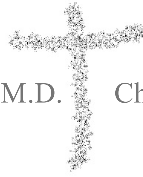
Karl D. Lehman, M.D.  Charlotte E.T. Lehman, M.Div.

ADD/ADHD and Immanuel Approach Emotional Healing

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I have gotten a steady stream of questions about Attention Deficit Disorder/Attention Deficit and Hyperactivity Disorder (ADD/ADHD), and I'm finally getting around to upgrading the draft version of this essay that has been posted on our website for the past ten years. This essay summarizes some of my general thoughts, and also the answers to frequently asked questions. This essay is *not* a comprehensive discussion of ADD/ADHD, but rather focuses on issues especially relevant to using the Immanuel Approach in the treatment of ADD/ADHD.

I. "True" Attention Deficit Disorder (ADD)/Attention Deficit and Hyperactivity Disorder (ADHD) vs "mimic" ADD/ADHD: One of the most important comment-questions I receive from those doing emotional healing work goes something like "I worked with someone who was ADD/ADHD, and they were completely healed when we found and resolved a bunch of underlying traumatic memories and threw out a bunch of demonic spirits – isn't ADD/ADHD just another manifestation of trauma, lies, and demonic oppression?" Review of the medical research, my personal clinical experience with patients that have been previously diagnosed with ADD/ADHD, and my personal experience with symptoms of ADD/ADHD in my own life have lead me to the conclusion that there are two separate clinical situations – "mimic" ADD/ADHD and "true" ADD/ADHD – both currently included in the group of people carrying the diagnosis of ADD/ADHD.[1]

"True," brain-biology ADD/ADHD: What I call "true" ADD/ADHD is a mental illness that includes an important component of what I call *primary* biological-brain abnormalities – biological-brain abnormalities that contribute to the mental illness *and that are **not** simply caused by spiritual and/or psychological issues*. People with true ADD/ADHD have biological-brain vulnerabilities that *predispose* them to respond to emotional and spiritual problems (truth-based pain in the present, unresolved trauma, immaturity, sinful defenses, other sin, and demonic infection) with the clinical picture that I call true ADD/ADHD. The exact neurological mechanisms are unclear, but my perception is that in people with these vulnerabilities, emotional and spiritual problems can push their biological brain function into the brain abnormalities of true ADD/ADHD. True ADD/ADHD is *not* "just" a manifestation of emotional and spiritual problems in an otherwise normal brain, and it *cannot* be completely resolved with emotional healing ministry.

Mimic ADD/ADHD: What I call "mimic" ADD/ADHD is a clinical picture that looks a lot like true ADD/ADHD, but that is actually a combination of unresolved trauma getting stirred up, dissociative phenomena, lack of maturity skills, and demonic infection. Mimic ADD/ADHD ***is*** "just" the manifestation of emotional and spiritual problems in an otherwise normal brain, and it *can* be completely resolved with emotional healing. For example, I think many of the symptoms in "mimic" cases that have been mis-diagnosed as ADD/ADHD are actually just the restlessness,

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[1]Of course there are also some people with *both* the trauma-dissociation-immaturity-demonic infection combination *and* true, genetic, brain-biology ADD/ADHD, and a few people with various other problems that occasionally mimic ADD/ADHD.

distraction, and cognitive interference that usually go along with lots of unresolved trauma. My own experience with ADD/ADHD symptoms (described in detail below) provides a good example of this kind of mimic ADD/ADHD picture.

Note that the combination of unresolved trauma, dissociative phenomena, lack of maturity skills, and demonic infection do not *always* cause mimic ADD/ADHD. Sometimes this combination can cause suffering and dysfunction, but *not* cause symptoms severe enough to meet criteria for any of the clinically recognized mental disorders. And sometimes this combination can cause symptoms that mimic other mental illnesses with prominent brain biology abnormalities, such as bipolar disorder or schizophrenia. Mimic ADD/ADHD results only when unresolved trauma, dissociative phenomena, lack of maturity skills, and demonic infection are *sufficiently severe* and also *interact in certain ways* so as to produce a clinical picture that is similar to true ADD/ADHD.

Medical-psychiatric research: There is a large collection of medical-psychiatric research supporting the existence of a "true" ADD/ADHD as described above. For example: case-control family pattern studies, studies comparing fraternal vs identical twins, adoption studies, gene mapping association studies, other molecular genetics research,[2] studies of neurotransmitters, neuroanatomical studies, and cerebral metabolism and blood flow studies.[34] A thorough discussion of this research is beyond the scope of this essay, but I would like to briefly summarize an especially compelling and easy to understand component of the medical research

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[2]Note that the evidence for genetic factors contributing to mental health problems is *NOT* just family patterns that could be explained by psychological and/or spiritual phenomena being passed down in families. For additional discussion regarding evidence for genetic, brain-biology factors contributing to ADD/ADHD, see Hechtman, Lily. "Chapter 39: Attention-Deficit Disorders," in Kaplan, H.I., Kaplan, Virginia A. (Eds.) *Kaplan and Sadock's Comprehensive Textbook of Psychiatry, 8th edition*, (Baltimore, MD: Lippincott Williams & Wilkins), 2004, pages 1582-94. For a good general discussion of genetics and mental illnesses, and an understandable explanation of the different kinds of research examining genetic contribution to mental illnesses, see Faraone, Stephen V., Tsuang, Ming T., Tsuang, Debby W. *Genetics of Mental Disorders: A Guide for Students, Clinicians, and Researchers*. (New York, NY: Guilford Press), 1999.

[3]For discussion of these additional sources of evidence indicating a true ADD/ADHD that includes neurobiological abnormalities *not* simply caused by spiritual and/or psychological issues, see Daniel G. Amen, *Healing ADD*, (New York, NY: G.P. Putnam & Sons), 2001, especially pages 40-66; and also Hechtman, Lily. "Chapter 39: Attention-Deficit Disorders," in Kaplan, H.I., Kaplan, Virginia A. (Eds.) *Kaplan and Sadock's Comprehensive Textbook of Psychiatry, 8th edition*, (Baltimore, MD: Lippincott Williams & Wilkins), 2004, pages 1582-94.

[4]An important caveat regarding the many neurobiological abnormalities seen in patients with true ADD/ADHD is that we need to consider the possibility that these brain abnormalities could be caused by psychological and spiritual issues (as discussed at length in the essay "Mind *and* Brain: Separate but Integrated." In fact, I am convinced that this is the case for some of these abnormalities, but the reason I include the reference to neurobiological abnormalities in support of my conclusions regarding true bipolar is that each mental illness is associated with it's own constellation of neurobiological disturbances. My perception is that some of this can be explained by certain mental illnesses also being associated with their own constellations of spiritual and psychological issues (for example, traumas with "It's hopeless, I'm worthless" will be associated with depression, while traumas with "I'm gonna die" will be associated with panic); However, I don't think this can adequately account for all of the neuro-biological abnormalities.

provided by a specific kind of twin study.

The results I would like to summarize here come from twin studies that work with sets of twins that have been reared together, and then compares the concordance rate[5] in fraternal twins with the concordance rate in identical twins. The two key points in these studies are 1) both the fraternal and identical twins have shared very similar intrauterine and family environments; and 2) the identical twins have *exactly the same genetic blueprint*, whereas fraternal twins share genes in the same way siblings do. Under these conditions, if a particular illness is *completely genetic*, identical twins will be concordant (both twins either having the illness or not having the illness) *100%* of the time because their genes are *100%* identical, whereas fraternal twins will be concordant at the same percentage as *non-twin siblings* – 50%, because they share 50% of their genetic material. In contrast, if a particular illness is *completely the result of environmental factors*, there will be *no difference between identical twins and fraternal twins*. And if an illness is ***partially genetic*** **and** ***partially environmental*** – that is, there is a genetic predisposition/ vulnerability, but some kind of environmental factor causes the underlying vulnerability to manifest as actual disease – then ***identical twins*** will be concordant at a ***greater percentage*** than fraternal twins, ***but at a percentage less than 100%***.

This is exactly what is found with ADD/ADHD – identical twins show concordance rates from 59 to 92%, while fraternal twins show concordance rates from 29 to 42%.[6] (Note: identical twins ***dramatically higher*** than fraternal twins, but ***less than 100%***) To my assessment, the results of these twin studies alone prove that there is a "true" ADD/ADHD where 1) primary biological-brain abnormalities make certain people vulnerable to the illness; and 2) environmental stressors (for example, truth-based pain, unresolved trauma, demonic infection) are required for the biological brain predisposition to be expressed as clinical ADD/ADHD.

Personal clinical observations: One very important observation in my personal clinical experience supports my conclusion that there is such a thing as mimic ADD/ADHD, that ***is*** "just" the manifestation of emotional and spiritual problems in an otherwise normal brain – I have worked with a number of clients who were initially diagnosed with ADD/ADHD, but their ADD/ADHD symptoms progressively resolved as we worked together over time to find and resolve the underlying emotional and spiritual issues that were the true source of their symptoms. For me, this data point has been particularly convincing, since of this has been exactly my own experience – my own ADD/ADHD symptoms have progressively resolved over time as I have worked to find and resolve the underlying emotional and spiritual issues that were the true source of the symptoms. (See section III, below, for a more detailed description.)

Bonus data point: The following is a particularly relevant quote from an internationally recognized authority on childhood emotional trauma, and it clearly supports my observations with respect to unresolved trauma and dissociative phenomena sometimes producing symptoms that are mistaken for symptoms of ADD/ADHD:

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[5]The concordance rate simply indicates the percentage of twin pairs where both twins are the same with respect to whatever is being measured in the particular study (for example, eye color, the presence of diabetes, or the presence of ADD/ADHD).

[6]See Hechtman, Lily. "Chapter 39: Attention-Deficit Disorders," in Kaplan, H.I., Kaplan, Virginia A. (Eds.) *Kaplan and Sadock's Comprehensive Textbook of Psychiatry, 8th edition*, (Baltimore, MD: Lippincott Williams & Wilkins), 2004, page 3184.

"Transient dissociative episodes are a common and normative phenomenon during childhood that generally decrease during adolescence to relatively low levels in adults. Retrospective clinical research has firmly established a connection between childhood trauma and the development of dissociative disorders in adults. A growing number of clinicians are now identifying dissociative symptoms in abused children, and there is increasing evidence that dissociative disorders represent a significant and hitherto unrecognized form of psychopathology in traumatized children. Pathological dissociation is a complex psychobiological process that results in a failure to integrate information into the normal stream of consciousness. It produces a range of symptoms and behaviors including: (a) amnesias; (b) disturbances in sense of self; (c) trance-like states; (d) rapid shifts in mood and behavior; (e) perplexing shifts in access to knowledge, memory, and skills; (f) auditory and visual hallucinations; and (g) vivid imaginary companionship in children and adolescents. **Many of these symptoms and behaviors are misdiagnosed as attention, learning, or conduct problems**, or even psychoses. Early identification and therapeutic intervention appear to be particularly efficacious in children in contrast to adults, although systematic studies of treatment and outcome are presently lacking."[7]

II. Specific phenomena that contribute to frequent misdiagnosis: As is clear from the above comments, I believe there is such a thing as true ADD/ADHD, and I also believe that many people with a combination of trauma, dissociative phenomena, lack of maturity skills, and demonic infection are misdiagnosed as having ADD/ADHD. Many mental health professionals, and especially those trained primarily in the medical psychopharmacology model, have a poor understanding of trauma, dissociative phenomena, maturity deficits, and especially demonic infection[8]. If you are working with someone who doesn't understand (or even believe in) psychological trauma, dissociation, lack of maturity skills, or demonic infection, he or she will try to fit the phenomena described below into the diagnostic box that is the next best fit. This is usually ADD/ADHD.

Triggering: The effects of any significant trauma getting triggered can mimic ADD/ADHD "distraction" and poor concentration. (Note that this can be significant even if the person does not meet criteria for PTSD and has only mild dissociative phenomena).

Dissociative switching: Switching between different internal parts mimics ADD/ADHD "distraction," poor concentration, inability to "Stay on task," and impulsivity (sudden behavior changes with switching can appear as impulsive behavior).

More subtle dissociative phenomena: Dissociative phenomena that is milder and more subtle than switching between different internal parts, such as subtle emotional disconnection, can also mimic ADD/ADHD distraction, poor concentration, and inability to stay on task.

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[7]Putnam FW. "Dissociative disorders in children: behavioral profiles and problems." *Child Abuse Negl*. 1993 Jan-Feb; Vol. 17(1): pages 39-45.

[8]Most mental health professionals have *no* place in their assessment for demonic infection. It causes the clinical picture to look strange and respond poorly to treatment, but they have no idea what is going on or what to do about it.

Being triggered to infant or child ego state: Being triggered to an infant or child ego state, and especially an infant or child ego state that is in the middle of a traumatic experience, can mimic many aspects of ADD/ADHD, including distraction, poor concentration, disorganization, interrupting, and inability to perform as would be expected by potential.

Being triggered to infant-child maturity: Being triggered to infant or child traumatic memories, and thereby blending with the corresponding infant or child ego states, also necessarily includes operating out of the associated infant or child maturity. And operating out of infant or child maturity can mimic many aspects of ADD/ADHD. For example, inattention *to others*, forgetting stuff related *to others*, failing to plan or organize ("Mom/Dad will do it"), and interrupting and other "impulsive" behavior are all *normal for infant and child maturity*, in that it is normal for infants and children to focus primarily on themselves, to be impulsive, and to expect that the "grown-ups" will take care of most of the practical, logistical concerns of day-to-day life. (I certainly observe all of these attitudes and behaviors in myself when I am triggered to an infant or child memory place and operating out of an infant/child maturity ego state, and they all go away when I'm not triggered).

Note: It would be easy to use ADD/ADHD as an excuse to continue infant/child maturity behavior, instead of embracing the challenge of owning baseline[9] immaturity and/or triggered immaturity, and owning the responsibility to move forward to appropriate maturity. The challenge is to balance appropriate grace and understanding for true ADD/ADHD with caution for using a mistaken diagnosis to justify baseline immaturity and immaturity associated with being triggered to childhood memories. Also, everybody with true, brain-biology ADD/ADHD will have triggering and baseline maturity issues, just like the rest of us, so they will have the additional challenge of sorting between the two.

Triggered restlessness: A variety of specific triggers can cause *restlessness* that can mimic ADD/ADHD hyperactivity, distractability, poor concentration, and inability to "stay on task."

Triggered pressure, intensity, and drivenness: A variety of specific triggers can produce internal pressure, intensity, and drivenness regarding certain issues, and this can be mistaken for the intensity, hyperactivity, and talkativeness of ADD/ADHD.

Positive triggering: Positive triggering can mimic the hyperactivity and talkativeness of ADD/ADHD.[10]

"The hard drive is fragmented and full": There is a phenomenon I refer to as "the hard drive is fragmented and full." With a computer, the overall function will steadily deteriorate as the hard drive becomes increasingly crowded and fragmented. The impaired function is not

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[9]What I refer to here as "baseline" immaturity is a challenge that all of us must deal with to some extent: all of us have areas of weakness in our maturity portfolio – certain maturity skills that we simply never developed, or have only developed very poorly. These maturity deficits are with us all the time, as part of our "normal" ego state. In contrast, "triggered" immaturity refers to areas of maturity weakness that are only present when we are triggered to childhood memories – areas in our maturity portfolio where we have appropriate adult maturity skills when we are in or normal adult ego state , but where we drop down to infant or child maturity when we are triggered to infant or child memories.

[10]See "'Triggered' Positive Thoughts and Emotions" on www.kclehman.com for definition and discussion of positive triggering.

caused by a specific hardware or software problem, but rather due to having such a large pile of material to sort through, and due to the accumulation of many, many fragmented files. I think our brains/minds display a similar pattern. If we have a large pile of unresolved issues, there is an overall impairment due to the cumulative burden on the system. This overall impairment due to the "hard drive" being crowded and fragmented can mimic the disorganization, distraction, poor concentration, and general "not performing to potential" seen with ADD/ADHD.

Demonic harassment/oppression: Demonic harassment/oppression, associated with traumatic memories, dysfunctional defenses, and reactive sins can mimic the distraction, poor concentration, and impulsivity seen with ADD/ADHD.

III. My own experience with mimic ADD/ADHD symptoms: As mentioned earlier, I have experienced ADD/ADHD symptoms in my own life, and these symptoms have progressively resolved over time as I have worked to find and resolve the underlying emotional and spiritual issues that were the true sources of the symptoms.

I can remember being called "chatter box" as a child. My report card from first grade commented "Karl needs more spacing between his words." During my teen years people would make subtle comments (and sometimes not-so-subtle) about how much I talked. Week after week I would catch myself talking too much in our church youth group. My college peers would also make comments of one sort or another indicating that my pressured talking was irritating. (For example, during my first week at college, out of the corner of my eye, I saw two other students nod towards me, roll their eyes, and exchange hand signals of a mouth going talk, talk, talk, talk. I knew that my constant and pressured speech got on people's nerves. I could see myself doing it, and I hated it, but I couldn't stop it.

The internal restlessness, pressure, and anxiety also made it very difficult for me to be emotionally present and connected when I was with others. At family gatherings or other times when I was supposedly "with" people, I would often be listening with 30% of my brain, reading a *National Geographic* with 30%, thinking about my professional work with 30%, and worrying/thinking "I should be doing something productive" with the remaining 10%.

Distractability was also a problem. Charlotte was especially hurt by this. She might be talking about something important, emotional, and intense – some painful memory we were working on, or some poignant, personal issue she was trying to share with me. Then, in the middle of this kind of intimate sharing, I would point out the window and interrupt with: "Look at that interesting bird – I think it might be a night heron," or "That's an unusual license plate." Charlotte would understandably be hurt and offended: "Aren't you listening to me? I'm talking about something really important!"

In retrospect, I can see how my internal restlessness drove this distractability. In some vague and subtle way, I often felt not fully satisfied with the conversation or context I was in, and would be scanning for something else to think about or do or look at that might help scratch that vague internal itch of dissatisfaction. This restlessness and distractability would not be evident in intense, focused situations, like client sessions in which I was providing psychotherapy; but it was tangibly and uncomfortably present in most other situations. As already described, Charlotte especially suffered the consequences of this constant internal scanning for "something else."

The bottom line with respect to all of this is that I was one criteria short of a full, DSM IV diagnosis of clinical Attention Deficit Disorder (there are twelve possible diagnostic criteria, nine are required for a formal diagnosis of clinical Attention Deficit Disorder, and I met the conditions for eight). Also, it was not much fun to be around me. I was honest, loyal, altruistic, hard working, conscientious, and well-intentioned, but tiring to be with – or just "absent" emotionally. Other than my older brother, I did not have a single close friend in my life throughout my childhood, adolescence, and college years.

And then in 1998 I started doing my own healing work, and began resolving a steady stream of healing targets. I would usually start by focusing on a specific trigger or issue, and then, after finding and resolving the underlying traumatic memories, Charlotte and I would be able to see specific changes that were logically connected to the cluster of trauma that had just been resolved. However, we had a very different and curious experience with respect to my ADD symptoms. I never once focused directly on a symptom of ADD as the initial target for a healing session, but at some point after two or three years of regular healing work we realized that most of my attention deficit symptoms had dramatically decreased or had resolved entirely – the anxiety, internal restlessness, and pressure that seemed to drive my talking, interruptions, and distractability had dramatically decreased or resolved entirely. Furthermore, we could not perceive any clear/direct connections between the improvement with respect to my ADD symptoms and the traumatic content that had been resolved.

I remember one day realizing that something had changed. Turning to Charlotte, I asked: "Do I still do the 'Look at the bird!' thing when you're talking?" She paused for a bit, and then responded with, "No. And you don't talk so much anymore either!" We were both amazed. "When did it change? How did it change?...etc." We could both perceive a clear difference, but neither could remember when it had changed or figure out a connection to any particular healing target. Note: my curiosity and scanning the world for interesting things is still here, but now it has less energy. Without the restlessness to drive it, I am able to be with Charlotte and pay attention to what she is saying, without being distracted and interrupting her in the middle of something important.

Shortly after this initial realization, we were with my parents for Christmas and realized I was just "there." I felt calm and content and was enjoying just being present and connected – listening to what others were saying, *not* reading a magazine at the same time, and not worrying or thinking about anything else. And again, neither of us could perceive any clear/direct connections between the improvement with respect to my ADD symptoms and the traumatic content that had been resolved.

Addendum/follow-up: As of December 2020 (now 22 years into my personal healing journey), both Charlotte and I perceive that my ADD/ADHD symptoms have continued to decrease as I have continued to receive healing. At this point I would say that 95% of my original ADD/ADHD symptoms have resolved. My thoughts regarding where my ADD/ADHD symptoms came from, and why they resolved, have also become much clearer. A very short summary of my current thinking is that "true" ADD/ADHD is a neurological illness with genetically determined brain abnormalities at its core, but that spiritual and emotional issues can cause "mimic" ADD/ADHD symptoms. In my case, it seems that essentially all of my ADD/ADHD symptoms were "mimic," caused by a number of spiritual and emotional issues:

> A variety of specific triggers combined to cause the anxious restlessness (described above) that mimicked ADD/ADHD hyperactivity, distractability, poor concentration, and difficulty

focusing on one task (especially in certain social situations, as described above).

A variety of specific triggers combined to produced internal pressure, intensity, and drivenness regarding certain issues, which mimicked the intensity, hyperactivity, and talkativeness of ADD/ADHD.

"Positive triggering" mimicked the hyperactivity and talkativeness of ADD/ADHD.

The specific moment of triggering of a wide variety of traumatic memories mimicked individual incidents of ADD/ADHD-like distraction and poor concentration.

Subtle dissociative disconnection would sometimes cause inattention, distraction, and poor concentration similar to those seen with true ADD/ADHD.

Being triggered to child ego states mimicked many aspects of ADD/ADHD, including inattention, distraction, poor concentration, failure to plan or organize, forgetfulness, interrupting, and inability to perform as would be expected by potential.[11]

Demonic infection associated with various wounds, lies, defenses, and reactive sins mimicked and/or exacerbated ADD/ADHD-like distraction, poor concentration, and inability to perform as would be expected by potential.

Finally, my hard drive was fragmented and full. As described above, I think our brains are similar to computer hard drives in certain respects, and that our overall cognitive function will steadily deteriorate as unresolved emotional and spiritual issues accumulate. I definitely had a large pile of unresolved issues, this large load of fragmented files definitely produce an overall impairment due to the cumulative burden on the system, and this overall impairment manifested as disorganization, distraction, forgetfulness, and poor concentration that mimicked the symptoms of ADD/ADHD.

As would be expected, each of these factors that contributed to my ADD/ADHD symptoms have decreased steadily as I have received more healing. And it also makes sense that Charlotte and I had difficulty identifying connections between specific healing targets and improvements in my ADD/ADHD symptoms, since so many of these emotional and spiritual issues are the results of trauma, triggering, and demonic infection *in general*, as opposed to the direct results of a specific traumatic memory (or cluster of related traumatic memories).

IV. Tips for making the differential diagnosis between mimic ADD/ADHD and "true," brain-biology ADD/ADHD:

Patterns regarding when symptoms are present: Carefully observe the pattern of when ADD/ADHD symptoms are present. With "true" ADD/ADHD, signs and symptoms will be

[11]This comment may seem confusing, in light of the many accomplishments on my CV. One piece is that some of the impairments occurred only when I was actually triggered (such as being triggered to child ego states). I could still function at a very high level when not triggered. Another piece is that even though I did well academically, and accomplished a lot, I know that I could have functioned at a higher level if I had not been impaired by spiritual and emotional issues.

present when predicted for true ADD/ADHD (for example, situations with boring tasks and many distractions), and absent when predicted for true ADD/ADHD (for example, hyperfocus with stimulating tasks such as video games). In contrast, with mimic ADD/ADHD, signs and symptoms will correspond to triggering, dissociation, and demonic harassment. The two may overlap in some situations (for example, situations with boring tasks and distractions that are also triggering), but the key is to look for situations where they don't overlap. Especially suspect mimic ADD/ADHD if:

• There are situations where true ADD/ADHD should be present, but isn't;

• there are other situations where true ADD/ADHD shouldn't be present, but is;

• and the presence of signs and symptoms correlates more with triggering, dissociation, and demonic harassment than with factors that would be expected to exacerbate true ADD/ADHD.

Dramatic hyperactivity: Dramatically increased motor activity (for example, "it's like he's motorized," "he *never* stops moving") makes me lean towards true ADD/ADHD.

Age at onset: True ADD/ADHD is usually observed to begin very early ("as early as anybody can remember" with respect to the person in question). Symptoms starting later in childhood dramatically increase my suspicion of mind/spirit issues mis-diagnosed as ADD/ADHD. Note that being present early in the person's life does not completely rule out mind/spirit issues, since intra uterine trauma, birth trauma, infancy trauma, and demonic infection with any of these can start very early; but when the ADD/ADHD picture is present from a very early age the possibility of true, biological ADD/ADHD must be considered much more carefully.

Dramatic benefit with stimulant medication: Dramatic benefit with stimulant medication (for example, Ritalin or Dexedrine) seems to be much more common with true, biological-brain ADD/ADHD, whereas mediocre response to these medications seems to be much more common with trauma, triggering, dissociation, maturity issues, and demonic interference that have been mis-diagnosed as ADD/ADHD.

Dramatic benefit with SSRI: SSRI mediations are know to provide significant benefit for people with lots of trauma – for example, people with PTSD and/or dissociative phenomena. So if the person experiences dramatic benefit with an SSRI, be especially careful to consider whether PTSD and/or dissociative phenomena are present – either in combination with true ADD/ADHD (trauma dramatically exacerbating the ADD/ADHD picture), or as the real root problem, with ADD/ADHD being a mis-diagnosis.

V. True, brain-biology ADD/ADHD is *exacerbated* by mind/spirit issues: True, brain-biology ADD/ADHD almost always results in emotional trauma for the child. For example, being misunderstood, punished, and/or humiliated in school. This ADD/ADHD related trauma can certainly be resolved with emotional healing tools, such as EMDR, Theophostic, or the Immanuel Approach. Furthermore, children with true, brain-biology ADD/ADHD are not immune from other spiritual issues and/or psychological trauma unrelated to the ADD/ADHD. Unresolved mind/spirit issues will always exacerbate the overall clinical picture, regardless of whether or not they were caused in some way by the ADD/ADHD. Therefore, it is *always*

beneficial to address mind/spirit issues with tools such as the Immanuel Approach.

VI. Emotional healing is more challenging but still possible: ADD/ADHD often makes it more difficult to do emotional healing work, because of difficulties with practical disorganization (for example, difficulties with scheduling and showing up for appointments), restlessness and distractability during sessions, etc; but I have found that a variety of emotional healing tools still work well (for example, the Immanuel approach, Theophostic®-based therapy or ministry, and EMDR). The healing work just requires more patience.

VII. Other resources: I don't agree with everything in these sources, and especially note that they often fail to consider the role of trauma-related phenomena discussed here, but there is a lot of good information that will especially be helpful for those with true ADD/ADHD.

Amen, Daniel G. *Windows into the A.D.D. Mind: Understanding and Treating Attention Deficit Disorders In the Everyday Lives of Children , Adolescents and Adults*. (Fairfield, CA: Mind Works Press), 1995.

Amen, Daniel G., *Healing ADD: The Breakthrough Program that Allows You to See and Heal the 6 Types of ADD.* (New York, NY: Berkley Publishing Group), 2001.

Dr. Amen also has many other resources regarding ADD/ADHD. See www.amenclinic.com for additional information.

Hallowell, Edward M., Ratey, John J. *Answers to Distraction (Revised and updated)*. (New York, NY: Bantam Books), 2010.

Hallowell, Edward M., Ratey, John J. *Driven to Distraction (Revised): Recognizing and Coping with Attention Deficit Disorder*. (New York, NY: Simon & Schuster), 2011.