Mind *And* Brain: Separate but Integrated – *Very* Condensed Version

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

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 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's very important to understand that the *biological, physical brain* and the *non-biological, non-physical mind* are *separate, qualitatively different* phenomena. The non-biological mind/spirit perspective and the physical science biological brain perspective will yield *qualitatively* different results. Physical science processes do not *produce* or *cause* the *qualitatively* different mind/spirit phenomena, and it's 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.

And it's very important 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's 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. 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 would 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 operator, and the brain is just the computer that the operator uses to express and implement his intentions.

Dr. Penfield wrote an entire book, *The Mystery of the Mind*, 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 – consciousness, self*

awareness, the ability to make free will choices, and the ability to initiate original, creative thought and activity. 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.

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. 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.

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.

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. 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. 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.

Since the anecdotal accounts described by authors publishing in the 1970's and 1980's, many careful research studies have examined near death experiences. The "Atlanta Study," carried out between 1994 and 1996 by Dr. Michael Sabom, provides an example of recent, careful research regarding near death experiences. One of the patients in this study described detailed memories of the events that had occurred in the operating room while she was clinically dead, with no heart beat and no respiration. Furthermore, since this occurred during a particular, unusual brain surgery procedure, there's 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. In a 2002 article published in *Resuscitation*, a 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."

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.

4. "Impossible" intra-uterine and birth memories: We have seen prayer for emotional healing sessions that appear to go to memories in the womb that are very early – when brain development is still very primitive, or even before the brain has begun to form at all – and we often see prayer for emotional healing sessions that appear to go to the person's birth. Other authors have also described case studies that include memories for events that occurred while the person was still in the womb, and/or memories for events during the person's birth. Some of these cases include memory content that is consistent with implicit memory systems now known to be neurologically "on line" by mid pregnancy – sensory fragments appropriate to the intrauterine environment, simple emotional associations, and primitive, vague thoughts. 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. 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).
- 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.

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

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

a. "Blind Tom," a musical prodigy: "Blind Tom," born as a slave in 1849, displayed

astonishing musical abilities in spite of being nearly blind, mentally retarded, and without musical training other than listening to others perform. For example, at 11 years of age he performed 33 pages of complicated original 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.

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..."

These astonishing, mysterious, "impossible" abilities are not explained by any brain biology theory I'm aware of, but they are consistent with the existence of higher, deeper, non-biological "mind" phenomena.

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 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 treatment.

From a "brain biology is the *only* reality" perspective: Brain biology can provide good guidance about how to use medication to moderate symptoms, but the huge pile of neuro-psychiatric theory and data are essentially useless for understanding or resolving any underlying mind/spirit issues. For example, if I'm working with someone who has major depression, neuropsychiatric research tells me that certain areas of the patient's brain are over-functioning and others are under-functioning, that these patterns of brain dysfunction are associated especially with decreased activity in serotonin pathways, that many of the patients symptoms, such as poor sleep and decreased energy, are directly connected to the decreased serotonin, and that medications that increase serotonin activity will moderate (or even temporarily resolve) the overall clinical picture of depression.

But information about the biological brain provides no insight regarding underlying mind/spirit issues, and no guidance regarding how to resolve them. Why does the person struggle with the same persistent, recurrent negative thoughts each time he gets depressed? Why does he believe he is powerless and worthless, even though this makes no sense in his present life? And how can these thoughts and emotions be permanently resolved so that he doesn't have to be on medication for the rest of his life? Neuropsychiatric research can ***describe*** the abnormal brain biology ***associated*** with the clinical picture of depression, and provide guidance about how to correct the brain biology abnormalities, but it 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®[1]-based emotional healing ministry, to be intuitively understandable and to be very useful in guiding my thoughts and decisions in actual clinical practice. For example, if I'm 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 in a way that "makes sense" intuitively. And I find that these negative cognitions, such as "I'm worthless," "I'm powerless," and "It's hopeless" 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 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!* And we have seen the same picture with many other mental health problems, such as panic attacks, phobias, sleep disorders, post traumatic stress disorder, and various compulsive and addictive behaviors.

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's 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. An analogy illustrating *qualitatively* different phenomena:

Car "behavior" – *driver* questions vs. *machinery* questions: Let's say you're 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

[1] Theophostic® Prayer Ministry is a trademark of Dr. Ed Smith and Alathia, Inc. The Lehmans do not claim any endorsement by, nor affiliation with the trademark holder.

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.

When the question has to do with the automobile *driver*, talking to the driver is most helpful. When there's a problem with the automobile *machinery*, getting a mechanic to work on the machinery is most helpful. For any aspect of the problem that's a mind wound or mind issue, it's most helpful to approach from a mind perspective. For any aspect of the problem that's a brain biology issue, it's most helpful to approach from a brain biology 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 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.* 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

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, 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 abnormalities are also resolved.

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 with 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 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.

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

1. My own patients: I've had the privilege of providing both the psychotherapy/ministry, and the medication management, for a number of patients. Several of these patients met rigorous, research level 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), 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. As we worked with these emotional healing tools, we identified and addressed mind wounds and associated spiritual issues that seemed, intuitively, to be connected to the symptoms of their mental illnesses. As the healing process continued, these people would say things like "I know that's where the panic was coming from – I can feel that the roots of the panic have been resolved," or "I feel like I'm on too much medication – I think we 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*.

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 *resolving **mind/spirit** wounds resulted in correction of these **brain biology** abnormalities*.

2. Other cases I am involved in: In addition to my own patients, I'm also involved with a number of similar cases where I'm not the care provider, but where I've 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.

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.

D. Beyond the driver/car analogy: 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 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 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.

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.

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.

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: 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 dysfunction *exposes* unresolved mind/spirit issues. For example, Alzheimer's disease is a very genetic, medical, biological brain illness. However, part of what happens in Alzheimer's disease is that increasing biological brain dysfunction steadily erodes 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/spirt issues increasingly affect the person's thoughts, emotions, and behavior.

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, 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.

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 developmental factors, environmental factors, genetic brain chemistry vulnerabilities, and medical illnesses that affect the brain determine which mental illness actually develops (panic vs. depression vs. obsessive compulsive disorder vs. substance abuse, etc).

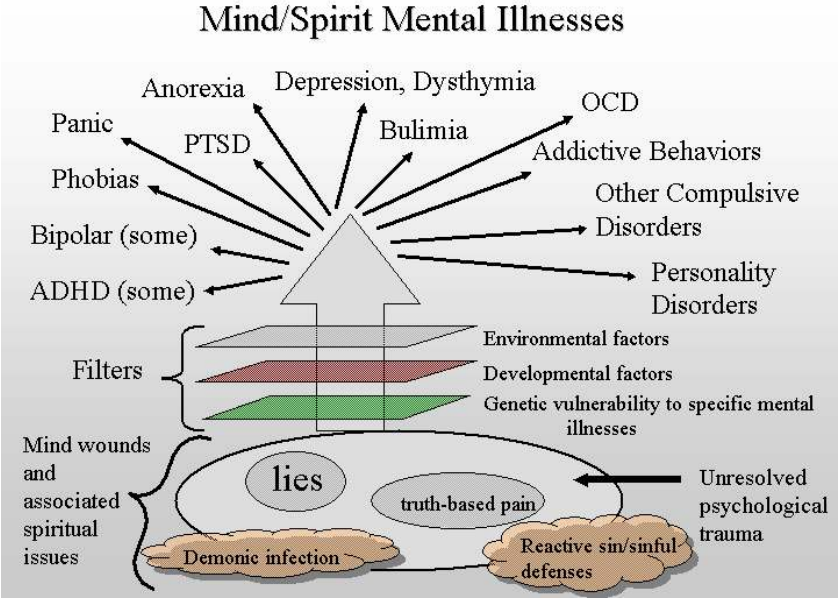

Figure #1

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

As discussed above, it is very important to recognize *both* biological brain phenomena *and* non-biological mind/spirit phenomena, and it is very helpful to begin with approaching biological brain phenomena from a biological brain perspective and non-biological mind/spirit phenomena from a mind/spirt perspective.

However, although it is *easiest* to approach a specific aspect of a situation from the primary perspective, and therefore it is wise to *begin* by approaching biological brain phenomena from a biological brain perspective and by approaching non-biological mind/spirit phenomena from a mind/spirt perspective, the biological brain and the non-biological mind/spirit are so intimately and profoundly connected that it is even valuable to study mind/spirit phenomena from a brain perspective, and to study brain phenomena from a mind/spirit perspective.

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. Amazingly, the biological brain and the non-biological mind/spirit are so intimately and profoundly connected that study of the brain processes associated with these mind/spirit phenomena have 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.

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 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 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.

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 _____ (fill in the blank with the name of the 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,

THEREFORE, 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,

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

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

"Therapists and/or emotional healing ministers approaching from the non-biological mind/spirit perspective have discovered mind/spirit issues associated with _____ (fill in the blank with the 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, such as hopelessness, sadness, 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,

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

THEREFORE, 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/spirt 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.

THEREFORE, 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.

THEREFORE, 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.

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.

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

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

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

Patient: *Eventually responds with a guarded, anxious* "What're 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 kinda like the ones you've told me about – just recently told me that they also have "other" voices that they'd 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.

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

Furthermore, psychological traumas – mind "wounds" – seem to make a person more vulnerable to demonic "infection" in much the same way as biological brain "wounds." In almost 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 his antidepressant medication, and just because a person's depression improves dramatically with medication does *not* prove that demonic oppression cannot be contributing. Just because a spirit of insanity has been identified and removed, with significant improvement, does *not* rule out the possibility that the person also has biological brain schizophrenia, and just because a person improves with antipsychotic medication does *not* prove that demonic spirits are not contributing to his psychotic symptoms.

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

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. 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.

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 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).

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

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

VIII. 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 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 directly 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. 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). 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. 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 gratefully 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.

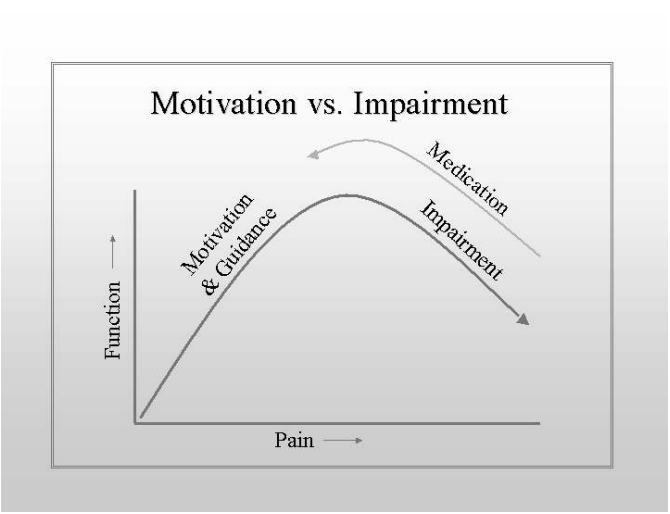

Figure #2

College students provide another good example to illustrate the principles portrayed in Figure #2. On the first day of class, the teacher says "Your term papers will be due on the Monday before exam week...." These comments, about an assignment that isn't due for months, produce almost no anxiety, and the students spend their free time flirting and playing frisbee. In the middle of the term, the teacher comments "You should have your subject chosen and most of your note cards completed by now...." The anxiety (pain) produced by these statements provides some motivation, and the students go to the library for a few hours – but then spend the rest of the day flirting and playing frisbee. A week before the paper is due, the teacher comments, "You should be working on your rough draft by now... I'm sure you're 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's 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. 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).

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. Prayer: 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's a place for dialogue to discuss points of disagreement, but there's ***no*** place for pride, judgment, or disrespect.

Sample prayers and commands:

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

Sample prayers and commands:

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

Lord, we confess that we often err in our thinking and beliefs. We confess that we have

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

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

"Amen."

C. Prayers of blessing and anointing:

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

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

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