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Mind *And* Brain: Separate but Integrated

I. Introduction: Charlotte and I perceive that part of what the Lord has given us to do is to remove stumbling blocks that cause division between different parts of the healing team that should be working together. Our hope is that the "mind and brain" paradigm presented here will remove some of these stumbling blocks by providing a foundation from which those studying the biological brain and those studying the mind/spirit can work together, as complementary players on the same team.

An increasing number of those working with mental health concerns are adopting a paradigm that is based on the belief that the biological brain is the foundation of all human experience, and that phenomena we think of as *mind* or *spirit* phenomena, such as thoughts, emotions, and choices, are ultimately just products of biological brain processes. Many of those who work from this "brain biology only" perspective are increasingly disrespecting, devaluing, or ignoring any understanding or technique that approaches mental health concerns from a mind/spirit perspective. These people seem to believe: "Now that we understand the brain biology of depression (or any other mental health concern), the mind/spirit perspective thoughts and insights about depression are obsolete. Now that we know it's just a brain chemistry imbalance, we can throw out all that psychology, psychotherapy, and spiritual stuff." For example, in their book about how dysfunctional biological brain systems can contribute to violent behavior, Dr. Vernon Mark and Dr. Frank Ervin, a neurosurgeon and a professor of psychiatry at Harvard Medical School, state:

> "The more brain scientists have discovered about the brain, the clearer it has become that brain responses and the parallel behavior are not separate events – that is, there is no aspect of human behavior that is supernatural [there is nothing that contributes to human behavior that is above/ outside of the physical, biological brain]. Once we are aware that thinking is a *physical process* [that is, our *thoughts* are completely produced and determined by the physical, biological brain], Aristotle's 'soul' and Descartes' 'mind' are no longer useful concepts."[1]

On the other end of the spectrum, some people working with emotional health concerns seem to think that mind/spirit phenomena are the only important phenomena. These "mind/spirit only" individuals tend to disrespect, devalue, or ignore any understanding or technique that approaches emotional health concerns from a brain biology perspective. For example, I was recently at a conference where one of the prayer ministers told a story about working with a person who had been diagnosed with a major mental illness. He described how he prayed with the person to address emotional and spiritual issues, with dramatic benefit. He also described how he advised the person that she no longer needed the diagnosis or treatment provided by the mental health professionals with whom she had been working, and even described his later interactions with the person's psychologist. The behavior and comments he described, and his demeanor as he told the story, were condescending and disrespectful, clearly devaluing any insight or treatment from

[1] Mark, Vernon H., & Ervin, Frank R. *Violence & the Brain*. (New York, NY: Harper & Row) 1970, page 139. Italics and bracketed comments mine.

the biological brain perspective.[2]

Most people involved in emotional healing aren't at either of these extremes, but our experience is that almost everybody is confused regarding the appropriate relationship between biological brain phenomena and mind/spirit phenomena.

We propose the following theses as a foundation for understanding emotional healing ministry, mental illnesses, mental health care, and especially how these all fit together:

- the *biological, physical brain* and the *non-biological, non-physical mind* are separate, *qualitatively*[3] *different* phenomena,
- the non-biological, non-physical mind is the more primary phenomena, and the leader/master in the mind-brain relationship,
- the biological brain and the non-biological mind are connected and woven together in ways that are profoundly intimate and complex,
- mental health problems always involve *both* biological brain phenomena *and* non-biological mind/spirit phenomena,
- we need to let exploration from *both* the biological brain perspective *and* the non-biological mind perspective shed light on the same phenomena, so that we can receive the important additional insights that this will provide.

II. The mind and brain are separate phenomena, with the mind being more primary: As just mentioned above, we perceive that it is very important to understand that the *biological, physical brain* and the *non-biological, non-physical mind* are *separate, qualitatively different* phenomena, and to recognize that the non-biological mind is the "leader," "master," and more primary phenomena.

A. Evidence supporting this hypothesis:

1. Brain mapping research: Epilepsy is often caused by an irritable focus in the brain – often a tumor or some kind of scar tissue. One way to treat epilepsy is to remove the irritating tumor or scar tissue. In order to do this, the neurosurgeons obviously have to *find* the irritating tissue that needs to be removed, and this was especially difficult in the early days before CT scans, MRI scans, and contrast dyes. One method that was developed for finding the location of the seizure source was to stimulate the brain with a small electrode, until the patient experienced symptoms similar to his seizures. For example, if the seizure always starts with the left thumb twitching, the surgeon would stimulate different areas of the cortex until the left thumb twitched. Sure enough, the offending tumor or scar tissue would be found

[2] My perception is that his interventions probably were powerfully effective, and probably did resolve the underlying emotional and spiritual issues that had been causing the clinical picture of mental illness, but I think his attitude towards the psychologist and the brain biology perspective was unnecessary and inappropriate, and his advice to discontinue treatment could have been seriously harmful to the person receiving ministry had she not been completely healed.

[3] The difference between 3 apples vs 7 apples, or the difference between 5 dollars and 10 dollars are *quantitative* differences. The difference between apples and screwdrivers, or the difference between apples and Handel's *Messiah* are *qualitative* differences.

very close to this spot.

When the neurosurgeon goes into the brain to remove the irritating tissue, it's good to know the best places to cut. This same technique was therefore used to identify especially important areas of the brain so that the surgeon could make sure to avoid them. For example, in a given surgery the neurosurgeon might have to choose between several different options with respect to how to approach the tumor or scar tissue that needs to be removed. If one option involves cutting through cortex that's shown to run your right index finger or cortex that's found to be your primary language center, and a second option goes through the brain tissue that provides touch sensation to a patch of skin in the middle of your back, you'd probably prefer to sacrifice the ability to experience an itch in a spot below your shoulder blades in preference to losing the motor control for your index finger or your ability to use language.

As this technique was used, neurosurgeons discovered that different anatomical areas of the brain have very predictable functions. For example, the motor functions of the body are always controlled by the cortex along a certain fold of the brain, touch is received by a certain fold right next to the motor cortex, the visual system is run by the optic cortex at the back of the brain, etc. This is how we got the "brain map" diagrams you see in every neurology and neurosurgery textbook.

Dr. Wilder Penfield is the neurosurgeon who developed and pioneered this technique of guiding brain surgery and mapping the brain. He started his career with the "biological brain only" perspective, believing that scientific research could and would ultimately explain all "mind" phenomena in terms of chemical and electrical activity in the biological brain. After a lifetime career as one of the world's leading brain surgeons and brain researchers *he concluded that he had been wrong*. He concluded that there are two separate phenomena, mind and brain, and that the mind is the more primary phenomena. An analogy Dr. Penfield often uses is that the mind is like the human computer programmer/operator, and the brain is just the computer that the programmer/operator uses to express and implement his intentions.

Dr. Penfield wrote an entire book, *The Mystery of the Mind*,[4] discussing the research evidence, personal experience, and thinking that lead him to this conclusion. The simplest, clearest point is that he spent his entire career mapping and studying the functions of various parts of the brain, and to his surprise, he never found the location of the *mind*. He found all of the different functions of the computer – the computer that the mind uses to implement its intentions – but he never found the brain location of the mind. He found that he could stimulate *any* area of the cortex *without producing forced/involuntary* ***mind*** *functions*, and he found that *any* area of the cortex could be injured or removed surgically *without losing the* ***mind*** *functions.*[5] Even if the pre-frontal cortex – the part of the brain associated with the

[4] Penfield, Wilder. *The Mystery of the Mind*, (Princeton University Press: Princeton, N.J.) 1975.

[5] One of the most dramatic examples of this are children who have had an entire hemisphere (half) of their brains removed as an extreme intervention to stop seizures that cannot be controlled in any other way. Children who have had this surgery suffer from marked neurological impairments, but still *feel* subjectively like "people," and clearly demonstrate "mind" functions. See Carson, Ben & Murphey, Cecil. *Gifted Hands* (Grand Rapids: Zondervan) 1990, pp 146-176 for discussion of the experience of children who have had this operation, and also the PBS documentary *The Secret Life of the Brain* (executive producer David Grubin, 2001, episode two) for video documentation of the experience of several children

highest level of abstract reasoning, complex thought, and cognitive management of emotions – is stimulated, the patient does not experience forced/involuntary *mind* functions, and even if the pre-frontal cortex is damaged or removed, the ***mind*** *– the subjective experiences of consciousness and self awareness, the ability to make free will choices, and the ability to initiate original, creative thought and activity* – still remains. The person is terribly impaired in his ability to function cognitively and emotionally, but *consciousness, self awareness, the ability to make free will choices, and the ability to initiate original, creative thought and activity* still remain.[6]

Furthermore, in his research and clinical experience with epilepsy, he found a location in the brainstem (the diencephalon) that seemed to be the connection point through which the *mind* accessed the *brain*. This area does not seem to have direct effects on any of the specific functions of the computer, such as walking, talking, seeing, hearing, etc, but it seems to be the switch, or access point for allowing the mind (the computer programmer) – to use the biological brain (the computer). The key observation was what the person could and/or could *not* do when a seizure (or some other injury) disabled this area. Dr. Penfield's summary is that the biological brain (the computer) could continue to carry out the last task the mind (the programmer) had instructed it to do – but that the biological brain/computer *no longer had consciousness, self-awareness, the ability to make free will choices, or the ability to initiate original, creative thought or activity*. And the subjective experience is that the "person" is gone.[7] For example, if I had begun to walk home from work when a seizure disabled the diencephalon, I could complete the trip, *making multiple turns at the correct places and even navigating crowded pedestrian traffic*.[8] Even though this is a fairly complex task, it can be carried in the biological brain as a complex, but *familiar and programmed routine*. However, if you stopped me and asked me to engage in original thought and/or make new choices ("Karl, I just got a call from your wife. She says that an emergency has come up and she is at Dan's office. She wants you to meet her there, and please bring the Johnson's medical chart"), I would stare at you blankly, and then resume my journey home as soon as you got out of my way. It would be as if you were trying to talk to the computer that I had programmed to "auto-pilot" my body from my work location to my home.

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after this surgical removal of a hemisphere.

[6] I have read case descriptions, but have never worked directly with patients who have had full, bilateral frontal lobotomies. It would seem that if the frontal cortex were completely removed on both sides, the mind might be present, but have no way to express itself. I would appreciate hearing from anyone who has worked with these patients – let me know whether or not you perceive *mind* functions operating in these patients. E-mail me at drkarl@kclehman.com.

[7] I have wondered about people in a vegetative state. I have worked with patients in this state. They do not demonstrate any *mind* functions (consciousness, self awareness, free will choice, original creative thought), and the *person* certainly seems to be gone. Is the mind absent, or is the mind present, but the "computer" is so severely damaged that the mind can't express itself in any tangible ways? PET scans and/or SPECT scans from these patients would be valuable – do they show damage and/or lack of function in the diencephalon? Or just especially widespread damage over the cortex, but a working diencephalon? I would appreciate an e-mail from anybody who has access to information regarding PET and/or SPECT scans for vegetative patients (drkarl@kclehman.com).

[8] See, for example, Dr. Penfield's description of "Patient B," *The Mystery of the Mind*, (Princeton University Press: Princeton, N.J.) 1975, p 39.

It is important to note that the diencephalon is *not* the most sophisticated, highest level of cortex, but rather a primitive area of the brain stem. The point here is that it does not make sense that the diencephalon is actually *producing* the highest mind functions (as opposed to just being the switch, or connection point, between the brain and the mind). Furthermore, Dr. Penfield studied many patients with a certain kind of seizure that first stimulates/activates the diencephalon before disabling it. Neither Dr. Penfield, nor anyone else working with patients who have this type of seizure, have observed evidence of "mind seizures" (forced/involuntary/externally activated *mind* phenomena).[9]

2. More recent brain research: Dr. Penfield's book was published in 1975, and a HUGE amount of brain research has been carried out since then – hundreds of millions of dollars of research even before the worldwide international efforts of the "Decade of the Brain." However, scientists still haven't found the brain location of the mind, and still don't have an explanation for how the biological brain produces the mind. In a 2002 Special Edition of *Scientific American*, Dr. D.J. Chalmers, professor of philosophy and director of the Center for Consciousness Studies at the University of Arizona, and an internationally recognized leader in the study of the mind, discusses the "mysterious" phenomena of consciousness, which he defines as "the subjective, inner life of the *mind"* (emphasis mine). He accurately identifies that simply describing the biological processes of the brain associated with consciousness does *not* explain how these biological processes *produce* mind phenomena, and he admits that neuroscience still does not have direct evidence supporting *any* of the proposed explanations for how the biological brain – neurons or neuronal circuits – might produce "the subjective essence of the mind and thoughts...."[10] In his most recent book (2003), Dr. Daniel Siegel, an internationally recognized neurobiological researcher, acknowledges: "Though scientists believe that the pattern of firing of the neuronal networks is what gives rise to the 'mind' – yielding processes such as attention, emotion, and memory – we don't know exactly how brain activity produces the subjective experience of mind."[11]

Note: Dr. Penfield's research and thoughts, our continued inability to find a focal brain area responsible for "mind" phenomena, and our continued profound inability to explain how the biological brain produces the "mind" do not *prove* that a *non-physical, non-biological* mind exists, is the more fundamental process, and uses the biological brain as its computer/servant. But these important pieces of information point in this direction, and are certainly *consistent with* this hypothesis.

3. Near death experiences (NDEs): Near death experiences provide powerful evidence for the existence of the non-biological, non-physical mind as a phenomena separate from the biological brain.

a. Valid data or new age deception?: There is lots of confusion and deception here, but I

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[9] See Penfield, Wilder. *The Mystery of the Mind*, (Princeton University Press: Princeton, N.J.) 1975, pages 28-30 and 37-43 for discussion of how a seizure at one location can activate brain activity at distant locations, and for discussion of how temporal and prefrontal cortex seizures stimulate the diencephalon.

[10] Chalmers, D.J. "The Puzzle of Conscious Experience." *Scientific American*, Vol. 12, Issue 1, August 2002 Special Edition, pp 90-100.

[11] Siegel, D.J., and Hartzell, M. *Parenting From the Inside Out*. New York: Jeremy P. Tarcher/ Putnam, a member of Penguin Putnam Inc., 2003. Pg 32.

think there is an important, real phenomena buried among the rubble. I think it is significant that many (most?) of the early researchers and writers about near death experiences are committed Christians. My perception is that the enemy worked hard to contaminate and confuse the study of near death experiences with demonic deception because they were being used so powerfully for Christian evangelism.

b. II Cor 5:8: Some perceive that II Cor 5:8, "to be absent from the body is to be with the Lord," presents a Biblical truth that precludes near death "out of body" experiences. My perception is that careful observation strongly indicates that near death "out of body" experiences are real, and so it is important to carefully consider the possibility that this interpretation of the passage is in error in some way. I am not a Biblical scholar, but when I examine II Cor 4:7-5:10 as the wider context, my perception is that the intention of II Cor 5:8 is not to make precise comments regarding whether or not there is a brief transition phase of mind-body separation after clinical death but before the person is with the Lord (the phenomena described in NDEs). My perception is that II Cor 5:8 is part of a bigger argument, and that it is referring to the general phenomena of going to be with the Lord after physical death as part of this larger discussion.

c. Personal acquaintances: One reason that I personally believe that near death experiences are real is that I know more than a dozen people who have had near death experiences, including my own grandfather and a personal friend whom I have known for 35+ years.

Grandfather Lehman: My own grandfather had a very profound near death experience the week before he died. He was 87 years old, he had had three heart attacks, and he suffered from severe congestive heart failure and longstanding diabetes. He needed surgery for some reason – I can't remember what, and when he came out of the recovery room after surgery he described a vivid near death experience. My guess is that he died on the operating table and was resuscitated, but that's not something the surgical team usually tells the family. Anyway, after the surgery he described this vivid near death experience, which included Jesus taking him on a guided tour of the new creation. Grandpa had always loved nature, and had always been grieved by pollution and disease in nature. He was sooo excited about the new creation. "You can't believe – you just can't *believe* how perfect everything is. You look out over this huge field, and you realize that *every* detail is perfect – every flower is perfect, every *blade of grass* is perfect. Not one blade of grass is broken, diseased, or out of place. There just aren't words to describe how perfect everything is." A striking observation is that, through this experience, Grandpa went from being afraid of death to complete peace about death. In fact, he was eagerly looking forward to being with Jesus in the new creation. During the last several days of his life he often commented spontaneously: "I can't wait to go back. It's so beautiful. It's so perfect – I can't wait to go back."

Russ Harris: Russ Harris, a man in our church whom I have known for more than 35 years, had a profound near death experience which he has described to me in detail. My father and other elders from our church were in his hospital room praying for him when he died (my father was standing at the foot of his bed and saw the heart monitor stop). They prayed, the heart monitor started back up, and when he regained consciousness he reported a very clear near death experience including an encounter with Jesus. Jesus: "You have to go back, your work isn't done yet," Russ: "You're the boss." Russ also reports that this near death experience has had a powerful, positive, transformative effect

on his life (see "Stories of Unusual Encounters with the Lord" on the "Other Resources" page of our website, www.kclehman.com, for a detailed account of this story).

d. Near death experiences described by other physicians: A number of physicians describe cases of patients who accurately reported, in detail, the comments of the medical personnel and the specific medical interventions the medical personnel had used during their resuscitations – medical procedures and comments that had occurred while they were clinically dead (unconscious, with no respiration or heart beat). Maurice Rawlings, a committed evangelical Christian and a cardiologist who has personally resuscitated many patients from clinical death, reports: "Some of my patients have demonstrated astounding powers of recall, accurately reconstructing the events that occurred during the resuscitation, exactly recalling which procedures we used, and describing what each person said in the room and what type and color of clothes each one wore." There are also numerous accounts where the resuscitated patients accurately reported events that had occurred in nearby rooms in the hospital during the time the patients were "dead," and the events they reported were corroborated by other medical staff and/or family members.[12] Especially intriguing data points are provided by case studies of blind patients who can accurately describe *visual* details of events that occurred during their near death experiences.[13]

Since the anecdotal accounts described by authors publishing in the 1970's and 1980's, many careful research studies have examined near death experiences. For example, in a 2001 article published in *Lancet*, one of the most prestigious medical journals in the world, doctors van Lommel, van Wees, Meyers, and Elfferich describe their *prospective*[14] study of 344 consecutive cardiac patients who were successfully resuscitated after cardiac arrests. The prospective study design allowed the investigators to interview the patients within days of being resuscitated, and also allowed for much more careful and accurate examination of all medical details during the cardiac arrests and resuscitations. 12% of the patients in this study acknowledged near death experiences, and in careful comparison with

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[12] Rawlings, Maurice. *Beyond Deaths Door*. (New York, N.Y.: Thomas Nelson Publishers) 1978, p 21-22, 69-75, Moody, Raymond. *Life After Life*, (Covington, GA: Mockingbird Books) 1975, p 98-107, Moody, Raymond. *The Light Beyond*, (New York, N.Y.: Bantam Books) 1988, p 18-20, Moody, Raymond. *Reflections on Life After Life*, (Covington, GA: Mockingbird Books) 1977, p 91-93, Wilkerson, Ralph. *Beyond and Back*, (New York, N.Y.: Bantam Books) 1977, p 7&8, Ritchie, George G. with Sherrill, Elizabeth. *Return from Tomorrow*. (Carmel, NY: Guideposts) 1978, pages 39 & 40, 98 & 99, and Sabom, M.B. *Recollections of Death: A Medical Investigation.* (New York, NY: Simon & Schuster), 1982, pages 81-115.

[13] Note that some of these patients have rigorous medical documentation that they were *blind from birth*. Some of these "blind from birth" patients specifically and explicitly describe "seeing" during their near death experiences, and describe it as fascinating, strange, and new. Some report that the subjective experience of "seeing" was so strange/foreign that it was initially disorienting, confusing, and even frightening. See Ring, K., Cooper, S. *Mindsight: near-death and out-of-body experiences in the blind*. (Palo Alto, CA: William James Center for Consciousness Studies), 1999, for a thorough description and discussion of near death experiences in the blind.

[14] *Retrospective* research involves investigating events that happened prior to the time the actual study is performed. For example, conducting personal interviews and examining the medical records of people who report having had a near death experience at some time in the past. Most of the early studies of near death experiences were retrospective, often investigating events that had occurred 5-10 years prior to the time of the actual study. *Prospective* research involves setting up the research project so that phenomena can be studied *prospectively*, as they occur, during the time of the actual study.

the patients who did not report near death experiences, Doctor van Lommel and colleagues could not find any physical science/medical explanation for the "near death experience" phenomena. This 2001 *Lancet* article also includes an account of one specific case in which a coronary care unit nurse verified the accuracy of the patient's detailed descriptions of events that had occurred while he was receiving CPR and in deep coma.[15] The "Atlanta Study," carried out between 1994 and 1996 by Dr. Michael Sabom, a practicing physician who is board certified in both internal medicine and cardiology, provides another example of recent, careful research regarding near death experiences. One of the patients in this study described detailed memories of the events that had occurred in the operating room while she was clinically dead (no heart beat and no respiration). Furthermore, since this occurred during a particular, unusual brain surgery procedure, there is rigorous medical documentation specifically verifying that there was no blood in her head during this time, and the EEGs from her cortex and her brainstem were both completely flat-line. Dr. Sabom also carefully documented the accuracy of her detailed descriptions, which were corroborated by both the surgical records and by testimonies from the operating room personnel.[16] In a 2002 article published in *Resuscitation*, another mainstream medical journal, Sam Parnia and Peter Fenwick state:

> "Recent studies in cardiac arrest survivors have indicated that....approximately 10% develop memories that are consistent with typical near death experiences. These include an ability to 'see' and recall specific detailed descriptions of the resuscitation, as verified by resuscitation staff. Many studies in humans and animals have indicated that brain function ceases during cardiac arrest, thus raising the question of how such lucid, well-structured thought processes with reasoning and memory formation can occur at such a time. This has led to much interest as regards the potential implications for the study of consciousness and its relationship with the brain, which still remains an enigma."[17]

In summary, carefully documented near death experiences indicate that the mind is present, reasoning, and laying down clear, detailed, long term memories *while the patient is clinically dead and the biological brain is off line*. A second, equally significant point is that the information the person remembers is sometimes obtained from an *observational perspective impossible to the biological brain*. These data points are baffling if we hold the biological brain to be the *only* reality, but simple to explain if we believe that the non-biological, non-physical mind is a separate, qualitatively different phenomena that can exist apart from the

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[15] van Lommel, P., van Wees, R., Meyers, V., Elfferich, I. "Near-death experience in survivors of cardiac arrest: A prospective study in the Netherlands." *Lancet*, 2001, Vol. 358, pages 2039-2045.

[16] See Sabom, M.B. *Light and death: one doctor's fascinating account of near death experiences.* (Michigan: Zondervan Publishing House) 1998, for description and discussion of the Atlanta Study. See pages 37-51 for description and discussion of the specific case of the woman describing a near death experience during brain surgery.

[17] Parnia S, Fenwick P, "Near death experiences in cardiac arrest: visions of a dying brain or visions of a new science of consciousness." *Resuscitation*, 2002-1-22, 52(1) 5-11. For additional recent medical research on near death experiences, see also Parnia S, Waller DG, Yeates R, Fenwick P, "A qualitative and quantitative study of the incidence, features and aetiology of near death experiences in cardiac arrest survivors." *Resuscitation*, 2001-6-28, 48(2):149-56, and Greyson B, "Incidence and correlates of near-death experiences in a cardiac care unit." *Gen Hosp Psychiatry*, 2003-7-10 25(4):269-76. These articles also include references for many studies examining specific aspects of near death experiences, such as circulation, metabolism, and cortical function in the brain during cardiac arrest.

biological brain (at least for short periods of time in special circumstances, such as near death experiences).

4. "Impossible" intra-uterine and birth memories: We have seen prayer for emotional healing sessions that appear to go to memories in the womb that are very early – when brain development is still very primitive, or even before the brain has begun to form at all – and we often see prayer for emotional healing sessions that appear to go to the person's birth. Other authors have also described case studies that include memories for events that occurred while the person was still in the womb, and/or memories for events during the person's birth. Some of these cases include memory content that is consistent with implicit memory systems now known to be neurologically "on line" by mid pregnancy – sensory fragments appropriate to the intrauterine environment, simple emotional associations, and primitive, vague thoughts.[18] However, some of the cases in our experience and some of the cases described in the literature include clear and detailed memory content that a person should not be able to remember with the immature brain biology in place during pregnancy or at the time of birth. For example, one of my patients seems to remember events from the time of her conception (before the brain has even begun to form), another of my patients seems to have intrauterine memories of the details of an argument her parents had about whether or not to abort her, and Dr. Thomas Verny describes an interesting case in which a young child appears to remember the specific words spoken by those present at his birth, including the "adult" vocabulary used by the stressed-out doctor, *and the Latin spoken by the priest who was present.* Neurologically, the memory content and detail that some of these people describe should not be possible. However:

- The material can sometimes be verified by the patient's parents (who are often astonished). For example, when my patient asked her parents about their argument regarding whether or not to abort her, they were astonished (and mortified). Nobody had been present, and they each knew they had never told anybody. But they verified that her memory was correct.[19] In the case of Dr. Verny's patient, it was actually the child's mother who realized that the words he was speaking were the specific words spoken by those present at his birth.[20]
- There is clear, profound, and lasting fruit. Following the sessions in which people appear to receive healing for traumatic intrauterine and/or birth memories, these people experience changes in their lives that seem clearly connected to the material addressed in the sessions. This was the case for the patient mentioned above who appeared to remember events from the time of her conception. The "Freedom from Bulimia" case study provides another good example, describing sudden, dramatic, and lasting clinical improvement following what

[18] See Verny, Thomas, with Kelly, John. *The Secret Life of the Unborn Child*. (New York, NY: Dell Publishing) 1981, for an excellent discussion of many case studies and research studies demonstrating implicit memory learning during pregnancy, birth, and early infancy.

[19] During the last 20 years, a number of my patients have described this kind of experience, but now I can't remember who they were. If you are one of these people, please contact me at drkarl@kclehman.com.

[20] Verny, Thomas, with Kelly, John. *The Secret Life of the Unborn Child*. (New York, NY: Dell Publishing) 1981, pages 103-104.

appeared to be healing for an intra-uterine traumatic experience.[21]

These data points are baffling if we hold the biological brain to be the only reality, but simple to explain if we believe that the non-biological, non-physical mind is a separate, qualitatively different phenomena that can store memory of experience before the biological brain is able to function (or even before the biological brain exists).

5. Prodigies. The dramatic and amazing abilities of prodigies have been extensively documented. Several examples illustrate the challenges presented by prodigy phenomena to current brain biology explanations of the mind:

a. "Blind Tom," a musical prodigy: "Blind Tom," born as a slave in 1849, displayed astonishing musical abilities in spite of being nearly blind, mentally retarded with respect to most cognitive functions, and without musical training other than listening to others perform. For example, at 11 years of age he performed 33 pages of complicated original[22] music, without error or apparent effort, after hearing it played once. He could also sing the words of any song after a single hearing, even if the lyrics were in foreign languages that he did not understand. Another particularly striking talent was the ability to perform three pieces of music simultaneously – playing one song with his right hand, playing a second song with his left hand, and singing a third song all at the same time.[23]

b. The twins, numerical and memory prodigies: The neurologist Oliver Sacks describes twin brothers, who have baseline IQs of 63 but also extraordinary numerical and memory abilities. John and Michael can describe the general public events they would have heard about, the weather, and the tiniest visual details of their own personal experience for any day of their lives. They also appear to possess an unlimited digit span.[24] "And if you ask them how they can hold so much in their minds – a three-hundred-digit figure, or the trillion events of four decades – they say, very simply, 'We see it.' And 'seeing' – 'visualizing' – of extraordinary intensity, limitless range, and perfect fidelity, seems to be the key to this." Even more unusual, in some ways, is their ability to generate ENORMOUS prime numbers, in a matter of minutes, by some inexplicable means. Dr. Sacks verified the accuracy of the six, eight, and ten digit primes they came up with (the largest primes available to the scientific and engineering community in the 1960's when he worked with the twins), and then they continued upwards to what appeared to be twenty digit primes – numbers *10 billion times larger* than the largest primes in the professional table he was

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[21] "Freedom from Bulimia: Case Study/Testimony," "Case Studies & Testimonies" page of www.kclehman.com.

[22] A team of professional musicians, skeptical that his public demonstrations were somehow contrived, wrote two pieces of original music – 13 and 20 pages in length – for the explicit purpose of "testing" Tom's purported ability to perform a composition after simply hearing it performed once.

[23] See Treffert, Darold A. *Extraordinary People: An Exploration of the Savant Syndrome.* (New York: Harper and Row), 1989, and Seguin, Edouard. *Idiocy and Its Treatment by the Physiological Method.* 1866. Reprint, (New York: Kelly) 1971, pages 37-41, as cited in Sacks, Oliver. *An Anthropologist on Mars*. (New York: Vintage Books) 1995, pg 189.

[24] "Digit span," a term used in memory testing, refers to the number of digits one can hear, remember, and then repeat. Most people can only remember and repeat 7-9 digits. Dr. Sacks tested the twins up to 300 digit numbers, which they repeated without error or apparent difficulty.

using.[25]

c. Sherashevsky, a memory prodigy: The Russian psychologist, A.R. Luria, presents an unusually well-documented case of a memory prodigy in *The Mind of a Mnemonist*. Among many prodigious memory abilities, this subject had photographic recall of numerical tables. After examining a table of 50 numbers for only several minutes, he could recall the table with such vivid internal mental clarity that he could "read" the numbers accurately in any direction/combination, even 10 to 15 years later, and in spite of thousands of similar memory exercises during the intervening time. After almost 30 years of careful, systematic study of Sherashevsky's memory, Luria comments: "It was impossible to establish a point of limit to the capacity or the duration of his memory,..."[26]

d. Robert Evans, a memory prodigy: Robert Evans, an amateur astronomer currently living in Australia, demonstrates phenomenal, "photographic" memory: "Evans single-handedly, with a small telescope, observed the incidence of supernovae in a sample of 1017 bright galaxies which he observed for a period of five years....Evans used no photographic or electronic assistance, and thus seemed able to construct and hold in his mind an absolutely precise and stable image or map of more than a thousand galaxies..."[27]

These astonishing, mysterious, "impossible" abilities are not explained by any brain biology theory I am aware of, but they are consistent with the existence of higher, deeper, non-biological "mind" phenomena. My hypothesis is that our non-biological minds have tremendous potential that is usually greatly hindered by our unresolved spiritual and psychological issues and by our "fallen" biological brains. Perhaps the rare prodigy in some way gets past these "usual/normal" limitations – at least for certain areas of ability.

6. The effects of the mind/brain on physical systems (random number generators): Over the last 30-40 years a number of investigators have been studying the ability of the mind/brain to influence random number generators – a physical system in which it is especially easy to evaluate for statistically significant effects. The experiments have involved some form of microelectronic random number generator[28] and a human observer who was instructed to attempt to "influence" the distribution of the random numbers solely by *intention – willing* the numbers to change in some particular way. One of the most intriguing aspects of this research is that many of the studies included will/intention *across time*. That is, the random number generator was run as much as *a week **before*** the experimental subject tried to influence the results. Amazingly, both the "regular" and the time delayed experiments showed statistically significant results. In fact, in 1989 Dean Radin, Department of Psychology at Princeton University, and Roger Nelson, Department of Mechanical and Aerospace

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[25] Sacks, Oliver. *The Man Who Mistook His Wife for a Hat*. (New York: Harper Collins) 1970, pages 195-213.

[26] Luria, A.R. *The Mind of a Mnemonist*. (Cambridge: Harvard University Press) 1968, see especially pages 11&12, 15-20, 33, 60&61. Direct quote from page 61.

[27] Sacks, Oliver. *An Anthropologist on Mars*. (New York: Vintage Books) 1995, page 198.

[28] Most of the random number generators were based upon a source of truly random events, such as electronic noise or radioactive decay.

Engineering at Princeton University, published a meta-analysis[29] of all the known studies of the effects of will/intention on random number generators – a total of 832 studies conducted by 68 different investigators. In most medical research, an experimental result is considered statistically "significant" if there is less than 5 chances out of 100 that the finding could have occurred by chance. Statistical analysis of the cumulative data in Radin and Nelson's meta-analysis revealed HUGELY significant results – the probability that the effects could have been produced by chance was 1 in 10 to the 35th power. That's 1 out of 100,000,000,000,000,000,000,000,000,000,000,000 – 20 million million billion trillion times less than the usual "5 chances out of 100" that most scientists consider statistically significant.[30] This might seem like a bit of overkill, but it actually seems to be necessary, since many scientists (and lay people) still refuse to believe will/intention can influence physical systems *even in spite of these overwhelming statistics*.

Radin and Nelson rigorously evaluated every possible "explanation" of these results, and also carefully considered concerns brought by critics. Their final conclusion was: "The overall effect size obtained in experimental conditions cannot be adequately explained by methodological flaws or selective reporting practices. Therefore, after considering all of the available evidence, published and unpublished, tempered by all legitimate criticisms raised to date, it is difficult to avoid the conclusion that under certain circumstances consciousness [intention/will] interacts with random physical systems." Note that this meta-analysis was published in *Foundations of Physics*, a mainstream peer reviewed hard science journal, and not *The National Enquirer* [31]

This is certainly pretty weird, "hard to explain" stuff, but if we *do* accept these experimental results as legitimate, then it seems easier to believe that non-biological *mind* phenomena could affect random number generators (even across time) than to believe that a purely biological brain could produce these effects.

7. "Mind *and* brain" works better in actual clinical experience: In my personal clinical experience, it works much better to use a model that acknowledges *both* biological brain phenomena *and* non-biological mind phenomena. Mental health problems become much more understandable when the situation is approached from the "mind *and* brain" perspective, and approaching mental health problems from the "mind *and* brain" perspective is also much more effective in guiding efforts to resolve the problems.

From a "brain biology is the *only* reality" perspective: Brain biology can provide good guidance about how to use medication to moderate symptoms, but the huge pile of neuro-psychiatric theory and data are essentially useless for understanding or resolving any

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[29] Meta-analysis combines many smaller experiments into one large experiment, thereby obtaining a much larger collection of experimental results. Since the methods of meta-analysis are specifically designed to take different experiments addressing the same question and make them statistically equivalent, the combined data can be used in a final *meta-analysis* with statistical power that is *much* greater than that provided by any of the individual studies.

[30] Broughton, Richard S. *Parapsychology: The Controversial Science*. (New York, NY: Ballantine Books), 1991, page 290.

[31] Radin, Dean I., and Nelson, Roger D. "Consciousness-Related Effects in Random Physical Systems," *Foundations of Physics*, 1989, Vol 19, pp. 1499-1514.

underlying mind/spirit issues. For example, if I am working with someone who has major depression, neuropsychiatric research tells me that certain areas of the patient's brain are over-functioning and others are under-functioning, that these patterns of brain dysfunction are associated especially with decreased activity in serotonin pathways, that many of the patients symptoms, such as poor sleep and decreased energy, are directly connected to the decreased serotonin, and that medications that increase serotonin activity will moderate (or even temporarily resolve) the overall clinical picture of depression. But information about the biological brain provides no insight regarding underlying mind/spirit issues and no guidance regarding how to resolve them. Why does the person struggle with the same persistent, recurrent negative thoughts each time he gets depressed? Why does he believe he is powerless and worthless, even though this makes no sense in his present life? And how can these thoughts and emotions be permanently resolved so that he doesn't have to be on medication for the rest of his life? Neuropsychiatric research can *describe* the abnormal brain biology *associated* with the clinical picture of depression, and provide guidance about how to correct the brain biology abnormalities, but it does not have a clue about how to answer these mind/spirit questions.

From a "mind *and* brain" perspective: When we use a model that recognizes both the biological brain *and* the non-biological mind/spirit we can also embrace mind/spirit-based observations and theories. I find the observations and theories included in mind/spirit-based treatment approaches, such as the Immanuel approach and Theophostic®-based[32] emotional healing ministry, to be intuitively understandable and to be very useful in guiding my thoughts and decisions in actual clinical practice.[33] For example, if I am working with someone who has major depression I find that psychological traumas, such as being abused and then abandoned by an alcoholic father, result in memory anchored negative cognitions/lies in a way that "makes sense" intuitively; I find that these negative cognitions/lies, such as "I'm worthless" and "I'm powerless," result in recurrent depression in a way that "makes sense" intuitively; and furthermore, I find that the principles and techniques included in the Immanuel approach, Theophostic®-based emotional healing, and other similar healing approaches (such as EMDR®) provide specific guidance about how to resolve these memory-anchored lies. An especially important data point in my personal clinical experience is that the guidance regarding how to resolve these distorted beliefs not only makes sense intuitively, but also *works*. I consistently see these principles and techniques result in the permanent resolution of the memory-anchored lies, and I then also

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[32] Theophostic®-based emotional healing ministry: We use the term "Theophostic®-based" to refer to emotional healing ministries that are built around a core of Theophostic® principles and techniques, but that are not identical to Theophostic® Prayer Ministry as taught by Dr. Ed Smith. Our own ministry would be a good example of a "Theophostic®-based" emotional healing ministry – it is built around a core of Theophostic® principles and techniques, but it also includes material that is not a part of what we understand Dr. Smith to define as Theophostic® Prayer Ministry (such as our material on dealing with curses, spiritual strongholds, generational problems, and suicide-related phenomena, and our material on journaling, spiritual disciplines, community, and medical psychiatry). Theophostic® Prayer Ministry is a trademark of Dr. Ed Smith and Alathia Ministries, Inc., of Campbellsville, Kentucky.

[33] I find useful and understandable theory and observations especially in cognitive therapy, exposure therapy, EMDR®, Theophostic®, and the Immanuel approach. EMDR® refers to Eye Movement Desensitization and Reprocessing, developed by Francine Shapiro, Ph.D. in 1987. For more information, see www.emdr.com; see also "Theophostic® & EMDR®: FAQs and Common Misunderstandings," on www.kclehman.com.

see the clinical picture of major depression resolve *and remain resolved, even without maintenance medication!* And we've seen the same picture with many other mental health problems, such as panic attacks, phobias, sleep disorders, post traumatic stress disorder, and various compulsive and addictive behaviors.

Furthermore, from the "mind *and* brain" perspective we can address the mind/spirit issues *and* use medication to correct abnormal brain biology (and thereby moderate the symptoms of depression) while we are working to resolve the underlying mind/spirit issues.

Note: "It makes more sense and it's more effective" doesn't provide conclusive proof that the "mind *and* brain" paradigm I propose here is true, but it is a data point. In general, the closer a model is to the truth the more sense it tends to make and the better it tends to work.

B. Analogies: Note that these analogies are not about "Does the big picture just get lost in all the scientific details because our minds aren't adequate to see it?" but rather illustrate the deeper point of "Physical science processes do not *produce* or *cause* the qualitatively different mind/spirit phenomena, and it is inherently impossible to fully explain or understand the qualitatively different mind/spirit phenomena by using physical sciences to study the biology, chemistry, and physics associated with them."

1. Mobile – suspended from the top vs. supported from the bottom: When dealing with mind questions, if we think of the biological brain and the non-biological mind as separate, with the brain serving as the "computer" that the mind uses to express itself, then the whole endeavor works like holding a mobile from the top. One sentence, "He is depressed because *his mind* believes the lie that he is worthless and powerless," explains the underlying mind roots of his depression in a way that "makes sense;" and a second sentence, "We need to find the memory where these lies are anchored, and then clear the way for Jesus to come with healing truth," provides guidance for how to proceed with treatment. It all falls into place so easily. On the other hand, trying to understand the mind aspects of mental illness, behavior, and emotions from the "biological brain only" perspective is like trying to support the mobile from below (try it sometime - what a mess). Even with 50,000 pages of information about neurological pathways, neurotransmitters, brain receptors, and PET scans, the physical sciences can't answer mind questions like "What are the thoughts behind her emotions and behavior? Where do these thoughts come from? And why do they keep coming back, in spite of repeated logical arguments showing that they are irrational?"

2. Computer "behavior" – *operator* questions vs *machinery* questions: Let's say you are trying to figure out "What's going on? Why is this happening?" with respect to a computer that has just closed a spreadsheet program. If you want to understand the observable "behavior" of this computer you need to approach *operator* behavior questions from a human mind perspective and *machinery* behavior questions from a technical science perspective. If the computer behavior in question is the result of computer operator choices, then talking to the computer operator will clarify the situation quickly and easily – the spread sheet window isn't open because he has closed the program in order to back up the hard drive, or because he is getting ready to go to lunch. The deepest, root, "real" reasons for what is happening are discovered by asking the human operator "Why did you close the spreadsheet?" You could study the mechanics and electronics of the computer machinery until the cows come home without providing any useful insight into the real underlying reasons for the computer's "behavior." On the other hand, occasionally the answer to "Why isn't the spreadsheet

window open?" is "The hard drive has crashed," or "The operating system has been upgraded, and now there isn't enough RAM to run the spreadsheet." If the computer is broken, talking to the operator won't fix the problem.

Another example: If the computer operator is playing computer games or e-mailing his friends instead of working, you need to talk to the computer operator about his work ethics and productivity – calling in the computer technician won't do much good. If the hard drive has crashed, you need to call in the technician – talking to the computer operator about his work ethics and productivity won't do much good.

3. Car "behavior" – *driver* questions vs *machinery* questions: Let's say you are trying to figure out "What's going on? Why is this happening?" with respect to a car traveling from Evanston, Illinois to a certain small town in Kansas. If you want to understand the observable "behavior" of this car you need to approach *driver* behavior questions from a human mind perspective and *machinery* behavior questions from a physical science perspective. For example, if you want to know *why* the car is taking the trip you study the mind of the driver. From the driver behavior perspective, one simple sentence answers your question: "Karl wanted to visit his parents, so he drove his car from his house to their house." From the machinery behavior perspective, you could analyze every aspect of the chemistry and physics of the situation – the energy released by combustion of gasoline, the pressure applied to the piston heads, the torque in the steering column, the traction and torque interactions between the tires and the road, etc – without getting any useful information regarding why the car is going to Kansas. The chemistry of combustion, the mechanics of the engine, and the traction between the tires and road did not *produce* the trip or *cause* me to go to Kansas. The car is simply the mindless vehicle that I use to implement my intention to visit my parents, and studying the chemistry of combustion, the mechanics of the engine, and the traction between the tires and the road can only provide the physical science explanation of *how* the car accomplished what I directed it to do. If Karl decides he doesn't want to go to Kansas after all, you need to talk to Karl about the importance of visiting his parents – getting a mechanic to work on the car won't fix the problem. However, if "What's going on? Why is this happening?" is being asked in reference to the unfortunate discovery that the car won't start after stopping at a rest area in Iowa, you study the machinery of the car. "Is the fluid in the battery too low? Did somebody leave the lights on? Is the alternator working properly?" If the alternator has burned out, you need to call a tow truck and find a mechanic – talking to Karl about whether or not he should visit his parents won't fix the problem.

Another example: During the trip, the answer to the question "Why did the car pull over and stop?" is sometimes "Karl had to go to the bathroom," or (more often) "Karl wanted to look at a bird." However, occasionally the answer is "The car has a flat tire." If Karl is stopping too often to look at birds, you need to talk to Karl. If the car has a flat tire, you need to get out the spare.

4. "Understanding" a picture – physical sciences perspective vs. mind perspective: If you want to understand the meaning of a picture, you can "look at it" from a *mind* perspective and say "Oh, it's a picture of a mother holding a baby." From the physical sciences perspective you can analyze the microscopic structure, chemical composition, light absorption, etc. of each spot on the canvas, and the complex neurological processes the brain uses to process the incoming visual stimuli. This is appropriate and valuable information if you are trying to design better canvas fabric or if you are treating certain medical vision problems, but even a

huge pile of this kind of scientific information will not be able to answer mind questions, such as "What is the picture *about*? What does it *mean*?"

The mind perspective and the physical science biological brain perspective will yield *qualitatively* different results. When the question has to do with the computer *operator*, talking to the computer operator is most helpful. When there is a problem with the computer *machinery*, getting a technician to work on the computer machinery is most helpful. When the question has to do with the automobile *driver*, talking to the driver is most helpful. When there is a problem with the automobile *machinery*, getting a mechanic to work on the machinery is most helpful. For any aspect of the problem that is a mind wound or mind issue, it is most helpful to approach from a mind perspective. For any aspect of the problem that is a brain biology wound or brain biology issue, it is most helpful to approach from a brain biology perspective. For example, schizophrenia, Alzheimer's disease, and traumatic brain injury each have a core, important component that is a *biological brain wound*. These biological brain wounds must be addressed with brain biology interventions, such as medications, surgery, physical therapy, or prayer focusing on healing for the *physical brain*. Note that people with these *brain* wounds will also have *mind* wounds, which will actually be easier to trigger because of the biological brain problems and which will certainly exacerbate the overall clinical picture, and the mind wound aspects of the overall clinical picture will need to be addressed from a mind perspective.

III. The biological brain and the non-biological mind are profoundly, intimately connected:

Even though the biological brain and the non-biological mind are separate and qualitatively different phenomena, the Lord has woven them together so profoundly that each affects the other in intimate and complex ways. Even though the mind is a non-physical, non-biological phenomena, it can powerfully affect the biological brain. For example, mind phenomena, such as thoughts and emotions, powerfully effect brain chemistry and even brain structure. Conversely, even though the non-biological mind is leader and master, the Lord has woven the mind and brain together in such an intimate way that the biological brain can profoundly influence the mind. For example, you can change the way a person thinks and feels by injecting LSD, cocaine, or Prozac into his brain. Even though the mind is leader and master in some profound way, the Lord has woven the mind and brain together so intimately that the mind must submit to the limitations of the brain in most situations. For example, the mind usually can't just ignore the effects of Alzheimer's disease, a stroke, or a traumatic brain injury.

A. Research demonstrating the profound and intimate mind-brain connection:

1. Learned helpless rats: A number of studies have worked with rats that were placed in an experimental set-up where they had no way to prevent or escape mild shocks. After initial protest, they appeared to learn "I'm helpless," and became clinically depressed (as indicated by all the signs and symptoms of depression that can be observed in a rat, such as decreased activity, social isolation, decreased pleasure seeking behavior, impaired attention, changes in appetite and eating, abnormal sleep patterns, etc.). The brain chemistry in the rats also became abnormal, consistent with biological brain depression. The experimental set-up was then changed so that the rats *did* have options, but they appeared to continue functioning with what in Theophostic® terms would be a metamorphic lie. They appeared to continue believing "I'm helpless," even though it was no longer true. They continued to lie (despondently?) in their cages, displaying the same indicators of depression and making no attempt to

escape or stop the shocks. The rats were then given antidepressant medication. The observable signs and symptoms of depression resolved, the brain chemistry returned to normal, *and the rats quickly discovered the new levers in their cages and learned to press them to escape the shock*.[34] This is a fascinating indicator of the intimate mind-brain connection – using antidepressants to manually correct the abnormal brain chemistry seems to protect the rats from being functionally/behaviorally crippled by the "I'm helpless" lie, which previously seemed to prevent them from discovering that they were no longer helpless.

One particular study is even more intriguing. A group of "learned helpless," clinically depressed, brain chemistry abnormal rats did *not* receive antidepressant medication *but did receive "therapy."* The researchers manually moved their paws to the new levers, and thereby "taught" them how to use the new levers to stop the shocks. The rats appeared to learn that they were no longer helpless and began to use the levers on their own. And the *observable signs and symptoms of depression disappeared after the rats learned that they were no longer helpless*. This research suggests that traumatic experience can result in negative beliefs (hypothesized in this experiment – but it sure looks like it), which then cause the clinical picture of "mental illness." It shows that medication can decrease the signs and symptoms of the mental illness at the same time that it corrects the brain chemistry abnormalities. Furthermore, it shows that when the "lie" ("I'm helpless") is eliminated, *even without medication*, the clinical picture of mental illness and corresponding brain chemistry abnormalities[35] are also resolved.[36]

I initially wondered about the ease with which these lies were resolved. Then I realized that these rats learned the "I'm helpless" lies as adults, through a brief series of training sessions, and then had new experiences only days or weeks later that helped them "unlearn" the "I'm helpless" lesson. This is very different from negative beliefs learned in childhood and carried for many years, and especially different from situations where childhood lies are reinforced by similar experiences that give the same message over and over again. I also wondered whether the improvement with medication was permanent, but then realized that the antidepressants chemically neutralized the immobilizing effects of the learned helplessness,

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[34] See, for example, Adrien J; Dugovic C; Martin P. "Sleep-wakefulness patterns in the helpless rat." *Physiol Behav* 1991 Feb;49(2):257-62; Gambarana C; Scheggi S; Tagliamonte A; Tolu P; De Montis MG. "Animal models for the study of antidepressant activity." *Brain Res Brain Res Protoc* 2001 Apr; 7(1):11-20; Van Dijken HH; Van der Heyden JA; Mos J; Tilders FJ. "Inescapable footshocks induce progressive and long-lasting behavioral changes in male rats." *Physiol Behav* 1992 Apr;51(4):787-94; Petty F; Kramer G; Wilson L; Chae YL. "Learned helplessness and in vivo hippocampal norepinephrine release." *Pharmacol Biochem Behav* 1993 Sep;46(1):231-5; Telner JI; Singhal RL; Lapierre YD. "Reversal of learned helplessness by nortriptyline." *Prog Neuropsychopharmacol* 1981;5(5-6):587-90; and Martin P; Pichat P; Massol J; Soubrie P; Lloyd KG; Puech AJ. "Decreased GABA B receptors in helpless rats: reversal by tricyclic antidepressants." *Neuropsychobiology* 1989;22(4):220-4.

[35] Note: This particular research study did not explicitly demonstrate the development of brain chemistry abnormality in association with learned helplessness, or the resolution of brain chemistry abnormality after the successful "therapy;" however, since there is so much careful research demonstrating that the observable signs and symptoms of learned helpless "depression" are *always linked* with brain chemistry changes, I think we can safely assume that the learned helpless rats in this experiment developed the same brain chemistry changes, and that the "therapy" resolved these brain chemistry abnormalities as it resolved the observable signs and symptoms of the learned helpless "depression."

[36] Seligman ME; Rosellini RA; Kozak MJ. "Learned helplessness in the rat: time course, immunization, and reversibility." *J Comp Physiol Psychol* 1975 Feb;88(2):542-7.

enabling the rats to *experientially* replace the lie with the new truth "I'm *not* helpless any more." In light of the comments above regarding adult vs. childhood experience, I would expect this to permanently resolve the problem (I have not found any studies where this prediction is tested by stopping the antidepressants and observing the rats for "relapse").

2. PET scans of medication and psychotherapy for OCD: One study used Positron Emission Tomography (PET) scans to observe the "real time," living activity of the brains in people with obsessive compulsive disorder (OCD). People who met full DSM IV criteria[37] for OCD were shown to have a consistent abnormal pattern on their PET scans. These people with OCD and abnormal PET scans were then divided into two groups. One group was treated with Prozac, and in this group the signs and symptoms of OCD were observed to decrease. Furthermore, the abnormal PET scan results were seen to return to normal as the signs and symptoms of OCD decreased. A second group received no medication, but rather used cognitive-behavioral therapy to challenge and change the behaviors, distorted negative beliefs, and emotions associated with OCD. This group also demonstrated decreased signs and symptoms of OCD and their abnormal PET scans also returned to normal as the signs and symptoms of OCD decreased. The striking point of this research is that therapy targeting distorted thoughts, feelings, and behavior can change the medical PET scan in the same way that medication does, and at the same time as it reduces the signs and symptoms of the mental illness (OCD).[38]

3. Recovery of paralyzed limbs after stroke: A surprising recent discovery has been made by Dr. Edward Taub, a neuroscientist at the University of Alabama. Much to the astonishment of the neurology establishment, Dr. Taub's research demonstrates that the supposedly inflexible brains of adults can undergo dramatic reorganization.

Dr. Taub made this discovery as he worked with stroke victims. The accepted understanding regarding stroke victims, thought and taught for many years, has been: "Lasting paralysis after a stroke is irreversible, and this lasting, irreversible paralysis is caused by death of the brain cells that had previously controlled the now paralyzed muscles – if a person's left arm and leg are still paralyzed several years after a stroke it's because the brain cells that used to control the left arm and leg have been permanently destroyed by the stroke, and there's no way to fix the problem." However, Dr. Taub demonstrated that stroke victims could recover most of the function of "paralyzed" limbs, even after *years* of complete disability due to paralysis, if they performed exercises using choice and will power to "push" the paralyzed limbs into resuming old tasks.

It had already been known that strokes usually cause *irreversible, lethal* injury to only a small area of brain tissue, but cause *reversible injury* to a much larger area. What Dr. Taub

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[37] "DSM IV criteria" refers to the specific list of signs and symptoms catalogued in the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, which many mental health professionals use in making diagnostic decisions. These criteria are especially used in research in order to standardize diagnosis – to ensure that different research studies working with the same diagnosis are actually working with appropriately parallel groups of patients.

[38] Baxter LR., Schwartz JM., Bergman KS., Szuba MP., Guze BH., Mazziotta JC., Alazraki A., Selin CE., Ferng HK., Munford P., et al. "Caudate glucose metabolic rate changes with both drug and behavior therapy for obsessive-compulsive disorder." *Arch Gen Psychiatry* September 1992, Vol. 49, No. 9, pages 681-9.

discovered was that, as the larger area of injured cells gradually recovered *but the patient continued to avoid using the (quote/unquote)"paralyzed" limbs*, neighboring areas of the brain would recruit the recovering brain cells – the brain would "rewire" it's neurological circuitry so that the *unemployed* recovering brain cells could be used for other purposes. AND, Dr. Taub discovered that the patients could recover the use of their "paralyzed" limbs because this process was reversible – if the patient spent many hours trying to make the paralyzed limbs resume old tasks, it seems that the person's persistent choice and will power could push and guide the brain to return to the original neurological circuitry, *and this enabled the now recovered brain cells to once again animate the no-longer paralyzed limbs*.[39]

The really important point for this discussion is that even in the supposedly fixed brains of adults, persistent choice and will – *mind/spirit phenomena* – can push and guide the biological brain to reorganize the neurological circuitry for large portions of the cerebral cortex.

B. Case studies demonstrating interaction between mental illness, psychiatric medication, and mind/spirit issues:

1. My own patients: I have had the privilege of providing both the psychotherapy and the medication management for a number of patients. Several of these patients met rigorous DSM IV diagnostic criteria for one or more major mental illnesses (such as major depression, panic disorder, obsessive compulsive disorder, phobias, post traumatic stress disorder, and eating disorders),[40] and experienced symptoms that were severe enough to cause marked disability. These people experienced marked improvement with medications (they required moderate to high doses of psychiatric medications in order to be able to function at work and/or at home), and experienced return of disabling symptoms if the medication dosages were decreased.

After this history had clearly been established, we began using various combinations of EMDR®, Theophostic®- based emotional healing, and the Immanuel approach for the psychotherapy component of their care.[41] As we worked with these emotional healing tools

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[39] Taub, E. "Harnessing brain plasticity through behavioral techniques to produce new treatments in neurorehabilitation." *Am Psychol*, Vol. 59, No. 8/November 2004, pages 692-704; Taub, E., Uswatte G.; Morris DM. "Improved motor recovery after stroke and massive cortical reorganization following constraint-induced movement therapy." *Phys Med Rehabil Clin N Am*, Vol. 14 (Suppl 1), Feb 2003, pages S77-91; Victor, Mark, & Taub, Edward. "Constraint-induced movement therapy for chronic stroke hemiparesis and other disabilities," *Restorative Neurology and Neuroscience*, Vol. 22, 2002, pages 317-336. For a fascinating presentation of this material, produced for the lay-public, see Grubin, David (executive producer), *The Secret Life of the Brain*, (New York, NY: Thirteen/WNET), 2001. Disc three, episode five, "The Aging Brain: Through Many Lives," chapter 2, "Overcoming Paralysis."

[40] I personally obtained thorough diagnostic histories and performed mental status exams, which revealed signs and symptoms meeting DSM IV diagnostic criteria, and these diagnostic histories and mental status exams are carefully documented in the medical records for these patients.

[41] For some of our patients, this history of rigorous diagnosis, need for medication, and relapse with decreased dosage had been thoroughly established before they came to us, and we began EMDR® and/or Theophostic®-based therapy and/or the Immanuel approach immediately. For others, we established the diagnostic and medication history in our practice before we had learned about these tools for permanently

we identified and addressed psychological and spiritual issues[42] that seemed, intuitively, to be connected to the symptoms of their mental illnesses. As the healing process continued, these people would say things like "I know that's where the panic was coming from – I can feel that the roots of the panic have been resolved," or "I feel like I'm on too much medication – I think we've been getting at the roots of my depression, and I don't think I need as much medication any more." In most of these situations we were then able to reduce or stop the medication *without relapse*.[43]

Marked improvement with medication, and relapse with previous trials of decreased dosage, are both indicators that ***brain biology*** *abnormalities were indeed present in association with the carefully diagnosed mental illnesses*. And improvement and/or resolution of the mental illnesses – including the ability to reduce or stop medication without relapse – in response to resolving mind/spirit issues demonstrates that *working with* ***mind/spirit*** *phenomena resulted in correction of these* ***brain biology*** *abnormalities*.

The biological brain and the non-biological mind are connected and woven together in such a profoundly intimate and complex way that influence can operate in either direction. Using medication to manually adjust the biological brain will cause changes in thoughts and emotions, and mind/spirit focused treatments causing changes in thoughts and emotions will result in adjusting the biological brain.

2. Other cases I am involved in: In addition to my own patients, I am also involved with a number of similar cases where I am not the care provider, but where I have obtained detailed history regarding the same clinical components. See, for example, the "Freedom from Bulimia" case study on the "Case Studies" page of www.kclehman.com. The woman described in this case study was tormented by severe, persistent bulimia for more than twenty years. She experienced some benefit from psychotherapy, prayer, and psychiatric medications, but continued to suffer from significant bulimic symptoms in spite of extensive appropriate treatment. She then experienced dramatic release from her bulimia with Theophostic®-based therapy. She has now remained free of bulimia for almost nine years, and has been off all psychiatric medication for almost six years, with no relapse of depression or bulimia since going off medication in December of 2003.

3. Case studies published by other authors: Other authors have also published case study descriptions that demonstrate these intimate mind-brain connections. For example, in *Why*

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resolving the underlying psychological and spiritual issues. In a few patients, the healing work was slow enough that we decided to use medication even as we continued ongoing work to address psychological and spiritual issues. We do not ever withhold emotional healing work in order to first make careful diagnoses and establish medication history.

[42] For example, various combinations of unresolved psychological trauma, truth-based pain in the present, unhelpful psychological defenses, lack of maturity skills, persistent sin, and demonic oppression.

[43] In most of these situations, I have been able to carefully follow the clinical picture for at least 2-5 years (some now with 8 years of follow-up), and so have been able to personally verify that the patient did not experience relapse after the medication reduction/discontinuation. Occasionally, some symptoms have returned when "new" (previously buried) issues were brought to the surface by some new and/or particularly intense trigger, but these symptoms again resolved when the newly discovered issues were resolved.

Do I Feel So Down When My Faith Should Lift Me Up?, Dr. Grant Mullen describes a patient with a long history of depression and mood instability that were so severe as to be disabling. This patient experienced dramatic and lasting improvement with medication – demonstrating that biological brain dysfunction was present; but was then able to reduce and eventually completely discontinue the medication as she received deliverance and emotional healing – demonstrating that resolving mind/spirit issues resulted in correction of the dysfunctional brain biology.[44]

Dr. Sachs provides another example. In *The Man Who Mistook His Wife for a Hat*, He was working with a patient, Ray, who suffered from Tourette's syndrome. Dr. Sachs prescribed a very small dose of Haldol to help moderate the disabling symptoms, and Ray experienced dramatic reduction in symptoms, but unfortunately he also experienced intolerable side effects (marked Parkinsonism, dystonia, catatonia, and psychomotor block), even on the minute dose of medication. Dr. Sachs noted that Ray seemed to value some aspects of his Tourette's syndrome, and that Ray was ambivalent about whether he truly wanted to be "normal." "He said he could not imagine life without Tourette's, nor was he sure he would care for it." So Dr. Sachs suggested that they meet weekly for several months to sort through Ray's ambivalent thoughts and feelings about his Tourette's and the possibility of effective treatment. Dr. Sachs reports that These sessions were intense and fruitful, and that at the end of this time Ray tried the medication again. Interestingly, *the same medication, at the exact same dose*, then produced the same dramatic benefits *but without significant side effects*. Furthermore, Ray has been able to continue this medication, with the same dose, benefits, and lack of side effects, for many years. Addressing non-biological mind/spirit issues clearly affected the way in which the medication interacted with his biological brain.[45]

C. Biological brain and non-biological mind in expression of mental illnesses: In previous versions of this essay I stated that "mind wounds and their associated spiritual issues cause the observable symptoms of mental illnesses *through* causing brain biology abnormalities," and presented brain biology as the "final common pathway" for the expression of *all* the symptoms associated with mental illnesses. After many additional hours of research and thought, I perceive that the accurate picture of how the biological brain and the non-biological mind interact in the expression of mental health concerns is more complex than this. My current perception is that physical symptoms, emotions, and the factors that seem most purely mind/-spirit (truth-based pain in the present, unresolved psychological trauma, reactive sin/sinful defenses, and demonic infection) each involve a different kind of mind-brain interaction.

1. Truth-based pain, unresolved psychological trauma, reactive sin/sinful defenses, and demonic infection associated with mental health concerns: I perceive the most mystery, and feel the most uncertainty, regarding the phenomena that seem most purely mind/spirit – truth-based pain in the present, unresolved psychological trauma, reactive sin/sinful defenses, and demonic infection. Near death experiences, as discussed above, prove that it is *possible* for mind/spirit phenomena to continue while the biological brain is totally off line, but do mind/spirit phenomena such as thoughts, beliefs, and choices *usually* have physical,

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[44] Mullen, Grant. *Why Do I Feel So Down When My Faith Should Lift Me Up?* (Kent: Sovereign World Ltd), 1999, pages 63-65.

[45] Sacks, Oliver. *The Man Who Mistook His Wife for a Hat*. (New York: Harper Collins) 1970, pages 92-101.

biological brain processes that are directly and closely associated with them? I don't know. Interestingly, there is no clear scientific evidence demonstrating biological brain processes directly corresponding to consciousness, self awareness, thoughts/beliefs, free will choices, or demonic phenomena. Therefore, the mind/spirit issues contributing to mental illnesses, such as truth-based psychological pain, unresolved psychological trauma, sinful defenses, other sin, and demonic infection *may* operate primarily in the non-biological mind/spirit realm. They can influence the physical body in various ways,[46] but there may not be closely connected biological brain processes directly associated with each detail of these mind/spirit phenomena in the same way that occurs with emotions and physical symptoms. Possibly the most important way that these mind/spirit phenomena interact with the biological brain is *through emotions.*

2. Emotions associated with mental health concerns: My perception is that the mind and brain are so intimately connected at the point of emotions that the final subjective experience of any given emotion is actually a mixture of biological brain phenomena and non-biological mind phenomena. One the one hand, it seems clear that our emotions at any given moment correspond exactly to our *true* thoughts and beliefs at that moment.[47] Furthermore, my perception is that our thoughts and beliefs *determine* our emotions – that our emotions always *follow* our thoughts and beliefs.[48] These are the foundational principles of Cognitive Therapy, and Cognitive Therapy research and case studies provide a lot of evidence supporting these principles.[49] These are also some of the foundational principles of Theophostic®,[50] and my personal and professional experience with the Immanuel approach and Theophostic®-based emotional healing has provided extensive case study observations consistent with these principles. I consistently see that a person's emotions match her thoughts and beliefs, and when Jesus replaces dysfunctional thoughts and beliefs with truth the person's dysfunctional emotions immediately change to match the new, truth-based

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[46] If the mind can affect random number generators, it should be able to exert effects on the biological brain and even the rest of the physical body. Case studies described by various people working in healing ministries also indicate that thoughts, beliefs, and choices (e.g., vows) can have significant and direct effects on the physical body (including the biological brain, but not limited to the brain). There is certainly a lot of mystery here.

[47] I include *"**true** thoughts and beliefs"* because our emotions do not correspond to what we ought to think and believe, to what we try to think and believe, to what we might know as true in our normal belief memory system, or to what we may tell ourselves we think and believe when we are in denial, but rather to our *true* thoughts and beliefs at any given moment.

[48] The material we now teach regarding right-sided emotions and left-sided emotions has been developed since this essay was written (for our discussion of right-sided and left-sided emotions, see the pre-introduction in Part II of "Brain Science, Psychological Trauma, and The God Who is With Us"). For those of you familiar with this material, you will recognize that all comments along the lines of "our emotions always correspond exactly to our true thoughts and beliefs," "our emotions are determined by our thoughts and beliefs," etc are referring to left-sided emotions.

[49] For an extensive discussion of these principles, and their place as the foundation of cognitive therapy, see Beck AT. *Cognitive Therapy and the Emotional Disorders*. New York, NY: International Universities Press, 1976.

[50] One way to find these principles in Dr. Smith's Theophostic® material is to review the references to emotion listed in the index of Smith, Ed. *Beyond Tolerable Recovery*. Fourth edition. (Campbellsville, KY: Alathia publishing) 2000.

thoughts and beliefs. For example, when Jesus replaces "I'm going to die" with "I'm not there any more, I'm okay now," the person's emotions change from panic to peace in a matter of seconds. Furthermore, truth-based psychological pain (such as loss of a loved one) produces corresponding emotions (such as anger and sadness), free will choices (such as the vow "I will not feel") dramatically affect the experience and expression of emotion, and demonic harassment often seems to affect emotions. Another interesting data point is provided by experiments with people who receive adrenaline injections in two different social settings. The group that received adrenaline injections in a pleasant situation experienced the adrenaline induced arousal as subjective happiness, whereas the group that received the *exact same injections* in a frustrating situation experienced the adrenaline induced arousal as a surge of anger. The same injection produced different emotional responses depending on what was happening in the mind/spirit at the time of the injection, clearly demonstrating that mind/spirit input plays a crucial role in shaping our final subjective experience of emotions.[51]

On the other hand, there are many fascinating research studies that clearly indicate that the biological brain plays an important role in the experience and expression of emotion. Some of the most straightforward research shows that direct stimulation of certain very specific areas of the brain immediately produces corresponding very specific simple emotions, such as anger, fear, and euphoria, and that damaging these same very specific brain areas can block these emotions.[52] It's not clear to me where mind/spirit phenomena fit into these experiments, but these dramatic demonstrations certainly indicate that the biological brain is intimately involved in the experience and expression of emotion. See also the chapter on emotion in Dr. Daniel Siegel's *The Developing Mind*,[53] and Dr. Allen Shore's three books, *Affect Dysregulation and Disorders of the Self*, *Affect Regulation and the Origin of the Self*, and *Affect Regulation and the Repair of the Self*[54] for an EXTENSIVE discussion of interdisciplinary research that reveals many different aspects of how the biological brain is

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[51] See Schacter, S., and Singer, J. "Cognitive, social, and physiological determinants of emotional learning." *Psychological Review*, 1962 Vol 69, pp 379-99 for a description of these classic experiments on the variable subjective interpretation of adrenaline-induced arousal.

[52] There is an extensive body of animal research and human case studies describing stimulation of and/or blockage of both the subjective internal experience and the external expression of simple emotions. For electrode stimulation and blockage experiments in animals, see, for example, Anand B.K., Dua S. "Stimulation of Limbic System of Brain in Waking Animals," *Science*. 1955 December 9, Vol. 122, page 1139; Egger, David M., Flynn, John P. "Effects of Electrical Stimulation of the Amygdala on Hypothalamically Elicited Attack Behavior in Cats," *J. Neurophysiol.* 1963, Vol. 26, pages 705-720; Hess, W.R. *The Functional Organization of the Diencephalon.* (New York, NY: Grune & Stratton) 1957, pages 23-25; and MacDonnell, Malcolm F., & Flynn, John P. "Attack Elicited by Stimulation of the Thalamus of Cats," *Science*. 1964, Vol. 144, pages 1249-50; For electrode stimulation and blockage case studies in human patients, see, for example, Chapman, William P. *et al*. "Physiological Evidence Concerning Importance of the Amygdaloid Nuclear Region in the Integration of Circulatory Function and Emotion in Man," *Science*, 1954, Vol. 129, pages 949-50; and Mark, V.H., & Ervin, F.R. *Violence & the Brain*. (New York, NY: Harper & Row) 1970, pages 70-85 and 92-121.

[53] Siegel, D.J. *The Developing Mind*. (New York: Guillford) 1999, pages 121-159.

[54] Shore, Allen N., Ph.D. *Affect Dysregulation and Disorders of the Self*. (New York, NY: W.W. Norton & Company), 2003; Shore, Allen N., Ph.D. *Affect Regulation and the Origin of the Self*. (Hillsdale, NJ: Lawrence Earlbaum Associates, Publishers), 1994; Shore, Allen N., Ph.D. *Affect Regulation and the Repair of the Self*. (New York, NY: W.W. Norton & Company), 2003.

intimately involved in the internal subjective experience of emotion and in the observable external expression of emotion.

My perception is that emotions – these fascinating, still somewhat mysterious *mixtures* of biological brain phenomena and non-biological mind phenomena – are an integral part of the bridge/link/connection/communication/interaction between the non-biological mind/spirit and the biological brain.

3. Physical symptoms associated with mental health concerns: With respect to the physical symptoms associated with mental illnesses (such as decreased energy with depression, increased energy with mania, racing heart and hyperventilation with panic, etc), my perception is that truth-based pain, lie-based thoughts/beliefs, choices, demonic spirts, and emotions cause most[55] of the physical symptoms of mental illness *through* causing changes in the chemical and electrical machinery of the biological brain. The chemical and electrical machinery of the biological brain *is* the "final common pathway" for the expression of most physical symptoms associated with mental illnesses.

D. Beyond the driver/car, programmer/computer analogies: The mind-brain connection is so close, so profound, that the mind being sick *can* make the brain sick, and in these situations talking to the mind *can* fix the brain. Using the driver/car analogy to illustrate the contrast, this would be like confusion in the driver causing the fuel filter to become clogged, and then talking to the driver to help resolve his confusion resulting in removal of the fuel filter obstruction.

E. Sick mind/spirit *causes* sick brain, sick brain *exposes* sick mind/spirit: In the above discussion and analogy, I describe how the mind/spirit being sick can actually make the biological brain sick. In the discussion and analogy above I almost continued with "and the brain being sick can make the mind sick," thinking about how a person can have a genetic biological brain predisposition to depression, or even about how low thyroid levels can precipitate depression. However, with more consideration I have come to the conclusion that the brain being sick (for example, biological brain abnormalities from genetic vulnerability to depression, experimentally depleted serotonin,[56] or low thyroid levels) simply *exposes* the sickness/wounds/unresolved issues *already present* in the mind. This means that changes in the biological brain cause changes in the mind/spirit by either *covering* or *exposing* unresolved issues in the wounded mind/spirit. My hypothesis at this point is that if the mind and spirit were completely well, then

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[55] I say "most" as opposed to "all" due to case studies indicating that mind/spirit phenomena can occasionally cause physical symptoms in mysterious ways that do not seem to go through the biological brain as the "final common pathway."

[56] Researchers have developed an ingenious dietary manipulation technique by which they can cause sudden, dramatic, and temporary reductions in brain serotonin levels: Tryptophan is the amino acid required for the synthesis of serotonin. Experimental subjects are maintained on a low tryptophan diet, and then given a special drink that contains all the other amino acids, but not tryptophan. This amino acid load stimulates a surge of protein synthesis, which quickly uses up what little tryptophan remains, resulting in a sudden and dramatic drop in serotonin synthesis. Consistent with our "exposure" theory, "normal" subjects experience only minor irritating symptoms when their serotonin is suddenly depleted, but people who have had major depression experience sudden and dramatic return of their depression when their serotonin is experimentally depleted (in case you were worrying, the depression quickly resolves when serotonin is replenished). Delgado, Pedro, L., Charney, Dennis, S., et al., "Serotonin Function and the Mechanism of Antidepressant Action: Reversal of Antidepressant-Induced Remission by Rapid Depletion of Plasma Tryptophan," *Archives of General Psychiatry*, 1990, Vol. 47, pages 411-418.

dysfunction in the biological brain would produce *physical body symptoms* (such as decreased energy, disturbed sleep, decreased libido, disturbed appetite, weight changes, etc), and certain *emotional symptoms* (such as decreased stability of emotions and more difficulty with managing the simple emotions of sadness, anger, and fear), but *not mind/spirit symptoms* (such as shame, hopelessness, helplessness, bitterness, low self esteem, pathological guilt, suicidal thoughts, etc).

I think that Alzheimer's disease provides an especially clear example of biological brain sickness *exposing* underlying mind/spirit issues. My perception is that part of what causes disruptive thoughts, emotions, and behaviors in Alzheimer's disease is that biological brain changes steadily erode the frontal cortex cognitive functions that the mind uses to run its psychological defenses. As these frontal cortex tools are lost, all the unresolved mind/spirit issues increasingly affect the person's thoughts, emotions, and behavior.[57] One of the most significant data points for me in developing this hypothesis about Alzheimer's disease was my experience with a personal acquaintance. This man was the most loving, humble, Christ-like man I have ever known, and when he got Alzheimer's disease I could hardly tell. His memory and cognitive functions deteriorated over years to the point that he did not recognize his own family, but as he lost his frontal cortex defenses there was very little unresolved garbage to leak out in the form of inappropriate and disruptive thoughts, emotions, and behavior.[58]

Intoxication, with alcohol or any other substance, provides another example of biological brain impairment that produces loss of normal cortical defenses, with unresolved mind/spirit issues that are usually hidden then being exposed.

F: Mind/spirit issues contribute to "exposure" of underlying genetic vulnerabilities: As discussed above, mind/spirit issues can actually *cause* biological brain abnormalities. Mind/spirit issues also contribute to the *exposure* of underlying brain *vulnerabilities* – genetic biological brain weaknesses/predispositions that have always been present, but that have not yet been expressed in observable signs and symptoms.

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[57] Note that emotional and behavioral problems in brain injury illnesses such as Alzheimer's disease can be especially difficult because, in addition to losing brain circuits that maintain psychological defenses, brain circuits that usually modulate emotional intensity can also be lost. Loss of these limbic system modulating circuits means that in addition to unresolved issues being exposed, the *intensity* of the emotional reaction can also be increased (even above the usual exaggerated intensity of triggered emotions).

[58] I developed this hypothesis from my personal experience with a number of patients and friends with Alzheimer's disease, and from my review of research regarding the neurological areas and the psychological functions affected by this disease. I have never seen this explanation for the disruptive thoughts, emotions, and behaviors usually seen in Alzheimer's disease presented in any psychiatric or psychological literature, but I *have* found a number of published case studies that are consistent with my hypothesis – case studies of elderly patients who had functioned without significant trauma-related impairment for many years, but then developed severe Post Traumatic Stress Disorder (PTSD) from *long* past trauma *only after developing dementia* (van Achterberg, Margriet E., Rohrbaugh, Robert M., Southwick, Steven M. "Emergence of PTSD in Trauma Survivors With Dementia," *The Journal of Clinical Psychiatry*, 2001, Vol. 62, No. 3, pages 206-7; and Johnston, Dierdre. "A series of cases of dementia presenting with PTSD symptoms in World War II combat veterans," *Journal of the American Geriatric Society*. 2000, Vol. 48, Pages 70-72). Note: I think some have trouble with this theory because it is very hard to accept the thoughts, emotions, and behaviors that come out of dear friends and family as they lose the tools they have always previously used to manage their hidden unresolved issues and pain.

Studies examining the concordance rate between identical twins provide some of the strongest evidence for mind/spirit issues contributing to the exposure of genetic biological brain predispositions. In a twin study, the concordance rate simply indicates the percentage of twin pairs where both twins are the same with respect to whatever is being measured in the particular study (eye color, the presence of diabetes, or the presence of a particular mental illness). Since identical twins have exactly the same genes, if the phenomena being studied is completely determined by genetic factors, then both twins in *every* pair will be the same. The concordance rate will be 100%.

A hugely significant data point regarding the role of mind/spirit issues is that twin studies reveal identical twin concordance of *50% or lower* in most mental illnesses – even in the mental illnesses where biological brain dysfunction is the most important contributing factor, such as true schizophrenia and true bipolar disorder – and twin studies find ***no*** mental illnesses with identical twin concordance of 100%.[59] For example, in identical twin pairs where one twin has schizophrenia, and the second twin in each pair shares the exact same genetic predisposition to schizophrenia, *only ~50%* of the second twins will actually develop clinical schizophrenia. This means that environmental factors, developmental factors, and unresolved mind/-spirit issues *determine whether an underlying genetic vulnerability will ever be "exposed" – whether or not a genetic biological brain predisposition will ever manifest as an actual mental illness, even in these illnesses where biological brain dysfunction is primary*.

G. Biological brain more than just a container: I have heard the biological brain referred to as simply the container, or "earth suit" for the non-biological, non-physical mind. While I think a strong case can be made for the mind being the leader, master, more primary phenomena, it seems inadequate to describe the brain as merely the mind's "container." I think the above discussion presents a connection between the thoughts, emotions, and choices coming ultimately from our minds, and the chemical and electrical activity in our brains, that is more profound, intimate, and mysterious than the brain simply providing a container for the mind.

There is certainly a lot of complexity and mystery here. The most important point is that the biological brain and the non-biological mind are intimately and profoundly connected, and that they each can affect the other in important ways.

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[59] See, for example, Skre I., Onstad S., Torgersen S., Lygren S., Kringlen E. "A twin study of DSM -III-R anxiety disorders," *Acta Psychiatr Scand.* 1993, Vol. 88, No. 2 pages 85-92 (identical twin concordance for panic disorder = 42%); Onstad S., Skre I., Torgersen S., Kringlen E. "Twin concordance for DSM-III-R schizophrenia," *Acta Psychiatr Scand*. 1991 Vol. 83, No. 5, pages 395-401 (identical twin concordance for schizophrenia = 48%); McGuffin P., Katz R., Watkins S., Rutherford J. "A hospital-based twin register of the heritability of DSM-IV unipolar depression," *Arch Gen Psychiatry*. 1996, Vol. 53, No. 2, pages 129-36 (identical twin concordance for major depression = 46%); and Kieseppa T., Partonen T., Haukka J., Kaprio J., Lonnqvist J. "High concordance of bipolar I disorder in a nationwide sample of twins," *Am J Psychiatry*. 2004, Vol. 161, No. 10, pages 1814-21 (identical twin concordance for bipolar I disorder = 43%); Kendler, Kenneth S., MacLean C., Neale M., Kessler R., Heath A., Eaves L., "The genetic epidemiology of bulimia nervosa," *Am J Psychiatry* December 1991, Vol. 148 No. 12, pages 1627-37 (identical twin concordance for bulimia = 22.9%); Kipman A., Gorwood P., Mouren-Simeoni MC., Ades J., "Genetic factors in anorexia nervosa," *Eur Psychiatry*, July 1999, Vol. 14, No. 4, pages 189-98 (identical twin concordance for anorexia nervosa = 44%); Levy Florence, Hay David A., McStephen Michael, Wood Catherine, Waldman Irwin. "Attention-Deficit Hyperactivity Disorder: A Category or a Continuum? Genetic Analysis of a Large-Scale Twin Study," *J. Am Acad. Child Adolesc. Pcychiatry*. June 1997, Vol. 36, No. 6, pages 737-744 (identical twin concordance for ADHD = 82%).

IV. Mental health problems always involve *both* mind phenomena *and* brain phenomena:

A. General discussion: There are many different factors that can contribute to mental health problems, some of these factors being primarily biological brain phenomena, some of these factors involving an intimate interweaving of brain biology and mind/spirit phenomena, and some of these factors being primarily mind/spirit phenomena. In my experience, ***every*** mental health problem I have ever encountered has involved a combination of *both* mind/spirit phenomena *and* biological brain phenomena.

Even in situations where mind/spirit issues are clearly the most important contributing factors, biological brain factors, such as genetic predispositions, developmental effects on the biological brain, and environmental effects on the biological brain always contribute, *determining how the mind/spirit issues will be expressed* in the overall clinical pictures of specific mental illnesses. For example, a person might have traumatic experiences resulting in memory anchored lies along the lines of "I'm helpless, I can't do it." One combination of genetic, developmental, and environmental biological brain factors will combine with these memory anchored lies to result in an anxiety disorder, while a different combination of genetic, developmental, and environmental biological brain factors, *interacting with these same lies*, will result in the overall clinical picture of depression.

On the other hand, even in situations where biological brain pathology is very important mind/spirit issues always contribute, powerfully affecting the overall clinical picture as biological brain weaknesses expose unresolved mind/spirit issues. For example, Alzheimer's disease is a very genetic, medical, biological brain illness. However, as describe above, the overall clinical picture has a huge mind/spirit component as the Alzheimer's disease neurology results in unresolved mind/spirit issues increasingly affecting the person's thoughts, emotions, and behaviors. Schizophrenia provides another example. On one hand, it is a very genetic, medical, biological brain illness. On the other hand, as described above, environmental factors, developmental factors, and *unresolved mind/spirit issues* determine whether or not somebody with schizophrenia genetic predisposition will actually manifest the clinical picture of schizophrenia. Furthermore, unresolved mind/spirit issues will certainly exacerbate the symptoms in those who do manifest clinical schizophrenia.[60]

B. Summary of factors contributing to mental health problems: A summary of our current formulation regarding both the biological brain factors and the non-biological psychological/spiritual factors contributing to mental health problems should provide a helpful overview.

1. Biological brain – *Genetic* strength endowments and vulnerabilities: (1,000 subtly combined bell curves). There is a HUGE collection of data proving some degree of genetic contribution to mental health problems. For example: case-control family pattern studies, studies comparing fraternal vs identical twins, studies comparing twins reared apart vs twins reared together, adoption studies, gene mapping association studies, and other molecular genetics research. Note that the evidence for genetic factors contributing to mental health problems is *NOT* just family patterns that could be explained by psychological and/or

[60] For additional discussion of the impact of unresolved mind/spirit issues in people with schizophrenia, see "Schizophrenia and the Immanuel Approach/Theophostic-based Emotional Healing: General Comments and Frequently Asked Questions."

spiritual phenomena being passed down in families.[61] A thorough discussion of this research is beyond the scope of this essay, but I would like to briefly summarize an especially compelling and easy to understand component of the medical research provided by another kind of twin study.

The results I would like to summarize here come from twin studies that work with sets of twins that have been reared together, and then compares the concordance rate in fraternal twins with the concordance rate in identical twins. The two key points in these studies are 1) both the fraternal and identical twins have shared very similar intrauterine and family environments; and 2) the identical twins have *exactly the same genetic blueprint*, whereas fraternal twins share genes in the same way siblings do. Under these conditions, if a particular illness is *completely genetic*, identical twins will be concordant (both twins either having the illness or not having the illness) *100%* of the time because their genes are *100%* identical, whereas fraternal twins will be concordant at the same percentage as *non-twin siblings* (50%). In contrast, if a particular illness is *completely the result of environmental factors*, there will be *no difference between identical twins and fraternal twins*. And if an illness is *partially genetic* and *partially environmental* – that is, there is a genetic predisposition/vulnerability, but some kind of environmental factor causes the underlying vulnerability to manifest as actual disease – then identical twins will be concordant at a greater percentage than fraternal twins, but at a percentage less than 100%.

The simple summary of this research is that many studies have found the concordance rates to be much higher for identical twins than for fraternal twins, and this pattern of dramatically higher concordance in identical twins has been found for almost every mental health problem that has been studied.[62] To my assessment, this evidence proves that genetics-based biological brain factors contribute to most mental health problems. To keep this in perspective, remember that *every* study has also found identical twin concordance rates *less than 100%*,

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[61] A number of current books discuss this extensive evidence. See, for example, Mellon, Charles David. *The Genetic Basis of Abnormal Human Behavior*. (Genetics Heritage Press), 1997. Another good source is the introductory sections on genetics, and then the genetics section within the discussion of each mental illness in Kaplan, H.I., Kaplan, Virginia A. (Eds.) *Kaplan and Sadock's Comprehensive Textbook of Psychiatry, 8th edition*, (Baltimore, MD: Lippincott Williams & Wilkins), 2004. For a good general discussion of genetics and mental illnesses, and an understandable explanation of the different kinds of research examining genetic contribution to mental illnesses, see Faraone, Stephen V., Tsuang, Ming T., Tsuang, Debby W. *Genetics of Mental Disorders: A Guide for Students, Clinicians, and Researchers.* (New York, NY: Guilford Press), 1999.

[62] See, for example, Schuckit, Marc A. "Chapter 11.2: Alcohol-Related Disorders: Etiology" (twin studies for alcoholism); Riley, Brien P., Kendler, "Chapter 12.3: Schizophrenia: Genetics" (twin studies for schizophrenia); Kelsoe, John R. "Chapter 13.3: Mood Disorders: Genetics" (twin studies for bipolar disorder and unipolar depression); McMahon, Francis J., Kassem, Layla. "Chapter 14.6: Anxiety Disorders: Genetics" (twin studies for panic disorder, generalized anxiety disorder, social phobia, obsessive compulsive disorder, and Post Traumatic Stress Disorder); Andersen, Arnold E., Yager, Joel. "Chapter 19: Eating Disorders: Etiology, Vulnerability" (twin studies for anorexia and bulimia); and Hechtman, Lily. "Chapter 39: Attention-Deficit/Hyperactivity Disorder: Genetics" (twin studies for ADHD), all in Kaplan, H.I., Sadock, B.J. (Eds.) *Kaplan and Sadock's Comprehensive Textbook of Psychiatry, eighth edition,* (Baltimore, MD: Lippincott Williams & Wilkins), 2004, pages 1173-74, 1354-71, 1582-94, 1759-62, 2006-8, 3185-5, respectively. See also Hechtman, Lily. "Genetic and Neurobiological Aspects of Attention Deficit Hyperactive Disorder: A Review," *J Psychiatr Neurosci*, Vol. 19, No. 3, 1994, pages 193-201.

which proves that the mental health problems studied are not *completely* determined by genetic factors.

2. Biological brain – *Medical illnesses* that affect the brain:
   a. Metabolic and hormonal diseases (for example, diseases causing abnormal thyroid levels or abnormal blood sugar levels).
   b. Neurological diseases (for example, brain tumors, seizure disorders, Parkinson's disease, Alzheimer's disease).

3. Biological brain – *Environmental* strengths vs deficits, injuries:
   a. Nutrition – optimum vs deficiencies
   b. Stimulation for neurological development – under stimulation vs optimum vs over stimulation.
   c. Infections (for example, viral encephalitis causing direct neurological injury)
   d. Toxins (for example, lead or mercury poisoning causing direct neurological injury)
   e. Physical trauma to the head

4. Biological brain and non-biological mind (especially interwoven) – *Developmental* strengths and/or deficits:
   a. Basic neurological skills and tools, strengths and/or deficits (secure attachment, language, social interactions, motor skills, problem solving/thinking skills, etc)
   b. Capacity strengths and/or deficits[63]
   c. Maturity skill strengths and/or deficits[64]

5. Non-biological mind/spirit – *"Mind/spirit genetics"* (the mind/spirit parallel to biological brain genetics)*:*
   a. Mind/spirit strength endowments from the Lord
   b. Mind/spirit generational vulnerabilities

6. Non-biological mind/spirit – *Information* strengths vs deficits:
   a. Scriptural truths and principles
   b. Mind and Brain paradigm: Being aware of the biological brain and the non-biological mind/spirit, and understanding how they fit together (as presented in this essay).
   c. Understanding of implicit and explicit memory
   d. Other knowledge/cognitive information that is helpful.

7. Non-biological mind/spirit – *Psychological trauma and associated issues*:
   a. Truth-based pain (for example, truth-based grief)

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[63] For a detailed discussion of biological, psychological, and spiritual capacity, and how deficits with respect to these capacities contribute to mental health concerns, see "Immanuel, Emotional Healing, and Capacity, Parts I & II," and also the pre-introduction to Part II of "Brain Science, Psychological Trauma, and the God Who is With Us."

[64] For good discussions on maturity and maturity skills, see Lehman, Karl D., "Brain Science, Psychological Trauma, and The God Who is With Us, Part II,"at www.kclehman.com; Wilder, E. James, *The Complete Guide to Living With Men*, (Pasadena, CA: Shepherd's House Publishing), 2004; and Friesen, James G., Wilder, E. James, Bierling, Anne, M., Koepcke, Rick, and Poole, Maribeth. *The Life Model: Living From the Heart Jesus Gave You*. (Van Nuys, CA: Shepherd's House Publishing), 2000 revision.

b. Lies associated with traumatic memories
c. Unhelpful defenses (unhelpful from the beginning, like self pity, or defenses that are appropriate initially but that get in the way later in life when better alternatives are available)
d. Reactive sins
e. Demonic infection

8. Non-biological mind/spirit – *primary spiritual issues:*
a. Salvation
b. Filling, gifts of the Holy Spirit
c. Persistent, willful sin

C. Diagrams illustrating our model regarding biological brain issues and non-biological mind/spirit issues in mental illnesses: Mainstream medical psychiatry currently sees abnormal brain biology as the deepest, root, primary cause of all mental illnesses. In contrast, from the "mind *and* brain" perspective that we are presenting here, every mental health concern involves *both* biological brain issues and non-biological mind/spirit issues. Furthermore, we perceive that there is a continuous spectrum from illnesses like Alzheimer's disease, where non-biological psychological/spiritual issues contribute but biological brain abnormalities are primary, to mental health concerns like uncomplicated grief, where biological brain factors contribute but non-biological mind/spirit issues are primary.

Some of the biological brain abnormalities associated with mental illnesses are the physical/biological *expression* of the underlying mind/spirit issues, some of the biological brain abnormalities associated with mental illnesses are the results of developmental and environmental factors, some of the biological brain abnormalities associated with mental illnesses are the results of medical illnesses that affect the biological brain, and some of the biological brain abnormalities associated with mental illnesses are the genetic predispositions that made the person vulnerable to her mind/spirit wounds being expressed in a particular picture of clinical mental illness. The diagrams below attempt to illustrate our model regarding biological brain issues and non-biological mind/spirit issues in mental illnesses:

1. From the perspective of starting with mind wounds and associated spiritual issues:
Figure #1 summarizes our current paradigm from the perspective of starting with mind wounds and associated spiritual issues. The interaction of each person's specific mind wounds (truth-based pain, unresolved psychological trauma, absence wounds) and associated spiritual

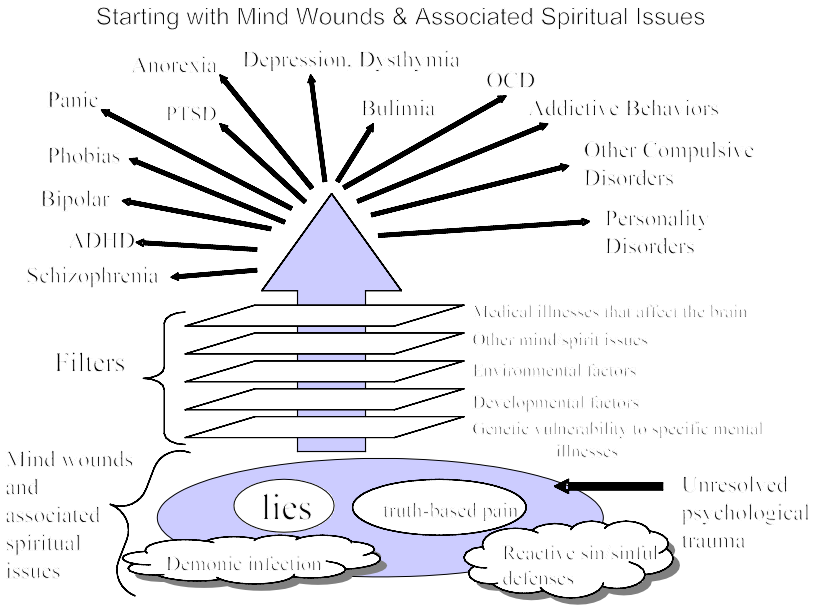

Figure #1: Mental Illness Starting with Mind Wounds & Associated Spiritual Issues

issues (reactive sin, sinful defenses, demonic infection) with other mind/spirit issues,[65] developmental factors,[66] environmental factors, genetic brain biology vulnerabilities,[67] and medical illnesses that affect the brain determine which DSM IV mental health diagnostic picture actually develops (panic vs. depression vs. obsessive compulsive disorder vs. substance abuse, etc).

2. From the perspective of starting with genetically based brain biology vulnerabilities: Figure #2 presents the same model, but from the perspective of starting with genetically based brain biology vulnerabilities that predispose the person to displaying the clinical picture of a specific mental illness. The interaction of each person's specific genetically based brain biology vulnerabilities with mind wounds, associated spiritual issues, other mind/spirit issues, developmental factors, environmental factors, and medical illnesses that affect the brain determine which DSM IV mental health diagnostic picture actually develops (panic vs. depression vs. obsessive compulsive disorder vs. substance abuse, etc).

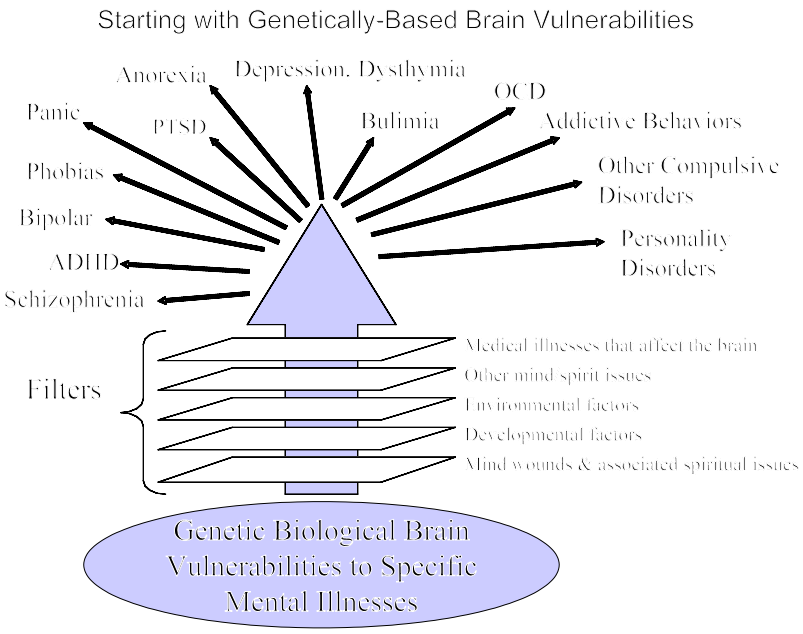

Figure #2: Mental Illness Starting with Genetically-Based Brain Vulnerabilities

D. Additional comments regarding the spectrum from **Biological brain** – mind/spirit to **Mind/Spirit** – biological brain: At this point I would like to take time for a more detailed discussion of the "continuous spectrum from illnesses...where non-biological psychological/spiritual issues contribute but biological brain abnormalities are primary, to mental health concerns...where biological brain factors contribute but non-biological mind/spirit issues are primary." As we consider this spectrum I want you to notice how widely the relative importance of biological brain factors versus mind/spirit issues can vary,

[65] For example, demonic opposition unrelated to unresolved trauma, persistent willful sin unrelated to trauma, and mind/spirit "genetics (mind/spirit strength endowments from the Lord and generational spiritual vulnerabilities).

[66] Note that developmental history includes more than just smaller, earlier wounds and lies that contribute to the key wounds and lies precipitating the final clinical picture. Developmental history also determines things like joy supply, maturity skills, and learned capacity for dealing with negative emotions.

[67] Note that genetically based brain biology vulnerabilities include both genetically based *structural* vulnerabilities and genetically based brain chemistry vulnerabilities.

and I also want you to notice that ***both*** *mind/spirit issues* ***and*** *biological brain factors contribute* even at the extremes on both ends of the spectrum.

At one end of the spectrum we have mental illnesses like schizophrenia, where both mind/spirit issues and biological brain factors contribute but the biological factors are primary. With people who have true[68] schizophrenia medication is almost always necessary to stabilize the overall clinical picture before emotional healing can even be considered; and addressing psychological and spiritual issues results in improvement but not complete resolution. For example, addressing psychological and spiritual issues may result in decreased need for medication, decreased symptoms even with lower doses of medication, fewer psychotic exacerbations, exacerbations that are less severe, and exacerbations that resolve more quickly; but even with optimal emotional healing work baseline signs and symptoms of schizophrenia will still remain and long term medication will still need to be an important part of the treatment plan.

Another illness at this end of the spectrum is Alzheimer's disease, which provides one of the most extreme examples of biological brain factors being dominant. Alzheimer's disease is an invariably progressive neurological disease with clearly defined, characteristic neuroanatomical features, such as cortical atrophy that develops in characteristic patterns as the disease progresses, and clearly defined, characteristic neurohistological features, such as neurofibrillary tangles and neuritic plagues. Furthermore, there is a direct correlation between the severity of observable cognitive impairment and the severity of the cortical atrophy, the density of neurofibrillary tangles, and the density of neuritic plagues. Research is also providing increasing clarity regarding the physiological mechanisms involved. For example, it is becoming increasingly clear that abnormal metabolism of beta-amyloid contributes in some way to the formation of neuritic plagues, it seems likely that neuritic plagues both interfere with the function of living neurons and contribute to premature neuron death, and the dysfunction and premature death of neurons contribute to both cognitive impairment and cortical atrophy.

As described above, research (such as the studies with learned helpless rats) and case studies show that psychological/spiritual issues can cause both the clinical picture and many[69] of the associated biological abnormalities of some mental illnesses. As also described above, case studies and research (such as the studies where PET scans are obtain as people with OCD respond to psychotherapy) demonstrate that with some mental illnesses addressing psychological/spiritual issues can both resolve clinical symptoms and normalize many of the biological brain abnormalities. Furthermore, as illustrated by the bulimia case study described below, addressing mind/spirit issues can sometimes even result in the permanent complete resolution of major mental illnesses. In marked contrast, there is absolutely no evidence indicating that psychological/spiritual issues can *cause* the clinical picture or brain

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[68] See "Schizophrenia and the Immanuel Approach/Theophostic-based Emotional Healing: General Comments and Frequently Asked Questions" for my discussion of *true* schizophrenia vs *mimic* schizophrenia.

[69] The reason I say "many" as opposed to "all" regarding associated biological abnormalities is that I don't think addressing psychological/spiritual issues resolves the subtle biological brain abnormalities (often genetically based) that predispose people to respond to unresolved psychological and spiritual issues with the clinical pictures of certain specific mental illnesses.

abnormalities of Alzheimer's disease, and there is absolutely no evidence indicating that resolving psychological/spiritual issues can *resolve* the clinical picture or brain abnormalities of Alzheimer's disease.

The evidence for strong and specific genetic contributions is another reason for my perception that Alzheimer's is one of the most biologically-based mental illnesses. As already described, research such as twin studies demonstrates that genetically-based biological abnormalities cause predispositions to specific mental illnesses. However, the specifics regarding these genetically-based biological abnormalities remain vague and mysterious for most mental health concerns. In contrast, much more is known about genetically determined abnormalities that contribute to Alzheimer's disease. For example, our bodies make a chemical, apolipoprotien E (ApoE), that transports lipids (fats) in the blood. The usual form of this lipoprotien, ApoE3, is associated with a low risk of Alzheimer's disease, while a clearly identified genetic variant of this lipoprotein, ApoE4, is associated with a dramatically increased risk of the disease. In fact, people who inherit the gene for the ApoE4 variant from one parent are ~three times more likely to develop Alzheimer's disease, and those who inherit two copies of ApoE4 gene (one from each parent) are ~**fifteen times** more likely to develop the disease.[70] Furthermore, recent research has been clarifying the specific mechanisms by which the genetic variant contributes to Alzhiemer's pathology. For example, one recent study demonstrated that the apolipoprotien E4 variant increases the transportation of amyloid precursor protein into brain cells.[71] Increased influx of amyloid precursor protein results in increased production of amyloid fragments, and it seems probable that increased amyloid fragments would contribute to increased production of the neuritic plagues that are so clearly associated with the development and progression of Alzheimer's disease.

However, even Alzheimer's disease, where biological brain factors are especially strongly dominant, is affected by psychological and spiritual issues. For example, some research indicates that good habits of cognitive stimulation can both delay the onset and slow the progression of the disease;[72] and as described earlier, resolving psychological and spiritual issues removes toxic content that would otherwise be increasingly exposed, and this dramatically decreases disturbing thoughts, painful emotions, demonic harassment, and overall disruptive behavior as the disease progresses.

My perception is that biological brain factors are primary in all cases of Alzheimer's disease,

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[70] Blennow K., de Leon, M.J., Zetterberg, H. "Alzheimer's disease," *Lancet* July 2006, Vol.368 (9533), pp 387-403.

[71] He X, Cooley K, Chung CH, Dashti N, Tang J. "Apolipoprotein receptor 2 and X11 alpha/beta mediate apolipoprotein E-induced endocytosis of amyloid-beta precursor protein and beta-secretase, leading to amyloid-beta production." *J Neurosci.* 2007 Apr 11;27(15):4052-4060.

[72] See, for example, Verghese J, Lipton R, Katz M, Hall C, Derby C, Kuslansky G, Ambrose A, Sliwinski M, Buschke H. "Leisure activities and the risk of dementia in the elderly," *New England Journal of Medicine*, 2003, Vol. 348, No. 25, pages 2508–16.

most cases of true schizophrenia and true[73] bipolar disorder, some cases of true[74] ADHD/ADD, rare cases of depression, and rare cases of obsessive compulsive disorder.

In the middle of the spectrum we have mental illnesses where biological brain factors and psychological/spiritual issues are more equally important. Certain[75] cases of depression provide an especially good example of mental illnesses in the middle of the spectrum. We know that biological brain factors are strongly important in these cases because we can often provide (temporary) complete relief from the signs and symptoms of depression by using appropriate medication to "manually" correct the abnormal brain chemistry associated with acute episodes of depression. However, we know that psychological/spiritual issues are also important because even in the cases where medication is able to produce complete remission the depression will return if the medication is stopped and the underlying issues are again triggered. The underlying psychological/spiritual issues contributing to the depression are still down there and they will once again produce the overall clinical picture of depression when they get activated at some point in the future.

On the other hand, we know that psychological/spiritual issues are strongly important in these cases because addressing psychological/spiritual issues will often provide complete relief from the signs and symptoms of depression *even when the person has previously required ongoing baseline medication, but the medication is stopped after emotional healing work resolves psychological/spiritual issues.* And this complete remission can last for many months (or even years). However, we know that biological brain factors are also important because the same, familiar clinical picture of depression will return if new triggers stir up other mind/spirit issues that have not yet been resolved, if the patient encounters significant new trauma, or if the person encounters overwhelming truth-based stressors in the present. The subtle (often genetically based) biological brain weaknesses/abnormalities that made the person vulnerable to depression are still present, so that if another set of mind/spirit issues stresses the system past a certain point the person will once again manifest with the overall clinical picture of depression.

My perception is that biological brain factors and psychological/spiritual issues are more equally important in rare cases of schizophrenia and bipolar disorder, most cases of true ADHD/ADD, some cases of depression, some cases of dysthymia, some cases of PTSD, some addictive disorders, some cases of obsessive compulsive disorder, some cases of eating disorders, some cases of other disorders of compulsive behavior, some cases of panic disorder, rare phobias, and rare cases of personality disorders.

At the other end of the spectrum we have mental illnesses where both mind/spirit issues and biological brain factors contribute, but the mind/spirit issues are primary. One of the most

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[73] See "Bipolar Disorder and the Immanuel Approach/Theophostic®-based Emotional Healing: General Comments and Frequently Asked Questions" for my discussion of *true* bipolar disorder vs *mimic* bipolar disorder.

[74] See "ADD/ADHD and Emotional Healing" for my discussion of *true* ADHD/ADD vs *mimic* ADHD/ADD.

[75] In our experience some cases of depression belong in the middle of the spectrum, as described here, whereas other cases of depression belong at the end of the spectrum where psychological/spiritual issues are primary, as described below.

important observations indicating that mind/spirit issues are primary in certain mental health concerns is that manually correcting the brain chemistry in these cases *without addressing the underlying mind/spirit issues* will result in only partial[76] and/or temporary resolution of symptoms. Even in the cases where medication is able to provide complete remission, the symptoms will return when the medications are stopped and the underlying issues are again triggered. In marked contrast, *if all of the underlying mind/spirit issues contributing to the particular clinical picture are resolved* in these cases, the medications can be stopped and the symptoms will not return. These people go for many years without relapse, even in the face of triggers that have always precipitated the problem in the past, even in the face of triggers that stir up other issues, and even in the face of intense stress/truth-based pain in the present. With respect to these cases, my perception is that the psychological/spiritual issues are inherently and logically linked to the specific symptoms of the particular mental illnesses, and when these underlying issues are resolved the mental illnesses in question are *completely* and *permanently* resolved. In these cases, the people do *not* have biological brain vulnerabilities predisposing them to manifest with the clinical pictures of these particular mental illnesses in response to a variety of issues and stressors.[77]

A case of bulimia that resolved with emotional healing provides an especially good example of a mental illness where psychological/spiritual issues were primary.[78] In early 2002, a little more than a year after her initial breakthrough healing, Mary (not her real name) wrote the following:

> Just after Thanksgiving, 2000, I was healed (through Theophostic®) by the Lord of a 21 year bondage to bulimia. I had been consumed with bulimia since the autumn of 1979. For 21 years – my entire adult life – my every waking moment was focused on looking for opportunities to binge and purge, planning the binges, binging, purging, cleaning up, covering up, over and over, ad nauseam (pun intended). I told a network of lies too intertwined to keep straight. Bulimia took over every aspect of my life; it permeated every corner of my mind. I went to great lengths (shoplifting, stealing from my husband and children, charging thousands of dollars on credit cards) – whatever it took to be able to binge and purge. I felt incredible shame, especially because I was a Christian (although I regularly wondered if I had committed the unforgivable sin), my husband loved me, and I was a mother of six children. In my moments of clarity, I would look around me, see my husband, children, all the trappings of the "good life," and wonder why I seemed willing to throw it all away, and to cause great pain to the people closest to me, in the pursuit of...I didn't know what exactly. I just knew I felt like I had to keep living this insane way – I didn't know how else to live.
>
> "For two decades I had sought help from every source I ever heard of. I had tapped into the best resources that the world and the church had to offer. I looked for answers from Freudian

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[76] For example, in the bulimia and phobia case studies described below psychiatric medication provided only mediocre, partial remission.

[77] In the real world things are seldom absolute, so a more accurately nuanced statement regarding most cases would be that the biological brain vulnerabilities are *so minimal* that they never again become apparent *even in spite of intense triggers that stir up many other issues, intense truth-based pain in the present, and even new psychological trauma.*

[78] For a much more detailed description and discussion of this case study, see: "Freedom from Bulimia: Case Study/Testimony" (available as free download from www.kclehman.com).

psychotherapy, hypnosis, cognitive therapy, behavior modification, endless self-help books (both secular and Christian), support groups, 12-step programs, six different anti-depressants, five 30-day stays at in-patient treatment centers (all specifically geared towards eating disorders), hundreds of prayer sessions (soaking, prophetic, inner healing, confessional, intensive, deliverance...you name it), approximately 20 different counselors (pastoral as well as traditional therapy), and three years of counseling with my priest (who is also a psychologist). In each instance, I found "answers;" I was given a myriad of advice, directions, character-building exercises, and more information than I knew what to do with. I would embrace each program, soak up everything they gave me, and go back into my world, often with a sense of renewed hope, determined to make it work. But always, without exception, I would eventually find myself back in the "pig sty," continuing in my old self-destructive pattern. I kept doing the very best I knew how to cooperate with each program, with each counselor; I would achieve varying periods of "recovery" (meaning I could abstain, with great effort, from binging and purging, but it was a constant mental battle), from a few days to a year or more, but each "recovery" ended with a crash of defeat, perpetuating my shame and leaving me with a burden of hopelessness. Each therapist would grow frustrated with my lack of success – they were giving me the best they had, so it must be my fault that I kept failing. Their confrontations heaped shame on me: "You're just not surrendered enough," "You're just not trying hard enough," "You're such a controlling person," "I don't know what more to do with you if you're not going to cooperate," "You obviously don't want recovery badly enough." Even two internationally recognized healing ministers, who have published many books on prayer for emotional healing, gave up, saying they just couldn't help me.

"I couldn't shake the conviction that my life was based on very deep, very ingrained lies that I had believed since early in my life. I didn't know what the lies were, but I knew they were in operation. I remember saying, "I don't think I can get any better (or behave any better) until these lies are exposed and replaced with God's Truth." I continued in counseling, although I'd become so discouraged with my failures that I'd periodically quit, and I even stayed away from church (where I'd feel like a filthy hypocrite). I got my only "fellowship" through our local Christian radio station.

"Then in the fall of 2000 I started hearing commercials for a counselor who was reporting to have witnessed miraculous healing results with her clients. My whole body would feel pulled toward the radio when I heard her describe some short testimonies of healing. I was aware of flickers of hope under the layers of discouragement and fear of trying and failing again. Out of loyalty to my priest, I asked for his permission to seek outside counseling. My priest asked me to first get a thorough physical (I was severely underweight from excessive purging, and quite exhausted). The physician, a Christian, referred me to a Christian therapist. I decided that I'd "try out" both the referral and the woman I'd heard on the radio, and choose. I saw the referred counselor three times before she announced: "Your case is one of the toughest I've seen; you need a long stay at an in-patient treatment center. You need to be prepared for a long, uphill 3-year battle, but you should be able to cope better after that." When I told her that another counselor was supposedly having fast and thorough results from some kind of praying, she scoffed and told me that there weren't any shortcuts. I was devastated. I'd already experienced five different 30-day stays at treatment centers, all of which had only short-term "success." I wasn't willing to leave my six children (including an eight-month old nursing infant) for 30 days, with absolutely no guarantee of improvement. I cried all the way home, saying, "Lord, there's got to be another way to be healed that won't harm my children.

I give up. It's up to You."

"When I got home, my husband listened to my frustration, and encouraged me to call the counselor I'd heard on the radio and make an appointment. She answered the phone, listened to my pain, and made an appointment for two days later. I asked her what kind of praying she did, because I was sure I'd been exposed to every type of inner healing prayer in existence. She said, "I help you to come into the Lord's presence, He brings you to where you're believing a lie, and He replaces it with His Truth." I heard bells go off in my head! This was exactly what I'd "felt" I needed more than a year before this. She then asked me to prepare and bring a list of all the reasons why I continued to binge and purge.

"I came up with a two-page list, which I brought with me to my first appointment. None of it was revelational to me, but it was amazing to see all of these "reasons" together. The counselor then asked me, "Which of these seems to be the strongest, most compelling reason to keep you in this pattern?" I replied: "If I don't binge and purge, the terrible deprivation I feel may destroy me."...She asked me to focus on the thought that if I didn't binge and purge, the deprivation would destroy me; she asked me to allow the feelings to grow, and to describe what I was experiencing mentally, emotionally, and even physically. I felt panicky, fearful, desperate, anxious, helpless, even terrified; my stomach felt as if it were in knots, my face frowned up, and I clasped my hands tightly together. She asked me to continue to focus on my discomfort while she asked Jesus to show me when and where this panicky-fearful-anxious feeling first came to me. She asked me to...just report any thought, feeling, sensation, impression, words or ideas that occurred to me, and to trust Him to interpret. I waited in silence as she prayed; at first I had nothing to report, except that the anxiety was still strong.

"After a few moments, I had a distinct impression of a small embryo, floating in warm darkness; somehow I knew that the embryo was me. I reported what I saw/sensed to the counselor. She asked what feelings I was experiencing. I said I had a fear of impending doom, as if something really bad was going to happen to me, and somehow I had to do something about it, only I couldn't because I was so helpless and couldn't be heard. I felt as if I was horribly empty, starving, deprived of something very necessary. I reported all this to the counselor; she asked the Lord to show me the lie imbedded in the "memory." Suddenly I felt the embryo/myself vowing, "When I am able to help myself, I'm going to make sure that I am never deprived again!" The vow had two lies hidden behind it: "If I don't binge and purge, the terrible deprivation I feel may destroy me" and "It's up to *me* to make sure that I'm never feeling deprived." Perhaps another, deeper lie was there as well: "God will not be there for me – I have to take care of myself." She had me renounce the vow, and then asked Jesus to show me His truth. Again, I waited in silence for a few moments. I then had the impression that I (still an embryo), was leaning up against someone, with large, strong arms encircling the area around me. Then I felt and saw the arms gently pushing the amniotic fluid toward me (much as a mother does during her baby's first bath, to help the child be unafraid of the water). Several times, the arms gently pushed the waves of water toward me, like a rocking sensation, then the arms wrapped around me in a gentle, yet firm, embrace. I knew instinctively that this was Jesus. Then I "heard" Him say, "I am the one who will keep you from deprivation. You do not have to take care of yourself; I will take care of you." Suddenly, all the anxiety, fear, emptiness, etc. left, leaving an assurance of peace. I reported all of this, and the counselor asked me to say aloud the lies. I repeated the lies, and realized that the statements which had felt very true minutes before now felt ridiculously false.

"I left that appointment feeling different, in a way I couldn't explain, and I didn't want to analyze it. I felt as if I were being carried. I had been binging and purging out of control for weeks, months and years before this day. The next day, I awoke, still feeling carried. Temptations occasionally fluttered nearby, but the power of them was greatly diminished – I felt as tempted to binge/purge as I felt to park my car in a handicapped space; they might both *occur* to me, but they *felt* ridiculous and wrong, very easy to dismiss. I continued with counseling appointments for the next few weeks; each time, the Lord revealed more lies, gently and simply replacing them with His truth. Day after day, I found myself not binging and purging, and not even thinking about it; I didn't even feel the slightest desire to do so. As more and more lies were replaced with truth (at a spirit level, not just a head level), my faith grew, slowly and surely. I immediately felt a strong desire to go back to church. My hunger for God, His Word and His people grew in a way that amazed me. I wanted to read the Bible, to pray, to worship, to praise. My mind felt transformed, and I was able to discern easily. I wanted to be closer to my husband and children, to actually have life between meals! I could put others first. I made amends for my wrongs, asking forgiveness of my husband, children, parents, sisters, and others I'd harmed over the years.

"Three weeks into this "new thing," my husband Mark and I sat down with our children to openly speak about what life had been like with a raging bulimic mother, and what was happening to me (they'd already noticed and commented on a difference in me). When I asked if they had any questions, my eldest daughter asked, "Mom, what do we do if we find you binging again?" I was about to say something along the lines of, "Tell your father," when I heard the following words come out of my mouth, "I don't ever have to do that again. I'm free." Mark did a double-take, and I said, "What did I just say?" At that moment, I knew that I knew that Jesus had completely and permanently set me free from the bondage of bulimia.... I was thrilled, excited, blessed beyond belief! After all the years of suffering, of others suffering because of me, of countless people praying on my behalf, of living a life consumed by sin, I was free."

February 2003, more than two years after her initial Theophostic sessions, Mary makes the following observations regarding "...the fruit that has remained (in spite of all the testing)":

1.) I'm no longer in bondage to binging and purging. Before, it was the lens through which I viewed myself and the world around me. My first thought would be, "*When* can I binge?", "When will my husband leave the house so I *can*?", "What can I binge *on*?", "Do I have any money to buy food to binge on?" Then I would pull myself together on the outside so as to appear calm (inside I was quivering with desire to binge). I would go through the motions of "normalcy:" take care of children (while considering them to be "in the way" of what I really wanted to do), tend to my husband (all the while desperately wanting him to leave for work so I could binge), clean the house (just to keep myself busy while waiting for a chance to binge), teach my children (again, to stay busy).

2.) I'm free from the need to lie in order to cover my tracks. Lying used to be my way of life. I no longer have to worry about when my husband comes home. I'm at peace if he decides to work from home (it used to *enrage* me). I no longer have to worry about what my children know about my behavior, or how they feel about me. When people ask me, "How are you?", I no longer suspect they really mean, "Have you thrown up lately?"

3.) I no longer have to resort to drinking alcohol in order to suppress the anxiety I lived with

while binging (and formerly shoplifting several years ago).

4.) I'm more at peace with my body....Now I keep myself in shape with walking and light weight-lifting – compare that to the pre-healing regimen of managing an aerobic studio, spending hours in the gym, and running even with stress fractures!

5.) My identity used to be, "I'm a bulimic." When I met new people, it wouldn't take long for me to reveal this to them. It was practically my answer to the question, "So, what do *you* do?" Answer: "Oh, I eat vast quantities of food and then throw it up. And you?" Now, I have many things to tell them: "I'm a Child of God, a follower of Jesus," "I'm a wife and a mother of 7 children," "I'm a home-schooler," "I'm an artist," "I'm a singer," "I'm a dancer," "I'm a seeker of truth and healing."

6.) I'm free of the compulsion to turn to food and purging as my only resource. Now, when I'm overwhelmed by emotions, I have many options for comfort: prayer, praise, singing, reading, journaling, listening to music, calling a friend, painting something, de-cluttering my home, snuggling with a child, taking a dog for a walk, playing with our new kitten, and yes, even cleaning the house (do you have *any* idea how messy a home that's lived in 24/7 by 9 people can get?!?).

7.) I'm free to participate in relationships with others. I used to have to keep people at arm's length. I *couldn't* have friends, because friends might show up unexpectedly, and I would most likely be somewhere in the binging and purging process. My only "intimacy" was with food. Everyone else was a potential enemy because they could get in the way of my "true love."...I can honestly communicate with my husband. My children like being with me. And I have real friends (yes, they do drop by unexpectedly, and they'll usually find me covered in paint rather than in food crumbs!).

8.) I'm no longer a slave to a "diet mentality." I eat what I want, when I want it. My only caveat is that I must be *truly* hungry (not just desiring to eat), and I must stop when I'm satisfied (rather than continuing to eat just because it tastes good, etc.)....When a meal is done, when I've had enough, it no longer grieves me that it's over. Nor do I sneak off to eat more and end up purging, as was the case prior to my healing. And, if I do end up eating more than I really need, I can peacefully wait until I'm hungry again, knowing that my body knows what to do with food.

9.) I'm free to take care of my body. To feed it well, to get enough sleep, to give it exercise, to take it to the doctor and dentist, to moisturize it and give it bubble baths. I no longer need to serve it, nor to punish it. Instead it serves me, and I treat it with respect (and humor! Sometimes bodies are very funny).

10.) I'm free to wake up and *choose* how I'm going to live that day. I no longer feel *compelled* to live as a bulimic. If I make a mistake, it's just a mistake, not a reason to give up and binge and purge. I can repent and start over. I'm free from obsessive thoughts of food and purging. It simply doesn't cross my mind. I'm free from needing to "maintain" my healing. Being bulimic is just not who I *am* anymore. It's no longer a part of me.

11.) I'm free to focus on others rather than just myself. I'm learning empathy, something I didn't have a file for before. I can be genuinely engaged in conversations with others, rather

than just going through the motions until I had a chance to binge. I have a desire to help others in any way I can.

12.) Mostly, I'm *just free*. Free to be and become who God created me to be. I'm free to be in community with His Body. I'm free to cooperate with His plan for me. I'm free to have a relationship with Him. I'm free to learn, to grow, to make mistakes and to receive His forgiveness. I'm free to forgive others. I'm free to participate in life going on around me. None of this was possible before.

And Mary is *still* doing well. We just checked in with her, and as of this month (November 2009) it has been 9 years since her initial healing and almost 6 years since she tapered off her psychiatric medications. In spite of many ongoing stressors, including moving across the country, fixing up two old houses, a miscarriage, two full term pregnancies (one including multiple medical complications), the dramatic hormonal changes following each of the two deliveries, caring for and home-schooling eight children, starting a new business, and many other challenges Mary continues to be completely free from bulimia. In her words, "No temptations, no stinkin' thinkin,' no thoughts of bulimia, no desire to binge or to purge. It simply never occurs to me..." She continues to deal with other issues as they come up, *but she has not had to deal with a single symptom of bulimia*.[79] Some readers may have trouble with Mary's perception that her healing included Jesus working with psychological and spiritual issues that originated from experiences in the womb, but the nine years of complete freedom after twenty-one years of raging, untreatable bulimia would indicate that the Theophostic emotional healing sessions did indeed resolve the psychological and spiritual roots of the problem.

A case of mouse phobia that resolved with emotional healing provides another good example of a mental illness where psychological/spiritual issues were primary. Nancy (not her real name) was not just afraid of mice, she was *terrified* of mice – when she encountered mice she would respond as if her life was in immediate danger. Her phobic fear was so intense that it had even caused her to lose employment. On several occasions mice were seen at her place of employment, and even though she liked her work and was doing well she lost the jobs because she was unable to return to the buildings where mice had been discovered. She received extended trials of full therapeutic doses with two different selective serotonin re-uptake inhibitors (SSRIs), medications recommended for treatment of phobias, but obtained only

[79] As described in the more detailed case presentation ("Freedom from Bulimia: Case Study/Testimony"), on one occasion about a year after her initial emotional healing work (during a time of especially intense neurological and psychological stressors) Mary experienced a brief wave of temptation to resume the addictive, "self medication" aspect of her dysfunctional eating. However, note that she did not experience the slightest hint of the compulsive aspects of her bulimia *even during this time of extremely intense stressors and triggers*. My perception regarding this brief temptation to resume self medication eating is that the psychological and spiritual issues that had previously driven the compulsive core of her bulimia had been fully and permanently resolved with the initial emotional healing, but that the neurological and psychological patterns that had been deeply embedded from many years of addictive, self medication eating had not yet been fully dismantled. For those who are interested, the more detailed presentation referenced above also includes additional discussion of the differences between the compulsive and addictive components of Mary's bulimia.

slight benefit with respect to her phobic reaction to mice.[80]

Fortunately, she obtained complete resolution with Eye Movement Desensitization and Reprocessing (EMDR) addressing the underlying psychological trauma. In the context of an EMDR session we asked the Lord to guide Nancy to any underlying psychological and spiritual issues contributing to her phobia, and after going through a number of "frightened by mice" memories from later in her life she eventually recalled the following incident: she was a very small child (she guessed herself to be three years old), and as she and her mother were standing together in the kitchen a mouse came out from under one of the cupboards. Her mother immediately jumped up on one of the chairs, and as Nancy watched her mother perched precariously on the chair, pointing frantically at the mouse, and screaming hysterically she concluded that mice must indeed be terrifyingly dangerous animals. With sudden insight she realized that this was where she had learned to fear mice, and that this memory-anchored belief was the true source of her longstanding phobia. As we continued to process the memory she was able to realize that this was an understandable interpretation for the little girl in the memory, *but that it was mistaken*. In a moment of insight and connection she realized that this longstanding distorted conclusion regarding mice was ridiculous, and that they were actually just small, harmless animals – it might be *disgusting* to find one in your cereal box, but there was no need to be *afraid* of them.

"Mice are terrifyingly dangerous animals" no longer felt true. For example, she had been avoiding working on her mouse phobia because she knew that in order to do this she would need to think about mice, and therefore feel the fear associated with them; and the reason she had finally been willing to try EMDR for her phobia was that a mouse had been found at her place of employment, and this was job she really wanted to keep. After this session she was able to return to work without fear *even though mice continued to be found on the premises.* She reported that she had even remained free of fear when several mice were trapped in her office. Her phobic fear of mice was completely resolved and never returned.[81]

However, even though psychological and spiritual issues are so clearly dominant in cases like these *the overall clinical picture is still also affected by biological brain factors*. For example, even uncomplicated grief, where psychological and spiritual issues are especially strongly dominant, is affected by biological brain factors. On one hand, it is clear that biological brain factors are much less important – there is no biological brain vulnerability predisposing a person to manifest the overall clinical picture of uncomplicated grief,[82] and when the person resolves the psychological and spiritual issues associated with her losses her uncomplicated

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[80] For the two years prior to her EMDR work Nancy was treated continuously with either Paxil 40mg/day in combination with Trazodone 25mg/day or Luvox 200mg/day. Each of these medication regimens provided marked benefit for her depression, but only very minimal benefit with respect to her mouse phobia.

[81] Nancy remained completely free from phobic fear of mice for the remainder of her life (she died from cancer several years after this session). ***fill in re date** EMDR session April 2000, passed away ****when?****

[82] Even though acute uncomplicated grief can be so painful and intense as to be temporarily debilitating, from the perspective of the biological brain it is "normal." That is, even a person with an optimal, completely healthy brain will develop the painful signs and symptoms of uncomplicated grief if she suffers a tremendous loss, such as the death of a spouse or child.

grief will resolve completely. But on the other hand, non-specific genetic factors, such as lower neurological capacity, can cause the presentation to be more severe and to resolve more slowly. Furthermore, other biological brain factors, such as fatigue due to sleep loss from caring for young children, subtle neurological impairment due to poor nutrition, or subtle neurological impairment due to other additional stressors can all cause the presentation of uncomplicated grief to be more severe and to resolve more slowly.

My perception is that spiritual and/or psychological issues are primary in many cases of PTSD, many addictive disorders, some cases of obsessive compulsive disorder, some cases of eating disorders, many cases of other disorders of compulsive behavior, some cases of panic disorder, most phobias, most cases of personality disorders, many cases of dysthymia, some cases of depression, and all cases of uncomplicated grief, *mimic* schizophrenia, *mimic* bipolar disorder, and *mimic*[83] ADHD/ADD.

E. Additional evidence supporting this paradigm: All of the evidence presented above in support of our "mind *and* brain" hypothesis also supports our hypotheses that ***both*** *biological brain factors* ***and*** *non-biological psychological/spiritual issues* contribute in some way to *all* mental health problems, and that there is a continuous range from illnesses where non-biological psychological/spiritual issues contribute but biological brain abnormalities are primary to mental health concerns where biological brain factors contribute but non-biological mind/spirit issues are primary. Below I summarize additional evidence supporting these hypotheses:

1. Extensive research with cognitive therapy shows that false negative cognitions (lies) are a necessary ingredient in many mental illnesses,[84] and many cognitive therapists have found that these false negative cognitions are anchored in unresolved psychological trauma.[85]

2. Psychotherapists working with exposure therapy are also coming to appreciate the connection between mental illnesses, negative cognitions, and unresolved psychological trauma.[86]

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[83] Again, see "Schizophrenia and the Immanuel Approach/Theophostic-based Emotional Healing: General Comments and Frequently Asked Questions," "Bipolar Disorder and the Immanuel Approach/Theophostic®-based Emotional Healing: General Comments and Frequently Asked Questions," and "ADD/ADHD and Emotional Healing" for my discussions of *true* schizophrenia vs *mimic* schizophrenia, *true* bipolar disorder vs *mimic* bipolar disorder, and *true* ADHD/ADD vs *mimic* ADHD/ADD.

[84] Kaplan HI, Sadock BJ, Grebb JA. *Kaplan and Sadock's Synopsis of Psychiatry, Seventh Edition*. Baltimore, MD: Williams & Wilkins; 1994, pages 860-61. For extensive discussion of two specific examples, see Beck AT, Emery G, Greenberg RL. *Anxiety Disorders and Phobias: A Cognitive Perspective*. New York, NY: Basic Books; 1985, and Beck AT, Rush AJ, Shaw BF, Emery G. *Cognitive Therapy of Depression*. New York, NY: Guilford; 1979.

[85] See "Cognitive Therapy and Theophostic® Based Emotional Healing Ministry" on the Articles and FAQs page of www.kclehman.com for discussion of cognitive therapists beginning to appreciate the connection between mental illnesses, negative cognitions, and unresolved psychological trauma.

[86] See "Exposure Therapy and Theophostic® Based Emotional Healing Ministry" (pending) on the Articles and FAQs page of www.kclehman.com for additional discussion of exposure therapists beginning to appreciate the connection between mental illnesses, negative cognitions, and unresolved psychological trauma.

3. The belief that many mental illnesses are caused by unresolved psychological trauma, and especially by false negative cognitions associated with trauma, is a foundational part of EMDR® theory.[87]

4. Dr. Ed Smith has come to the conclusion that many mental illnesses are expressions of unresolved psychological trauma (and associated "lie-based thinking") as a result of his experience with Theophostic® ministry (starting with many different mental illnesses, following the Lord back to wounds and lies, and then observing the illnesses disappear when the wounds and lies are resolved).

5. We have seen the same patterns and connections in our clinical experience with psychotherapy (especially EMDR®) and emotional healing work (especially the Immanuel approach and Theophostic®-based emotional healing).

6. Extensive research shows that the mental illnesses we believe to be especially rooted in underlying psychological trauma are often found together in the same patients, and that these illnesses are especially common in patients with PTSD from documented severe psychological trauma.[88] One large study of Vietnam veterans found that 99% of those diagnosed with PTSD also met criteria for at least one other psychiatric diagnosis.[89] A recent study with 1,411 female adult twins found that childhood sexual abuse was associated with major depression, generalized anxiety disorder, panic disorder, alcohol or drug dependence, and bulimia nervosa. The prevalence of these disorders increased with increasing severity of abuse, and when only one twin had been abused, she was more likely to have these psychiatric disorders than the twin who had not been abused.[90] This study is especially significant because twins have the same genetic risk, and therefore the increased incidence of psychiatric disorders in abused twins supports the hypothesis that childhood sexual abuse itself, and not some other genetic risk factor for which it is a marker, contributes to later mental illness. All of these results would be expected if the same root of unresolved psychological trauma is contributing prominently to each of these mental illnesses.

7. Bessel Van der Kolk and colleagues (international leaders in psychological trauma research), examining the data presented here and also much additional research, propose that Post Traumatic Stress Disorder (PTSD) and many other comorbid mental illnesses (mental illnesses found alongside of PTSD in the same person) are not separate disorders, but rather

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[87] Shapiro, Francine & Silk Forrest, Margot. *EMDR®: The Breakthrough Therapy for Overcoming Anxiety, Stress, and Trauma* (HarperCollins: New York, NY) 1997 is full of well written case studies that illustrate this principle. See Shapiro, Francine. *Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols, and Procedures*. (New York, NY: Guilford Press) 1995 for more rigorous discussion of the place of this principle as part of the theoretical foundation for EMDR®.

[88] See Brady KT, et al. Comorbidity of Psychiatric Disorders and Posttraumatic Stress Disorder. *J Clin Psychiatry* 2000;61(suppl 7):22-32 for a recent review of the statistics regarding other mental illnesses commonly occurring with PTSD.

[89] Kulka RA, Schlenger WE, Fairbank JA, et al. *Trauma and the Vietnam War Generation*. New York, NY: Brunner/Mazel; 1990.

[90] Kendler KS et al. "Childhood sexual abuse and adult psychiatric and substance use disorders in women." *Arch Gen Psychiatry* 2000 Oct, Vol. 57, pages 953-9.

many different ways in which people manifest the effects of psychological trauma.[91]

F. "Most of DSM IV can be condensed into PTSD": I have heard psychotherapists and emotional healing ministers comment "Most of DSM IV can be condensed into PTSD." This statement makes a good sound bite but it seriously oversimplifies the situation. As just discussed, the final clinical presentation in many mental illnesses is produced by the interaction of psychological/spiritual issues with biological brain abnormality predispositions. PTSD itself actually provides a good example. Research shows that PTSD is a specific clinical presentation,[92] and is just *one* of the many ways in which unresolved psychological trauma can be expressed. For example, extensive medical research shows that PTSD and depression are both common long term consequences of psychological trauma, but that they demonstrate distinct and different (opposite) results with respect to certain biological indicators. For example, one category of receptors in the brain (mononuclear leukocyte Type II glucocorticoid receptors) are elevated in PTSD, but decreased in major depression; the body's excretion of the chemical cortisol in the urine is reduced in PTSD, but increased in major depression; and suppression of cortisol excretion in response to dexamethasone is increased in PTSD, but decreased in major depression.[93] There is a kernel of truth in "Most of DSM IV can be reduced to PTSD," but if you want to make this kind of statement I would suggest something more humble, along the lines of: "Psychological trauma is an important component contributing to most of the illnesses in DSM IV." Even more accurate would be "Psychological and spiritual issues (especially psychological trauma) are important components contributing to most of the illnesses in DSM IV."

V. Exploring the same specific issues, questions, and phenomena from *both* the biological brain perspective *and* the non-biological mind perspective:

As discussed above, it is very important to recognize *both* biological brain phenomena *and* non-biological mind/spirit phenomena, and it is very helpful to begin with approaching biological brain phenomena from a biological brain perspective and non-biological mind/spirit phenomena from a mind/spirt perspective. However, although it is wise to *begin* by approaching biological brain phenomena from a biological brain perspective and by approaching non-biological mind/spirit phenomena from a mind/spirt perspective, the biological brain and the non-biological mind/spirit are so intimately and profoundly connected that it is even valuable to study mind/spirit phenomena from a brain perspective, and to study brain phenomena from a mind/spirit

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[91] Van der Kolk BA. "The Complexity of Adaptation to Trauma: Self-Regulation, Stimulus Discrimination, and Characterological Development," Chapter 9 in Van der Kolk, Bessel A, McFarlane, Alexander C, Weisaeth, Lars, Editors. *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society*. (New York: Guilford Press) 1996; Van der Kolk BA, Pelcovitz D, Roth S, et al. "Dissociation, somatization, and affect dysregulation: the complexity of adaptation to trauma." *Am J Psychiatry* 1996;153(7, suppl):83-93.

[92] Segman, RH; et al. "Association between the dopamine transporter gene and post traumatic stress disorder." *Mol Psychiatry* 2002;7(8):903-7.

[93] Yehuda R, et. al. "Lymphocyte glucocorticoid receptor number in post traumatic stress disorder. *American Journal of Psychiatry*. 1991;148:499-504; Yehuda R, et. al. "Glucocorticoid receptor number and cortisol excretion in mood, anxiety, and psychotic disorders." *Biological Psychiatry*. 1993;34:18-25; Yehuda R, et. al. "Enhanced suppression of cortisol following dexamethasone administration in post traumatic stress disorder. *Am J Psychiatry* 1993 Jan;150(1):83-6; and Kocsis JH; Brockner N; Butler T; Fanelli C; Stokes PE. "Dexamethasone suppression in major depression." *Biol Psychiatry* 1984 Aug; 19(8):1255-9.

perspective.

Although it is slow and difficult to approach a specific aspect of a situation from the non-primary perspective, those who have been gifted and anointed to do this have made valuable contributions. If we embrace the "mind *and* brain" paradigm, letting exploration from both perspectives shed light on the *same specific issues, questions, and phenomena*, we will discover important additional insights. For example, Dr. Allen Shore, Dr. Daniel Siegel, and Dr. E. James Wilder have carefully studied biological brain processes associated with phenomena that have usually been considered to be in the realm of the mind/spirit, such as bonding, attachment, relationships, maturity, and joy.[94] Amazingly, the biological brain and the non-biological mind/spirit are so intimately and profoundly connected that study of the brain processes associated with these mind/spirit phenomena has actually provided important new mind/spirit understanding. Insights regarding capacity provide one of the best examples of crossover discoveries: studying emotional healing, relationships, maturity, and joy from a brain biology perspective lead to the discovery that inadequate brain/mind/spirit capacity can block emotional healing, and these insights regarding capacity contributed to mind/spirit discoveries regarding how Jesus' Immanuel presence can resolve this blockage.[95]

Furthermore, careful study of a specific aspect of a situation from the non-primary perspective can provide important corroboration for insights that have been discovered through study from the primary perspective. For example, my examination of memory system SPECT scans and neurological case studies of multiple parallel memory systems provides important biological brain corroboration for the mind/spirit theory that "normal" beliefs are stored and processed differently than beliefs associated with unresolved trauma.[96]

Note that *both* of the following are true:

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[94] See, for example, Shore, Allen N., Ph.D. *Affect Dysregulation and Disorders of the Self*. (New York, NY: W.W. Norton & Company), 2003, Shore, Allen N., Ph.D. *Affect Regulation and the Origin of the Self*. (Hillsdale, NJ: Lawrence Earlbaum Associates, Publishers), 1994, Shore, Allen N., Ph.D. *Affect Regulation and the Repair of the Self*. (New York, NY: W.W. Norton & Company), 2003, Siegel, D.J. *The Developing Mind*. (New York: Guilford) 1999, and Siegel, D.J., and Hartzell, M. *Parenting From the Inside*. (New York: Jeremy P. Tarcher/ Putnam, a member of Penguin Putnam Inc.) 2003. E. James Wilder, Ph.D. also has excellent material, especially studying joy from a biological brain perspective. Unfortunately, this material has not yet been published in a book, but is available in audio and video tape format – for example, his tapes on Joy Bonds, available from C.A.R.E. Packaging. (www.carepkg.org/wilder/materials.htm).

[95] For additional discussion of these biological brain – mind/spirit "crossover" insights regarding Jesus' Immanuel presence, emotional healing, and capacity, see "Immanuel, Emotional Healing, & Capacity: Parts I & II," and "Brain Science, Psychological Trauma, and The God Who is With Us," Part II (available as free downloads from www.kclehman.com).

[96] In actual history, Dr. Smith discovered these important principles through approaching emotional healing from a mind/spirit perspective, and biological brain information has provided important confirming support. However, when I think about the SPECT scans and neurological case studies that I have recently reviewed, I can imagine starting with this biological brain information and arriving at these important mind/spirit insights even though approaching from the biological brain perspective. In fact, additional examination of these memory phenomena from the biological brain perspective has recently resulted in significantly improving the theoretical model for Theophostic-based therapy/ministry (see discussion of separate memory systems for normal beliefs vs trauma-associated beliefs in "Immanuel, An Especially Pernicious Blockage, & The Normal Belief Memory System").

1. It is *easiest* to approach from the primary perspective – to approach from a biological brain perspective when dealing with any aspect of a situation that is primarily a biological brain phenomena, and to approach from a mind/spirit perspective when dealing with any aspect of a situation that is primarily a mind wound/mind phenomena. It is therefore wise and helpful to *begin* with approaching any given issue, question, or phenomena from the primary perspective; *And*,

2. Although it is slow and difficult, it is still worthwhile to also examine each specific issue, question, or phenomena from the non-primary perspective.

VI. False dichotomies: Once we accept the "Mind *and* brain" paradigm, as opposed to either of the extreme paradigms where one perspective is overemphasized and the other disregarded, there are false dichotomies that need to be exposed and challenged. People often speak and/or write as if we have to approach a given mental health concern from only one paradigm – *either* the biological brain perspective *or* the non-biological mind/spirit perspective. For example, people often speak and/or write as if a given problem is *either* caused by lie-based thinking *or* by a "real" mental illness, as if a given problem is *either* caused by psychological trauma *or* by brain chemistry imbalances. These are *false dichotomies* that cause much unnecessary confusion and conflict between mind/spirit focused emotional healing ministries and biological brain focused main stream mental health care.

As seen in the above discussion, *all* mental health problems have *both* biological brain *and* non-biological mind/spirit components. Mind/spirit issues combine with genetic brain biology vulnerabilities, developmental factors, environmental factors, and sometimes also medical illnesses to result in each particular mental health problem. When these factors combine to create overall clinical pictures that the mental health community considers major mental illnesses,[97] these major mental illnesses will include *both* non-biological mind/spirit issues (such as lies anchored in traumatic memories) *and* abnormalities in the biological brain (such as dysfunctional brain chemistry and abnormal SPECT scans). As just discussed, in some cases mind/spirit issues are the most important contributing factors, and in these cases the primary focus of treatment should be on the mind spirit issues. However, even in these cases the overall clinical picture also involves biological brain components, and medical intervention can help to moderate symptoms as the person is working to address mind/spirit issues. As also discussed above, in other cases the biological brain dysfunctions are the most important contributing factors, and in these cases the primary focus of treatment should be on the biological brain components of the illness. However, even in these cases the overall clinical picture will also involve mind/spirit components, and mind/spirit interventions can help to decrease the effects of the primary biological brain problems.

A. Errors in logic from the "biological brain only" perspective:

"Physical scientists approaching from the biological brain perspective have discovered the brain biology abnormalities associated with _____ *(mental illness in question)*, and can demonstrate clinical improvement when medication manually corrects these brain biology abnormalities. THEREFORE:

[97] Even rigorously meeting careful diagnostic criteria for "real" mental illnesses, such as major depression, panic disorder, obsessive compulsive disorder, eating disorders, and post traumatic stress disorder.

"We do not need to examine _____ *(mental illness in question)* from the non-biological mind/spirit perspective,

"Biological brain abnormalities are the true and only factors contributing to _____ *(mental illness in question)* – this mental illness cannot be caused by underlying mind/spirit issues,

"Medical interventions (such as psychiatric medication) to correct the biological brain abnormalities are the only treatments required – we don't need mind/spirt interventions to find and address the non-existent underlying mind/spirit issues."

B. Errors in logic from the "non-biological mind/spirit issues only" perspective:

"Therapists and/or emotional healing ministers approaching from the non-biological mind/spirit perspective have discovered mind/spirit issues associated with _____ *(target symptoms in question – often symptoms associated with a mental illness that has not been diagnosed, or at least not named in the ministry setting)*, and can demonstrate clinical improvement when mind/spirit techniques are used to address the mind/spirit issues. For example, we start with _____ *(target symptoms in question, such as sadness, hopelessness, and suicidal thoughts)*, the Lord leads the person to important mind/spirit issues contributing to the symptoms, and the symptoms go away when these mind/spirit issues are resolved. THEREFORE:

"We do not need to examine _____ *(the symptoms in question)* from the biological brain perspective,

"Non-biological mind/spirit issues are the true and only factors contributing to _____ *(the symptoms in question)* – biological brain factors cannot also be contributing to these symptoms, and these people did not have 'true' mental illnesses.

"Mind/spirit interventions (such as the Immanuel approach or Theophostic®-based emotional healing) to correct the mind/spirit issues are the only treatments required – we don't need medications or other medical interventions to address the non-existent mental illnesses or biological brain abnormalities."

C. Clear thinking (as opposed to errors in logic):

All mental health problems involve *both* biological brain factors *and* non-biological mind/spirit factors. THEREFORE, the study and treatment of all mental health problems should include *both* approaching the biological brain components from a biological brain perspective *and* approaching the non-biological mind/spirit components from a mind/spirit perspective.

Furthermore, it can even be valuable to examine biological brain phenomena from a mind/spirit perspective, and to examine non-biological mind/spirit phenomena from a biological brain perspective. THEREFORE, there is ***no*** situation where we should need to chose *either* the biological brain perspective *or* the non-biological mind/spirit perspective.

The biological brain and the non-biological mind/spirit are so intimately connected that they each influence the other. Mind wounds and their associated spiritual issues cause biological brain dysfunction, and biological brain dysfunction exposes unresolved mind/spirit issues.

THEREFORE,

- Underlying mind wounds and associated spiritual issues can be the most important factors contributing to the signs, symptoms, and biological brain abnormalities of "true" mental illnesses, such as panic disorder, depression, and obsessive compulsive disorder, and a mind/spirit intervention, such as the Immanuel approach, can completely resolve the observable symptoms of these "true" mental illnesses by resolving the underlying mind/spirit issues.

  Therefore (yes, the second "therefore" is intended here), discovering mind/spirit factors contributing to certain symptoms, and demonstrating that mind/spirit interventions completely resolve the symptoms, does *not* prove that there were no biological brain abnormalities associated with the symptoms, that there were no biological brain factors also contributing to the illness, that the person did not have a "true" mental illness, or that it would never be appropriate to include biological brain interventions as a part of the treatment plan.

- Discovering the brain abnormalities associated with a given mental illness, and demonstrating that biological brain interventions reduce the symptoms, does *not* rule out underlying mind/spirit issues as the most important contributing factors or prove that mind/spirit interventions should not be the primary focus of treatment.

- Biological brain dysfunctions can be the most important contributing factors in "true" mental illnesses such as Alzheimer's disease and true schizophrenia, even though these illnesses can expose mind/spirit issues and thereby cause the overall clinical picture to include dramatic mind/spirit symptoms.

  Therefore (again), discovering mind/spirit factors contributing to the overall clinical picture, and demonstrating that mind/spirit interventions dramatically improve the overall clinical picture, does *not* rule out true mental illness with biological brain disease as the most important contributing factor or prove that biological brain interventions should not be included as a necessary part of the treatment plan.

  Therefore (again), discovering biological brain disease as the most important contributing factor in true mental illnesses such as Alzheimer's disease and schizophrenia, and demonstrating that biological brain interventions are a necessary part of the treatment plan, does *not* prove that there are no mind/spirit issues also contributing to the illness or that mind/spirit interventions should not be included as part of the treatment plan.

I think there is some practical value in making a distinction between a.) Mental health problems in which biological brain injuries/illnesses are the most important contributing factors[98] and for which brain biology interventions[99] should be the primary focus of

[98] For example, true bipolar disorder, schizophrenia, Alzheimer's disease, mental status changes resulting from thyroid disorder, mental status changes resulting from seizure disorder, mental status changes resulting from traumatic brain injury or strokes, or mental retardation.

[99] For example, psychiatric medications for bipolar disorder, schizophrenia or Alzheimer's disease, medical intervention to correct thyroid excess or deficiency, medication to control seizures, neurosurgery as a part of treatment for seizure disorder or traumatic brain injury, or neurological rehabilitation therapy

treatment, and b.) Mental health problems in which mind/spirit issues are the most important contributing factors and for which mind/spirit interventions[100] should be the primary treatment. However, if one makes this distinction it is important to remember that mental health problems always involve *both* biological brain phenomena *and* non-biological mind/spirit phenomena. Medical interventions may be appropriate as part of the overall treatment plan, even in cases where mind/spirit issues are the root, primary source of the problem; and mind/spirit interventions will *always* be beneficial, even in cases where biological brain problems are the primary cause of the problem.

D. *Either* demonic phenomena *or* other factors – an especially important false dichotomy: Our experience is that people seem especially prone to false dichotomies, *in both directions*, when it comes to demonic phenomena. Those in deliverance ministry seem especially prone to assume that ministry for psychological trauma and/or treatment for biological brain dysfunction are no longer necessary if the person experiences significant benefit with the identification and expulsion of demonic spirits, and mental health professionals or those in other ministries seem especially prone to assume that demonic spirits cannot be involved if the person experiences significant benefit with ministry for psychological trauma and/or medical treatment for brain biology problems.

My own experience provides good examples of false dichotomy thinking errors regarding demonic phenomena. At the beginning of my psychiatric career, when I first started working with schizophrenic patients, I already believed in the reality of demonic spirits and had heard stories of people who had been completely freed from "schizophrenia" through deliverance ministry. However, in each case where I had access to clinical details, it seemed like these patients had actually had what I would call demonic "mimic" schizophrenia – they described psychotic symptoms, such as experiencing intense fears that the average mental health professional would consider delusional, seeing frightening images that would be considered visual hallucinations, and hearing voices and other frightening sounds that would be considered auditory hallucinations. But all of these psychotic symptoms seemed to be directly caused by demonic spirits, and the patients did not have any of the many other symptoms that are also present in true biological brain schizophrenia. With typical false dichotomy thinking, I incorrectly concluded that a person could have *either* demonic "mimic" schizophrenia *or* true, biological brain schizophrenia – if I was careful and thorough to evaluate that a person had true, biological brain schizophrenia then I didn't need to worry about demonic phenomena, and if I was careful and thorough to evaluate that a person had demonic phenomena then I didn't need to worry about true schizophrenia.

Eventually I observed patients with true biological brain schizophrenia who *also* seemed to have demonic phenomena exacerbating their overall clinical picture. One of the most dramatic was a patient who described psychotic thoughts and auditory hallucinations typical of schizophrenia, but also certain "voices" that were especially negative, angry, and hateful. These voices repeatedly told him to stop going to church, reading the Bible, talking to Christians, listening to worship music, and especially to stop praying, and they would threaten to punish him if he did participate in any of these Christian activities. Both the persistent opposition to all Christian activity and his spontaneous comments about these voices being so hateful made

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for traumatic brain injuries or strokes.

[100] For example, psychotherapy methods, such as EMDR®, and emotional healing ministry approaches, such as the Immanuel approach and Theophostic®-based emotional healing.

me suspicious, so I did an experiment and discovered that *these particular voices* seemed to decrease, or even disappear completely (temporarily), with simple binding commands in the name of Jesus.

After this discovery I asked all my other schizophrenic patients about whether they ever heard "other" voices. I had to question them very carefully, gently, and persistently because the demonic spirits had usually threatened to harm the patients if they "told," and my patients were therefore very hesitant to talk about these "other" voices. These interactions usually went something like:

Dr. Lehman: "You've told me about the voices that talk to you about the other people on the bus, and the voices that comment on whether you're fixing your hair the right way, but I'm wondering if you ever hear "other" voices?

Patient: *Immediately appears wary, but remains silent.*

Dr. Lehman: *Waits quietly, with a non-anxious, curious expression on his face.*

Patient: *Eventually responds with a guarded, anxious* "What are you talking about? What do you mean?"

Dr. Lehman: "Sometimes people have voices that they tell me about, but also 'other' voices that they don't tell me about. Maybe voices that are meaner, or scarier."

Patient: *(Angry, suspicious, demanding)* "Who told you?!"

Dr. Lehman: "Well, some of my other patients – people who have voices kind of like the ones you've told me about – just recently told me that they also have "other" voices that they had never talked about, and that these other voices were meaner and scarier. So I wondered whether you might have these other, mean, scary voices too. Do you have these 'other' voices?"

Patient: *(increasingly anxious)* "I can't tell you. They'll hurt me if I tell."

Dr. Lehman: "I'm wondering whether they talk a lot about religious stuff? Whether they might tell you not to do certain things?"

Patient: *(Again angry, suspicious, demanding)* "How did you know?!"

At this point, I would use a simple command in the name of Jesus to prevent the demonic spirits from directly intimidating the patients as I was speaking to them, and the patients would then be much more willing to talk about the "other" voices.[101]

[101] It is best if the care provider knows his authority in Christ, and can *start* the session with some kind of simple prayer/command to prevent the demonic spirits from directly intimidating the patient during the conversation about "other" voices. Sometimes I used a silent command and at other times spoke aloud, depending on what seemed most appropriate for the particular situation (see, for example, "Opening Prayers and Commands: Prayer for the Facilitator, Dealing with the Demonic, and General Introductory Prayer" on the "Ministry Aids" page of www.kclehman.com).

To my amazement, I discovered previously hidden "other" voices in almost every one of my schizophrenic patients[102] – voices that were clearly distinguishable from typical schizophrenic auditory hallucinations – voices that were especially negative, scary, and hateful, that constantly tried to prevent the patients from participating in Christian activities, and that usually[103] reacted in some way to prayers or commands in the name of Jesus.

These voices usually seemed to decrease in response to prayer and commands in the name of Jesus, *but they also seemed to respond to antipsychotic medication*. As these patient's psychotic symptoms improved in response to appropriate antipsychotic medication they *also* consistently reported that the demonic voices didn't feel as true, weren't as loud, didn't have as much power, or were easier to ignore. Initially, this observation confused me because of another false dichotomy thinking error: "symptoms can *either* respond to medication *or* be caused by demonic spirits. That is, if the symptoms improve with medication they must be solely a biological brain phenomena, and therefore not demonic after all."

After carefully observing my own patients, and also reviewing many case descriptions from other Christian care providers, my perception is that conditions that impair the *biological brain*, such as intoxication, seizure disorders, traumatic brain injuries, and all mental illnesses also make the *non-biological mind* more susceptible to demonic harassment/oppression. A person's skin usually provides a very effective defense against bacterial infection. If your skin is intact, you can handle raw sewage and not get infected. However, if you have a skin injury even minute amounts of dirt in the wound can cause infection. Injury or illness of a person's biological brain seems to make him more vulnerable to demonic "infection" in much the same way that injury to a person's skin makes him more vulnerable to bacterial infection. As noted above, I was initially confused when a number of my patients reported reduced demonic harassment that seemed to be directly associated with benefits from psychiatric medication. And then I realized that this makes complete sense in light of this wound/infection analogy – when psychiatric medication moderates biological brain dysfunction, it should, logically, also moderate the increased vulnerability to demonic "infection" caused by the biological brain "wound." And in place of the false dichotomy thinking "a person can have *either* biological brain mental illness *or* demonic harassment/oppression" I realized that people with biological brain mental illnesses are actually *especially* likely to *also* have demonic "infection." In fact, in mental illnesses where biological brain dysfunction is a major contributing factor[104] (in cases where it has been possible for me to specifically evaluate for possible demonic contribution), I have *almost always* found some degree of demonic harassment/oppression contributing to the overall clinical picture. In these patients, using mind/spirit interventions to deal with[105] the

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[102] Unfortunately, I didn't make these discoveries until after my clinical practice had shifted focus so that I wasn't seeing as many patients with schizophrenia. I would be glad to hear from other Christian mental health professionals who have the opportunity to check for these anti-Christian demonic voices, or any other demonic phenomena, in patients with true schizophrenia.

[103] See "Dealing With Demonic Interference/Opposition During the Session, Prayers and Commands to Neutralize Demonic Interference" on the "Ministry Aids" page of www.kclehman.com for discussion of reasons why demonic spirits will sometimes not respond to prayers or commands in the name of Jesus.

[104] For example, true schizophrenia, true bipolar disorder, Alzheimer's disease, severe major depression.

[105] Mind/spirit interventions to "deal with" demonic infection can include such things as worship, simple commands in the name of Jesus, renouncing choices that gave the demonic spirits a place, and resolving "anchor" traumatic memories. See "Dealing With Demonic Interference/Opposition During the

demonic "infection" consistently improves their overall clinical picture *even if the underlying biological brain dysfunction is still present and the person still requires medication.*

Furthermore, psychological traumas – mind "wounds" – seem to make a person more vulnerable to demonic "infection" in much the same way as biological brain "wounds." In almost[106] every case we are aware of where demonic spirits were causing symptoms that mimicked a major mental illness, and where deliverance ministry resulted in sudden and dramatic improvement, important issues related to unresolved psychological trauma have also been present. In these cases the trauma-related issues appeared to have contributed to making the person vulnerable to the demonic attack, and the person has had to resolve the trauma-related issues in order to retain the freedom received through deliverance.

Therefore, we want to especially encourage people to avoid false dichotomies with respect to demonic phenomena. Just because a spirit of depression has been identified and removed, with significant improvement, does *not* give you reason to assume that the person no longer needs emotional healing ministry, or even that it is time to stop their antidepressant medication, and just because a person's depression improves dramatically with medication does *not* prove that demonic oppression cannot be contributing. Just because a spirit of insanity has been identified and removed, with significant improvement, does *not* rule out the possibility that the person also has biological brain schizophrenia, and just because a person improves with antipsychotic medication does *not* prove that demonic spirits are not contributing to his psychotic symptoms.

E. Examples of false dichotomy thinking in current mental health and healing ministry literature: We have been sobered and amazed by how easily people make these simple logical errors, and by how widespread these false dichotomy misunderstandings have become. For example:

Amen, Daniel G., M.D.: Dr. Amen is a gifted Christian psychiatrist who has made important contributions to mental health care and to emotional healing ministry. Unfortunately, he is also an example of an intelligent, competent medical professional who frequently falls into false dichotomy logical errors with respect to "*either* biological brain dysfunction *or* unresolved mind/spirit issues." For example, in one of his recent books, *Change Your Brain Change Your Life*, he comments:

> "If you are anxious, depressed, obsessive-compulsive, prone to anger, or easily distracted, you probably believe these problems are 'all in your head.' In other words, you believe your problem is purely psychological. However, research that I and others have done shows that the problems are related to the physiology of the brain..."
>
> "These [SPECT scan] images make it plain that many problems long thought of as

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Session, Prayers and Commands to Neutralize Demonic Interference," "'Binding' the Enemy: Prayers and Commands to Alleviate Demonic Harassment and/or Oppression," "Opening Prayers and Commands: Prayer for the Facilitator, Dealing with the Demonic, and General Introductory Prayer," and "Closing Prayer and Commands" on the "Ministry Aids" page of www.kclehman.com for additional discussion of dealing with demonic infection.

[106] See the comments at the end of "Major mental illness, spiritual oppression, and deliverance" on the "Case Studies and Testimonies" page of www.kclehman.com for discussion of one of the few cases where the connections between unresolved psychological trauma and the demonic oppression that seemed to be causing mental health symptoms were less clear.

psychiatric in nature – depression, panic disorders, attention deficit disorders – are actually medical problems...."

"Dr. Zametkin demonstrated that when adults with ADD try to concentrate, there is decreased activity in the prefrontal cortex, rather than the expected increase seen in normal 'control' adults. Here was physical evidence of a problem many people thought was psychological!"

"Sally, a forty year old woman, had been hospitalized under my care for depression, anxiety, and suicidal ideas. In my clinical interview with her, I discovered that she had many adult ADD symptoms.... I decided to order a SPECT study on Sally. Sally's studies were abnormal .... when she was asked to perform math problems (an exercise to challenge her ability to concentrate), she had marked decreased activity...especially in the prefrontal cortex! With that information, I placed her on a low dose of Ritalin (methylphenidate), a brain stimulant used to treat ADD.... She had a wonderful response. Her mood was better, she was less anxious, and she could concentrate for longer periods of time.... Seeing the SPECT pictures was very powerful for Sally. She said, 'having ADD is not my fault. It's a medical problem, just like someone who needs glasses.'... Sally could see that the problem wasn't 'all in her head.'"[107]

These comments clearly imply that if the SPECT scan is abnormal, and especially if the person also improves with medication, then the problems must be caused by biological brain problems *only* and are *not* being caused by underlying "psychological" (mind/spirit) problems. Clear thinking would be: "The abnormal SPECT scan and response to medication show that there is biological brain dysfunction of some kind, and this brain dysfunction may be caused by an underlying mind/spirit problem, by a primary biological brain problem, or by some combination of these two."

Mullen, Grant W., M.D.: Dr. Mullen is a Christian physician who has focused his practice on mental health problems. He has done excellent work regarding the importance of addressing biological brain mental illnesses *and* demonic oppression *and* psychological wounds, but he discusses these as three *separate* issues.[108] He does perceive some interaction,[109] but he seems to think that in *most cases* demonic oppression, psychological wounds, and the abnormal bran biology of mental illnesses are three separate components of overall mental/emotional health – that they are each important, and that all three need to be addressed, but that they are

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[107] Amen, Daniel G. *Change Your Brain, Change Your Life: The Breakthrough Program for Conquering Anxiety, Depression, Obsessiveness, Anger, and Impulsiveness.* (New York, NY: Three Rivers Press), 1998, specific quotes on pages 3, 15, 6, and 6, respectively.

[108] See, for example, his recent book: *Why Do I Feel So Down When My Faith Should Lift Me Up?* (Kent: Sovereign World Ltd), 1999. Dr. Mullen's specific words for these three components are "physical illnesses of thought control (chemical imbalances)," "harassment of Satan (demonization)," and "personality injury (woundedness)," page 22 (note that the words in parentheses are part of his text).

[109] Dr. Mullen discusses how mental illness and psychological wounds make a person more vulnerable to demonic harassment (see, for example, pages 67, 78, 122-37), he mentions how demonic spirits often exacerbate mental illnesses (see, for example, pages 123-4), he mentions that, in rare cases, demonic spirits can even *cause* biological brain mental illnesses (see, for example, pages 63-5, 123-4), and he mentions that psychological "stress" can sometimes precipitate the *onset* of mental illnesses (see, for example, page 48).

essentially separate. He never mentions or discusses how dysfunctional thoughts and emotions can actually *cause* the biological brain abnormalities of many mental illnesses. This foundation naturally leads to false dichotomy logical errors – "Is this particular problem being caused by a 'medical' (biological brain) mental illness, requiring medication as the treatment, *or* is the problem being caused by psychological wounds?" "Is this particular problem being caused by a 'chemical imbalance,' *or* by demonic harassment?" Sample comments from Dr. Mullen include:

> "It is now well established that mental illnesses are usually the result of an imbalance in the chemicals associated with mood control....As a result of the discovery of the above facts, depression is now seen as a physical illness needing and responding to medical treatment."
>
> "It is important to realize that since depression is an illness,....It needs specific medical treatment to correct the imbalance just like insulin is used to treat diabetes. The most important first step is for the patient to accept the diagnosis and consent to treatment [meaning psychiatric medication]."[110]
>
> And "Christians don't realize that depression is the only *medical* condition with spiritual symptoms. The root cause is *medical not spiritual [or psychological]*."[111] (Italics mine)

As discussed above, I agree that in *some* cases mental illnesses are primarily biological brain illnesses, and that in these cases medication needs to be the foundation for the rest of the treatment plan; however, as also discussed above, I believe that in *most* cases even "true" mental illnesses have mind/spirit issues as the most important contributing factors. Biological brain vulnerabilities can predispose the mind/spirit issues to be expressed in a certain way (panic vs major depression vs OCD vs PTSD vs eating disorders ... etc), but the most important contributing factors are mind/spirit issues, and the clinical picture of mental illness will resolve with resolution of the mind/spirit issues. As discussed at various points in this essay, an important data point consistent with this assessment is that medication can be stopped, *without relapse*, in *most* cases of mental illness *once the underlying mind/spirit issues are resolved.*

Schacter, Daniel L., Ph.D.: Dr. Schacter is chair of the Department of Psychology at Harvard University, and has been studying neuropsychology, with a special interest in memory phenomena, for almost 30 years. He has written a number of books on memory, has *many* publications in mainstream peer-reviewed professional journals, and is considered one of the foremost authorities on the neuropsychology of memory. He is a rigorous academician, and usually a clear and careful thinker, but he makes the simple logical errors that lead to "non-biological mind vs biological brain, psychological trauma *vs.* biological brain dysfunction" false dichotomies. In one of his most recent books about memory, he comments:

> "A recent report by the psychiatrists Joseph Lipinski and Harrison Pope dramatically illustrates that such flashbacks must be viewed with a great deal of caution. They describe three

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[110] NOTE: when dealing with mental illnesses where genetic, biological brain dysfunction is the most important contributing factor, such as true bipolar disorder and true schizophrenia, I agree with Dr. Mullen's statement: "The most important first step is for the patient to accept the diagnosis and consent to treatment."

[111] Mullen, Grant. *Why Do I Feel So Down When My Faith Should Lift Me Up?* (Kent: Sovereign World Ltd), 1999, specific quotes on pages 48, 83, and 91, respectively.

> patients who developed vivid, intrusive images of highly disturbing incidents....In all three cases, the images were interpreted as flashbacks of repressed childhood trauma, and the patients were referred for appropriate psychotherapy. Something was amiss with these patients, however. All three of them compulsively engaged in unusual rituals, such as cleaning or washing over and over again. These disturbed behaviors are characteristic of the psychiatric disturbance known as obsessive-compulsive disorder. When the patients were given drugs that are ordinarily used to treat this debilitating condition, the intrusive imagery disappeared completely. It turned out that the images were not flashbacks of actual events; they were symptoms of the patients' obsessive-compulsive disorder. This in turn suggests that the diagnosis of repressed childhood trauma was incorrect."[112]

Smith, Ed, D.Min.: Dr. Ed Smith, the founder of Theophostic® Prayer Ministry, provides more examples of these false dichotomy logical errors. Dr. Smith is a personal friend, Charlotte and I apply Theophostic® principles in our personal and professional lives every day, and we have had a number of good conversations with Dr. Smith about how medical psychiatry, clinical psychology, and Theophostic®-based emotional healing ministry can be complimentary. I know that Dr. Smith is not generally antagonistic towards mental health professionals or appropriate mental health care. But his comments about mental illnesses, psychiatric medication, and professional mental health care have been full of these false dichotomy logical errors. For example, in the current edition of the Theophostic® Prayer Ministry client manual, *Genuine Recovery*, he comments:

> "When a person is suffering from true mental illness or brain damage, this method will not work. True mental illness and/or brain damage is a physical problem resulting in a mental failure. True mental illness or brain damage is not the consequence of faulty thinking. It is not rooted in lies embedded in memories.
>
> "Many people we see have been labeled as mentally ill, when in fact they were suffering from lies. I do not question the reality of mental illness. It is real and has a crippling effect on those who bear it. What I question is the number of people who have been written off as beyond help through this labeling system.
>
> "Sometimes it is difficult to know when a person is truly mentally ill and when they are merely in bondage to faulty thinking. I assume it is lies people suffer from and will pursue this until I am convinced otherwise. It has become too easy to diagnose and prescribe without seeking to free people from their real sources of pain."[113]

Again, "we must approach a particular problem from *either* the biological brain perspective *or* the non-biological mind/spirit perspective," "a particular problem must be caused by *either* lie-based thinking *or* by true mental illness," and "a particular problem must be caused by *either* psychological trauma *or* biological brain dysfunction" **are *false* dichotomies based on *errors* in logic**.

Note: The point here is not to criticize these good people, but rather to alert you to the reality

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[112] Schacter, D.L. *Searching for Memory*. (New York: Basic Books) 1996, pages 266-7.

[113] Smith, Ed. *Genuine Recovery*. (Campbellsville, KY: Alathia Publishing), 2000. Very similar comments are included in the fourth edition of the Theophostic® Prayer Ministry basic training manual, Smith, Ed. *Beyond Tolerable Recovery*. (Campbellsville, KY: Alathia publishing) 2000, pages 170-171, and also in Dr. Smith's most recent publication, *Theophostic® Prayer Ministry: Basic Seminar Manual*, (Campbellsville, KY: New Creation Publishing) 2005, pages 263-4.

that this false dichotomy thinking is EVERYWHERE, including in the teaching of many of the best ministry leaders, scientists, and health care professionals.

F. Practical implications of false dichotomy thinking: In any place where it occurs, false dichotomy[114] thinking leads to operating out of one of the three extreme positions: "biological brain problems *only*," or "non-biological mind issues *only*," or "spiritual concerns *only*." False dichotomy thinking *inherently* results in picking one of the extreme perspectives, and operating out of that unbalanced perspective regarding whatever specific problem is being addressed. This can lead to important and unfortunate decisions regarding practical treatment options.

For example, when false dichotomy thinking leads to the erroneous conclusion "This depression is a 'medical,' genetic, biological brain problem, *and is therefore not* a problem caused by underlying mind or spirit issues," it inherently results in thinking about the specific problem in question from a "biological brain only" perspective. Even if the person is not *generally* operating out of the "biological brain only" paradigm, *with respect to this specific problem*, the false dichotomy thinking error logically leads to approaching *this specific problem* from the "biological brain only" perspective. As discussed below, the "biological brain only" perspective logically leads to the practical and important treatment decisions of turning away from efforts to find and resolve underlying mind/spirit issues, of increasing medication dose until the symptoms have been completely resolved, and often also the decision to continue medication for the rest of the person's life.

I *agree* with these treatment decisions with respect to mental illnesses where genetic, biological brain dysfunction is the most important contributing factor, such as true bipolar disorder, true schizophrenia, and Alzheimer's disease.[115] However, the "biological brain only" perspective makes these recommendations for *all* mental health problems. As discussed below, the insights included in our "Mind *and* Brain" paradigm reveal that "don't waste time on looking for underlying causes, medicate until all symptoms have been resolved, and stay on medication for the rest of your life" are *unfortunate, erroneous* treatment decisions for *most* mental illnesses.

Dr. Grant Mullen provides a good example of these principles. Even though he accurately identifies the importance of biological brain mental illnesses *and* psychological trauma *and* demonic oppression, and is therefore clearly *not* generally operating from the "biological brain only" perspective, he falls into false dichotomy thinking with respect to depression (see quotes above), and then logically makes treatment recommendations from the "biological brain only" perspective:

> "It is generally recommended that the best way to prevent or reduce the risk of relapse is to stay on antidepressant medications indefinitely [the rest of your life]. For those people who remain on treatment, medications must be considered equivalent to eyeglasses, insulin or heart pills which must be taken for life. These medications are not a crutch but they actually

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[114] Actually, when one includes biological brain problems, psychological trauma, and demonic spirits, you have false *tri* chotomy thinking.

[115] As already discussed, it is *not* helpful to search for underlying mind/spirit issues *causing* the bipolar disorder, schizophrenia, or Alzheimer's disease; but it *is* helpful to address mind/spirit issues that exacerbate the overall clinical picture, even for primary biological brain illnesses such as true bipolar disorder, true schizophrenia, and Alzheimer's disease.

correct the problem as long as they are taken continuously."[116]

VII. The appropriate place for mental illness diagnoses: Almost all mental health professionals routinely use diagnostic labels for mental illnesses. In marked contrast, many people in emotional healing ministry think of diagnostic labels as harmful pronouncements that actually hinder the healing process. I think there is a valid place for diagnostic labels, but that this appropriate role is obscured by false dichotomy confusion, other thinking errors, and also by the unfortunate negative stigma that is associated with many mental illness diagnoses.

A. The empirical and descriptive approach to diagnosis [and a *Very* brief summary of the history and theory behind the Diagnostic and Statistical Manuals (DSMs)]: Most of the mental health professionals in the United States use the Diagnostic and Statistical Manual, fourth edition (DSM IV), which is based on an empirical and descriptive approach to diagnosis. Empirical means "Based on practical observations and not relying on theory about underlying causes." The history behind this is that psychiatrists, psychologists, and other mental health professionals have been profoundly unable to agree on theory about the underlying causes for most mental illnesses, and the DSM IV approach of basing diagnoses on *practical observations*, and then simply *describing* the signs and symptoms of each illness (with no discussion of theory or underlying causes) was adopted in order to establish a common ground platform that we could actually agree on as a foundation for research, discussion, and treatment.

There is a core of validity to this empirical and descriptive approach. Patterns of practical observations can be identified that correspond to real and legitimate underlying illnesses, even before the specific mechanisms of the underlying illnesses are understood. If people with a certain group of signs and symptoms also display a consistent pattern with respect to a wide range of practical observations, such as genetic predisposition, environmental risk factors, exacerbating factors, beneficial factors, course of illness, and effective treatments, then the identified group of signs and symptoms probably *does* correspond to a real underlying illness. And each of these illnesses, "labeled" with a diagnosis, are associated with specific patterns of biological brain abnormalities. Correctly identifying empirical patterns that correspond to true underlying illnesses can provide valuable guidance regarding practical treatment, since people with the same underlying illnesses will usually respond similarly to the same treatments. For example, lithium is one of the most effective medications for people with bipolar disorder but it is minimally effective for people with schizophrenia. For people with schizophrenia, it would be very important to use an antipsychotic as opposed to lithium. Making an accurate diagnosis between bipolar disorder and schizophrenia therefore has very important practical implications with respect to medication decisions.

And we can use these descriptive, empirical diagnoses to help organize and direct our research, discussion, and treatment decisions *even if we don't agree on theory about underlying causes of the illnesses.* This is the primary theoretical foundation for the Diagnostic and Statistical Manuals.

Note that effective treatment can also be discovered empirically, even before the underlying causes of the illness are understood and/or the mechanism of action of the treatment is understood. The "empirical" approach to discovery of effective treatment could be summarized as:

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[116] Mullen, Grant. *Why Do I Feel So Down When My Faith Should Lift Me Up?* (Kent: Sovereign World Ltd), 1999, page 83.

"Keep your eyes open for anything that seems to produce benefit, and anything that actually works will be included in the list of effective treatments *regardless of whether or not we understand or agree about why it works*." If there are manic-depressive patients who also happen to have seizure disorders, and their manic symptoms are observed to improve whenever they are given Tegretol for their seizures, then Tegretol should be studied as a possible treatment for bipolar disorder. The empirical approach doesn't care whether or not we agree on the theory about how Tegretol works in the treatment of mania, it simply focuses on the observation that Tegretol consistently produces observable benefits.

Medical history provides good examples of this kind of descriptive and empirical approach to diagnosis and treatment. For example, when penicillin was discovered we knew it worked by killing the bacteria causing certain infectious illnesses, but we didn't know the chemical structure of penicillin or understand the biological and chemical mechanisms of *how* it killed the bacteria without harming the patient. It was used with great benefit for years before we elucidated its structure or began to figure out the specific mechanisms of action through which it worked.[117] Malaria provides another good example. The clinical picture of malaria was empirically described and diagnosed, and treatment was available, *for hundreds of years* before we understood what caused the illness or how the treatment worked. Doctors accurately perceived that any patient with a certain pattern of recurrent fevers, pain, shakes, and chills had a common underlying illness, and South American Jesuit priests had discovered that the bark from a certain plant could cure this illness.[118] Therefore, making the correct diagnosis of malaria could guide the physician to the appropriate treatment even though these correct empirical discoveries about the diagnosis and treatment of malaria were made *centuries* before any underlying theory was understood.[119]

Note that in each of these cases it has been important to continue the search for deeper under-

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[117] Actually, although we have learned much about the structure and function of penicillin that has helped us in developing more effective antibiotics medical researchers are still working to clarify details about penicillin's mechanism of action. See, for example, Bayles, KW. "The bactericidal action of penicillin: new clues to an unsolved mystery," *Trends Microbiol*. June 2000, Vol. 8, No. 6, pages 274-8.

[118] Around 1600 A.D., Jesuit priests at missions in the foothills of the Andes mountains observed that the Native Americans drank powdered cinchona bark in hot water to calm their trembling muscles when they were shivering from cold exposure. Although there was little problem with malaria in these mountain foothills, the Jesuits had an extensive network of missions in South America, including missions in areas where malaria was common. It occurred to the priests that cinchona might be helpful for the intense shivering that is associated with malaria, and they therefore tested the powdered bark on several patients suffering from malarial fever. They were pleased when this treatment proved helpful in controlling the shivering, but much more excited to discover that it also cured the underlying illness! Note: there are a number of different stories regarding the discovery of quinine (the active ingredient in cinchona bark), but this account makes the most sense, and is described by a number of independent sources written in the early 1600's [see Rocco, Fiammetta. *The Miraculous Fever-Tree*. (New York, NY: Harper Collins), 2003, pages 60-63].

[119] To put things in perspective: the symptoms of malaria have been accurately identified as a specific disease for possibly thousands of years, cinchona bark was identified as a cure about 1600, Quinine was identified as the active ingredient of cinchona bark in 1820, the microscopic parasite causing malaria was discovered in 1880, the Anopheles mosquito as the transmission vector was discovered in 1897, the chemical structure of quinine was discovered in 1918, and the mechanism of action of quinine was not discovered until the 1940's [Honigsbaum, Mark. *The Fever Trail: In Search of the Cure for Malaria*. (New York, NY: Farrar, Straus, and Giroux) 2002, pages 57, 189, 191, 286, and Rocco, Fiammetta. *The Miraculous Fever-Tree*. (New York, NY: Harper Collins), 2003, pages 299-300].

standing. Discoveries of the chemical structure of penicillin, and discoveries regarding why penicillin is safe for humans but lethal for bacteria, have helped scientists develop safe antibiotics that are effective against a wider spectrum of microorganisms.[120] The discoveries of quinine as the active ingredient in the curative bark, the microbial basis for malaria, the mosquito transmission of the disease-causing microorganisms, the chemical structure of quinine, and the mechanism of action of quinine dramatically improved preventative measures, improved the efficiency of treatment with quinine, and contributed to the development of other antimalarial medications.[121]

B. False dichotomies with respect to diagnoses for mental illnesses: Thoughts and opinions about diagnostic labels for mental illnesses are often clouded by false dichotomy confusion. For example, as the emotional healing minister described in the introduction to this essay presented his case study example he re-enacted the following excerpt from his conversation with the psychologist who had been working with the person:

> "Her psychologist called, and objected, 'My client says you told her she no longer needs mental health care?!' I replied, 'Yes, that's true.'
>
> "Then the psychologist exclaimed, 'And she says you disagree with my diagnosis of bipolar disorder?!' And I replied, 'Yes, that's true. Do you want to use your diagnosis of 'bipolar disorder,' or my diagnosis of 'healed by Jesus?' Do you want to use your diagnosis of "hopelessly mentally ill," or my diagnosis of "delivered by her Lord and Savior?' 'Do you want to use your diagnosis, that condemns her to a lifetime of mind numbing medications, or my diagnosis, that sets her free?' Do you want to use your diagnosis of 'mentally ill,' that she will have to carry around as a label for the rest of her life, or my diagnosis that says she is a child of God, just like the rest of us?'"

False dichotomy! False dichotomy! False dichotomy! Your false dichotomy warning system should be flashing and buzzing. With a few moments of clear thinking, you should realize that one does not have to chose *either* mental illness diagnosis *or*:

> Openness to the possibility that mind/spirit issues might be causing the symptoms of the mental illness that has been diagnosed.
>
> Openness to the possibility that Jesus can resolve these underlying mind/spirit issues, with the corresponding possibility of complete freedom from the mental illness that has been diagnosed.
>
> Openness to the possibility that the person can reduce, or even completely discontinue their medication as the Lord progressively resolves their mind/spirit issues.
>
> Actual participation in the saving, delivering, and healing power of Jesus, to release all of these possibilities.

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[120] For an especially thorough and well documented history of penicillin, see Hobby, Gladys L. *Penicillin: Meeting the Challenge*. (Binghamton, NY: Vail-Ballou Press) 1985.

[121] For discussion of how these discoveries regarding malaria contributed to more effective prevention and treatment, see especially chapters ten and eleven (pages 187-223) of Honigsbaum, Mark. *The Fever Trail: In Search of the Cure for Malaria*. (New York, NY: Farrar, Straus, and Giroux) 2002.

> Respect for the person, without toxic and inappropriate stigma and stereotype regarding the mental illness that has been diagnosed.

You can correctly determine that a person's pattern of symptoms corresponds to a valid mental illness diagnosis, such as depression, panic disorder, Post Traumatic Stress Disorder, or bulimia, and still respect the person, refuse to accept limiting stereotypes, believe that underlying mind/spirit issues could be causing the mental illness symptoms, work with Jesus to find and resolve these issues, and then taper the person off of medication as it is no longer needed.

C. Additional thinking errors: In addition to his false dichotomy confusion, this emotional healing minister seemed to be implying that the mental health professional's diagnosis of bipolar disorder had actually somehow contributed to *causing* the problem. He seemed to imply that the diagnosis was in and of itself confining and oppressing the person – that the *diagnosis itself* was a toxic force that was actually helping to keep the person confined in a rigid and oppressive box of mental illness. These are logical errors. The diagnosis, in and of itself, is not doing any of these things.

Mental health professionals *do* need to address legitimate concerns about mental illness diagnostic labels:

> It is important to address the soberingly common problem of *incorrect* diagnoses. I think incorrect diagnosis was actually part of the problem in this particular situation – I think the woman being ministered to had Post Traumatic Stress Disorder, with dissociation and demonic exacerbation, as opposed to true bipolar disorder (it is significant to note that in this particular situation, correcting this diagnostic error would have resolved some of the biggest problems regarding mistaken prognosis and unnecessary medication).[122]
>
> It is important to address the tendency of some mental health professionals to quickly label patients with the closest mental illness diagnosis when they can't figure out what's going on.
>
> It is important to address incorrect information about the prognosis for many mental illnesses. For example, in many cases "this is a biological brain illness, there is no cure, and you will need to be on medication for the rest of your life" should be replaced with "biological brain abnormalities are consistently observed in association with the symptoms of this illness, but the illness can be completely cured (including reversal of the brain abnormalities) if the underlying mind/spirit issues are resolved."

And it is important for all of us to expose, challenge, and eliminate toxic stigmatizing and stereotyping associated with many mental illness diagnoses. But the diagnosis, in and of itself, is not doing any of these things. Let's not throw the baby out with the bath water. One way to get some perspective on mental illness diagnoses is to consider what would happen in other

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[122] For additional discussion regarding diagnostic errors, and especially regarding specific diagnostic issues for psychotic symptoms, schizophrenia, bipolar disorder, and Attention Deficit and Hyperactivity Disorder (ADHD), see "Psychosis and Psychotic Symptoms: Definitions and Diagnostic Considerations," "Schizophrenia and the Immanuel Approach/Theophostic-based Emotional Healing: General Comments and Frequently Asked Questions," "Bipolar Disorder and the Immanuel approach/Theophostic-based emotional healing: General Comments and Frequently Asked Questions," "ADD/ADHD and emotional healing," and "Case Study: Attention Deficit, What Fixed It?," all available as free downloads from www.kclehman.com.

areas of medicine if we demanded that health care professionals stop using diagnoses. If they were not allowed to identify and name specific illnesses, how would they organize their thinking regarding the cause and/or treatment of any given problem? How would they communicate with each other regarding patients' situations? How would the medical community organize or focus research? Or communicate about the results?

D. Proposed alternative for emotional healing ministers: Instead of the "don't do it like this" example presented by the emotional healing minister described in this essay, I would propose the following alternative for dealing with mental illness diagnoses:

1. Tell the person receiving ministry: "I think the Lord may have just revealed and resolved underlying root issues that have been contributing to the symptoms of your mental illness. If I'm right about this, then your _____ (fill in the blank) will now be less severe, and may even be completely resolved. I would like to work with your mental health professional to observe the fruit – to test my hypothesis, and hopefully confirm that you have been healed." Then *test the fruit*, in cooperation with the person receiving ministry and in cooperation with their mental health professional. Celebrate healing if it is indeed verified by lasting fruit.

2. Call the mental health professional working with the person receiving ministry, and say: "I have been working with your patient, _____. I think the Lord may have just revealed and resolved underlying root issues that have been contributing to the symptoms that have lead to her carrying the diagnosis of _____ (fill in the blank). If I'm right about this, then her _____ will be less severe, and possibly even completely resolved. I would like to work with you and with her to test my hypothesis. Would you be willing to re-evaluate her over the next several months to see whether her _____ has been reduced or resolved?" Then *test the fruit*, in cooperation with the person receiving ministry and in cooperation with their mental health professional. Celebrate healing if it is indeed verified by lasting fruit.

Again, I think there is a valid place for diagnostic labels but that this appropriate role is obscured by false dichotomy confusion, other thinking errors, and also by the unfortunate negative stigma that is associated with many mental illness diagnoses. I think we can avoid a lot of unnecessary confusion and conflict if we avoid false dichotomies regarding diagnosis, if those in emotional healing ministries can understand, acknowledge, and respect the valid aspects of the DSM IV approach to empirical and descriptive diagnosis, and if we all work to expose, challenge, and resolve hurtful stigma and stereotypes.

VIII. Some practical implications of working from a "mind *and* brain" paradigm:

A. A more accurate model is always more valuable in guiding exploration, understanding, and treatment: The "mind *and* brain" paradigm allows us to approach from a biological brain perspective when addressing any aspect of a problem that is caused by a biological brain phenomena, and to approach from a mind/spirit perspective when addressing any aspect of a problem that is caused by a mind/spirit phenomena. As presented in discussion and analogies above, approaching a given problem from the appropriate perspective will make it much easier to understand the problem, and will also provide much better guidance with respect to the treatment plan.

B. Psychiatric medications: Some of the most important practical implications of the "mind *and* brain" paradigm presented here pertain to the use of psychiatric medications.

1. Psychiatric medication in situations where biological brain dysfunctions are primary: In some cases, biological brain dysfunctions are the most important contributing factors, and the primary focus of treatment should be medical interventions, such as psychiatric medications, that address the biological brain components of the illness. However, the "mind *and* brain" paradigm says that even in these cases the overall clinical picture will also involve mind/-spirit components. The "mind *and* brain" paradigm also says that the biological brain and the non-physical mind/spirit are so intimately connected that they can influence each other – mind/spirit issues can exacerbate the primary biological brain dysfunction, and resolving mind/spirit issues can reduce the biological brain dysfunction. Therefore, the "mind *and* brain" paradigm recommends mind/spirit interventions be included even in situations where biological brain dysfunctions are the most important contributing factors. Resolution of exacerbating mind/spirit issues will result in decreased biological brain dysfunction; and, correspondingly, the patient will need less biological brain intervention (lower doses of medication, for example).

As discussed above, Alzheimer's disease provides a good example. Genetic, medical, biological brain disease is the most important contributing factor, and medication assisting the person's brain biology is a necessary core of the treatment; but mind/spirit factors also powerfully affect the overall clinical picture as the biological brain deterioration increasingly exposes unresolved mind/spirit issues. Unresolved issues increasingly affect the person's thoughts, emotions, and behaviors as Alzheimer's disease erodes his cortical defenses; and although resolving mind/spirit issues does not seem to stop the progressive neurological deterioration, it dramatically improves the overall clinical picture and decreases the need for medication. Schizophrenia provides another example. In true[123] schizophrenia, genetic, medical, biological brain disease is the most important contributing factor and medication assisting the person's biological brain is a foundational part of the treatment plan, but mind/spirit factors still powerfully affect the overall clinical picture. In my experience working with many patients with schizophrenia, mind wounds and the associated spiritual issues consistently exacerbated their overall clinical pictures, and acute psychotic decompensations were often precipitated by mind/spirit issues getting stirred up.[124] Although resolving mind/-spirit issues does not seem to cure the underlying biological brain illness, it consistently improves the overall clinical picture and decreases the need for medication.

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[123] My current assessment is that "true" schizophrenia is a mental illness with genetic, biological brain disease as the most important contributing factor. It is important to distinguish this genetic, biological brain disease from other conditions that can be mistaken for schizophrenia, such as severe demonic oppression, severe post traumatic stress disorder, severe dissociative disorders, and especially a combination of these three factors. For additional discussion of these important diagnostic considerations see: "Schizophrenia and the Immanuel Approach/Theophostic-based Emotional Healing: General Comments and Frequently Asked Questions," available as free download from www.kclehman.com.

[124] A 1998 study supports my clinical impression that unresolved psychological trauma is a significant exacerbating factor in biological mental illnesses such as schizophrenia, and also my personal experience that many care providers do not recognize the importance of unresolved trauma in these illnesses. Mueser and colleagues studied 275 patients with severe chronic mental illness, and found that 98% reported significant trauma exposure, that 43% met full diagnostic criteria for PTSD, but that only 2% had the diagnosis of PTSD recognized in the medical chart (Mueser K, Trumbetta S, Rosenberg S. "Trauma and Posttraumatic stress disorder in severe mental illness." *J Consult Clin Psychol.* 1998, Vol. 66, pages 493-499). For additional discussion of the effects of psychological trauma in patients with schizophrenia, see also a very recent article: Muenzenmaier Kristina, Castille Dorothy M., Shelley Anne-Marie, Jamison Andrea, Battaglia Joseph, Opler Lewis A., and Alexander Mary Jane. "Comorbid Posttraumatic Stress Disorder and Schizophrenia," *Psychiatric Annals*, January 2005, Vol. 35, No. 1, Pages 51-56.

Comparison of the "mind *and* brain" paradigm, the "brain only" paradigm, and the "mind/-spirit only" paradigm: The "mind *and* brain" paradigm recommends that treatment for Alzheimer's disease and schizophrenia should include *both* biological brain interventions *and* interventions to address mind/spirit issues. In contrast, the "biological brain only" paradigm recommends medication but does *not* perceive any need for mind/spirit interventions, and the unresolved mind/spirit issues therefore exacerbate the overall clinical picture. More simultaneous medications and higher doses of medications are required to manage the increased symptoms, and the overall clinical picture is usually worse, even with the additional medication. The "mind/spirit only" paradigm addresses mind/spirit issues, but does not perceive any need for biological brain interventions such as medication. This approach works wonderfully if miraculous physical healing occurs as part of the ministry to address mind/-spirit issues, but does *not* work so well if the Alzheimer's disease or schizophrenia are *not* miraculously healed.

Alzheimer's disease: Alzheimer's disease is caused by a neurological disease process that progresses over time. In the past, there have been no medical treatments available to slow this steady deterioration; however, new medications are being developed that will significantly slow the progression of the disease. Once these medications are available, if the person has *not* been truly healed and he is mistakenly taken off appropriate medication, not only will the short term clinical picture deteriorate, but the underlying biological brain illness will also progress more quickly.[125]

Schizophrenia: Some forms of schizophrenia include neurological degeneration that steadily progresses, and research has shown that treatment with appropriate medication can definitely slow this process. For example, studies have demonstrated that stopping medication dramatically increases the risk of relapse, and that when a person does relapse neurological degeneration progresses in a way that increases the risk of not responding to medication, that increases the time to response (for those who do respond), and that decreases the completeness of the response (more residual symptoms after response). Furthermore, research indicates that this neurological damage tends to be irreversible once it has occurred. The good news is that research also indicates that *staying on medication may be able to slow (or even prevent) the otherwise progressive and irreversible deterioration*. Therefore, mistakenly stopping medication can result in the person having *much more severe illness* and *much more serious disability* for the *rest of his life*. The physical, emotional, spiritual, social, and financial costs of these long term consequences can obviously be HUGE[126]

2. Psychiatric medication in situations where mind/spirit issues are primary: Situations where

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[125] For a review discussion of research regarding medications that will actually slow the progression of Alzheimer's disease, see Salloway, Stephen, "Taking the next steps in the treatment of Alzheimer's disease: Disease-modifying agents." *CNS Spectrums*, March 2008 Vol. 13, No. 3, Supplement 3, pages 11-14.

[126] For further discussion of the progressive neurological degeneration aspect of schizophrenia, and the protective effects of medication, see Buckley, Peter F., "Treatment of first-episode psychosis." *CNS Spectrums*, October 2007, Vol. 12, No. 10 (Supplement 18), pages 7-10; Lieberman, Jeffrey A., "Neurobiological basis of neurodegeneration and neuroprotection." *CNS Spectrums*, October 2007, Vol. 12, No. 10 (Supplement 18), pages 4-6; and Perkins, Diana O., "Early detection and intervention." *CNS Spectrums*, October 2007, Vol. 12, No. 10 (Supplement 18), pages 10-14.

mind/spirit issues are primary, but symptoms become so severe as to be disabling, provide one of the best examples of the value of the "mind *and* brain" perspective.

In many cases mind/spirit issues are the most important contributing factors, and in these cases the primary focus of treatment should be on the mind spirit issues. However, the "mind *and* brain" paradigm says that even in these cases the overall clinical picture also involves biological brain components. For example, mind/spirit issues are the most important contributing factors in most cases of panic disorder, and the primary focus of treatment in these cases should be using tools such as the Immanuel approach and/or Theophostic®-based emotional healing to resolve the underlying psychological and spiritual issues. However, the overall clinical picture also involves biological brain components. Panic disorder results from inherited brain biology weaknesses that predispose the person to respond to certain kinds of mind wounds in this particular way (panic attacks), combined with developmental deficiencies that add to the brain biology predisposition, specific mind wounds (always including some kind of memory anchored "panic" lies), spiritual issues associated with the mind wounds, and some final stressor that triggers the onset of the disorder. These factors combine to result in the overall clinical picture of panic disorder, including the biological brain abnormalities corresponding to the specific dysfunctional emotions and physical symptoms associated with panic attacks.

When the problem is mild to moderate, a mental health problem such as panic disorder causes psychological pain and painful emotions that motivate and guide interventions to address the underlying mind/spirit issues. At mild to moderate levels pain serves a useful and important purpose. For example, if I chip a tooth I might say to myself "I need to make an appointment to have my dentist look at this," but I will procrastinate and rationalize because I don't want to take the time and because I'm afraid I might need repair that will be both expensive and painful (both big triggers for me). However, if the tooth starts to hurt I will get myself into the dentist's office very quickly. Furthermore, if I go to my internist complaining of "pain" she will ask lots of questions about the pain. Starting with "Where does it hurt?," and then moving on to "When did it start?" "What makes it worse or better?" "Describe the pattern of fluctuation" etc. In addition to motivating me to get help, pain also provides lots of valuable information that assists in diagnosis and treatment.[127]

However, as the problem becomes increasingly severe the mind/spirit dysfunctions and biological brain dysfunctions can become disabling instead of providing motivation and guidance (see figure #2, below). Two of the best examples of this phenomena are panic disorder and major depression. As panic disorder becomes increasingly severe, the combination of mind/spirit dysfunction and biological brain dysfunction can cause fearful thoughts to race so uncontrollably that the person is unable to think effectively. Fearful emotions can become so overwhelming that the person has difficulty functioning emotionally, physical symptoms such as episodes of dizziness and trembling can be disruptive, and persistent sleep disruption can result in all the symptoms associated with chronic sleep deprivation. Similarly, as depression becomes increasingly severe the combination of mind/spirit dysfunction and biological brain dysfunction result in the person losing the ability to think effectively – in some cases the person seems to get stuck in a racing loop of overwhelming

[127] See Brand, Paul, & Yancey, Philip. *Pain: the Gift Nobody Wants*. (New York, NY: Harper Collins publishers) 1993, for a clear, fascinating, and powerful discussion of the motivating and guiding functions of pain. *This is the best discussion of the appropriate functions of pain that I have ever encountered* Note that the current printing of this same book has been given the new title of *The Gift of Pain.*

depressive thoughts, and in other cases the person's thoughts seems to get bogged down, so that he feels like he is "thinking in molasses." The person often experiences profound loss of motivation, initiative, and "will power." Depressive emotions, such as sadness, lack of interest, and hopeless despair can become so overwhelming that the person has difficulty functioning emotionally; physical symptoms, such as severe loss of energy, can be disruptive; and persistent sleep disruption can again cause all the symptoms associated with chronic sleep deprivation. In these cases of *severe* panic disorder or depression the person will have great difficulty fulfilling his job responsibilities, relating to his spouse, taking care of his children, or participating in interventions to address the underlying mind/spirit issues.

At this point, we remember that the "mind *and* brain" paradigm also says that the biological brain and the non-physical mind/spirit are so intimately connected that they can influence each other – biological brain dysfunction can expose and/or exacerbate mind/spirit issues, and *medication correcting biological brain dysfunction* can *moderate the impact of mind/spirit issues*. This is what I perceive to be the appropriate role for psychiatric medications in situations where mind/spirit issues are the most important contributing factors – *medication can moderate the biological brain dysfunction*, and *thereby moderate disabling symptoms during the time required for the person to resolve the underlying mind/spirit issues*. Medication can move the mind/spirit dysfunction and biological brain dysfunction from the "impairment" side of the pain/function curve in Figure #2 back to the "motivation and guidance" side of the curve.

College students provide another good example to illustrate the principles portrayed in Figure #2. On the first day of class, the teacher says: "Your term papers will be due on the Monday before exam week...." These comments, about an assignment that isn't due for months, produce almost no anxiety, and the students spend their free time flirting and playing frisbee. In the middle of the term, the teacher comments: "You should have your subject chosen and most of your note cards completed by now...." The anxiety (pain) produced by these statements provides some motivation, and the students go to the library for a few hours, but then spend the rest of the day flirting and playing frisbee. A week before the paper is due, the teacher comments: "You should be working on your rough draft by now... I'm sure you are all remembering that this assignment will account for one third of your grade...." These comments produce more anxiety (pain), which motivates the students to spend most of their time in the library, and only take occasional breaks to play frisbee. The day before the paper is due, there is a lot of anxiety (pain), and the students are VERY motivated. Nobody is playing frisbee, and most of them won't sleep, either. Occasionally, a student will postpone work until too late.[128] The

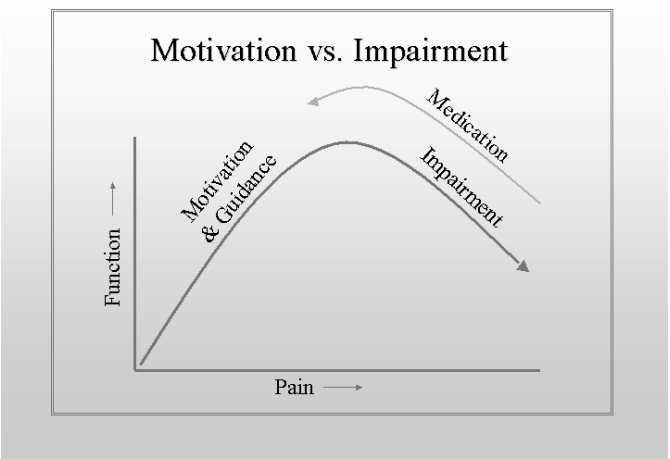

Figure #2

[128] As most readers will probably realize, just putting off a paper until too late and not being able to finish it – even if this results in failing a required course, won't necessarily result in panic, insomnia, and decompensation. Some students can deal with this situation – experiencing pain (and hopefully learning from the experience), but not decompensating. But, in order to keep the example simple, I am not discuss-

anxiety (pain) will become too intense, and be disabling instead of motivating – he will feel overwhelmed, experience panic attacks, become disorganized, and be unable to sleep for the entire week before the due date. This unfortunate student will decompensate instead of working harder and getting his term paper finished. At this point, medication can help stabilize his brain chemistry so that he can sleep and function (in order to deal appropriately with the consequences of not finishing the term paper).

In addition to the clinical and practical examples just described, there are also many psychological research studies demonstrating the principles illustrated in figure #2. The first study demonstrating this inverted "U" shaped curve was performed by Yerkes and Dobson in 1908, and examined the relationship between strength of punishment stimulus and rapidity of learning. In this classic experiment, Yerkes and Dobson showed that learning initially increased sharply as the intensity of punishment was increased, but that learning then began to deteriorate as intensity of punishment was increased past a certain point.[129] A number of studies since then have examined the connection between level of anxiety (from any source) and performance, and these studies show that performance is lower with both low and high levels of anxiety, with peak performance corresponding to moderate anxiety in the middle of the curve.[130]

Comparison of the "mind *and* brain" paradigm, the "brain only" paradigm, and the "mind/-spirt only" paradigm: "Mind *and* brain" paradigm: Medication may be used to moderate symptoms in order to decrease impairment/prevent disability, but you want to avoid medication hindering access to the underlying emotional and spiritual issues. Mind wounds and spiritual issues are recognized as the most important considerations, and working to resolve mind wounds and spiritual issues will be the primary focus of treatment. Medication can be reduced as mind wounds and spiritual issues are addressed, and medication can be stopped completely once the underlying issues are resolved. "Brain biology only" paradigm: Medication is the primary treatment. The physician medicates to accomplish as complete a resolution of symptoms as possible, and then maintains this as a long term treatment plan – often for the rest of the person's life. This approach will recommend using higher doses of medication, use of more different simultaneous medications, and longer duration of medication use. The multiple medications, higher doses, and longer duration will increase side effects, increase costs, and also sometimes make it more difficult to work with the underlying mind/spirit issues. If the patient and treatment team fully accept "the biological brain is everything" perspective, this can completely block addressing underlying psychological and spiritual issues because they are believed to be nonexistent. "Mind/spirit only" paradigm: Medications are perceived as unnecessary, or even as evidence of a sinful lack of faith. Medications are therefore not used at all, which is okay if the symptoms are mild or if the patient is instantly healed. However, in some situations the patient suffers from severe symptoms that are *not* instantly healed and that could have been moderated with medication,

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ing the other variables that affect whether or not a given situation is overwhelming to the point of decompensation.

[129] Yerkes, Robert M., and Dobson, John D. "The relation of strength of stimulus to rapidity of habit formation," *Journal of Comparative Neurology and Psychology*. 1908, Vol. 18, pages 459-482.

[130] See, for example, Cox, F.N., "Correlates of general and test anxiety in children." *Australian Journal of Psychology*, 1960, Vol. 12, pages 169-177, and Matarazzo J.D., and Phillips Jeanne S. "Digit symbol performance as a function of increasing levels of anxiety." *J. Consult. Psychol.*, 1955, Vol. 19, pages 131-4.

and the lack of assistance from medication in these cases can result in serious "real life" consequences, such as toxic parenting, failed marriages, loss of employment, and even suicide.

C. More optimistic regarding some "irreversible" brain injury: Authors such as Dr. Allan Schore and Dr. James Wilder write about biological brain changes that occur as a result of psychological traumas and/or deficiencies, especially during childhood development. They often refer to these biological brain changes as "permanent," and/or comment that they "never resolve."[131] The clearly observable data is that psychological trauma and/or deficiencies, especially during childhood development, do cause biological brain abnormalities. Furthermore, these brain abnormalities are observed to remain for many years (they are not observed to resolve). However, the "biological brain only" and the "mind *and* brain" perspectives differ in their interpretations and recommendations regarding this information. Biological brain only perspective: The brain is primary, and the observed brain changes are the deepest roots and most fundamental aspect of the problem. There is no known biological process for reversing the structural changes that result from trauma or deficiency during development, and the observation that these changes continue into adulthood, and appear to be permanent, is completely expected. The focus of treatment should be on prevention if damage has not yet occurred, and on symptom management for those who have already been injured. Mind *and* Brain perspective: The mind/spirit is the primary phenomena in many situations, and abnormalities in the biological brain often simply reflect or express underlying mind/spirit issues. It may be that research shows "permanent," "irreversible" biological brain changes associated with some psychological traumas and/or deficiencies because we have not had tools that are effective in addressing the corresponding underlying mind/spirit issues. If the mind wounds and spiritual issues causing the brain biology abnormalities usually haven't gotten resolved, *the corresponding brain biology abnormalities would be expected to remain as well*. However, if mind wounds and/or spiritual issues are the deepest roots/primary causes of some of these brain biology abnormalities, then the brain biology abnormalities are *not* truly irreversible, and will correct when the underlying issues are resolved. In these situations, the "mind *and* brain" paradigm would recommend finding and resolving the source mind/spirit issues, as opposed to simply moderating and managing the symptoms of "irreversible" brain injury.

D. Freedom to think from both perspectives at the same time: As discussed above, exposing the false dichotomy of "We can only approach a given problem from one perspective or the other" gives us the freedom to think from both perspectives at the same time. As is also included at different points in the above material, this freedom to use both models should be applied at two levels: 1. When looking at the overall clinical picture in any given situation, it is very important to recognize both biological brain phenomena and non-biological mind/spirit phenomena, and it is very helpful to begin with approaching biological brain phenomena from a biological brain perspective *and* with approaching non-biological mind/spirit phenomena from a mind/spirt perspective; 2. although slow and difficult, it is even valuable to study mind/spirit phenomena from a brain perspective, and to study brain phenomena from a mind/spirit perspective. Freedom to approach from both perspectives at the same time, letting exploration from both paradigms shed light on the *same specific phenomena*, will result in valuable confirmation of insights that have been discovered through study from the primary perspective, and

[131] See, for example, Schore, Allen N., Ph.D. *Affect Regulation and the Origin of the Self*. (Hillsdale, NJ: Lawrence Earlbaum Associates, Publishers), 1994, where Dr. Schore makes many comments about "permanent" and "irreversible" biological brain changes caused by trauma and/or deficiency during development.

can even result in discovery of completely new insights.

IX. "Mind *and* Brain paradigm = foundation for unity and cooperation:

The "mind *and* brain" paradigm presented here provides a foundation from which those studying the biological brain and those studying the non-biological mind/spirit can work together, as complementary players on the same team.

X. Putting other material in the larger "mind *and* brain" frame work:

Amen, Daniel G., M.D.: Dr. Amen is a gifted Christian psychiatrist who has made important contributions to mental health care and to emotional healing ministry. He acknowledges that brain biology and emotional healing interact, but sometimes sounds as if he believes, *experientially*, that brain biology is the more primary process. In my assessment, he over-emphasizes "The person just has a broken brain, and the problem needs to be fixed/treated with medication," and under-emphasizes "The brain chemistry abnormality might be caused by a wounded mind, and should be treated primarily with emotional healing." As discussed in the "false dichotomy" section, above, Dr. Amen is an intelligent, competent medical professional who frequently falls into false dichotomy logical errors with respect to "*either* biological brain dysfunction *or* unresolved mind/spirit issues."

One particularly helpful point to be aware of when reading Dr. Amen's material is that SPECT scans *do* indicate biological brain dysfunction, but that they *do not* clarify the underlying cause of the biological brain dysfunction. That is, SPECT scans have *no ability* to distinguish between abnormal brain function *primarily* caused by an underlying *mind/spirit* issue and abnormal brain function *primarily* caused by a wound or disease in the *biological brain*.

Lehman, Karl D., M.D. (me): I acknowledge biological brain factors, non-biological mind issues, and non-biological spirit issues, and I am constantly working to further clarify how they interact. However, some of my previous writing has not been so clear and/or explicit with respect to the "mind *and* brain" paradigm presented here.

Mullen, Grant, M.D.: Dr. Mullen acknowledges brain biology problems, psychological issues, and spiritual concerns, but is not as sharp/clear about how they interact. As discussed above, he mostly discusses them as three *separate* issues, and never mentions or discusses how dysfunctional thoughts and emotions can actually *cause* the biological brain abnormalities of many mental illnesses. He also falls into false dichotomy thinking.

Siegel, Daniel, M.D.: Dr. Siegel is a brilliant clinician and researcher, and presents many helpful thoughts and insights; but he clearly believes that the biological brain is the more primary phenomena, and that the mind is *created by*, and *arises from* the activity of the biological brain.[132] As one reads his material one must constantly remember that all of his thinking is developed from this "brain only/brain before mind" perspective.

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[132] The first sentence on page one of one of his most recent books reads: "The mind emerges from the activity of the brain,...." (Siegel, D.J. *The Developing Mind*. New York: Guilford Press, 1999. Page 1). See pages 3, 143, 159, 160, 215, 222, 223, 239, 245, and 300 for similar comments. In the introduction to his most recent book, Dr. Siegel states: "The mind emanates from the activity of the brain,..." (Siegel, D.J. *Parenting from the Inside Out*. New York, NY: Jeremy P. Tarcher/Putnam, 2003, page 8). See pages 22, 31, 32, 42, 53, for similar comments.

Smith, Ed, D.Min.: Dr. Ed Smith, the founder of Theophostic® Prayer Ministry, has formulated important insights that have greatly blessed Charlotte, myself, our clients, and many others. Dr. Smith is a personal friend, and we have had a number of good conversations with him regarding how medical psychiatry, clinical psychology, and Theophostic®-based emotional healing ministry can be complimentary. However, as discussed in the "false dichotomy" section above, his comments about mental illnesses, psychiatric medication, and professional mental health care have been full of false dichotomy logical errors with respect to "*either* biological brain dysfunction *or* unresolved mind/spirit issues, *either* 'true mental illness' *or* mind/spirit problems."

Wilder, E. James, Ph.D.: One of Dr. Wilder's important points, "The younger brain patterns after the older brain," is sometimes presented as if the most basic, fundamental process is a brain biology process, that occurs independently of the mind. His material is presented as if the younger *brain* patterns after the older brain, as a primarily neurological process, even independently of the younger *mind* learning from the older mind. My hypothesis is that Dr. Wilder's brain biology stuff simply describes how the brain biology follows, expresses, and implements, providing a biological substrate for the younger mind learning from the older mind. For those of you studying Dr. Wilder's material in detail: It is important to recognize the subtle, and often unconscious aspects of how a younger mind can learn from an older mind – aspects of learning that can especially appear as "just neurological processes."

XI. Frequently asked questions:

A. Since the brain and the mind are so intimately connected, can resolution of emotional/spiritual issues heal even "primary" brain biology issues, such as traumatic brain injury, strokes, Alzheimer's disease, or true schizophrenia?

1. I have seen emotional/spiritual healing result in resolution of brain biology problems that were simply expressions of the mind/spirit issues – such as the abnormal brain biology of a depression that is primarily caused by underlying memory anchored lies. I have seen emotional/spiritual healing result in resolution of physical/medical problems that had been caused by demonic spirits (which were dis-empowered and sent away in the course of the emotional healing work).[133] I have seen emotional/spiritual healing result in physical healing because mind/spirit issues had been crippling the person's faith, and healing prayer could then be effective after the mind/spirit wounds were resolved. But I, *personally*, have not seen emotional/spiritual healing result directly in the resolution of primary brain biology problems, such as traumatic brain injury, strokes, Alzheimer's disease, or true genetic schizophrenia.

2. Even with this said, the more we learn the fuzzier the lines get. For example, the experience and teaching of people like Agnes Sanford seem to indicate that the thoughts and attitude of the mind play a powerful role in prayer for physical healing. The research on mind intention affecting physical systems also lives in the mysterious zone of interconnection between the biological brain and the non-biological mind.

XII. Sample Prayers: After preparing the material in this essay, we felt it was valuable to pray

[133] This would include illnesses such as "mimic" schizophrenia and "mimic" bipolar disorder, in specific cases where the "mimic" illnesses were caused by demonic spirits (as opposed to "true" schizophrenia or "true" bipolar disorder caused by primary brain biology abnormalities).

regarding several specific issues. If these issues and prayers seem valid for you, then we encourage you to join us in your hearts for these prayers (or your own versions, customized to fit your own style).

A. Pride, judgment, and disrespect: As mentioned in the introduction, Charlotte and I perceive that part of what the Lord has given us to do is to remove stumbling blocks that cause division between different parts of the healing team that should be working together. One important part of removing stumbling blocks, and encouraging cooperation and integration, is to confess and repent of any pride, judgements, or disrespect towards others working in healing professions and/or healing ministries. There is a place for dialogue to discuss points of disagreement, but there is ***no*** place for pride, judgment, or disrespect.

Sample prayers and commands:

Pride, judgments, and disrespect from the biological brain perspective:

"Lord Jesus, I confess pride, arrogance, and even idolatry regarding physical sciences and especially regarding the study of the biological brain. I confess thinking/believing along the lines of 'Physical sciences and the study of the brain will eventually provide explanation and treatment for everything. We don't need anybody else. This is the only really important work.' I ask Your forgiveness for this pride, arrogance, and idolatry, and ask You to give me Your humility and truth regarding the appropriate place for the scientific study of the biological brain.

"Lord, I confess disrespecting and devaluing mind/spirit perspective insights and interventions. I ask You to forgive me for this, and ask You to give me Your respect and appreciation regarding mind/spirit insights and interventions.

"Lord Jesus, I confess judging and disrespecting people who refuse to take medications, therapists/ministers who are ignorant regarding brain biology, and especially therapists/ministers who advise others away from medications. I ask You to forgive me for this judgment and disrespect, and ask You for Your heart and mind towards these people.

"Amen."

Pride, judgments, and disrespect from the mind/spirit perspective:

"Lord Jesus, I confess pride and arrogance regarding mind/spirit insights and interventions for mental health concerns. I confess thinking/believing along the lines of 'Mind/spirit insights and interventions are all we need. This is the only really important work.' I ask You to forgive me for this pride and arrogance, and ask You to give me Your humility and truth regarding the appropriate place for mind/spirit insights and interventions.

"Lord, I confess disrespecting and devaluing biological brain perspective understanding and treatments. I ask You to forgive me for this, and ask You to give me Your respect and appreciation regarding biological brain understanding and treatments.

"Lord Jesus, I confess judging and disrespecting people who take medications, and especially mental health professionals who 'just medicate,' and don't address the underlying issues. I ask You to forgive me for this judgment and disrespect, and ask You for Your heart and mind towards these people.

"Amen."

B. Pronouncements, beliefs, and attitudes that can act as curses and/or cut us off from resources the Lord may want us to use: Our belief, *and experience*, is that God heals. Our observation is that the Lord routinely releases healing for mind/spirit issues, and that He will *always* eventually heal mind/spirit issues if the person persists in working with Him to find and remove any blockages. Our observation is that the Lord sometimes heals physical issues, such as the biological brain components of bipolar disorder, schizophrenia, or Alzheimer's disease, but that sometimes He does not release miraculous healing for these physical problems.

Our belief, *and experience*, is that God also works through medicine and medication. Our observation is that medication is sometimes helpful as *temporary assistance* during the process of resolving mind/spirit issues, and that long term medication is often helpful in situations where biological brain illnesses are the most important contributing factor.

Unfortunately, healing ministers sometimes make pronouncements, such as "You've been healed, and you will never take medication again," when healing has not yet occurred, and mental health professionals sometimes make pronouncements, such as "This is a genetic, lifelong brain chemistry imbalance. You will always need to take medication," when the Lord wants to release healing. We perceive that pronouncements such as these can actually act as a kind of curse, cutting us off from resources the Lord wants us to use. We have also observed that those involved in healing ministry can sometimes have unfortunate attitudes or beliefs, such as "Taking medication demonstrates lack of faith," and mental health professionals can have unfortunate attitudes or beliefs, such as "It's just a brain chemistry imbalance, so pursuing psychotherapy or emotional healing ministry are wastes of time, energy, and money." We perceive that attitudes and beliefs such as these can cut us off from resources the Lord wants us to use.

Sample prayers and commands:

"Lord Jesus, we confess that we often speak more than we know. We thank You, Lord, for healing, but confess that we sometimes pronounce healing when it has not yet occurred. We thank You, Lord, for medication, but confess that we sometimes pronounce the need for long term medication when there are underlying mind/spirit issues, or even physical issues, that you want to heal. In the name of the true Lord Jesus, we break the power of any pronouncements that are not true, and that act as curses and/or cut us off from appropriate resources.

"Lord, we confess that we often err in our thinking and beliefs. We confess that we have maintained confused attitudes and beliefs that have cut us off from resources that You want us to use. Lord, we ask that You would replace these confused attitudes and beliefs with Your truth, that You would give us Your mind and heart regarding healing, medicine, and how You want them to work together. In the name of the true Lord Jesus, we break the power of any attitudes or beliefs that are not accurate, and that cut us off from appropriate resources.

"Lord, we ask that You would reveal any other pronouncements, beliefs, or attitudes that are cutting us off from resources You want us to use. We ask that you would expose the confused thinking behind these pronouncements, beliefs, and attitudes. Help us especially to see where we have been mislead into false dichotomies, and release us from them with Your truth and light.

"Amen."

C. Prayers of blessing and anointing:

"Lord Jesus, we ask that you would give us unity, that we might work together more effectively.

"Lord, we ask for wisdom and understanding – anointing for discovering and understanding the principles and patterns that You have established to govern creation, so that we can cooperate with them. We ask especially that You would give us more light and understanding regarding how the brain, mind, and spirit fit together and work together.

"In Your name, Lord Jesus, we thank You for all these things. Amen."

Scraps:

Biological brain abnormalities that contribute to the mental illness and that are *not* caused by spiritual and/or psychological issues.