The Convergence

Why Mental Health Requires a Larger Conversation About Mind, Soul, Body, and Spirit

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Independent working paper. This paper presents the author's theological convictions, developing framework, research questions, and interdisciplinary inquiry. It has not undergone peer review. Statements of Christian belief are identified as theological propositions rather than empirical findings.

Abstract

Mental health is often discussed through separate disciplinary lenses: psychology examines thought, emotion, behavior, and identity; neuroscience studies the brain and nervous system; medicine examines the body; and theology addresses God, soul, spirit, meaning, sin, suffering, and spiritual reality. I believe this separation leaves something essential out. My starting conviction is explicitly Christian: **all mental illness has a spiritual root or spiritual dimension at some capacity**, even when biological, psychological, developmental, relational, environmental, or traumatic factors are also present. By *spiritual root*, I do not mean that every diagnosis is caused by a demon, that every symptom has the same spiritual explanation, or that medical and psychological mechanisms are unreal. I mean that no form of human suffering is finally disconnected from the spiritual condition and reality of the person. This paper introduces what I call **the convergence**: a framework for examining mind, soul, physical body, and spirit together. It distinguishes theological conviction from empirical evidence while arguing that spiritual questions should not be excluded simply because they cannot be reduced to biological measurement.

Author's Note: My Starting Conviction

I want to state my position more clearly than I did in the first version of this paper. I do believe that mental illness has a spiritual root at some capacity. That belief is not a conclusion I am claiming neuroscience has already demonstrated. It is a theological conviction grounded in my Christian understanding of the human person and the spiritual nature of human life.

For me, this means the spiritual dimension is not an optional category that becomes relevant only when a person happens to be religious. Human beings are spiritual beings. Therefore, what happens psychologically and biologically occurs within a person whose life also has a spiritual dimension.

That conviction does **not** require me to deny biology. A person may have genetic vulnerability, altered sleep, hormonal disruption, nervous-system dysregulation, traumatic conditioning, medication effects, neurological disease, relational injury, or other measurable contributors to distress. Those mechanisms matter. They may require medical, psychiatric, psychological, social, or practical responses. But I do not believe identifying a mechanism automatically answers the deeper question of spiritual root or meaning.

> *This distinction is central to the work I am building:* ***source and mechanism are not necessarily the same question.***

I Keep Coming Back to the Same Problem

We talk about the human person in pieces. The brain is discussed in one room. The nervous system in another. Trauma somewhere else. Identity somewhere else. Spirituality may be assigned its own category. Scripture is often treated as belonging to an entirely different conversation. Miraculous healing, deliverance, spiritual oppression, sin, forgiveness, prayer, and the work of God may be excluded from serious mental-health inquiry before the questions are even asked.

But the person experiencing depression, fear, trauma, confusion, compulsion, intrusive thoughts, unusual perceptions, or psychological distress is not experiencing herself in departments.

Fear can involve a thought, a memory, a belief, a bodily sensation, an expectation, a learned response, a relationship, an identity, and a spiritual interpretation at the same time. Depression may involve sleep, inflammation, loss, cognition, hopelessness, social conditions, meaning, belief, and spiritual struggle. The existence of one level does not automatically erase the others.

My proposition is stronger than saying spirituality can sometimes be relevant. I am proposing that **the spiritual is always relevant because the person herself is spiritual**. What varies is not whether a spiritual dimension exists, but how it is expressed, how directly it contributes to the presenting problem, and whether we currently have the tools to identify or study it responsibly.

What I Mean by the Convergence

When I use the word **convergence**, I mean the disciplined consideration of the human person across four working dimensions: **mind, soul, physical body, and spirit**.

The **mind** includes thought, attention, perception, memory, imagination, belief, interpretation, and meaning-making. The **physical body** includes the brain and nervous system as well as sleep, hormones, immune activity, sensation, movement, stress physiology, and the other biological systems through which life is experienced. I use **soul** as a theological and philosophical category for the interior person - including identity, desire, will, emotion, and the lived sense of self. **Spirit** refers to relationship with God and the spiritual dimension of reality as understood within a Christian worldview.

These are not four perfectly isolated scientific compartments. They are working distinctions. Their interaction is precisely the point. When a thought changes heart rate, where does mind end and body begin? When trauma reshapes identity, where do psychology and soul meet? When prayer changes emotion or physiology, what are we observing? When a person reports deliverance and a symptom disappears, what changed - psychologically, biologically, spiritually, or across several dimensions at once?

> *Those are convergence questions.*

What I Mean by a Spiritual Root

The phrase *spiritual root* can easily be misunderstood, so I want to define how I am using it in this developing framework.

I am **not** using it as a synonym for demonic causation. Christian theology contains multiple categories for spiritual disorder and suffering: the fallen condition of creation, sin and its consequences, deception and false belief, broken relationship, bondage, fear, shame, idolatry, spiritual oppression, and other realities described in Scripture. I am not claiming that every psychiatric diagnosis can be mapped neatly onto one biblical category.

Instead, I use *spiritual root* to mean that mental suffering cannot be fully separated from the person's spiritual reality and from the larger Christian account of what has happened to humanity and creation. In some cases, the spiritual dimension may be indirect and deeply intertwined with biology or experience. In others, a person may understand it as much more immediate. These possibilities should be distinguished rather than collapsed into one explanation.

This is currently a **theological and theoretical proposition within my framework**. Establishing which specific spiritual claims can be operationalized, observed, or empirically tested is a separate research task.

Scripture Is Not Neuroscience - and Neuroscience Does Not Exhaust Reality

One of the easiest mistakes in this work would be to find a brain scan that changes during prayer and declare that science has proved God. I do not think that is intellectually responsible. If prayer is associated with activity in a particular neural network, the scan tells us something about what is happening in the person's brain during prayer. It does not establish whether God heard the prayer, whether God responded, or whether the experience had a supernatural source.

But the opposite mistake is also limiting: assuming that because an experience has a biological correlate, biology has therefore explained the entire experience. An embodied person will have biological activity while praying, grieving, remembering, fearing, loving, worshiping, or encountering what she understands to be God. Biological mechanism is expected.

The question I want to preserve is whether **mechanism and source are always the same question**. My position is that they should not be treated as interchangeable without argument.

This is why the convergence requires both openness and restraint. Openness means spiritual hypotheses are not excluded merely because they cross disciplinary boundaries. Restraint means I do not present a theological conviction as though a laboratory has already proven it.

Science Is Already Entering Part of This Conversation

Religious and spiritual experiences are already objects of scientific study. Researchers have used neuroimaging and neurophysiological methods to examine prayer, meditation, worship, chanting, mystical experience, and other spiritual practices. A 2026 systematic review synthesized 105 studies and reported recurring involvement of systems associated with attention, emotion regulation, self-referential processing, social cognition, and reward (Husain et al., 2026).

This does not reveal a single 'God spot,' nor does it prove or disprove spiritual reality. It does show that spiritual practices and experiences can have measurable human correlates.

Research has also examined psychotherapies that intentionally incorporate a person's religious or spiritual framework. Meta-analytic evidence suggests that religiously and spiritually integrated approaches can be meaningful in mental-health care for some populations (Bouwhuis-Van Keulen et al., 2024).

These findings do not establish my stronger proposition that all mental illness has a spiritual root. They establish something narrower but important: spirituality can be studied without ceasing to be a serious scientific subject. My larger proposition remains something to define, interrogate, and - where possible - test.

What Do We Actually Mean by Healing?

If the person is more than a brain, then healing may also require a larger vocabulary.

Do we mean symptoms decreased? That a person can work again? That sleep returned? That panic stopped? That voices ceased? That compulsive behavior lost its power? That the nervous system became more regulated? That relationships changed? That identity was restored? That the person reconciled with God? That what she experienced as spiritual bondage ended?

Clinical research needs measurable outcomes, and measurement matters. But people frequently describe healing in language larger than a symptom score: *I became myself again. I became free. God healed me.*

I do not think the scientific response should be to abandon measurement. I think it should be to ask better questions: What changed? What can be documented? How long did the change last? What else changed at the same time? Which explanations fit the evidence? Which remain theological interpretations? Are our measures broad enough to capture the transformation the person is describing?

The Kind of Work I Want to Build

I am not approaching this work from theological neutrality. I begin with a Christian conviction: the human person is spiritual, and mental illness therefore has a spiritual root or dimension at some capacity. But conviction does not eliminate the need for disciplined inquiry. It makes clarity about categories even more important.

I want to be able to say, without blurring the distinctions: **This is what Scripture says. This is what I believe. This is what people report. This is what research has found. This is the mechanism I am proposing. This is the spiritual interpretation I am considering. And this is what we still do not know.**

For me, that distinction does not weaken faith. It gives the inquiry integrity.

Questions I Want to Carry Forward

If every form of mental illness has a spiritual dimension at some capacity, how should that proposition be defined precisely enough to study rather than merely asserted? What would distinguish a spiritual *root* from a spiritual *consequence*, a spiritual *interpretation*, or a spiritual *context*? Can those categories overlap?

How do thought, imagination, memory, belief, nervous-system activity, hormones, identity, relationships, behavior, trauma, environment, and spiritual life interact over time? When a person reports spiritual oppression, deliverance, miraculous healing, or extraordinary recovery, what psychological and biological changes can be documented before and after the reported event?

Can explicitly Christian practices produce measurable changes in psychological or biological functioning? If so, what mechanisms are involved? Can research compare spiritually congruent interventions with structurally similar secular interventions without pretending that such a comparison can adjudicate the existence of God?

Can a whole-person intervention be developed that is explicitly Christian, scientifically testable, ethically responsible, and transparent about the difference between theological conviction and empirical demonstration? What outcomes would show whether it is helping? What findings would challenge or refine the model?

And perhaps the larger question underneath all of this remains the simplest one:

> ***What becomes visible when we stop dividing the human person before we begin trying to understand her?***

That is the convergence I want to keep studying.

References

Bouwhuis-Van Keulen, A. J., et al. (2024). The evaluation of religious and spirituality-based therapy compared to standard treatment in mental health care: A multi-level meta-analysis of randomized controlled trials. *Psychotherapy Research, 34*(3).

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