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

ADD/ADHD and Emotional Healing

DRAFT VERSION DRAFT VERSION DRAFT VERSION DRAFT VERSION

Draft version: Someday I hope to expand this essay, with detailed examples (many from my own experience) and expanded explanations. However, it has been waiting in this "draft" state since 2002, and we have decided to release this version so that people can use the information during the (possibly very long) delay before a more refined version can be completed.

1. True, biological Attention Deficit Disorder (ADD) and Attention Deficit and Hyperactivity Disorder (ADHD): I think there is "true," biological ADD/ADHD that is *not* caused by underlying mind/spirit issues, and that does not resolve with emotional healing. As mentioned below, the overall clinical picture can improve with resolution of mind/spirit issues, but the underlying biological illness will not resolve with the resolution of psychological trauma and/or other mind/spirit issues.

Twin studies with especially high concordance between identical twins: ****additional material pending****

Twin studies finding dramatic difference between the concordance rate for identical twins and the concordance rate for nonidentical twins: ****additional material pending****

Other studies indicating a genetic, biological component in "true" ADD/ADHD: ****additional material pending****

2. True, biological ADD/ADHD exacerbated by mind/spirit issues: True, biological 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®[1], or the Immanuel approach. Furthermore, children with true, biological ADD/ADHD certainly 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 or Theophostic®-based[2] emotional healing.

---

[1] Theophostic is a trademark of Dr. Ed Smith and Alathia, Inc. We do not claim any endorsement by the trademark-holder.

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

3. Mind/spirt issues *misdiagnosed* as ADD/ADHD: I think mind/spirit issues can mimic ADD/ADHD, and that many cases of ADD/ADHD are actually caused by underlying mind/spirit issues that have been mis-diagnosed as ADD/ADHD. I think many cases diagnosed as ADD/ADHD are actually just the distraction/interference that results from lots of unresolved trauma. My own experience with ADD symptoms provides a good example of this kind of ADD picture (see "Case Study: Attention Deficit, What Fixed it?" on our website, www.kclehman.com).

PTSD mimics ADD/ADHD (look at the diagnostic criterial for PTSD, picture a child with PTSD, and then look at the criteria for ADD/ADHD)

Dissociation mimics ADD/ADHD

Specific overlap/mimics between unresolved trauma, dissociation, and ADD/ADHD:

The moment of triggering of any significant trauma mimics ADD/ADHD "distraction" and poor concentration (this can be significant even if the person does not meet criteria for PTSD and does not have marked dissociation). **included in my experience**

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).

Being triggered to child ego state can mimic many aspects of ADD/ADHD, including distraction, poor concentration, and disorganization. **included in my experience**

Maturity: infant and 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 focusing only on self. I observe all of these behaviors in myself when I am triggered to a child place and operating at infant/child maturity *and they all go away when I'm not triggered and/or as I have pressed into my maturity issues.* 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 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 and caution for using mistaken diagnosis to justify triggered and immature behavior. Also, everybody with ADD/ADHD will have triggering and maturity issues, just like the rest of us, so they will have the challenge of sorting between the two.

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

A variety of specific triggers can produce internal pressure/intensity/drivenness regarding certain issues, and this can be mistaken for the intensity, hyperactivity, and talkativeness of ADD/ADHD. **included in my experience**

---

disciplines, and medical psychiatry).

Positive triggering can mimic the hyperactivity and talkativeness of ADD/ADHD. **included in my experience**

"The hard drive is full" can mimic the disorganization, distraction, poor concentration, and general "not performing to potential" seen with ADD/ADHD. **included in my experience**

Demonic harassment can mimic the distraction, poor concentration, and impulsivity seen with ADD/ADHD. **some of my experience**

4. Tips for making the differential diagnosis between mind/spirit issues and "true," biological 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 present when predicted for true ADD/ADHD (e.g., situations with boring tasks, many distractions), and absent when predicted for true ADD/ADHD (e.g., 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 (e.g., 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 (e.g., "it's like he's motorized," "he *never* stops moving") makes me lean towards true 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 ADD/ADHD, whereas mediocre response to these medications seems to be much more common with PTSD/dissociation (mis-diagnosed as ADD/ADHD)

Dramatic benefit with SSRI: 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.

5. Emotional healing possible with ADD/ADHD: ADD, ADHD might make it more difficult to work with the person because of the distraction, but we have found that emotional healing (the Immanuel approach, Theophostic®-based therapy or ministry, EMDR) still works well. It just requires more patience.

6. Related essays: Two related essays, "Bipolar Disorder and the Immanuel Approach/ Theophostic®-based Emotional Healing: General Comments and Frequently Asked Questions"[3] and "Schizophrenia and the Immanuel Approach/Theophostic-based Emotional Healing: General Comments and Frequently Asked Questions"[4] present a similar discussion for bipolar disorder and schizophrenia, especially providing a more detailed discussion of principles to apply in differentiating between the "true" disorders that include prominent biological brain abnormalities and the "mimic" disorders caused by psychological trauma and other psychological and spiritual issues. Reviewing these related essays will probably provide additional information that would be helpful in addressing these same issues for ADD/ADHD.

A second related essay, "Case Study: Attention Deficit, What Fixed It?"[5] describes my own experience with symptoms for Attention Deficit Disorder. My experience, described in this essay, provides an especially good example of mind/spirit issues misdiagnosed as ADD/ADHD. I had eight of the diagnostic criteria, with nine required for a full clinical diagnosis (per the Diagnostic and Statistic Manuel, Fourth edition), and most of these have resolved as I have persistently pursued healing for the underlying issues.

7. 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*. (New York, NY: Bantam Books), 1996.

Hallowell, Edward M., Ratey, John J. *Driven to Distraction: Recognizing and Coping with Attention Deficit Disorder from Childhood Through Adulthood*. (New York, NY: Simon & Schuster), 1994.

---

[3] To find this essay, put "bipolar disorder" in the search box on our website, www.kclehman.com.

[4] To find this essay, put "schizophrenia" in the search box on our website, www.kclehman.com .

[5] To find this essay, put "Attention deficit" in the search box on our website, www.kclehman.com.

Weiss Margaret, Trokenberg Hechtman L., Weiss G., *ADHD in Adulthood*. (Baltimore, MD: Johns Hopkins University Press), 1999.

The following is a particularly relevant quote from an internationally recognized authority on childhood emotional trauma:

> "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; © 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."[6]

Scraps:

ADHD/ADD: Kap & Sad pg 3184, Concordance for monozygotic twins ranges from 59 to 92%, whereas concordance for dizygotic ranges from 29 to 42%.

"...includes an important component of biological brain abnormalities.

Biological brain abnormalities that contribute to the mental illness and that are *not* caused by spiritual and/or psychological issues.

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