with a living Redeemer. Through prayer, Scripture, worship, confession, and fellowship, the spirit begins to govern the soul again, and the soul restores right order to the body.

Ephesians 4:15 speaks to this integration: ***"Instead, we will speak the truth in love, growing in every way more and more like Christ, who is the head of His body, the church."***

Philippians 1:6 adds, ***"And I am certain that God, who began the good work within you, will continue his work until it is finally finished."*** This is not instant healing, but it is ongoing, transformative work.

In Conclusion - The Soul Must Be Healed

The world is treating trauma with shallow tools. A diagnostic checklist. A pill. A support group. These are not evil. But they are insufficient.

What we are seeing in addiction, anxiety, depression, and dysregulation is not just a clinical crisis. It is a spiritual one. The soul has been orphaned. The story has been hijacked. The image of God has been obscured by pain and shame.

The NeuroFaith™ model calls us to something deeper. To a science that respects the soul, and to a faith that engages the brain. This model is not just innovative. It is necessary.

Because without Christ, there is no final healing.

The Honorary Pillar

Movement as Medicine

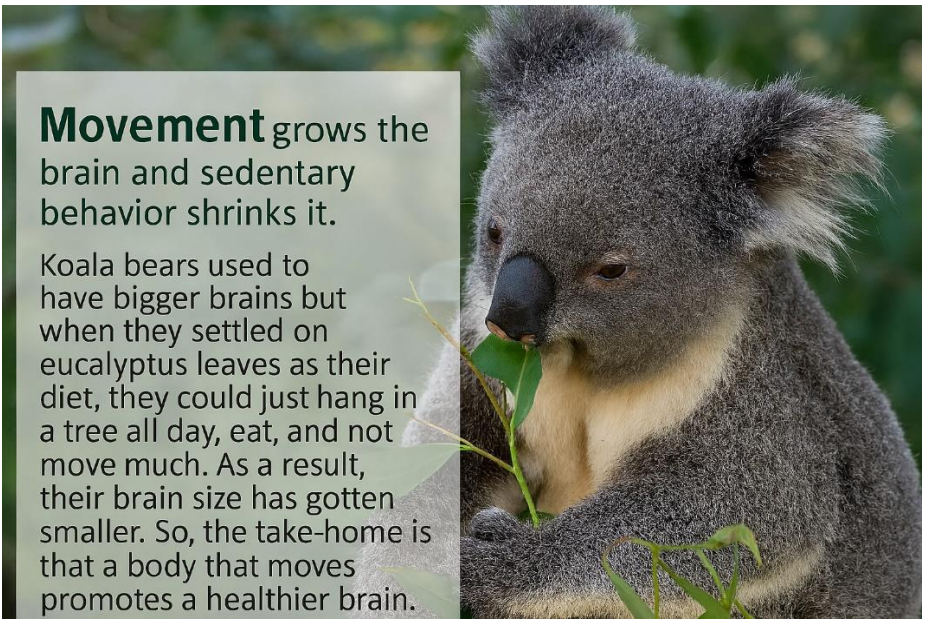
Although not formally listed among the four foundational pillars of the NeuroFaith™ model, exercise deserves a prominent place in any serious discussion on healing

depression and anxiety. To leave it out would be a disservice not only to the science but to the lived experience of those who have found movement to be nothing short of transformational. So, we offer it here, not as a footnote but as an honorary pillar, a companion to our spiritual, neurological, and emotional strategies for healing.

To be clear: if scientists could bottle the effects of exercise and turn it into a pill, it would be hailed as one of the most potent antidepressants ever developed. Regular movement enhances mood, improves sleep, boosts energy, increases cognitive clarity, reduces inflammation, and upregulates brain-derived neurotrophic factor (BDNF)—a key player in neuroplasticity and long-term brain health (Ratey, 2008; Erickson et al., 2011).

Movement as Sacred Participation

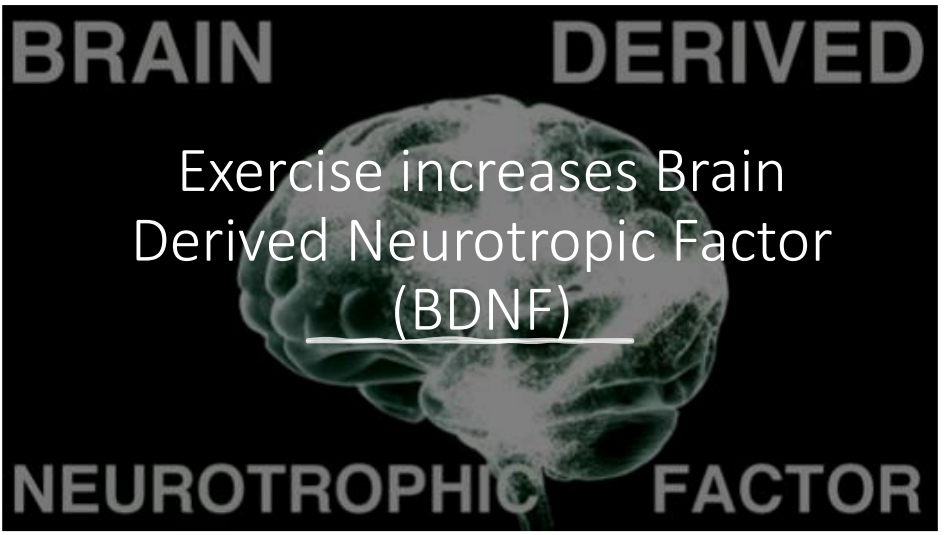
Exercise is not merely a physical task. It is an embodied prayer, a declaration of hope, and a direct act of resistance against the immobilizing weight of depression. When someone battling depressive symptoms chooses to get up and move, they are sending a powerful signal to their brain and body that 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

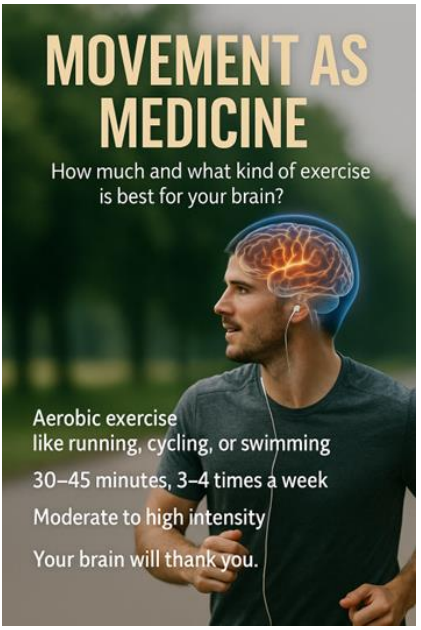
Meta-analyses have confirmed that exercise is as effective, and in some cases more effective, than pharmacotherapy for mild to moderate depression (Blumenthal et al., 2007; Cooney et al., 2013). Unlike medication, which often comes with side effects and long-term

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

Healing is not passive. It asks something of us. It asks for courage, consistency, and sometimes, sweat. But this is not the drudgery of self-help performance. It is the joyful declaration that your body still matters, that your soul still yearns, and that your future is not written in stone.



To those struggling with depression: you do not have to run marathons. Start where you are. Walk. Stretch. Breathe. Move. Let your body remind your brain that you are still here and still worthy of wholeness.

As we continue into the next chapters, we return to our core pillars—faith, neurocardiology, polyvagal regulation, and internal family systems. But let us carry this honorary pillar with us as we go.

Because when the soul rises, the body often follows. And sometimes, it is the other way around.

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).

Sadly, many therapists are poorly trained, and many others, although well-trained initially, fail to stay current with the literature that either supports or fails to support their therapeutic techniques. Finally, far too many therapists, encouraged by their training institutions, see their primary responsibility as promoting progressive ideology, believing it is in their clients' best interests to expand their thinking to align with the therapist's perspective. This, in itself, is a violation of informed

consent. Nowhere is this more evident than in early affirmative care when children are encouraged to progress through radical and permanent physical changes without being able to fully comprehend the consequences of those changes. And yes, the lawsuits are coming and rightly so.

Finding the right therapist for you or your loved one is a tremendously important matter, and it pays to do your homework and carefully evaluate your prospective therapist. If you do, the rewards are considerable. Here is a list of things you may wish to consider:

- Credentials and Licensing: Verify the therapist's qualifications, including education, licensing, and certifications. Check with the appropriate licensing board for any negative actions or complaints. You might want to consider seeking a therapist with a Ph.D. in Clinical Psychology from an American Psychological Association (APA) accredited school. Such Ph.D. psychologists are also trained as scientists, enabling them to better understand research and, therefore, more likely to appreciate and apply relevant findings to your concerns. That said, and to be fair, there are many skilled and talented master's-level therapists who also value and follow the research, just as there are many PAs who provide excellent medical care and, in some cases, may even surpass MDs.
- Consultation: Many therapists offer a free initial consultation, which can help you gauge compatibility and comfort. Keep score of the initial phone contact. If they are dismissive and unwilling to take the time to connect with you, it can be a negative sign.

- Recommendations: Seek referrals from trusted sources or read reviews that can provide insights into the therapist's effectiveness.

- Comprehensive Training: Look for a therapist who specializes in treating your specific issues, such as anxiety, depression, or trauma. Ask your prospective therapist if they have a deep understanding and training of various psychological conditions and the skills to address your specific needs effectively.

- Continual Learning: The field of psychotherapy evolves with new research; ongoing education allows therapists to stay current with the most effective treatments. Ask about what training your prospective therapist has done or is undertaking to stay current.

- Client-Centered Approach: Ask if your prospective therapist will tailor their approach to meet your unique needs rather than applying a one-size-fits-all ideology. Even effective therapies can feel cultish when applied too rigidly and dogmatically to all presenting problems without adaptation or consideration of better alternatives. Please remember, you are seeking a therapist, not a cult leader.

- Ideology: Do not be afraid to ask your prospective therapist if they will keep personal ideology out of the therapy relationship and will instead provide treatment in alignment with well-supported empirical and evidence-based therapeutic techniques.

- You are the boss: Remember, you are the boss and, as such, your therapist works for you. You have the right to agree, disagree, and/or question. A good therapist will not only respect that but will encourage your right to do just that.
- Trust Your Instincts: After meeting with the therapist, trust your gut feeling about whether you can work well together. If it's a bad fit, end it sooner rather than later. To be fair, most therapists are very well-meaning and have a heart to help others. But well-meaning, although wonderful, does not necessarily equate to competence or being a good fit for your unique needs.

The HeartMath® approach reminds us that the heart is more than just a physical organ—it is central to our emotional and spiritual well-being. By aligning the rhythms of our heart, mind, and emotions through techniques like heart rate variability and the Heart Lock-In® technique, we can achieve greater emotional stability, resilience, and clarity. The Bible speaks to the wisdom of guarding and cultivating our heart: "Above all else, guard your heart, for everything you do flows from it" (Proverbs 4:23, NIV).

HeartMath® provides us with practical tools to bring this scriptural truth to life, helping us to live in a state of emotional coherence where our thoughts, emotions, and decisions are more aligned with peace, love, and wisdom. As we learn to regulate our heart's rhythms, not only do we improve our own well-being, but we also positively influence the emotional state of those around us. Just as Philippians 4:7 promises, "And the peace of God, which transcends all understanding, will guard your hearts and your minds in Christ Jesus" (NIV). Through

HeartMath®, we can experience this peace in a deeply practical way, bringing balance and coherence to our lives.

Summary: As we conclude this chapter, let's take a moment to reflect on the journey toward healing and depression. This is a profound battle, one that touches the very core of our being, but it's also a battle that can be won. Through therapies like Polyvagal-Informed Therapy, HeartMath® , and Internal Family Systems, we have seen that there is hope. These approaches offer tools not only to understand ourselves better but also to embrace a life where we are no longer defined by our struggles.

Just as Jesus invites us in Matthew 11:28, ***"Come to me, all who are weary and burdened, and I will give you rest,"*** the path to recovery is also about laying down the weight of depression and finding the rest we so deeply need. It's about stepping into the truth that healing is possible, and we are not alone on this journey.

"I can do all things through Christ who strengthens me" (Philippians 4:13). Remember, the road to recovery may have its challenges, but you are not walking it alone. There is a strength within you, bolstered by faith, by knowledge, and by the support of therapies that align mind, body, and spirit. You are equipped for this journey, and with each step forward, you are moving closer to the peace and wholeness you deserve, and God promises. ***He forgives all my sins and heals all my diseases*** (Psalm 103:3, NLT). ***He heals the brokenhearted and bandages their wounds*** (Psalm 147:3, NLT).

Healing is not a destination; it's a journey, and you are already on the right path. Stay the course, trust in the process, and know that brighter days are ahead. ***"The Lord will fight for you; you need only to be still"***

(Exodus 14:14). Let that assurance guide you forward, one step at a time.

Rethinking Medication

Before You Swallow the Solution

WE live in a culture of quick fixes. If you're struggling with sadness, anxiety, or overwhelm, chances are someone, maybe even a well-meaning doctor, has asked, ***"Have you thought about going on something?"*** Medication is often the first suggestion, sometimes before your story has even been heard.

Let us be clear: this is not an anti-medication chapter.

Psychotropic medications can, and do, save lives. They can stabilize someone in the throes of suicidal despair. They can soften the jagged edges of panic. They can bring enough relief to help a suffering adult

re-engage with work, family, or faith. For some, medication is a necessary lifeline, and for that, we are deeply grateful. We respect those who have found healing through psychiatric prescriptions and those clinicians who prescribe with wisdom, humility, and care.

But something has gone wrong in our system.

Antidepressants and other psychotropics have become commonplace, not only for acute crises but for everyday sadness, anxiety, grief, fatigue, and existential unease. Many prescribers act with the best intentions. But the system itself has become hurried, reductionistic, and over-medicalized. And increasingly, it is more responsive to profit and protocol than to the actual process of healing.

We cannot ignore the higher systems of influence at play here. The late Polish psychiatrist Andrew Lobaczewski, in his seminal work ***Political Ponerology: A Science on the Nature of Evil Adjusted for Political Purposes*** (Lobaczewski, 2006), described how pathological individuals and ideologies infiltrate and distort institutions over time. He argued that systems become corrupted not through overt malice alone but through a subtle process of disconnection from truth and conscience.

In our field, corruption can look like top-down treatment mandates, broad diagnostic categories, and symptom-based protocols that often benefit institutions more than individuals. Michael Rectenwald, in his book ***The Great Reset and the Struggle for Liberty: Unraveling the Global Agenda*** (Rectenwald, 2022), further explores how centralized ideologies, often dressed up in the language of safety and science, can eclipse real debate, suppress dissent, and dehumanize the very people they claim to serve.

In other words, those making the decisions are not always following the science. And often, those who raise honest concerns are dismissed as fringe, resistant, or anti-science. We are none of those. What we are is deeply concerned.

Where is Informed Consent?

What is too often missing from this conversation is true informed consent. The phrase is used freely, but its definition in psychiatric practice is disturbingly shallow. Informed consent means that a person is given a full, accurate, and transparent understanding of what they are agreeing to. It includes:

- The likelihood of a positive outcome but also the likelihood of no effect or even a negative one.
- An honest presentation of what the outcome research actually shows, particularly over time instead of baked and disguised date.
- An accurate explanation of the drug's mechanism of action, not the outdated and misleading serotonin imbalance theory for example.
- A frank discussion of the risks of long-term use, including cognitive dulling, emotional numbing, dependency, and loss of vitality, Post SSRI Sexual Dysfunction (PSSD), etc.
- Clear, science-based information about how to taper off the medication safely and what withdrawal can actually look like.

- Acknowledgment that withdrawal itself can be injurious, and that symptoms during withdrawal are often mistaken for relapse.
- The recognition that most patients are not told these things when the prescription is handed over.

This is not informed consent. It is more like informed compliance.

In this chapter, we examine the overreliance on antidepressants in the treatment of adult depression and anxiety. We are not condemning their use. We are calling for clarity, patience, and discernment. We explore how cultural narratives, pharmaceutical marketing, institutional ideology, and centralized treatment models have created a climate in which medication is the default answer to suffering.

According to the Mayo Clinic, as cited by Salmassi (2013), antidepressants are the second most-prescribed class of medication in the United States, surpassed only by antibiotics:

1. Antibiotics
2. Antidepressants
3. Opioid painkillers

Medical journalist Robert Whitaker (2023) notes that in 1987, the United States spent approximately 80 million dollars on psychotropic medications. By 2007, that number had ballooned to 40 billion dollars, a 50-fold increase in just twenty years.

That is not just a change in practice. It is a cultural and economic shift in how we view the human experience of suffering.

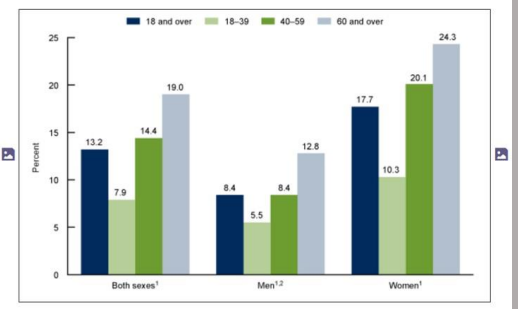
Because depression and anxiety are not just chemical glitches. They are the cries of the nervous system, the body, the soul. And while pills may silence those cries, they rarely answer them.

> Healing begins not with a prescription but with a pause.
> A return to presence, to story, to truth.
> Let's begin.

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



Robert Whitaker Speaks Out:

One of the most thoughtful and challenging critiques of antidepressant use comes from medical journalist Robert Whitaker, whose book ***Anatomy of an Epidemic*** (2010) raised deeply unsettling questions about the long-term effectiveness of psychiatric medications. Drawing from decades of scientific literature, Whitaker suggests that while antidepressants may provide short-term relief, their long-term outcomes are far more complex, and for some individuals, potentially worse.

Criticism of Efficacy and Long-term Outcomes

One of Robert Whitaker's most sobering questions is also one of the most necessary:

What if the very medications we rely on to treat depression are, for many people, prolonging it instead of resolving it?

In ***Anatomy of an Epidemic***, Whitaker traces the parallel rise of two disturbing trends: the explosion in antidepressant prescribing and the sharp increase in long-term psychiatric disability. If these medications were reliably restoring health, we would expect to see less disability, not more. Instead, we're seeing the opposite. The number of people on long-term psychiatric medication has skyrocketed, yet rates of recovery have stagnated or worsened.

Whitaker points to large-scale longitudinal studies that follow patients over years, not weeks. These studies suggest that individuals who remain on antidepressants for extended periods may, on average, experience poorer outcomes than those who either never initiate treatment or who are able to taper off. Many continue to report symptoms of depression, emotional flattening, cognitive dulling, and diminished resilience. Rather than helping the brain recover, in some cases, the medications may interfere with its natural healing process.

One reason for this may lie in how antidepressants alter the brain over time.

Selective Serotonin Reuptake Inhibitors, or SSRIs, work by blocking the reabsorption of serotonin at the synapse, which increases serotonin levels in the brain. Initially, this may produce a boost in mood or energy. But the brain is not a passive recipient of these changes. It is exquisitely designed to maintain balance, and it responds to artificially elevated serotonin by pushing back. Over time, it may downregulate serotonin receptors, reduce natural serotonin production, or alter other signaling pathways in an attempt to reestablish equilibrium.

When the medication is eventually reduced or stopped, the artificially supported serotonin levels drop. But now the brain's own natural production has been suppressed, and receptor sensitivity altered. This can leave the person in a neurochemical deficit state, which may be experienced as a profound worsening of mood, anxiety, fatigue, or emotional instability. The result is often misinterpreted by both patient and prescriber as a relapse of the original depression.

In reality, this may not be a relapse at all but withdrawal physiology. It is the nervous system recalibrating after long-term disruption. Some individuals may even develop what is now referred to as tardive dysphoria: a persistent and treatment-resistant depression that appears to have been induced, not resolved, by prolonged antidepressant use.

The tragedy is that most patients are never told this could happen. They are not counseled on the brain's compensatory mechanisms. They are rarely warned about the possibility of long-term dependency or the risk of worsening symptoms during or after withdrawal. Instead, when they feel worse after stopping the drug, they are told it's proof that they need to stay on it. But this is not always true. Sometimes, it is evidence of the brain trying to heal from a pharmacological imbalance that the medication itself helped create.

Whitaker also shines a light on publication bias, the tendency of journals and pharmaceutical companies to publish studies with positive outcomes while suppressing or ignoring those with negative or inconclusive results. This selective visibility creates an illusion of consistency and efficacy that is not supported by the full body of evidence. The result is a distorted public and professional

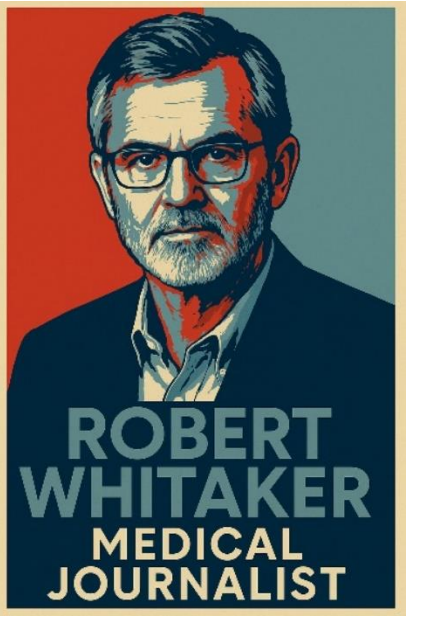
understanding of how well these medications actually work, and at what cost.

It is important to emphasize that Whitaker does not argue that antidepressants have no place in mental health care. He acknowledges that for some people, especially in moments of acute crisis, they may be helpful or even life-saving. But he invites a deeper, more honest look at the long-term picture. Not only does this help in the moment, but how does it impact us in the long run? Not just, can this provide symptom relief, but can this support real recovery?

The questions are critical.

> Are we addressing the roots of suffering, or simply numbing the symptoms?
>
> Are we building resilience or creating dependency?
> Are we empowering patients or keeping them tethered to a system that rarely explains the full risks?

If we want to practice truly informed care, then we must be willing to face these uncomfortable truths. Because if the tools we are using to help people are, in some cases, making them worse, then silence is not safety. It is complicity.



Dependence and Withdrawal

Whitaker also draws attention to an often-overlooked consequence of long-term antidepressant use: dependence and withdrawal. While antidepressants are not considered addictive in the traditional sense, they can create a powerful physical dependence that makes discontinuation difficult for many patients. Withdrawal symptoms may include brain zaps, nausea, irritability, insomnia, emotional volatility, and in some cases, severe agitation. For some individuals, these symptoms can persist for weeks, months, or even longer, and are frequently mistaken for relapse rather than recognized as withdrawal.

According to Whitaker, most patients are not adequately warned about this risk. Many are led to believe they can stop whenever they choose, only to find that tapering requires careful planning, medical oversight, and deep resilience.

One particularly disturbing and underrecognized effect is Post-SSRI Sexual Dysfunction, or PSSD. Although it is considered rare, for those affected, it can be profoundly life-altering. PSSD may include persistent genital numbness, loss of libido, erectile or orgasmic dysfunction, and a haunting sense of detachment from one's own body. What makes this condition especially unsettling is that it does not always begin while the person is taking the medication. For some, the symptoms emerge gradually after discontinuation, often as part of what appears to be a successful taper. For others, the symptoms begin while still on the medication and then persist long after it has been stopped. In both cases, the dysfunction can endure indefinitely, with no clear explanation or universally effective treatment. This lingering and deeply personal impairment often leaves individuals feeling isolated, unheard, and betrayed by a system that never warned them such a thing was possible.

What makes this condition even more devastating is the fact that it is so often dismissed or ignored. Many physicians have never heard of PSSD. Some who are aware of it refuse to acknowledge its seriousness, and others offer little more than hollow reassurance. But for those suffering, PSSD is not rare. It is real. And it can feel like a theft of something deeply human.

Among those bringing this issue into the light is Dr. Joseph Witt-Doerring, a psychiatrist originally from Australia who formerly worked for both the pharmaceutical industry and the U.S. Food and Drug Administration. He is now one of the most respected figures in the psychiatric field for his advocacy on behalf of patients harmed by poorly understood or inadequately managed medication protocols. Dr. Witt-

Doerring is particularly known for his work in responsible tapering and for validating the lived experience of individuals navigating antidepressant withdrawal and post-drug syndromes.

His YouTube channel is a valuable resource for both patients and professionals. It features accessible, compassionate, and research-informed content that offers practical help without sensationalism. In a field often driven by haste and denial, his work is a reminder that science and empathy are not mutually exclusive, and that sometimes, simply telling the truth is a radical act of healing.

The Role of the Pharmaceutical Industry

A major part of Robert Whitaker's critique centers on the pharmaceutical industry and the way it has shaped public understanding of antidepressants. He argues that drug companies have

consistently exaggerated the benefits of these medications while downplaying the risks. Their marketing strategies have not only influenced prescribers but have saturated the culture with a simplistic narrative: depression is caused by a chemical imbalance, and medications like SSRIs fix it.

This message, repeated in commercials, physician offices, and mental health clinics, gave people a comforting explanation for their suffering and an easy solution. Millions came to believe that taking an antidepressant was like taking insulin for diabetes. But the problem is; that comparison was never scientifically valid.

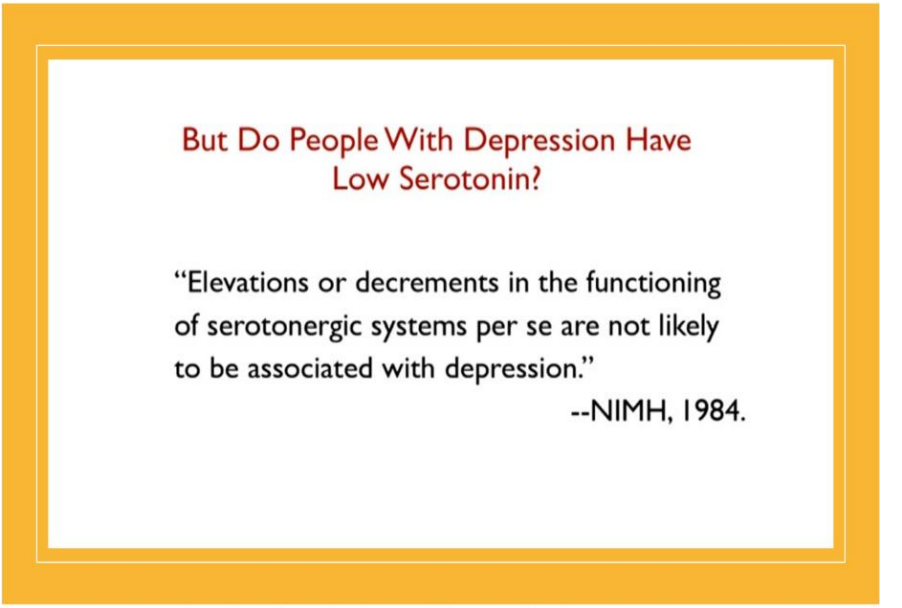
The idea that depression is caused by low serotonin levels has now been thoroughly dismantled. One of the most definitive blows came from a major umbrella review conducted by psychiatrist Joanna Moncrieff and colleagues (2022). This large-scale meta-analysis looked at decades of studies and found no consistent evidence that serotonin deficiency causes depression. In other words, the core theory behind SSRI prescribing has no solid scientific foundation.

And yet, despite this, many prescribers continue to promote the serotonin imbalance narrative. Some are unaware. Others acknowledge the science privately but justify the myth by saying it gives patients hope, keeps them compliant with treatment, and may help prevent suicide. But this is a dangerous form of paternalism. Telling someone a lie, even a comforting one, is still deception. And deception has consequences.

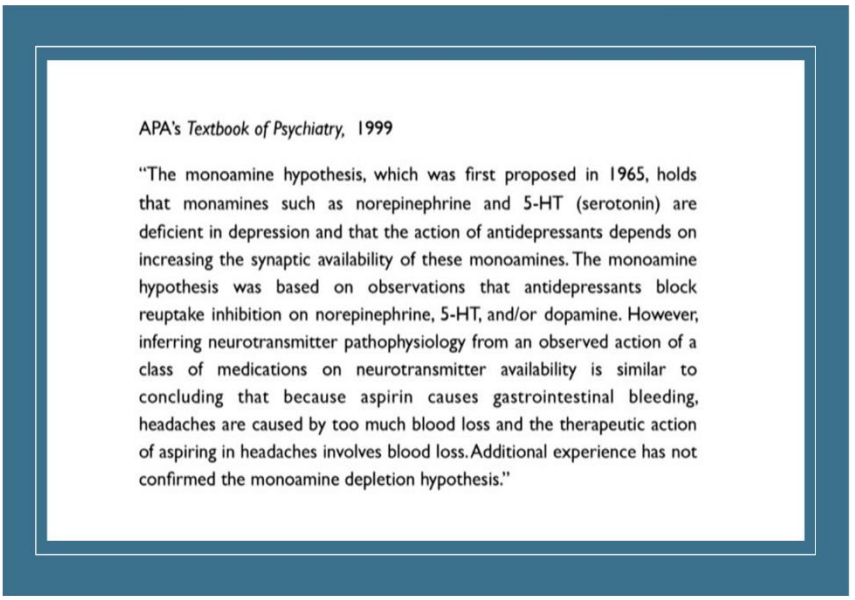
The false narrative of chemical imbalance has become deeply embedded in the minds of millions. People walk around believing there is

something biologically broken in them, often internalizing this as a lifelong defect. This framing disempowers people, steering them away from exploring the real roots of their pain, trauma, disconnection, stress, lifestyle, existential struggle, and more.

The truth is, the chemical imbalance theory was never science. It was marketing. And many within psychiatry have known this for years. But the myth has been profitable, both financially and professionally. It simplifies the problem, makes prescribing easier, and reinforces the authority of the medical model. But the cost of that convenience is a public misled and often pathologized for being human.



Whitaker (2018): https://youtu.be/FY-5npruTGc



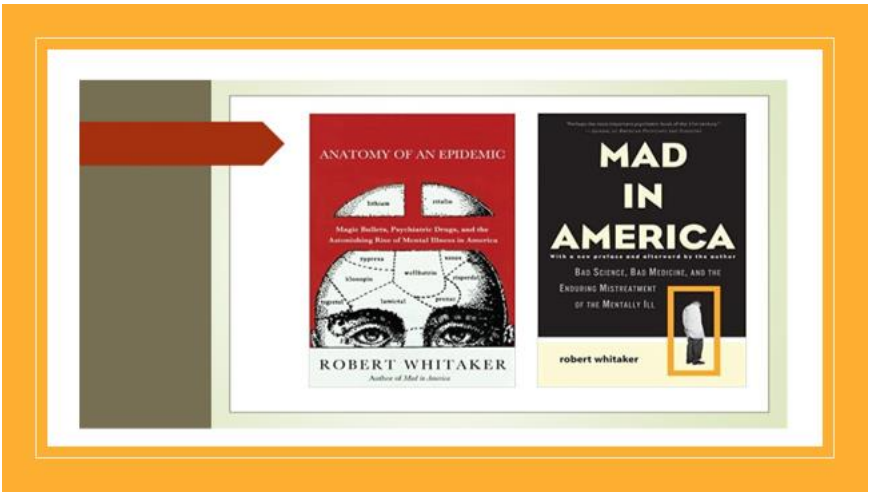
Whitaker (2018): https://youtu.be/FY-5npruTGc

Alternatives to Medication

Whitaker advocates, and we fully agree, for a broader approach to treating depression and other mental health issues, beyond the pharmacological/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 very 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, very concerning, this occurs in 25% to 80% of patients, depending on the study.

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 Salute to the Brave Voices Speaking Truth

As we have explored, the field of psychiatry, while lifesaving for some, is deeply flawed in its current application, particularly in the overprescription of psychotropics and the propagation of outdated or misleading theories and deeply flawed and/or misrepresented outcome research. Thankfully, there are those within the medical and scientific community who have had the courage to speak out. Some of these individuals have already been referenced in this chapter, while others are introduced below.

What unites them is not dogma but discernment. They are doctors, researchers, and thinkers who refuse to let convenience or conformity override ethical responsibility. Some argue that psychiatric medications should be used only in the most severe cases, while others challenge their use entirely. All are committed to exposing systemic problems,

advocating for informed consent, and centering patient care over profit.

What follows is a visual tribute to the leaders I (jeff) most admire, those whose work has informed my own thinking and whose voices deserve to be amplified. These are the individuals I turn to when I need clarity, courage, or conviction. I offer this summary in the spirit of honoring their integrity and encouraging you to explore their work for yourself.


Robert Whitaker
An American journalist and a thor critical of modern psychiatry, is critical on opposing simollve of modern psychiatry.
Peter Gótzscheh
Peter Götzsche is a co-founder of the Cochrane Collaboration, opposing the psychiatric uses of antidepressants and AHDH drugs.
Joanna Moncrieff
A British psychiatrist, who criticisz anti-aniitepressancsts at some point of alternative treatments.
Irving Kirsch
Medical researcher on bias on the concern o placet co effect in antidepressant ets.
Peter Breggin
An American psychiatrist who criticizes the harmful of psychiatric drugs.
Robert Raffa
Pharmacologist who downplays the benefits of antidepressan- t and raises concems ab out ther seversue effects
Anna Lembke
An American psychiatrist known for her work on prescripti - drug opidemics, and prudent prescribing
James Davies
Co-founder of CEP and critcis of conventional psychiatric practices and criticizes their efficacy
Kelly Brogan
A holistic psychlatrist, warmes about the risks or psychiatric predications and critics conventional opert
Josef Witt-Doerring
An Australian psychiatrist outspo- ken on identifying latrogenic in- juries and Post-SSRsexual Dysfunction

Conclusion

A Pathway Forward for the Wounded Soul

If you've traveled with us to this final chapter, then you already know what's at stake. We are living in an age marked by pervasive despair. Depression and anxiety have become the ambient air of a culture dislocated from truth, unanchored from meaning, and increasingly divorced from God. People are not just overwhelmed, they are unraveling. Not simply stressed but spiritually depleted, emotionally fragmented, and physically dysregulated.

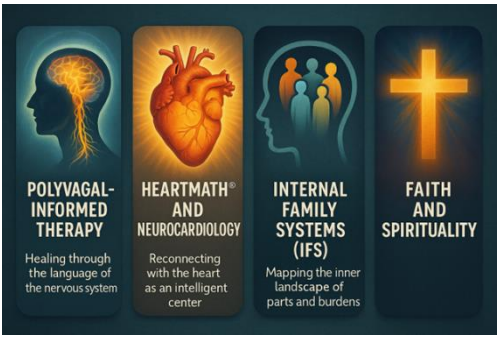
This book has not been written to provoke controversy but to stir compassion and awaken a deeper urgency. Behind every diagnosis is a story, and behind every symptom is a person created in the image of God. We are not just facing a medical crisis. We are witnessing a collapse of meaning, a rupture in the human spirit that no pill or protocol alone can fix.

Too often, our culture attempts to manage suffering through numbness. Quick fixes, overprescription, false promises of identity reinvention, and the empty seductions of performance and validation leave us more hollow than before. We are not just overmedicated, we are under-attuned, under-connected, and underloved.

But there is another way. A better way.

The NeuroFaith™ Model: Integration Without Compromise

The NeuroFaith™ model is not just a collection of therapies. It is a paradigm shift. It brings together the best of neuroscience, the insights of trauma-informed psychology, and the timeless wisdom of Scripture. It is built on four central pillars:



Polyvagal-Informed Therapy, which helps calm the body's survival responses and restores a felt sense of safety.

HeartMath® and Neurocardiology, which reconnect us with the intelligent, healing rhythms of the heart.

Internal Family Systems (IFS), which gently uncovers the fragmented parts of the self and invites them into wholeness.

Faith and Spirituality, with Christ as the cornerstone, reminding us that healing is not only physiological or psychological, but deeply spiritual.

Each of these pillars is powerful on its own. But together, they form a truly integrative framework—one that honors the complexity of human suffering and the sacredness of each person's story.

NeuroFaith™ is a Christ-centered, grounded, neuroscience-based model. It is not merely an alternative to mainstream therapy; it is a

reorientation of how we see suffering and how we respond to it. It addresses the body, mind, and spirit in one unified approach. It is, to our knowledge, the only model that brings together these four pillars in a clinically sound, spiritually faithful way.

But we do not present it as the only way. We humbly recognize the value of other pathways, modalities, and traditions. We support whatever truly brings healing. Yet, we believe NeuroFaith™ offers a uniquely powerful, biblically grounded, and neurobiologically informed path to restoration.

As Psalm 147:3 reminds us, ***"He heals the brokenhearted and binds up their wounds."***

Healing is not linear, and it is rarely fast. But it is real. And it begins not with the erasure of pain, but with the courageous act of facing it, surrounded by community, guided by compassion, and centered in Christ.

A Word on Multiplicity, Mercy, and Agency

We must avoid the trap of dogmatism. Healing from depression and anxiety is never just about one thing. It is not just brain chemistry, or just trauma history, or just spiritual disconnection. It is all of these, and more. The work of healing requires a willingness to honor the full human story.

But here is where the crisis deepens. When a diagnosis is rushed, when clinicians fail to listen deeply, when they do not take the time to understand the person sitting before them, and when there is a push for quick and easy solutions—especially the premature offering of

medication without explanation or collaboration—something sacred is lost. The individual is no longer seen as a meaning-bearing person with a story, but as a broken machine to be fixed.

In this model, people are often told they have a disease. Yet what they may actually have is a nervous system shaped by years of dysregulation, a brain altered by long-term stress and disconnection. And if that truth is overlooked, healing becomes nearly impossible. They are encouraged to become passive recipients of care, waiting for external solutions instead of discovering their God-given capacity to heal, grow, and choose.

This is the danger of the reductionistic, medicalized model. It breeds alienation, collapse, and fragmentation.

By contrast, NeuroFaith™ offers a different lens. It sees depression and anxiety not as final verdicts but as invitations. It affirms that the brain can change, the heart can awaken, and the soul can reconnect. It calls the person back into agency and participation. It says, "You are not your diagnosis. You are not defective. You are not beyond hope. You are in process—and that process matters deeply to God."

This model honors what modern psychiatry often misses: that healing requires meaning, not just medicine. Relationship, not just regulation. Presence, not just prescriptions. And most of all, it requires truth and love, working in tandem, to restore what trauma and fear have stolen.

Some may find healing through relationships, or exercise, or creativity. Others through prayer, medication, nature, community, or therapy. Still others may experience breakthrough in solitude, grief, or

surrender. What matters most is that healing be rooted in truth, infused with grace, and pointed toward wholeness.

We are not here to shame those who take medication or who have walked paths different from ours. We are here to say, simply and clearly: you are not beyond hope. And you are not alone.

Where Do We Go From Here?

What would it mean to treat adult depression and anxiety with the same reverence and intentionality we might offer a spiritual crisis, a medical emergency, or a profound loss?

It would mean:

- Creating spaces where people feel safe enough to tell the truth about their suffering.
- Teaching clinicians, pastors, and families to regulate their own nervous systems so they can be present with those in pain.
- Using medication, when appropriate, not as a primary solution but as a bridge, never a substitute, for real connection and care.
- Guarding the human soul against ideologies and narratives that diminish their sacred worth.
- Centering the healing journey on love, truth, faith, embodiment, attunement, and time.
- And above all, reminding every struggling person that they matter, that they are designed, and that they are deeply loved by God.

Kintsugi and the Beauty of the Broken

There is a centuries old Japanese artform called Kintsugi, meaning "golden joinery." It began in the 15th century, when a Japanese shogun sent his favorite tea bowl to China for repair after it had cracked. When the bowl was returned roughly stapled together with metal, he was dissatisfied. So, he turned to his own craftsmen, who created something extraordinary: they filled the cracks with lacquer mixed with powdered gold. The repaired bowl was not only functional again, it was more beautiful and valuable than before.

What began as a simple act of restoration became a lasting philosophy. Kintsugi does not hide the damage. It honors it. The cracks are not disguised. They are accentuated. They become part of the object's story, part of what makes it precious.

This artform reminds us of something sacred about healing. That it does not mean returning to what we were before. It means becoming something more whole, more honest, more radiant because of what we have walked through, not in spite of it.

We believe this is how God heals.
We have found, time and again, that God will let no pain go unused if you allow Him in.

There is no suffering so deep, no shame so stubborn, no loss so final that God cannot redeem it. If we offer our broken places to Him, He will not discard us. He will not shame us. He will restore us. He will fill the cracks, not with gold, but with grace. With love. With meaning. And in His hands, what was once fractured becomes sacred.

This is the heart of the NeuroFaith model, and the heart of our testimony: God wastes nothing. Not a tear. Not a failure. Not a wound.

As Romans 8:28 assures us, *"And we know that in all things God works for the good of those who love him, who have been called according to his purpose."*

But the truth is, God does not force this. He honors our will. He waits for an open heart, a yielded soul, a quiet invitation. And when we say yes, when we trust Him with the broken pieces, He begins the slow, beautiful work of healing. Not erasing the past but transforming it into testimony. Into gold.

Kintsugi teaches us that the history matters. The break matters. What was endured becomes what is illuminated. The cracks, when filled with mercy, become the most beautiful part of the vessel.

And so, it is with you.

We hope and pray that this book has helped you begin to see that your pain is not a detour. It is part of your story's sacred shape. What we have learned, what we have lived, is that God will use it all if you let Him. Every scar. Every mistake. Every moment of collapse. He will weave it into the tapestry of your life, and into the lives of others, for healing, for connection, and for good.

So, if you feel cracked, exhausted, or lost, we say this with tenderness and truth: you are not disqualified. You are not too far gone. You are in process. You are loved. And in God's hands, you are being made whole.

Let Kintsugi stay with you, not just as a metaphor but as a promise. The gold is coming. The light is breaking through. The cracks are not the end. They are the beginning of something beautiful.

Final Words of Hope

There is hope. Real hope. Lasting hope. Not just for surviving, but for becoming whole again.
We pray that this book has helped you begin that journey.

With hearts of compassion and love,

-Jeff, Pastor Earl, and Tim

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.

American Psychological Association. (2024). ***Stress in America™ 2024: Stress and anxiety continue to rise.*** https://www.apa.org/news/press/releases/stress/2024/reportfa

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).

The Aspen Institute. (2019). Lisa Miller presentation. https://www.youtube.com/watch?v=BzAVgMdCrjM (accessed July 11, 2025).

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).

Bandura, A. (1977). ***Social Learning Theory***. Englewood Cliffs, NJ: Prentice Hall.

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/u0a-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.0b013e3180304 4e2

Blumenthal, J. A., Babyak, M. A., Doraiswamy, P. M., Watkins, L., Hoffman, B. M., Barbour, K. A., ... & Sherwood, A. (2007). Exercise and pharmacotherapy in the treatment of major depressive disorder. ***Psychosomatic Medicine***, 69(7), 587-596.

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=_ohxlo3J0A0

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. (2024). ***QuickStats: Percentage of adults aged ≥18 years who reported being told they had depression, by***

year — National Health Interview Survey, United States, 2013–2023. Morbidity and Mortality Weekly Report (MMWR), 73(5), 105. https://www.cdc.gov/mmwr/volumes/73/wr/mm7305a6.htm

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.

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

Compton, W. M., Conway, K. P., Stinson, F. S., Colliver, J. D., & Grant, B. F. (2006). ***Prevalence, correlates, and comorbidity of DSM-IV major depressive episode in the United States: Results from the National Epidemiologic Survey on Alcohol and Related Conditions.*** Journal of Clinical Psychiatry, 67(8), 1067–1074. https://doi.org/10.4088/JCP.v67n0803

Cooney, G. M., Dwan, K., Greig, C. A., Lawlor, D. A., Rimer, J., Waugh, F. R., ... & Mead, G. E. (2013). Exercise for depression. ***Cochrane Database of Systematic Reviews***, (9).

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-peRiYo (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).

Duman, R. S., & Monteggia, L. M. (2006). A neurotrophic model for stress-related mood disorders. ***Biological Psychiatry***, 59(12), 1116-1127.

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.

Erickson, K. I., Voss, M. W., Prakash, R. S., Basak, C., Szabo, A., Chaddock, L., ... & Kramer, A. F. (2011). Exercise training increases size of hippocampus and improves memory. ***Proceedings of the National Academy of Sciences***, 108(7), 3017-3022.

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. J., 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).

Fletcher, T. (2022). ***Tim Fletcher – Trauma and Addiction***. Bing Videos (accessed July 11, 2025).

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).

GBD 2017 Disease and Injury Incidence and Prevalence Collaborators. (2018). ***Global, regional, and national incidence, prevalence, and years lived with disability for 354 diseases and injuries for 195 countries and territories, 1990–2017: A systematic analysis for the Global Burden of Disease Study 2017.*** The Lancet, 392(10159), 1789–1858. https://doi.org/10.1016/S0140-6736(18)32279-7

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. (2020). ***Power vs. Force: The Hidden Determinants of Human Behavior*** (revised edition). Hay House.

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=yFxMeoaIc3c (accessed March 8, 2024).

Hedegaard, H., Minino, 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., Minino, 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., Minino, 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).

Johansson, A., & Hagnell, O. (1980). ***Prevalence of depression in a Swedish community 1947–1972: The Lundby study.*** Scandinavian Journal of Social Medicine, 8(4), 179–187. https://doi.org/10.1177/140349488000800405

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

Lobaczewski, A. M. (2006). ***Political ponerology: A science on the nature of evil adjusted for political purposes*** (L. Harrison, Trans.). Red Pill Press.

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.

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.

Miller, A. H., & Raison, C. L. (2016). The role of inflammation in depression: From evolutionary imperative to modern treatment target. ***Nature Reviews Immunology***, 16(1), 22-34

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).

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).

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.

Porges, S. W. (2011). ***The polyvagal theory: Neurophysiological foundations of emotions, attachment, communication, and self-regulation***. W. W. Norton & Company.

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).

Ratey, J. J. (2008). ***Spark: The revolutionary new science of exercise and the brain***. Little, Brown Spark.

Rectenwald, M. (2022). ***The Great Reset and the struggle for liberty: Unraveling the global agenda***. Encounter Books.

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.

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.

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.

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.

Udermann, B. E. (2000). The effect of spirituality on health and healing: A critical review for athletic trainers. ***Journal of Athletic Training***, 35(2), 194–197.

University of Lancaster. (2020). Ethics of epigenetics. https://www2.le.ac.uk/projects/vgec/highereducation/epigenetics_ethics/introduction (accessed June 9, 2020).

U.S. Army Chaplain Corps. (2018). Lisa Miller lecture. https://www.youtube.com/watch?v=6QLuBtkaKxA (accessed July 11, 2025).

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.

Verywellmind. (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

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).

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.155.9.116

Addendum

The Hippocratic Revival

Bringing Medicine and Mental Health Back to First Principles

(*Portions of this chapter are adapted from the work of Dr. Alexander Nesbitt, a distinguished physician with great sensitivity to medical ethics who presented in Williamsport, PA, and are graciously shared with his permission.*)

Medicine, at its core, transcends mere science or technique; it is a profound and sacred calling. Originating from the island of Kos amidst the intellectual ferment of Greece's Golden Period, Hippocrates reshaped healing into a pursuit grounded in reason, ethics, and compassion. He boldly set medicine apart, establishing it as a blend of art and science—distinctly human and unmistakably purposeful.

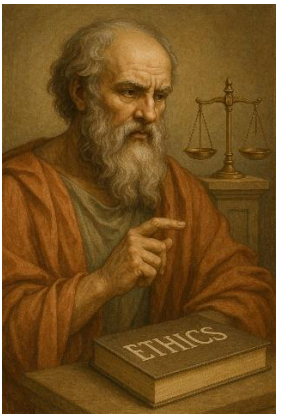
Yet, Hippocrates' legacy runs even deeper. By establishing a school of medicine set apart from contemporary healers by swearing to and obeying the Hippocratic Oath, he transformed the practice of medicine from a simple occupation into a profound covenant between healer and patient. This solemn promise, invoking the transcendent and binding practitioners to ethical standards and humane care, echoes through the centuries, continuing to define the very soul of the healing professions.

Central to the Hippocratic Oath, believed to have been written around 400 BCE, is the first and foremost command to work for the "benefit of my patients...and to do no harm or injustice to them." A prime example of this is the vow: "Neither will I administer a poison to anybody when asked to do so, nor will I suggest such a course. Similarly, I will not give a woman a pessary to cause abortion." In an ancient world where life was often disposable—and practices like suicide, infanticide, and euthanasia were widely accepted—Hippocrates drew a stark line. His insistence on the sanctity of life set the physician apart, dedicated exclusively to healing and preservation rather than convenience or societal preferences.

Moreover, the Oath urged practitioners toward a life of personal purity and integrity: "But I will keep pure and holy both my life and my techne." This call underscored the belief that healing was not merely a job but a way of life, demanding virtue, honor, and unwavering moral character. Physicians were expected to embody classical virtues:

- Prudence (practical wisdom)
- Justice (fairness and righteousness)
- Courage (fortitude, strength, and perseverance)
- Temperance (self-control and moderation)

Virtue ethics, championed by classical philosophers like Plato, Aristotle, and the Stoics, provided the framework for these moral imperatives, emphasizing character over mere rules, and highlighting the transformative power of living virtuously. This tradition was later enriched by Christian philosophers such as Augustine and Aquinas, who emphasized the cardinal virtues alongside faith, hope, and love. Non-Western traditions, too, echoed similar virtues, as seen in the teachings of Confucius, Lao-tzu, and various Hindu sages.



Over millennia, virtue ethics remained a dominant moral compass, suggesting that virtuous living was essential to genuine happiness and fulfillment, deeply intertwined with personal and professional integrity. Yet, in the last several centuries, medicine began to drift away from its covenantal origins.

Modernity brought profound shifts. The once-clear understanding of medicine as a sacred calling slowly transformed into a transactional, contractual interaction between providers and patients. Medical oaths began to change—no longer invoking higher powers, no longer emphasizing accountability or purity of life. Crucially, the proscription against causing harm through euthanasia, abortion, or exploitation weakened or disappeared altogether. Some modern institutions even allowed medical students to write their own oaths, signaling a profound shift away from a universally binding ethical framework toward subjective, individualized interpretations.

Medicine's ethical foundation began to erode, and the grim consequences were starkly visible in 20th-century atrocities. With a move away from a shared understanding of the physician's commitment to do what is best for the patient and to do no harm as their highest obligation, other considerations sometimes took precedence. These included:

- Pursuing eugenic goals ("purifying the gene pool") through the involuntary sterilization of "unfit" individuals
- Increasing medical knowledge through the appalling Tuskegee syphilis study, where poor Black men were observed for decades without treatment
- Collecting medical data through the dreadful experimentation on Nazi prisoners during World War II.

These dark chapters underscored the catastrophic consequences of abandoning virtue-based ethics, revealing the profound moral peril of medical practice without transcendent grounding.

In response to these moral crises, contemporary bioethics sought to establish a framework based on principle-driven ethics, notably the "Georgetown principles" articulated in the 1970s. These emphasized autonomy, beneficence, non-maleficence, and justice. While these principles offered clear analytical tools for resolving clinical dilemmas, they failed to fully restore medicine's lost ethical soul. Detached from the deeper, covenantal foundations of virtue ethics, medicine became increasingly impersonal and transactional.

Psychiatry and psychology, too, have similarly drifted from their foundational ethics and rigorous evidence-based principles. Originally dedicated to alleviating human suffering through compassionate, scientifically validated treatments, mental health professions have increasingly succumbed to ideological capture and market-driven forces. Problematic trends include:

- Prioritizing pharmaceutical solutions without sufficient evidence of efficacy
- Over-relying on psychotropic medications
- Pathologizing normal human experiences
- Introducing treatments shaped more by social narratives and pharmaceutical marketing than by careful science.

Misguided practices, often driven by powerful narratives rather than robust evidence, place patients at risk and violate the essential ethical commitment to do no harm. Psychiatric medications are prescribed at unprecedented rates, often without thorough evaluation or exploration of alternative interventions such as psychotherapy, community-based care, or lifestyle modifications.

Today, the crisis deepens as healthcare systems increasingly prioritize efficiency, economics, and standardization over individualized, compassionate care. Patients have become "clients" or "customers," and physicians have become "providers," reducing the sacred covenant to a mere commercial transaction. Amidst cost-cutting pressures, technological advances, and bureaucratic mandates, the very essence of healing—the compassionate, relational, and deeply human interaction—is at risk.

Moreover, a troubling trend has emerged, driven by ideological capture and misinformation, leading to inappropriate treatments and medications lacking robust evidence-based support. Therapies increasingly reflect powerful social narratives rather than scientific rigor, placing patients in jeopardy and further distancing the practice of healing from its ethical roots.

Returning to Hippocrates, we find not just history but urgent contemporary wisdom. Medicine's soul resides not in technological prowess or economic efficiency but in its foundational commitment: to do no harm, to heal with compassion, and to honor the sacred trust between healer and patient. Integrity in all treatments—whether medical, psychological, or psychiatric—demands rigorous evidence-based scrutiny, free from ideological distortions.

This book is a call to action—a clarion reminder that the path forward must begin by looking back, reaffirming medicine's, psychiatry's, and psychology's sacred covenant, and recommitting wholeheartedly to the timeless principle at its heart: Primum non nocere—first, do no harm.

About the Authors

Jeffrey E. Hansen, Ph.D., is a Clinical Psychologist specializing in addiction and trauma, with degrees from the University of California at Berkeley and the University of Arkansas. He has over four decades of clinical experience, including service in the U.S. Army (active duty) and the Defense Health Agency. Jeff and serves as Clinical Director of Holdfast Recovery and AnchorPoint, two faith-centered treatment centers for addiction and trauma recovery. He is the author of eight published books and is deeply committed to shaping public policy to protect children and adolescents from the ideological capture of psychology, the rushed medicalization of gender identity, and the premature use of psychotropic medications without sufficient exploration of root causes and non-pharmaceutical alternatives.

Earl Heverly is a retired pastor who served for 46 years in Northern California as an associate pastor, senior pastor, and Bible college instructor. He holds a bachelor's degree in Sociology from the University of Illinois, a Biblical Studies Degree from the Berean School of the Bible, and Ordination Ministerial Credentials through the Assemblies of God USA. Throughout his ministry, Earl has remained deeply committed to Scripture-centered teaching and pastoral care. He is also a co-author of ***NeuroFaith™: The Intersection of Faith and Science in the Healing of Trauma and Addiction***.

Tim Hayden is a corporate leader, entrepreneur, and consultant based in Prescott, Arizona. He is the Co-Founder of Holdfast Recovery, AnchorPoint, and Anchor Behavioral Health, all dedicated to helping individuals overcome addiction and mental health challenges through a faith-centered, neuroscience-based model. Tim's personal faith drives his mission to strengthen spiritual, physical, and emotional resilience. With over 20 years of leadership experience at major tech firms and healthcare, he brings a unique blend of business excellence and compassion to the behavioral health field. Tim is also a co-author of ***NeuroFaith™: The Intersection of Faith and Science in the Healing of Trauma and Addiction*** and holds degrees in Management, Marketing, and Communication from Mount Vernon Nazarene University.