



Mind *And* Brain: Separate but Integrated

(©Copyright 2004 K.D. Lehman MD & C.E.T. Lehman MDiv, DRAFT-New 12/11/2004, revised 2/3/2005)

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

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

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

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

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

from the biological brain perspective.²

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

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

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

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

A. Evidence supporting this hypothesis:

1. Brain mapping research: Epilepsy is often caused by an irritable focus in the brain – often some kind of scar tissue. One way to treat epilepsy is to remove the irritable scar tissue. When neurosurgeons do this, it is very important to know exactly where to cut, which was especially difficult in the early days before CT scans, MRI scans, and contrast dyes. One method that was developed for finding the location of the seizure source was to stimulate the brain with a small electrode, until the patient experienced symptoms similar to his seizures – this was done with the patient awake during the surgery. For example, if the seizure always starts with the left thumb twitching, the surgeon would stimulate different areas of the cortex until the left thumb twitched. Sure enough, the offending scar tissue/tumor/whatever would

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

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

be found very close to this spot. This technique was also used to identify and avoid especially important areas during surgery (for example, the right index finger or the primary language center). As this technique was used, neurosurgeons discovered that different anatomical areas of the brain have very predictable functions. For example, the motor functions of the body are always controlled by the cortex along a certain fold of the brain, touch is received by a certain fold right next to the motor cortex, the visual system is run by the optic cortex at the back of the brain, etc. This is how we got the “brain map” diagrams you see in every neurology and neurosurgery textbook.

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

Dr. Penfield wrote an entire book, *The Mystery of the Mind*,⁴ discussing the research evidence, personal experience, and thinking that lead him to this conclusion. The simplest, clearest point is that he spent his entire career mapping and studying the functions of various parts of the brain, and to his surprise, he never found the location of the *mind*. He found all of the different functions of the computer – the computer that the mind uses to implement its intentions – but he never found the brain location of the mind. He found that he could stimulate *any* area of the cortex *without producing forced/involuntary mind functions*, and he found that *any* area of the cortex could be injured or removed surgically *without losing the mind functions*.⁵ Even if the pre-frontal cortex – the part of the brain associated with the highest level of abstract reasoning, complex thought, and cognitive management of emotions – is stimulated, the patient does not experience forced/involuntary *mind* functions, and even if the pre-frontal cortex is damaged or removed, the *mind* – *the subjective experiences of consciousness and self awareness, the ability to make free will choices, and the ability to initiate original, creative thought and activity* – still remains. The person is terribly impaired in his ability to function cognitively and emotionally, but *consciousness, self awareness, the ability to make free will choices, and the ability to initiate original, creative thought and activity* still remain.⁶

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

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

⁶ I have read case descriptions, but have never worked directly with patients who have had full, bilateral frontal lobotomies. It would seem that if the frontal cortex were completely removed on both

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

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

sides, the mind might be present, but have no way to express itself. I would appreciate hearing from anyone who has worked with these patients – let me know whether or not you perceive *mind* functions operating in these patients. E-mail me at drkarl@kclehman.com.

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

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

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

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

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

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

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

b. II Cor 5:8: Some perceive that II Cor 5:8, “to be absent from the body is to be with the Lord,” presents a Biblical truth that precludes near death “out of body” experiences. My perception is that careful observation strongly indicates that near death “out of body” experiences are real, and so it is important to carefully consider the possibility that this interpretation of the passage is in error in some way. I am not a Biblical scholar, but when I examine II Cor 4:7-5:10 as the wider context, my perception is that the intention of II Cor

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

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

5:8 is not to make precise comments regarding whether or not there is a brief transition phase of mind-body separation after clinical death but before the person is with the Lord (the phenomena described in NDEs). My perception is that II Cor 5:8 is a part of a bigger argument, and that it is referring to the general phenomena of going to be with the Lord after physical death as part of this larger discussion.

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

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

Russ Harris: Russ Harris, a man in our church whom I have known for more than 35 years, had a profound near death experience which he has described to me in detail. My father and other elders from our church were in his hospital room praying for him when he died – my father was standing at the foot of his bed and saw the heart monitor stop. They prayed, he came back, and he reported a very clear near death experience including an encounter with Jesus. Jesus: "You have to go back, your work isn't done yet," Russ: "You're the boss." Russ also reports that this near death experience has had a powerful, positive, transformative effect on his life (see "Stories of Unusual Encounters with the Lord" on the "Other Resources" page of our website, www.kclehman.com, for a detailed account of this story).

d. Near death experiences described by other physicians: A number of physicians describe cases of patients who accurately reported, in detail, the comments of the medical personnel and the specific medical interventions the medical personnel had used during their resuscitations – medical procedures and comments that had occurred while they were clinically dead (unconscious, with no respiration or heart beat). Maurice Rawlings, a committed evangelical Christian and a cardiologist who has personally resuscitated many patients from clinical death, reports: "Some of my patients have demonstrated astounding powers of recall, accurately reconstructing the events that occurred during the resuscitation, exactly recalling which procedures we used, and describing what each person

said in the room and what type and color of clothes each one wore.” There are also numerous accounts where the resuscitated patients accurately reported events that had occurred in nearby rooms in the hospital during the time the patients were “dead,” and the events they reported were corroborated by other medical staff and/or family members.¹² Especially intriguing data points are provided by case studies of blind patients who can accurately describe *visual* details of events that occurred during their near death experiences.¹³

Since the anecdotal accounts described by authors publishing in the 1970's and 1980's, many careful research studies have examined near death experiences. For example, in a 2001 article published in *Lancet*, one of the most prestigious medical journals in the world, doctors van Lommel, van Wees, Meyers, and Elfferich describe their *prospective*¹⁴ study of 344 consecutive cardiac patients who were successfully resuscitated after cardiac arrests. The prospective study design allowed the investigators to interview the patients within days of being resuscitated, and also allowed for much more careful and accurate examination of all medical details during the cardiac arrests and resuscitations. 12% of the patients in this study acknowledged near death experiences, and in careful comparison with the patients who did not report near death experiences, Doctor van Lommel and colleagues could not find any physical science/medical explanation for the “near death experience” phenomena. This 2001 *Lancet* article also includes an account of one specific case in which a coronary care unit nurse verified the accuracy of the patient’s detailed descriptions of events that had occurred while he was receiving CPR and in deep coma.¹⁵ The “Atlanta Study,” carried out between 1994 and 1996 by Dr. Michael Sabom, a practicing physician who is board certified in both internal medicine and cardiology, provides another example of recent, careful research regarding near death experiences. One of the patients in this

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

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

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

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

study described detailed memories of the events that had occurred in the operating room while she was clinically dead, with no heart beat and no respiration. Furthermore, since this occurred during a particular, unusual brain surgery procedure, there is rigorous medical documentation specifically verifying that there was no blood in her head during this time, and the EEGs from her cortex and her brainstem were both completely flat-line. Dr. Sabom also carefully documented the accuracy of her detailed descriptions, which were corroborated by both the surgical records and by testimonies from the operating room personnel.¹⁶ In a 2002 article published in *Resuscitation*, another mainstream medical journal, Sam Parnia and Peter Fenwick state:

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

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

4. “Impossible” intra-uterine and birth memories: We have seen prayer for emotional healing sessions that appear to go to memories in the womb that are very early – when brain development is still very primitive, or even before the brain has begun to form at all – and we often see prayer for emotional healing sessions that appear to go to the person’s birth. Other authors have also described case studies that include memories for events that occurred while the person was still in the womb, and/or memories for events during the person’s birth. Some of these cases include memory content that is consistent with implicit memory systems

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

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

now known to be neurologically “on line” by mid pregnancy – sensory fragments appropriate to the intrauterine environment, simple emotional associations, and primitive, vague thoughts.¹⁸ However, some of the cases in our experience and some of the cases described in the literature include clear and detailed memory content that a person should not be able to remember with the immature brain biology in place during pregnancy or at the time of birth. For example, one of my patients seems to remember events from the time of her conception (before the brain has even begun to form), another of my patients seems to have intrauterine memories of the details of an argument her parents had about whether or not to abort her, and Dr. Thomas Verny describes an interesting case in which a young child appears to remember the specific words spoken by those present at his birth, including the “adult” vocabulary used by the stressed-out doctor, and the *Latin* spoken by the priest who was present. Neurologically, the memory content and detail that some of these people describe should not be possible. However:

- The material can sometimes be verified by the patient’s parents (who are often astonished). For example, when my patient asked her parents about their argument regarding whether or not to abort her, they were astonished (and mortified). Nobody had been present, and they each knew they had never told anybody. But they verified that her memory was correct.¹⁹ In the case of Dr. Verny’s patient, it was actually the child’s mother who realized that the words he was speaking were the specific words spoken by those present at his birth.²⁰
- There is clear, profound, and lasting fruit. Following the sessions in which people appear to receive healing for traumatic intrauterine and/or birth memories, these people experience changes in their lives that seem clearly connected to the material addressed in the sessions. This was the case for the patient mentioned above who appeared to remember events from the time of her conception. The “Freedom from Bulimia” case study provides another good example, describing sudden, dramatic, and lasting clinical improvement following what appeared to be healing for an intra-uterine traumatic experience.²¹

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

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

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

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

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

²¹ “Freedom from Bulimia: Case Study/Testimony,” “Case Studies & Testimonies” page I www.kclehman.com.

a. “Blind Tom,” a musical prodigy: “Blind Tom,” born as a slave in 1849, displayed astonishing musical abilities in spite of being nearly blind, mentally retarded with respect to most cognitive functions, and without musical training other than listening to others perform. For example, at 11 years of age he performed 33 pages of complicated original²² music, without error or apparent effort, after hearing it played once. He could also sing the words of any song after a single hearing, even if the lyrics were in foreign languages that he did not understand. Another particularly striking talent was the ability to perform three pieces of music simultaneously – playing one song with his right hand, playing a second song with his left hand, and singing a third song all at the same time.²³

b. The twins, numerical and memory prodigies: The neurologist Oliver Sacks describes twin brothers, who have baseline IQs of 63 but also extraordinary numerical and memory abilities. John and Michael can describe the general public events they would have heard about, the weather, and the tiniest visual details of their own personal experience for any day of their lives. They also appear to possess an unlimited digit span.²⁴ “And if you ask them how they can hold so much in their minds – a three-hundred-figure digit, or the trillion events of four decades – they say, very simply, ‘We see it.’ And ‘seeing’ – ‘visualizing’ – of extraordinary intensity, limitless range, and perfect fidelity, seems to be the key to this.” Even more unusual, in some ways, is their ability to generate ENORMOUS prime numbers, in a matter of minutes, by some inexplicable means. Dr. Sacks verified the accuracy of the six, eight, and ten digit primes they came up with (the largest primes available to the scientific and engineering community in the 1960's when he worked with the twins), and then they continued upwards to what appeared to be twenty digit primes – numbers *10 billion times larger* than the largest primes in the professional table he was using.²⁵

c. Sherashevsky, a memory prodigy: The Russian psychologist, A.R. Luria, presents an unusually well-documented case of a memory prodigy in *The Mind of a Mnemonist*. Among many prodigious memory abilities, this subject had photographic recall of numerical tables. After examining a table of 50 numbers for only several minutes, he could recall the table with such vivid internal mental clarity that he could “read” the numbers accurately in any direction/combination, even 10 to 15 years later, and in spite of thousands of similar memory exercises during the intervening time. After almost 30 years of careful,

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

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

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

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

systematic study of Sherashevsky's memory, Luria comments: "It was impossible to establish a point of limit to the capacity or the duration of his memory..."²⁶

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

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

6. The effects of the mind/brain on physical systems (random number generators): Over the last 30-40 years a number of investigators have been studying the ability of the mind/brain to influence random number generators – a physical system in which it is especially easy to evaluate for statistically significant effects. The experiments have involved some form of microelectronic random number generator²⁸ and a human observer who was instructed to attempt to "influence" the distribution of the random numbers solely by *intention* – *willing* the numbers to change in some particular way. One of the most intriguing aspects of this research is that many of the studies included will/intention *across time*. That is, the random number generator was run as much as *a week before* the experimental subject tried to influence the results. Amazingly, both the "regular" and the time delayed experiments showed statistically significant results. In fact, in 1989 Dean Radin, Department of Psychology at Princeton University, and Roger Nelson, Department of Mechanical and Aerospace Engineering at Princeton University, published a meta-analysis²⁹ of all the known studies of the effects of will/intention on random number generators – a total of 832 studies conducted by 68 different investigators. In most medical research, an experimental result is considered statistically "significant" if there is less than 5 chances out of 100 that the finding could have occurred by chance. Statistical analysis of the cumulative data in Radin and Nelson's meta-analysis revealed HUGELY significant results – the probability that the effects could have been produced by chance was 1 in 10 to the 35th power. That's 1 out of

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

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

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

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

100,000,000,000,000,000,000,000,000,000 – 20 million million billion trillion times less than the usual “5 chances out of 100” that most scientists consider statistically significant.³⁰ This might seem like a bit of overkill, but it actually seems to be necessary, since many scientists (and lay people) still refuse to believe will/intention can influence physical systems, even in spite of these overwhelming statistics.

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

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

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

From a “brain biology is the *only* reality” perspective: Brain biology can provide good guidance about how to use medication to moderate symptoms, but the huge pile of neuropsychiatric theory and data are essentially useless for understanding or resolving any underlying mind/spirit issues. For example, if I am working with someone who has major depression, neuropsychiatric research tells me that certain areas of the patient’s brain are over-functioning and others are under-functioning, that these patterns of brain dysfunction are associated especially with decreased activity in serotonin pathways, that many of the patients symptoms, such as poor sleep and decreased energy, are directly connected to the decreased serotonin, and that medications that increase serotonin activity will moderate (or even temporarily resolve) the overall clinical picture of depression. But information about the biological brain provides no insight regarding underlying mind/spirit issues, and no guidance regarding how to resolve them. Why does the person struggle with the same persistent, recurrent negative thoughts each time he gets depressed? Why does he believe he is powerless and worthless, even though this makes no sense in his present life? And how can these thoughts and emotions be permanently resolved so that he doesn’t have to be

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

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

on medication for the rest of his life? Neuropsychiatric research can *describe* the abnormal brain biology *associated* with the clinical picture of depression, and provide guidance about how to correct the brain biology abnormalities, but it doesn't have a clue about how to answer these mind/spirit questions.

From a “mind *and* brain” perspective: When we use a model that recognizes both the biological brain *and* the non-biological mind/spirit, then we can also embrace mind/spirit-based observations and theories. I find the observations and theories included in mind/spirit-based treatment approaches, such as Theophostic[®]-based³² emotional healing ministry, to be intuitively understandable and to be very useful in guiding my thoughts and decisions in actual clinical practice.³³ For example, if I am working with someone who has major depression, I find that psychological traumas, such as being abused and then abandoned by an alcoholic father, result in memory anchored negative cognitions/lies in a way that “makes sense” intuitively. And I find that these negative cognitions/lies, such as “I’m worthless” and “I’m powerless,” result in recurrent depression in a way that “makes sense” intuitively. And furthermore, I find that the principles and techniques included in “Theophostic[®]-based” emotional healing ministry (or similar healing approaches, such as EMDR) provide specific guidance about how to resolve these memory-anchored lies. An especially important data point in my personal clinical experience is that the guidance regarding how to resolve these lies not only makes sense intuitively, but also *works*. I consistently see these principles and techniques result in the permanent resolution of the memory-anchored lies, and I then also see the clinical picture of major depression resolve *and remain resolved, even without maintenance medication!*

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

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

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

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

³³I find useful and understandable theory and observations especially in cognitive therapy, exposure therapy, EMDR, and Theophostic[®] Prayer Ministry.

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

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

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

3. Car “behavior” – *driver* questions vs *machinery* questions: Let’s say you are trying to figure out “What’s going on? Why is this happening?” with respect to a car traveling from Evanston, Illinois to a certain small town in Kansas. If you want to understand the observable “behavior” of this car, you need to approach *driver* behavior questions from a human mind perspective, and *machinery* behavior questions from a physical science perspective. For example, if you want to know why the car is taking the trip in the first place, you study the mind of the driver. From the driver behavior perspective, one simple sentence answers your question: “Karl wanted to visit his parents, so he drove his car from his house to their house.” From the machinery behavior perspective, you could analyze every aspect of the chemistry and physics of the situation – the energy released by combustion of

gasoline, the pressure applied to the piston heads, the torque in the steering column, the traction and torque interactions between the tires and the road, etc – without getting any useful information regarding why the car is going to Kansas. The chemistry of combustion, the mechanics of the engine, and the traction between the tires and road did not *produce* the trip or *cause* me to go to Kansas. The car is simply the mindless vehicle that I use to implement my intention to visit my parents, and studying the chemistry of combustion, the mechanics of the engine, and the traction between the tires and the road can only provide the physical science explanation of how the car accomplished what I directed it to do. If Karl decides he doesn't want to go to Kansas after all, you need to talk to Karl about the importance of visiting his parents – getting a mechanic to work on the car won't fix the problem. However, if “What's going on? Why is this happening?” is being asked in reference to the unfortunate discovery that the car won't start after stopping at a rest area in Iowa, you study the machinery of the car. “Is the fluid in the battery too low? Did somebody leave the lights on? Is the alternator working properly?” If the alternator has burned out, you need to call a tow truck and find a mechanic – talking to Karl about whether or not he should visit his parents won't fix the problem.

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

4. “Understanding” a picture – physical sciences perspective vs. mind perspective: If you want to understand the meaning of a picture, you can “look at it” from a *mind* perspective, and say “Oh, it's a picture of a mother holding a baby.” From the physical sciences perspective, you can analyze the microscopic structure, chemical composition, light absorption, etc. of each spot on the canvas, and the complex neurological processes the brain uses to process the incoming visual stimuli. This is appropriate and valuable information if you are trying to design better canvas fabric or if you are treating certain medical vision problems, but even a huge pile of this kind of scientific information will not be able to answer mind questions, such as “What is the picture about? What does it mean?”

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

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

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

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

1. Learned helpless rats: A number of studies have worked with rats that were placed in an experimental set-up where they had no way to prevent or escape mild shocks. After initial protest, they appeared to learn "I am helpless," and became clinically depressed (as indicated by all the signs and symptoms of depression that can be observed in a rat, such as decreased activity, social isolation, decreased pleasure seeking behavior, impaired attention, changes in appetite and eating, abnormal sleep patterns, etc.). The brain chemistry in the rats also became abnormal, consistent with biological brain depression. The experimental set-up was then changed so that the rats did have options, but they appeared to continue functioning with what in Theophostic® terms would be a metamorphic lie. Even though they had options, they still appeared to believe what was now a lie: "I am helpless." They continued to lie (despondently?) in their cages, displaying the same indicators of depression and making no attempt to escape or stop the shocks. The rats were then given antidepressant medication. The observable signs and symptoms of depression resolved, the brain chemistry returned to normal, *and the rats quickly discovered the new levers in their cages and learned to press them to escape the shock*.³⁴ This is a fascinating indicator of the intimate mind-brain connection – using antidepressants to manually correct the abnormal brain chemistry seems to protect the rats from being functionally/behaviorally crippled by the "I am helpless" lie, which previously seemed to prevent them from discovering that they were no longer helpless.

One particular study is even more intriguing. A group of "learned helpless," clinically

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

depressed, brain chemistry abnormal rats did not receive antidepressant medication, but did receive “therapy.” The researchers manually moved their paws to the new levers, and thereby “taught” them how to use the new levers to stop the shocks. The rats appeared to learn that they were no longer helpless, and began to use the levers on their own. And the *observable signs and symptoms of depression disappeared after the rats learned that they were no longer helpless*. This research suggests that traumatic experience can result in internal negative beliefs (hypothesized in this experiment – but it sure looks like it), which then cause the clinical picture of “mental illness.” It shows that medication can decrease the signs and symptoms of the mental illness at the same time that it corrects the brain chemistry abnormalities. Furthermore, it shows that when the “lie” (“I am helpless”) is eliminated, *even without medication*, the clinical picture of mental illness and corresponding brain chemistry abnormalities³⁵ are also resolved.³⁶

I initially wondered about the ease with which these lies were resolved. Then I realized that these rats learned the “I am helpless” lies as adults, through a brief series of training sessions, and then had new experiences only days or weeks later that helped them “unlearn” the “I am helpless” lesson. This is very different from lies learned in childhood and carried for many years, and especially different from situations where childhood lies are reinforced by similar experiences that give the same message over and over again. I also wondered whether the improvement with medication was permanent, but then realized that the antidepressants chemically neutralized the immobilizing effects of the learned helplessness, enabling the rats to *experientially* replace the lie with the new truth “I am not helpless any more.” In light of the comments above regarding adult vs. childhood experience, I would expect this to permanently resolve the problem (I have not found any studies where this prediction is tested by stopping the antidepressants and observing the rats for “relapse”).

2. PET scans of medication and psychotherapy for OCD: One study used Positron Emission Tomography (PET) scans to observe the “real time,” living activity of the brains in people with obsessive compulsive disorder (OCD). People who met full DSM IV criteria³⁷ for OCD were shown to have a consistent abnormal pattern on their PET scans. One group was treated with Prozac. The signs and symptoms of OCD decreased and the abnormal PET scan results were seen to return to normal as the signs and symptoms of OCD decreased. A second group received no medication, but rather used cognitive-behavioral therapy to challenge and change

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

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

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

the behaviors, distorted negative beliefs, and emotions associated with OCD. This group also demonstrated decreased signs and symptoms of OCD and their abnormal PET scans also returned to normal as the signs and symptoms of OCD decreased. The striking point of this research is that therapy targeting distorted thoughts, feelings, and behavior can change the medical PET scan in the same way that medication does, and at the same time as it reduces the signs and symptoms of OCD.³⁸

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

1. My own patients: I have had the privilege of providing both the psychotherapy/ministry and the medication management for a number of patients. Several of these patients met rigorous DSM IV diagnostic criteria for one or more major mental illnesses (such as major depression, panic disorder, obsessive compulsive disorder, phobias, post traumatic stress disorder, and eating disorders),³⁹ and experienced symptoms that were severe enough to cause marked disability. These people experienced marked improvement with medication (they required moderate to high doses of psychiatric medications in order to be able to function at work and/or at home), and experienced return of disabling symptoms if the medication dosage was decreased.

After this history had clearly been established, we began using EMDR and/or Theophostic®-based emotional healing ministry for the psychotherapy component of their care.⁴⁰ As we worked with these emotional healing tools, we identified and addressed psychological trauma (and associated lies, truth-based pain, reactive sin, demonic infection, etc.) that seemed, intuitively, to be connected to the symptoms of their mental illnesses. As the healing process continued, these people would say things like “I know that’s where the panic was coming from – I can feel that the roots of the panic have been resolved,” or “I feel like I am on too much medication – I think we have been getting at the roots of my depression, and I don’t think I need as much medication any more.” In most of these situations, we were then able to reduce or stop the medication *without relapse*.⁴¹

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

³⁹ I personally obtained thorough diagnostic histories and performed mental status exams, which revealed signs and symptoms meeting DSM IV diagnostic criteria, and these diagnostic histories and mental status exams are carefully documented in the medical records for these patients.

⁴⁰ For some of our patients, this history of rigorous diagnosis, need for medication, and relapse with decreased dosage had been thoroughly established before they came to us, and we began EMDR and/or Theophostic®-based therapy immediately. For others, we established the diagnostic and medication history in our practice, before we learned about EMDR or Theophostic®-based emotional healing. In a few patients, the healing work was slow enough that we decided to use medication even as we continued ongoing healing work with EMDR and/or Theophostic®-based therapy. We do not ever withhold emotional healing work in order to first make careful diagnoses and establish medication history.

⁴¹ In most of these situations, I have been able to carefully follow the clinical picture for at least 2-5 years (some now with 8 years of follow-up), and so have been able to personally verify that the patient did not experience relapse after the medication reduction/discontinuation. Occasionally, some symptoms

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

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

2. Other cases I am involved in: In addition to my own patients, I am also involved with a number of similar cases where I am not the care provider, but where I have obtained detailed history of the same clinical components. See, for example, the “Freedom from Bulimia” case study on the “Case Studies” page of www.kclehman.com.

3. Case studies published by other authors: Other authors have also published case study descriptions that demonstrate these intimate mind-brain connections. For example, in *Why Do I Feel So Down When My Faith Should Lift Me Up?*, Dr. Grant Mullen describes a patient with a long history of depression and mood instability that were so severe as to be disabling. This patient experienced dramatic and lasting improvement with medication – demonstrating that biological brain dysfunction was present, but was then able to reduce, and eventually completely discontinue the medication as she received deliverance and emotional healing – demonstrating that resolving mind/spirit issues resulted in correction of the dysfunctional brain biology.⁴²

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

have returned when “new” (previously buried) issues were brought to the surface by some new and/or particularly intense trigger, but these symptoms again resolved when the newly discovered issues were resolved.

⁴²Mullen, Grant. *Why Do I Feel So Down When My Faith Should Lift Me Up?* (Kent: Sovereign World Ltd), 1999, pages 63-65.

and lack of side effects, for many years. Addressing non-biological mind/spirit issues clearly affected the way the medication interacted with his biological brain.⁴³

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

1. Truth-based psychological pain, memory anchored lies, reactive sin/sinful defenses, and demonic infection associated with mental health concerns: I perceive the most mystery, and feel the most uncertainty, regarding the phenomena that seem most purely mind/spirit – truth-based psychological pain, memory anchored lies, reactive sin/sinful defenses, and demonic infection. Near death experiences, as discussed above, prove that it is *possible* for mind/spirit phenomena to continue while the biological brain is totally off line, but do mind/spirit phenomena such as thoughts, beliefs, and choices *usually* have physical, biological brain processes that are directly and closely associated with them? I don’t know. Interestingly, there is no clear scientific evidence demonstrating biological brain processes directly corresponding to consciousness, self awareness, thoughts/beliefs, free will choices, or demonic phenomena. Therefore, the mind/spirit issues contributing to mental illnesses, such as truth-based psychological pain, memory anchored lies, sinful defenses, and demonic infection, *may* operate primarily in the non-biological mind/spirit realm. They can influence the physical body in various ways,⁴⁴ but there may not be closely connected biological brain processes directly associated with each detail of these mind/spirit phenomena in the same way that occurs with emotions and physical symptoms. Possibly the most important way that these mind/spirit phenomena interact with the biological brain is *through emotions*.

2. Emotions associated with mental health concerns: My perception is that the mind and brain are so intimately connected at the point of emotions that the final subjective experience of any given emotion is actually a mixture of biological brain phenomena and non-biological mind phenomena. On the one hand, it seems clear that our emotions at any given moment correspond exactly to our *true* thoughts and *experiential* beliefs at that moment.⁴⁵

⁴³ Sacks, Oliver. *The Man Who Mistook His Wife for a Hat*. (New York: HarperCollins) 1970, pages 92-101.

⁴⁴ If the mind can affect random number generators, it should be able to exert effects on the biological brain and even the rest of the physical body. Case studies described by various people working in healing ministries also indicate that thoughts, beliefs, and choices (e.g., vows) can have significant and direct effects on the physical body (including the biological brain, but not limited to the brain). There is certainly a lot of mystery here.

⁴⁵ I include “*true* thoughts and *experiential* beliefs” because our emotions do not correspond to what we ought to think and believe, to what we try to think and believe, to what we might know as true in our cognitive minds, or to what we may tell ourselves we think and believe when we are in denial, but rather

Furthermore, my perception is that our thoughts and beliefs *determine* our emotions – that our emotions always *follow* our thoughts and beliefs. These are the foundational principles of Cognitive Therapy, and Cognitive Therapy research and case studies provide a lot of evidence supporting these principles.⁴⁶ These are also some of the foundational principles of Theophostic[®],⁴⁷ and my personal and professional experience with Theophostic[®]-based emotional healing has provided extensive case study observations consistent with these principles. When working with Theophostic[®], I consistently see that a person's emotions match her thoughts and beliefs, and when Jesus replaces dysfunctional thoughts and beliefs with truth, the person's dysfunctional emotions immediately change to match the new, truth-based thoughts and beliefs. For example, when Jesus replaces "I'm going to die" with "I'm not there any more, I'm okay now," the person's emotions change from panic to peace in a matter of seconds. Furthermore, truth-based psychological pain (such as loss of a loved one) produces corresponding emotions (such as anger and sadness), free will choices (such as the vow "I will not feel") dramatically affect the experience and expression of emotion, and demonic harassment often seems to affect emotions. Another interesting data point is provided by experiments with people who receive adrenaline injections in two different social settings. The group that received adrenaline injections in a pleasant situation experienced the adrenaline induced arousal as subjective happiness, whereas the group that received the *exact same injections* in a frustrating situation experienced the adrenaline induced arousal as a surge of anger. The same injection produced different emotional responses depending on what was happening in the mind/spirit at the time of the injection, clearly demonstrating that mind/spirit input plays a crucial role in shaping our final subjective experience of emotions.⁴⁸

On the other hand, there are many fascinating research studies that clearly indicate that the biological brain plays an important role in the experience and expression of emotion. Some of the most straightforward research shows that direct stimulation of certain very specific areas of the brain immediately produces corresponding very specific simple emotions, such as anger, fear, and euphoria, and that damaging these same very specific brain areas can block these emotions.⁴⁹ It's not clear to me where mind/spirit phenomena fit into these

to our *true* thoughts and *experiential* beliefs at any given moment.

⁴⁶For an extensive discussion of these principles, and their place as the foundation of cognitive therapy, see Beck AT. *Cognitive Therapy and the Emotional Disorders*. New York, NY: International Universities Press, 1976.

⁴⁷One way to find these principles in Dr. Smith's Theophostic[®] material is to review the references to emotion listed in the index of Smith, Ed. *Beyond Tolerable Recovery*. Fourth edition. (Campbellsville, KY: Alathia publishing) 2000.

⁴⁸See Schacter, S., and Singer, J. "Cognitive, social, and physiological determinants of emotional learning." *Psychological Review*, 1962 Vol 69, pp 379-99 for a description of these classic experiments on the variable subjective interpretation of adrenaline-induced arousal.

⁴⁹There is an extensive body of animal research and human case studies describing stimulation of and/or blockage of both the subjective internal experience and the external expression of simple emotions. For electrode stimulation and blockage experiments in animals, see, for example, Anand B.K., Dua S. "Stimulation of Limbic System of Brain in Waking Animals," *Science*. 1955 December 9, Vol. 122, page 1139; Egger, David M., Flynn, John P. "Effects of Electrical Stimulation of the Amygdala on Hypothalamically Elicited Attack Behavior in Cats," *J. Neurophysiol.* 1963, Vol. 26, pages 705-720;

experiments, but these dramatic demonstrations certainly indicate that the biological brain is intimately involved in the experience and expression of emotion. See also the chapter on emotion in Dr. Daniel Siegel's *The Developing Mind*,⁵⁰ and Dr. Allen Shore's three books, *Affect Dysregulation and Disorders of the Self*, *Affect Regulation and the Origin of the Self*, and *Affect Regulation and the Repair of the Self*⁵¹ for an EXTENSIVE discussion of interdisciplinary research that reveals many different aspects of how the biological brain is intimately involved in the internal subjective experience of emotion and in the observable external expression of emotion.

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

3. Physical symptoms associated with mental health concerns: With respect to the physical symptoms associated with mental illnesses (such as decreased energy with depression, increased energy with mania, racing heart and hyperventilation with panic, etc), my perception is that truth-based pain, lie-based thoughts/beliefs, choices, demonic spirits, and emotions cause many⁵² of the physical symptoms of mental illness *through* causing changes in the chemical and electrical machinery of the biological brain. The chemical and electrical machinery of the biological brain *is* the “final common pathway” for the expression of many physical symptoms associated with mental illnesses.

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

E. Sick mind/spirit *causes* sick brain, sick brain *exposes* sick mind/spirit: In the above discussion and analogy, I describe how the mind/spirit being sick can actually make the biological brain sick. In the discussion and analogy above I almost continued with “and the brain being

Hess, W.R. *The Functional Organization of the Diencephalon*. (New York, NY: Grune & Stratton) 1957, pages 23-25; and MacDonnell, Malcolm F., & Flynn, John P. “Attack Elicited by Stimulation of the Thalamus of Cats,” *Science*. 1964, Vol. 144, pages 1249-50; For electrode stimulation and blockage case studies in human patients, see, for example, Chapman, William P. *et al.* “Physiological Evidence Concerning Importance of the Amygdaloid Nuclear Region in the Integration of Circulatory Function and Emotion in Man,” *Science*, 1954, Vol. 129, pages 949-50; and Mark, V.H., & Ervin, F.R. *Violence & the Brain*. (New York, NY: Harper & Row) 1970, pages 70-85 and 92-121.

⁵⁰ Siegel, D.J. *The Developing Mind*. (New York: Guilford) 1999, pages 121-159.

⁵¹ Shore, Allen N., Ph.D. *Affect Dysregulation and Disorders of the Self*. (New York, NY: W.W. Norton & Company), 2003; Shore, Allen N., Ph.D. *Affect Regulation and the Origin of the Self*. (Hillsdale, NJ: Lawrence Earlbaum Associates, Publishers), 1994; Shore, Allen N., Ph.D. *Affect Regulation and the Repair of the Self*. (New York, NY: W.W. Norton & Company), 2003.

⁵² I think there are some situations where mind/spirit phenomena directly affect the physical body, without going through the biological brain.

sick can make the mind sick,” thinking about how a person can have a genetic biological brain predisposition to depression, or even about how low thyroid levels can precipitate depression. However, with more consideration I have come to the conclusion that the brain being sick (for example, biological brain abnormalities from genetic vulnerability to depression, experimentally depleted serotonin,⁵³ or low thyroid levels) simply *exposes* the sickness/wounds/unresolved issues *already present* in the mind. This means that changes in the biological brain cause changes in the mind/spirit by either *covering* or *exposing* unresolved issues in the wounded mind/spirit. My hypothesis at this point is that if the mind and spirit were completely well, dysfunction in the biological brain would produce *physical body symptoms* (such as decreased energy, disturbed sleep, decreased libido, disturbed appetite, weight changes, etc), and certain *emotional symptoms* (such as decreased stability of emotions and more difficulty with the simple emotions of sadness, anger, and fear), but not *mind/spirit symptoms* (such as shame, hopelessness, helplessness, bitterness, low self esteem, pathological guilt, suicidal thoughts, etc).

I think that Alzheimer’s disease provides an especially clear example of biological brain sickness *exposing* underlying mind/spirit issues. My perception is that part of what causes disruptive thoughts, emotions, and behaviors in Alzheimer’s disease is that biological brain changes steadily erode the frontal cortex cognitive functions that the mind uses to run its psychological defenses. As these frontal cortex tools are lost, all the unresolved mind/spirit issues increasingly affect the person’s thoughts, emotions, and behavior.⁵⁴ One of the most significant data points for me in developing this hypothesis about Alzheimer’s disease was my experience with a personal acquaintance. This man was the most loving, humble, Christ-like man I have ever known, and when he got Alzheimer’s disease I could hardly tell. His memory and cognitive functions deteriorated over years to the point that he did not recognize his own family, but as he lost his frontal cortex defenses there was very little unresolved garbage to leak out in the form of inappropriate and disruptive thoughts, emotions, and behavior.⁵⁵

⁵³ Researchers have developed an ingenious dietary manipulation technique by which they can cause sudden, dramatic, and temporary reductions in brain serotonin levels: Tryptophan is the amino acid required for the synthesis of serotonin. Experimental subjects are maintained on a low tryptophan diet, and then given a special drink that contains all the other amino acids, but not tryptophan. This amino acid load stimulates a surge of protein synthesis, which quickly uses up what little tryptophan remains, resulting in a sudden and dramatic drop in serotonin synthesis. Consistent with our “exposure” theory, “normal” subjects experience only minor irritating symptoms when their serotonin is suddenly depleted, but people who have had major depression experience sudden and dramatic return of their depression when their serotonin is experimentally depleted (in case you were worrying, the depression quickly resolves when serotonin is replenished). Delgado, Pedro, L., Charney, Dennis, S., et al., “Serotonin Function and the Mechanism of Antidepressant Action: Reversal of Antidepressant-Induced Remission by Rapid Depletion of Plasma Tryptophan,” *Archives of General Psychiatry*, 1990, Vol. 47, pages 411-418.

⁵⁴ Note that emotional and behavioral problems in brain injury illnesses such as Alzheimer’s disease can be especially difficult because, in addition to losing brain circuits that maintain psychological defenses, brain circuits that usually modulate emotional intensity can also be lost. Loss of these limbic system modulating circuits means that in addition to unresolved issues being exposed, the *intensity* of the emotional reaction can also be increased (even above the usual exaggerated intensity of triggered emotions).

⁵⁵ I developed this hypothesis from my personal experience with a number of patients and friends with Alzheimer’s disease, and from my review of research regarding the neurological areas and the psychological functions affected by this disease. I have never seen this explanation for the disruptive thoughts,

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

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

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

A hugely significant data point regarding the role of mind/spirit issues is that twin studies reveal identical twin concordance of 50% or lower in most mental illnesses – even in the mental illnesses where biological brain dysfunction is the most important contributing factor, such as true schizophrenia and true bipolar disorder – and twin studies find *no* mental illnesses with identical twin concordance of 100%.⁵⁶ For example, in identical twin pairs where one twin has schizophrenia, and the second twin in each pair shares the exact same genetic

emotions, and behaviors usually seen in Alzheimer’s disease presented in any psychiatric or psychological literature, but I *have* found a number of published case studies that are consistent with my hypothesis – case studies of elderly patients who had functioned without significant trauma-related impairment for many years, but then developed severe Post Traumatic Stress Disorder (PTSD) from *long* past trauma *only after developing dementia* (van Achterberg, Margriet E., Rohrbaugh, Robert M., Southwick, Steven M. “Emergence of PTSD in Trauma Survivors With Dementia,” *The Journal of Clinical Psychiatry*, 2001, Vol. 62, No. 3, pages 206-7; and Johnston, Dierdre. “A series of cases of dementia presenting with PTSD symptoms in World War II combat veterans,” *Journal of the American Geriatric Society*. 2000, Vol. 48, Pages 70-72). Note: I think some have trouble with this theory because it is very hard to accept the thoughts, emotions, and behaviors that come out of dear friends and family as they lose the tools they have always previously used to manage their hidden unresolved issues and pain.

⁵⁶ See, for example, Skre I., Onstad S., Torgersen S., Lygren S., Kringlen E. “A twin study of DSM - III-R anxiety disorders,” *Acta Psychiatr Scand*. 1993, Vol. 88, No. 2 pages 85-92 (identical twin concordance for panic disorder = 42%); Onstad S., Skre I., Torgersen S., Kringlen E. “Twin concordance for DSM-III-R schizophrenia,” *Acta Psychiatr Scand*. 1991 Vol. 83, No. 5, pages 395-401 (identical twin concordance for schizophrenia = 48%); McGuffin P., Katz R., Watkins S., Rutherford J. “A hospital-based twin register of the heritability of DSM-IV unipolar depression,” *Arch Gen Psychiatry*. 1996, Vol. 53, No. 2, pages 129-36 (identical twin concordance for major depression = 46%); and Kiesepa T., Partonen T., Haukka J., Kaprio J., Lonnqvist J. “High concordance of bipolar I disorder in a nationwide sample of twins,” *Am J Psychiatry*. 2004, Vol. 161, No. 10, pages 1814-21 (identical twin concordance for bipolar I disorder = 43%); Kendler, Kenneth S., MacLean C., Neale M., Kessler R., Heath A., Eaves L., “The genetic epidemiology of bulimia nervosa,” *Am J Psychiatry* December 1991, Vol. 148 No. 12, pages 1627-37 (identical twin concordance for bulimia = 22.9%); Kipman A., Gorwood P., Mouren-Simeoni MC., Ades J., “Genetic factors in anorexia nervosa,” *Eur Psychiatry*, July 1999, Vol. 14, No. 4, pages 189-98 (identical twin concordance for anorexia nervosa = 44%).

predisposition to schizophrenia, *only* ~50% of the second twins will actually develop clinical schizophrenia. This means that environmental factors, developmental factors, and unresolved mind/spirit issues *determine whether an underlying genetic vulnerability will ever be “exposed” – whether or not a genetic biological brain predisposition will ever manifest as an actual mental illness, even in these illnesses where biological brain dysfunction is primary.*

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

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

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

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

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

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

B. Summary of factors contributing to mental health problems:

1. Biological brain – *Genetic* strength endowments and vulnerabilities to mental health problems: (1,000 subtly combined bell curves). There is a HUGE collection of data proving some degree of genetic contribution to mental health problems – for example: case-control family pattern studies, studies comparing fraternal vs identical twins, studies comparing twins reared apart vs twins reared together, adoption studies, gene mapping association studies, and other molecular genetics research. Note that the evidence for genetic factors contributing to mental health problems is *NOT* just family patterns that could be explained by psychological and/or spiritual phenomena being passed down in families.⁵⁷

Some of the strongest and most straightforward evidence for genetic contribution in mental illnesses comes from research studying sets of twins that have been reared together, and then comparing the concordance rate in fraternal twins with the concordance rate in identical twins. In these studies, both the fraternal and identical twins have shared very similar intrauterine and family environments. Under these conditions, if a given mental illness is determined solely by environmental factors, the concordance rate should be essentially the same for the fraternal and identical twins. However, if a given mental illness has a significant genetic component, there should be a dramatic difference, since the genetic overlap for fraternal twins is the same as that for any other siblings (50% genetic overlap), whereas the genetic overlap for identical twins is 100% – both twins having the exact same genes. The concordance rate for eye color – a phenomena that is usually completely determined by genetic factors – provides a simple example. If one parent has two blue eye genes, and the second parent has one brown and one blue, then non-twin siblings and fraternal twins will have the same color eyes half the time – a concordance rate of 50%. Identical twins, on the other hand, will *always* have the same color eyes – a concordance rate of 100%.

The simple summary of this research is that many studies have found dramatic differences between the concordance rates for fraternal twins and the concordance rates for identical twins, and these significant differences have been found for almost every mental health problem that has been studied.⁵⁸ To my assessment, this evidence proves that genetic,

⁵⁷ A number of current books discuss this extensive evidence. See, for example, Mellon, Charles David. *The Genetic Basis of Abnormal Human Behavior*. (Genetics Heritage Press), 1997. Another good source is the introductory sections on genetics, and then the genetics section within the discussion of each mental illness in Kaplan, H.I., Kaplan, Virginia A. (Eds.) *Kaplan and Sadock's Comprehensive Textbook of Psychiatry, 8th edition*, (Baltimore, MD: Lippincott Williams & Wilkins), 2004. For a good general discussion of genetics and mental illnesses, and an understandable explanation of the different kinds of research examining genetic contribution to mental illnesses, see Faraone, Stephen V., Tsuang, Ming T., Tsuang, Debby W. *Genetics of Mental Disorders: A Guide for Students, Clinicians, and Researchers*. (New York, NY: Guilford Press), 1999.

⁵⁸ Schuckit, Marc A. "Alcohol-Related Disorders: Etiology," Chapter 11.2 (twin studies for alcoholism); Riley, Brien P., Kendler, "Schizophrenia: Genetics," Chap. 12.3; Kelsoe, John R. "Mood Disorders: Genetics," Chapter 13.3 (twin studies for bipolar disorder and unipolar depression); McMahon, Francis J., Kassem, Layla. "Anxiety Disorders: Genetics," Chapter 14.6 (twin studies for panic disorder and obsessive compulsive disorder); Andersen, Arnold E., Yager, Joel. "Eating Disorders: Etiology, Vulnerability," Chapter 19; all in Kaplan, H.I., Sadock, B.J. (Eds.) *Kaplan and Sadock's Comprehensive Textbook of Psychiatry, eighth edition*, (Baltimore, MD: Lippincott Williams & Wilkins), 2004, pages 1173-74, 1354-71, 1582-94, 1759-62, 2006-8, respectively.

biological brain factors contribute to most mental health problems. To keep this in perspective, remember that *every* study has also found identical twin concordance rates *less than 100%*, which proves that the mental health problems studied are not *completely* determined by genetic factors.

2. Biological brain – *Medical illnesses* that affect the brain:
 - a. Metabolic and hormonal diseases (for example, diseases causing abnormal thyroid levels or abnormal blood sugar levels).
 - b. Neurological diseases (for example, brain tumors, seizure disorders, Parkinson’s disease, Alzheimer’s disease).
3. Biological brain – *Environmental* strengths vs deficits, injuries:
 - a. Nutrition – optimum vs deficiencies
 - b. Stimulation for neurological development – under stimulation vs optimum vs over stimulation.
 - c. Infections (for example, viral encephalitis causing direct neurological injury)
 - d. Toxins (for example, lead or mercury poisoning causing direct neurological injury)
 - e. Physical trauma to the head
4. Biological brain and non-biological mind (especially interwoven) – *Developmental* strengths and/or deficits:
 - a. Basic neurological skills and tools, strengths and/or deficits (secure attachment, language, social interactions, motor skills, problem solving/thinking skills, etc)
 - b. Capacity strengths and/or deficits⁵⁹
 - c. Maturity strengths and/or deficits⁶⁰
5. Non-biological mind/spirit – “*Mind/spirit genetics*” (the mind/spirit parallel to biological brain genetics):
 - a. Mind/spirit strength endowments from the Lord
 - b. Mind/spirit generational vulnerabilities
6. Non-biological mind/spirit – *Information* strengths vs deficits:
 - a. Scriptural truths and principles
 - b. Mind and Brain paradigm: Being aware of the biological brain and the non-biological mind/spirit, and understanding how they fit together (as presented in this essay).
 - c. Understanding of implicit and explicit memory
 - d. Other knowledge/cognitive information that is helpful.
7. Non-biological mind/spirit – *Psychological trauma and associated issues*:
 - a. Truth-based pain (for example, truth-based grief)

⁵⁹The best material regarding capacity that we are aware of is presented by E. James Wilder at the THRIVE conferences. Unfortunately, this material is currently only available to those who attend the conferences. Information about THRIVE conferences can be obtained at www.care1.org.

⁶⁰For good discussions on maturity, see Wilder, E. James, *The Complete Guide to Living With Men*, (Pasadena, CA: Shepherd’s House Publishing), 2004, and Friesen, James G., Wilder, E. James, Bierling, Anne, M., Koepcke, Rick, and Poole, Maribeth. *The Life Model: Living From the Heart Jesus Gave You*. (Van Nuys, CA: Shepherd’s House Publishing), 2000 revision.

- b. Lies associated with traumatic memories
 - c. Reactive sins/sinful defenses
 - d. Demonic infection
8. Non-biological mind/spirit – *primary spiritual issues*:
- a. Salvation
 - b. Filling, gifts of the Holy Spirit
 - c. Persistent, willful sin

C. Diagrams illustrating our model regarding biological brain issues and non-biological mind/spirit issues in mental illnesses: Mainstream medical psychiatry currently sees abnormal brain biology as the deepest, root, primary cause of all mental illnesses. In contrast, from the “mind and brain” perspective that we are presenting here, every mental health concern involves both biological brain issues and non-biological mind/spirit issues. Furthermore, we perceive that non-biological mind/spirit issues are actually the *most important* contributing factor for many mental illnesses.

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

1. From the perspective of starting with mind wounds and associated spiritual issues:

Figure #1 summarizes our current paradigm regarding what we call “mind/spirit mental illnesses.” As illustrated in the figure, our perception is that mind/spirit issues are the core underlying phenomena for many mental illnesses. The interaction of each person’s specific mind wounds (psychological trauma, lies, truth-based pain) and associated spiritual issues (sinful defenses, demonic infection) with develop-

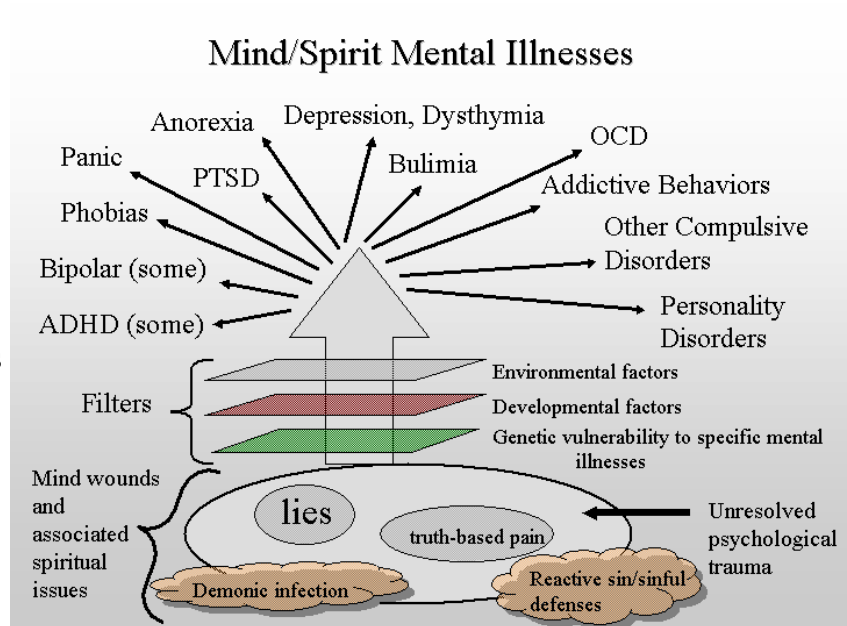


Figure #1

mental factors,⁶¹ environmental factors, genetic brain chemistry vulnerabilities, and medical illnesses that affect the brain determine which DSM IV mental health diagnostic picture actually develops (panic vs. depression vs. obsessive compulsive disorder vs. substance abuse, etc).

Additional evidence supporting this paradigm: All of the evidence, presented above, in support of our “mind *and* brain” hypothesis also supports our paradigm regarding mind/spirit issues being a part of all mental illnesses, and mind/spirit issues being the most important contributing factor in many mental illnesses. Below I summarize additional evidence supporting various aspects of our model for mind/spirit mental illnesses presented in Figure #1.

- a. Extensive research with cognitive therapy shows that false negative cognitions (lies) are a necessary ingredient in many mental illnesses,⁶² and many cognitive therapists have found that these false negative cognitions are anchored in unresolved psychological trauma.⁶³
- b. Psychotherapists working with exposure therapy are also coming to appreciate the connection between mental illnesses, negative cognitions, and unresolved psychological trauma.⁶⁴
- c. The belief that many mental illnesses are caused by unresolved psychological trauma, and associated false negative cognitions, is a foundational part of EMDR theory.⁶⁵
- d. Dr. Ed Smith has come to the conclusion that many mental illnesses are expressions of unresolved psychological trauma, and associated “lie-based thinking,” as a result of his experience with Theophostic[®] ministry (starting with many different mental illnesses,

⁶¹ Note that developmental history includes more than just smaller, earlier wounds and lies that contribute to the key wounds and lies precipitating the final clinical picture. Developmental history also determines things like ego strength, joy supply, and the amount of learned capacity for dealing with negative emotions.

⁶² Kaplan HI, Sadock BJ, Grebb JA. *Kaplan and Sadock's Synopsis of Psychiatry, Seventh Edition*. Baltimore, MD: Williams & Wilkins; 1994, pages 860-61. For extensive discussion of two specific examples, see Beck AT, Emery G, Greenberg RL. *Anxiety Disorders and Phobias: A Cognitive Perspective*. New York, NY: Basic Books; 1985, and Beck AT, Rush AJ, Shaw BF, Emery G. *Cognitive Therapy of Depression*. New York, NY: Guilford; 1979.

⁶³ See “Cognitive Therapy and Theophostic[®] Based Emotional Healing Ministry” on the Articles and FAQs page of www.kclehman.com for discussion of cognitive therapists beginning to appreciate the connection between mental illnesses, negative cognitions, and unresolved psychological trauma.

⁶⁴ See “Exposure Therapy and Theophostic[®] Based Emotional Healing Ministry” (pending) on the Articles and FAQs page of www.kclehman.com for additional discussion of exposure therapists beginning to appreciate the connection between mental illnesses, negative cognitions, and unresolved psychological trauma.

⁶⁵ Shapiro, Francine & Silk Forrest, Margot. *EMDR: The Breakthrough Therapy for Overcoming Anxiety, Stress, and Trauma* (HarperCollins: New York, NY) 1997 is full of well written case studies that illustrate this principle. See Shapiro, Francine. *Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols, and Procedures*. (New York, NY: Guilford Press) 1995 for more rigorous discussion of the place of this principle as part of the theoretical foundation for EMDR.

following the Lord back to wounds and lies, and then observing the illnesses disappear when the wounds and lies are resolved).

e. We have seen the same patterns and connections in our clinical experience with psychotherapy (especially EMDR), and emotional healing ministry (especially Theophostic®-based emotional healing ministry).

f. Extensive research shows that the mental illnesses we believe to be rooted in underlying psychological trauma are often found together in the same patients, and that these illnesses are especially common in patients with PTSD from documented severe psychological trauma.⁶⁶ One large study of Vietnam veterans found that 99% of those diagnosed with PTSD also met criteria for at least one other psychiatric diagnosis.⁶⁷ A recent study with 1,411 female adult twins found that childhood sexual abuse was associated with major depression, generalized anxiety disorder, panic disorder, alcohol or drug dependence, and bulimia nervosa. The prevalence of these disorders increased with increasing severity of abuse, and when only one twin had been abused, she was more likely to have these psychiatric disorders than the twin who had not been abused.⁶⁸ This study is especially significant because twins have the same genetic risk, and therefore the increased incidence of psychiatric disorders in abused twins supports the hypothesis that childhood sexual abuse itself, and not some other genetic risk factor for which it is a marker, contributes to later mental illness. All of these results would be expected if these mental illnesses are springing up from the same root of unresolved psychological trauma.

g. Bessel Van der Kolk and colleagues (international leaders in psychological trauma research), examining the data presented here and also much additional research, propose that Post Traumatic Stress Disorder (PTSD) and many other comorbid mental illnesses (mental illnesses found alongside of PTSD in the same person) are not separate disorders, but rather many different ways in which people manifest the effects of psychological trauma.⁶⁹

h. One of the most important observations indicating that mind/spirit issues are primary *in the mental health concerns portrayed in Figure #1* is that manually correcting the brain chemistry without addressing the underlying mind/spirit issues will result in partial

⁶⁶ See Brady KT, et al. Comorbidity of Psychiatric Disorders and Posttraumatic Stress Disorder. *J Clin Psychiatry* 2000;61(suppl 7):22-32 for a recent review of the statistics regarding other mental illnesses commonly occurring with PTSD.

⁶⁷ Kulka RA, Schlenger WE, Fairbank JA, et al. *Trauma and the Vietnam War Generation*. New York, NY: Brunner/Mazel; 1990.

⁶⁸ Kendler KS et al. "Childhood sexual abuse and adult psychiatric and substance use disorders in women." *Arch Gen Psychiatry* 2000 Oct, Vol. 57, pages 953-9.

⁶⁹ Van der Kolk BA. "The Complexity of Adaptation to Trauma: Self-Regulation, Stimulus Discrimination, and Characterological Development," Chapter 9 in Van der Kolk, Bessel A, McFarlane, Alexander C, Weisaeth, Lars, Editors. *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society*. (New York: Guilford Press) 1996; Van der Kolk BA, Pelcovitz D, Roth S, et al. "Dissociation, somatization, and affect dysregulation: the complexity of adaptation to trauma." *Am J Psychiatry* 1996;153(7, suppl):83-93.

and/or temporary resolution of symptoms. Even if it is possible to attain complete remission of the symptoms resulting from the underlying mind/spirit issues, the symptoms will return when the medications are stopped and the underlying issues are again triggered. However, if the underlying mind/spirit issues are resolved, the medications can be stopped and the symptoms will not return – even in the face of triggers that have always precipitated problems in the past.

Clarification regarding post traumatic stress disorder (PTSD): I have heard psychotherapists and emotional healing ministers comment “Most of DSM IV can be condensed into PTSD.” Research shows that PTSD is a specific clinical presentation,⁷⁰ and is just *one* of the many ways in which unresolved psychological trauma can be expressed. For example, extensive medical research shows that PTSD and depression are both common long term consequences of psychological trauma, but that they demonstrate distinct and different (opposite) results with respect to certain biological indicators. For example, one category of receptors in the brain (mononuclear leukocyte Type II glucocorticoid receptors) are elevated in PTSD, but decreased in major depression; the body’s excretion of the chemical cortisol in the urine is reduced in PTSD, but increased in major depression; and suppression of cortisol excretion in response to dexamethasone is increased in PTSD, but decreased in major depression.⁷¹ It is much more accurate to say “Most of DSM IV can be reduced to ‘consequences of unresolved psychological trauma,’ with PTSD being one of the many presentations.” Even more accurate, in our current paradigm, would be to say “Most of DSM IV can be reduced to ‘clinical expression of underlying mind wounds and their associated spiritual issues.’”

2. From the perspective of starting with biological brain and mind/spirit “genetics”: Figures ** (pending) present an alternative model, which simply looks at the picture from a different perspective.

(To be developed) Present model with biological brain genetic strengths and vulnerabilities, and mind/spirit “genetics” (mind/spirit endowments from the Lord, mind/spirit generational blessings and vulnerabilities) as the beginning point, with arrow passing through all the other factors as filters. For each of the different categories below, the respective components and/or filters can be drawn as more or less thick/large/important.

Biological brain predisposition and/or injury are the most important contributing factors:

- a. Traumatic brain injury, severe infectious brain injury, severe nutritional deficiency, severe overstimulation or under-stimulation, stroke, etc

⁷⁰ Segman, RH; et al. “Association between the dopamine transporter gene and post traumatic stress disorder.” *Mol Psychiatry* 2002;7(8):903-7.

⁷¹ Yehuda R, et. al. “Lymphocyte glucocorticoid receptor number in post traumatic stress disorder. *American Journal of Psychiatry*. 1991;148:499-504; Yehuda R, et. al. “Glucocorticoid receptor number and cortisol excretion in mood, anxiety, and psychotic disorders.” *Biological Psychiatry*. 1993;34:18-25; Yehuda R, et. al. “Enhanced suppression of cortisol following dexamethasone administration in post traumatic stress disorder. *Am J Psychiatry* 1993 Jan;150(1):83-6; and Kocsis JH; Brockner N; Butler T; Fanelli C; Stokes PE. “Dexamethasone suppression in major depression.” *Biol Psychiatry* 1984 Aug;19(8):1255-9.

- b. Alzheimer's disease
- c. Schizophrenia
- d. True bipolar
- e. Some cases of true ADD/ADHD?

Biological brain factors and non-biological mind/spirit factors both very important:
Some cases of schizophrenia, true bipolar, and true ADD/ADHD, some cases of the mental health concerns in figure #1. Varying degrees of contribution from biological and non-biological factors.

Non-biological mind/spirit issues are the most important contributing factors:
Most cases of the mental health concerns in figure #1. When you resolve the mind/spirit issues, the clinical picture essentially resolves, with minimal lingering symptoms or risk of relapse.
Uncomplicated grief – when you resolve the mind/spirit pain, the whole thing resolves completely.

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

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

Although it is slow and difficult to approach a specific aspect of a situation from the non-primary perspective, those who have been gifted and anointed to do this have made valuable contributions. If we embrace the “mind *and* brain” paradigm, letting exploration from both perspectives shed light on the *same specific issues, questions, and phenomena*, we will discover important additional insights. For example, Dr. Allen Shore, Dr. Daniel Siegel, and Dr. E. James Wilder have carefully studied biological brain processes associated with phenomena that have usually been considered to be in the realm of the mind/spirit, such as bonding, attachment, relationships, maturity, and joy.⁷² Amazingly, the biological brain and the non-biological mind/spirit are so

⁷² See, for example, Shore, Allen N., Ph.D. *Affect Dysregulation and Disorders of the Self*. (New York, NY: W.W. Norton & Company), 2003, Shore, Allen N., Ph.D. *Affect Regulation and the Origin of the Self*. (Hillsdale, NJ: Lawrence Earlbaum Associates, Publishers), 1994, Shore, Allen N., Ph.D. *Affect Regulation and the Repair of the Self*. (New York, NY: W.W. Norton & Company), 2003, Siegel, D.J. *The Developing Mind*. (New York: Guilford) 1999, and Siegel, D.J., and Hartzell, M. *Parenting From the Inside*. (New York: Jeremy P. Tarcher/ Putnam, a member of Penguin Putnam Inc.) 2003. E. James Wilder, Ph.D. also has excellent material, especially studying joy from a biological brain perspective. Unfortunately, this material has not yet been published in a book, but is available in audio and video tape format – for example, his tapes on Joy Bonds, available from C.A.R.E. Packaging (www.carepkg.org/wilder/materials.htm).

intimately and profoundly connected that study of the brain processes associated with these mind/spirit phenomena has actually provided important new mind/spirit understanding. Furthermore, careful study of a specific aspect of a situation from the non-primary perspective can provide important corroboration for insights that have been discovered through study from the primary perspective. For example, my examination of memory system SPECT scans and neurological case studies of multiple parallel memory systems provides important biological brain corroboration for Dr. Ed Smith's mind/spirit theory that logical/cognitive truth and experiential truth are stored and processed separately.⁷³

Note that *both* of the following are true:

1. It is *easiest* to approach from the primary perspective – to approach from a biological brain perspective when dealing with any aspect of a situation that is primarily a biological brain phenomena, and to approach from a mind/spirit perspective when dealing with any aspect of a situation that is primarily a mind wound/mind phenomena. It is therefore wise and helpful to *begin* with approaching any given issue, question, or phenomena from the primary perspective; *And*,
2. Although it is slow and difficult, it is still worthwhile to also examine each specific issue, question, or phenomena from the non-primary perspective.

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

As seen in the above discussion, *all* mental health problems have *both* biological brain *and* non-biological mind/spirit components. Mind/spirit issues combine with genetic brain biology vulnerabilities, developmental factors, environmental factors, and sometimes also medical illnesses to result in each particular mental health problem. When these factors combine to create overall clinical pictures that the mental health community considers major mental

⁷³ In actual history, Dr. Smith discovered these important principles through approaching emotional healing from a mind/spirit perspective, and biological brain information has provided important confirming support. However, when I think about the SPECT scans and neurological case studies of multiple parallel memory systems that I have recently reviewed, I can imagine starting with this biological brain information and arriving at these important mind/spirit insights about cognitive truth vs experiential truth even though approaching from the biological brain perspective. See “Implicit and Explicit Memory” (pending), on the Articles and FAQs page of www.kclehman.com, for discussion of biological brain information supporting Dr. Smith's teaching about the differences between cognitive/logical truth and experiential truth.

illnesses,⁷⁴ these major mental illnesses will include *both* non-biological mind/spirit issues (such as lies anchored in traumatic memories) *and* abnormalities in the biological brain (such as dysfunctional brain chemistry and abnormal SPECT scans). In some cases, mind/spirit issues are the most important contributing factors, and the primary focus of treatment should be on the mind spirit issues. However, even in these cases the overall clinical picture also involves biological brain components, and medical intervention can help to moderate symptoms as the person is working to address mind/spirit issues. In other cases, the biological brain dysfunctions are the most important contributing factors, and the primary focus of treatment should be on the biological brain components of the illness. However, even in these cases the overall clinical picture will also involve mind/spirit components, and mind/spirit interventions can help to decrease the effects of the primary biological brain problems.

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

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

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

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

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

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

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

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

“Non-biological mind/spirit issues are the true and only factors contributing to _____ (*the*

⁷⁴ Even rigorously meeting careful diagnostic criteria for “real” mental illnesses, such as major depression, panic disorder, obsessive compulsive disorder, eating disorders, and post traumatic stress disorder.

symptoms in question) – biological brain factors cannot also be contributing to these symptoms, and these people did not have ‘true’ mental illnesses.

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

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

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

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

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

- Underlying mind wounds and associated spiritual issues can be the most important factors contributing to the signs, symptoms, and biological brain abnormalities of “true” mental illnesses, such as panic disorder, depression, and obsessive compulsive disorder, and a mind/spirit intervention, such as Theophostic[®]-based emotional healing ministry, can completely resolve the observable symptoms of these “true” mental illnesses by resolving the underlying mind/spirit issues.

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

- Discovering the brain abnormalities associated with a given mental illness, and demonstrating that biological brain interventions reduce the symptoms, does *not* rule out underlying mind/spirit issues as the most important contributing factors, or prove that mind/spirit interventions should not be the primary focus of treatment.
- Biological brain dysfunctions can be the most important contributing factors in “true” mental illnesses such as Alzheimer’s disease and true schizophrenia, even though these illnesses expose mind/spirit issues, causing the overall clinical picture to include dramatic mind/spirit symptoms.

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

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

I think there is some value in making a distinction between a.) Mental health problems in which biological brain injuries/illnesses are the most important contributing factors,⁷⁵ and for which brain biology interventions⁷⁶ should be the primary focus of treatment, and b.) Mental health problems in which mind/spirit issues are the most important contributing factors, and for which mind/spirit interventions⁷⁷ should be the primary treatment. NOTE: If one makes this distinction, it is important to remember that mental health problems always involve *both* biological brain phenomena *and* non-biological mind/spirit phenomena. Medical interventions may be appropriate as part of the overall treatment plan, even in cases where mind/spirit issues are the root, primary source of the problem, and mind/spirit interventions will always be beneficial, even in cases where biological brain problems are the primary cause of the problem.

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

My own experience provides good examples of false dichotomy thinking errors regarding demonic phenomena. At the beginning of my psychiatric career, when I first started working with schizophrenic patients, I already believed in the reality of demonic spirits, and had heard stories of people who had been completely freed from “schizophrenia” through deliverance

⁷⁵ For example, true bipolar disorder, schizophrenia, mental status changes resulting from thyroid disorder, mental status changes resulting from seizure disorder, mental status changes resulting from traumatic brain injury or strokes, or mental retardation.

⁷⁶ For example, psychiatric medications for bipolar disorder or schizophrenia, medical intervention to correct thyroid excess or deficiency, medication to control seizures, neurosurgery as a part of treatment for seizure disorder or traumatic brain injury, or neurological rehabilitation therapy for traumatic brain injuries or strokes.

⁷⁷ For example, psychotherapy methods, such as EMDR, and emotional healing ministry approaches, such as Theophostic[®]-based emotional healing ministry.

ministry. However, in each case where I had access to clinical details, it seemed like these patients had actually had what I would call demonic “mimic” schizophrenia – they described psychotic symptoms, such as experiencing intense fears that the average mental health professional would consider delusional, seeing frightening images that would be considered visual hallucinations, and hearing voices and other frightening sounds that would be considered auditory hallucinations. But all of these psychotic symptoms seemed to be directly caused by demonic spirits, and the patients did not have any of the many other symptoms that are also present in true biological brain schizophrenia. With typical false dichotomy thinking, I incorrectly concluded that a person could have *either* demonic “mimic” schizophrenia *or* true, biological brain schizophrenia – if I was careful and thorough to evaluate that a person had true, biological brain schizophrenia, then I didn’t need to worry about demonic phenomena, and vice versa.

Eventually I observed patients with true biological brain schizophrenia who *also* seemed to have demonic phenomena exacerbating their overall clinical picture. One of the most dramatic was a patient who described psychotic thoughts and auditory hallucinations typical of schizophrenia, but also certain “voices” that were especially negative, angry, and hateful. These voices repeatedly told him to stop going to church, reading the Bible, talking to Christians, listening to worship music, and especially to stop praying, and they would threaten to punish him if he did any of these things. The persistent opposition of all Christian activity, and his spontaneous comments about these voices being so hateful, made me suspicious, so I did an experiment and discovered that *these particular voices* seemed to decrease, or even disappear completely (temporarily), with simple binding commands in the name of Jesus. After this discovery, I asked each of my schizophrenic patients about whether they ever heard “other” voices. I had to question them very carefully, gently, and persistently because the demonic spirits had usually threatened to harm the patients if they “told,” and my patients were therefore very hesitant to talk about these “other” voices. These interactions usually went something like:

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

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

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

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

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

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

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

voices?”

Patient: (*increasingly anxious*) “I can’t tell you. They’ll hurt me if I tell.”

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

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

At this point, I would use a simple command in the name of Jesus to prevent the demonic spirits from directly intimidating the patients as I was speaking to them, and they would then be much more willing to talk about the “other” voices.⁷⁸

To my amazement, I discovered previously hidden “other” voices in almost every one of my schizophrenic patients⁷⁹ – voices that were clearly distinguishable from typical schizophrenic auditory hallucinations – voices that were especially negative, scary, and hateful, that constantly tried to prevent the patients from participating in Christian activities, and that usually⁸⁰ reacted in some way to prayers or commands in the name of Jesus.

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

After carefully observing my own patients, and also reviewing many case descriptions from other Christian care providers, my perception is that conditions that impair the *biological brain*, such as intoxication, seizure disorders, traumatic brain injuries, and all mental illnesses, also make the *non-biological mind* more susceptible to demonic harassment/oppression. A person’s skin usually provides a very effective defense against bacterial infection. If your skin is intact, you can handle raw sewage and not get infected. However, if you have a skin injury,

⁷⁸ It is best if the care provider knows his authority in Christ, and can *start* the session with some kind of simple prayer/command to prevent the demonic spirits from directly intimidating the patient during the conversation about “other” voices. Sometimes I used a silent command, and at other times spoke aloud, depending on what seemed most appropriate for the particular situation (see, for example, “Opening Prayers and Commands: Prayer for the Facilitator, Dealing with the Demonic, and General Introductory Prayer” on the “Ministry Aids” page of www.kclehman.com).

⁷⁹ Unfortunately, I didn’t make these discoveries until after my clinical practice had shifted focus, and I wasn’t seeing as many patients with schizophrenia. I would be glad to hear from other Christian mental health professionals who have the opportunity to check for these anti-Christian demonic voices, or any other demonic phenomena, in patients with true schizophrenia.

⁸⁰ See “Dealing With Demonic Interference/Opposition During the Session, Prayers and Commands to Neutralize Demonic Interference” on the “Ministry Aids” page of www.kclehman.com for discussion of reasons why demonic spirits will sometimes not respond to prayers or commands in the name of Jesus.

even minute amounts of dirt in the wound can cause infection. Injury or illness of a person's biological brain seems to make him more vulnerable to demonic "infection" in much the same way that injury to a person's skin makes him more vulnerable to bacterial infection. As noted above, I was initially confused when a number of my patients reported reduced demonic harassment that seemed to be directly associated with benefits from psychiatric medication. And then I realized that this makes complete sense in light of this wound/infection analogy – when psychiatric medication moderates biological brain dysfunction, it should, logically, also moderate the increased vulnerability to demonic "infection" caused by the biological brain "wound." And in place of the false dichotomy thinking "a person can have *either* biological brain mental illness *or* demonic harassment/oppression, I realized that people with biological brain mental illnesses are actually *especially* likely to *also* have demonic "infection." In fact, in mental illnesses where biological brain dysfunction is a major contributing factor⁸¹ – in cases where it has been possible for me to specifically evaluate for possible demonic contribution – I have *almost always* found some degree of demonic harassment/oppression contributing to the overall clinical picture. In these patients, using mind/spirit interventions to deal with⁸² the demonic "infection" consistently improves their overall clinical picture, *even if the underlying biological brain dysfunction is still present and the person still requires medication.*

Furthermore, psychological traumas – mind "wounds" – seem to make a person more vulnerable to demonic "infection" in much the same way as biological brain "wounds." In almost⁸³ every case we are aware of, where demonic spirits were causing symptoms that mimicked a major mental illness, and where deliverance ministry resulted in sudden and dramatic improvement, important issues related to unresolved psychological trauma have also been present. In these cases, the trauma-related issues appeared to have contributed to making the person vulnerable to the demonic attack, and the person has had to resolve the trauma-related issues in order to retain the freedom received through deliverance.

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

⁸¹ For example, true schizophrenia, true bipolar disorder, Alzheimer's disease, severe major depression.

⁸² Mind/spirit interventions to "deal with" demonic infection can include such things as worship, simple commands in the name of Jesus, renouncing choices that gave the demonic spirits a place, and resolving "anchor" traumatic memories. See "Dealing With Demonic Interference/Opposition During the Session, Prayers and Commands to Neutralize Demonic Interference," "Binding the Enemy: Prayers and Commands to Alleviate Demonic Harassment and/or Oppression," "Opening Prayers and Commands: Prayer for the Facilitator, Dealing with the Demonic, and General Introductory Prayer," and "Closing Prayer and Commands" on the "Ministry Aids" page of www.kclehman.com for additional discussion of dealing with demonic infection.

⁸³ See the comments at the end of "Major mental illness, spiritual oppression, and deliverance" on the "Case Studies and Testimonies" page of www.kclehman.com for discussion of one of the few cases where the connections between unresolved psychological trauma and the demonic oppression that seemed to be causing mental health symptoms were less clear.

identified and removed, with significant improvement, does *not* rule out the possibility that the person also has biological brain schizophrenia, and just because a person improves with antipsychotic medication does *not* prove that demonic spirits are not contributing to his psychotic symptoms.

E. Examples of false dichotomy thinking in current mental health and ministry literature: We have been sobered and amazed by how easily people make these simple logical errors, and by how widespread these false dichotomy misunderstandings have become. For example, Daniel L. Schacter, Ph.D., is chair of the Department of Psychology at Harvard University, and has been studying neuropsychology, with a special interest in memory phenomena, for almost 30 years. He has written a number of books on memory, has *many* publications in mainstream peer-reviewed professional journals, and is considered one of the foremost authorities on the neuropsychology of memory. He is a rigorous academician, and usually a clear and careful thinker, but he makes the simple logical errors that lead to “non-biological mind vs biological brain, psychological trauma vs. biological brain dysfunction” false dichotomies. In one of his most recent books about memory, he comments:

“A recent report by the psychiatrists Joseph Lipinski and Harrison Pope dramatically illustrates that such flashbacks must be viewed with a great deal of caution. They describe three patients who developed vivid, intrusive images of highly disturbing incidents....In all three cases, the images were interpreted as flashbacks of repressed childhood trauma, and the patients were referred for appropriate psychotherapy. Something was amiss with these patients, however. All three of them compulsively engaged in unusual rituals, such as cleaning or washing over and over again. These disturbed behaviors are characteristic of the psychiatric disturbance known as obsessive-compulsive disorder. When the patients were given drugs that are ordinarily used to treat this debilitating condition, the intrusive imagery disappeared completely. It turned out that the images were not flashbacks of actual events; they were symptoms of the patients’ obsessive-compulsive disorder. This in turn suggests that the diagnosis of repressed childhood trauma was incorrect.”⁸⁴

Ed Smith, D. Min., the founder of Theophostic[®] Prayer Ministry, provides more examples of these false dichotomy logical errors. Dr. Smith is a personal friend, Charlotte and I apply Theophostic[®] principles in our personal and professional lives every day, and we have had a number of good conversations with Dr. Smith about how medical psychiatry, clinical psychology, and Theophostic[®]-based emotional healing ministry can be complimentary. I know that Dr. Smith is not generally antagonistic towards mental health professionals or appropriate mental health care. But his comments about mental illnesses, psychiatric medication, and professional mental health care have⁸⁵ been full of these false dichotomy logical errors. For example, in the current edition of the Theophostic[®] Prayer Ministry client manual, *Genuine Recovery*, he comments:

“When a person is suffering from true mental illness or brain damage, this method will not

⁸⁴ Schacter, D.L. *Searching for Memory*. (New York: Basic Books) 1996, pages 266-7.

⁸⁵ Dr. Smith and I are currently in dialogue regarding editing possibilities for the next editions of the basic training manual and client manual. Hopefully, the next editions will be edited to correct these false dichotomy logical errors, or these sections will simply be eliminated as material not truly necessary for basic Theophostic[®] training.

work. True mental illness and/or brain damage is a physical problem resulting in a mental failure. True mental illness or brain damage is not the consequence of faulty thinking. It is not rooted in lies embedded in memories.

Many people we see have been labeled as mentally ill, when in fact they were suffering from lies. I do not question the reality of mental illness. It is real and has a crippling affect on those who bear it. What I question is the number of people who have been written off as beyond help through this labeling system.

Sometimes it is difficult to know when a person is truly mentally ill and when they are merely in bondage to faulty thinking. I assume it is lies people suffer from and will pursue this until I am convinced otherwise. It has become too easy to diagnose and prescribe without seeking to free people from their real sources of pain.⁸⁶

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

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

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

There is a core of validity to this empirical and descriptive approach. Patterns of practical observations can be identified that correspond to real and legitimate underlying illnesses, even before the specific mechanisms of the underlying illnesses are understood. If people with a certain group of signs and symptoms also display a consistent pattern with respect to practical observations, such as genetic predisposition, environmental risk factors, exacerbating factors, beneficial factors, course of illness, effective treatments, etc., the identified group of signs and symptoms probably *does* correspond to a real underlying illness. And each of these illnesses,

⁸⁶ Smith, Ed. *Genuine Recovery*. (Campbellsville, KY: Alathia Publishing), 2000. Very similar comments are also included in the 2000 edition of the Theophostic[®] Prayer Ministry basic training manual, Smith, Ed. *Beyond Tolerable Recovery*. (Campbellsville, KY: Alathia publishing) 2000, pages 170-171.

“labeled” with a diagnosis, are associated with specific patterns of biological brain abnormalities. Correctly identifying empirical patterns that correspond to true underlying illnesses can provide valuable guidance in practical treatment, since people with the same underlying illnesses will usually respond similarly to the same treatments. For example, lithium is one of the most effective medications for people with bipolar disorder, but it is minimally effective for people with schizophrenia. For people with schizophrenia, it would be very important to use an antipsychotic as opposed to lithium. Making an accurate diagnosis between bipolar disorder and schizophrenia is therefore very important in practical decisions regarding medication treatment.

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

Note that effective treatment can also be discovered empirically, even before the underlying causes of the illness are understood and/or the mechanism of action of the treatment is understood. The “empirical” approach to discovery of effective treatment could be summarized as: “Keep your eyes open for anything that seems to produce benefit. Anything that actually works is included in the list of effective treatments, regardless of whether or not we understand or agree about why it works.” If there are manic-depressive patients who also have seizure disorders, and their manic symptoms are observed to improve whenever they are given Tegretol for their seizures, then Tegretol should be studied as a possible treatment for bipolar disorder. The empirical approach doesn't care whether or not we agree on the theory about how Tegretol works in the treatment of mania, it simply focuses on the observation that Tegretol consistently produces observable benefits.

Medical history provides good examples of this kind of descriptive and empirical approach to diagnosis and treatment. For example, when penicillin was discovered, we knew it worked by killing the bacteria causing certain infectious illnesses, but we didn't know the chemical structure of penicillin or understand the biological and chemical mechanisms of *how* it killed the bacteria without harming the patient. It was used with great benefit for years before we elucidated its structure or began to figure out the specific mechanisms of action through which it worked.⁸⁷ Malaria provides another good example. The clinical picture of malaria was empirically identified and described, and treatment was available, *for hundreds of years* before we understood what caused the illness or how the treatment worked. Doctors accurately perceived that any patient with a certain pattern of recurrent fevers, pain, shakes, and chills had a common underlying illness, and South American Jesuit priests had discovered that the bark from a certain plant could cure this illness.⁸⁸ Therefore, making the correct diagnosis of malaria

⁸⁷ Actually, although we have learned much about the structure and function of penicillin that has helped us in developing more effective antibiotics, medical researchers are still working to clarify details about penicillin's mechanism of action. See, for example, Bayles, KW. “The bactericidal action of penicillin: new clues to an unsolved mystery,” *Trends Microbiol.* June 2000, Vol. 8, No. 6, pages 274-8.

⁸⁸ Around 1600 A.D., Jesuit priests at missions in the foothills of the Andes mountains observed that the Native Americans drank powdered cinchona bark in hot water to calm their trembling muscles when they were shivering from cold exposure. Although there was little problem with malaria in these mountain foothills, the Jesuits had an extensive network of missions in South America, including missions in

could guide the physician to the appropriate treatment, even though these correct empirical discoveries about the diagnosis and treatment of malaria were made *centuries* before any underlying theory was understood.⁸⁹

Note that in each of these cases, it has been important to continue the search for deeper understanding. Discoveries of the chemical structure of penicillin, and discoveries regarding why penicillin is safe for humans but lethal for bacteria have helped scientists develop safe antibiotics that are effective against a wider spectrum of microorganisms.⁹⁰ Discovery of quinine as the active ingredient in the curative bark, the microbial basis for malaria, the mosquito transmission of the disease-causing microorganisms, the chemical structure of quinine, and the mechanism of action of quinine dramatically improved preventative measures, improved the efficiency of treatment with quinine, and contributed to the development of other antimalarial medications.⁹¹

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

“Her psychologist called, and objected, ‘My client says you told her she no longer needs mental health care?!’ I replied, ‘Yes, that’s true.’

“Then the psychologist exclaimed, ‘And she says you disagree with my diagnosis of bipolar disorder?!’ And I replied, ‘Yes, that’s true. Do you want to use your diagnosis of ‘bipolar disorder,’ or my diagnosis of ‘healed by Jesus?’ Do you want to use your diagnosis of “hopelessly mentally ill,” or my diagnosis of “delivered by her Lord and Savior?” ‘Do you want to use your diagnosis, that condemns her to a lifetime of mind numbing

areas where malaria was common. It occurred to the priests that cinchona might be helpful for the intense shivering that is associated with malaria, and they therefore tested the powdered bark on several patients suffering from malarial fever. They were pleased when this treatment proved helpful in controlling the shivering, but much more excited to discover that it also cured the underlying illness! Note: there are a number of different stories regarding the discovery of quinine (the active ingredient in cinchona bark), but this account makes the most sense, and is described by a number of independent sources written in the early 1600's [see Rocco, Fiammetta. *The Miraculous Fever-Tree*. (New York, NY: Harper Collins), 2003, pages 60-63].

⁸⁹To put things in perspective: the symptoms of malaria have been accurately identified as a specific disease for possibly thousands of years, cinchona bark was identified as a cure about 1600, Quinine was identified as the active ingredient of cinchona bark in 1820, the microscopic parasite causing malaria was discovered in 1880, the Anopheles mosquito as the transmission vector was discovered in 1897, the chemical structure of quinine was discovered in 1918, and the mechanism of action of quinine was not discovered until the 1940's [Honigsbaum, Mark. *The Fever Trail: In Search of the Cure for Malaria*. (New York, NY: Farrar, Straus, and Giroux) 2002, pages 57, 189, 191, 286, and Rocco, Fiammetta. *The Miraculous Fever-Tree*. (New York, NY: Harper Collins), 2003, pages 299-300].

⁹⁰For an especially thorough and well documented history of penicillin, see Hobby, Gladys L. *Penicillin: Meeting the Challenge*. (Binghamton, NY: Vail-Ballou Press) 1985.

⁹¹For discussion of how these discoveries regarding malaria contributed to more effective prevention and treatment, see especially chapters ten and eleven (pages 187-223) of Honigsbaum, Mark. *The Fever Trail: In Search of the Cure for Malaria*. (New York, NY: Farrar, Straus, and Giroux) 2002.

medications, or my diagnosis, that sets her free?’ Do you want your diagnosis, of ‘mentally ill,’ that she will have to carry around as a label for the rest of her life, or my diagnosis, that says she is a child of God, just like the rest of us?’”

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

Openness to the possibility that mind/spirit issues might be causing the symptoms of the mental illness that has been diagnosed.

Openness to the possibility that Jesus can resolve these underlying mind/spirit issues, with the corresponding possibility of complete freedom from the mental illness that has been diagnosed.

Openness to the possibility that the person can reduce, or even completely discontinue their medication as the Lord progressively resolves their mind/spirit issues.

Actual participation in the saving, delivering, and healing power of Jesus, to release all of these possibilities.

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

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

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

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

It is important to address the soberingly common problem of *incorrect* diagnoses. I think incorrect diagnosis was actually part of the problem in this particular situation – I think the woman being ministered to had Post Traumatic Stress Disorder, with dissociation and demonic exacerbation, as opposed to true bipolar disorder (it is significant to note that in this particular situation, correcting this diagnostic error would have resolved some of the biggest

problems regarding mistaken prognosis and unnecessary medication).⁹²

It is important to address the tendency of some mental health professionals to quickly label patients with the closest mental illness diagnosis when they can't figure out what's going on.

It is important to address incorrect information about the prognosis for many mental illnesses. For example, in many cases "this is a biological brain illness, there is no cure, you will need to be on medication for the rest of your life" should be replaced with "this illness includes biological brain abnormalities, but it can be completely cured if the underlying mind/spirit issues are resolved."

And it is important for all of us to expose, challenge, and eliminate toxic stigmatizing and stereotyping associated with many mental illness diagnoses. But the diagnosis, in and of itself, is not doing any of these things. Let's not throw the baby out with the bath water. One way to get some perspective on mental illness diagnoses is to consider what would happen in other areas of medicine if we demanded that health care professionals stop using diagnoses. If they were not allowed to identify and name specific illnesses, how would they organize their thinking regarding the cause and/or treatment of any given problem? How would they communicate with each other regarding patients' situations? How would the medical community organize or focus research? Or communicate about the results?

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

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

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

⁹²For additional discussion regarding diagnostic errors, and especially regarding specific diagnostic issues for psychotic symptoms, bipolar disorder, and Attention Deficit and Hyperactivity Disorder (ADHD), see "Psychosis/Psychotic Symptoms and Theophostic®-based Emotional Healing Ministry: General Comments and Frequently Asked Questions," and "Bipolar (Manic Depressive) Disorder and Theophostic® Ministry: General Comments and Frequently Asked Questions" on the "Articles and FAQs" page of www.kclehman.com, and "Case Study: Attention Deficit, What Fixed It?" on the "Case Studies" page of www.kclehman.com.

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

VIII. Some practical implications of working from a “mind and brain” paradigm:

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

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

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

As discussed above, Alzheimer’s disease provides a good example. Genetic, medical, biological brain disease is the most important contributing factor, and medication assisting the person’s brain biology is a necessary core of the treatment, but mind/spirit factors powerfully affect the overall clinical picture as the biological brain deterioration increasingly exposes unresolved mind/spirit issues. Unresolved issues increasingly affect the person’s thoughts, emotions, and behaviors as Alzheimer’s disease erodes his cortical defenses, and although resolving mind/spirit issues does not seem to stop the progressive neurological deterioration, it dramatically improves the overall clinical picture and decreases the need for medication. Schizophrenia provides another example. In true⁹³ schizophrenia, genetic,

⁹³ My current assessment is that “true” schizophrenia is a mental illness with a genetic, biological brain disease as the most important contributing factor. It is important to distinguish this genetic,

medical, biological brain disease is the most important contributing factor, and medication assisting the person's biological brain is a foundational part of the treatment plan, but mind/spirit factors still powerfully affect the overall clinical picture. In my experience working with many patients with schizophrenia, mind wounds and the associated spiritual issues consistently exacerbated their overall clinical pictures, and acute psychotic decompensations were often precipitated by mind/spirit issues getting stirred up.⁹⁴ Although resolving mind/spirit issues does not seem to cure the underlying biological brain illness, it consistently improves the overall clinical picture and decreases the need for medication.

Comparison of the “mind *and* brain” paradigm, the “brain only” paradigm, and the “mind/spirit only” paradigm: The “mind *and* brain” paradigm recommends that treatment for Alzheimer's disease and schizophrenia should include *both* biological brain interventions *and* interventions to address mind/spirit issues. In contrast, the “biological brain only” paradigm recommends medication, but does not perceive any need for mind/spirit interventions, and the unresolved mind/spirit issues therefore exacerbate the overall clinical picture. More simultaneous medications and higher doses of medications are required to manage the increased symptoms, and the overall clinical picture is usually worse, even with the additional medication. The “mind/spirit only” paradigm addresses mind/spirit issues, but does not perceive any need for biological brain interventions such as medication. This approach works wonderfully if miraculous physical healing occurs as part of the ministry to address mind/spirit issues, but does not work so well if the Alzheimer's disease or schizophrenia are not miraculously healed. Without appropriate medication, even the short term overall clinical picture will be worse, and the underlying biological brain illness will also progress more quickly over the course of years, making the long term clinical picture much worse.

2. Psychiatric medication in situations where mind/spirit issues are primary: Situations where mind/spirit issues are primary, but symptoms become so severe as to be disabling, provide one of the best examples of the value of the “mind *and* brain” perspective.

In many cases, mind/spirit issues are the most important contributing factors, and the primary focus of treatment should be on the mind spirit issues. However, the “mind *and* brain” paradigm says that even in these cases the overall clinical picture also involves biological brain components. For example, mind/spirit issues are the most important contributing factors in panic disorder, and the primary focus of treatment for panic disorder should be using tools such as Theophostic[®]-based emotional healing ministry to resolve the mind

biological brain disease from other conditions that can be mistaken for schizophrenia, such as severe demonic oppression, severe post traumatic stress disorder, severe dissociative disorders, and especially a combination of these three factors.

⁹⁴ A 1998 study supports my clinical impression that unresolved psychological trauma is a significant exacerbating factor in biological mental illnesses such as schizophrenia, and also my personal experience that many care providers do not recognize the importance of unresolved trauma in these illnesses. Mueser and colleagues studied 275 patients with severe chronic mental illness, and found that 98% reported significant trauma exposure, that 43% met full diagnostic criteria for PTSD, but that only 2% had the diagnosis of PTSD recognized in the medical chart (Mueser K, Trumbetta S, Rosenberg S. “Trauma and Posttraumatic stress disorder in severe mental illness.” *J Consult Clin Psychol.* 1998, Vol. 66, pages 493-499). For additional discussion of the effects of psychological trauma in patients with schizophrenia, see also a very recent article: Muenzenmaier Kristina, Castille Dorothy M., Shelley Anne-Marie, Jamison Andrea, Battaglia Joseph, Opler Lewis A., and Alexander Mary Jane. “Comorbid Posttraumatic Stress Disorder and Schizophrenia,” *Psychiatric Annals*, January 2005, Vol. 35, No. 1, Pages 51-56.

wounds and associated spiritual issues. However, the overall clinical picture also involves biological brain components. Panic disorder results from inherited brain biology weaknesses that predispose the person to respond to certain kinds of mind wounds in this particular way (panic attacks), developmental deficiencies that add to the brain biology predisposition, specific mind wounds (always including some kind of memory anchored “panic” lies), spiritual issues associated with the mind wounds, and some final stressor that triggers the onset of the disorder. These all combine to result in the overall clinical picture of panic disorder, including the biological brain abnormalities corresponding to the dysfunctional emotions and physical symptoms associated with panic attacks.

When the problem is mild to moderate, a mental health problem such as panic disorder causes psychological pain and painful emotions that motivate and guide interventions to address the underlying mind/spirit issues.⁹⁵ However, as the problem becomes increasingly severe, the mind/spirit dysfunctions and biological brain dysfunctions can become disabling instead of providing motivation and guidance (see figure #2, below). Two of the best examples of this phenomena are panic disorder and major depression. As panic disorder becomes increasingly severe, the combination of mind/spirit dysfunction and biological brain dysfunction can cause fearful thoughts to race so uncontrollably that the person is unable to think effectively. Fearful emotions can become so overwhelming that the person has difficulty functioning emotionally, physical symptoms such as episodes of dizziness and trembling can be disruptive, and persistent sleep disruption can result in all the symptoms associated with chronic sleep deprivation. As depression becomes increasingly severe, the combination of mind/spirit dysfunction and biological brain dysfunction result in the person losing the ability to think effectively – sometimes he seems to get stuck in a loop of overwhelming depressive thoughts, and sometimes the person’s thought processes seem to get bogged down, so that he feels like he is thinking in molasses, or in a tar pit. The person often experiences profound loss of motivation, initiative, and “will power.” Depressive emotions, such as sadness, lack of interest, and hopeless despair, can become so overwhelming that the person has difficulty functioning emotionally, physical symptoms, such as severe loss of energy, can be disruptive, and persistent sleep disruption can again cause all the symptoms associated with chronic sleep disruption. In these situations, the person will have great difficulty fulfilling his job responsibilities, relating to his spouse, taking care of his children, or participating in interventions to address the underlying mind/spirit issues.

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

⁹⁵ See Brand, Paul, & Yancey, Philip. *Pain: the Gift Nobody Wants*. (New York, NY: HarperCollins publishers) 1993, for a clear, fascinating, and powerful discussion of the motivating and guiding functions of pain. *This is the best discussion of the appropriate functions of pain that I have ever encountered*

College students provide another good example to illustrate the principles portrayed in Figure #2.⁹⁶ On the first day of class, the teacher says “Your term papers will be due on the Monday before exam week....” These comments, about an assignment that isn’t due for months, produce almost no anxiety, and the students spend their free time flirting and playing frisbee. In the middle of the term, the teacher comments “You should have your subject chosen and most of your note cards completed by now....” The anxiety (pain) produced by these statements provides some motivation,

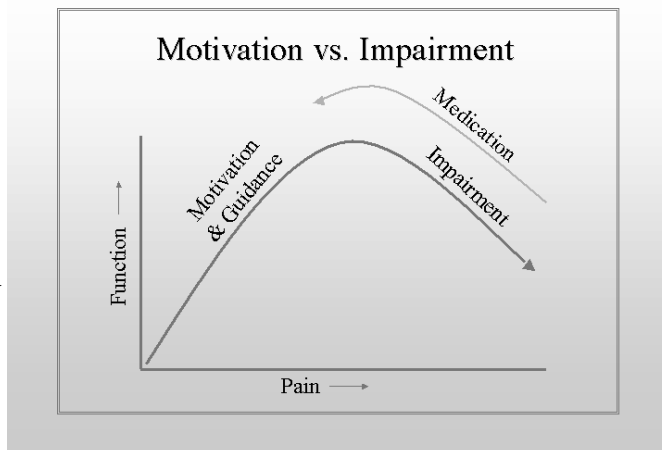


Figure #2

and the students go to the library for a few hours – but then spend the rest of the day flirting and playing frisbee. A week before the paper is due, the teacher comments, “You should be working on your rough draft by now... I’m sure you are all remembering that this assignment will account for one third of your grade....” These comments produce more anxiety (pain), which motivates the students to spend most of their time in the library, and only take occasional breaks to play frisbee. The day before the paper is due, there is a lot of anxiety (pain), and the students are VERY motivated. Nobody is playing frisbee, and most of them won’t sleep, either. Occasionally, a student will postpone work until *too* late.⁹⁷ The anxiety (pain) will become too intense, and be disabling instead of motivating – he will feel overwhelmed, experience panic attacks, become disorganized, and be unable to sleep. This unfortunate student will decompensate instead of working harder and getting his term paper finished. At this point, medication can help stabilize his brain chemistry so that he can sleep and function (in order to deal appropriately with the consequences of not finishing the term paper).

Comparison of the “mind and brain” paradigm, the “brain only” paradigm, and the “mind/spirt only” paradigm: “Mind and brain” paradigm: Medication may be used to moderate

⁹⁶ There are many research studies demonstrating the principles illustrated in figure #2. There are a number of studies that simply examine the connection between level of anxiety (from any source) and performance. As illustrated in figure #2, these studies show that performance is lower with both low and high levels of anxiety, with peak performance corresponding to moderate anxiety in the middle of the curve. See, for example, Cox, F.N., “Correlates of general and test anxiety in children.” *Australian Journal of Psychology*, 1960, Vol. 12, pages 169-177, and Matarazzo J.D., and Phillips Jeanne S. “Digit symbol performance as a function of increasing levels of anxiety.” *J. Consult. Psychol.*, 1955, Vol. 19, pages 131-4. In other studies, test performance was evaluated as pressure to succeed was steadily increased. Initially, pressure to succeed seemed to produce anxiety that energized and motivated the subjects to perform. However, at a certain point of increasing pressure, anxiety became so severe that it increasingly impaired performance. See, for example, ****get references. for these studies****

⁹⁷ As most readers will probably realize, just putting off a paper until too late and not being able to finish it – even if this results in failing a required course, won’t necessarily result in panic, insomnia, and decompensation. Some students can deal with this situation – experiencing pain (and hopefully learning from the experience), but not decompensating. But, in order to keep the example simple, I am not discussing the other variables that affect whether or not a given situation is overwhelming to the point of decompensation.

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

C. More optimistic regarding some “irreversible” brain injury: Authors such as Allan Shore, Ph.D., and James Wilder, Ph.D. write about biological brain changes that occur as a result of psychological traumas and/or deficiencies, especially during childhood development. They often refer to these biological brain changes as “permanent,” and/or comment that they “never resolve.”⁹⁸ The clearly observable data is that psychological trauma and/or deficiencies, especially during childhood development, do cause biological brain abnormalities. Furthermore, these brain abnormalities are observed to remain for many years (they are not observed to resolve). However, the “biological brain only” and the “mind and brain” perspectives differ in their interpretations and recommendations regarding this information. Biological brain only perspective: The brain is primary, and the observed brain changes are the deepest roots and most fundamental aspect of the problem. There is no known biological process for reversing the structural changes that result from trauma or deficiency during development, and the observation that these changes continue into adulthood, and appear to be permanent, is completely expected. The focus of treatment should be on prevention if damage has not yet occurred, and on symptom management for those who have already been injured. Mind and Brain perspective: The mind/spirit is the primary phenomena in many situations, and abnormalities in the biological brain often simply reflect or express underlying mind/spirit issues. It may be that research shows “permanent,” “irreversible” biological brain changes associated with some psychological traumas and/or deficiencies because we have not had tools that are effective in addressing the corresponding underlying mind/spirit issues. If the mind wounds and spiritual issues causing the brain biology abnormalities usually haven’t gotten resolved, the corresponding brain biology abnormalities would be expected to remain as well. However, if mind wounds and/or spiritual issues are the deepest roots/primary causes of some of these

⁹⁸ See, for example, Shore, Allen N., Ph.D. *Affect Regulation and the Origin of the Self*. (Hillsdale, NJ: Lawrence Earlbaum Associates, Publishers), 1994, where Dr. Shore makes many comments about “permanent” and “irreversible” biological brain changes caused by trauma and/or deficiency during development.

brain biology abnormalities, then the brain biology abnormalities are *not* truly irreversible, and will correct when the underlying issues are resolved. In these situations, the “mind and brain” paradigm would recommend finding and resolving the source mind/spirit issues, as opposed to simply moderating and managing the symptoms of “irreversible” brain injury.

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

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

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

X. Putting other material in the larger “mind and brain” frame work:

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

Daniel Amen, M.D.: Dr. Amen acknowledges that brain biology and emotional healing interact, but sometimes sounds as if he believes, *experientially*, that the brain biology is the more primary process. In my assessment, he over-emphasizes “The person just has a broken brain, and the problem needs to be fixed/treated with medication,” and under-emphasizes “The brain chemistry abnormality might be caused by a wounded mind, and should be treated primarily with emotional healing.” One particularly helpful point to be aware of when reading Dr. Amen’s material is that SPECT scans have no ability to distinguish between abnormal brain function caused by an underlying *mind* wound and abnormal brain function caused by a primary wound in the *biological brain*.

Grant Mullen, M.D.: Dr. Mullen acknowledges both brain biology and emotional healing, but is not as sharp/clear about how they interact. In my assessment, he over-emphasizes “The person just has a broken brain, and the problem needs to be fixed/treated with medication,” and under-emphasizes “The brain chemistry abnormality might be caused by a wounded mind, and should be treated primarily with emotional healing.”

Daniel Siegel, M.D.: Dr. Siegel is a brilliant clinician and researcher, and presents many helpful thoughts and insights, but he clearly believes that the biological brain is the more primary phenomena, and that the mind is *created by*, and *arises from* the activity of the biological brain.⁹⁹ As one reads his material, one must constantly remember that all of his thinking is developed from this “brain only/brain before mind” perspective.

Karl Lehman, M.D. (me): I acknowledge both the biological brain and the non-biological mind, and I have been working on how they interact. However, some of my previous writing has not been as clear with respect to the “mind *and* brain” picture as described here.

XI. Frequently asked questions:

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

1. I have seen emotional/spiritual healing result in resolution of brain biology problems that were simply expressions of the mind/spirit issues – such as the abnormal brain biology of a depression that is primarily caused by underlying memory anchored lies. I have seen emotional/spiritual healing result in resolution of physical/medical problems that had been caused by demonic spirits (which were dis-empowered and sent away in the course of the emotional healing work).¹⁰⁰ I have seen emotional/spiritual healing result in physical healing because mind/spirit issues had been crippling the person’s faith, and healing prayer could then be effective after the mind/spirit wounds were resolved. But I, *personally*, have not seen emotional/spiritual healing result directly in the resolution of primary brain biology problems, such as traumatic brain injury, strokes, Alzheimer’s disease, or true genetic schizophrenia.

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

⁹⁹ The first sentence on page one of one of his most recent books reads: “The mind emerges from the activity of the brain,....” (Siegel, D.J. *The Developing Mind*. New York: Guilford Press, 1999. Page 1). See pages 3, 143, 159, 160, 215, 222, 223, 239, 245, and 300 for similar comments. In the introduction to his most recent book, Dr. Siegel states: “The mind emanates from the activity of the brain,....” (Siegel, D.J. *Parenting from the Inside Out*. New York, NY: Jeremy P. Tarcher/Putnam, 2003, page 8). See pages 22, 31, 32, 42, 53, for similar comments.

¹⁰⁰ This would include illnesses such as “mimic” schizophrenia and “mimic” bipolar disorder – in specific cases where the “mimic” illnesses were caused by demonic spirits (as opposed to “true” schizophrenia or “true” bipolar disorder caused by genetic brain biology abnormalities).

XII. Sample Prayers: After preparing the material in this essay, we felt it was valuable to pray regarding several specific issues. If these issues and prayers seem valid for you, then we encourage you to join us in your hearts for these prayers (or your own versions, customized to fit your own style).

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

Sample prayers and commands:

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

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

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

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

“Amen.”

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

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

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

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

“Amen.”

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

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

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

Sample prayers and commands:

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

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

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

"Amen."

C. Prayers of blessing and anointing:

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

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

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