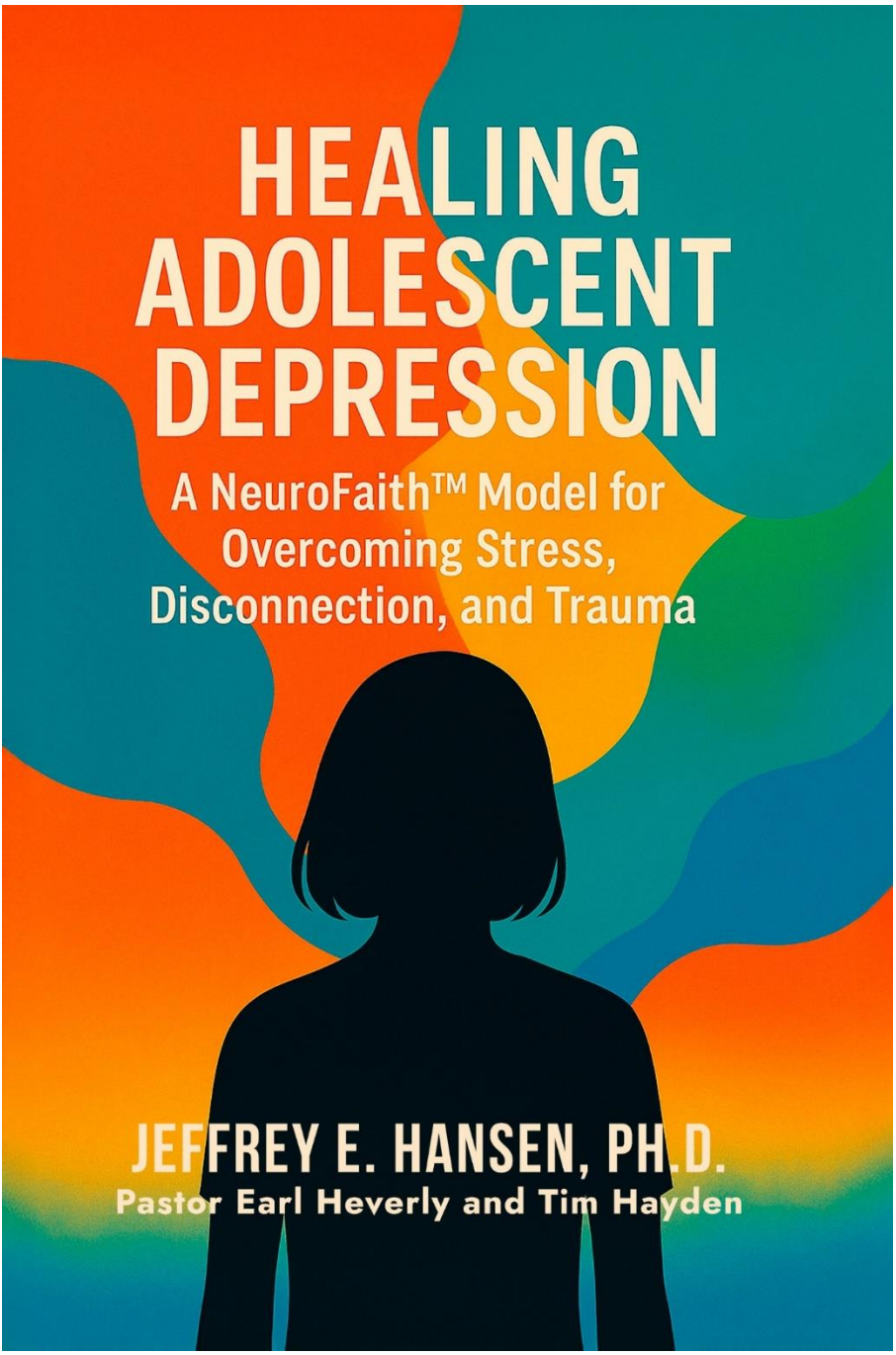
HEALING
ADOLESCENT
DEPRESSION
A NeuroFaith™ Model for
Overcoming Stress,
Disconnection, and Trauma
JEFFREY E. HANSEN, PH.D.
Pastor Earl Heverly and Tim Hayden

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Endorsements

for

Adolescent Depression: A NeuroFaith™ Model for Healing Mind, Body, and Soul

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There are few books I have read that bring together neuroscience, clinical wisdom, and spiritual depth in the way this one does. NeuroFaith™ is a timely, compelling, and much-needed contribution to the mental health field—particularly in the care of adolescents, who are facing a crisis of identity, despair, and emotional disconnection unlike anything we've seen before.

As a physician, neuroscientist, and follower of Christ, I believe this book stands in the gap between two worlds that too often remain divided: the world of science and the world of faith. Dr. Hansen offers a bold but thoughtful model that honors both. He engages with difficult topics—medication overuse, ideological confusion, trauma, pornography, and disembodiment—with a balance of clinical insight, compassion, and biblical truth.

What I appreciate most about NeuroFaith™ is that it does not vilify. It invites. It challenges us not to abandon the tools of modern medicine but to place them within a more integrative, person-centered framework that sees each human being as more than a brain, more than

a diagnosis, more than an identity category. It recognizes that healing requires not just pharmacology or therapy, but relationship, narrative, and often, reconciliation with God and self.

This book is especially relevant now, in an age where young people are not only medicated at alarming rates but are also being asked to navigate a cultural minefield around gender, sexuality, and identity—with little support for their developmental or spiritual needs. NeuroFaith™ offers a compassionate roadmap that prioritizes attunement, nervous system regulation, meaning-making, and the restoration of dignity and coherence in the adolescent experience.

I wholeheartedly endorse this work. For clinicians, pastors, educators, and parents alike—this book will inform your practice, deepen your empathy, and strengthen your resolve to care for the next generation in a way that is scientifically grounded and spiritually rooted. NeuroFaith™ is not just a model. It is a call to return to what truly heals."

Dr. Andrew P. Doan, MPH, MD, PhD
Adjunct Associate Professor of Surgery, Uniformed Services University
Ophthalmology and Aerospace Medicine

As a practicing internist and pediatrician with a Christ-centered model of care, I wholeheartedly endorse this publication. Our culture has witnessed a tremendous transformation away from traditional family and faith values to a world of intense, and often harmful exposures, without the necessary support at home or in faith communities. My view on optimal health involves the triad of mind, body, and soul. Our current practice of medicine has not met the challenge of the rapidly

changing world and the stress this places on the developing brain of adolescents. I commend the authors for thinking outside the box and presenting a 'NeuroFaith' model that may serve as a solution to guide us through the minefield of adolescent depression and anxiety care.

Russell Gombosi, MD
I*nternal Medicine, Pediatrics, and Sleep Medicine*

As a registered nurse—and more importantly, a mother of four adopted, deeply traumatized children—I was desperate for real help. "Dr. Jeff," as he's affectionately known in our home, became a lifeline for our entire family. His deep insight into trauma and healing has transformed not only our children's lives but our family as a whole. Through his compassionate and research-backed guidance, each of our children began to recognize their trauma responses, develop healthier coping strategies, and embrace healing through relationship. Dr. Hansen's unique ability to blend neuroscience with faith helped our kids see the power and purpose of family and gently led them to trust and connection. We are still walking the road of healing, but we are doing so with hope, clarity, and tools we never had before. ***Adolescent Depression: A NeuroFaith™ Model for Healing Mind, Body, and Soul*** reflects the very wisdom that changed our home. May God continue to bless your work, Dr. Jeff—you are helping rescue children and restore ***families.***

Rachel
Mother and Registered Nurse

In Dedication

This book is lovingly dedicated to my twin brother, Gregg, who was my best friend in this world. He lived an amazing and inspirational life and celebrated the highs in my journey and held me through the lows, giving me hope and light when I could not see the way. Lending further testament to Gregg's grit and character was that he did all of this despite his episodic battles with profound depression. He fought this pain nobly and courageously until it finally overtook him. I lost a part of myself when Gregg moved on, and the empty space in my heart will forever lend witness to how profoundly he blessed me. And fear not dear brother, I will not allow your pain to be without meaning and will use your story to encourage others to seek healing for their wounds.

Gregg and Jeff doing together what we loved most standing in front of our childhood home in Ft. Collins, CO.

Adolescent Depression

A NeuroFaith™ Model for Healing Mind, Body, and Soul

By Jeffrey E. Hansen, Ph.D., Pastor Earl Heverly, and Tim Hayden

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Authors' Note on AI Contributions

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

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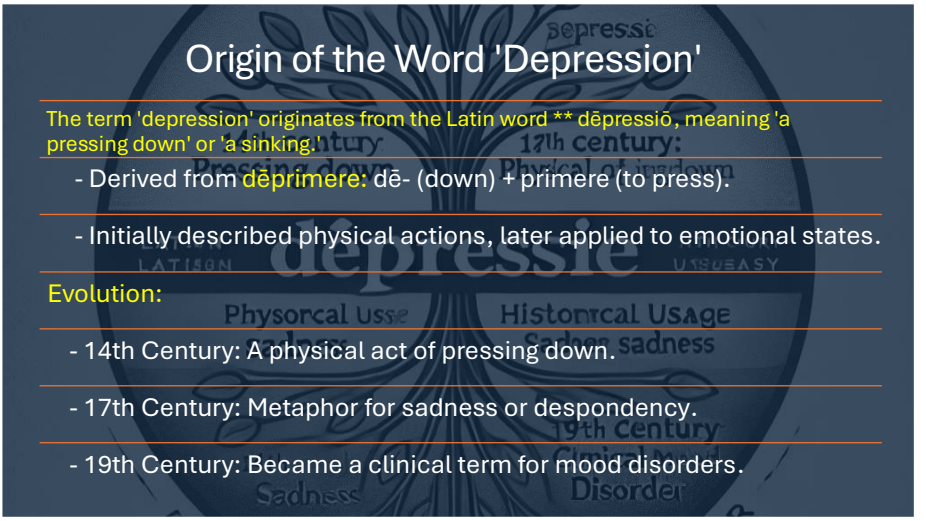
Introduction

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

—Inspired by Friedrich Nietzsche

Adolescent depression is not just an emotional downturn or a clinical diagnosis—it is a soul-deep cry for meaning in a fragmented world. Today, more teens than ever before are feeling lost, anxious, disconnected, and hopeless. Suicide is now the second leading cause of death among adolescents in the United States. Antidepressant prescriptions for this age group have surged. And yet, despite an explosion of mental health awareness and interventions, teen depression continues to rise. Why?

This book seeks to answer that question by taking a different path—one that does not begin with a pill or a label, but with the human heart. ***NeuroFaith™*** represents a groundbreaking model that unites cutting-edge neuroscience with timeless spiritual truth. Drawing on years of clinical experience, deep biblical wisdom, and emerging insights into trauma, brain plasticity, and heart-based healing, this book offers a compassionate, science-informed, faith-rooted response to the adolescent mental health crisis.



Unlike conventional models that focus narrowly on symptom management or neurochemical fixes, ***NeuroFaith™*** sees teen depression as a physiological, emotional, relational and spiritual disconnection. Depression, in this view, is not a random chemical malfunction but a meaningful signal of brokenness and pain—an intelligent nervous system crying out for safety, connection, and identity.

Here, we explore how trauma and disconnection disrupt the autonomic nervous system, how shame warps the adolescent brain, and how our

children's sense of self is under siege from within and without. But more than this, we explore how teens can heal. Using a model that integrates Polyvagal Theory, neurocardiology (HeartMath), Internal Family Systems (IFS), and a Christ-centered understanding of identity, ***NeuroFaith™*** offers a roadmap out of despair.

This is not a book of theory. It is a book born of heartbreak, hope, and hard-won experience. It is for the teen who can't find the words. For the parent who doesn't know what else to try. For the clinician who wants more than protocols. And for the church that longs to love its hurting youth in a way that is both wise and effective.

We will journey through the neuroscience of suffering, the spiritual battle for identity, and the power of love to restore what shame has shattered. We will meet teens who have walked through darkness and emerged into light. And we will discover that healing is not only possible—it is within reach.

This book is your companion through that journey. It unfolds in three parts:

In Part I: Unveiling the Crisis, we begin by surveying the emotional landscape of today's teens, where rising rates of sadness, anxiety, and even suicide paint a sobering picture. In Chapter 1, we look at the alarming data and the emotional toll on young people. Chapter 2 challenges the prevailing assumptions about depression and explores why conventional approaches—focused primarily on diagnosis and medication—often fail to bring lasting healing.

In Part II: The Deeper Causes of Adolescent Depression, we dig beneath the surface. We examine how childhood has been reshaped—from

active, play-based exploration to screen-dominated isolation (Chapter 3). We unpack how ideological forces, often rooted in critical theory and postmodernism, have disrupted normal identity development (Chapter 4). In Chapter 5, we confront the impact of pornography, not merely as a behavior, but as a heart and soul-level wound. Chapter 6 reflects on the profound sense of disconnection many teens experience today, inspired by the work of Johann Hari. And in Chapter 7, we turn to the findings of Dr. Vincent Felitti and the ACE study to understand the deep imprint of early trauma on the developing brain.

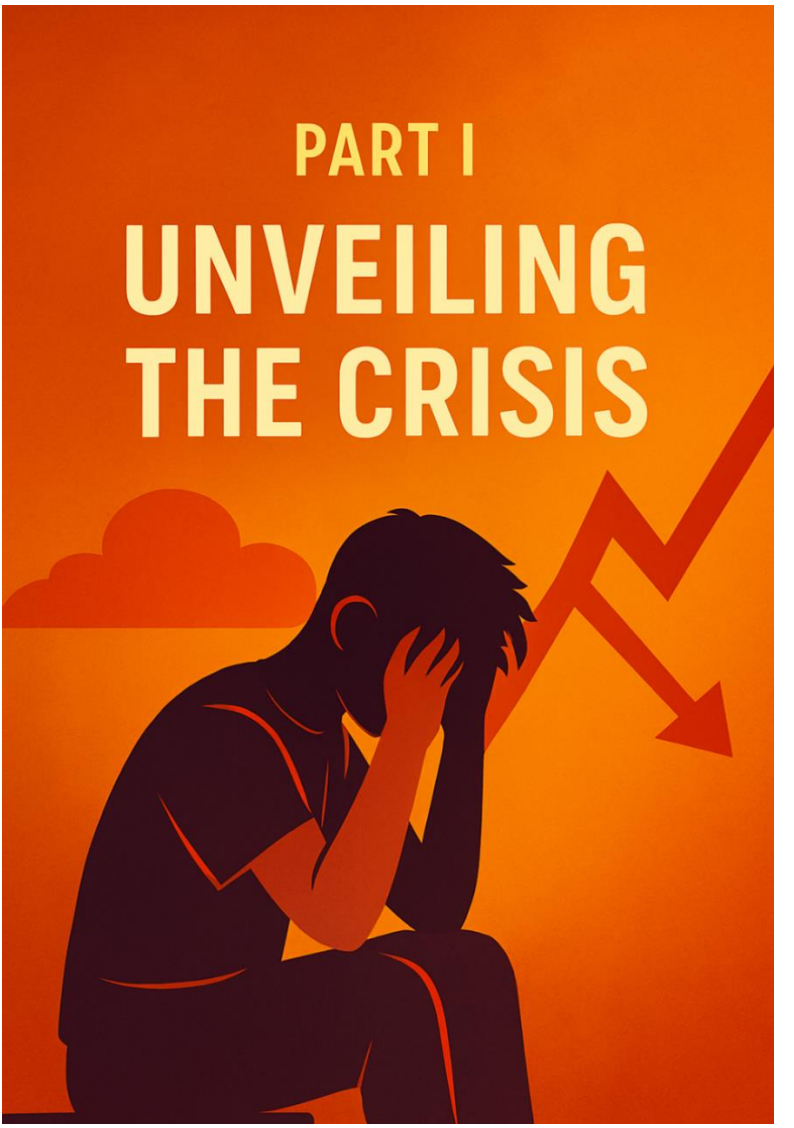
Part III: The ***NeuroFaith™*** Framework brings together the tools, truths, and therapies that point toward healing. Chapter 8 introduces Polyvagal-Informed Therapy—understanding the nervous system's language of safety and threat. Chapter 9 explores the healing power of neurocardiology and HeartMath, offering practical ways to restore emotional coherence through breath and intention. Chapter 10 opens up the Internal Family Systems (IFS) approach, helping teens befriend their inner world and reconnect with their God-given Self. Finally, Chapter 11 is about restoration—where identity is no longer shaped by shame or diagnosis, but rooted in faith, love, and belonging.

This roadmap is more than a reading plan. It is an invitation—an invitation to believe that healing is possible, that your story isn't over, and that the God who made the heart and brain also knows how to heal them.

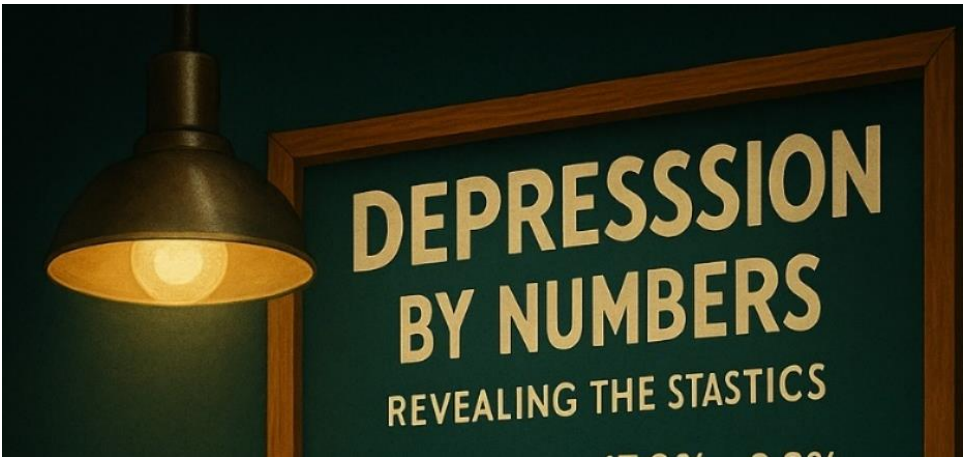
Welcome to NeuroFaith™ ***where faith meets science, and brokenness meets hope.***

Before we dive headfirst into brain science, depression stats, and all things neurotransmitter-related, let's take a breath and appreciate the wonderfully perplexing creature known as the adolescent. Equal parts philosopher, rebel, comedian, and night owl, teens are not broken mini-adults—they're brilliant, bewildering works-in-progress. Their brains are still under construction, their emotions run hot, and their priorities… well, let's just say they don't always match ours. But behind the eye rolls, late-night existential crises, and questionable fashion choices lies a soul craving love, connection, clarity, and purpose. So, as we explore how to support them through the valleys of depression, let's begin with grace, humor, and maybe a decent pair of noise-canceling headphones.

Part I:
Unveiling the Crisis

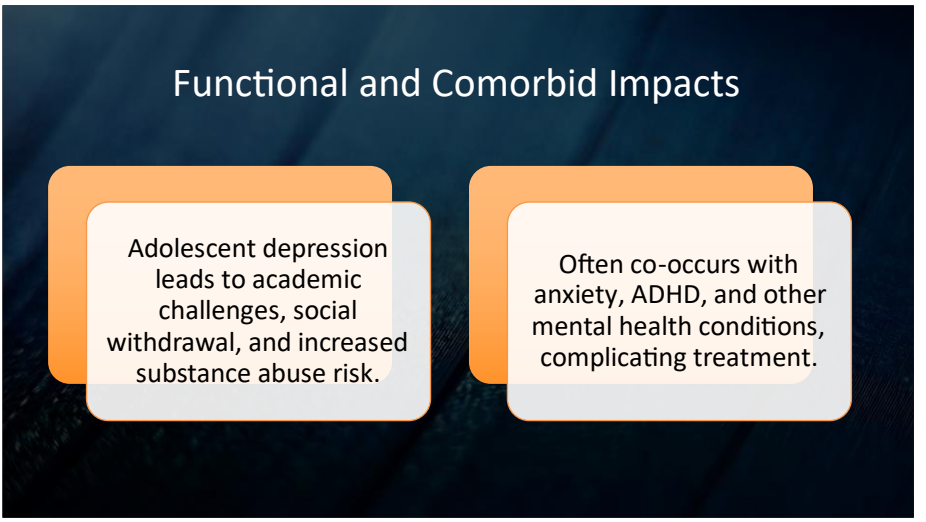


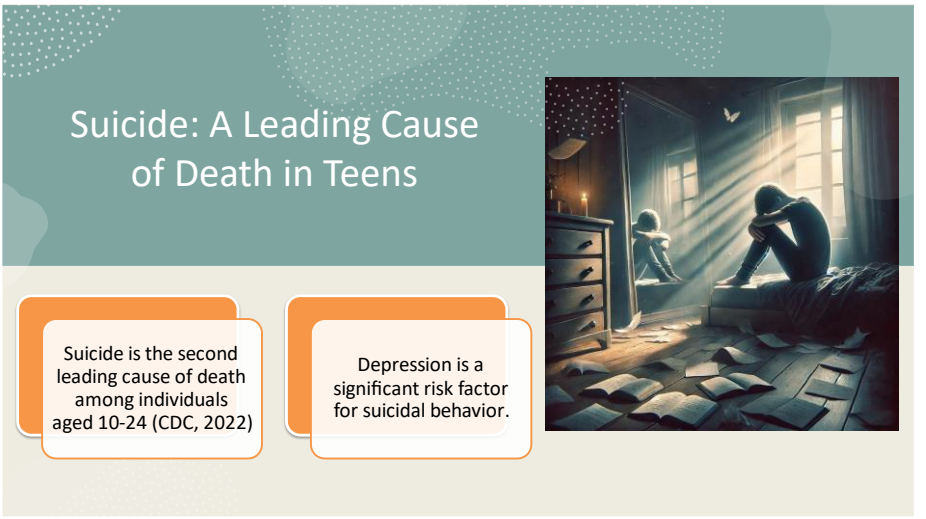
Numbers Don’t Lie



Adolescent depression is not a phase. It is not moodiness. It is not merely a reaction to academic stress, social pressure, or hormonal shifts. It is a medical, emotional, neurological, and spiritual emergency. And we are failing to see it for what it truly is.

The statistics are staggering. Depression affects one in five teens in the United States, and suicide is now the second leading cause of death for individuals aged 10 to 24. The rates of self-harm and suicidal ideation have risen dramatically over the last decade. According to the CDC (2022), suicide now claims more young lives than cancer, heart disease, birth defects, stroke, and pneumonia combined. Behind each statistic is a teen who may feel invisible, ashamed, or beyond saving.





Complicating the picture, adolescent depression frequently overlaps with other psychiatric conditions like generalized anxiety disorder, ADHD, bipolar spectrum disorders, and PTSD. This comorbidity clouds the clinical picture, resulting in misdiagnosis and treatments that often target symptoms rather than the deeper roots of the pain.

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

The Fading Teen

See the Signs. Step In. Save a Life

But what does depression look like in the real world? Beyond statistics and diagnosis codes, it shows up in lived moments—when a once-social teen suddenly isolates in their room. When grades plummet and apathy takes root. When a young person speaks with hopelessness about their future or starts giving away personal possessions.

Behaviorally, key signs include withdrawal from activities and hobbies, isolation from friends and family, a noticeable decline in academic performance or motivation, experimentation with substances, and increasingly reckless behavior.

Behavioral Changes

Key behavioral changes to watch for include:

- Withdrawal from activities and hobbies.
- Isolation from friends and family.
- Decline in academic performance or motivation.
- Substance use or experimentation.
- Risk-taking behaviors, such as reckless driving.

Emotionally, teens may express or display persistent sadness, irritability, or anger. They may voice feelings of hopelessness or helplessness, carry intense guilt, or become unpredictably moody.

Emotional Symptoms

Signs of emotional distress may include:

- Persistent sadness or irritability.
- Hopelessness or helplessness.
- Low self-esteem or excessive guilt.
- Mood swings or emotional unpredictability.

Physically, depression can cause changes in sleep and appetite, chronic fatigue, or even unexplained complaints like stomachaches and headaches.

Physical Symptoms

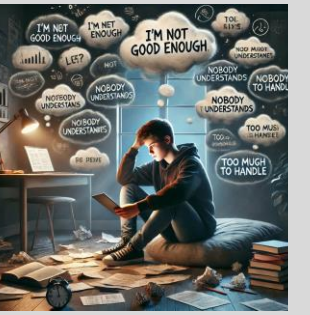
Noticeable physical changes include:

- Changes in sleep patterns, such as insomnia or oversleeping.
- Appetite or weight changes.
- Fatigue or lack of energy.
- Unexplained physical complaints, like headaches or stomachaches.

Cognitively, many struggle to concentrate, make decisions, or escape cycles of self-criticism and negative thought patterns. Some begin to show preoccupation with death or dying.

Cognitive and Psychological Indicators

Difficulty concentrating or focusing.
Indecisiveness, even with simple decisions.
Negative thought patterns or self-criticism.
Preoccupation with death or dying.



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

Social Signs

Changes in social behavior to watch for include:

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

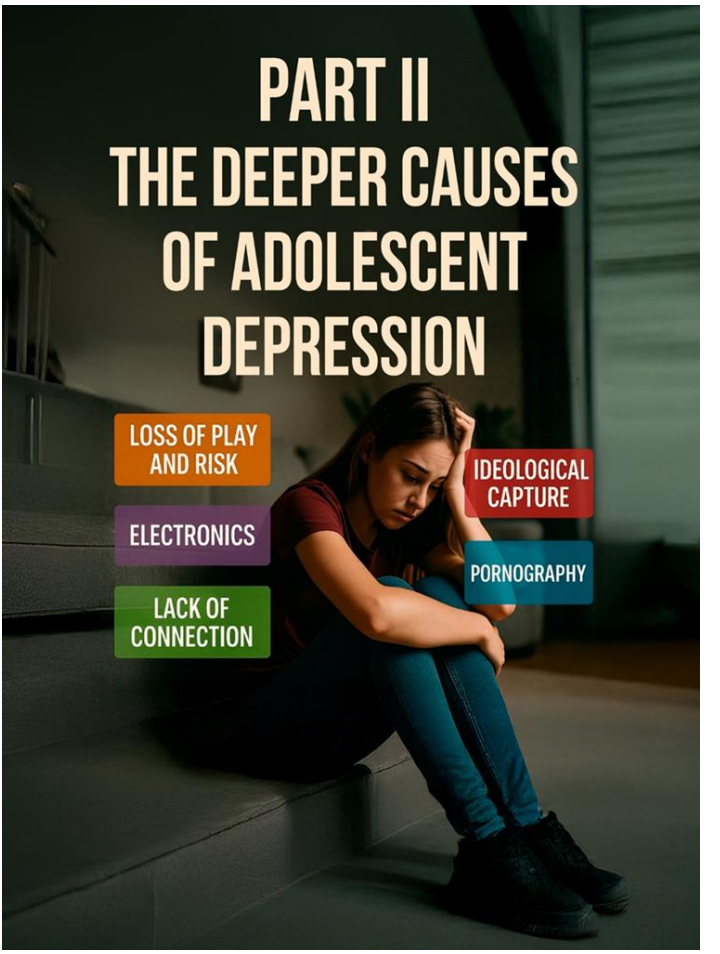
What makes this crisis so tragic is not just the suffering—but that so much of it is preventable. With timely intervention, compassionate understanding, and the right tools, many teens can not only recover but emerge stronger, more resilient, and more connected to themselves and others.

In the chapters that follow, we will break the silence and dismantle the shame. We will explore both the clinical realities and the spiritual wounds of depression. And we will introduce a new path forward—one that integrates neuroscience and faith into a holistic model of restoration and renewal: the ***NeuroFaith™*** approach.

That is the promise of this work. This is the invitation: to see, to understand, and to respond with more than labels or prescriptions. To listen. To act. And to believe that healing is not only possible—it's already beginning.

This is where the healing begins.

Part II:
The Deeper Causes of Adolescent Depression



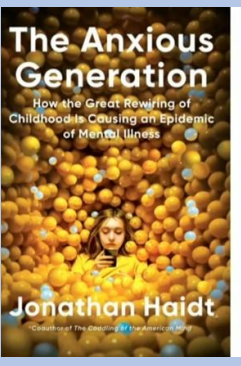
Cause I:

Replacing Play-Based Childhood with Screen-Based Childhood

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

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

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



The Great Rewiring of Childhood:

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

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

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

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

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

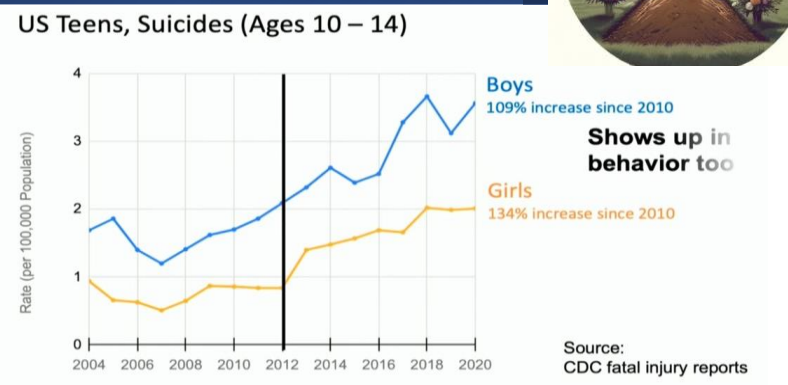
"We overprotected our children in the real world and underprotected them in the online world," Haidt writes (2024, p. 13).

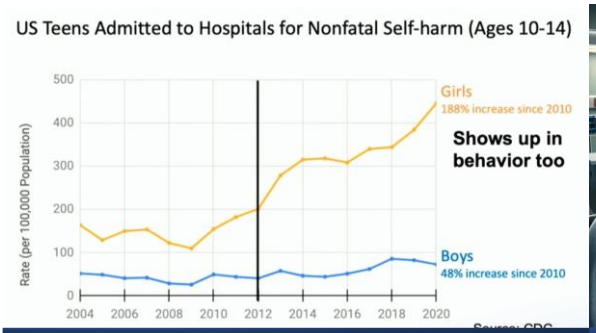
And the cost has been catastrophic.

A Crisis Measured in Mental Illness and Lost Potential

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

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



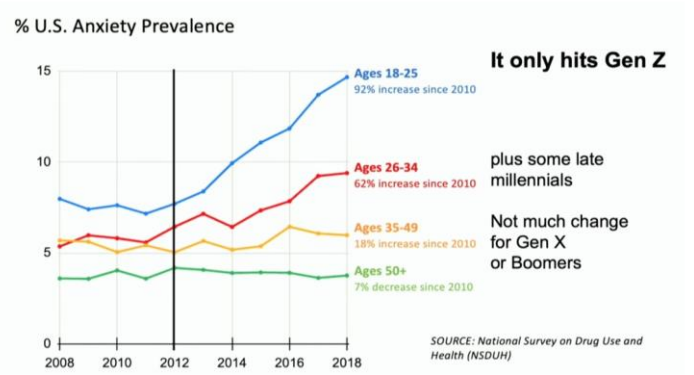


Jonathan Haidt notes that US teens ages 10 – 14 are being admitted to hospitals for nonfatal self-harm at terrifying rates since 2010 (Haidt, 2024).

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

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

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



The Displacement of Developmentally Necessary Risks

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

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

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

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

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

A Parallel Crisis in Cognitive Development

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

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

Clinically, We're Seeing the Fallout

As a pediatric psychologist, I've watched this crisis unfold in real time. Young children present with profound anxiety, poor distress tolerance, identity confusion, and an underdeveloped capacity for relationship repair—all symptoms of disrupted attachment and overstimulated nervous systems. Their play is often scripted by YouTube. Their identities are curated rather than discovered. Their sense of agency is hollowed out by endless scrolling and algorithm-driven manipulation.

Many of these children never had a real chance to become themselves before the online world began shaping them.

Haidt's Call: Restore the Real World

Jonathan Haidt is not anti-technology. He is not nostalgic for some golden age. He is calling for balance. In ***The Anxious Generation***, he urges parents,

educators, clinicians, and policymakers to restore real-world childhood. That means unstructured play. In-person interaction. Climbing trees. Getting dirty. Navigating conflict without a mute button.

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

Where We Go From Here

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

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

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

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

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

-Alexander Pope's essay on man

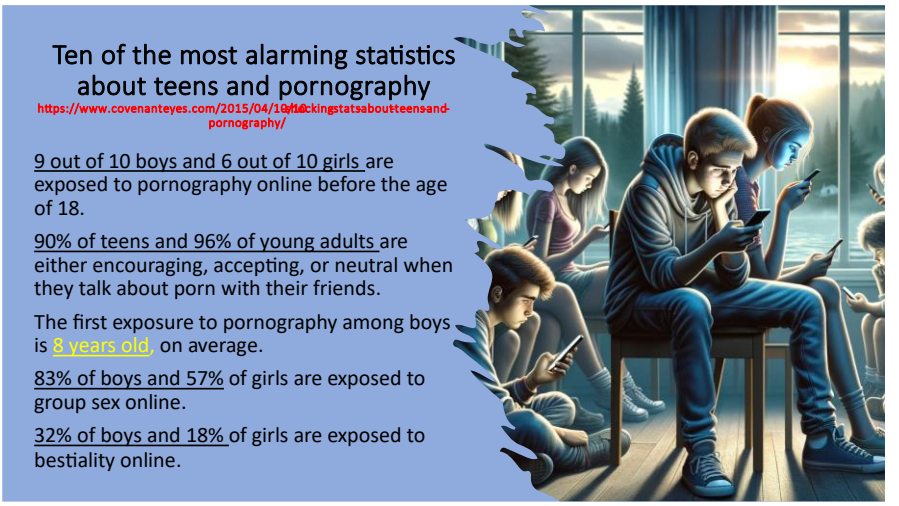
In the words of Stephen Arterburn, world renowned expert on sexual addiction, "***I don't know of any plague to ever reach into the homes and families all over the world and create as much damage or heartaches than the struggle of lust, affairs, pornography, perversion, and sexual addiction. It seems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

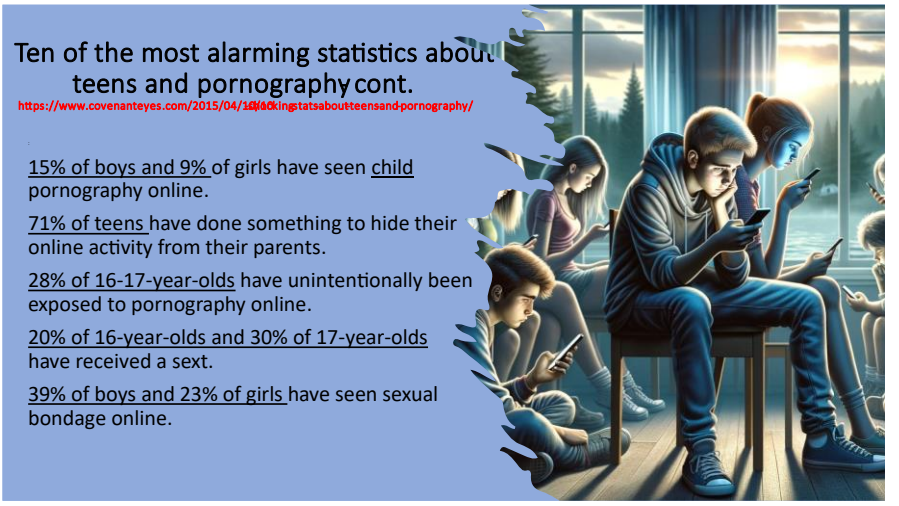
When I entered the field of pediatric psychology over three decades ago, I never imagined I would be writing about pornography as one of the most serious threats to adolescent mental health. Back then, we worried about bullying, learning issues, and early signs of depression. But today, there is a more insidious enemy—one that travels silently into bedrooms, bypasses parental filters, and rewires the developing adolescent brain: pornography.

The Startling Statistics: A Generation Exposed

The data is as disturbing as it is consistent. According to Covenant Eyes (2015), 9 out of 10 boys and 6 out of 10 girls are exposed to pornography before age 18. Even more disturbing is the average age of first exposure for boys: just eight years old.

This is not casual exposure either. More than 80% of boys and over 50% of girls report viewing group sex content, and a shocking percentage of teens report seeing bestiality and other extreme material. What's perhaps most chilling is that 90% of teens and 96% of young adults either encourage, accept, or remain neutral about pornography when discussing it with peers.



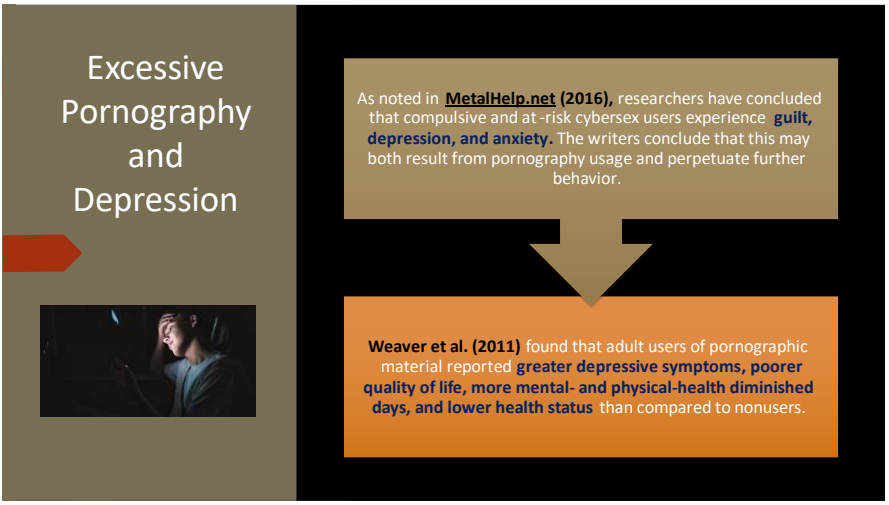


The result is a generation for whom porn is not just tolerated—it's normalized.

Emotional Collapse: Depression, Anxiety, and Disconnection

Dr. David Skinner reviewed a study of 450 users and found a clear correlation between frequent pornography consumption and

depression. Those who watched porn daily scored an average of 21 on depression inventories—compared to 6.5 in the general population.



A 2016 report from *MentalHelp.net* noted that compulsive and at-risk users frequently experience guilt, depression, and anxiety, and that these emotional states not only result from porn use but also sustain it in a vicious feedback loop.

In a landmark study, Weaver et al. (2011) found that porn users report:

- Greater depressive symptoms
- Lower overall health
- More days of diminished mental and physical well-being
- Poorer quality of life compared to nonusers

Dr. Gail Dines, the founder of Culture Reframed and a world leader in porn research, adds to this body of evidence. Her review of the literature concludes that adolescent porn users experience:

- Increased depression

- Lower emotional bonding with caregivers
- Greater conduct issues
- Higher delinquency
- And dramatically lower levels of social integration (CultureReframed.org)

Other studies support this, including Doornwaard et al. (2016), which found that compulsive pornography users had lower self-esteem and higher depressive symptoms, and Owens et al. (2012) and Sun et al. (2016), who noted damage to body image and rising fears of inadequacy in both boys and girls.

Pornography and Sexual Dysfunction: A New Epidemic

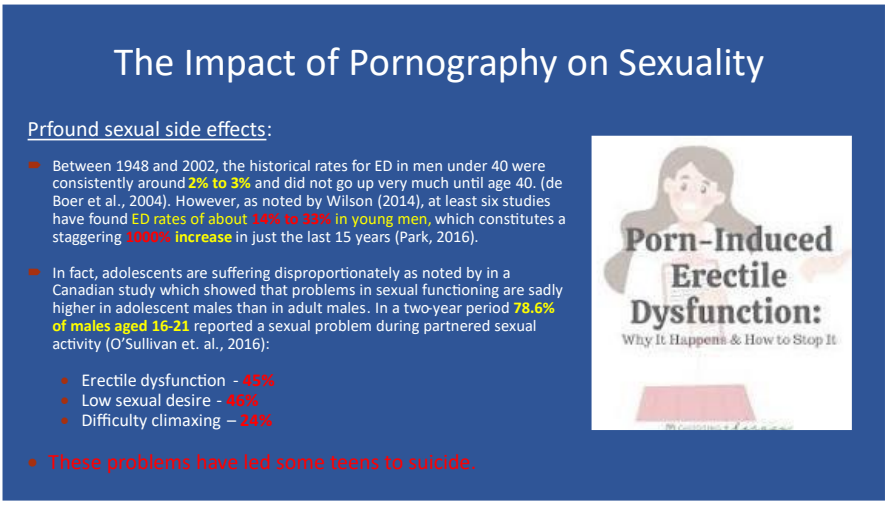
Gary Wilson's ***Your Brain on Porn*** offers perhaps the clearest neurological lens through which to understand the sexual fallout of this crisis. Young men, often exposed to porn by age 8 or 9, report difficulty with real-world sex by their early 20s. They describe delayed ejaculation, loss of interest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

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

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

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

Neuroscientific research explains this well. Dopamine, the brain's pleasure and reward chemical, surges with novelty. Internet porn, with its endless stream of hyperstimulating content, outcompetes the subtle, nuanced experience of real intimacy. As Wilson explains, real sex becomes neurologically "boring," leading to a drop in dopamine—and arousal.



The Path to Escalation: From Curiosity to Compulsion

Perhaps most troubling is how quickly users escalate to increasingly extreme content. Wilson (2017) documents cases of users shifting from simple searches to fetishes they once found repulsive. The brain, always seeking novelty and intensity, begins to crave content that the person's moral compass may deeply reject.

Downing et al. (2016) found that nearly 21% of heterosexual men view gay porn, and over 55% of gay men view heterosexual content. These aren't signs of fluid identity—they are signs of escalation and confusion, driven by neural adaptation and craving.

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

There is a Way Out
This is not the end of the story.

The same brain that was hijacked by compulsive use can be restored. The same adolescent heart wounded by shame and disconnection can heal. The good news is this: the brain is plastic, and the soul is resilient.

In the chapters ahead, we will explore the NeuroFaith™ model, a comprehensive treatment approach that integrates neuroscience, trauma therapy, and deep spiritual renewal. It is a model forged from science, clinical experience, and the redemptive power of faith—and it offers a path toward restoration for those ensnared in this crisis.

Exposure to pornography and sexually explicit content can have significant impact on children, but there are differences between the two:

- Pornography: Pornography is typically created and distributed explicitly for the purpose of sexual arousal and gratification. It often features explicit sexual acts and is intended for adult audiences.
- Sexually Explicit Content: Sexually explicit content can encompass a broader range of material that includes explicit depictions of sexual content but may not necessarily be created for the sole purpose of sexual arousal. It can include explicit discussions of sexuality, nudity, or sexual behavior.

One of the most underrecognized yet devastating contributors to adolescent emotional health decline is pornography use. While often

dismissed as a private or harmless behavior, research has consistently shown that compulsive pornography consumption is strongly linked to heightened levels of depression, anxiety, guilt, and emotional disconnection. Adolescents, particularly those already vulnerable or digitally saturated, are falling into a trap of artificial stimulation that rewires the brain and reshapes the soul.

Personal testimonies, like Turner (2017), echo the emotional toll of digital overstimulation. His words describe a mind lost in compulsive thought loops, disconnected from real joy and consumed by constant mental noise. His is not an isolated case. Multiple studies—from Carnegie Mellon to Missouri State, from the Netherlands to Pakistan—confirm that excessive Internet and pornography use increases loneliness, worsens depression, and leads to a measurable decrease in real-world relationships (Kardaras, 2016).

According to Twenge (2014), today's teens are far more likely than previous generations to report trouble sleeping, chronic stress, and depressive symptoms. These outcomes align with skyrocketing media engagement and the rise of smartphones. In fact, the most digitally connected generation also holds the highest rates of depression (Blue Cross Blue Shield, 2018). This reality is not coincidental—it is causal.

Pornography, in particular, intensifies these trends. Dr. David Skinner's study found that frequent pornography users scored significantly higher on depression scales than non-users. Other researchers have noted additional patterns: decreased bonding with caregivers, increased behavioral problems, lower self-esteem, and higher dropout and substance abuse rates (Weaver et al., 2011; Dines, 2016).

As Owens et al. (2012) and Sun et al. (2016) note, pornography alters self-perception. Girls often internalize feelings of inferiority, while boys wrestle with shame around performance and adequacy. These identity disruptions feed the shame that fuels depression.

In sum, pornography offers a powerful illusion of connection but delivers the opposite. It fragments the mind, hardens the heart, and isolates the soul. And while these effects often hide in silence, the research is clear: frequent pornography use among adolescents is not just a behavioral issue—it is a driver of deep emotional dysfunction.

But there is hope. These patterns can be interrupted. Brains can heal. Shame can be replaced by self-understanding, and compulsions by connection. The work ahead is not to condemn but to clarify. Not to shame but to shine light. This book offers a path forward.

Healing is not only possible—it is likely when we respond with wisdom, compassion, and tools that truly work. That is the promise of this work. This is the invitation: to see, understand, and respond with more than labels or prescriptions. To listen. To act. And to believe that healing is not only possible—it's already beginning.

Cause III:

Disconnection and the Descent into Adolescent Depression

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

– Viktor Frankl

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

Johann Hari (2018), one of Jeff's favorite writers in the world, in his provocative and deeply compassionate work ***Lost Connections***, invites us to rethink everything we thought we knew about depression. He argues that depression and anxiety are not simply malfunctions of the brain or deficits in serotonin, but rather signals—intelligent, painful signals from a life that has lost its connected roots. When we lose connection to what matters, suffering takes up residence. For teens, these disconnections are not abstract theories. They are lived realities.

As previously noted, since 2010—the inflection point in what Jonathan Haidt (2024) calls "the great rewiring of childhood"—youth suicide among ages 10 to 14 has spiked by over 130% in girls and 109% in boys (Centers for Disease Control and Prevention [CDC], 2021). Self-harm hospitalizations have surged. Depression and anxiety among Gen Z have skyrocketed. Academic performance has plummeted. Attention spans have shrunk. And hope? For many, it has disappeared into the blue glow of a screen.

Why? Because we have raised a generation immersed in digital stimulation but starved of human and spiritual connection. We have replaced presence with performance, wonder with Wi-Fi, relationships with reactions.

Disconnection from Meaningful Work

Hari (2018) highlights a Gallup study conducted between 2011 and 2012, surveying millions of workers across 142 countries, which found that only 13% of people reported being "engaged" in their work. A staggering 63% were "not engaged," and 24% were "actively disengaged," meaning they were not only disconnected but acting out their dissatisfaction. This disconnection from meaningful labor doesn't just lead to dissatisfaction—it contributes to depression. The Whitehall Study on British civil servants found that lack of autonomy and the inability to see a connection between effort and reward strongly predicted poor mental health (Marmot et al., 2002).

Although this may seem adult-centric, adolescents are also affected. When teens observe their caregivers returning home disheartened and exhausted, they internalize those scripts of disempowerment. When their own educational or extracurricular pursuits lack relevance or reward, they, too, can spiral into disengagement. Without a sense of progress, contribution, or purpose, teens may fill the void with numbing behaviors: social media, substance use, or escapist fantasy. This disconnection from meaningful action is a breeding ground for depression.

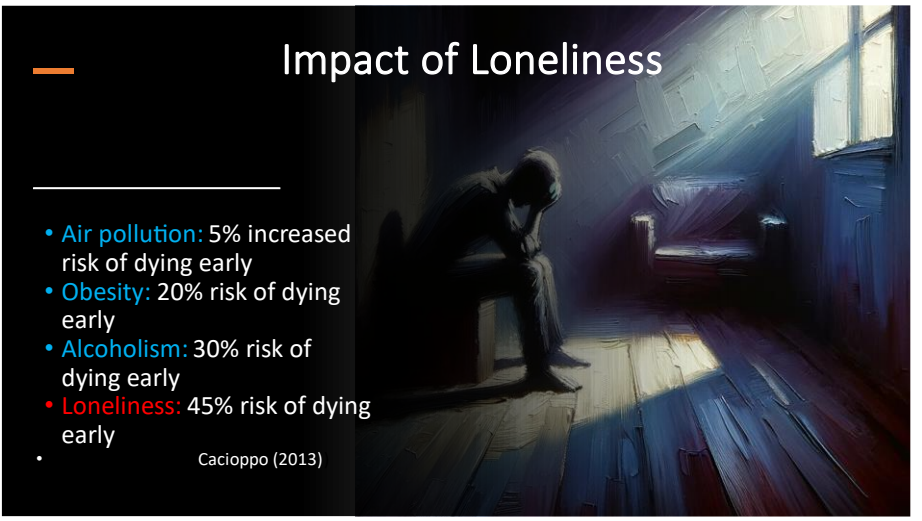
In addition to seeing adults model this disengagement, teens also need to be successful in their own work. Their primary job—school—must offer opportunities for growth, mastery, and recognition. Contributing meaningfully at home through chores and, when appropriate, participating in real-world employment can also foster self-respect and competence. These experiences build internal confidence and help adolescents connect their effort to a meaningful impact, which is essential for healthy development.

Moreover, when such work is complemented by involvement in spiritual practices—such as attending church services, participating in youth group activities, and engaging in Bible studies—it can help teens connect their efforts to a deeper sense of purpose. These experiences build internal confidence and assist adolescents in linking their efforts to meaningful impacts, which is essential for healthy development.

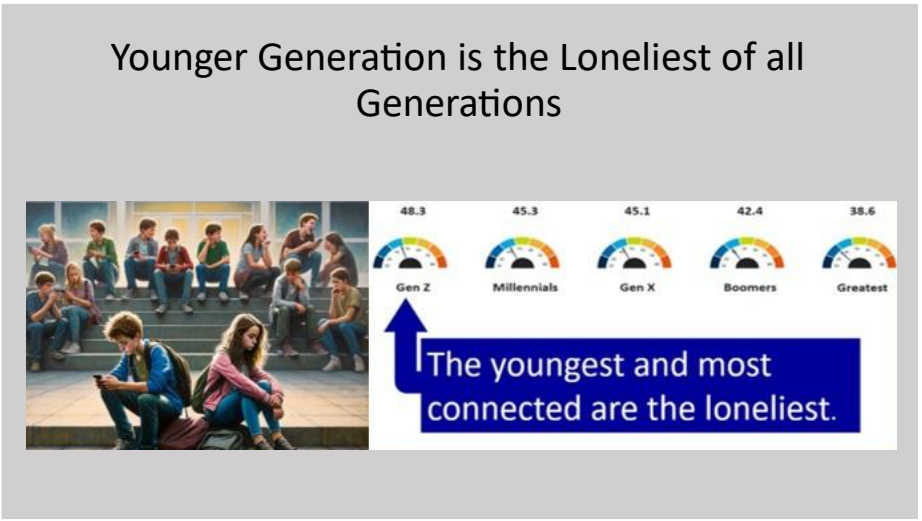
Disconnection from Meaningful People

Loneliness is more than a feeling. It is a physiological and psychological threat. Cacioppo et al. (2010) found that loneliness triggers stress responses as severe as physical attack. Over time, this chronic isolation alters brain structure, elevates cortisol, and dismantles emotional regulation. Teens are particularly susceptible: those with elevated loneliness are up to eight times more likely to develop depression. And today's teens, despite being hyperconnected online, report the highest rates of loneliness of any generation (Cigna, 2018).

Dr. John Cacioppo et al. (2006, 2008, 2010), a neuroscience researcher, studied the impact that loneliness has on health. He and his colleagues determined that loneliness causes cortisol levels to go through the roof – as much as that caused by some of the most disturbing things that can ever happen in your life. Hari (2018) summarizes Cacioppo's research, "Becoming acutely lonely, the experiment(s) found, was as stressful as experiencing a physical attack." Another researcher, Lisa Bergman, followed both isolated and highly connected people over nine years and found that isolated people were two to three times more likely to die during lonely periods and that, specifically, almost everything during lonely periods becomes more fatal for lonely people, including heart disease, cancer, and respiratory problems (Pinker, 2015). In short, loneliness can be deadly (Monbiot, 2014). In addition, Cacioppo et al. (2010) conducted a five-year longitudinal study, which showed that loneliness is not merely the result of depression but indeed leads to depression as well. In this study, he found that on a measure of 0 percent loneliness to 100 percent loneliness, moving from 50 percent loneliness to just 65 percent loneliness increases your chances of becoming depressed by eightfold. He concluded that loneliness is causing a significant amount of depression and anxiety in our society. In a Ted Talk presentation, Cacioppo (2013) reported a rather shocking meta-analysis study of over 100,000 participants, which found increased risks of dying early due to the following:



A 2018 study conducted by Cigna (see diagram below) revealed that compared to older generations, the youngest is the loneliest generation ever (Cigna, 2018).



The implications of this research are clear; specifically, it is to our benefit that we stop allowing teens to isolate themselves and connect in positive and fulfilling family and social relationships.

Disconnection from Childhood Trauma

As we have discussed in earlier chapters, unresolved childhood trauma is often the fuel driving many forms of depression. While we will not repeat this discussion here, it is very important to recognize that trauma often creates a lingering "fire" within, as Johann Hari (2018) described: “There’s a house fire inside many of us.”

But there is hope, and healing is possible. Jesus Himself extended compassion to the brokenhearted, reminding us that we do not have to carry our burdens alone. He invites us to "Come to me, all who are weary and burdened, and I will give you rest” (Matthew 11:28, NIV). True recovery requires more than just abstaining from harmful and addictive behaviors; it calls us to bring our pain into His light and let Him heal those wounded places that He can heal. The process of healing most effectively occurs in community and that should include the church. Addressing the trauma underlying depression is not about re-living past hurts, but rather, opening ourselves to God’s transformative grace and love. “Therefore encourage one another and build one another up, just as in fact you are doing” (I Thessalonians 5:11 NLT).

As we walk this path, remember that healing is a journey. Through faith, counseling, and support, we find not only relief from depression but also a new identity and wholeness. With Christ as our foundation, the cycle of substitution can be broken, making space for true freedom, restoration, and lasting peace.

Disconnection from Status and Respect

🌟 Status and Respect 🏆

Robert Sapolsky's research on baboon social structures offers striking parallels to the adolescent experience of social hierarchy. In his studies, low-status baboons were observed to exhibit behaviors that closely resembled clinical depression: lowered heads, lack of movement, withdrawal from others, and a loss of appetite or motivation (Sapolsky, 1992, 2002). These behaviors were accompanied by a surge in cortisol—the body's primary stress hormone—and mirrored the same neurological patterns seen in depressed humans.

This speaks volumes about our teens. Adolescents are acutely attuned to their place in the social order, whether it's in school, sports, social media, or peer groups. When they perceive themselves as outsiders or "low status," they often internalize that position. They may withdraw, feel invisible, or act out in harmful ways. And just like those baboons, their bodies respond with stress, their brains shift into survival mode, and depression can set in.

Modern teen culture, shaped heavily by digital media, amplifies this pressure. Likes, followers, and online clout can become proxies for worth. But social media rarely offers the real validation teens need—the kind that comes from meaningful connection, competence, and shared purpose. Jean Twenge (2006) notes that self-esteem isn't conjured from thin air; it's built through real-world mastery and the respect that emerges from competence and contribution. Teens who don't have those opportunities—who aren't building skills, making a difference, or receiving real affirmation—may lose not only the respect of others but also their own self-respect.

To thrive, teens need opportunities to earn respect in ways that matter. They need to develop mastery, to be needed, and to be seen. That doesn't happen through screens. It happens through sweat, challenge, connection, and real-life contribution.

Disconnection from Meaningful Values

When adolescents feel they lack a sense of direction, when their days are filled with scrolling but empty of meaning, they begin to drift into despair. Tim Kasser's (2002) research shows that materialistic values—

the relentless pursuit of image, likes, and external validation—are strongly correlated with depression, anxiety, and anger. These false values promise happiness but deliver emptiness.

In the adolescent brain, which is wired to seek novelty and identity, this becomes especially dangerous. Teens who fail to connect with intrinsic values like creativity, community, higher purpose, and contribution are left with a hollow core—a void often filled by addiction, disordered eating, or numbing behaviors.

Disconnection from the Natural World

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

-Wendell Berry

Nature is not a luxury. It is a biological necessity. Berman et al. (2012) demonstrated that even short walks in nature significantly improve mood, concentration, and mental clarity—especially in depressed individuals. Yet many teens now spend 90% of their time indoors, immersed in artificial light and filtered realities.

Louv (2005) coined the term "nature deficit disorder" to describe what happens when children are severed from wildness, wonder, and the grounding rhythms of creation. Teens who never touch soil, hear birdsong, or feel the unfiltered stillness of a forest are not just missing a recreational experience—they are missing neural nourishment.

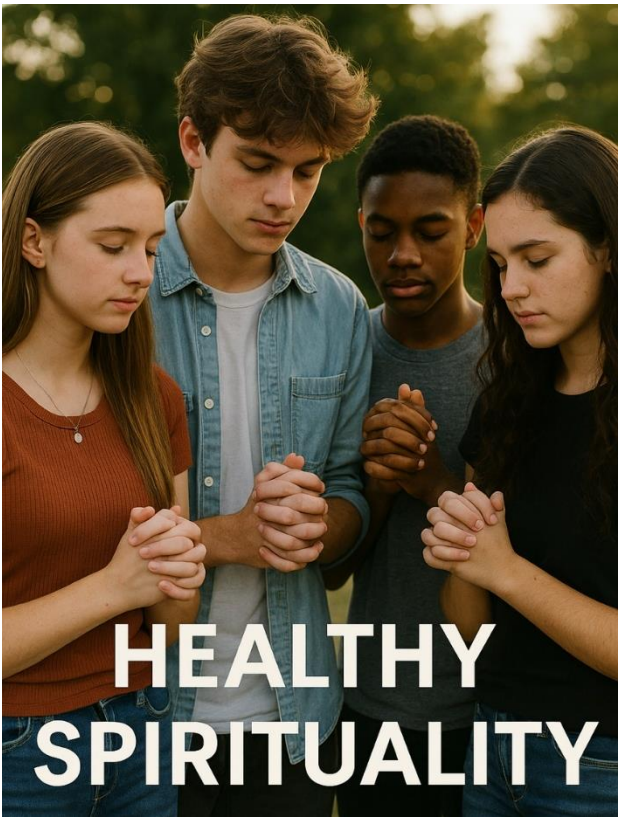
Disconnection from Hope and the Future

Adolescents are meant to live forward with a purpose greater than they currently see. They are wired to envision who they will become. But in

a world of collapsing institutions, overwhelming crises, and constant comparisons, many teens today feel as though the future has already been foreclosed.

Snyder's (1991) Hope Theory defines hope as the combination of agency (the will) and pathways (the ways). Without both, despair takes root. And when teens feel they cannot act meaningfully toward a better tomorrow, their minds often default to paralysis and self-destruction. They stop dreaming. They stop trying. They stop believing.

Disconnection from Faith and Meaning



Though Johann Hari did not include it in his list, we, rightly add a critical disconnection: the spiritual. Adolescents who have no connection to a transcendent narrative, no sense of divine love or purpose, are far more likely to feel untethered.

Dr. Lisa Miller's (2021) research confirms that a strong spiritual life in adolescents is one of the most robust protective factors against depression. It reduces suicide risk, fosters resilience, and enhances meaning-making in the face of trauma. Spirituality doesn't bypass suffering—it reframes it. It says, "You are not alone. Your pain has purpose. You are seen." More on this later.

We Are Not Meant to Heal Alone

All of these disconnections are invitations—to reorient, restore, and reconnect. Depression is not a personal failure. It is often the body and soul calling us back to what we were made for: community, purpose, nature, hope, eternity, and God.

The NeuroFaith™ model recognizes that healing is not just a clinical process—it is a relational, spiritual, and embodied one. By restoring core connections, we restore vitality. We give adolescents a future filled with hope and adventure worth moving toward.

Let us not underestimate what reconnection can do. For in even the darkest moments, one voice, one hand, one spark of meaning can begin to turn the tide.

"I know the plans I have you, says the Lord. They are plans for good and not for disaster, to give you a future and a hope" (Jeremiah 29:11 NLT).

Cause IV:
Trauma

The Hidden Epicenter of Adolescent Depression

Of all the causes of adolescent depression, trauma may be the most devastating—and the most overlooked. Trauma exposure, particularly child maltreatment, such as neglect, emotional, physical, and sexual abuse, has been identified as a major contributor to emotional dysregulation and poor mental health outcomes. It is one of the most significant risk factors for depression and post-traumatic stress disorder (McLaughlin et al., 2012, 2013).

Studies have shown that trauma compromises the ability to regulate emotion across the lifespan, starting as early as preschool and continuing into adolescence and adulthood (Langevin et al., 2016; Shields & Cicchetti, 1997; Briere & Rickards, 2007; Dunn et al., 2018). Trauma occurs when our natural defenses are overwhelmed—when we are unable to process or integrate emotionally threatening experiences (Barta, 2018). It is not just about what happens to us but how we are left to face it—isolated, unsupported, unseen.

One of the most devastating and long-lasting consequences of unresolved trauma is the formation of negative core beliefs. These are deeply embedded, often unconscious assumptions about ourselves and our place in the world—beliefs like "I am not lovable," "I am not worthy," or "I have no value." These beliefs are not merely fleeting thoughts; they are lies perpetrated by Satan, the father of lies, which become etched into the brain's implicit memory systems, particularly in the default mode network (DMN), which governs self-referential thought and autobiographical memory. Over time, the DMN becomes the carrier of a toxic narrative: that we are broken, fundamentally flawed, and unworthy of love or belonging.

Tim Fletcher, a leading voice in trauma-informed therapy , highlights how trauma doesn't just affect behavior—it rewrites a person's identity. According to Fletcher, these core beliefs—"I am bad," "I don't matter," "I'm invisible," "I'm a burden"—become the emotional background music of the traumatized mind. They hum beneath every interaction, every failure, every success, whispering lies about worth, safety, and identity. For teens especially, whose brains are still under construction, these negative core beliefs can become the organizing

principles of the self. They shape the lens through which all future relationships and challenges are viewed.

Fletcher emphasizes that trauma is not just remembered through facts or images; it is encoded in the nervous system and expressed in how a person lives and relates. Teens who hold these distorted core beliefs may become avoidant, perfectionistic, oppositional, or self-destructive—not because they are defiant, but because they are desperately trying to survive a world they believe they are unfit to live in.

These trauma-driven beliefs quietly sabotage every arena of life. They distort how teens perceive themselves, how they interpret the intentions of others, and how they engage in relationships. They can make simple social interactions feel threatening, academic challenges feel insurmountable, and hopeful futures feel unreachable. Teens with trauma-scarred core beliefs often carry invisible scripts of shame and fear that stain their sense of identity for decades unless directly addressed through healing relationships and integrative therapy.

This distortion of self has devastating downstream effects. Research from the Adverse Childhood Experiences (ACE) Study shows that trauma is not only linked to emotional disorders but is also a major risk factor for physical illness, substance abuse, relational breakdowns, and early death (Felitti et al., 1998, 2009). An adolescent who internalizes the belief, "I don't matter," will often find ways to prove that belief—through self-harm, isolation, numbing addictions, or entering harmful relationships.

In my work as a pediatric psychologist, I see this every day. The teens who suffer most deeply are not only those who have endured dramatic, life-threatening events but also those who have grown up with a consistent absence of attunement. They were never emotionally mirrored. They were made to feel invisible or responsible for the emotions of others. They were punished for being authentic or were taught that their feelings didn't matter. These "ordinary" traumas quietly devastate the developing brain and corrupt the sense of self at its core.

Dr. Peter Levine (2008) writes, "Trauma is about loss of connection—to ourselves, our bodies, our families, others, and the world around us." And that disconnection doesn't happen all at once. It happens subtly, and over time, until what remains is not a sense of safety and identity—but a deep, confusing ache. This ache becomes a filter through which every experience is interpreted.

Trauma exposure, particularly child maltreatment (e.g., neglect, emotional, physical and sexual abuse), has been established as one of the main determinants of emotional dysregulation and well-being and is also a known risk factor for psychiatric disorders, especially depression and PTSD (McLaughlin et al.,2012; McLaughlin et al., 2013). Moreover, several prior studies have shown that trauma exposure is clearly associated with profound deficits in emotional regulation across the entire lifespan, including during preschool (Langevin, Hebert, Allard-Dansereau; Bernard-Bonnin, 2016), adolescence (Shields & Cicchetti, 1997; Vettese, Dyer, Li, & Wekerle, 2011) and even adulthood (Briere & Rickards, 2007; Thompson, Hannan, & Miron, 2014; Dunn et al., 2018).

Trauma occurs when we are faced with an experience that overwhelms our ability to process incoming information, both at the time of that experience and in future situations (Barta, 2018). Dr. Michael Barta suffered from trauma himself as a child, which led him to addictions that ultimately landed him in jail and almost destroyed his life. In his book, ***TINSA***, he wrote that trauma occurs when our natural defenses are unable to keep us safe from physical, emotional, or mental threats or harm (Barta, 2018).

In the mid-1980's, Kaiser Permanente commissioned Dr. Vincent Felitti to explore the issues of obesity since nothing this hospital group was doing helped make a significant impact on improving this epidemic. His research led him to explore the impact of what he called the Adverse Childhood Experiences (ACE) Study (Felitti et al., 2014). In this study, people were asked about ten different categories of horrible things that happened to them when they were children, including physical and sexual abuse, family problems, and neglect. The results indicated that with each category of traumatic experience we faced as a child, the likelihood of experiencing depression as an adult increased significantly. (Felitti et al., 2014; Felitti 2004; Felitti and Anda, 2009).

Adverse Childhood Experiences

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

Abuse

- Emotional – recurrent threats, humiliation (11%)
- Physical - beating, not spanking (28%)

- Contact sexual abuse (28% women, 16% men; 22% overall)

Household dysfunction

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

Neglect

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

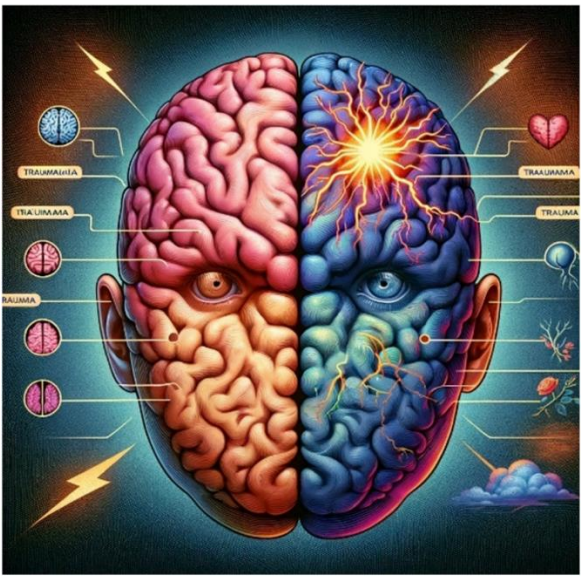
Somewhat surprising in the Felitti studies was that emotional abuse was more likely to cause depression than any other kind of trauma – even sexual abuse. This suggests that the way children are treated by their parents is a highly significant predictor of positive outcomes, and the consequences can be devastating when that trust is broken.

The experts in the field divide trauma into two categories:

Big T trauma: Traumas associated with horrific single events, such as natural disasters, terrorism, and war.

Little t trauma: Trauma smaller in nature, such as bullying, neglect, and betrayal. I respectfully take issue with the term "little t" as this type of trauma is devastating to normal development, and there is nothing "little" about it.

In my (Jeff) work as a pediatric psychologist, far more of my patients have been subjected to "little t" traumas, and I agree with Barta that these experiences have a tremendous impact on how children view themselves, their relationships, and their place in the world. Moreover, the long-term consequences of these traumas are profound, often resulting in a reduced or impaired ability to respond appropriately to threatening situations. This can lead to chronic hyperarousal, intense anxiety, panic, mood instability, poor emotional/behavioral regulation, feelings of powerlessness, helplessness, shame, and even immobility. Of all traumas, relational trauma is particularly devastating.



Trauma changes the brain neurologically

The implications here are enormous. Specifically, for adolescents to heal from their depression, we need to help them identify when, during their lifetime, others have harmed them —physically, emotionally, mentally, or spiritually— whether the harm was intentional or accidental. Barta (2015) provides several examples of trauma often reported by individuals who suffer from sexual/pornography addiction, as noted below. To be clear, most teens experience at least some of these traumas. If we can resolve them, we can help them move on and experience a more fulfilling life.

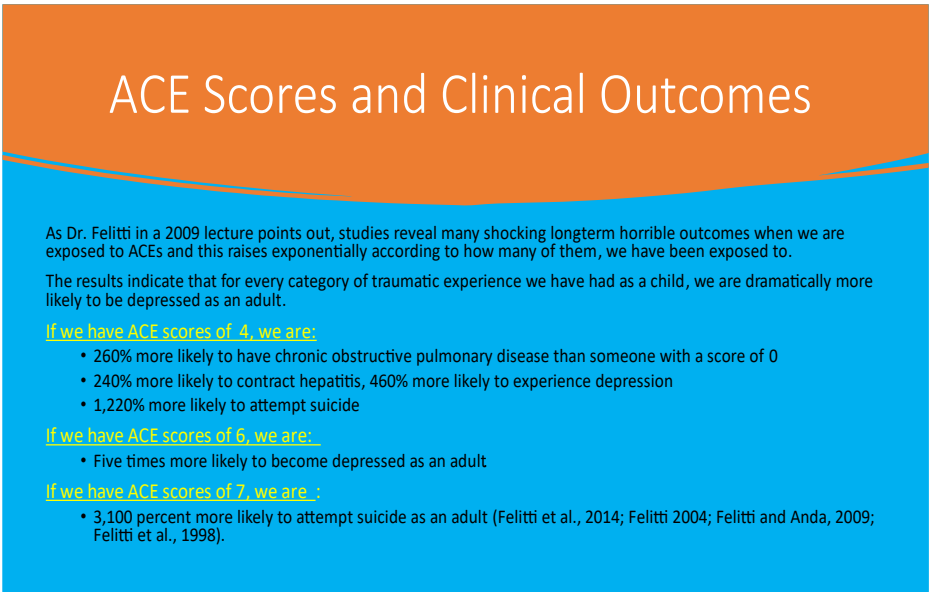
Our experience is that the most common forms of trauma are due to a lack of attunement or connection with parental or adult figures while growing up. As Barta (2015) writes, "These deficiencies are not about bad parenting but about a parent's inability or diminished ability to respond to the child's emotional needs. Most parents are doing the best they can with the tools they have, but whether deliberately or inadvertently, the traumas of our childhood can have tremendous impact on our lives (Barta, 2018, p. 17).

As trauma expert Dr. Peter Levine notes in his book, ***Healing Trauma***, "Trauma is much about loss of connection – to ourselves, our bodies, our families, others, and the world around us. This loss of connection is often hard to recognize because it doesn't happen all at once. It can happen slowly over time, and we adapt to these subtle changes sometimes without even noticing them. These are the hidden effects of trauma, the ones most of us keep to ourselves…Our choices become limited as we avoid certain feelings, people, and situations. The result of a gradual constriction of freedom is the loss of vitality and potential for the fulfilment of our dreams" (Levine, 2008, p. 9).

Most important to normal development is "social engagement," which is the ability to know, understand, regulate, and express emotions in the present moment. Even though everyone is born with a social engagement system (i.e., a neurological system that promotes human connection), we know that early trauma can disrupt normal development. Anda et al. (2018) note, "Early adverse experiences may disrupt the ability to form long-term attachments in adulthood. The unsuccessful search for attachment may lead to sexual relations with multiple partners with resultant promiscuity and other issues related to sexuality." As a result of adverse developmental trauma, the ensuing loss of connection with our inner self, our bodies, others, and the world around us, we are predisposed to engage in maladaptive and/or addictive behaviors to relieve the emotional dysregulation that torments us.

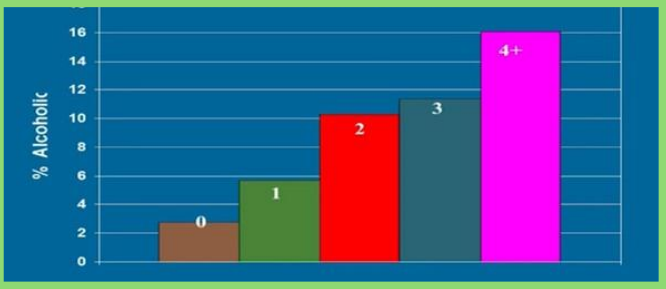
As Dr. Felitti highlighted in an outstanding 2009 lecture, studies reveal numerous alarming long-term consequences of being exposed to ACEs, with the severity of these outcomes increasing exponentially with the number of ACEs experienced. The results indicate that for every category of traumatic experience we have had as a child, we are dramatically more likely to be depressed as an adult. If we have ACE scores of four or higher, we are 260% more likely to have chronic obstructive pulmonary disease than someone with a score of 0, 240% more likely to contract hepatitis, 460% more likely to experience depression, and 1,220% more likely to attempt suicide. If we have

had six categories of traumatic events as a child, we are five times more likely to become depressed as an adult, and if we have had seven categories, we are a terrifying 3,100 percent more likely to attempt suicide as an adult (Felitti et al., 2014; Felitti 2004; Felitti and Anda, 2009; Felitti et al., 1998).



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

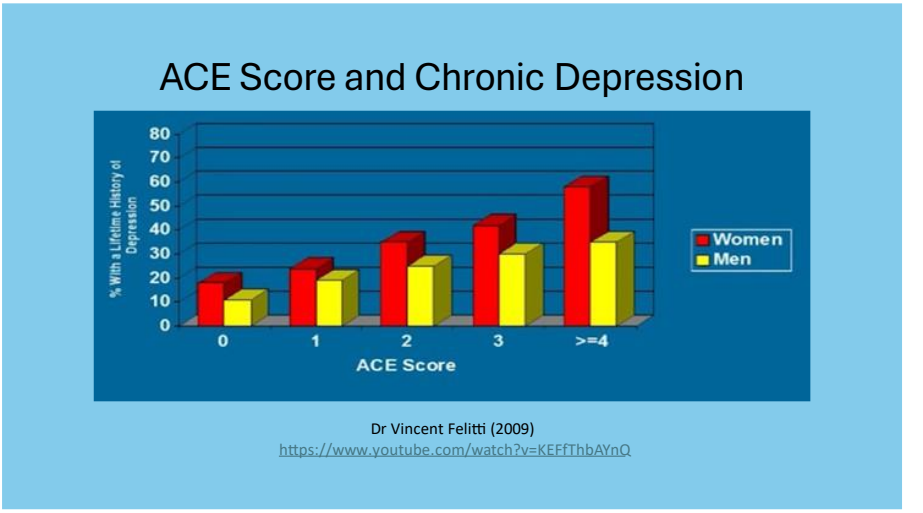
Childhood Experiences vs Adult Alcoholism

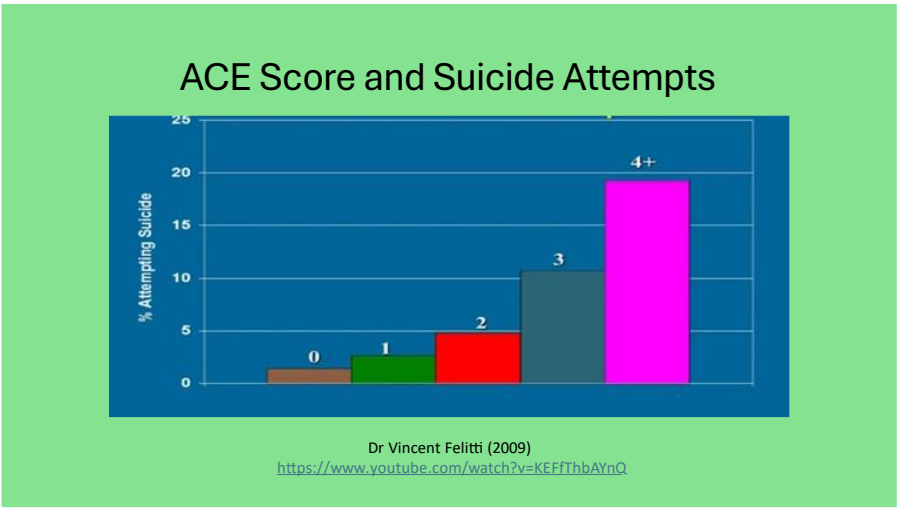


Dr Vincent Felitti (2009)
https://www.youtube.com/watch?v=KEFfThbAYnQ

ACE Score and Intravenous Drug USE

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





The implications are sobering: unresolved trauma in childhood is a breeding ground for not only depression but also addiction, suicidality, chronic illness, and lifelong struggles with emotional regulation and interpersonal functioning. Teens growing up with untreated trauma often reach adulthood with fragmented identities, sabotaged relationships, and overwhelming shame. And without intervention, the disempowering beliefs formed in trauma often become self-fulfilling prophecies.

But this is not the end of the story. This is not just about pathology—it is about healing. We must treat trauma as the centerpiece of adolescent mental health. Every therapeutic intervention must begin with the question: ***"Where, when, and how and were you wounded?"*** And the follow-up must be, "***How can we help you rewrite the story that trauma told you?"***

Because until we treat the wound, the symptoms will persist. And until we help adolescents recover their sense of worth, safety, and connection, no medication or school intervention will reach the root.

But healing is possible. The story can be rewritten. The default mode network can be reshaped and even replaced. And the belief "I am not worthy" can be transformed into ***"I am loved, I belong, I have a purpose, and I matter."***

Cause V:
Ideologies of Disorientation:

How Radical Theories Are Rewriting Childhood and Undermining Identity

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

—Robert M. Pirsig

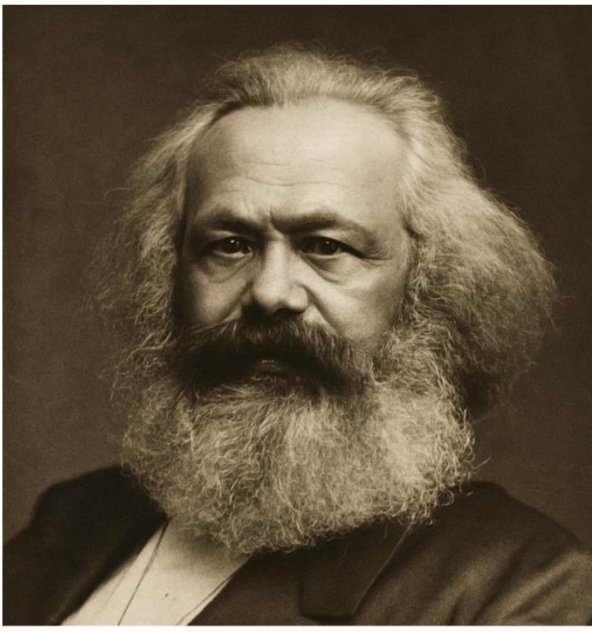
To speak candidly about the current ideological landscape surrounding children, gender, and sexuality is to wade into controversial waters. Yet to remain silent is to risk surrendering the emotional, psychological, and even spiritual well-being of our youth to forces that neither understand nor respect the fragile developmental arc of childhood. What we are witnessing is not merely a cultural shift but a profound ideological reordering—one that began decades ago and has now reached into classrooms, clinics, and digital spaces where children are increasingly taught to question their bodies, their identities, and even their families' values.

"Have nothing to do with the fruitless deeds of darkness, but rather expose them."

—Ephesians 5:11

In this chapter, we respectfully aim to trace the roots of these movements and show how they have contributed to the destabilization of identity in today's adolescents—creating confusion, alienation, and a dangerous preoccupation with sexuality at the expense of resilience, competence, and authentic personhood.

From Oppression to Alienation: The Marxist Foundation



Karl Marx – ChatGPT

At the foundation lies Karl Marx's belief that the central human struggle was one of oppression and alienation (Tinker, 2020). In Marx's

model, the capitalist system dehumanized the worker, estranging him from the fruit of his labor, from his fellow man, and ultimately from himself. This fourfold alienation—***from the act of production, the product made, other workers, and identity***—was not just an economic condition for Marx but a psychological one. The remedy, in his view, was radical upheaval: "revolutionary terror" to accelerate the demise of the old order and usher in a classless utopia (Smith, 2020).

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

Gramsci and the Long March Through Culture

Antonio Gramsci - ChatGPT

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

This strategy came to be known as ***cultural hegemony***—the slow takeover of society's formative institutions, including schools, churches, media, and civil agencies (Tinker, 2020). The goal was not to overthrow power but to ***reshape the cultural consciousness itself***, redefining what was considered "normal" and "good." As German student radical Rudi Dutschke would later call it, this was "the long march through the institutions."

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

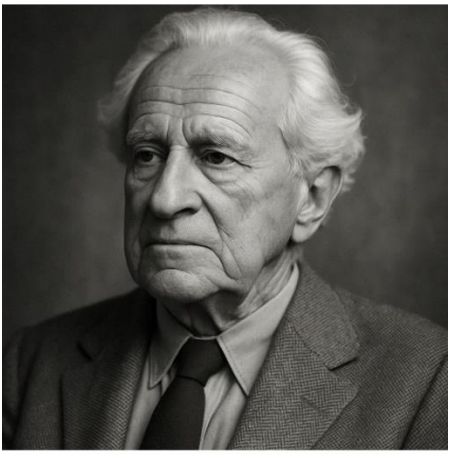
The Frankfurt School and the Critical Deconstruction of Norms

The Frankfurt School – ChatGPT

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

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

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



Herbert Marcuse – ChatGPT

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

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

Queer Theory and the Disassembly of Identity

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

Michel Foucault's ***The History of Sexuality*** (1976) laid the groundwork by arguing that sexuality was socially constructed, not biologically fixed. Judith Butler's ***Gender Trouble*** (1990) built on this, positing that gender is not something we are but something we do - a performance repeated until it becomes internalized (Duignan, 2023).

Michel Foucault – ChatGPT

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

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

Judith Butler - ChatGPT

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

Confusion and Collapse: What Children Are Losing

The adolescent years are meant to be a season of becoming—of forming an identity rooted in resilience, competence, and authentic connection to others. Instead, young people have been immersed in a world that

encourages them to disidentify from their own biology and distrust inherited wisdom.

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

1. Distorts perceptions of sexuality, replacing relational bonding with commodified or performative sexuality.
2. Prematurely sexualizes children, which disrupts emotional regulation and developmental sequencing.
3. Diverts attention from academic and relational growth, undermining competence and self-esteem.
4. Leads to addiction and compulsivity, as exposure rewires reward circuits.
5. Exacerbates anxiety, depression, and body image disorders.
6. Undermines the importance of consent, safety, and personal boundaries.
7. Erodes trust between parents and schools, fueling intergenerational tension.
8. Pressures children to conform to hypersexual norms, damaging authenticity.
9. Opens institutions to legal and ethical consequences, particularly when content is developmentally inappropriate.

In summary, what began as a critique of capitalism metastasized into a cultural reengineering project that seeks to dismantle the very foundations upon which identity is built—biology, family, faith, morality. We've shifted from fighting oppression to fighting ***definition itself***. And our children, caught in the ideological crossfire, are paying the price.

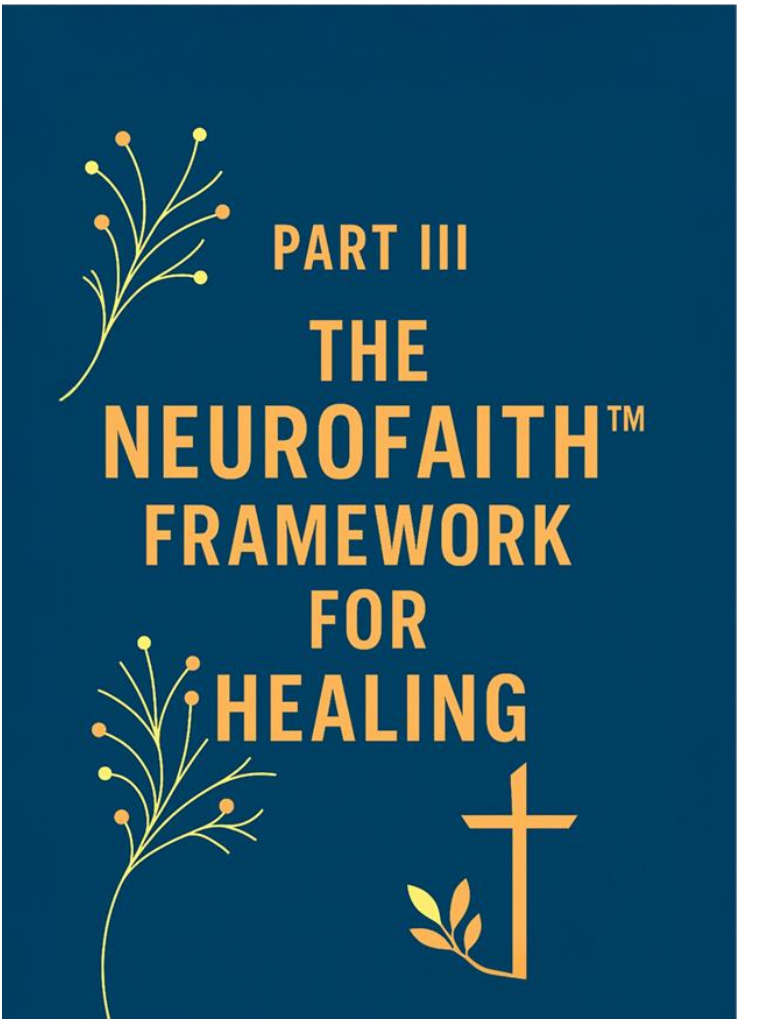
Rather than developing grit, character, and community, teens are being led to fragment themselves—to fixate on identity labels and confuse feelings with truth. In the name of liberation, we are delivering them into a new bondage: a disassociation from reality, their families, and most tragically, from themselves.

"For you created my inmost being; you knit me together in my mother's womb. I praise you because I am fearfully and wonderfully made; your works are wonderful, I know that full well."

—Psalm 139:13–14

We must, with courage and compassion, reclaim a narrative of childhood that honors innocence, upholds moral clarity, and champions the slow, beautiful work of becoming whole – everything that God created and intended teens to be. ***"So, God created human beings in His own image. In the image of God he created them: Male and female He created them"*** (Genesis 1:27).

Part III
The *NeuroFaith™* Framework for Healing



The Therapeutic Pathway to Healing and Peace

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

- Psalm 103:2-3

AS we have established, adolescent depression leaves deep wounds, not just in the mind but in the body and soul. However, even in the midst of darkness, there is a pathway toward healing—a journey where rest for the weary can be found, and where hope, rooted in the promise of restoration, begins to grow. As we step into the therapeutic world of healing, we uncover profound wisdom from both neuroscience and Scripture. Together, they form a holistic and transformative approach to recovery.

In this chapter, we will explore three groundbreaking therapies that serve as powerful tools for healing the wounds of teen depression: Polyvagal-Informed Therapy, HeartMath®, and Internal Family Systems (IFS). These methods help us reconnect with the body, mind, and heart, aligning them toward peace and wholeness. Just as Jesus invites us to find rest in Him, these therapies work to restore balance, helping teens release the burdens that depression has placed upon them

"The Lord is close to the brokenhearted and saves those who are crushed in spirit" (Psalm 34:18). Healing is not just about overcoming depression - it is about reclaiming peace, reconnecting with our true selves, and finding restoration for the broken pieces of our lives. The therapeutic pathway is not just a journey back to sobriety but a road to lasting peace. So, here we go:

1. Polyvagal-Informed Therapy
2. HeartMath®
3. Internal Family Systems (IFS)

These therapies have the potential to guide us toward lasting recovery and well-being, offering hope for a healthier, more balanced life.

One:
Polyvagal-Informed Therapy

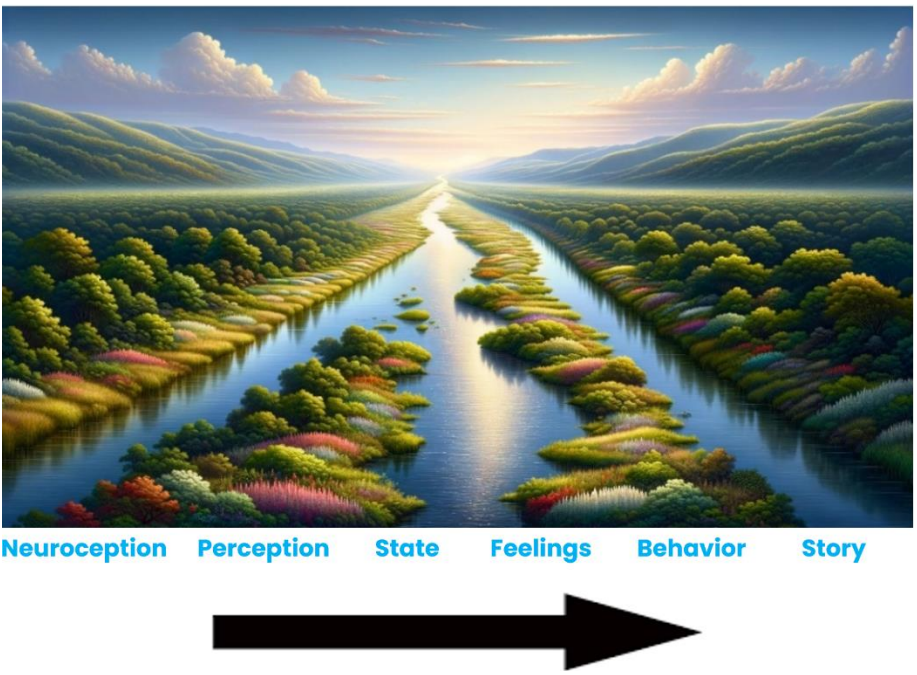
Building on what we have previously discussed about the body, specifically the autonomic nervous system, Polyvagal-informed therapy focuses on our body's nervous system and how it responds to stress and safety. It uses the idea that our sense of well-being is closely tied to how our body feels safe, connected, and calm. By understanding and influencing our nervous system's responses, we can more effectively manage our emotions, feel more connected in relationships, and recover from stress and trauma. In essence, we tune into our body's safety signals to improve our emotional health and resilience.

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

They later add, "When we feel safe, our nervous systems and entire bodies undergo a massive physiological shift that primes us to be healthier, happier, and smarter; to be better learners and problem-

solvers; to have more fun; to heal faster; and generally, to feel more alive" (Porges & Porges, 2023, p.13). Now, how cool is it that - Polyvagal-Informed Therapy can do all of that by helping us achieve regulation through safety! They point out that trauma affects not only our brains but extends throughout our entire nervous system, impacting every part of our body. It alters how our senses perceive, how our organs function, and nearly every aspect of our mental and physical health. As such, trauma changes our bodies in addition to our brains, and Polyvagal Theory gives us an explanation for how specifically these changes occur and, more importantly, how we can deal with them and heal.

Steven and Seth assert that Polyvagal Theory shifts our discussion away from the actual event to how it transforms and becomes embedded in our bodies, with these changes occurring through the vagus nerve. Therefore, it is through the vagus nerve that we find a way out of neurological disorder and disruption to a pathway to peace and healing. To quote, "A light at the end of trauma's tunnel, and a pathway toward healing and happiness in a world that seems designed to threaten and traumatize us at every turn (Porges & Porges, 2023, p.13." This is neuroscience poetry to me, and my desire for you is that this neuroscience equally inspires you to feel hope and embark on your own healing journey.

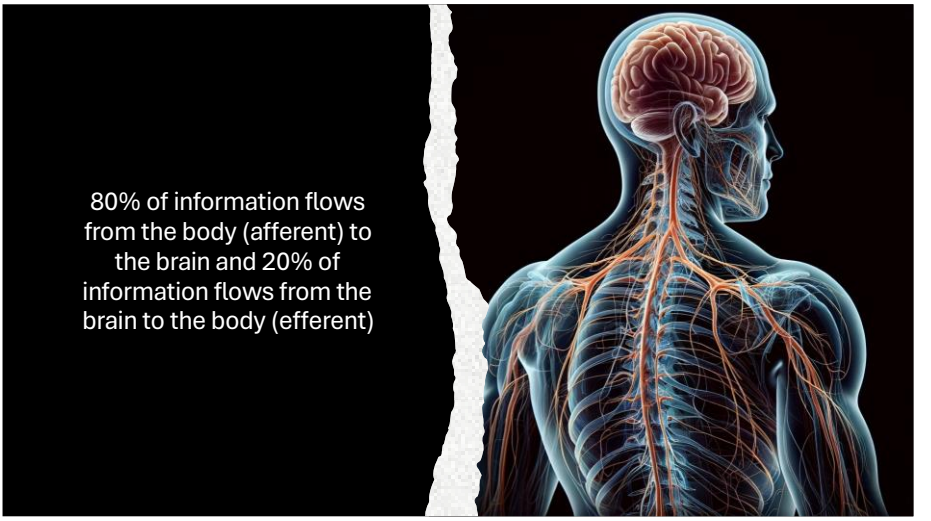


Borrowing from a metaphor of flowing down a stream, the first step in healing is to move our neuroception - what our autonomic nervous system is automatically sensing regarding safety and danger without our awareness to awareness of sensing, which is called perception. Flowing downstream, we can then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

enter into a negative feedback loop, a process that leads to emotional problems/illness and/or physical problems.

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

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



As previously noted by Deb Dana, a ventral vagal state and a neuroception of safety brings the possibility for connection, curiosity,

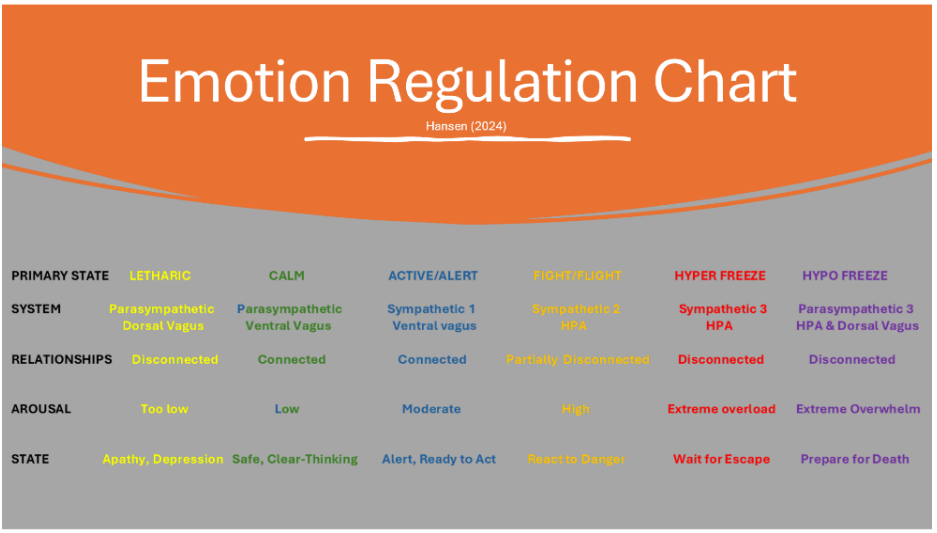
and change. She nicely presents a polyvagal approach, which she calls the four R's (the first three are bottom-up (body to brain) and the last is top down (brain to body) (Dana, 2018):

The Four R's

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

Recognize the autonomic state

I recommend making the Emotion Regulation Chart I developed below as our companion to help us recognize where we are on that continuum of regulation. In doing so, we can make what is implicit (under the table and outside of our awareness) explicit (on the table and in our awareness). We can use the color codes to describe for ourselves and others where we and others are with just one neutral and non-judgmental word. This is also particularly helpful for children as it helps give them a physical and emotional language that connects the mind with the body.



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

- Rapid heartrate
- Hyperventilation
- Panic attacks
- Inability to focus or follow through
- Distress in relationships
- Emotions of fear, terror, rage, anger
- Possible health consequences, including heart disease, high cholesterol, high blood pressure, weight gain, memory impairment, headaches, chronic neck shoulder and back tension, stomach problems, and increased vulnerability to illness (lower immune response) (Dana, 2018).

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

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

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

- Regulated heart rate (vagal brake lowers heartrate by 20 beats per minute)
- Breath is full
- Feeling regulated
- We take in the faces of others
- We can "tune in" to conversations and "tune out" distractions
- We can see the "big picture"
- We can connect with the world and the people in it
- Able to reach out to others
- Able to play and take time to enjoy life and others
- Able to be productive in work
- Able to organize and follow-through
- Able to heal emotionally and physically
- Emotions of happiness, joy, love, peace, calm

- Possible health consequences include a healthy heart, regulated blood pressure, a healthy immune system, decreased vulnerability to illness, good digestion, quality sleep, and an overall sense of well-being (Dana, 2018)

Respect the adaptive survival response

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

Regulate or co-regulate in a ventral vagal state

Once we recognize that we are dysregulated and have pinpointed which defensive physiological state we are in and where we are on the emotional

regulation continuum (see emotional regulation chart above) i.e., activation or slowing/shutting down, we can act by using bottom-up self-regulation strategies and co-regulation strategies.

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

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

Connection is a wired-in biological necessity, and isolation or even the perception of social isolation can lead to a compromised ability to regulate our autonomic state, which diminishes our physical and emotional well-being (Porges & Furman, 2011). We can all appreciate that when we feel alone, we suffer. In a Ted Talk presentation, Cacioppo (2013) reported a rather shocking meta-analysis study of over 100,000 participants, which found increased risks of dying early due to the following:

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

Deb Dana notes that when there is ongoing mis-attunement, when ruptures are not recognized and repaired, the autonomic experience of persistent danger ends up moving the system away from connection into patterns of protection, and loneliness is the subjective experience (Dana, 2018).

So, when we recognize that we are suffering and dysregulated, it is very helpful and sometimes lifesaving to seek safe refuge in others. Conversely, when we are emotionally regulated ourselves, we can offer our safe regulation to others, be they adults or children. This is a particularly important and essential component of good parenting. We can gift our safe regulation to ourselves and others by choosing the

following strategies below. Remember, through the process of neuroception, others read our cues of safety just as we read theirs. Quid pro quo, we receive back what we give and vice versa. We would do well to practice these strategies, so they become automatic whenever we move out of the green zone and want to return.

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

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

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

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

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

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

Re-story

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

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

As the Bible reminds us, "Do not conform to the pattern of this world, but be transformed by the renewing of your mind" (Romans 12:2, NIV). By renewing our narratives, we transform our minds and begin to see ourselves and our stories in a new light—one filled with resilience, hope, and purpose.

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

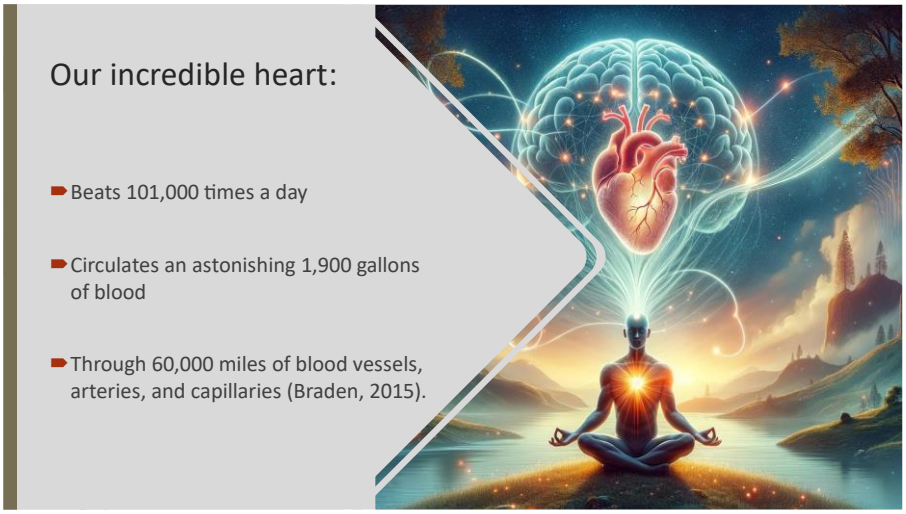
In this process of re-storying, we not only rewrite our past but also open ourselves to a future of peace and healing.

Two: HeartMath®

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

The wisdom of the heart is not new—it was known to the ancients and has been referenced throughout Scripture. ***"Above all else, guard your heart, for everything you do flows from it"*** (Proverbs 4:23, NIV). This verse reminds us that our heart is central to the essence of life, influencing not only our emotions but the quality of our decisions and

actions. In modern times, much of this wisdom was dismissed and then forgotten, but it is being rediscovered through scientific and spiritual lenses alike, leading us toward fuller, more meaningful lives.



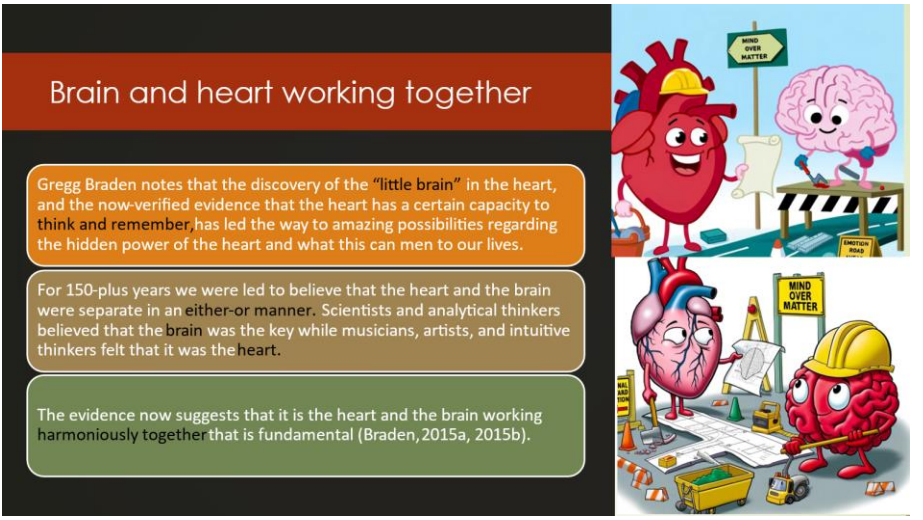
Again, the ancients knew of the importance of the heart, but that wisdom was lost with time. Happily, this knowledge is coming back to us and can lead us to fuller and more meaningful lives.

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

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

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

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

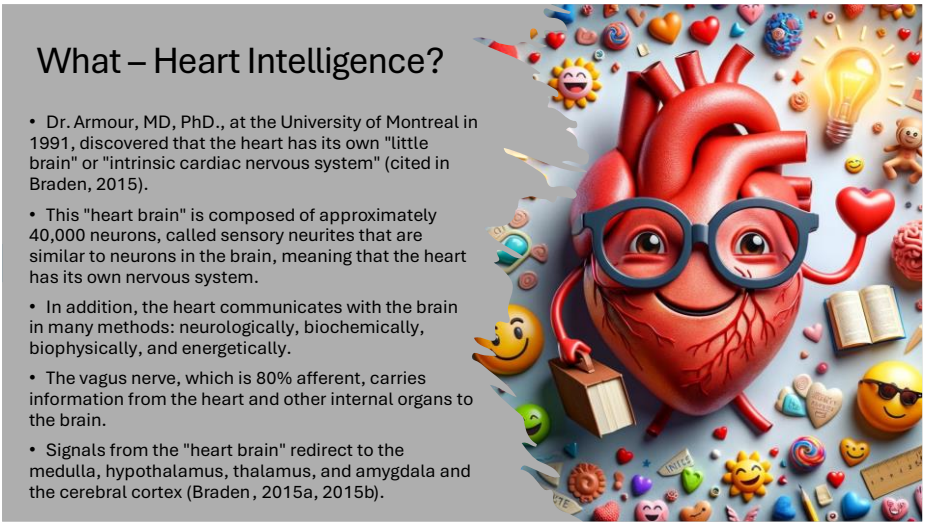


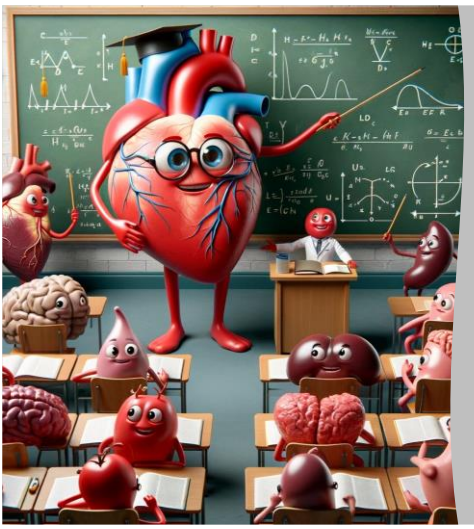
One of my heroes who advocates for new and innovative ways to promote mental health is Gregg Braden. He is an author and speaker who has actively bridged science and spirituality. He has a background in earth sciences and worked in the aerospace and defense industries during the 1980s. Braden is also widely known for his work in popularizing the concept of HeartMath®. Although not a founder of the HeartMath® Institute, he has been a strong proponent of its work, particularly in the areas of emotional self-regulation and the connection between the heart and brain. Braden's work often explores the role of human emotion in physical health, healing, and the interconnectedness of all life. Braden's approach combines science with spirituality to offer perspectives on personal and collective wellness, emphasizing the importance of harmony within oneself, others, and with the environment. He is a brilliant, sincere, and inspirational speaker, and I encourage you to search out some of his YouTube presentations on HeartMath®. His one entitled "***Practice this Technique to Relieve Daily***

Stress… Three Keys to Heart - Brain - Earth Harmony" is one of my favorites. Give it a try, you will love it.

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

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



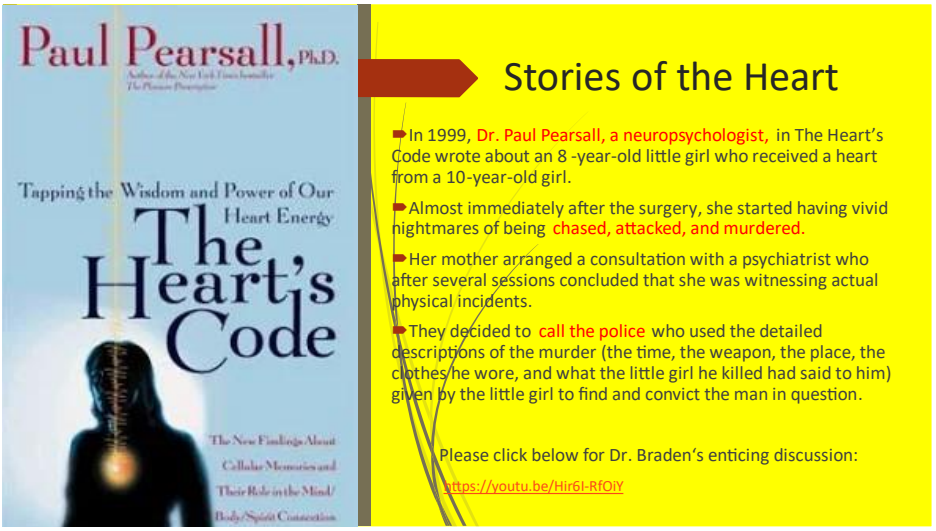


What – Heart Intelligence?

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

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

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



HeartMath® is a magnificent therapy that uses techniques that focus on heart rate variability and the heart's influence on emotional well-being and stress management. By learning to regulate our heart rhythm, we can achieve a more coherent state, where emotions, mind, and body are in sync. This approach helps reduce stress, enhance emotional regulation, and improve overall health. In therapy, HeartMath® tools

teach us how to access our heart's intelligence to foster resilience, improve decision-making, and deepen personal connections. Learning to live more from the heart is a game-changer, allowing you to relate to others in safer, more profound ways, bringing much more groundedness and stability to your life.

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

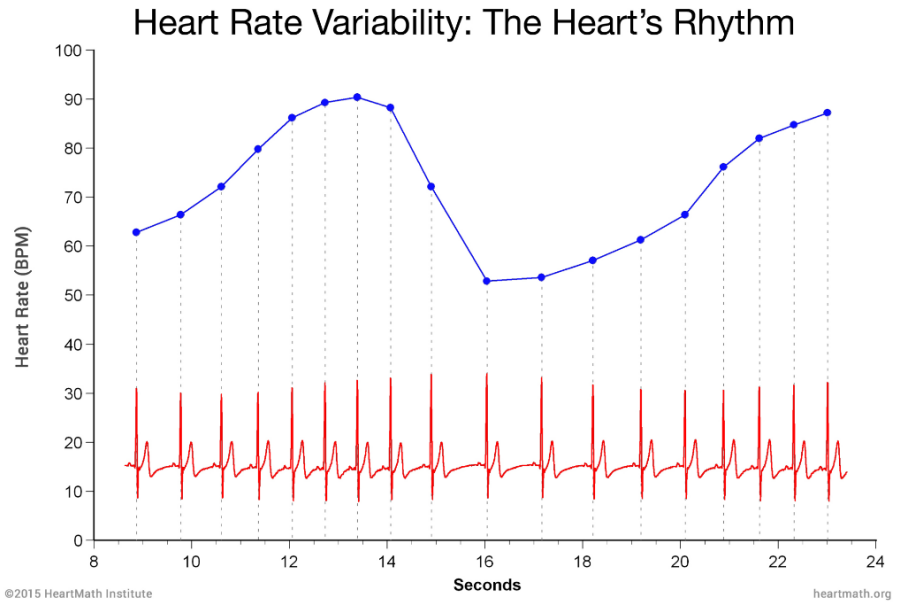


Image courtesy of the HeartMath® Institute – www.heartmath.org.

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

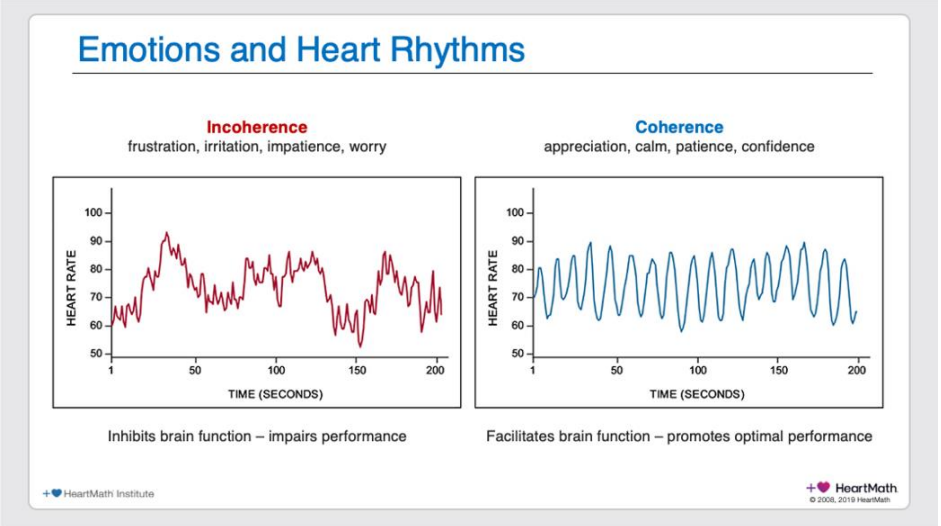


Image courtesy of the HeartMath® Institute – www.heartmath.org.

Once we attain coherence in the heart, the coherent heart then communicates in four distinct ways to the brain enabling it to achieve coherence. Dr. McCraty notes that the heart communicates to the brain in four main ways: (1) nerves connecting the heart to the brain,

particularly the vagus nerve, (2) hormones, (3) blood pressure shifts, and (4) electromatic waves (McCraty 2023). This allows the brain to be more integrated and efficient, while an incoherent heart inhibits cortical function. Note that 80% of information flows from body to brain (efferent).

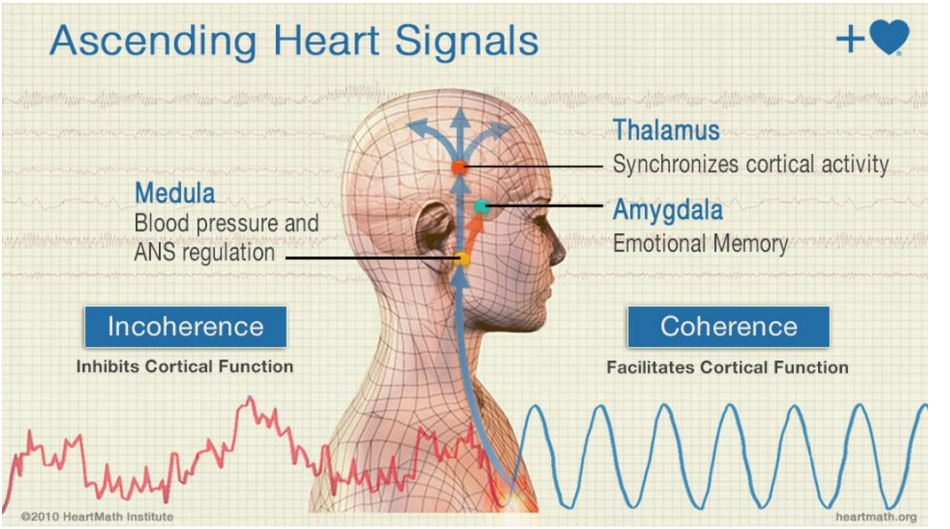


Image courtesy of the HeartMath® Institute – www.heartmath.org.

This following graphic nicely illustrates how an incoherent heart increases the activity of the amygdala and diminishes the activity of the prefrontal cortex (thinking brain/executive functioning). In this state, our thinking is governed by lower brain centers, and we thus make impulsive, emotionally driven decisions. On the other hand, the right side of the graphic demonstrates how a coherent heart signals the amygdala to quiet down, allowing the higher order processes of the prefrontal cortex to reign so great decisions can be thereby authored.

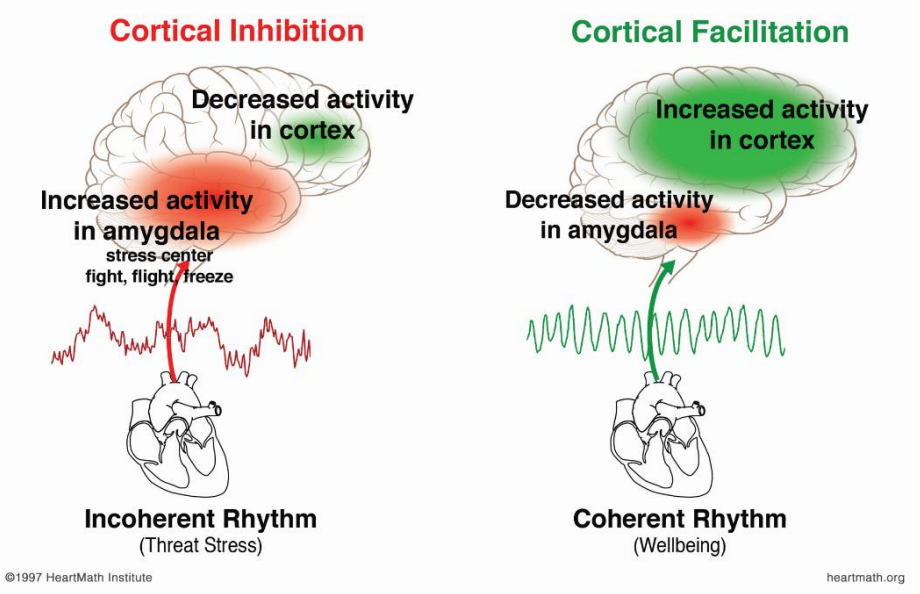


Image courtesy of the HeartMath® Institute – www.heartmath.org.

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

1. Heart Coherence: As previously noted, heart coherence refers to a harmonious, ordered pattern in the heart rhythms, characterized by a stable, sine-wave-like pattern in the heart rate variability (HRV). This state is associated with positive emotions, physiological efficiency, and a sense of well-being. It is achieved when the heart, mind, and emotions are in energetic alignment and cooperation.

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

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

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

nerve is active, which promotes social engagement (Hansen, 2021).

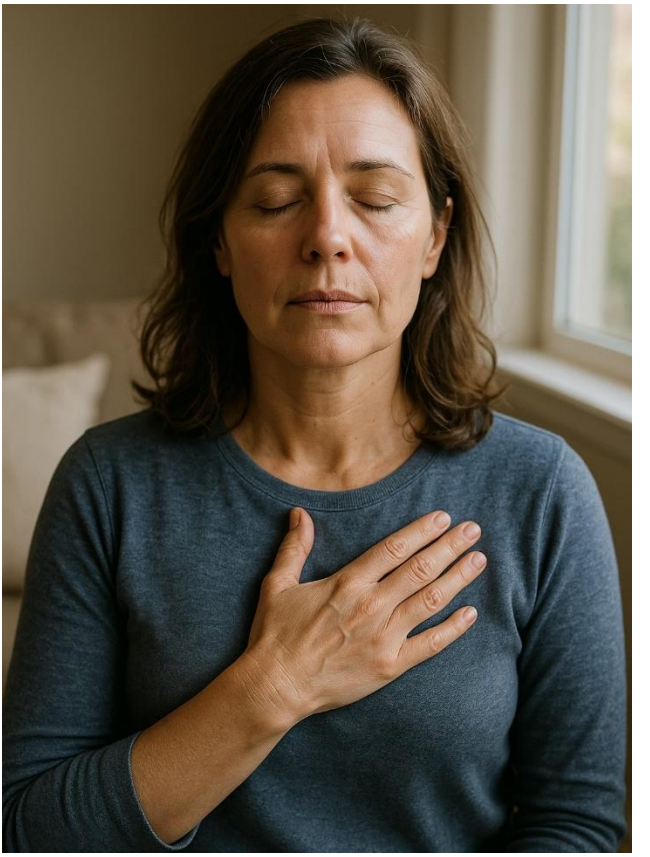
5. Improved Group Dynamics: When applied in groups, this phenomenon can lead to improved cooperation, understanding, and a collective increase in coherence among individuals. This not only benefits emotional and mental health but can also enhance group performance, creativity, and problem-solving abilities.

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

The coherent HRV of one person positively regulates the other

Heart Lock-In® Technique:

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



The Heart Lock-In® Technique is a practice developed by the HeartMath® Institute, designed to help individuals enter a state of heart coherence, where the heart, mind, and emotions are in alignment. This technique is beneficial for reducing stress, enhancing emotional

stability, and fostering a sense of inner peace and well-being. Here is a step-by-step guide on how to perform the Heart Lock-In® Technique:

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

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

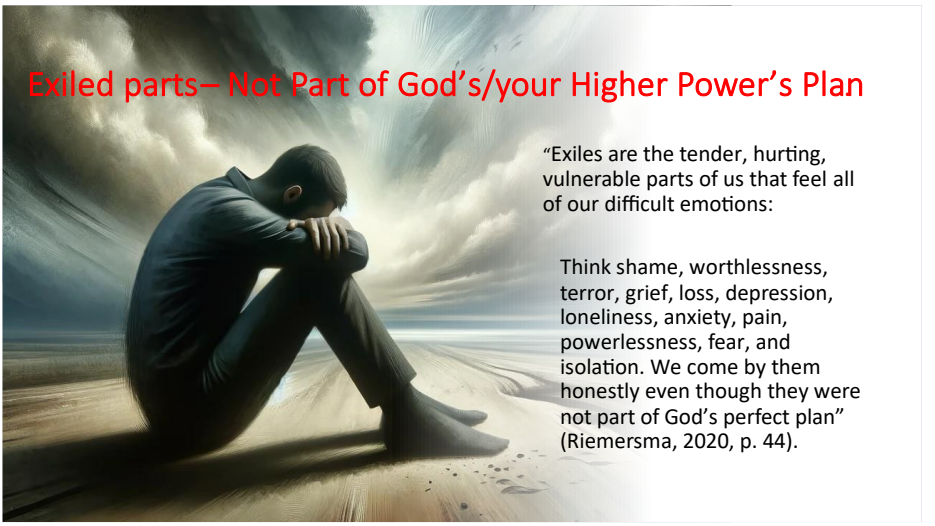
3. Radiate that renewing feeling to yourself and others.

Three: Internal Family Systems (IFS)

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

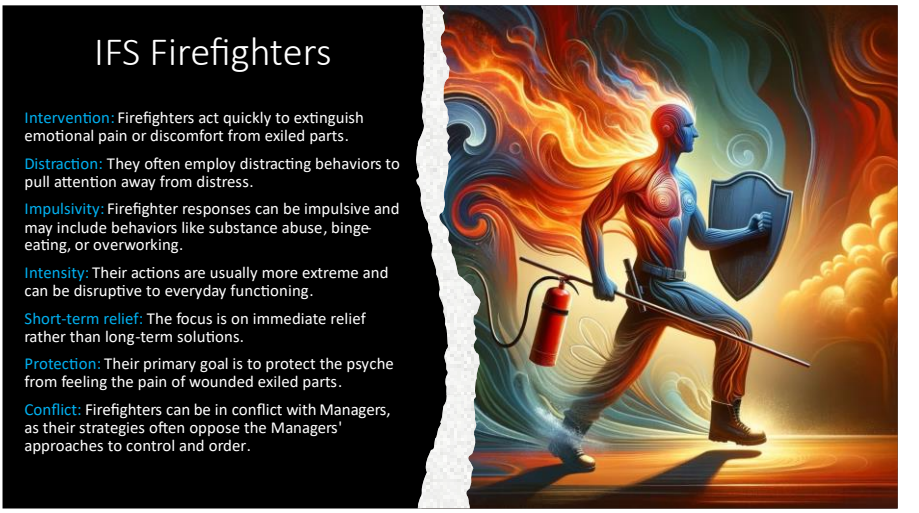
Internal Family Systems (IFS) is a therapeutic approach that identifies and addresses multiple sub-personalities or parts within each person's mental system.

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



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

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



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

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

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

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

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

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

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

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

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

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

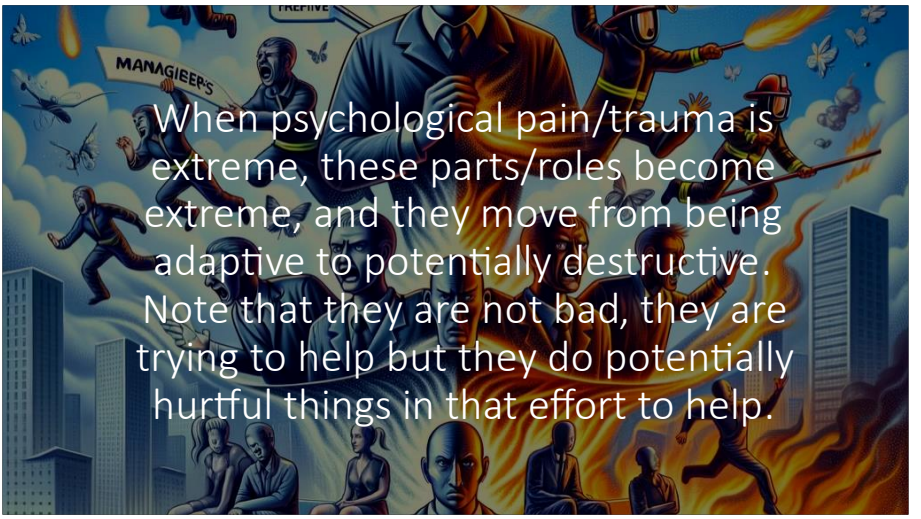
8. Integrates Well with Other Therapeutic Approaches: IFS is a non-pathologizing and hopeful model that can be integrated with other forms of therapy, including cognitive-behavioral therapy (CBT), dialectical behavior therapy (DBT), faith-based

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

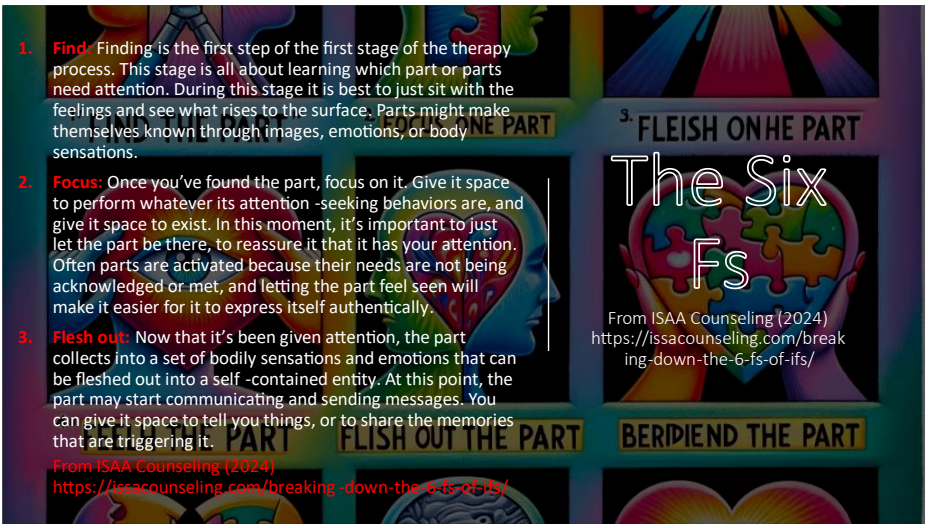
9. Evidence-Based: Research on IFS is growing, and it has been recognized as an evidence-based practice for treating certain conditions, such as PTSD, demonstrating its effectiveness and reliability.
10. Cultivates Mindfulness: The process of identifying and interacting with different parts requires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

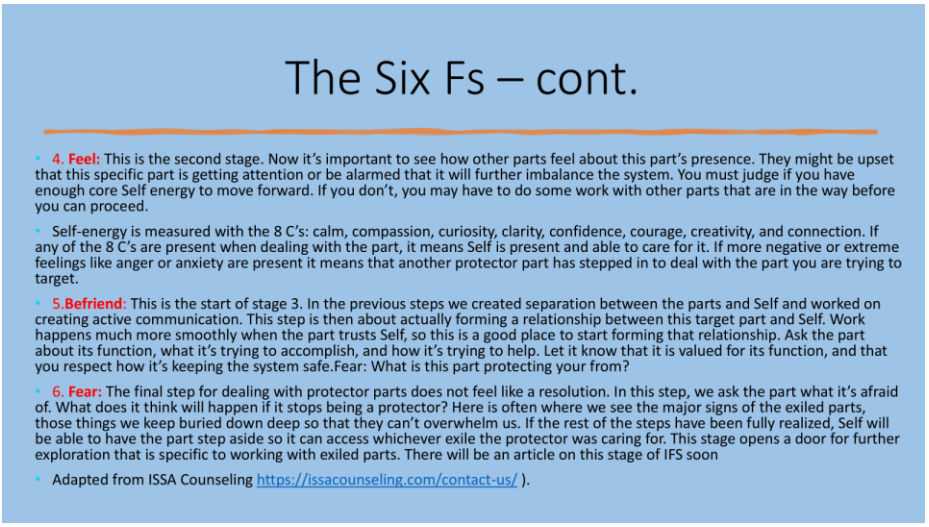
IFS therapy's holistic approach to healing emphasizes understanding and integration of all parts of the Self, including the spirt, leading to profound and lasting psychological change.

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



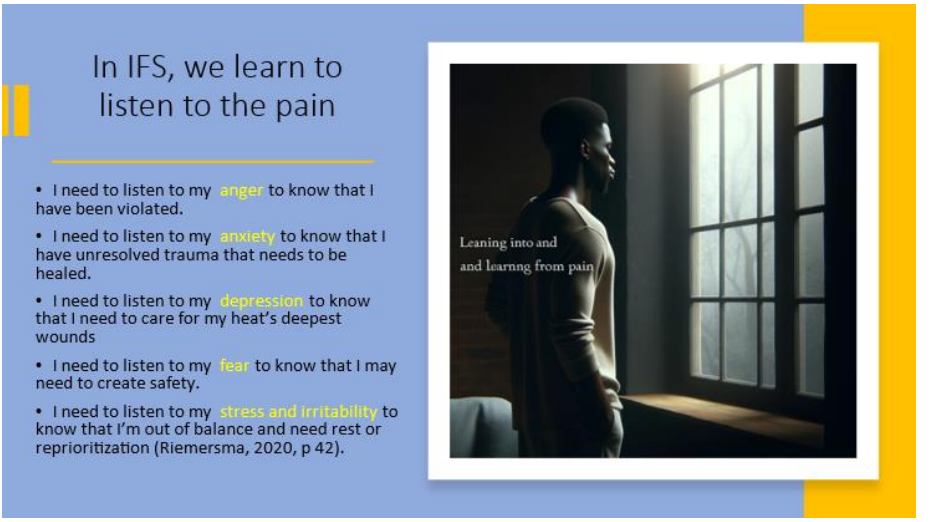
In order to access and resolve the pain that has been largely exiled out of consciousness, we must access the defensive parts and get them to back off from defending as this keeps us distanced from our true self. There are six important steps involved in this process: Find, Focus, Flesh Out, Feel, Befriend,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





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

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



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

Lean into pain and ask three questions:

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

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

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

A few of my favorite speakers on IFS.

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

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

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

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

Creating a Safe Place for Teens to Talk

The doorway to an adolescent's heart is narrow—and fragile. Step toward it with grace, and it may open. Push too hard, and it slams shut.

This chapter is about helping create that doorway - a safe space where depressed and hurting teens can feel secure enough to speak. We cannot overstate this: the wrong approach will shut them down. One careless remark, one dismissive glance, one moment of mis-attunement can cause a teen to retreat into silence. Our posture, tone, and facial expressions must be one of care, humility, and sacred attentiveness.

Adolescence is not merely a stage to endure—it's a sacred window of becoming. It's a time of dramatic neurological development, emotional intensity, and identity exploration. For parents, providers, and mentors, walking alongside teens can feel daunting, even overwhelming. But with insight and intentional care, this journey can also be one of the most rewarding. This chapter offers both practical strategies and deep encouragement for those walking with adolescents through depression, confusion, or emotional pain.

We offer this with humility and hope—recognizing that there are no perfect formulas when working with teens, only postures of presence, patience, and persistent grace.

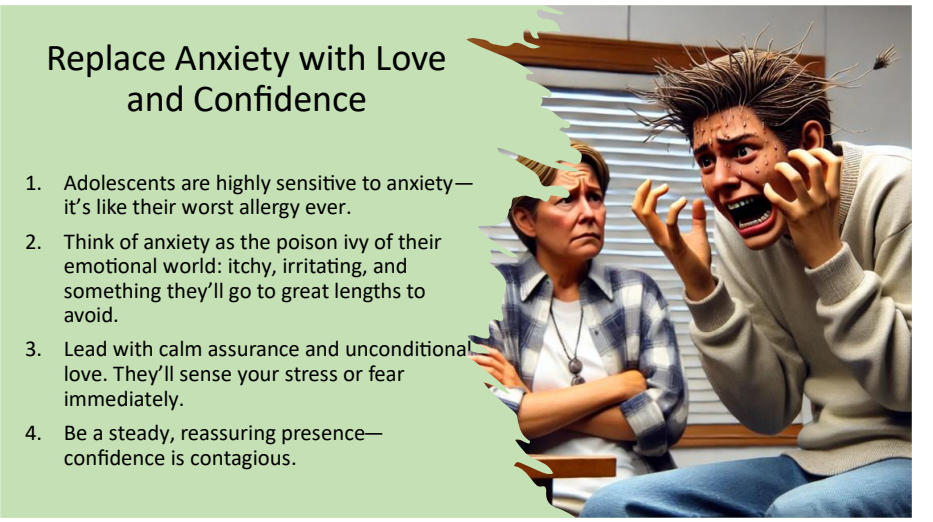
One of the first and most essential postures we can adopt is learning to listen more and speak less. In our eagerness to help, we may be tempted to lecture or preach, thinking our wisdom will pull them out of their despair. But for many teens, those well-intended monologues land with a thud or even worse. They don't need our sermons—they need our presence. We must resist the urge to correct and instead learn to co-regulate. A teen doesn't want to be told how to fix their feelings; they want to know someone is strong enough to sit with them in and through the storm.

Many of us fall into the trap of over-talking. Yet the 80/20 rule is a simple and powerful corrective: listen 80% of the time and speak only 20%. If we fill every pause with our own fears or advice, we rob them of the space they need to hear their own voice. Even silence can be healing when held with compassion. The goal isn't to fill the air with solutions but to offer a safe space where teens can begin to hear and accept themselves again. When the emotional stakes are high—and they often are—a teenager needs to feel that they can share without judgment or interruption. The wrong approach can shut them down in an instant. One wrong word, one critical look, and the opportunity for honest dialogue may vanish. The aim, always, is to create a sacred and secure space that invites openness rather than demands it.

Listen More, Speak Less

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

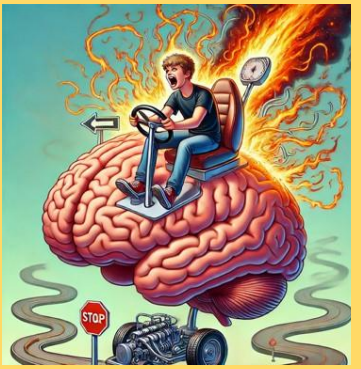
Of course, this means managing our own anxiety. Adolescents are profoundly sensitive to emotional tone. If we bring stress into the conversation, they'll pick it up before we say a word. Think of anxiety as emotional poison ivy—it spreads fast and leaves everyone irritated. When we lead with calm assurance and grounded love, we offer something their nervous systems can mirror. In essence, we become the thermostat for the emotional climate. If we are regulated, we invite regulation. If we are panicked, they absorb it and escalate.



This capacity to stay steady becomes even more important when we understand the adolescent brain. It's undergoing a radical neurological renovation. The limbic system, which processes emotion, matures early—while the prefrontal cortex, responsible for judgment and self-regulation, comes online much later. This imbalance leaves teens with intense emotions and underdeveloped brakes. They are, quite literally, "all gas, no brakes." That's not a character flaw—it's biology. But it does mean they need adults who can lend them their prefrontal cortex in moments of overwhelm. We do this not by controlling them but by containing the chaos with wisdom and warmth.

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

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

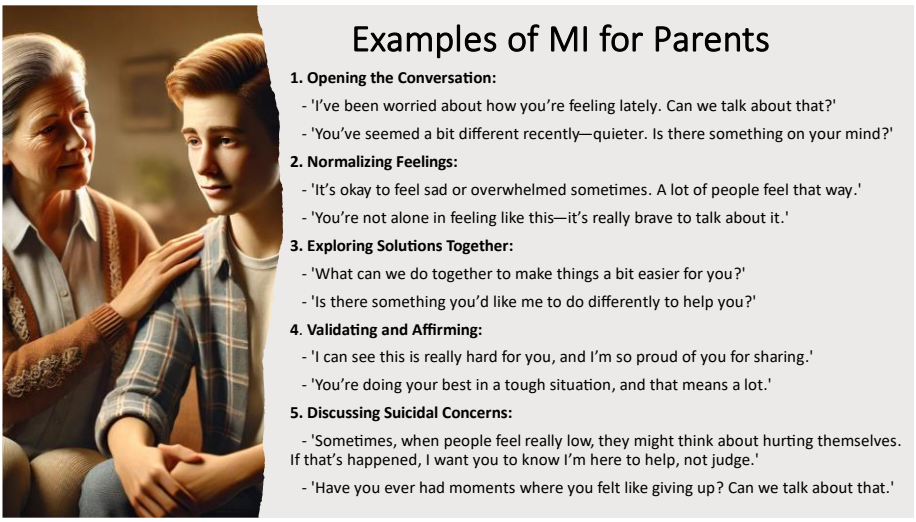


When a teen is depressed, their emerging independence can feel especially fragile. They may interpret offers of help as threats to their autonomy. What they often need is not intervention but invitation. We can affirm their autonomy even as we extend support. Let them know that needing help is not weakness but wisdom. We must meet their despair not with directives but with dignity. Often, this means being quietly and compassionately available, ready to walk beside them rather than push them forward or hold them back.

Handle Adolescent Individuation Struggles with Sensitivity

1. Adolescence is a time of individuation—they're striving to pull away and establish independence.
2. Being depressed and needing help can feel shaming and humiliating, threatening their emerging autonomy.
3. Approach with empathy and encouragement, avoiding blame or judgment.
4. Show them that needing support is a strength, not a weakness.
5. Reinforce their worth and capability while creating a safe, non-judgmental space.

Motivational Interviewing (MI) is one of the most powerful tools we can use to support hurting teens in a way that respects their agency. MI helps us guide rather than drag, to explore ambivalence with empathy rather than agenda. Instead of saying, "Here's what you need to do," we say, "Can we talk about what's been hard lately?" This opens doors rather than closing them. With MI, we reflect their thoughts back to them, explore possibilities together, and empower even small steps forward. This approach helps teens feel heard, respected, and safe to consider change.



Sometimes, what we need most in these moments is a little levity. Humor, when used wisely, can disarm tension and build rapport. As one illustration in this chapter notes, trying to force a teen to open up the wrong way is like poking a bear and expecting a hug. Best case, you get ignored. Worst case, you're running for your life. A little humor, gently offered, can remind everyone, teen and adult alike, that we're all just human, trying to do our best. It can be the thread that reweaves connection in a relationship frayed by fear, failure, or frustration.

Humorous Insight

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

Ultimately, none of this is about being perfect. It's about being present. It's about learning to sit with discomfort without rushing to fix it. To hold a space where teens can breathe again, believe again, and begin—slowly and with support—to hope again. Our words may fade, but our presence lingers. When we stay, when we soften, when we believe in them even when they cannot believe in themselves, we plant seeds that may not bloom for years—but bloom they will.

The path is narrow and steep, but it is holy ground. And the impact of showing up well for an adolescent? It can echo for generations. You don't have to be a perfect parent or provider to make a profound difference. You only have to be a faithful one—compassionate, patient, and willing to walk the path with love.

Take heart: every small act of presence, every moment of understanding, is shaping a future adult who knows they are not alone.

A Few Thoughts on Finding the Right Therapist and Therapy

Before we leave this chapter, we would like to say a few words about the importance of finding the right therapy and therapist to meet your teenager's needs. This can be difficult as the psychotherapeutic community can be confusing, especially for the first time consumer.

It is unfortunate that there is much to criticize about the current state of psychotherapy. To begin with, psychotherapy's outcomes can be

hard to measure, with variable effectiveness across different types of therapy and individual therapists. In some cases, it is reasonable to be concerned about potential harm, including dependency on the therapist, misdiagnosis, or worsening of symptoms.

Abigail Schrier (2024), in her new book, ***Bad Therapy: Why the Kids Aren't Growing Up,*** expresses her concern about too many bad therapies. In fact, Abigail devotes an entire chapter to iatrogenesis, which refers to any condition, symptom, or complication caused directly by medical treatment, intervention, or advice rather than by the underlying disease or condition itself. She specifically comments on how psychotherapy can be harmful and notes that therapists often do not want to acknowledge that the "medicine" is not working because the therapist is "the medicine." Moreover, she notes that it is often in the therapist's best interest to treat the ***least sick for the longest period of time*** and, on the other hand, many therapists shy away from more complex clinical presentations, such as complex trauma, bipolar disorder, and borderline personality disorder, to name a few (Schrier, 2024).

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

permanent physical changes without being able to fully comprehend the consequences of those changes. And yes, the lawsuits are coming and rightly so.

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

- Credentials and Licensing: Verify the therapist's qualifications, including education, licensing, and certifications. Check with the appropriate licensing board for any negative actions or complaints. You might want to consider seeking a therapist with a Ph.D. in Clinical Psychology from an American Psychological Association (APA) accredited school. Such Ph.D. psychologists are also trained as scientists, enabling them to better understand research and, therefore, more likely to appreciate and apply relevant findings to your concerns. That said, and to be fair, there are many skilled and talented master's-level therapists who also value and follow the research, just as there are many PAs who provide excellent medical care and, in some cases, may even surpass MDs.

- Consultation: Many therapists offer a free initial consultation, which can help you gauge compatibility and comfort. Keep score of the initial phone contact. If they are dismissive and unwilling to take the time to connect with you, it can be a negative sign.

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

- Comprehensive Training: Look for a therapist who specializes in treating your specific issues, such as anxiety, depression, or trauma. Ask your prospective therapist if they have a deep understanding and training of various psychological conditions and the skills to address your specific needs effectively.
- Continual Learning: The field of psychotherapy evolves with new research; ongoing education allows therapists to stay current with the most effective treatments. Ask about what training your prospective therapist has done or is undertaking to stay current.
- Client-Centered Approach: Ask if your prospective therapist will tailor their approach to meet your unique needs rather than applying a one-size-fits-all ideology. Even effective therapies can feel cultish when applied too rigidly and dogmatically to all presenting problems without adaptation or consideration of better alternatives. Please remember, you are seeking a therapist, not a cult leader.
- Ideology: Do not be afraid to ask your prospective therapist if they will keep personal ideology out of the therapy relationship and will instead provide treatment in alignment with well-supported empirical and evidence-based therapeutic techniques.
- You are the boss: Remember, you are the boss and, as such, your therapist works for you. You have the right to agree, disagree, and/or question. A good therapist will not only respect that but will encourage your right to do just that.

- Trust Your Instincts: After meeting with the therapist, trust your gut feeling about whether you can work well together. If it's a bad fit, end it sooner rather than later. To be fair, most therapists are very well-meaning and have a heart to help others. But well-meaning, although wonderful, does not necessarily equate to competence or being a good fit for your unique needs.

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

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

Summary: As we conclude this chapter, let's take a moment to reflect on the journey toward healing and depression. This is a profound battle, one that touches the very core of our being, but it's also a battle that

can be won. Through therapies like Polyvagal-Informed Therapy, HeartMath® , and Internal Family Systems, we have seen that there is hope. These approaches offer tools not only to understand ourselves better but also to embrace a life where we are no longer defined by our struggles.

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

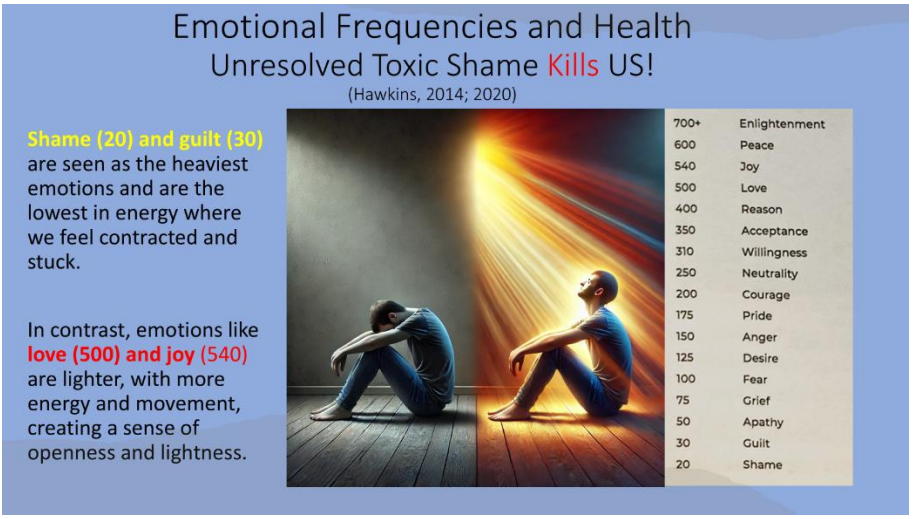
"I can do all things through Christ who strengthens me" (Philippians 4:13). Remember, the road to recovery may have its challenges, but you are not walking it alone. There is a strength within you, bolstered by faith, by knowledge, and by the support of therapies that align mind, body, and spirit. You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

Healing is not a destination; it's a journey, and you are already on the right path. Stay the course, trust in the process, and know that brighter days are ahead. ***"The Lord will fight for you; you need only to be still"*** (Exodus 14:14). Let that assurance guide you forward, one step at a time.

Transformational Change Healing Shame Through Christ Alone

Shame is a profound and often hidden wound that impacts the soul at its deepest level. Unlike guilt, which focuses on what we've done, shame targets who we believe we are, fostering feelings of unworthiness and self-rejection. Dr. David Hawkins' groundbreaking yet controversial research highlights that shame resonates at one of the lowest energies measurable by kinesiology (muscle testing) in the human experience, which he reports is a 20 on a 0 – 1,000 scale (no unit of measurement was specified). This low energy indicates the heavy, debilitating nature of shame, which can manifest physically, psychologically, and spiritually. Over time, the oppressive weight of shame affects not only our mental health but also our physical well-being, contributing to chronic stress, immune system suppression, and even an increased risk of illness.

While psychology can do much to help heal and manage the impact of shame, it is only through Christ that the deepest wounds of the soul can be fully healed. The transformative power of Jesus brings hope and renewal, reaching into the innermost parts of our being to replace shame with grace, love, and a restored sense of worth. Christ's redemptive work offers the wholeness and peace that psychology alone cannot fully provide, lifting the burden of shame and allowing for true freedom and spiritual healing.



Hawkins (2014, 2020) argues that such low-energy emotions, like shame, essentially "kill the body and soul" by eroding one's sense of vitality, worth, and connection to others. Those trapped in shame often find it difficult to receive love, forgiveness, and grace, creating a barrier that isolates them from relationships with others and, ultimately, from God. However, through Christ alone, there is hope for transformational change that lifts us out of shame's grip and restores our souls.

Note: In fairness to the scientific method, we acknowledge that Hawkins' research has been criticized in the scientific community; mainly for its reliance on subjective muscle testing without rigorous scientific validation. Nonetheless, we appreciate that many people have found value in this framework for understanding consciousness and personal growth.

In this chapter, we will explore how the healing power of Christ reaches into the depths of our shame, replacing it with a new identity grounded in grace and love. Only through the restorative work of Jesus can the

wounds of shame be fully healed, allowing us to embrace the wholeness, freedom, and peace that He promises and provides.

Theologically, our soul is comprised of three parts: intellect, will, emotions. We tend to lump these together into our mind and heart, but in truth they work together in forming and delivering our thoughts, speech and actions through our physical self—our body.

God designed our spirit to be closely aligned and connected with Him. Our spirit is to guide and guard our soul, which, in turn, gives

expression to our body. We interact with our world and other people primarily through our body, but we should interact with God primarily through our spirit.

Romans 12:2 says transformation is the complete change of one life form into another. The Greek word for transformation is METAMORPHOO, the basis for our English word metamorphosis, which describes the biological process of a tadpole becoming a frog or a caterpillar becoming a butterfly. The latter life form is nothing like the former. Our new life in Christ will be equally distinct and separate from our old.

METAMORPHOO also describes the transformation of Jesus' physical body in Matthew 17:2. As the disciples watched, His appearance was transformed so that His face shone like the sun, and His clothes became as white as light. Our physical bodies will also be transformed when Jesus returns, and we are changed into His likeness in our entirety (see also 1 Corinthians 15:53).

Finally, Paul writes that the renewing of our mind results in our inner man(soul) being transformed: our intellect, will, and emotions, one aspect at a time, as long as we're living on this planet, making us more like Jesus.

"Instead, we will speak the truth in love, growing in every way more and more like Christ, who is the head of His body, the church" (Ephesians 4:15, NLT).

Remember, transformation is not just about changing our behaviors; it's about renewing our very essence. It is about becoming more like Christ, day by day, choice by choice, as our intellect, will, and emotions

align with His divine character and will. And as we embrace this process, we fulfill the beautiful truth that, through Him, we can truly become new creations.

Let this chapter be a reminder that transformation is possible, promised, and powerful. Keep moving forward in faith, knowing that God's work in you is not finished—it is only just beginning. May you find strength, courage, and the profound joy that comes from walking in His light and love.

"*And I am certain that God, who began the good work within you, will continue his work until it is finally finished on the day when Christ Jesus returns"* (Philippians 1:6, NLT).

Rethinking Medication:

Are We Reaching Too Quickly?

Allow us to begin this chapter by saying that we are not advising you to take or avoid any psychotropic medication. Please know that we respect those who have sought healing through psychiatric medication, and for those who prescribe with compassion and care. Many individuals have found real relief through psychotropic medications, and we do not question the sincerity or the good intentions behind their use. This is not a condemnation—it is a call for reflection.

That said, we believe it is time to slow down.

In recent years, we've watched with growing concern as medication has become one of the first responses to emotional and behavioral distress in children and adolescents. While there are cases where medication is absolutely warranted—particularly in severe or acute situations—it has become a default intervention far too often, offered before other meaningful paths are explored.

Our concern is not with medication itself but with the speed and frequency with which it is being turned to—often in the absence of deeper inquiry. Emotional pain, identity confusion, trauma, and developmental struggles cannot always be reduced to neurochemical imbalances. Nor can healing always be found in a pill.

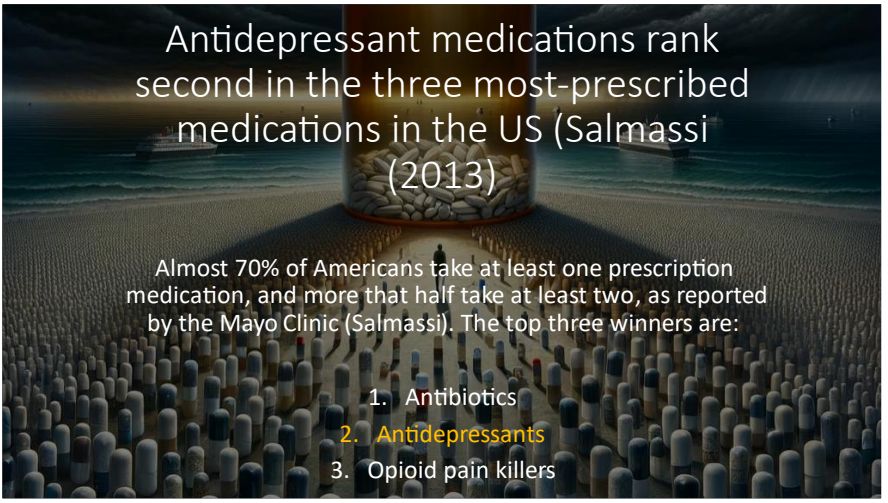
What if, before reaching for a prescription, we first reached for understanding? What if we prioritized connection, nervous system regulation, purpose-building, and truth-telling? What if we supported young people not just with symptom management but with the tools, guidance, and presence they need to become whole?

In this chapter, we explore how cultural pressures, institutional models, and ideological forces have contributed to an overreliance on psychotropics. We offer this not as an attack but as an invitation—to consider another way. A way that honors the complexity of the adolescent journey. A way that treats each young person not as a diagnosis but as a developing soul. A way that seeks first to understand, then to act—with wisdom, patience, and love.

Therefore, we recommend that you familiarize yourself with the outcome research as thoroughly as possible before taking any psychotropic medication. We have chosen to discuss only

antidepressant medications, as they are the most-prescribed of the psychotropics and, sadly, are the second most-prescribed medication in the United States – in rank order of number of prescriptions according to the Mayo Clinic and cited by Salmassi (2013):

1. Antibiotics
2. Antidepressants
3. Opioid pain killers

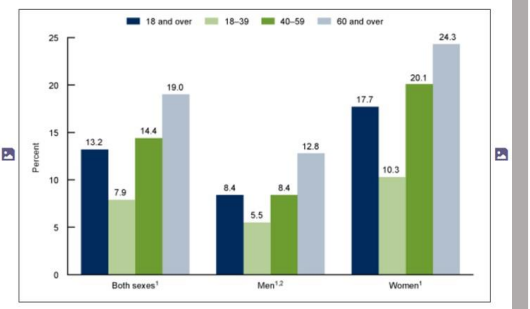


Empower yourself to ask your prescriber about any concerns you might have, including the content of this discussion. It has been said that as a culture, we are too quick to run from pain, and part of that process involves an overreliance on psychotropic medications. Robert Whitaker (2023) notes that in 1987, we spent about 80 million dollars on psychotropics, and in 2007, that figure rose to 40 billion dollars – an astounding 50 fold increase in just 20 years.

The data from the CDC indicates that an alarming percentage of people in the US are taking antidepressant medication.

SOURCE: National Center for Health Statistics, National Health and Nutrition Examination Survey, 2015–2018. (CDC, 2020)

Figure 1. Percentage of adults aged 18 and over who used antidepressant medication over past 30 days, by age and sex: United States, 2015–2018



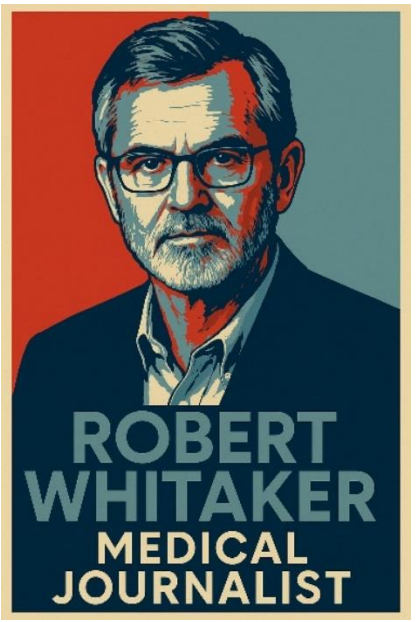
Robert Whitaker Speaks Out:

One of Jeff's literary heroes, Robert Whitaker, is an American journalist and author. He has been a prominent critic of the psychiatric medication paradigm, including antidepressants (Whitaker, 2010). Through his investigative work, Whitaker has raised significant concerns about the efficacy, safety, and long-term impacts of antidepressants, drawing attention to what he perceives, and we agree, as the over-medication of society and the influence of the pharmaceutical industry on psychiatric treatment.

Criticism of Efficacy and Long-term Outcomes

One of Whitaker's main criticisms regarding antidepressants is their efficacy and the quality of the evidence supporting their use. In his ground-breaking book, ***Anatomy of an Epidemic*** (2010), he examines the scientific literature and argues that while antidepressants may offer short-term relief, their long-term efficacy is questionable. He cites

studies that suggest the possibility of antidepressants worsening long-term outcomes for many patients. Whitaker addresses the issue of publication bias, where studies showing positive outcomes are more likely to be published than those showing negative or inconclusive results, potentially skewing the perceived effectiveness of these medications.



Dependence and Withdrawal

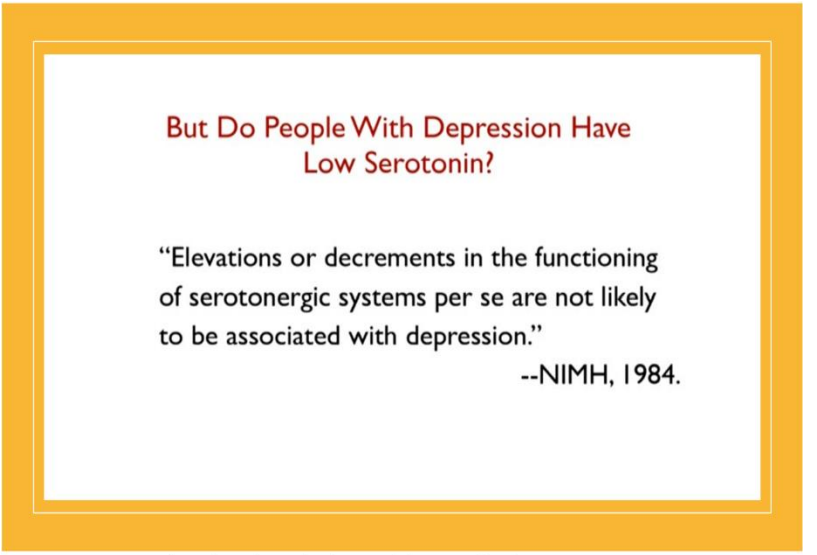
Whitaker also addresses the issue of dependence and withdrawal from antidepressants. He argues that the long-term use of antidepressants can lead to a physical dependence, making it difficult for patients to stop taking them due to severe withdrawal symptoms. This dependence is often not adequately discussed with patients prior to starting medication, according to Whitaker's findings. We are amazed that many of patients have not been sufficiently counseled about the side

effects of psychotropics such as Post SSRI (Selective Serotonin Reuptake Inhibitors) Sexual Dysfunction (PSSD).

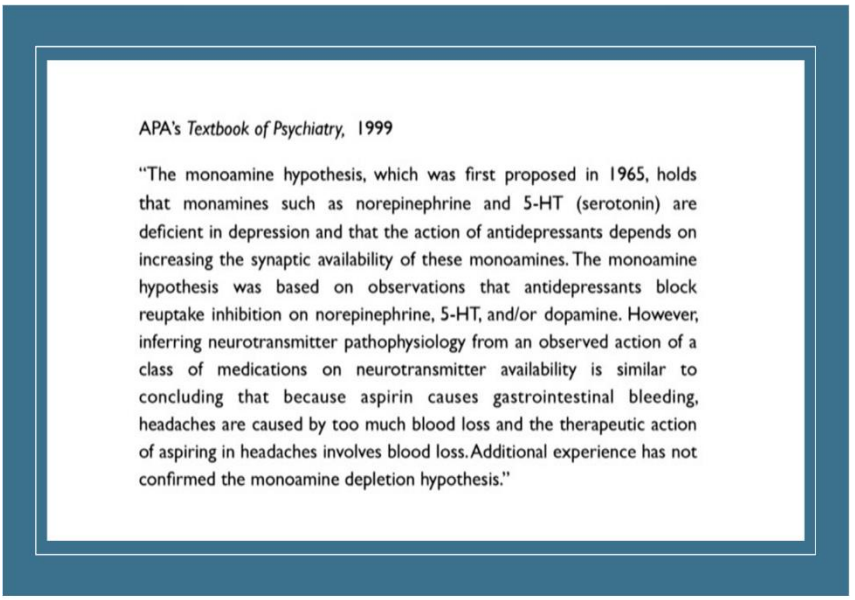
The Role of the Pharmaceutical Industry

A significant part of Whitaker's critique focuses on the role of the pharmaceutical industry in promoting the use of antidepressants. He accuses the industry of exaggerating the benefits and underplaying the risks of antidepressants and intentionally misrepresenting and influencing both prescribers and patients. Whitaker's investigative work argues that marketing strategies and financial incentives have contributed to the widespread use of these medications, often at the expense of more comprehensive approaches to mental health care.

The pharmaceutical industry knew early-on that the low serotonin model of depression was not valid, yet they propagated the myth, along with either mis-informed, naïve, or patently unethical and/or incompetent prescribers, that SSRIs corrected an imbalance.



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


APA's *Textbook of Psychiatry*, 1999

"The monoamine hypothesis, which was first proposed in 1965, holds that monamines such as norepinephrine and 5-HT (serotonin) are deficient in depression and that the action of antidepressants depends on increasing the synaptic availability of these monoamines. The monoamine hypothesis was based on observations that antidepressants block reuptake inhibition on norepinephrine, 5-HT, and/or dopamine. However, inferring neurotransmitter pathophysiology from an observed action of a class of medications on neurotransmitter availability is similar to concluding that because aspirin causes gastrointestinal bleeding, headaches are caused by too much blood loss and the therapeutic action of aspiring in headaches involves blood loss. Additional experience has not confirmed the monoamine depletion hypothesis."

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

Moreover, in an extensive metanalytic study, psychiatrists Joanna Moncrieff and Mark Horowitz (3023) critically examined and challenged the serotonin hypothesis of depression. The serotonin hypothesis posits that depression is caused by an imbalance of serotonin levels in the brain and that increasing serotonin activity through antidepressants can correct this imbalance. However, Moncrieff, Horowitz, and other researchers have presented unquestionable evidence that the low serotonin hypothesis is dead (Moncrieff & Horowitz, 2023).

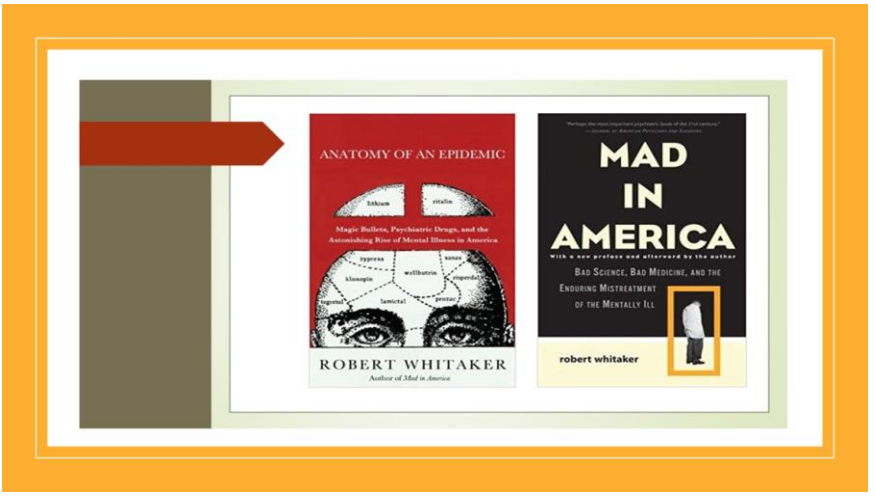
The deception that depression is an imbalance in serotonin promotes a disease model of depression and can lead one down the wrong path of healing. Moncrieff (2023), in a brilliant podcast interview, notes that Horowitz's research, along with her own, alternatively revealed that most depression stems from past trauma and/or difficult life circumstances and, moreover, that negative feelings serve as signals

that something is wrong and needs to be addressed. While antidepressants might offer some initial relief, namely, "If I just fix my brain with this medicine, my depression will remit," this reasoning comes at a steep price in that it takes away any sense of agency and reduces the likelihood that we can take responsibility for our lives and heal the pain rather than masking that pain.

Alternatives to Medication

Whitaker advocates, and we fully agree, for a broader approach to treating depression and other mental health issues, beyond the pharmacological/medical model. He highlights the importance of psychotherapy, lifestyle changes, social support, and addressing the underlying causes of mental health conditions as critical components of treatment that are often overshadowed by the focus on medication.

Robert Whitaker's criticism of antidepressant medications is part of a broader challenge to the conventional psychiatric treatment model. His work encourages a more nuanced conversation about mental health care, urging a reevaluation of the reliance on medication as the primary form of treatment. Whitaker's contributions have spurred an important and essential debate within the medical community and among the public, highlighting the dire need for a more holistic and informed approach to mental health treatment (Whitaker, 2010; Whitaker & Cosgrove, 2015).



Antidepressant Side Effects:

Although many good prescribers competently review side effects with their patients, far too many do not. Dr. Mark Horowitz is a psychiatrist, clinical researcher, and one of my heroes, and is known for his critical examination of antidepressant medications, particularly focusing on their efficacy, side effects, and the challenges associated with discontinuing their use. He has a background in psychiatry and neuroscience and has been involved in research and advocacy related to the careful use of psychiatric drugs, the importance of evidence-based approaches to medication tapering, and the reconsideration of how mental health conditions are understood and treated. Mark Horowitz has openly discussed his personal struggles with antidepressants, providing a unique perspective that blends professional expertise with personal experience. His journey with antidepressant withdrawal has informed his research interests and advocacy for better understanding and management of antidepressant discontinuation syndrome.

Horowitz has shared how his own attempt to taper off antidepressants led to severe withdrawal symptoms, underscoring the lack of guidance and support available for individuals trying to reduce or stop their medication. This experience highlighted the gap between clinical practice and the real-world challenges patients face when discontinuing antidepressants. It spurred him to focus on researching the mechanisms of withdrawal and advocate for the development of evidence-based tapering protocols to help patients safely discontinue these medications.

His personal encounter with the difficulties of antidepressant withdrawal has made him a vocal advocate for greater awareness of these issues within the medical community. He emphasizes the importance of prescribing clinicians being well-informed about the potential for withdrawal symptoms and developing personalized tapering schedules that account for each patient's response to medication reduction. Horowitz's work aims to bridge the gap between clinical research and practice, ensuring that patients receive care that supports both the initiation and discontinuation of antidepressant therapy in a way that minimizes harm and maximizes well-being. In his excellent and just published book, ***Deprescribing Guidelines for Psychiatric Medications***, he details, along with his co-author, Dr. David Taylor, the all-too-frequent mismanagement of these medications and how to safely taper off them. Specific to this discussion, he does a superlative job of bringing together the most recent research on antidepressant side effects, many of which are not shared with patients before they take them.

Emotional Numbing and Other Effects

- Emotional numbness – 71%
- Feeling foggy or detached – 70%
- Feeling not like me – 66%
- Drowsiness – 63%
- Reduction in positive feelings – 60%

Horowitz and Taylor (2024) note that emotional blunting appears to be a rather common and dependent consequence of antidepressant use. This is to say that you may feel the lows less, but you also feel the highs less.

Weight Gain:
It appears that long-term use of antidepressants may result in more weight gain than suggested in short-term trials. Specifically, studies suggest that there is a 30% risk of normal weight people becoming obese after 10 years of common antidepressant use than those not taking antidepressants.

Cognitive Effects:
Metanalytic Studies have found that some antidepressants can produce cognitive impairment in otherwise healthy controls – specifically on tests of information processing, memory, eye-hand coordination, and concentration. This finding might be particularly troubling for children and teens who may be struggling with academics.

Potential Increase in Dementia:
Horowitz and Taylor (2024) report that the research suggests that there is a dose-dependent relationship between total exposure to antidepressants and risk for eventual diagnosis of dementia. Quite

alarmingly, patients with the highest exposure to more antidepressants – more than three years of daily use of standard antidepressants – had a 34% chance of dementia than patients who had no exposure to antidepressants at all.

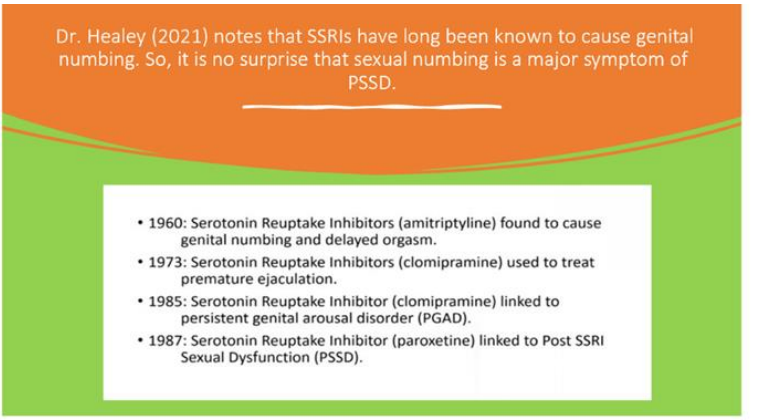
Bleeding:

Horowitz and Taylor (2024) note that SSRIs (Selective Serotonin Reuptake Inhibitors) and SNRIs (Serotonin-Norepinephrine Reuptake Inhibitors) inhibit the uptake of serotonin into platelets. Depletion of platelet serotonin reduces the body's ability to form clots and hence increases the risk of bleeding. This can, of course, have very serious consequences. For example, in coronary bypass procedures, they note research, which indicates a 50% increased risk of mortality in serotonergic antidepressants than non-users.

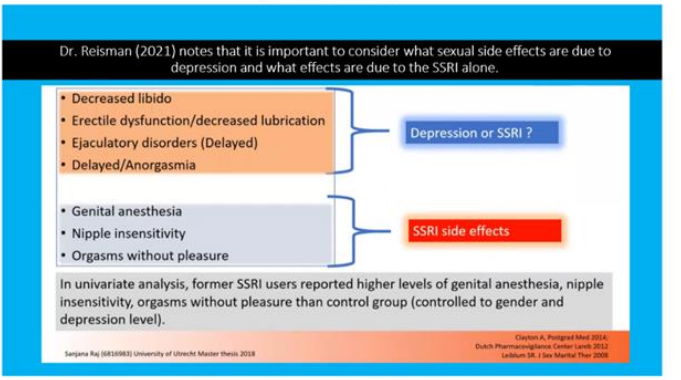
Sexual Effects:

And then there's the elephant in the room that far too many do not want to talk about. Horowitz and Taylor report that sexual adverse effects include a lack of desire, as well as reduced sexual sensation, and

failure to reach orgasm in both sexes and, very concerning, this occurs in 25% to 80% of patients, depending on the study. Moreover, and even more alarming, is that these sexual effects can persist even after cessation of antidepressants in a minority of patients. This condition is now called Post-SSRI Sexual Dysfunction (PSSD) and has been formally recognized by the European Medicines Agency. This is a devastating condition, and patients deserve to be warned about it, especially adolescents just beginning to explore their sexuality.



Healey (2021)
https://www.youtube.com/watch?v=yFxMeoaIc3c&ab_channel=ISSMInternationalSocietyforSexualMedicine



Reisman (2021)
https://www.youtube.com/watch?v=yFxMeoaIc3c&ab_channel=ISSMInternationalSocietyforSexualMedicine

Black Box Warning - Increased Suicide Risk

Surprisingly not summarized by Horowitz and Taylor (2024), suicide risk needs to be mentioned. Black Box Warnings are the most stringent labeling requirements that the U.S. Food and Drug Administration (FDA) can mandate for prescription drugs. They signify that medical studies have shown that the drug carries a significant risk of serious or even life-threatening adverse effects.

The warning about Selective Serotonin Reuptake Inhibitors (SSRIs), a class of drugs commonly prescribed for depression and anxiety disorders, is a notable example. In 2004, the FDA issued a Black Box Warning for all antidepressants, including SSRIs, highlighting the increased risk of suicidal thinking and behavior in children, adolescents, and young adults up to the age of 24, especially during the initial treatment phases (FDA, 2004). This decision was based on a comprehensive review of clinical trials that showed a higher rate of suicidal ideation and behavior in individuals within these age groups when taking antidepressants than those receiving a placebo. It is crucial for healthcare providers to closely monitor patients for worsening depression or emergent suicidality, especially during the first few months of treatment or when changing doses. The FDA's action underscores the importance of cautious use and vigilant monitoring of these medications in vulnerable populations (U.S. Food and Drug Administration, 2004).

Listed below are several of my distinguished and favorite medication critics who offer brilliant and well-researched perspectives on the topic

of psychotropic mismanagement. Some have taken a radical approach that no psychotropics are warranted, and others argue that there are times when psychotropics makes sense, but only in more severe cases, after all alternatives have been exhausted and when side effects are fully and completely disclosed. Personally, I subscribe to the latter camp. Judicious and well-thought-out medication can indeed save lives, but outcomes can be disastrous when incompetently administered. To be clear, we are not saying that antidepressants have no place. It is clear that in cases of severe depression, antidepressants can save lives. On the other hand, there is consensus amongst many professionals that there is little convincing evidence in cases of mild to moderate depression. Additionally, the potential side effects should make us cautious about starting these medications too quickly, especially given their significant side effects. We encourage you to talk with your prescriber about your concerns, and if that prescriber is indifferent to them or is not on top of the literature, consider moving on.

Criticism of the DSM:

This chapter would not be complete without a few comments on the DSM-5-TR, as it is the basis on which diagnoses are made that pave the path to medication and/or psychotherapy. Additionally, it allows providers to bill insurances for reimbursement. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR), despite being a crucial tool in psychiatry and clinical psychology, has faced several criticisms since its publication. Key concerns include its categorization of mental disorders, the validity and reliability of some diagnostic criteria, and its influence on clinical practice and insurance reimbursement.

Before we address the DSM-5-TR, we will need to take a look at the DSM III, as it is this revision that the DSM took a wrong turn. The time was 1980 when psychiatry was struggling to maintain its legitimacy and joined forces with the pharmaceutical industry. The decision was made to broadly expand pretty much everything to be a "disorder" because, in doing so, the disorders could be considered a "medical problem" that requires medication and, therefore, a billable event (Davies, 2013).

Dr. James Davies, a medical anthropologist, psychotherapist, and one of my favorite critics, questioned the utility of the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III) and its subsequent editions for several key reasons. His criticisms focused on the DSM's conceptualization, development, and impact on mental health practice (Davies, 2013, 2016, 2019). Here is a brief summary of his main points:

1. Pathologization of Normal Behavior: Davies argues that the DSM-III and its successors have increasingly pathologized normal variations in human behavior, leading to a massive inflation of mental disorder diagnoses. This expansion of diagnostic categories can turn what is really everyday challenges and emotions into unwarranted medical conditions, potentially leading to unnecessary medicalization and treatment (Davies, 2016).

2. Lack of Empirical Basis: Davies critiques the DSM-III for its lack of solid empirical foundations for many of its diagnostic categories. According to Davies (2016), the criteria for numerous disorders are not based on rigorous scientific research but on committee consensus, which can be influenced by various

non-scientific factors, including pharmaceutical industry interests.

3. Pharmaceutical Industry Influence: Davies (2016) has raised concerns about the potential influence of the pharmaceutical industry on the development of the DSM. He argues that the expansion of diagnostic categories can serve the interests of pharmaceutical companies by enlarging the market for psychiatric medications. This relationship between the DSM committees and the industry may bias the manual toward pharmacological treatments.

4. Reductionist Approach: He criticizes the DSM's reductionist approach to mental illness, which focuses on symptoms rather than the underlying causes of distress. This approach, according to Davies (2016), overlooks the complexity of mental health issues, including the socio-cultural and psychological factors that contribute to mental illness.

5. Impact on Clinical Practice: Davies (2016) is concerned about the impact of the DSM on clinical practice, suggesting that it encourages a checklist approach to diagnosis. This can lead to oversimplification of complex human experiences and may neglect the individual's unique context, root causes, and story.

6. Global Influence: Finally, Davies (2016) critiques the global influence of the DSM, arguing that it exports a Western model of mental illness to non-Western cultures. This can lead to cultural insensitivity and the inappropriate application of Western diagnostic categories in diverse cultural contexts.

Current concerns about the DSM-5-TR, which is the version now in use, repeats and expands on Davies (2013) points and include:

1. Over-pathologization and Expansion of Diagnostic Criteria: Critics argue that the DSM-5-TR has expanded diagnostic criteria for many disorders, potentially leading to the overdiagnosis of normal behavior as pathological. This expansion no doubt increases the prevalence rates of certain disorders without sufficient empirical evidence (Frances, A., 2013). For example, the broadening of criteria for disorders like Attention Deficit Hyperactivity Disorder (ADHD) and Generalized Anxiety Disorder (GAD) raises significant concerns about over-pathologizing normal variations in behavior and mood.

2. Lack of Empirical Support: Previous revisions and new additions in the DSM-5-TR lack robust empirical support. Certain diagnostic categories were included based on limited research, potentially leading to misdiagnosis and inappropriate treatment (Paris, J., & Phillips, J., 2013).

3. Reliance on a Categorical Model: The DSM-5-TR continues to use a categorical approach to diagnose mental disorders, which fails to capture the complexity and full spectrum of mental health issues (Kendell, R., & Jablensky, A., 2003). I would argue that a dimensional or spectrum-based approach could more accurately reflect the nuances of mental health conditions.

4. Financial Conflicts of Interest: Concerning questions have been raised about the potential conflicts of interest among the DSM-5-TR's authors and the insidious influence of the pharmaceutical

industry. It is probable that decisions may have been driven by interests that could benefit from expanded diagnostic criteria and increased medication prescriptions (Cosgrove, L., & Krimsky, S., 2012).

Summary: While we are not against the use of medication, we believe that it should be approached with more thoughtfulness and caution. Psychotropic medications, including antidepressants, certainly have their place, especially in severe cases where other interventions may fall short. However, there is a growing body of research indicating that their efficacy in mild to moderate cases may not be as robust as once thought, and the potential side effects—both immediate and long-term—must be carefully weighed. As the Bible reminds us, ***"The prudent see danger and take refuge, but the simple keep going and pay the penalty"*** (Proverbs 27:12, NIV). In the same way, it is prudent to fully understand both the benefits and pitfalls of these medications before deciding to use them.

The DSM-5-TR, which guides diagnoses and treatment plans, also has significant limitations. It has been criticized for over-pathologizing normal human behaviors, possibly driven by financial incentives rather than a holistic understanding of mental health. In our practice, we aim to look beyond this medicalized framework to see the person as a whole, considering their unique experiences and underlying traumas, not just their symptoms. ***"For the LORD gives wisdom; from his mouth come knowledge and understanding"*** (Proverbs 2:6, NIV). It is through this broader, more thoughtful approach that we can truly promote healing and well-being.

As we move forward, let us seek a balance—using medication judiciously when needed but always with an eye toward holistic healing that addresses the root causes of emotional pain. Through therapy, community, spiritual practices, and self-awareness, we can work toward true transformation.

Conclusion

A Journey of Hope and Healing

If you've journeyed with us to this final chapter, then you already sense the gravity of what we're facing: a generation in pain. Not just struggling—but unraveling. Not simply sad—but disoriented, fragmented, and often disconnected from the truth of who they are.

We've not written these pages to provoke controversy but to provoke ***compassion***—and awaken a sense of ***urgency***.

We are living through a moment in history when the emotional and spiritual scaffolding of childhood is being dismantled in real time. Adolescents, whose brains are still forming and whose identities are still emerging, are not being handed maps but mirrors—distorted ones. They are being asked to define themselves before they've even discovered all the elements of themselves. To choose their identity before they've built the character, purpose, or maturity to carry it. And they are being medicated, sexualized, politicized, and pathologized before they've had the chance to develop the resilience and rootedness that every child deserves.

We believe this is more than a medical crisis. It is a ***moral*** one. A ***cultural*** one. A ***spiritual*** one.

But we also believe something else, something deeper and more enduring: ***healing is possible***. Healing of the mind. Healing of the body. Healing of the fractured sense of self. And it doesn't begin with ideology but with ***truth***. Not with chemical suppression but with ***connection***. Not with reactivity but with ***reverence*** for what it means to be human.

NeuroFaith™: A Better Way Forward

The ***NeuroFaith™*** model is not simply a therapy framework. It is a reorientation of how we see suffering—and how we respond to it. It honors the best of neuroscience and the wisdom of Scripture. It integrates polyvagal-informed therapy, Internal Family Systems (IFS), and the revelations of neurocardiology and HeartMath. But it also does what few modern models dare to do, it brings faith into the clinical room.

Because without God, we may explain the brain, but we cannot touch or comprehend the soul.

NeuroFaith™ says to the hurting teenager: "You are not broken beyond repair. You are not your trauma, your diagnosis, or your disordered thoughts. You are beloved. You are designed. And you are not alone."

This approach reminds us that the body is not just a machine to be corrected but a vessel for meaning. That emotions are not symptoms to be suppressed but signals to be understood. That behavior is often the language of unmet needs, unprocessed pain, and forgotten worth.

When we work with adolescents, we don't ask, ***What's wrong with you?*** We ask, ***What happened to you?*** And then we listen. We attune. We walk with them. And we bear witness to the holy and often non-linear process of becoming whole.

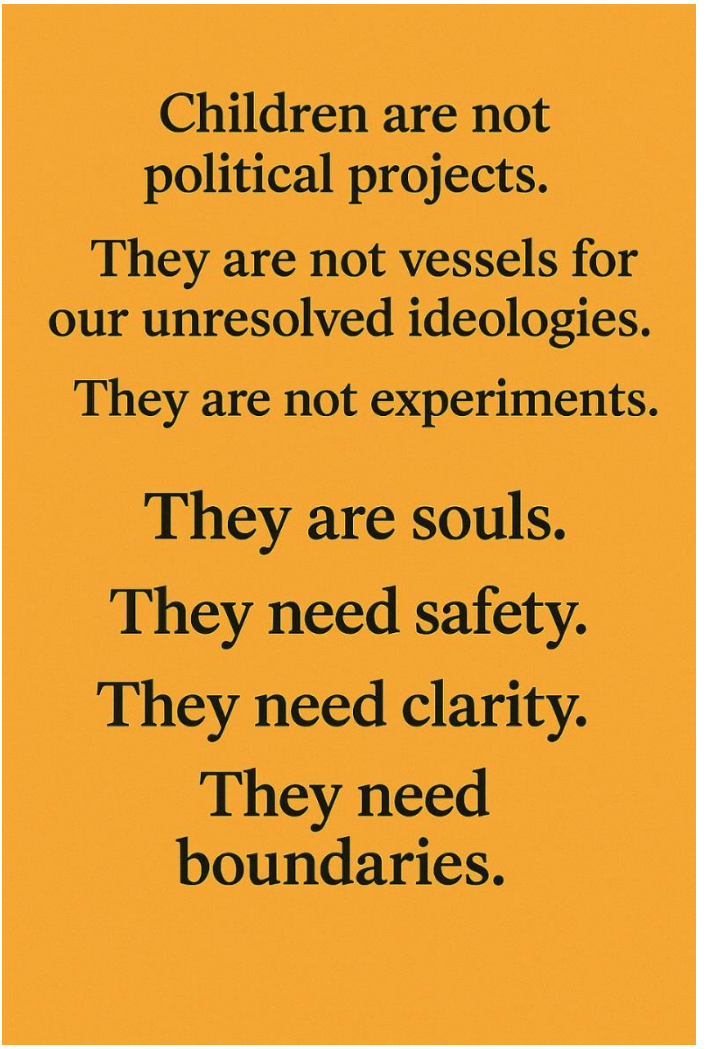
Where DO We Go From Here?

What would it look like if we approached the adolescent depression epidemic with the same gravity and intentionality we give to cancer, heart disease, or trauma surgery?

- It would mean creating spaces where children are safe to tell their stories without being labeled.
- It would mean training parents, teachers, and clinicians to regulate their own nervous systems so they can co-regulate with kids in distress.
- It would mean using medication sparingly, wisely, and only when the situation is acute—and not as a substitute for relationship or presence.
- It would mean protecting children from ideologies that confuse more than clarify and guarding their hearts and minds as sacred ground.
- It would mean re-centering childhood around the things that truly heal: love, truth, faith, attunement, and time.
- And it would mean giving adolescents what they most need—not more noise, more screens, or more labels—but ***meaning***.

A Final Word of Hope

We wrote this book because we believe some things are profoundly simple, yet increasingly radical:



Yes, they need ***us***—not as experts or enforcers but as witnesses, shepherds, and co-regulators who will walk with them into the wholeness that God designed them for.

Let us remember, adolescent depression is not a phase. It is a cry for something deeper. A longing for groundedness in a world that offers only identity performance. A hunger for authentic connection in a culture drowning in artificial validation. A search for truth in an age of confusion.

We must not be silent. We must not be passive. But we must also not despair. There is a better way.

There is ***NeuroFaith™***.

And there is hope.

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Addendum

The Hippocratic Revival

Bringing Medicine and Mental Health Back to First Principles

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

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

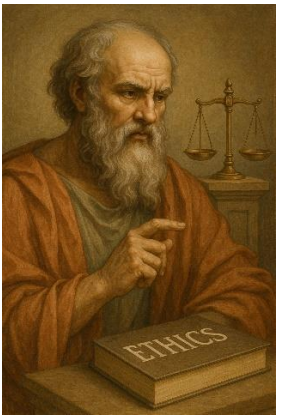
Yet Hippocrates' legacy runs even deeper. By establishing a school of medicine set apart from contemporary healers by swearing to and obeying the Hippocratic Oath, he transformed the practice of medicine from a simple occupation into a profound covenant between healer and patient. This solemn promise,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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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