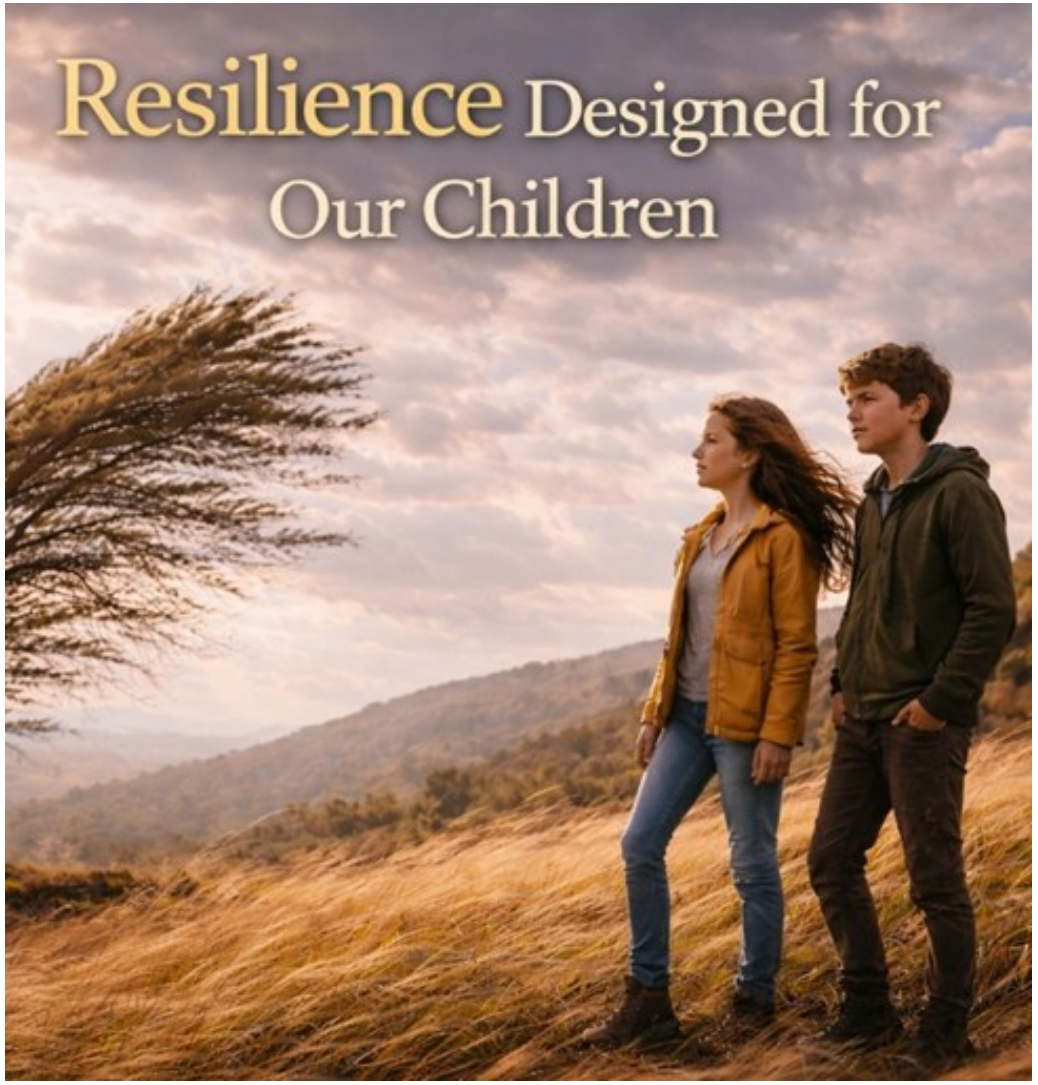


Risk Taking and Resiliency

Shed Some Light
Medical Conference
Williamsport, PA
March 26, 2026

Jeffrey E. Hansen, Ph.D.
Founder and Director, NeuroFaith® LLC

Disclaimers

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

Just what is an adolescent anyway ?

Adolescent (noun):

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

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

Proceed with humor and headphones.

Teen Brain (Current Operating System)

POWERFUL
EMOTIONAL ENGINE

UNDER-CONSTRUCTION
BRAKING SYSTEM

Or more simply...

ALL GAS.
NO BRAKES.

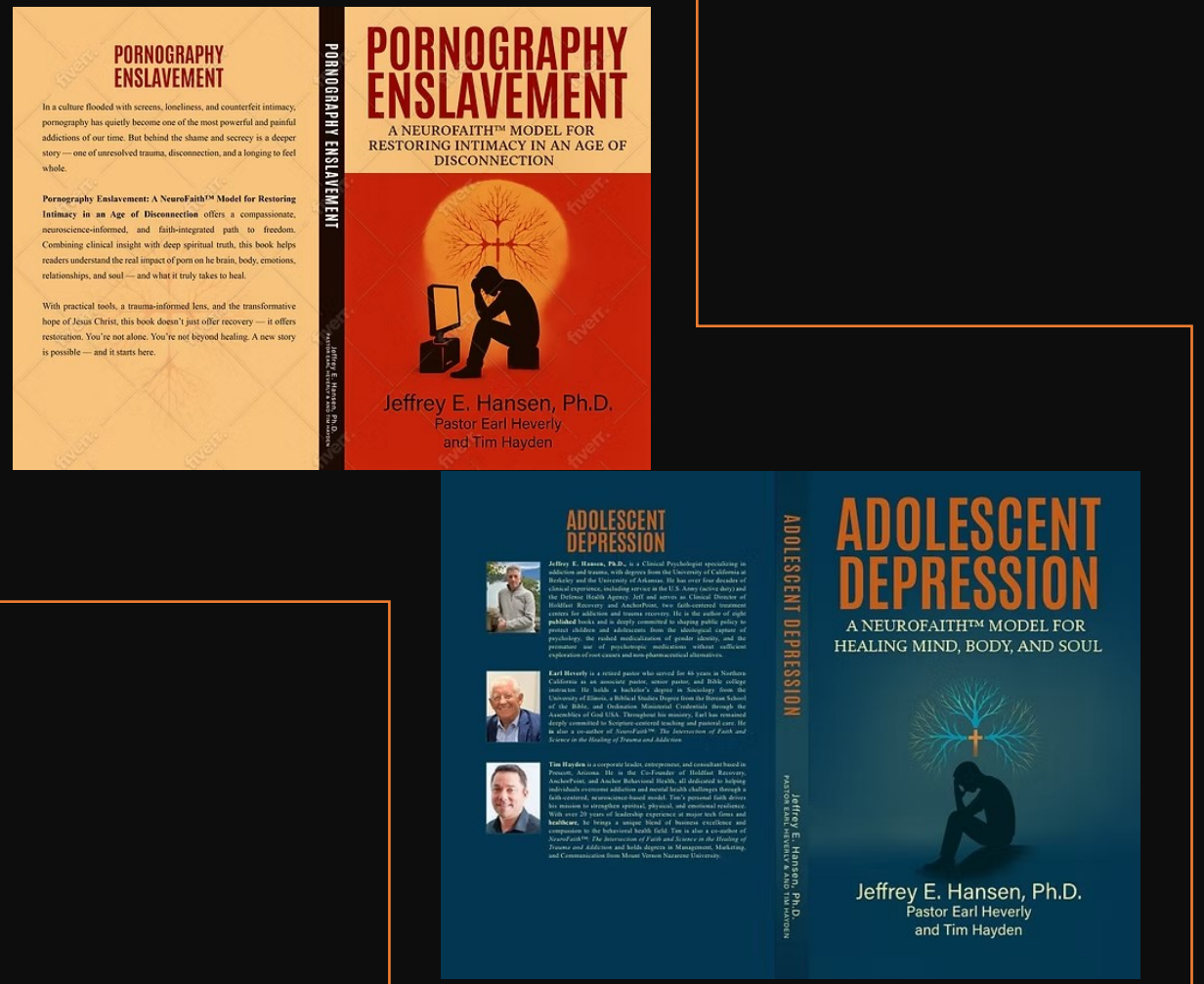
LOOK THROUGH THE TURN

Target fixation pulls us toward danger.
Resilience trains us to focus on the path forward.

Much of the content of this talk is included in my recently published books, *Adolescent Depression* and *Digital Enslavement*

We will happily provide a PDF of my slides upon request

So, no need to take notes; unless you are one of those overachievers ☺



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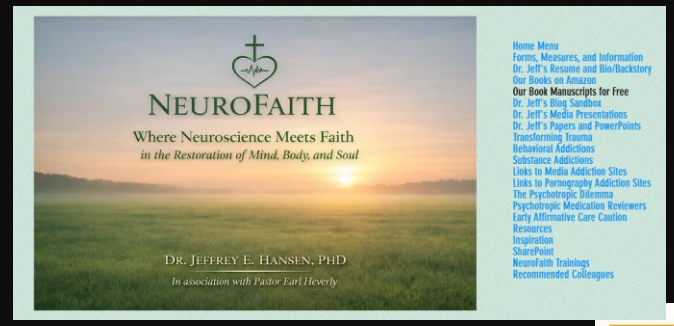
1. NeuroFaith.net
2. Go to: *Our Book Manuscripts for Free* page

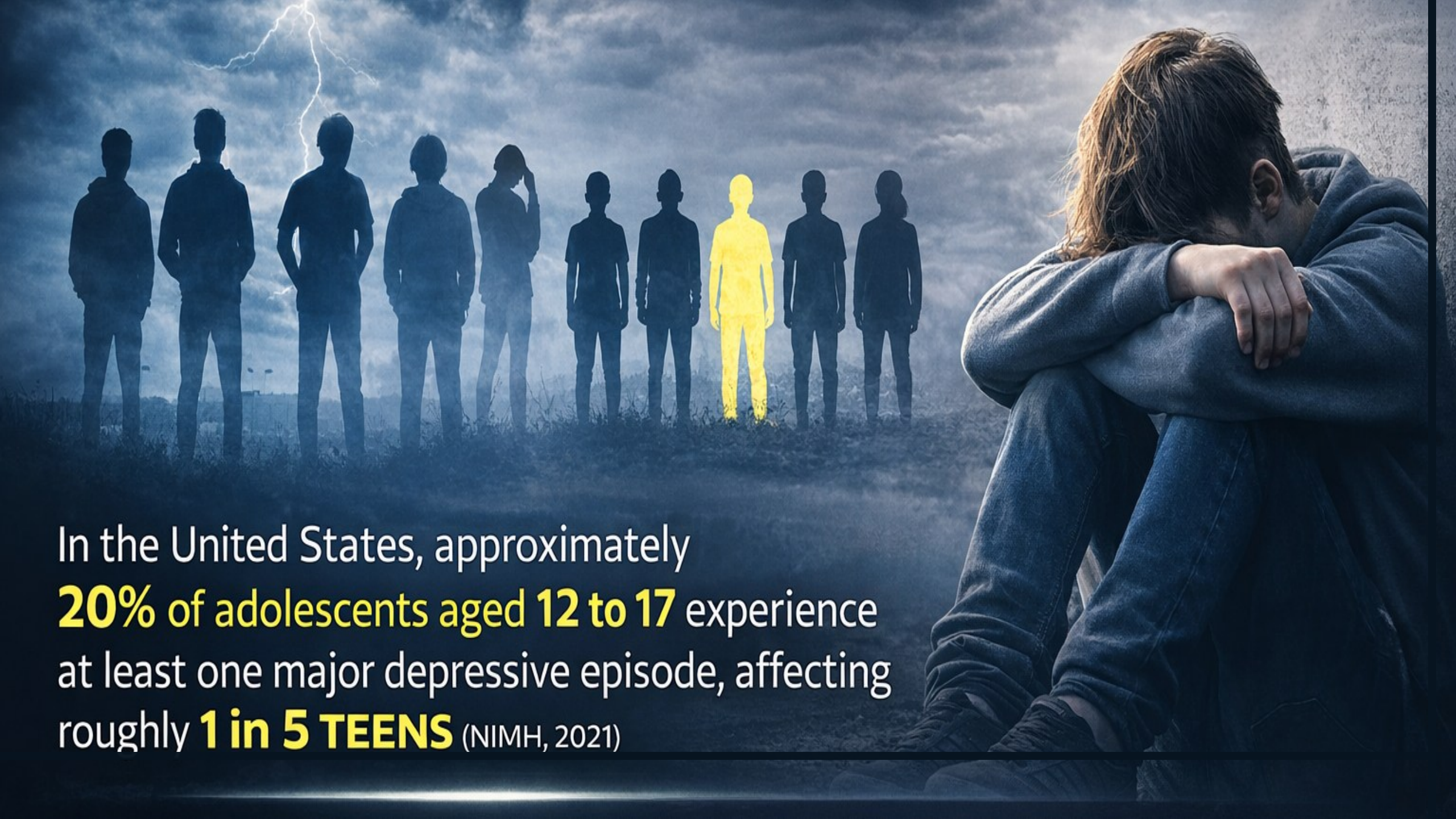


NeuroFaith® Objectives – Risk, Regulation & Resilience

Bottom-Up Co-Regulation → Top-Down Executive Function → Integrated Resilience

- Understand adolescent risk-taking through a neurodevelopmental lens
- Recognize why regulation must precede reasoning
- Apply the *NeuroFaith*® bottom-up → top-*down* model
- Integrate brain and heart in resilience-building
- Incorporate spirituality as a *protective resilience factor*

"Crisis in the Making: The Epidemic of Teen Depression and Anxiety”


In the United States, approximately
20% of adolescents aged 12 to 17 experience
at least one major depressive episode, affecting
roughly 1 in 5 TEENS (NIMH, 2021)

Suicide: A Leading Cause of Death in Teens

Suicide is the second leading cause of death among individuals aged 10-24 (CDC, 2022)

Depression is a significant risk factor for suicidal behavior.

What's Driving the Avalanche of Mental Health Problems in Our Teens?

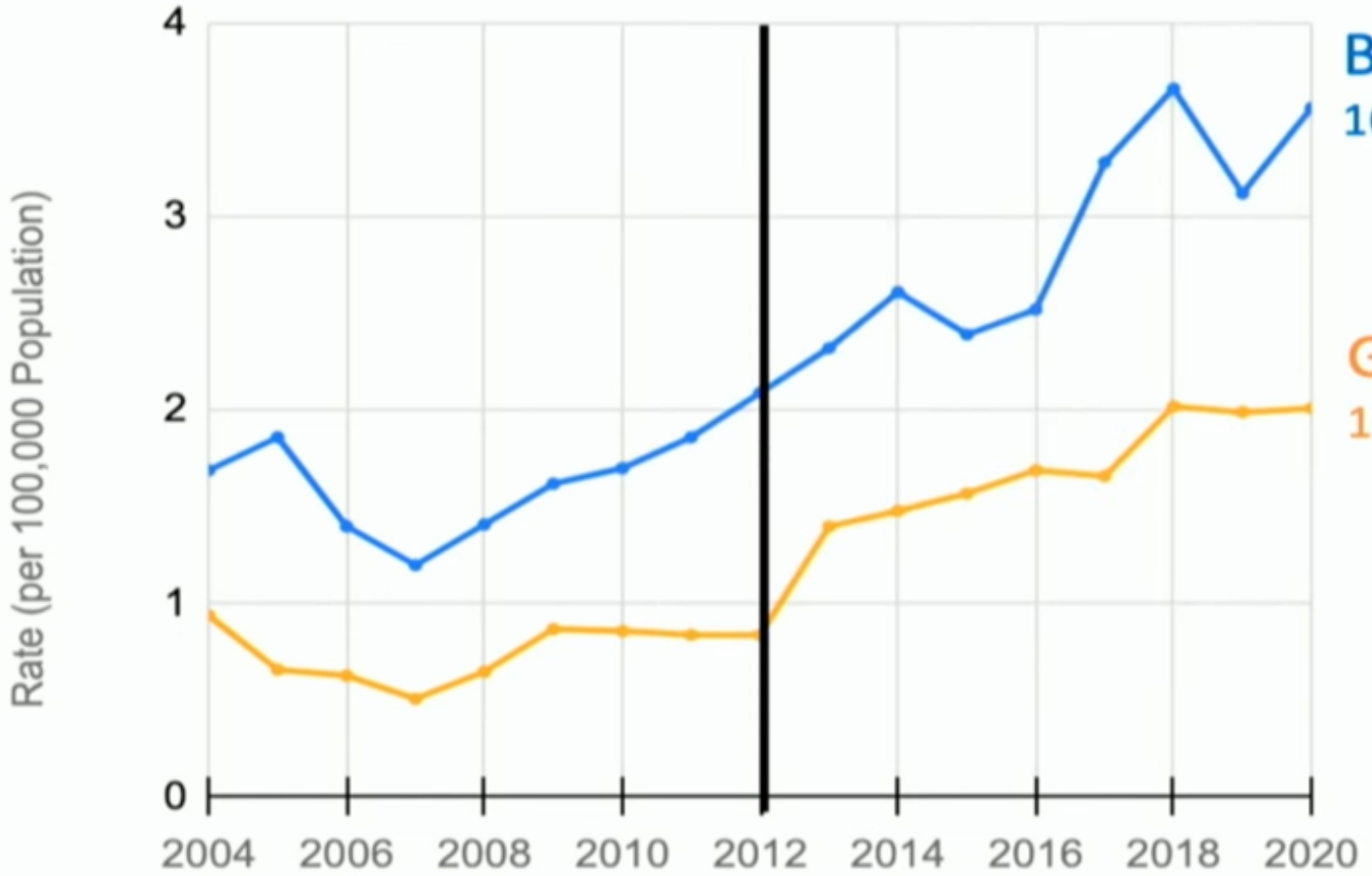
1. Replacing play-based childhood with screen-based childhood per Jonathan Haidt.
2. Ideologically-based dogma undermining normal psychosexual development per Gramsci, the Frankfurt School, and Queer Theory.
3. Pornography – attack on the soul
4. Losing healthy "Connected Living" per Johann Hari.
5. Childhood Trauma per Felitti.

Why the Rise in Depression in Teens?

Replacing play-based childhood with screen-based childhood per Jonathan Haidt

Social Psychologist Jonathan Haidt notes that suicides among youth 10 – 14 have increased significantly since 2010 (Haidt, 2014).

US Teens, Suicides (Ages 10 – 14)

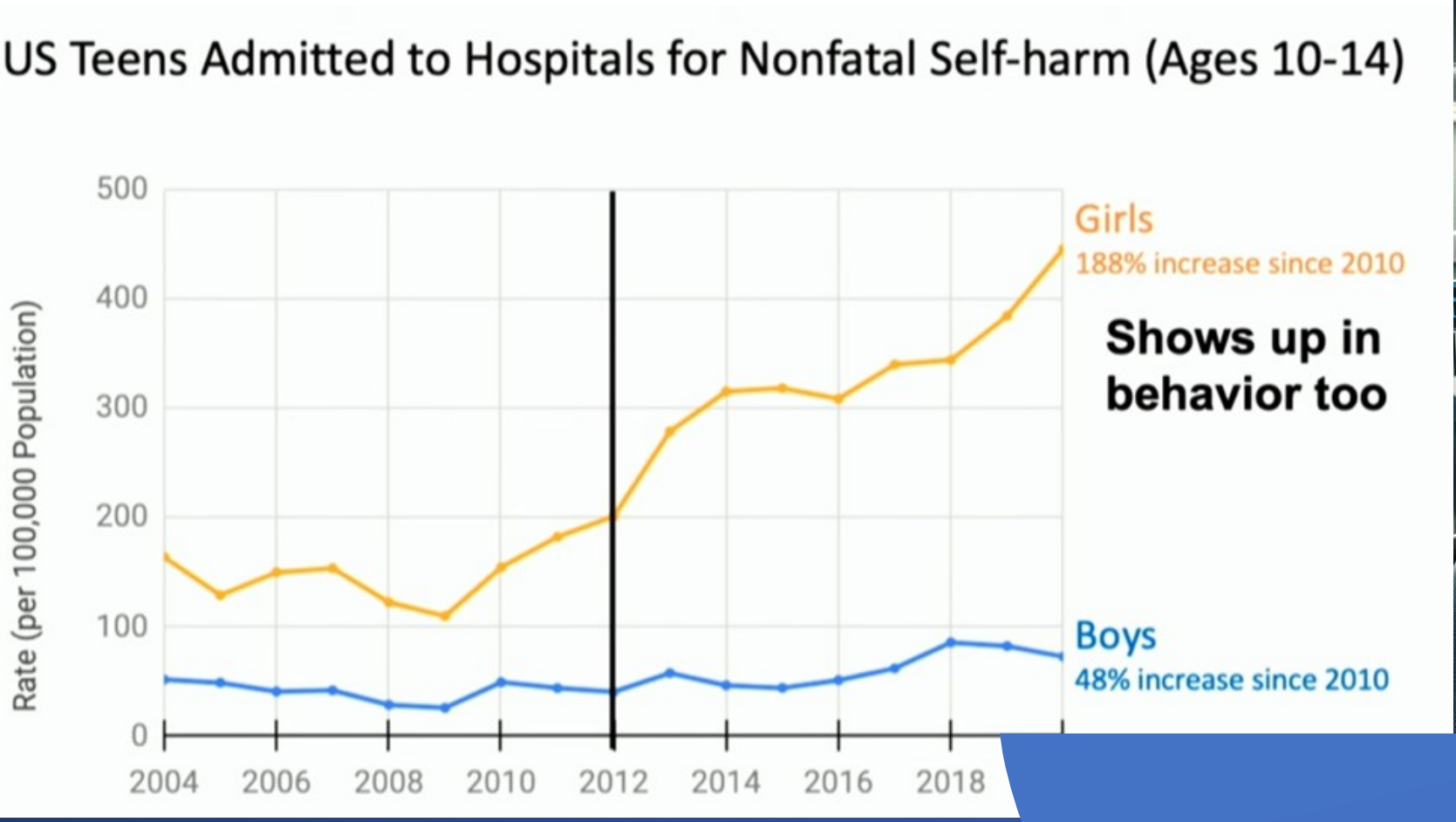


Boys
109% increase since 2010

Shows up in behavior too

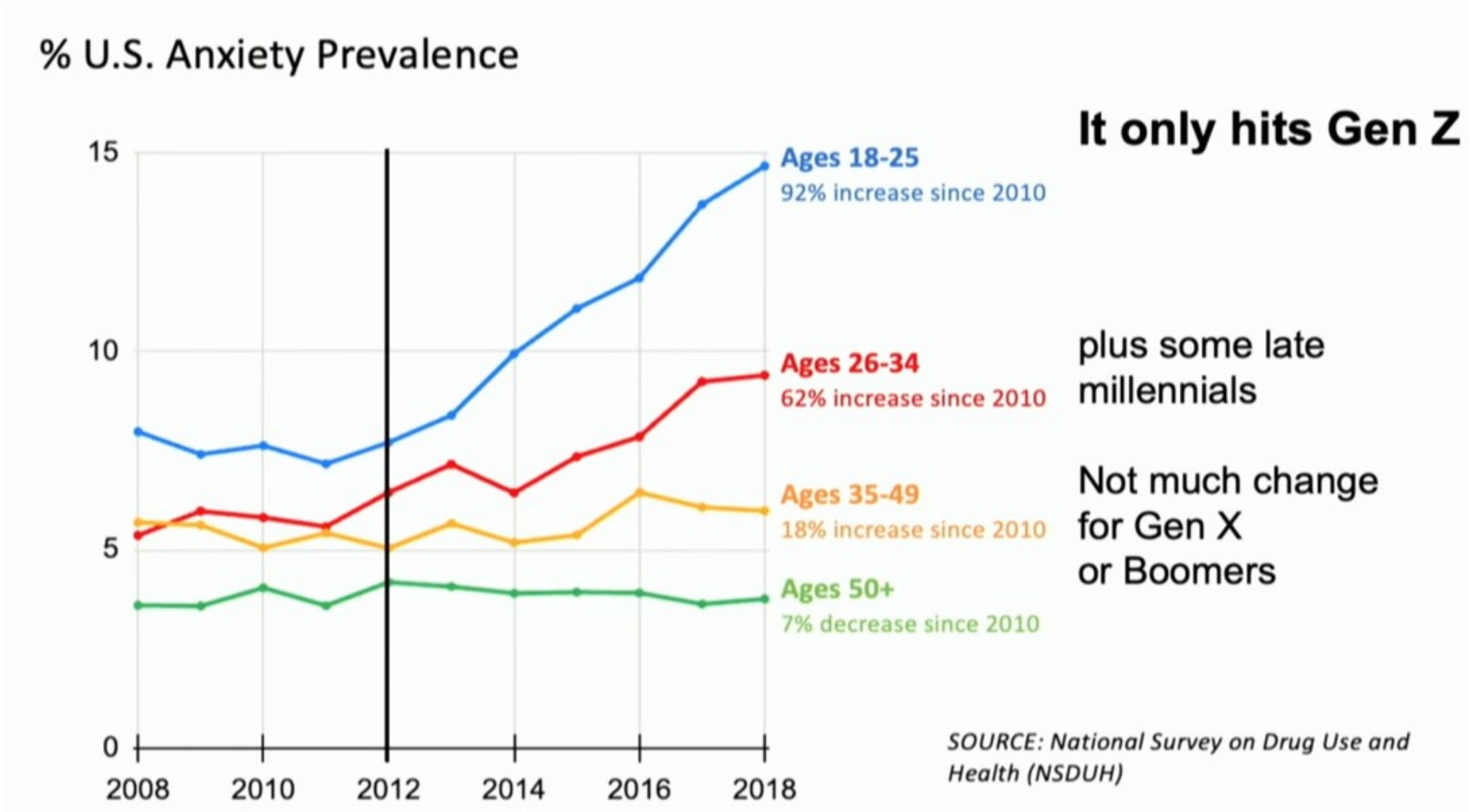
Girls
134% increase since 2010

Source:
CDC fatal injury reports

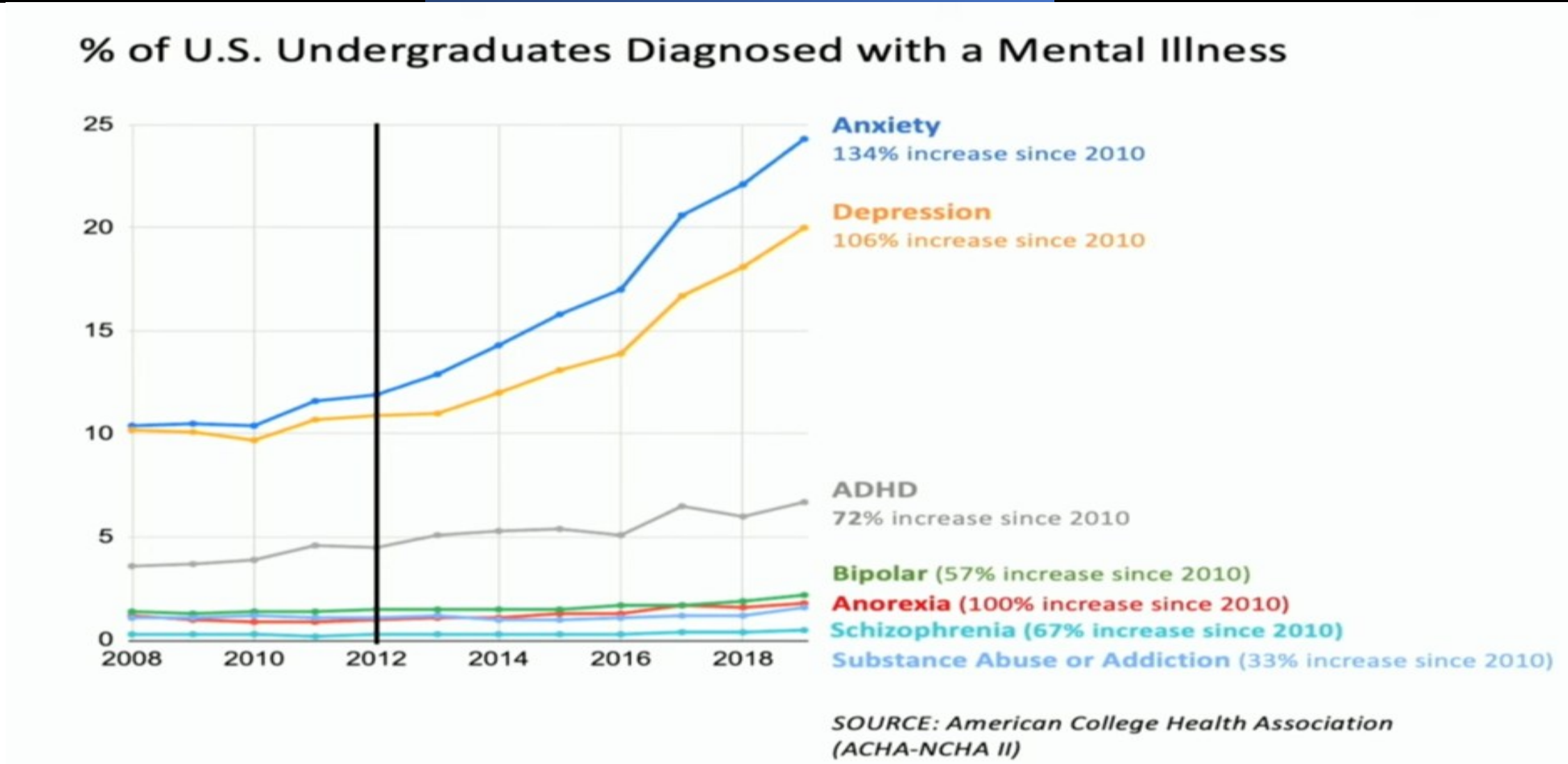


Jonathan Haidt notes that US youth ages 10 – 14 are being admitted to hospitals for nonfatal self-harm at terrifying rates since 2010 (Haidt, 2024).

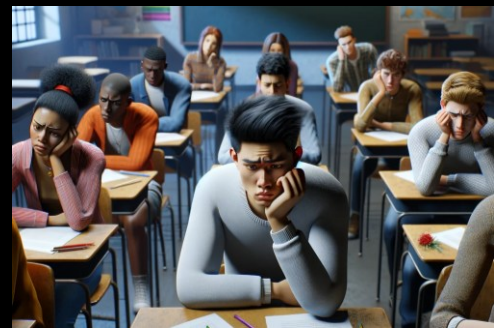
Jonathan Haidt asserts that Gen Z's anxiety has skyrocketed since 2010 (Haidt, 2024).

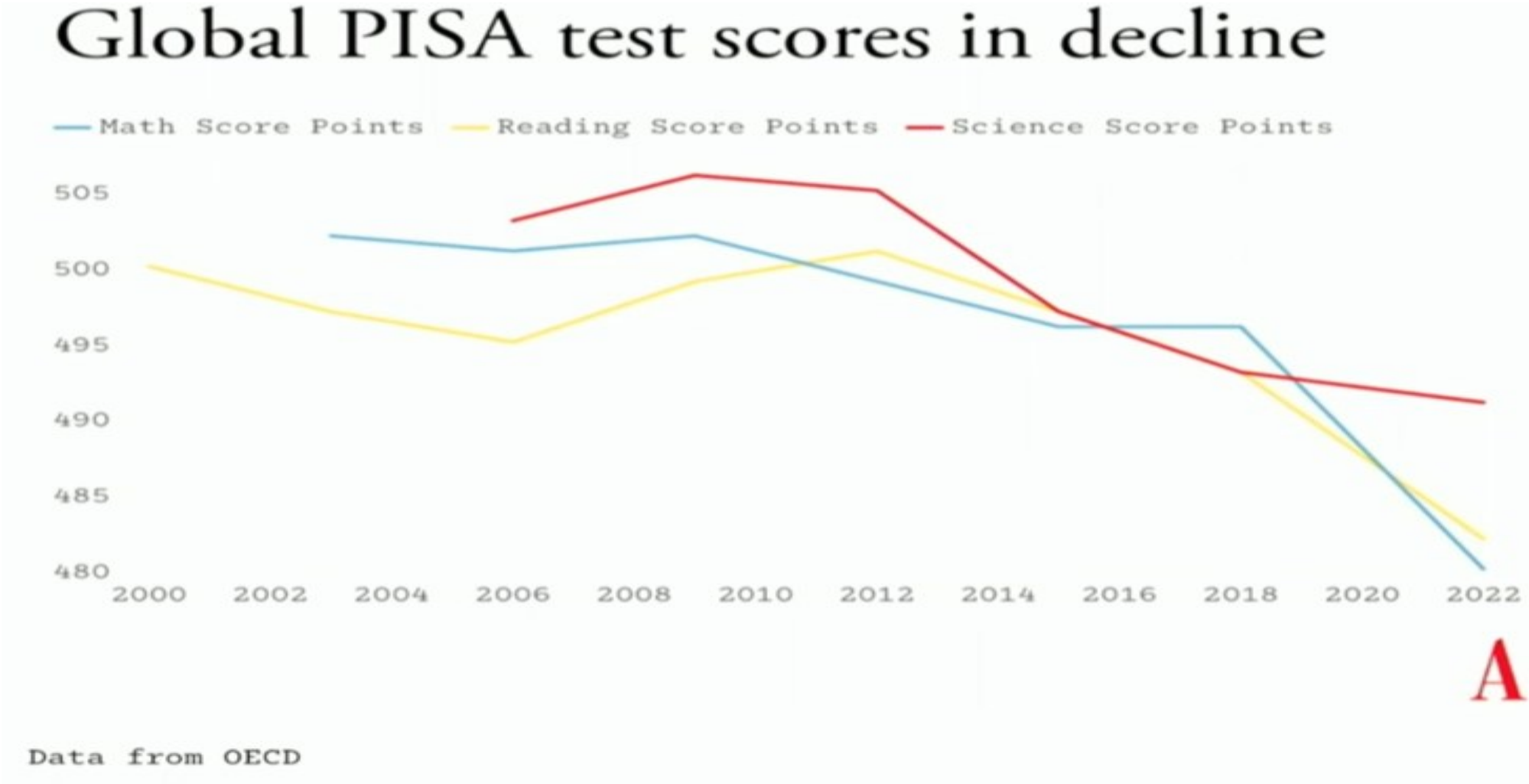


Jonathan Haidt states that undergraduates are becoming increasingly anxious and depressed since 2010 (Haidt, 2024).



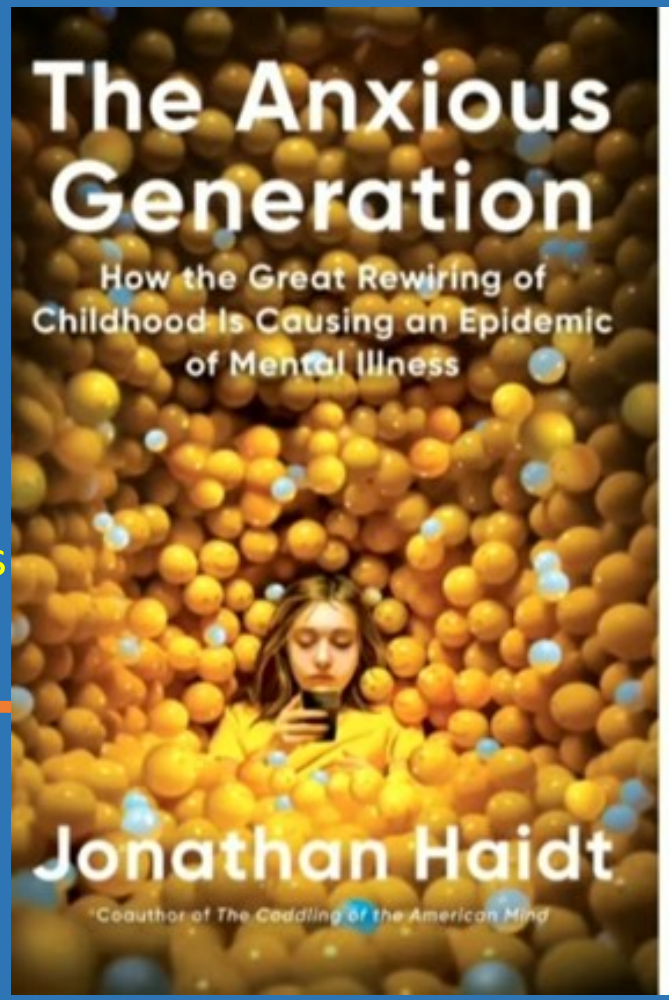
Jonathan Haidt asserts that our children have had declining Global PISA test scores in industrialized nations (Haidt, 2024).





Jonathan Haidt identifies part of the cause: **Rewiring of Childhood** (Haidt, 2024).

His book, *The Anxious Generation* is a very high recommend.



The Great Rewiring of Childhood:

The play-based childhood faded out gradually, 1980-2010

The phone-based childhood stormed in with the iPhone and high-speed internet, 2010-2015

We have overprotected our children in the real world and underprotected them online.

NeuroFaith®

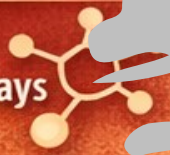
THE ADOLESCENT BRAIN IN A DIGITAL CULTURE

Attunement Disrupted

Screens replace real eye contact & empathy

Dopamine Overload

Instant gratification rewires reward pathways



Externalized Identity

Social media distorts self-image & worth

Emotional Escape

Numbing & avoidance of real emotions

Sleep & Arousal Disrupted

Late-night screens impair brain function

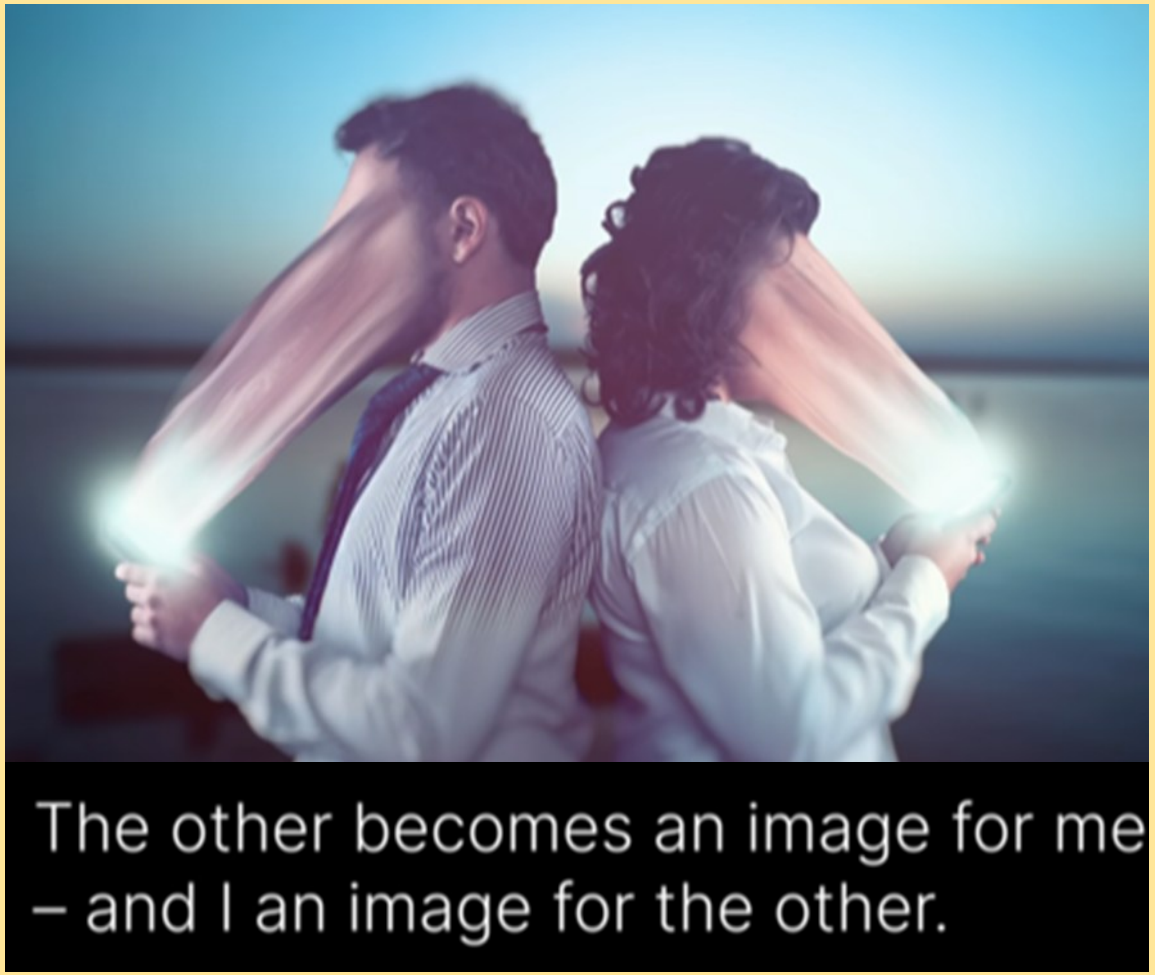
Before

Now

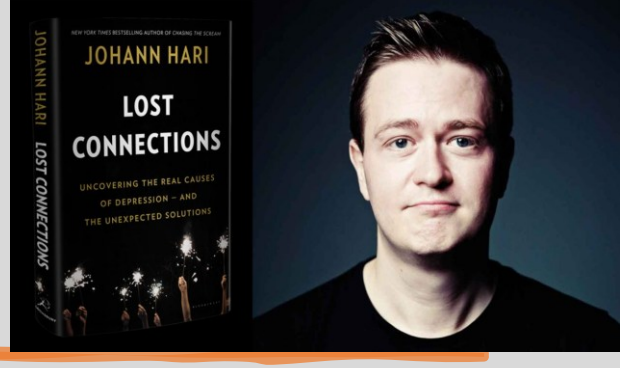
Before

Now

We no longer experience the “real thing.”



Johann Hari's Disconnection Model of Depression



1. Disconnection from **Meaningful Work**
2. Disconnection from **Other People**
3. Disconnection from **Meaningful Values.**
4. Disconnection from **Childhood Trauma**
5. Disconnection from **Status and Respect**
6. Disconnection from the **Natural World**
7. Disconnection from a **Secure and Hopeful Future**
8. Disconnection from **Faith (emphasis mine)**

If not well connected with good things, the alternative is to connect with bad things.

We are wired to connect and in the words of Johann Hari

"Addiction is about bonding.

If you can't do it with people, you will do it with a substance.

Now that might be gambling, that might be media, that might be cocaine, that might be cannabis.

You will bond to something because that is our nature.

That's what we want as human beings."

Victimhood Culture and Overdiagnosis

- In today's neo-Marxist /progressive ideology framework, victimhood confers moral status.
- Mental illness labels become badges of honor.
- This encourages teens to adopt diagnoses instead of resilience. Normal teen experiences—heartbreak, angst, identity searching—are now pathologized.

Victimhood Culture and Overdiagnosis

- In today's neo-Marxist /progressive ideology framework, victimhood confers moral status.
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- This leads teens to adopt diagnoses instead of resilience. Normal teen experiences—heartbreak, angst, identity searching—are now pathologized.

Just what is resilience?

The word ***resilience*** itself quietly carries this truth. It comes from the

Latin ***resilire*****,** meaning “to spring back,” “to rebound,” or “to leap again.”

Embedded in the word is the assumption of impact. Nothing springs back unless it has first been pressed, bent, or struck.

Resilience does not describe a life without **stress**. It describes a life that has been acted upon and yet is able to return. That return is not accidental. It is built in.

What does the Neuroscience Say
Risk Taking and Resilience in Tee

When Resilience Fails to Develop

- Resilience is not innate
- It is built through attachment, co-regulation, repair, and meaning
- When these are disrupted, resilience does not form

Internalizing

- Depression
- Anxiety
- Withdrawal
- Shame turned inward

Externalizing

- Hypersexuality
- Substance use
- Risk-taking
- Aggression

Same root problem. Different expression.


The Nervous System Still Demands Regulation
When resilience is not built internally, regulation is sought externally

Predictable Acting-Out Outcomes

These are not random behaviors

CDC and related sources highlight dangerous transportation practices:

- ~43% of high school students did *not always* wear a seat belt.
- ~16.7% rode with a driver who had been drinking alcohol in the past month.
- Among students who drove, ~5.4% reported driving after drinking alcohol during the past 30 days.
- ~39% of teen drivers texted or emailed while driving.

Also, teen drivers are 2.5–3× more likely to engage in risky behaviors (speeding, unsafe driving) when driving with peers vs alone.

But newer, more dangerous forms of risk-taking are increasing in part due to lack of resilience

- **Digital & neurological risks**
- Dramatic rise in **screen exposure, dopamine-seeking behaviors, and impulsivity**
- Increased **compulsive behaviors** (gaming, porn exposure, social media)
- Earlier exposure to adult content
- Higher emotional dysregulation despite lower substance use

Teens today may drink less — but their nervous systems are under far more chronic stimulation.

MODERN DEVELOPMENTAL SCIENCE

REWARD > REGULATION

Adolescents aren't reckless because they don't care —
They're vulnerable because their reward systems mature before their regulation systems.

The environment has changed, but the brain imbalance has not.

- **Faster dopamine hits**
- **Constant stimulation**
- **Less unstructured play**
- **Reduced attunement**
- **Increased social comparison**
- **Slower nervous-system recovery**

Even if behaviors improve, vulnerability still increases.

The New Adolescent Risk

The Risk Is No Longer Just What Teens Are Doing — It's What They're Avoiding

- Less dating
- Less face-to-face interaction
- Less unsupervised social exploration
- Less tolerance for rejection or awkwardness

→ **Safety is replacing development.**

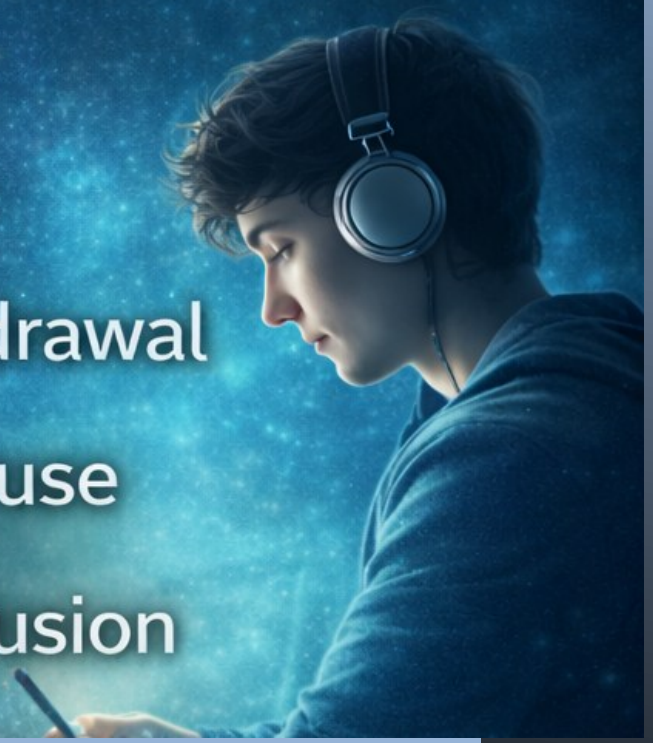
From Acting Out → To Shutting Down

PAST: "Traditional Risk"

- Substance use
- Behavioral acting out
- Externalizing distress

NOW: Internalized Risk

- Anxiety
- Depression
- Social withdrawal
- Digital overuse
- Identity diffusion



The Brain Requires Risk to Mature

DIGITAL ADOLESCENCE

- Low risk
- High stimulation
- Isolation

REAL-WORLD DEVELOPMENT

RISK → BRAIN MATURITY

- Relational risk
- Challenge
- Challenge
- Connection

When risk disappears, distress moves inward.

Anxiety replaces acting-out.

High Dopamine → Low Development

DIGITAL SEXUALITY

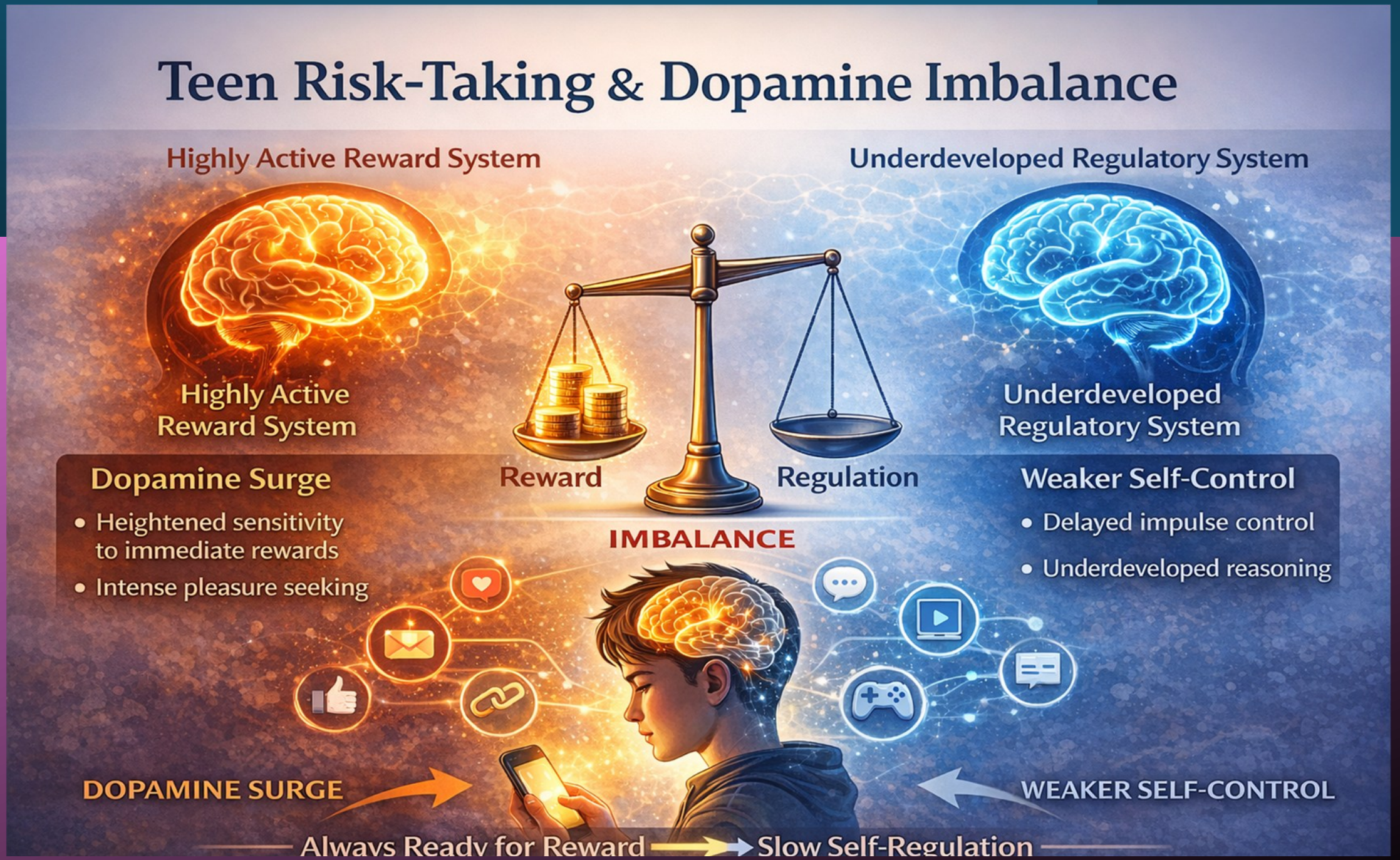
- Novelty without vulnerability
- Control without mutuality
- Arousal without attachment

REAL-WORLD INTIMACY AVOIDED

- Fear of rejection
- Fear of exposure
- Fear of inadequacy

→ You cannot individuate without relational risk.

Teen Risk-Taking & Dopamine Imbalance



Why adolescence is such a vulnerable window

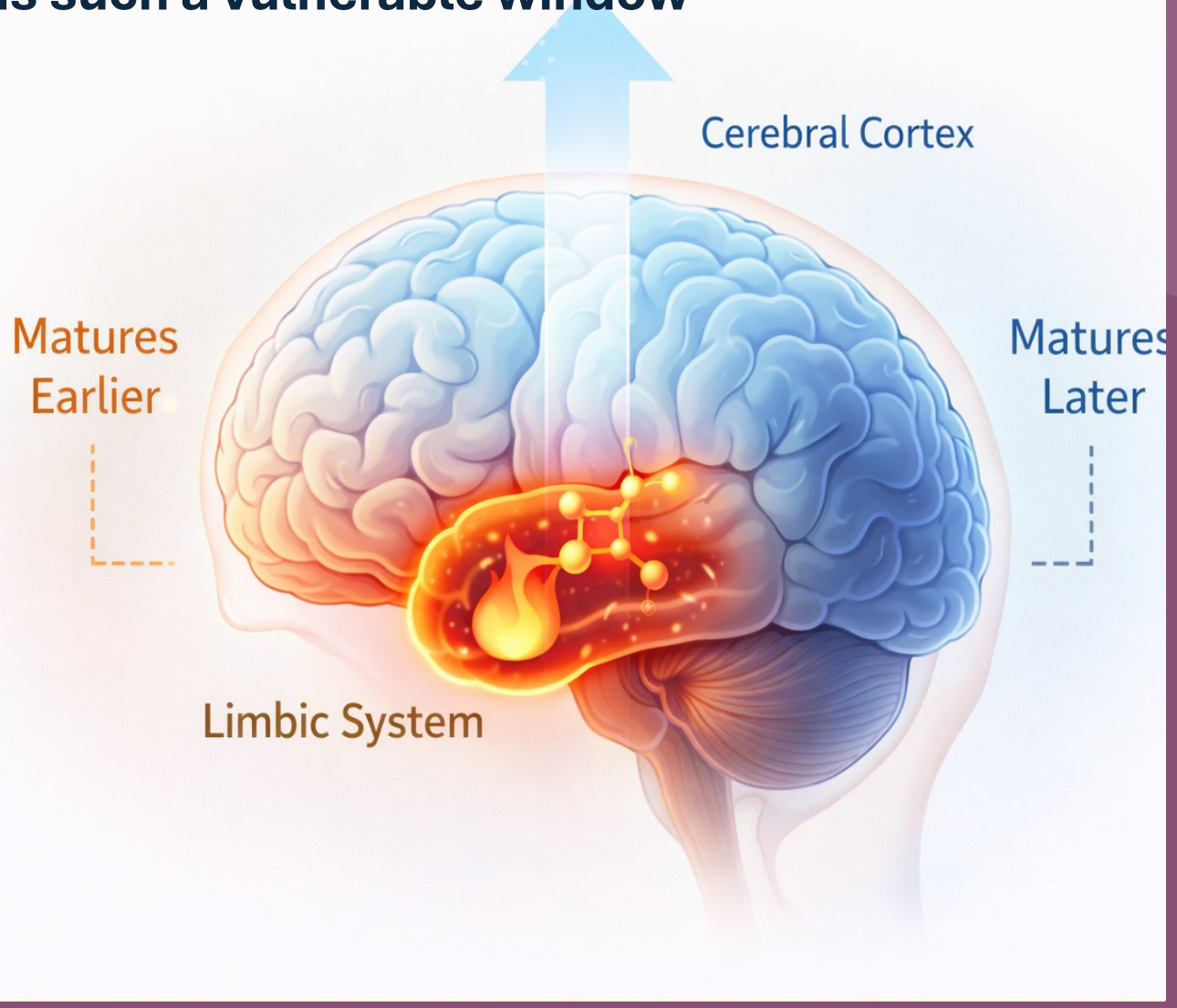
The brain develops bottom-up, not top-down.

Limbic system (emotion, reward, dopamine) matures **earlier**

Prefrontal cortex (inhibition, judgment, foresight) matures **later**

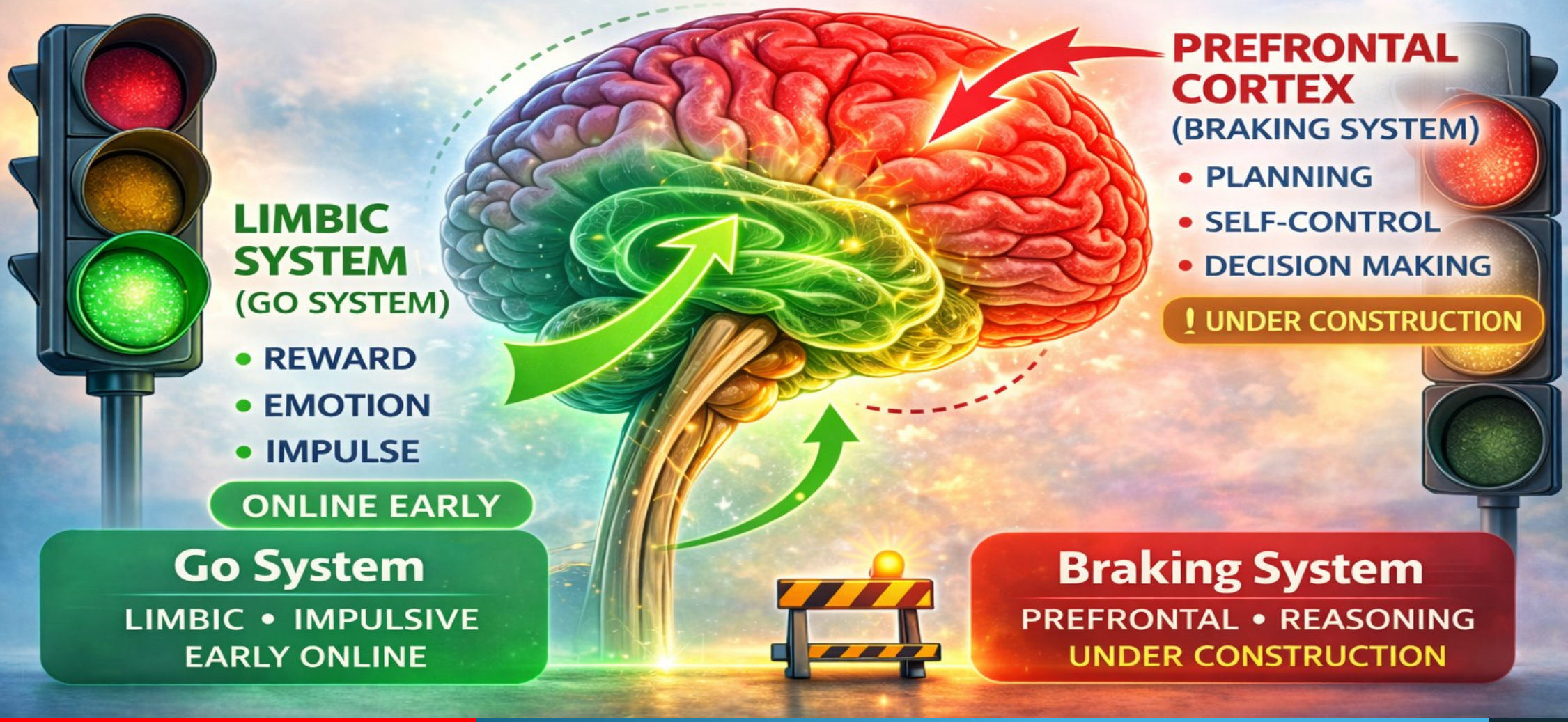
So, during adolescence you have:

🔥 A highly sensitive reward system
🧊 An underdeveloped regulation system



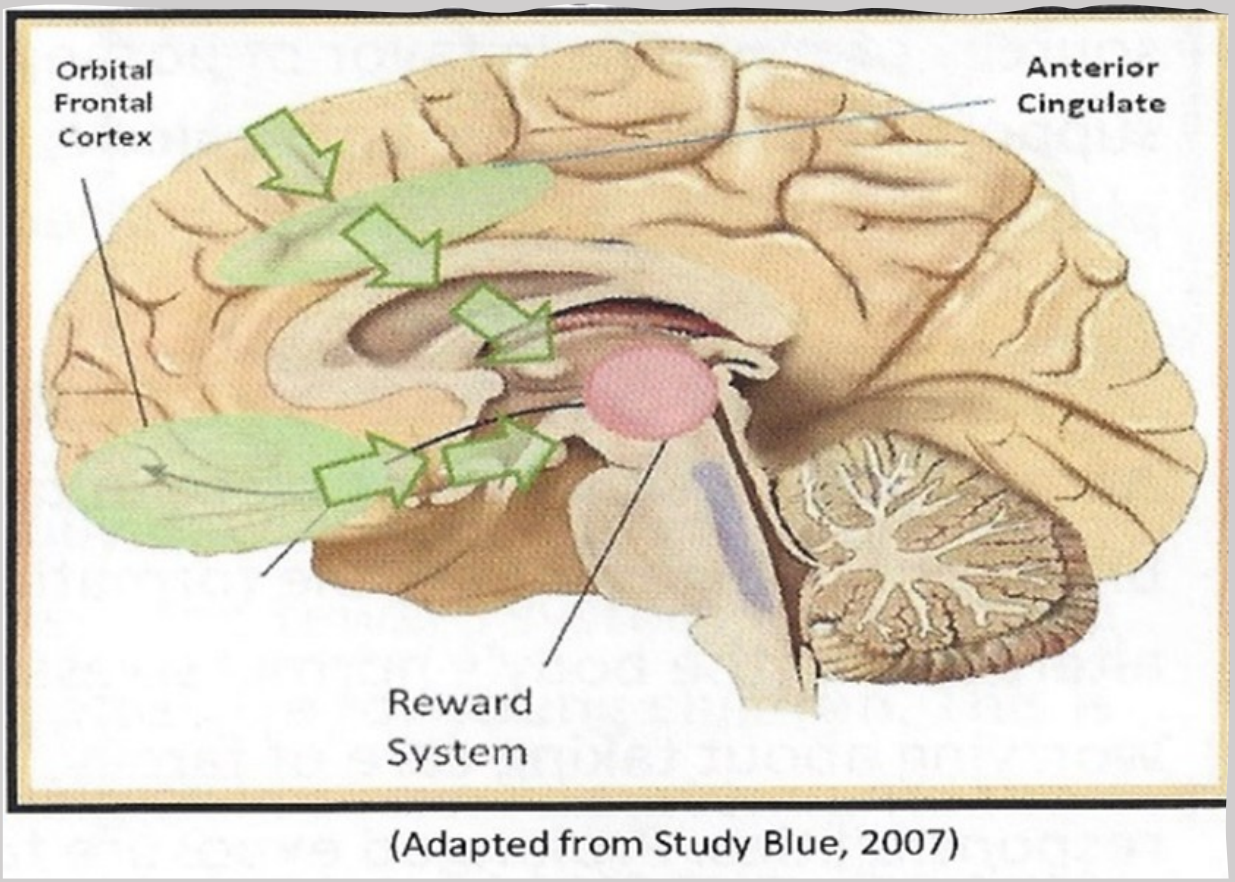
THE BRAIN'S GO & BRAKE SYSTEMS

WHY TEENS ACT FIRST — AND THINK LATER

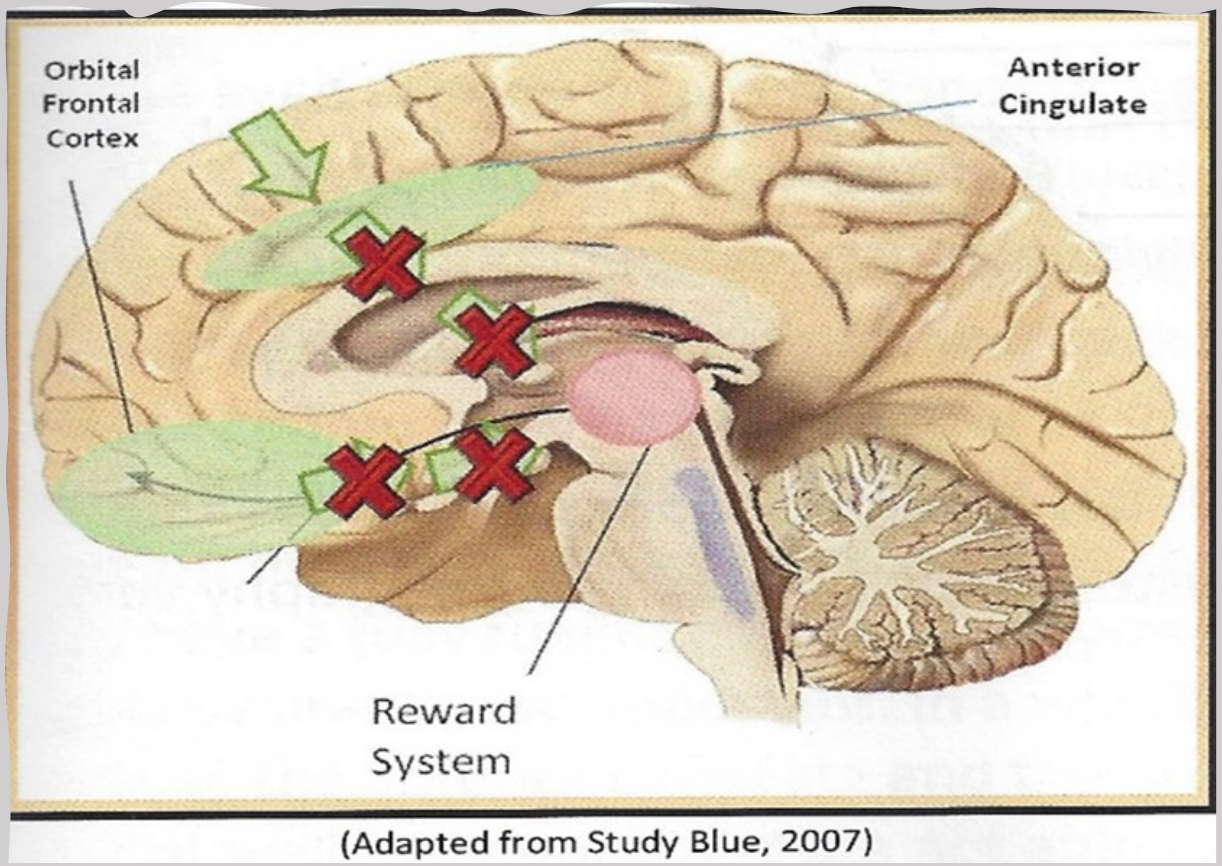


Impact of Hypofrontality – not a good thing:

Two areas of the brain, the anterior cingulate and the orbital frontal cortex, serve as a protective mechanism to override the reward system's desire for ever increasing dopamine. **Sadly, hypofrontality involves the rewiring of our brain so that when an impulse to engage in a dopamine-related behavior is activated, the brain ends up shutting down its ability to override the reward system. This is the breeding ground for horrible choices and impacts on social development in a really bad way.**



(Adapted from Study Blue, 2007)

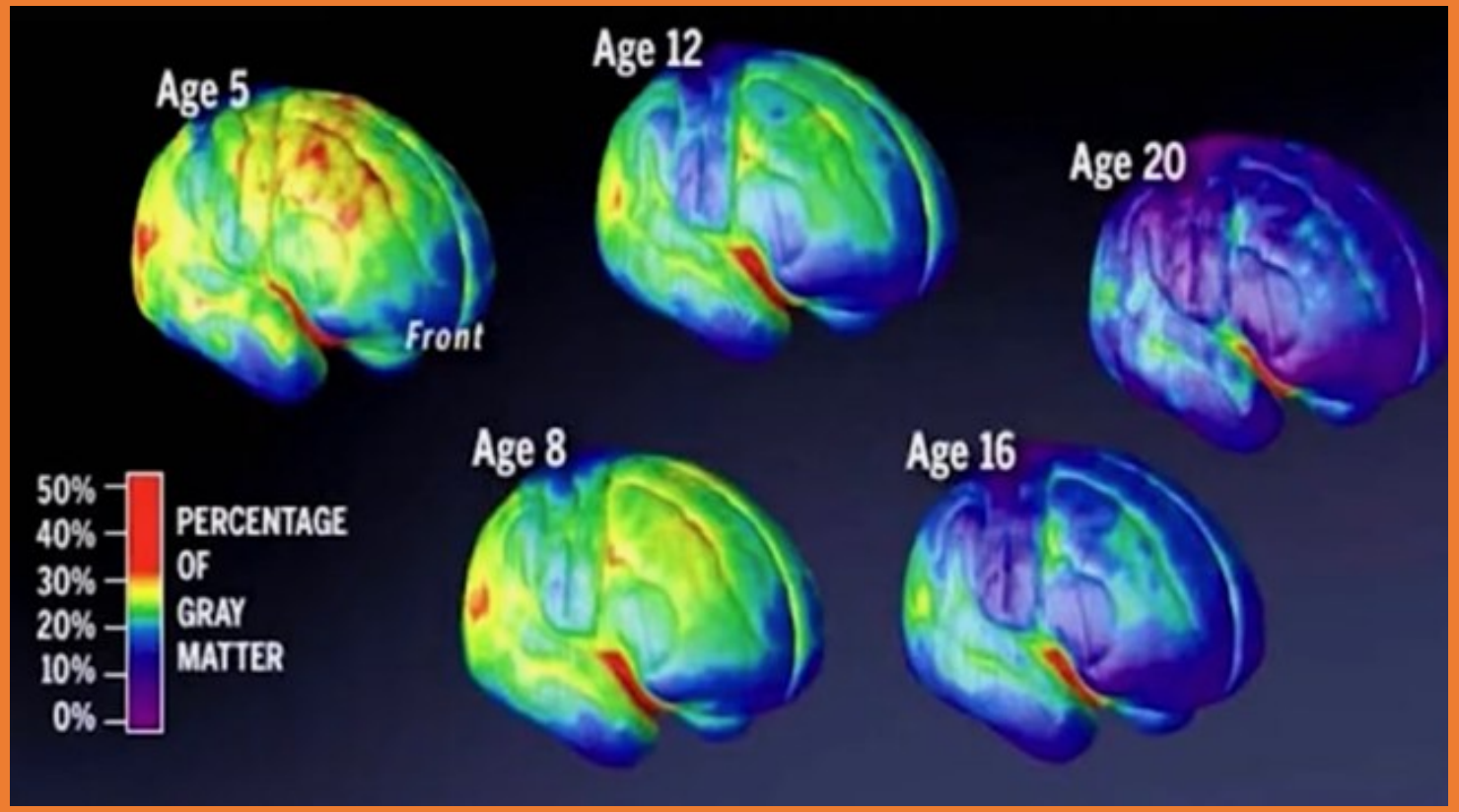


(Adapted from Study Blue, 2007)

Yellow and **red** areas represent an abundance of gray matter — a less developed brain rich in potential but limited in regulation.

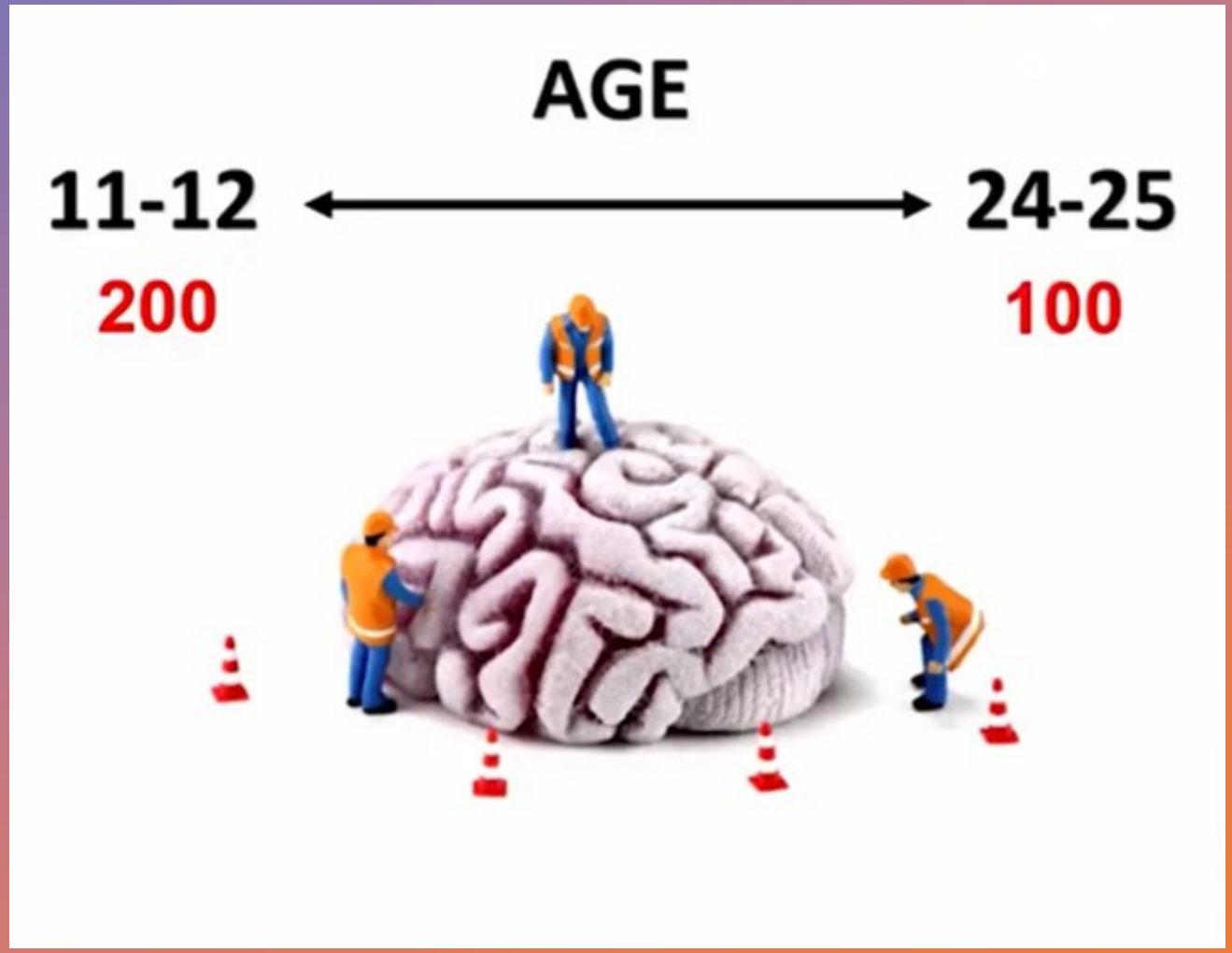
Over time, the brain shifts toward **blue** and **purple** as white matter increases through myelination, strengthening efficiency, integration, and self-control.

Gogtay, N., er al. (2004). Dynamic mapping of human cortical development during childhood through early adulthood. *Proceedings of the National Academy of Sciences, 101*(21), 8174–8179



The Second Phase of Brain Growth

The second phase of brain growth starts at about 12 and continues to age 25. During this time, the brain prunes out little-used/unneeded neurons and the brain thus decreases from **200 billion to 100 billion neurons.** During this time, pathways that are used myelinate to increase efficiency. So, ensure that a teen is learning and doing good things during this time as this will wire into what becomes the adult brain.



Treatment

"Healing doesn't mean the damage never existed; it means the damage no longer controls your life."

-Akshay Dubey

-

Remember Why Adolescents Take Risks

- Reward systems mature early
- Regulation systems mature later
- Peer presence amplifies intensity
- This is developmental vulnerability, not rebellion

Cautionary Notes in Dealing with Adolescents

Practical Insights for Effective Communication and Support

Humorous Insight

Forcing a teen to open up the wrong way is like poking a bear and expecting a hug—best case, you get ignored; worst case, you're running for your life.

Listen More, Speak Less

1. Follow the 80/20 Rule: Listen 80% of the time, speak 20%.
2. Avoid becoming a preacher—preachers are for church, not the dinner table.
3. Don’t try being a lecturer either; teens hear lectures like dogs hear fireworks— they cringe, shut down, and look for the nearest exit.
4. Keep it short, meaningful, and conversational. Teens engage better in a dialogue, not a monologue.

Teenagers Have One Superpower

Hypocrisy Detection

And it works perfectly on parents.

- **"You need to get off your phone."**
  – said while checking email during the lecture.
- **"You need to control your emotions."**
  – shouted at maximum volume.
- **"You need more discipline."**
  – delivered from the couch.
- **"You need better sleep habits."**
  – after staying up scrolling until midnight.

If we want our teens to regulate themselves...
they have to see us regulating ourselves.

Replace Anxiety with Love and Confidence

1. Adolescents are highly sensitive to anxiety—it’s like their worst allergy ever.
2. Think of anxiety as the poison ivy of their emotional world: itchy, irritating, and something they’ll go to great lengths to avoid.
3. Lead with calm assurance and unconditional love. They’ll sense your stress or fear immediately.
4. Be a steady, reassuring presence—confidence is contagious.

Remember that teen brains are 'All Gas, No Brakes'

1. Adolescents' brains undergo massive changes, trimming neurons from 200 billion to 100 billion.
2. The limbic system (emotions, impulses) wires in first, driving intense feelings and impulsive behaviors.
3. The prefrontal cortex (judgment, regulation) matures later, leaving teens like cars with powerful gas pedals but weak brakes.
4. Step in gently to provide prefrontal cortex assistance, helping them pause, reflect, and make better decisions.
5. Approach carefully to avoid shaming or angering them—build trust instead.

Motivational Interviewing and Depressed Adolescents

A Compassionate Strategy for Parents and Providers

What is Motivational Interviewing?

Motivational Interviewing (MI) is an evidence-based, client-centered approach that enhances intrinsic motivation for change by resolving ambivalence.

This method is particularly effective for adolescents with depression, fostering collaboration, trust, and empowerment.

Examples of MI

1. Asking Permission to Discuss Concerns (The Golden Question):

"Would it be okay if we talked about some of the feelings you've been experiencing?'

I've noticed you seem down lately. Can I ask you about that?'

2. Reflective Listening:

'It sounds like you've been feeling really stuck, like nothing seems to help.'

'If we could work together to change one small thing, what would you choose?'

3. Empowering Change:

'What's one thing you feel you could do to start feeling better today?"

Why Symptom-Focused Treatment Fails

- Pills do not build resilience
- Behavior control does not heal shame
- What is required is **transformational healing**

Pills Before Therapy: Rethinking Resilience-building Adolescents

The growing epidemic of adolescent depression has been met with a disturbing trend: hasty diagnoses followed almost immediately by antidepressant prescriptions.

This pill-first mentality ignores root causes and fosters dependency.

For my rant on overprescription of adolescent depression:

https://www.jeffreyhansenphd.com/

on Dr. Jeff's Sandbox Blog website page

Consequences of Overprescription

- Emotional blunting and numbness
- Impaired development of coping skills
- Dependency and identity tied to meds
- Post-SSRI Sexual Dysfunction (PSSD):likely permanent, side effects

These outcomes rob teens of the chance to grow through adversity.

Therapy builds resilience. Pills should never be the first answer.

Avoid Bad Therapy

Abigail Shrier's critique

- Pathologizes normal pain
- Creates symptom identities
- Undermines parents
- Rewards rumination over resilience
- Poorly trained clinicians
- Ideology over psychology

Good therapy** builds **Capacity.

Bad therapy** builds **Dependency.

Healing involves mind, body, and soul.

As such, treatment must be multidimensional

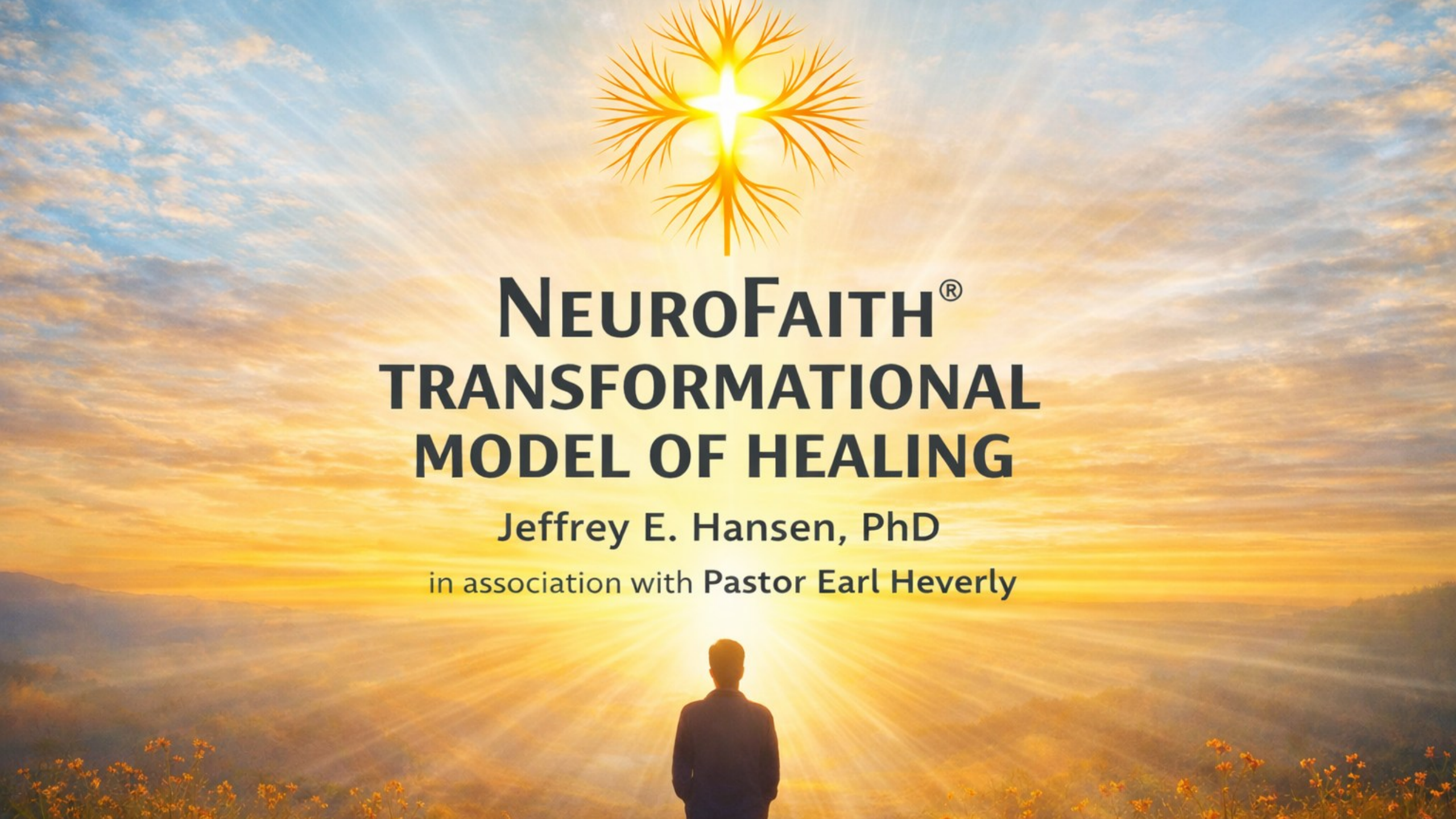
Look Beyond Quick Fixes

- Avoid knee-jerk, quick-fix solutions—explore the root causes.
- Depression is often linked to deep wounds of identity and self-worth.
- Shame, frequently rooted in trauma or adversity, must be addressed.
- Adolescents need a safe space to process their experiences and emotions.
- Healing comes through restoring authentic identity, connection, and resilience.

Remember Johann Hari's Connected Living Model
You must reconnect on each dimension

- Reconnect to Meaningful Work
- Reconnect to Other People
- Reconnect to Meaningful Values
- Reconnect to Childhood Trauma
- Reconnect to Status and Respect
- Reconnect to the Natural World
- Reconnect to a Secure Future
- Reconnect to a Sense of Hope
- Reconnect to Spirituality (emphasis mine)

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.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TRANSFORMATIONAL
MODEL OF HEALING
Jeffrey E. Hansen, PhD
in association with Pastor Earl Heverly

POLYVAGAL-INFORMED THERAPY

Healing through the language of the nervous system

HEARTMATH® AND NEUROCARDIOLOGY

Reconnecting with the heart as an intelligent center

INTERNAL FAMILY SYSTEMS (IFS)

Mapping the inner landscape of parts and burdens

FAITH AND SPIRITUALITY

Pillar I

Polyvagal Theory

Made simple

Autonomic Nervous System

Sympathetic

Activated, anxiety, fear, terror, anger

Parasympathetic

Ventral Vagal

Connected, calm, safety

Dorsal Vagal

Shut-down, depressed

Hypothalamic Pituitary Adrenal Activation

FIGHT OR FLIGHT

- Anxious & Angry
- Heart Racing
- Rapid Breathing
- High Cortisol & Adrenaline

Ventral Vagus "Calm & Connect"

SAFE & ENGAGED

- Calm & Present
- Steady Heartbeat
- Slow Breathing
- Balanced Nervous System

Dorsal Vagal Shutdown

SHUT DOWN

- Sad & Numb
- Low Heart Rate
- Fatigue & Withdrawal
- Feeling Frozen

The chart below adapted by Dr. Rothschild nicely demonstrates the shifting in body sensations, physiological symptoms, and emotions as we move between autonomic states (Rothschild, 2017).

AUTONOMIC NERVOUS SYSTEM: PRECISION REGULATION
** WHAT TO LOOK FOR **

"Normal" Life

Threat to Life

		LETHARGIC Parasympathetic I (PNS I)	CALM Parasympathetic II (PNS II) *Ventral Vagus*	ACTIVE/ALERT Sympathetic I (SNS I)	FLIGHT/FIGHT Sympathetic II (SNS II)	HYPER FREEZE Sympathetic III (SNS III)	HYPO FREEZE Parasympathetic III (PNS III) *Dorsal Vagus* Collapse
PRIMARY STATE		Apathy, Depression	Safe, Clear Thinking, Social Engagement	Alert, Ready to Act	React to Danger	Await Opportunity to Escape	Prepare for Death
AROUSAL		Too Low	Low	Moderate	High	Extreme Overload	Excessive Overwhelm Induces Hypoarousal
MUSCLES		Slack	Relaxed/toned	Toned	Tense	Rigid (deer in the headlights)	Flaccid
RESPIRATION		Shallow	Easy, often into belly	Increasing rate	Fast, often in upper chest	Hyperventilation	Hypo-ventilation
HEART RATE		Slow	Resting	Quicker or more forceful	Quick and/or forceful	Tachycardia (very fast)	Bradycardia (*very* slow)
BLOOD PRESSURE		Likely low	Normal	On the rise	Elevated	Significantly high	Significantly low
PUPILS, EYES, EYE LIDS		Pupils smaller, lids may be heavy	Pupils smaller, eyes moist, eye lids relaxed	Pupils widening, eyes less moist, eye lids toned	Pupils very dilated, eyes dry, eye lids tensed/raised	Pupils very small or dilated, eyes very dry, lids very tense	Lids drooping, eyes closed or open and fixed
SKIN TONE		Variable	Rosy hue, despite skin color (blood flows to skin)	Less rosy hue, despite skin color (blood flows to skin)	Pale hue, despite skin color (blood flow to muscles)	May be pale and/or flushed	Noticeably pale
HUMIDITY	Skin	Dry	Dry	Increased sweat	Increased sweat, may be cold	Cold sweat	Cold sweat
	Mouth	Variable	Moist	Less moist	Dry	Dry	Dry
HANDS & FEET (TEMPERATURE)		May be warm or cool	Warm	Cool	Cold	Extremes of cold & hot	Cold
DIGESTION		Variable	Increase	Decrease	Stops	Evacuate bowel & bladder	Stopped
EMOTIONS (LIKELY)		Grief, sadness, shame, disgust	Calm, pleasure, love, sexual arousal, "good" grief	Anger, shame, disgust, anxiety, excitement, sexual climax	Rage, fear	Terror, may be dissociation	May be too dissociated to feel anything
CONTACT WITH SELF & OTHERS		Withdrawn	Probable	Possible	Limited	Not likely	Impossible
FRONTAL CORTEX		May or may not be accessible	Should be accessible	Should be accessible	May or may not be accessible	Likely inaccessible	Inaccessible
INTEGRATION		Not likely	Likely	Likely	Not likely	Impossible	Impossible
RECOMMENDED INTERVENTION		Activate, Gently Increase Energy	Continue Therapy Direction	Continue Therapy Direction	Put on Brakes	*Slam on Brakes*	*Medical Emergency CALL PARAMEDICS*

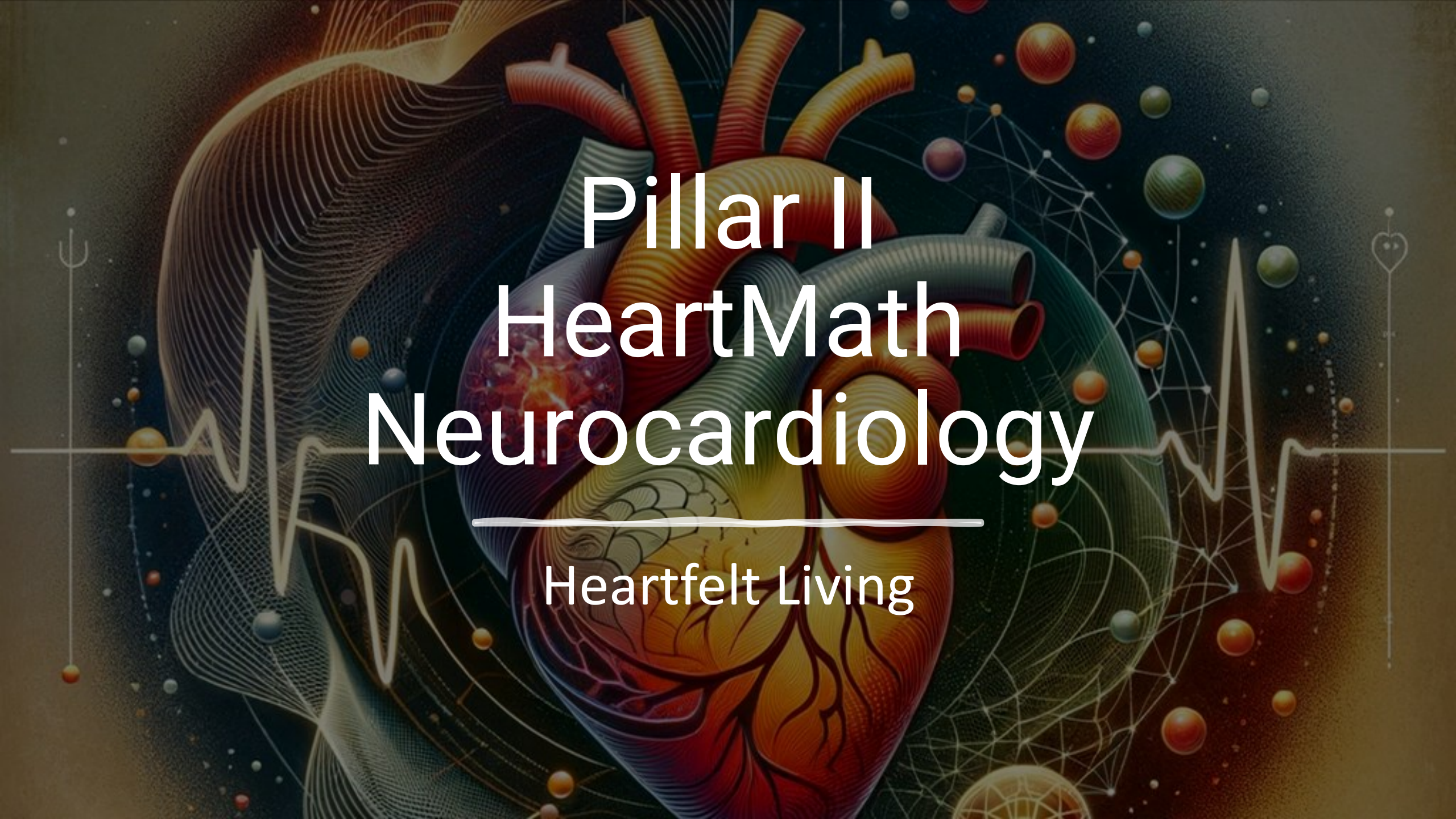
The Autonomic Nervous System Precision Regulation Chart is Available for purchase on Amazon for $8.99 (a very high recommend):
Babette Rothschild (2017) https://www.amazon.com/Autonomic-Nervous-System-Table-Laminated/dp/039371280X/ref=sr_1_15?dchild=1&keywords=deb+dana&qid=1590326813&s=books&sr=1-15

Polyvagal Theory and Treatment

As noted by Deb Dana, it is in a ventral vagal state and a neuroception of safety that 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 and the last is top down (Dana, 2018):

The Four R's

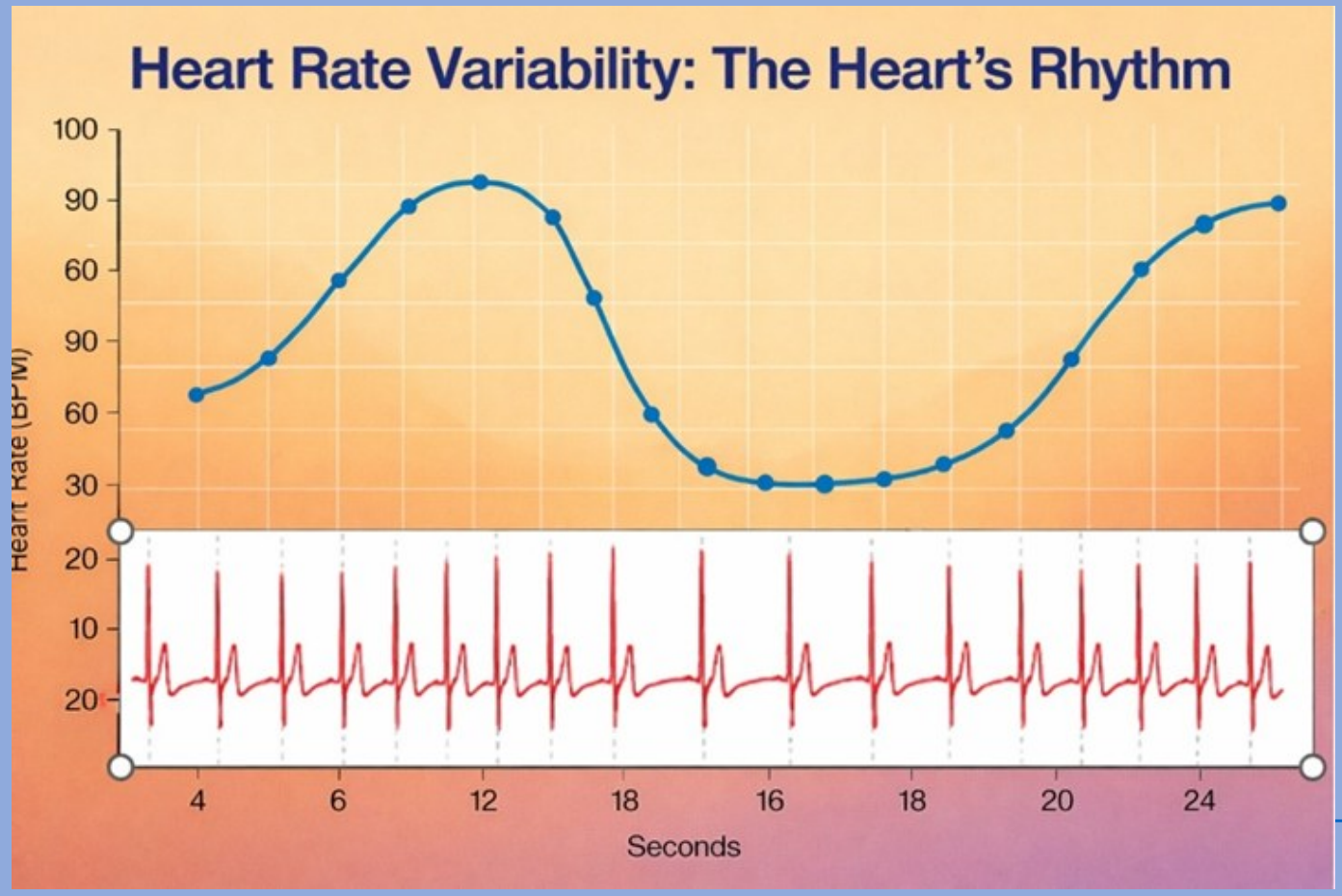
- Recognize the autonomic state
- Respect the adaptive survival response
- Regulate or co-regulate in a ventral vagal state
- Re-story


Pillar II
HeartMath
Neurocardiology
Heartfelt Living

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).

Heart Rate Variability and Your Health



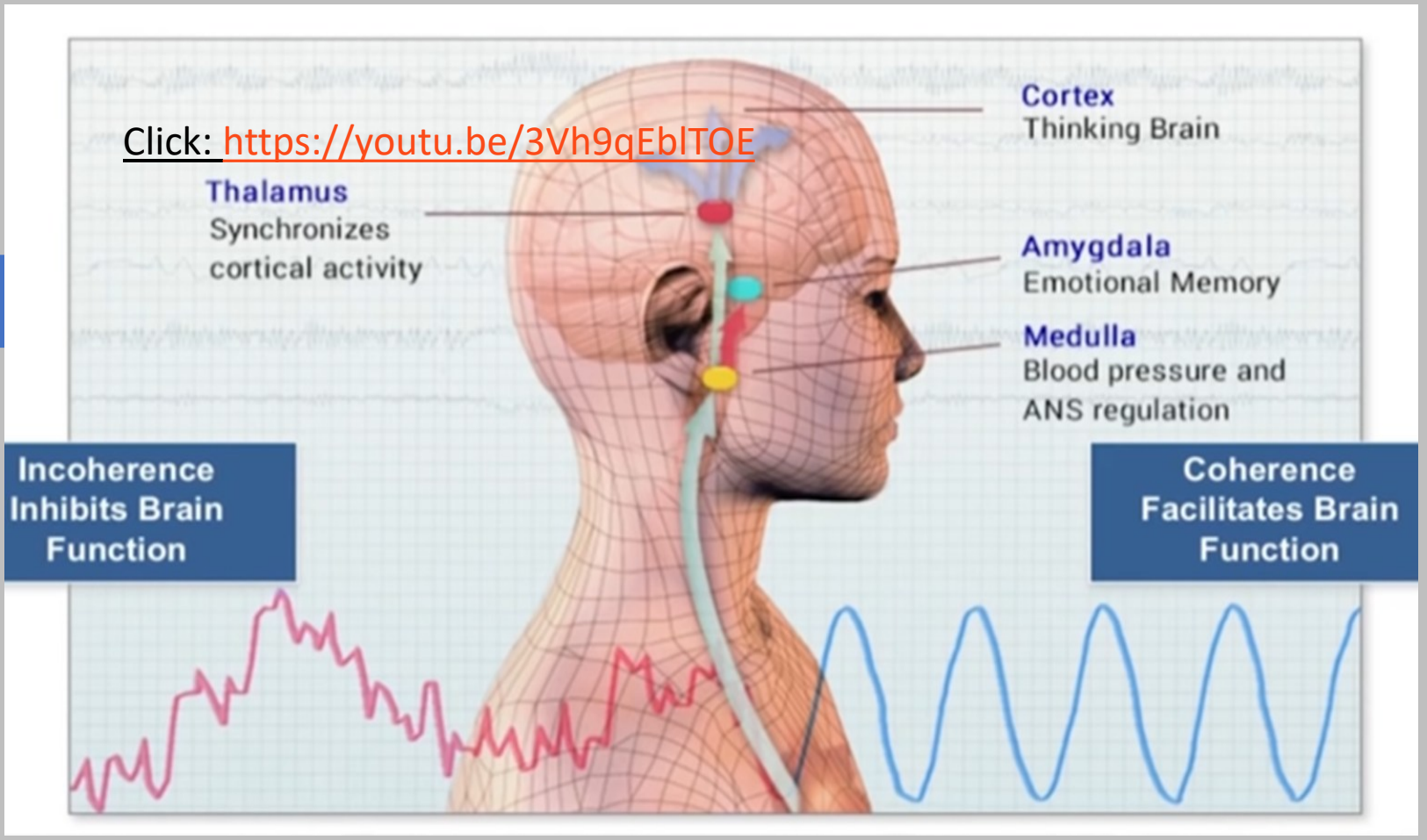
These graphs show examples of real-time heart rate variability patterns (heart rhythms) recorded from individuals experiencing different emotions

The bottom red part of the graph is simply the EEG reading of each pulse. Note that the intervals between the beats change with time.

The upper blue graph reflects the collection of these intervals across time. This is the beginning of a sign wave that is read from people in a coherent heart state reflecting positive emotions

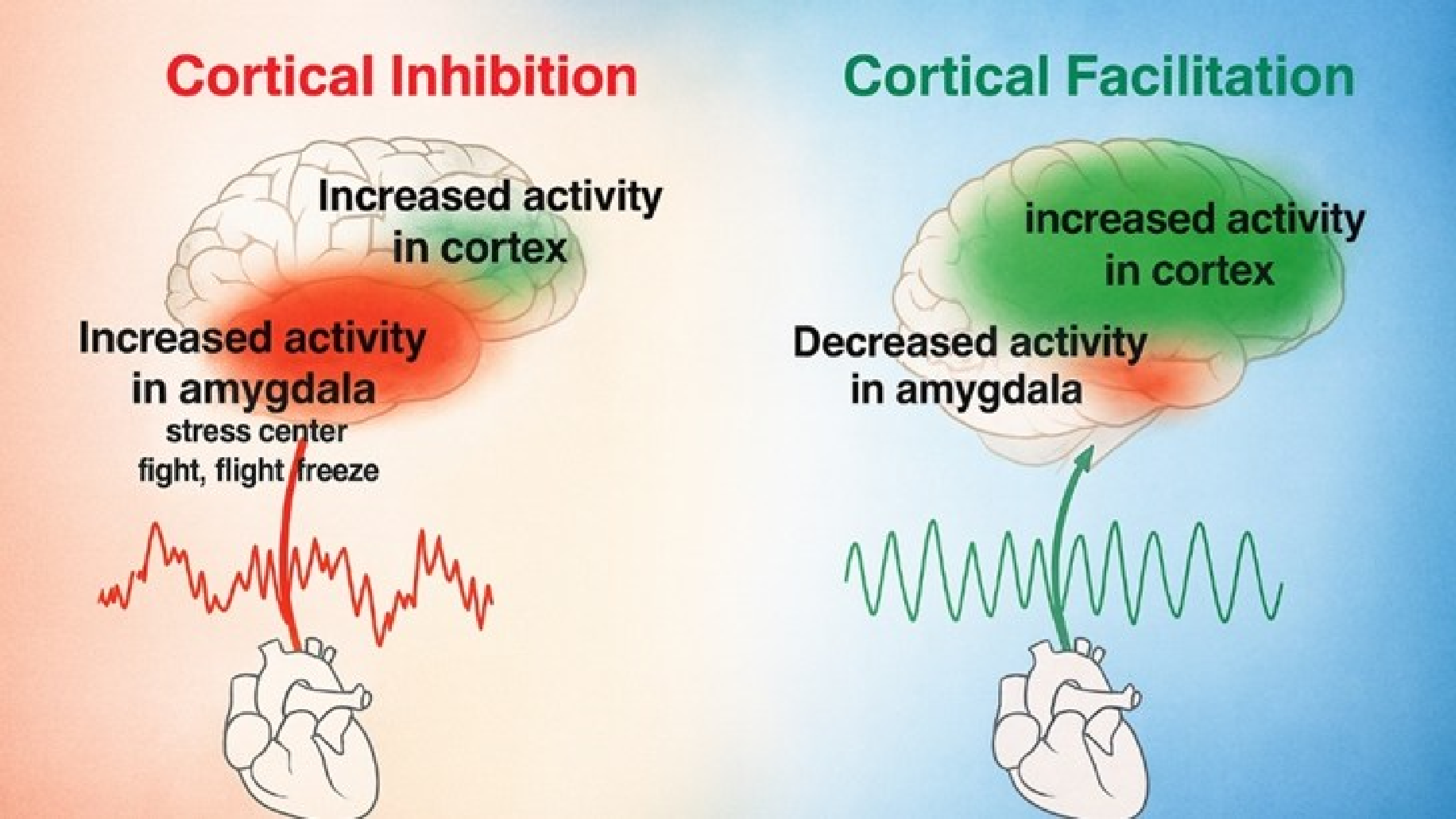
https://youtu.be/3Vh9qEblTOE

Heart-to-Brain



➨Dr. McCraty notes that the heart communicates to the brain in four main ways: (1) nerves connecting the heart to the brain, particularly the vagus nerve, (2) hormones, (3) blood pressure shifts, and (4) electromatic waves.

➨When the heart is coherent, it sends messages to the brain that, likewise, promote brain coherence which allow the brain to be more integrated and efficient and, to the contrary, an incoherent heart inhibits cortical function.


Cortical Inhibition
Increased activity
in cortex
Increased activity
in amygdala
stress center
fight, flight freeze
Cortical Facilitation
increased activity
in cortex
Decreased activity
in amygdala

Pillar III

Internal Family Systems (IFS) Therapy

Wholeness is not achieved by cutting off a portion of one's being, but by integration of the contraries.

- C. G. Jung

Treating a System, Not a Symptom

Managers

- Stabilize/Improve
- Future-oriented
- Proactive
- Over-identified

Firefighters
Distracters

- Avoid/Soothe
- Present-oriented
- Reactive
- Reject/Concealed

SELF

Exiles

- Absorb Energy
- Past-oriented
- Overwhelming
- Repress/Ignore

Cese Sykes notes that in IFS, we treat a system, not a symptom.

IFS Self

- The self is the “moderator” that the parts are talking to, that likes or dislikes, listens to, or shuts out various parts
- When differentiated, the Self is competent, secure, self-assured, relaxed, and able to listen and respond to feedback.
- The Self can and should lead the internal system.
- Various levels of experience of the Self:
  - When completely differentiated from all parts (Self alone), people describe a feeling of being "centered."
  - When the individual is "in Self" or when the Self is in the lead while interacting with others (day-to-day experience), the Self is experienced along with the non-extreme aspects of the parts.
- An empowering aspect of the model is that everyone has a Self.

8 C's of Internal Family Systems (IFS)

The qualities of the Self when it is present and leading:

Calm – A grounded, regulated inner state; not reactive or overwhelmed.

Curiosity – Open, interested, and non-judgmental toward inner experiences and parts.

Clarity – The ability to see situations, parts, and dynamics clearly and accurately.

Compassion – Genuine care and concern for oneself and one's parts, especially wounded ones.

Confidence – A quiet inner assurance in one's capacity to handle whatever arises.

Courage – Willingness to face pain, fear, or difficulty rather than avoid it.

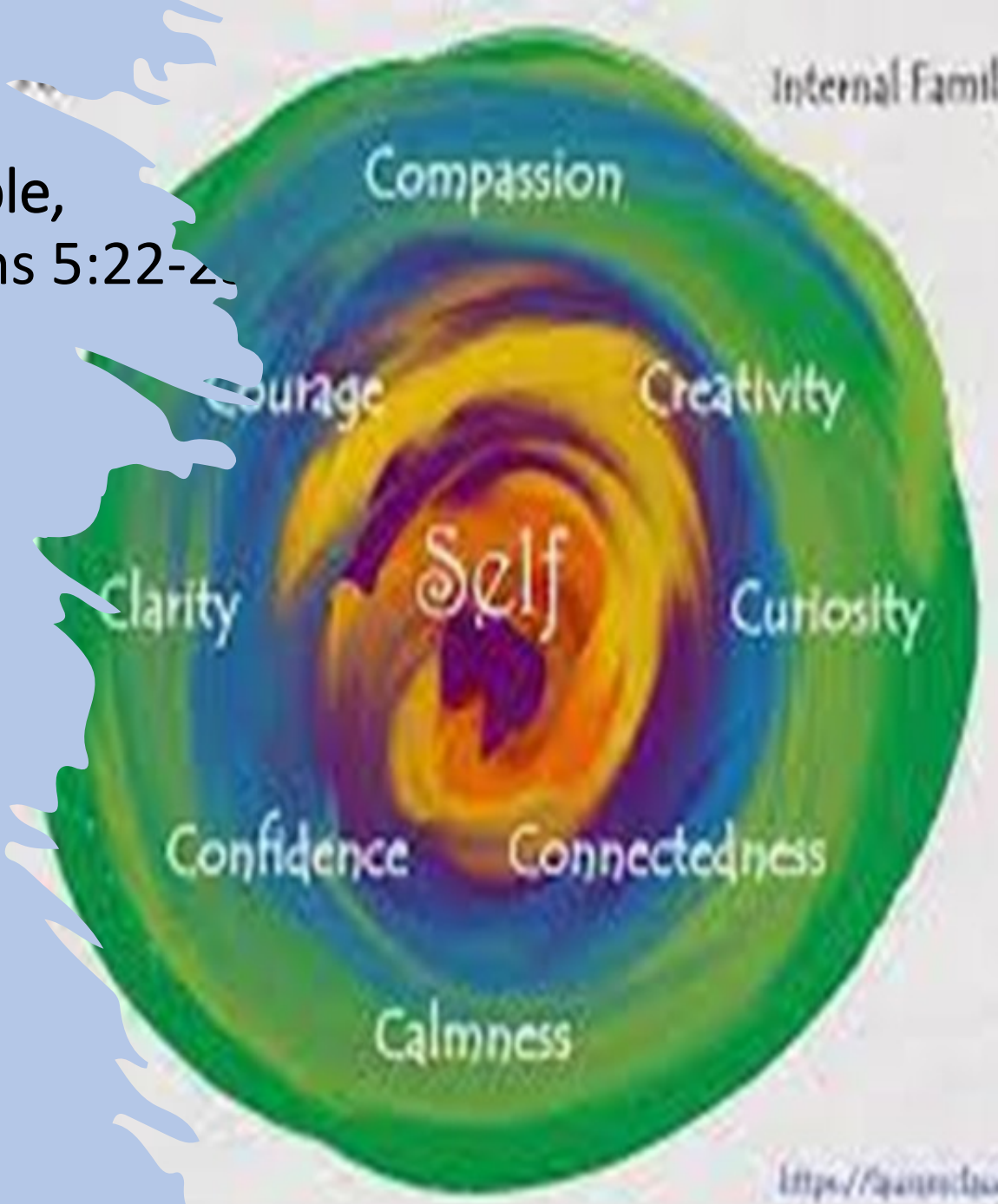
Creativity – Flexible, adaptive problem-solving and openness to new possibilities.

Connectedness – A felt sense of connection to oneself, others, and something larger than the self.

For some faith-oriented people,
IFS's 8 correspond nicely to Galatians 5:22-2

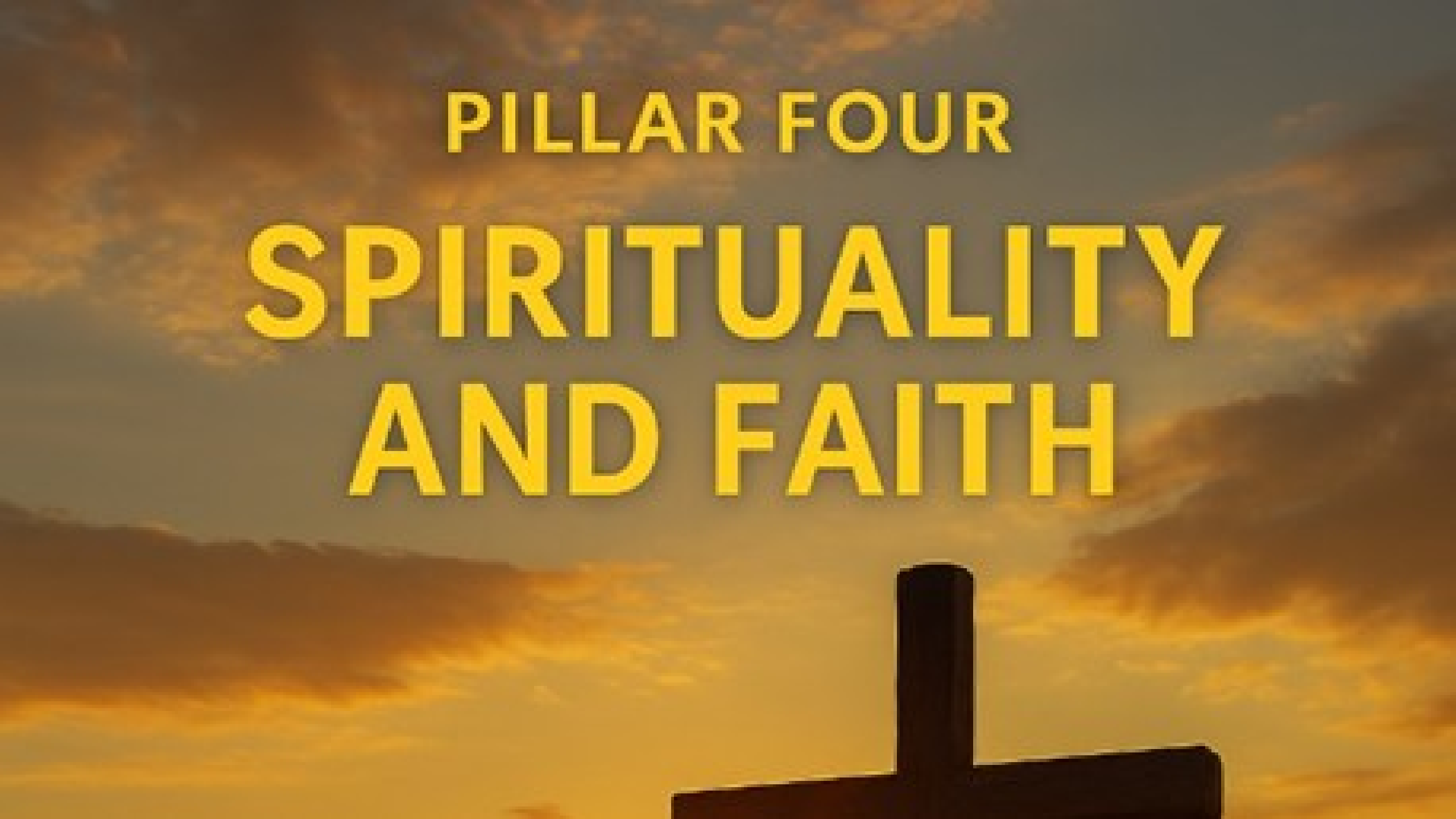
Fruits of the Spirit:

Love
Joy
Peace
Forbearance
Kindness
Goodness
Faithfulness
Gentleness
Self-control



PILLAR FOUR

SPIRITUALITY AND FAITH



Spirituality hugely enhances resilience and healing

Who is Lisa Miller, Ph.D.?

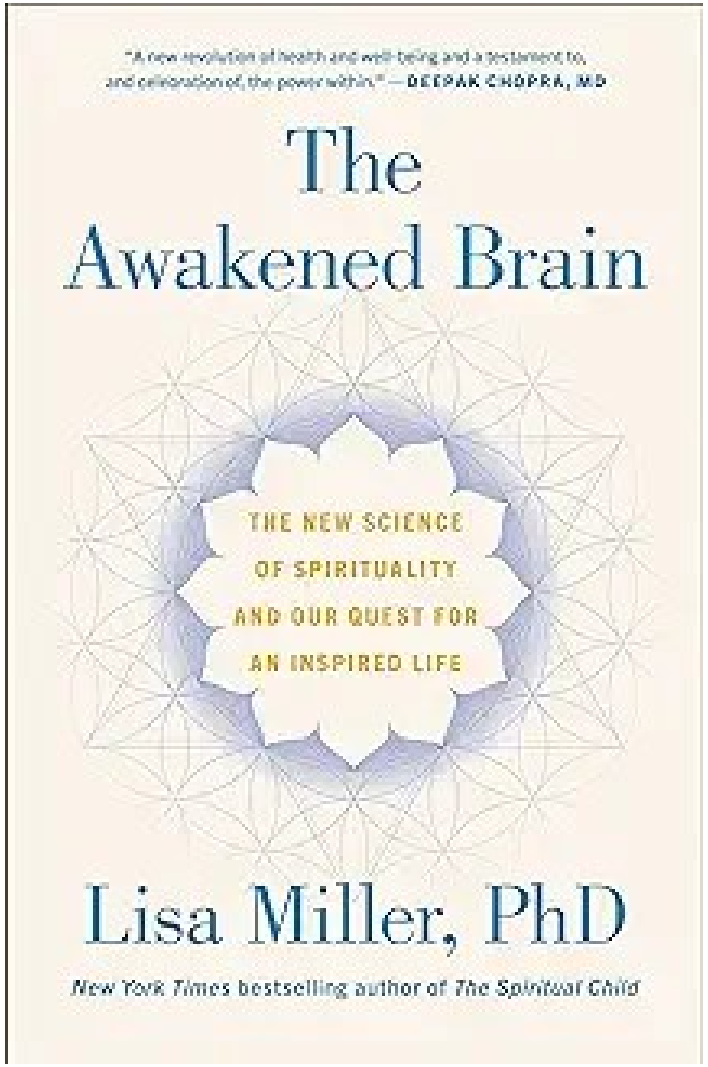
Lisa Jane Miller is an American professor, researcher and clinical psychologist, best known as a research scholar on spirituality in psychology.[Miller is a tenured Full Professor at Columbia University, Teachers College in the Clinical Psychology Program and Founder of the Spirituality Mind Body Institute. Miller's published science on spirituality in renewal from addiction, depression and struggle has been reported in articles focusing on her research in the *New York Times* and the *Wall Street Journal*, as well as in television interviews and podcasts.

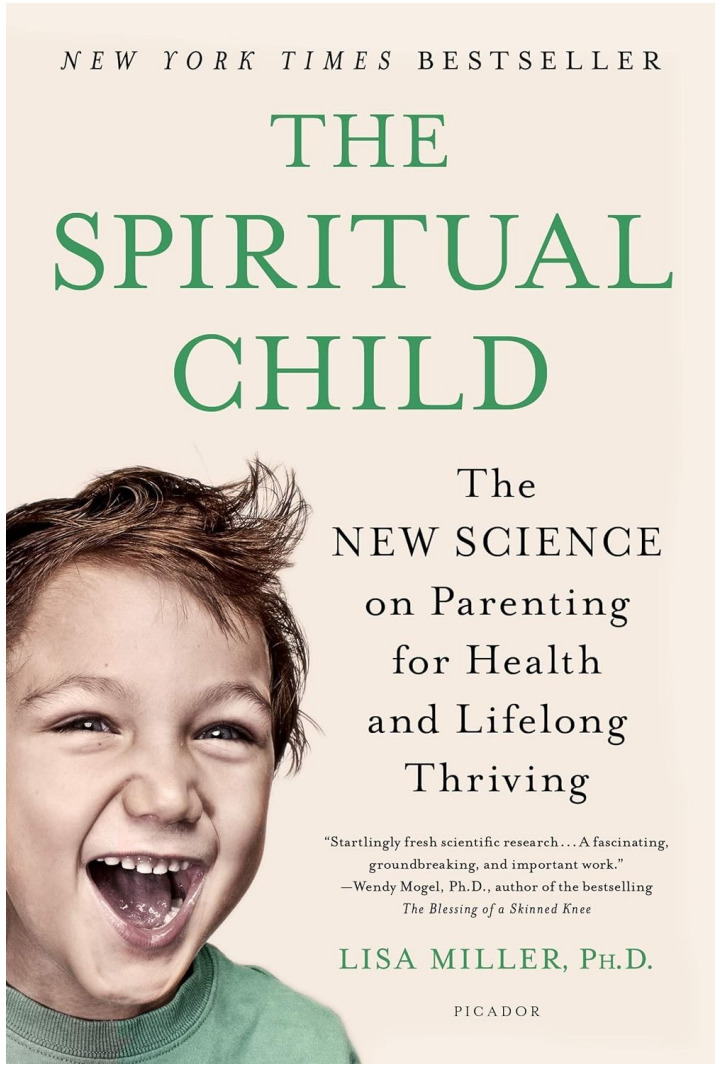
Early life and early career:

Miller obtained a bachelor's degree in Psychology from Yale University and a doctorate under Martin Seligman, founder of the positive psychology movement, at the University of Pennsylvania.

- Wikipedia

Dr. Miller's books on Spirituality and Health





Dr. Lisa Miller reports that research indicates incredible protective factors ensue with spirituality

There is an additive protective factor when both mother and child share spirituality according to Dr. Miller's research.

"when the mother and child were both high in spirituality, the child was 80 percent protected against depression"

80%

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THE IDENTITY QUESTIONS

Children Ask:

Do I Have **Value?** | Do I **Matter?** | Am I **Lovable?**

DEVELOPMENTAL TRAUMA FORMS

NEGATIVE CORE BELIEFS

- I DO NOT HAVE VALUE
- I DO NOT MATTER
- I AM NOT LOVABLE
- I MUST PERFORM TO MATTER

TRAUMA IS NOT JUST AN EVENT —

It is a belief about **WHO I AM.**

CORE BELIEF CHANGE

Re-narrating the self through

RELATIONSHIP + SAFETY + REPEATED EVIDENCE

GOOD THERAPY MUST BE
TRANSFORMATIONAL

RESOLVE
Trauma

IDENTIFY
Core Beliefs

PROVIDE
Corrective Experience

CREATE
New **Embodied** Evidence

RE-NARRATE
The Story of Self

Healing happens when the nervous system experiences **SAFETY** where it once experienced threat.

GOOD THERAPY IS NOT COPING —

THE ULTIMATE
CORRECTIVE EXPERIENCE

Psychology Re-Narrates Evidence

Faith Anchors Identity in Truth

- You are **BELOVED**
- You are **ADOPTED**
- You are **CHOSEN**
- You are **KNOWN**
- You are **VALUED**

Apart from Performance

TRANSFORMATION OCCURS WHEN

Lived Experience + Spiritual Truth ALIGN

John 3:16 • Romans 8:15 • Ephesians 1

How Christianity Heals Shame

1.Identity Rooted in Christ

- Believers are 'fearfully and wonderfully made' (Psalm 139:14).
- A new identity as a 'new creation' (2 Corinthians 5:17) counters shame.

2. Wonder in God's Creation

- Belief in God's intentional design instills awe and gratitude.
- Reframes self-perception and replaces negative thoughts.

3. Forgiveness Through Grace

- Assurance of forgiveness removes guilt and shame (Psalm 103:12).
- Promotes emotional freedom and well-being.

4. Healing Power of Confession and Repentance

- Confession fosters emotional release and renewal (1 John 1:9).

5. Purpose Beyond Pain

- God uses brokenness for growth and healing (Romans 8:28).
- Finding meaning in suffering reduces shame and fosters hope.

In Conclusion

RESILIENCE

Resilience grows:

when adolescents experience
secure attachment, emotional regulation, and meaning.

It is strengthened through:

- connection to people, purpose, nature, work, and faith

True healing integrates brain and heart

addressing trauma at its roots rather than managing symptoms.

We go where we look.
Help them see past the danger and
around the turn toward resilience.