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SHADES:

Study of Hyperactivity and Attention Deficit using Energy Systems

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1. Introduction

This is an exploratory case study in the use of hands-on healing to treat Attention Deficit Hyperactivity Disorder (ADHD). ADHD has been recognized as a psychiatric disorder that significantly impairs at least 3-7% of children and adolescents in the U.S. (American Psychiatric Association, 2001) and 1% of schoolchildren in the U.K. (UK National Health Service). In addition, school surveys completed by teachers have shown that 8-11% of students show enough impairment from ADHD symptoms to warrant further diagnostic investigation (Gaub & Carlson, 2002(2002).

According to DSM-IV-TR diagnostic criteria, ADHD is characterized by symptoms of either inattention or hyperactivity-impulsivity that have persisted for at least six months to a degree that is maladaptive and inconsistent with developmental level (American Psychiatric Association, 2001). Children with ADHD tend to have a variety of behavioral and learning problems, including Inconsistent and unmotivated behavior, lack of age appropriate self-care and self-control, poor sleep patterns, greater risk of accidental injuries, and an elevated high school drop-out rate (Barkley, 1998).

Brown's (2001) classification of ADHD shows it operating in the following six main problem areas:

- ***a.*** ***Activation***: problems organizing, prioritizing and activating work tasks.
- ***b.*** ***Focus***: difficulty focusing and sustaining attention, shifting focus to tasks. Those with ADHD often forget what has been read. This happens in normal children when tired but in ADHD all the time.
- ***c.*** ***Effort***: trouble regulating alertness and sustaining effort, with slower processing speed, including processing speed of writing. Those with ADHD are also usually slow to fall asleep and slow to get up.
- ***d.*** ***Emotion***: difficulty managing frustration and modulating emotion. Those with ADHD tend to be over-sensitive to emotion and have trouble containing it.
- ***e.*** ***Memory***: difficulty utilizing what to memorize, as well as how to access and recall information.

f. ***Action***: problems monitoring and self-regulating action. Social parallel is learning to cross the road.

2. Etiology of ADHD

There are a number of theories on the causes of ADHD. However, there is little research evidence to support most of these theories and it is unclear how they relate to specific treatment approaches.

The present study therefore focuses on the presenting needs of children with ADHD, rather than causes of ADHD.

3. Treatment for ADHD

3.1 Current orthodox treatments

Orthodox health professionals have tried a range of pharmacological and psychological treatments for ADHD. These are summarized below.

3.1.1 Stimulant pharmacotherapy

The most common and effective medications for ADHD are amphetamine-like stimulants, mainly Ritalin and Dexedrine. Ritalin reduces hyperactivity and impulsiveness and helps to focus a child's attention (Douglas, Barr, O'Niell, 1986). Evans *et al.* (1986) studied children with ADD and found that ADD children on Ritalin become less aggressive, seem to comply with requests, and become less forgetful. Many parents report their child's behavior vastly improves as a result of Ritalin.

***Limitations*:** Like amphetamines, Ritalin is classified as a class A stimulant drug. Many parents and professionals are worried about potential and experienced side effects, including damage to the cardiovascular and nervous systems *(*Bussing & Gary, 2002). Also, studies following children treated with psychostimulant medication for periods up to 5 years have provided little evidence that drugs improve the long-term prognosis of their ADHD (Weiss & Hechtman, 1993).

3.1.2 Sedative pharmacotherapy

It seems a logical option that hyperactivity may need sedating.

Limitations: Ritalin boosts the immature inhibitory function of the left hemisphere of the brain giving ADHD patients better 'brakes,' when ADHD patients take sedatives the opposite can occur; stimulation and hyperactivity may get worse. It seems with sedatives the inhibitory centers on the left hemisphere are sedated with fewer "'brakes"' and more activity takes place. This is the 'paradoxical reaction' to medication often seen in ADHD children (Levin, 2004).

3.1.3 Sleep medication

Sleep disruption may cause children diagnosed with sleep disorders to be inattentive and hyperactive. A study of five children treated with the drug Levodopa found improved symptoms of sleep disorders. The children's attention spans improved, along with their memory, and parents also reported that their children's behavior improved (Walters et al (1988). Such approaches may be promising for children with ADHD as they often have poor sleep patterns.

Limitations: Although results suggest that ADHD children would benefit from sleep improvement, the study was on sleep disorders, not ADHD. More specific ADHD research is needed.

3.1.4 School treatment plans

School treatment plans have been developed for children with learning disorders and usually involve in-school educational interventions only (Barkley, 1997).

***Limitations*:** In-school interventions do not include medication or other interventions implemented outside of school, and usually need to be supplemented by out-of-school interventions that are generally arranged separately by parents and students (Pelham, Wheeler & Chronis 1998). There may be overlap or even conflict between the two approaches.

3.1.5 Out-of-school treatment plans

In an out-of-school treatment plan, parents are taught by professionals such as psychologists or behavioral therapists to give clear instructions to their ADHD children, to positively reinforce good behavior, to ignore some behaviors, and to use punishment effectively. The most powerful parent training programs use a combination of written materials, verbal instruction in social learning principles and contingency management, modelling by the clinician, and behavioral rehearsal of specific skills *&Pelham, W. E., Wheeler, T., & Chronis, A. (1998). Empirically supported psychosocial treatments for attention deficit hyperactivity disorder. *Journal of Clinical Child Psychology, 27,* 190-205 Accepted.

Limitations: The substantial prevalence of parents of ADHD children who also have ADHD often makes compliance with training programs and execution of interventions difficult (American Academy of Child and Adolescent Psychiatry, 1997). Also, there is little research to assess the effectiveness of out-of-school interventions, particularly their in-school effect (DuPaul , et al. 1999). .

3.1.6 Combined in-school and out-of-school treatment plans

These involve teaching children how to behave in different situations, combined with behavioral parent training and behavioral interventions in the classrooms, and have become a well-established treatment approach (Pelham, Wheeler & Chronis, 1998).

Limitations: Combined interventions are time consuming and have a high financial cost.

3.1.7 Psychological treatments

Forms of psychological treatment include anxiety therapy, individual psychotherapy and social and psychosocial skills training.

***Limitations*:** It was reported by Pelham and colleagues accepted (1998) that regular outpatient psychosocial treatments might not be adequate for many if not most ADHD children. Rather, intensive psychosocial treatment programs may be necessary, which are likely to have major financial implications. In addition, non-behavioral psychotherapeutic interventions seem to have limited impact on disruptive behavior disorders (Weisz, Donenberg & Han et al., 1995).

3.1.8 Cognitive-behavioral treatments

Cognitive-behavioral treatments would seem to be a natural match for the disorder because by teaching ADHD children how to understand their behavior and thinking processes, this could result in better interaction and reduction of symptoms.

Limitations: Controlled studies have not supported this approach. The results of the majority of cognitive-behavioral studies have not found clinically significant changes in the behavior and academic performance of children with ADHD (Pelham, 1998).

3.1.9 Behavioral management techniques

Behavioral management techniques that are administered by professionals for mild ADHD are usually the treatment of choice in the USA. With recommendations for combining prescription drugs, nutraceutical therapy, cognitive reprogramming, parenting and educational strategies,

biofeedback, self-hypnosis, and more, these provide a comprehensive treatment program that can lead to a fully functional and normal life (Bussing & Zima, 2002).

***Limitations*:** These programs only work for mild ADHD and are financially costly.

3.1.10 EEG biofeedback

There has been much research into brain wave patterns. EEG biofeedback measures brainwaves as the subject relaxes, and shows them how they are affected by relaxation. ADHD children tend to have an abnormal preponderance of one brain wave or another.

Forty sessions of EEG biofeedback resulted in significant increases in IQ and reduced parental reports of inattentiveness (Linden, Habib & Radcjevic, in press). A study by Cartozzo and colleagues (1995) found that 30 sessions of EEG biofeedback led to a significant reduction in theta (4-7 Hz) amplitude, and increased attention span.

Activity in the theta range (4-8 Hz) should be suppressed with children and adolescents up to the age of fourteen, and beta (16-20Hz) should be increased or sensorimotor rhythm (SMR) output (12-15 Hz) with adults twenty years and older. It has been recommended that a combination of theta suppression and beta or SMR enhancement should be used for those aged fourteen to twenty *(*Lubar & Lubar, 1984).

Research by Othmer & Othmer (1992) showed that Beta (15-18Hz) or SMR (12-15Hz) should be enhanced for all ages. Suppression of theta (4-7Hz) and high beta (22-3014z) is of secondary importance.

Thatcher et al found that a treatment protocol designed to increase the amplitude of 12 to 15 hertz brain wave activity in the sensorimotor region is appropriate. That is, there were no other significant brain wave abnormalities that might account for the diagnosis of an attention deficit/hyperactivity disorder *(*Thatcher, et al., 1989).

Limitations: These studies appear to contradict each other, and could show that a more individual approach is needed, one that takes more than just age groups into account, and one that does not assume that one brain wave activity adjustment will be right for everyone.

3.1.11 Research into parts of brain affected by ADHD

Models describing what is happening in the brains of people with ADHD suggest that several areas of the brain may be affected, in particular the frontal lobes and the inhibitory mechanisms of the cortex. Frontal lobes facilitate the paying of attention, concentration, the making of decisions, planning, learning and remembering, and behaving appropriately for given situations. Inhibitory mechanisms of the cortex facilitate the prevention of hyperactivity, saying things out of turn, and inhibiting behaviors such as getting upset at inappropriate times *(*ADHD Information Library and Harvard Medical School 2005*)*.

Limitations: There is inadequate evidence that this is a cause or a side effect of ADHD. No therapies appear to have been modeled as a relevant treatment.

3.1.12 Costs of orthodox treatments

From a review of the literature it is clear first, that different treatments have different cost implications, and second, that the cost of a single treatment can vary within and between countries.

The NHS in the UK has calculated the entire financial cost to the government of a child diagnosed with **conduct disorder** (within ADHD DSM-IV criteria). These include direct costs of agencies such as local authority, education, social, National Health Service and voluntary sector, and indirect costs such as loss of employment for some parents, allowances and benefits, and estimated at GB accepted £15,270 per child per annum. (UK National Health Service, (2001 accepted).

The two lowest costs our literature review discovered were for EEG biofeedback in the US and stimulant drug treatment in the UK. Young (2004) found that the annual cost of EEG biofeedback treatment for an ADHD child ranges from $1,800 to $4,000 (United States Dollars) depending on the provider's charges for his/her services, including direct and indirect costs (as noted in previous paragraph).

The annual cost of stimulant drug treatment for an ADHD child in the UK is about £632, including direct and indirect costs, and excluding any potential drug side effects or contraindications (UK National Health Service, 2001) accepted.

3.2 Current complementary and alternative medicine (CAM) treatments

Estimates of CAM use in children range from 9% to 64% and vary by type of treatment, study population, time period and geographic region (Pendergrass & Davis, 1981*)*. CAM seems to be a popular option for those seeking more cost-effective treatment options with fewer side effects.

A review of the literature found that research on the effectiveness of CAM treatment for children with an ADHD diagnosis has been conducted in the following five main areas: Complementary medicine; Sleep disorders; Breath control; Physical relaxation; and Mental calming

These will now be briefly explained in turn.

3.2.1 Healing

Benor (2001) collated many studies that showed that healing might have a significantly positive outcome on many conditions. However, after an extensive review of the literature, no previous studies were found using hand healing of the frequencies of the aura, body or brain of ADHD children. We discovered just one current study that is being formulated with Bojana Zrinski.

3.2.2 Sleep disorders

There are many studies into sleep disorders and their effect on ADHD children.

Children with sleep apnea are often diagnosed with ADHD or some other behavioral disorder. The symptoms of sleep apnea include lack of concentration and attention, tension, irritability, inadequate memory retention, decreased academic performance, oppositional behavior and restlessness *(*Stevens, Quittner, Abikoff, 1997).

In addition, children with sleepwalking, restless leg syndrome, narcolepsy, insomnia, or other sleep problems may also be misdiagnosed with Attention Deficit Disorder *(ADD) (Neurology,* Jan 1996*)*.

When parents of children with ADD are interviewed, they usually say that their kids are poor or restless sleepers **(**Ball, Tiernan, Janusz**,**et al. 1997).

Children diagnosed with ADD wake up more often at night than their peers (Kaplin, McNicol, Conte, et al. 1987). It is agreed that it can be very difficult to discern whether interrupted sleep is the cause or the result of ADD.

The good news is that even when ADD is the correct diagnosis, addressing the sleep issues can dramatically improve the behavior of the child *(*Dahl, R.E, Pelham, W.E, Weirson, M, (1991).

3.2.3 Breath control

The following biological process should be noted because although no good quality studies were found that demonstrated conclusively that breathing could help ADHD children, they often breathe erratically and shallowly. This breathing pattern can cause carbon dioxide in the blood to reduce below its optimum level, and arteries to constrict, including the carotid artery

going to the brain. When this occurs the brain and body receive a slower flow of blood, and consequently less oxygen. Also, shallow chest breathing means the rib cage cannot expand enough for deep breaths, and neck muscles have to be used to pull up the body. This causes physical stress. The lack of oxygen may turn on the sympathetic nervous system that can cause significant problems. For children diagnosed with ADHD, this may include anxiety, panic attacks, stress, lack of concentration, tension, coping and emotional disturbances, behavioral problems, repetitive muscle disorders, lack of concentration, tension, anxiety, irritability and asthma accepted,.

Since 1997 Sweeney has noticed in his practise that ADHD children usually have an ADHD-unique stressful, tensed breathing pattern. This was checked by watching them take deep breaths in and out. Most first lean forwards and down, then jerk their body upwards as they breathe in, then raise their shoulders as their head goes backwards. The out-breath is the same in reverse.

3.2.4 Physical relaxation

The 'relaxation response,' named in the mid-1970s by Herbert Benson, a Harvard cardiologist, refers to changes that occur in the body when in a deep state of relaxation. These changes include decreased blood pressure, heart rate, muscle tension and rate of breathing, as well as feelings of being calm and in control.

Between 60 and 90 per cent of all medical office visits in the United States are for stress-related disorders. Relaxation techniques are helpful tools for coping with stress and promoting long-term health by slowing down the body and quieting the mind (Mind/Body Medical Institute at Harvard University).

An extensive review of the research literature *(Arnold,* Gadow, Pearson et al., 1998*)* rated relaxation as one of the top three recommended alternative treatments for ADHD. Arnold's EMG biofeedback process revealed that relaxation results in reduction of ADHD symptoms, and is worthy of further investigation.

Studies have concluded that relaxation training conducted by parents in the home has been found not only to be effective in improving behavior and other symptoms but also to improve overall relaxation (Donney and Poppen, 1989).).

A review of studies that have used relaxation techniques with children found that relaxation training is at least as effective as other treatment approaches for a variety of learning, behavioral and physiological disorders *(*Hinswaw, Henker, Whalen, 1984).

3.2.5 Mental calming

As previously shown, certain sub-bands of brainwaves relate to specific functions of the body and mind. ADHD tends to produce an overabundance of low frequency accepted theta brainwaves (and inability to maintain 'beta' concentration states). Arenander & Sheppard (2000) used DSM-IV criteria to show that ADHD symptoms could be improved during a Transcendental Meditation Program.

3.3 A gap in the knowledge base

Although there has been substantial research conducted into healing for problems of accepted general medical diagnoses, there appear to be effectiveness gaps in orthodox medicine's treatment of ADHD because treatments are either potentially damaging (stimulant and sedative medication); fail to provide evidence of long-term benefits (stimulant medication); are inadequate (psychological); have little effect on more severe ADHD cases (behavioral management); have been inadequately researched (sleep medication and out-of-school treatment plans); or are very expensive financially (behavioral management, combined in-school and out-of-school treatment plans, and psycho-social therapies) accepted.

A review of evidence-based CAM approaches show no studies of combinational hands-on healing of the aura, body or brain frequencies in ADHD, or of using a combination of breath control, physical relaxation and mental calming to help ADHD children, especially those with sleep disorders accepted.

Whereas orthodox medicine has attempted combinational treatment plans, there seems to be no history of treating ADHD with a combination of CAM therapies in the spiritual healing spectrum, even though some appear promising in the treatment of ADHD. Whereas orthodox medicine has explored combined treatment plans, there appears to be no history of treating ADHD with healing modalities such as spiritual healing combined with CAM interventions.

4. Study objective

As a pilot project, the objective of the current study was to experiment with a range of techniques to assess which may be worthy of further research.

5. Methods

This study was conducted at Goble's Healing Centre in Mexico City, Mexico, based on the pioneering ADHD healing work of Allan Sweeney who is a Doctor of Philosophy in Alternative Medicine. During the past ten years he has found promising treatment outcomes when healing ADHD children in their home and at his Harley Street clinic in London UK. Sweeney and Goble conducted this exploratory pilot, which we call *SHADES*, to test whether results could be developed, standardized and all accepted replicated within a scientific framework to provide a new hypothesis that could be tested in a larger sample as part of a UK-Mexico PhD research project. Goble was responsible for the measures; Sweeney designed and administered the healing methods and wrote the report.

5.1 The participants

A girl, Maria, and her brother, Juan, aged 8 and 10 years, respectively, were volunteered by their parents to participate in the study. There had been no formal medical diagnosis of ADHD of either prior to their participation in the present study. The diagnosis of ADHD was confirmed, however, after assessing the children using Brown's Scales (see 5.2).

5.2 Measures

The pilot adopted a mix of quantitative and qualitative measures. It used triangulation wherever possible to establish trustworthiness by showing vigorousness with three viewpoints, which increases the study's validity. Correlations of the different measures were crosschecked with other measures to see if any additional interpretations could be identified.

Four main measures were used to assess ADHD and document behavior changes. Two standardized scales were used to obtain a medical diagnosis of ADHD, both of which are based on the Diagnostic and Statistical Manual of Mental Disorders (DSM IV-TR) published by the American Psychiatric Association. These were:

5.2.1 Brown's (1996) ADD Scales

These scales are designed to diagnosis a child with ADHD. They include three questionnaires: one for parents, one for teachers and a self-report questionnaire for the participant.

5.2.2 ASEBA Child Behavior Checklist

This checklist is for those aged 6-18 years and is designed to look at behavior in general, with a specific section on ADHD **(**Achenbach and Rescorla, 2001).

Using these two measures, scores on the six features of ADHD were assessed before treatment and at the end of each of the series of treatments.

These orthodox medical measures were supplemented with energy frequency measurements and video observation.

5.2.3 RFI (Resonant Field Imaging)

Resonant Field Imaging (RFI) is an experimental electromagnetic feedback and imaging process. RFI consists of a sensitive frequency counter device and a software program which gives scientific information and objective interpretations for bio-energy fields, and identifies the type and function of all bio-energies present in specific regions of the human brain (ITEM 2004)**.**

This approach was used to measure the frequency fluctuations in both the energy field and brain, and to analyze whether an aura was stable or unstable. Changes to brain states appear to concur with changes in the aura/energy field.

Using RFI (5.2.3), the auras were measured before and after each treatment for the last 2 phases of treatment. The system is founded on the theory that when the Coefficient of Variation (CV) decreases over time the aura becomes stable.

5.2.4 Video observations

All sessions were videoed to summarise observations by the healer, the observer and the parents, as well as documenting changes in the ADHD behavior of the child.

5.3 Techniques

The following techniques were used in the SHADES research. Many of these are new techniques and will be described fully in Sweeney (in press, 2007).

5.3.1 Deep Breathing Control (DBC)

DBC, a three-step process, controls many breathing-related problems; including providing oxygenation for the brain that was lacking due to a negative breathing pattern (Sweeney, 1996a; 2007).

5.3.2 Physical Relaxation Including Muscular Energy Release (PRIMER)

The ADHD child uses a different three-step process to that of DBC, the PRIMER technique, to relax the stressed energies of the physical structure and the stressed energies in the energy field within and around the body (Sweeney, 1996b/ 2007).

5.3.3 Mental Calming through Focused Alpha (MCFA)

This is another three-step process, with ADHD children focusing on peaceful breathing (happiness for mental peace), calmness (for an ideal emotional state), relaxation (for the ideal state of the physical body) and safety (to reduce hyperactivity visualizations) (Sweeney, 1996c; 2007).

5.3.4 Combined Breathing, Relaxation, and Calming Method (CBRC)

This includes a combination of DBC, PRIMER and MCFA (Sweeney, 2000; 2007).

5.3.5 Aura, Body & Brain Frequency (ABBF)

This is a healing system to heal the aura, the body, and the brain using a color frequency. These processes have been applied by Sweeney in his clinic since 1996. (Sweeney, 1996; 2007).

5.3.6 Waves using Frequency Amplitude and Phasing (WFAP)

WFAP is a healing treatment that may cause a `like with like' effect known in physics as a 'mirror' effect. (Sweeney, 2007).

5.3.7 Jakikiri-joka Technique

This is used to `cut' negative energy out of the aura The healer senses negative energy

in the energy field around a person with one hand, and with the other, chops the connection to the physical body so that the negative energy is released

5.3.8 Spiral release

This is used to release negative energy from the aura. (Sweeney 2007).

5.3.9 Intention

This can be described as thought as a mantra to affect phasing of a healing wave.

5.3.10 Amplitude

This is the amount of the healing energy used - the healer allows more, or less, healing energy to flow into the patient. (Sweeney, 2007)

5.4 Sessions

In total, eleven sessions were conducted. The two children were given 45-minute treatments once a day for four days, followed by a break of two days. This was repeated with a further four sessions and a second two-day break before the third series and final three sessions were administered. One session could not be administered for logistical reasons.

6. Results

6.1 General comments

Both children were part of the same, middle-class Mexican family. Both parents are teachers in local schools. . Neither of the children had received formal evaluation for ADHD prior to study. However, indications from the children's school psychologist and the parents led the parents to suspect both children had ADHD. This was confirmed prior to the study by test scores on the Brown's ADD Scales. Maria's scores were very high, with extreme hyperactivity, scoring 63 on both Inattention total and ADD combined score, and Juan's scores were moderately high, 56 on both Inattention total and ADD combined score. Juan showed signs of inattentive type ADHD. Both children were having problems with conduct and performance and school and in the home.

The parents' reported that the children had been showing these behaviors of ADHD for more than two years. The children were not taking any medication for ADHD. Neither the child psychologist nor the family general practitioner had suggested any form of treatment. The techniques used in study were the parents' first attempts at treating the condition.

Overall, both children and parents seemed to enjoy the healing sessions, and were eager to return. Most sessions of healing the physical body and/ or the aura made each child feel relaxed and tranquil, something they had previously not been able to achieve. Both children fell asleep during most sessions. According to the grandmother, this was the first time Maria had ever slept in the afternoon, because even if she felt tired normally, she could not close her eyes and sleep. Overall, Juan fell asleep more often and for longer than Maria.

Healing these ADHD children whilst sitting in a chair was not as useful as when they were lying on a treatment bed, as the latter allowed more opportunity for them to relax, sleep, and receive better healing while being still.

6.2 Specific techniques

The DBC technique (See 5.3.1), the PRIMER technique (5.3.2) and the MCFA (5.3.3) technique were initially difficult for the ADHD children, but seemed successful. They were willing to learn how to do the techniques correctly, and the parents were keen to help them at home.

Because the parents were stressed, they used the CBRC (5.3.4) method together with the ADHD children just before sleep. This had a beneficial effect for the whole family. They all

reported improved sleep, confirming the value of sleep noted by Walters and colleagues (1998).

The ABBF healing system (5.3.5) used green frequency that seemed the best option as the children often fell asleep during the treatments. Various other healing frequencies were tried, with high frequencies such as gold or white and low frequencies such as red and orange. These did not seem to have as relaxing an effect as green.

The WFAP (5.3.6) process was used in combination with the ABBF (5.3.5), intention and amplitude techniques, and gained good results. It seemed that slightly higher amplitudes gained better success.

The Jakikiri-joka technique (5.3.7) was successful in cutting out disharmonized energy residing in the energy field, as shown in the bar charts.

Spiral release (5.3.8) was used in the aura around the head, which often seemed to have a greater need of healing than other areas of the aura. Improvements are shown in the aura interpretation chart.

Intention (5.3.9), used to affect phasing, resulted in a calm mind and relaxed body and seemed to help both children on most occasions.

Starting the hands-on healing around the sides and back of the head and face seemed to have a quicker relaxation response than starting elsewhere.

This combination of techniques was used in order to explore whether treatment of ADHD could be demonstrated. In this study we did not focus on assessment of the effects of any one treatment.

6.3 Frequency measures

The RFI (5.2.3) measures detected irregular theta and alpha ranges in the parietal lobe, cerebral cortex and prefrontal cortex in both children, which may be consistent with Harvard Medical School's findings that different parts of the brain are affected by ADHD and perhaps confirming why EEG researchers do not agree on findings.

An analysis of both children's brainwave states was conducted before the second set and after the third set of treatments. Juan's dominant brainwave state for the first session was Level 7 Alpha State (8 - 7 CPS). The dominant brain state before the last session was a Low Beta State (22 - 14 CPS). The dominant state after the last session changed to a Level 2 Alpha State (13 - 12 CPS). These findings could potentially concur with Sweeney's hypothesis that brain state/waves of children with ADHD are erratic. Therefore the brain may need to be trained with a more focused alpha state with some children, and a beta state with others.

The Maria's dominant brain state was also measured at the same intervals. The first session reading was a Level 4 Alpha State (11 - 10 CPS) in the parietal lobe, cerebral cortex, prefrontal cortex. The reading before the last session was a Level 5 Alpha State (10 - 9 CPS). The reading after the session was an All States type (30 - 1 CPS). These findings suggest that Maria may need a higher state of alpha in order to minimize emotional and mental distractions or disturbances. These examples provide grounds for future exploration.

One piece of our research in MariaMaria seemed to contradict all our other findings, as well as the guidelines for RFI. Using RFI, specific parts of the brain analyzed before treatment found two brain wave abnormalities in the right brain in the cerebral cortex (level 2 alpha state), and 2 cerebral cortex brain wave abnormalities on the left brain side (theta state).

After the treatment, additional brain wave abnormalities were discovered – five in the right brain cerebral cortex (level 2 alpha state, theta state, low-beta state), plus one left-sided brain

cerebral cortex irregularity (level 4 alpha state) and one left brain prefrontal cortex (theta state). The treatment seemed to cause more brain wave abnormalities in the brain. Future research needs to be conducted to determine whether these brain wave abnormalities are significant.

6.4 Observational data

The use of the video was important, especially in recording the behavior and breathing pattern of the children, assessing parents' subjective comments, and recording comments of the healer and observer as each treatment progressed.

Observations made by the healer, observer and child were scored against the DSM-IV and Brown's Executive function categories. The data provided many correlations. The strongest correlations were the 'Total DSM-IV Observations'

The highest percentile for Total DSM-IV Observations for both children was the 'action' category, followed by 'effort. However, there were differences between category scores for 'emotion' and 'focus.' Juan scored higher on 'emotion,' whilst Maria had equal percentiles for 'emotion' and 'focus.'

Figures 1 and 2 represent the total scores of DSM-IV observations made during each session. Both the action and effort category demonstrate a higher number of positive sub-categories. The pie charts show that both action and effort were the most prominent behavior-related categories present throughout the treatment. It also shows that a higher number of positive changes were registered overall. This correlation suggests an improvement in condition as a direct result of treatment.

These scores were cross-triangulated with the same categories on the Brown ADD Scores to see whether a correlation was present.

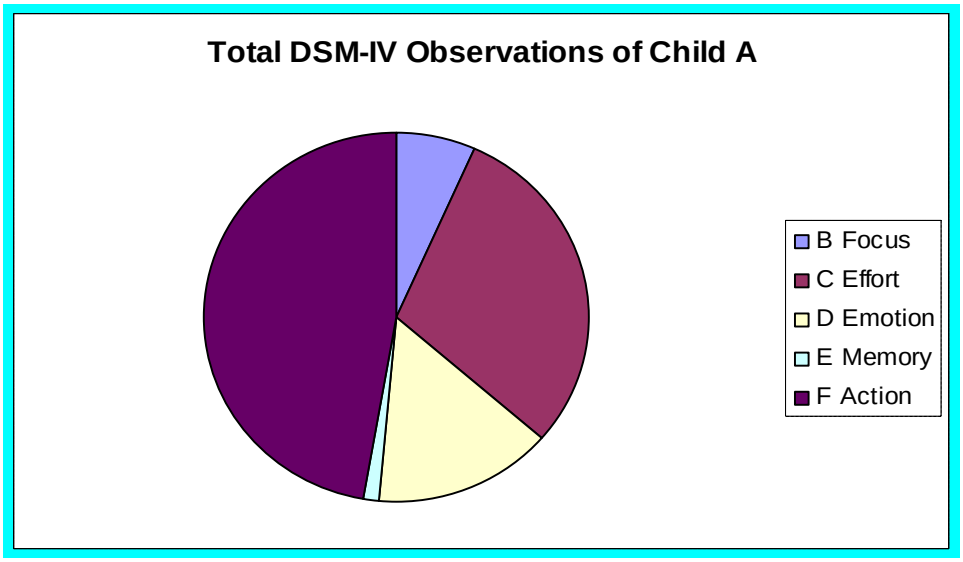

Figure 1-Total DSM-IV Observation Results - Juan

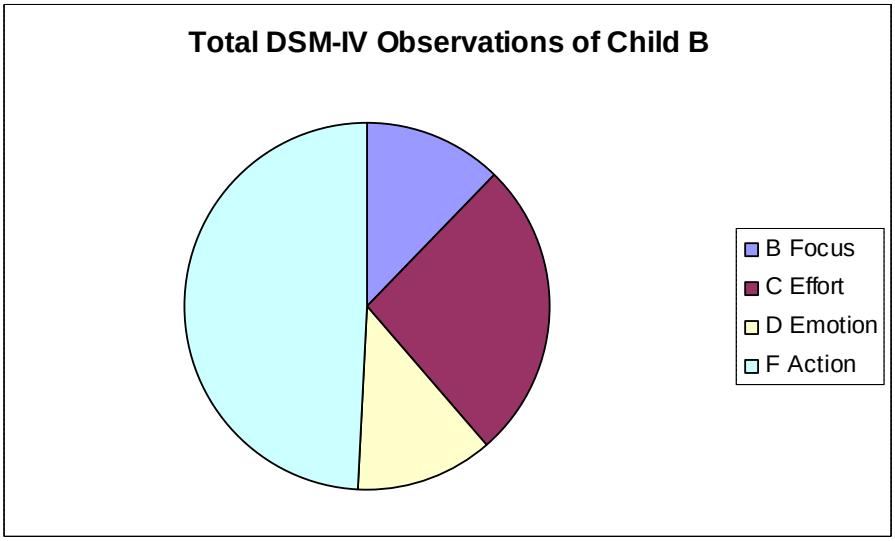

Figure 2-Total DSM-IV Observation Results - Maria

Energetic differences detected and observed by the healer and observer were also analyzed. Differences were detected in both the energy field and physical body of the children. Again, the data provided various correlations. The most prominent related to the degree to which treatment was having a positive energetic effect over the duration of the treatment.

Categories for energetic changes were established based on Sweeney's extensive healing experience and energetic changes felt and observed by Sweeney in the first treatment session for each child. These categories were developed into a coding scheme that was used for each treatment thereafter. Positive energetic categories ranged from observed positive effects on the body to changes or shifts in the aura. Negative energetic categories ranged from little energetic effect on body to resisting healing energy.

The healer verbalized his observations, which were captured on video. An independent observer also scored the number of times the child demonstrated any energetic changes before, during and after each treatment. Every energy change noted by healer and observer was tallied. The mean score of both the positive and negative changes were calculated based on total observations made.

The mean scores were:

Positive Observations made = 14.3

Negative Observations made =12.6

The positive observation mean score demonstrates that the treatment had a more positive effect overall. These scores are shown in Figure 3.

This correlation was then compared with Energy Field Stabilization (RFI co-efficient scores) to see whether there was a correlation.

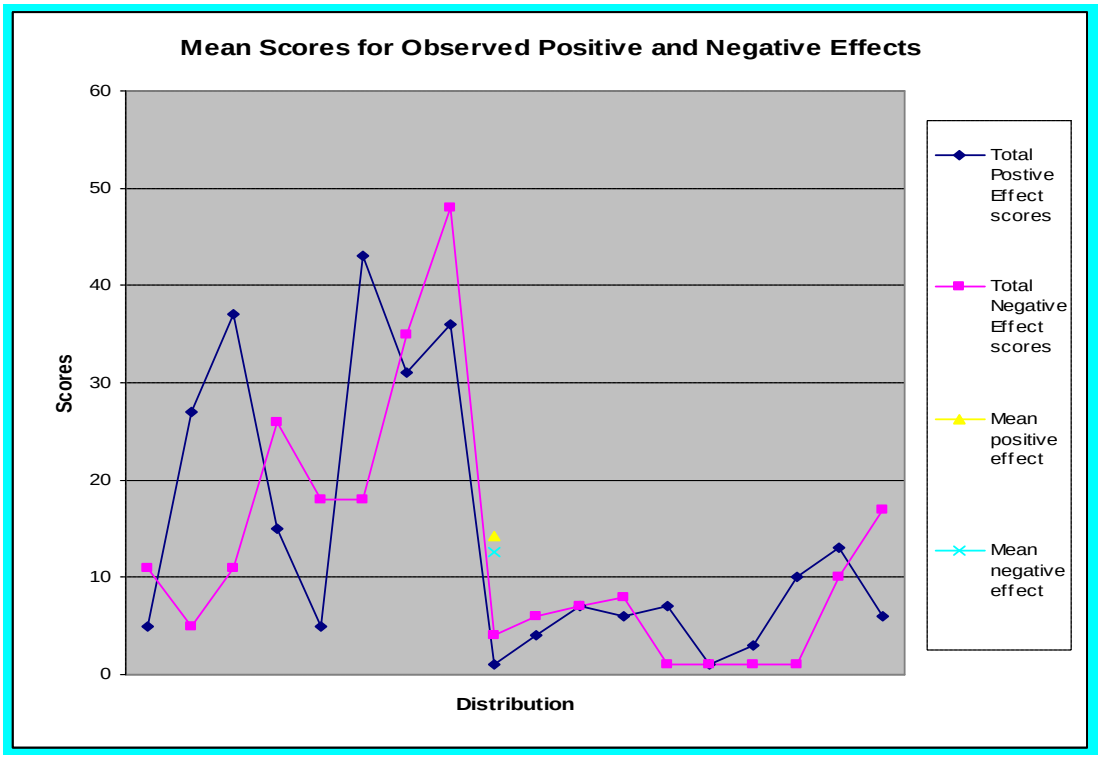

Figure 3-Mean Positive and Negative Observation Scores

6.5 Secondary correlations

The parents demonstrated difficulties whilst undertaking the breathing training. These difficulties mirrored difficulties experienced by both children. The strongest parallels were erratic breathing demonstrated by all four participants. The parents were also rated according to DSM-IV criteria for ADHD. Both mother and father demonstrated the same behavior in Brown's Action category as the 2 children.

6.6 Coefficient of variation scores The coefficient of variation (CV) is a statistical measurement for variability. RFI readings data set with a reduction of CV is considered stabilization in the child's aura. These scores capture reductions or increases in the fluctuationsin the electromagnetic waves in the aura. The fewer fluctuations noted the more stable the aura. The more stable the aura the more stable the physiology and psychology of the subject.

The coefficient scores of Maria decreased by the end of the 2-week period and the before and after scores after each session consistently decreased after the fifth day of treatment. This indicates a reduction in fluctuations in the child's energy field.

The coefficient scores of Juan were less consistent. However, CV scores did stay below 0.2 from the second day of treatment and onwards.

Both sets of scores suggest both energy fields were starting to stabilize. This stabilization appeared to be a direct response to the treatment. The scores are shown in Figures 4 and 5. More tests are needed to verify these results.

With both participants, the coefficient decreased over the 2-week period, suggesting possible stabilization of the energy field due to a treatment effect. The scores are shown in Figures 4 and 5. More research is needed to verify these results.

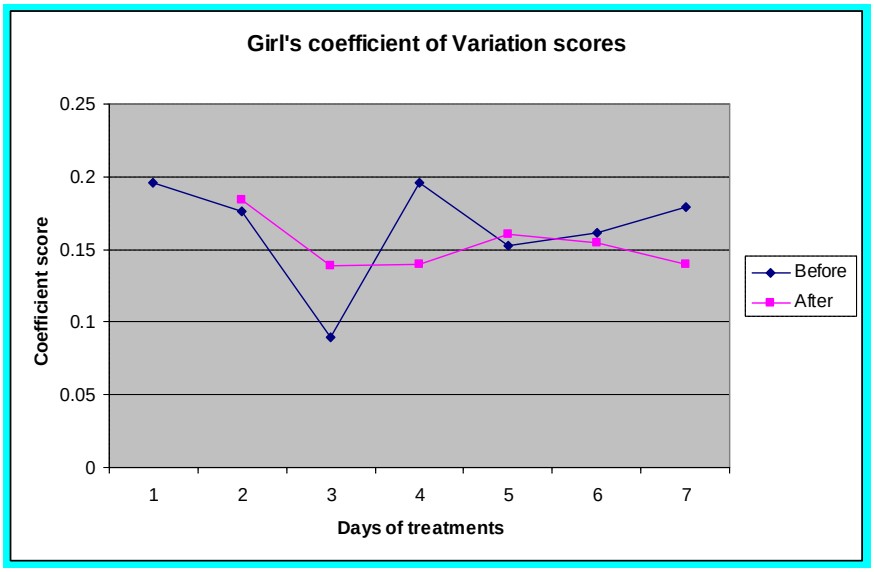

Figure 4 - Girl's coefficient/Energy Field Stabilization Scores.

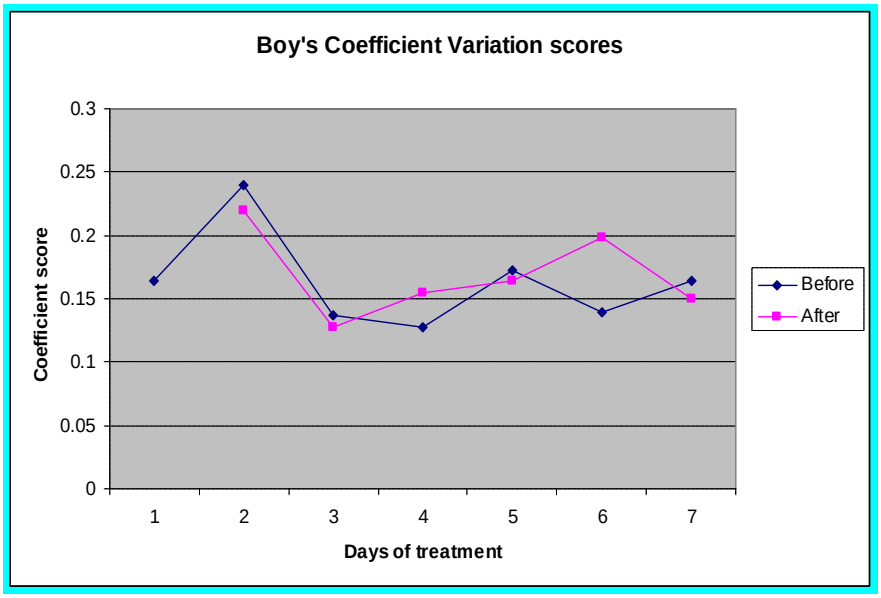

Figure 5 - Boy's coefficient/Energy Field Stabilization Scores.

As mentioned in the observations section, the coefficient (stabilization) scores were crosschecked with the positive observation scores to see whether there was a correlation. The 50th percentile of positive observations was on treatment day 4, which is when the overall coefficient scores started to decrease. This indicates a positive correlation between Energy Field Stabilization and Positive Energy Field Observations. Again further investigations need to be carried out to confirm the findings.

These cross correlations also correspond to the decreases detected on the Brown ADD Scales for self, parents and teacher. This suggests that the observed positive changes and

stabilization of the Energy Field were simultaneous to the improvements in each child's ADHD. These correlations need to researched and verified in larger study.

6.7 Brown's ADD scores

Prior to the first set of treatments, ADD combined scores on Brown's Scales for both the parents' and the children's assessments were above the recognized threshold scores of 52 as an indication of the children having ADHD. However, after the third set of treatments both were well below the ADHD recognized level. The scores are presented in Figures 6a-b and 7a-b. The decrease suggests a potentially significant improvement for both children.

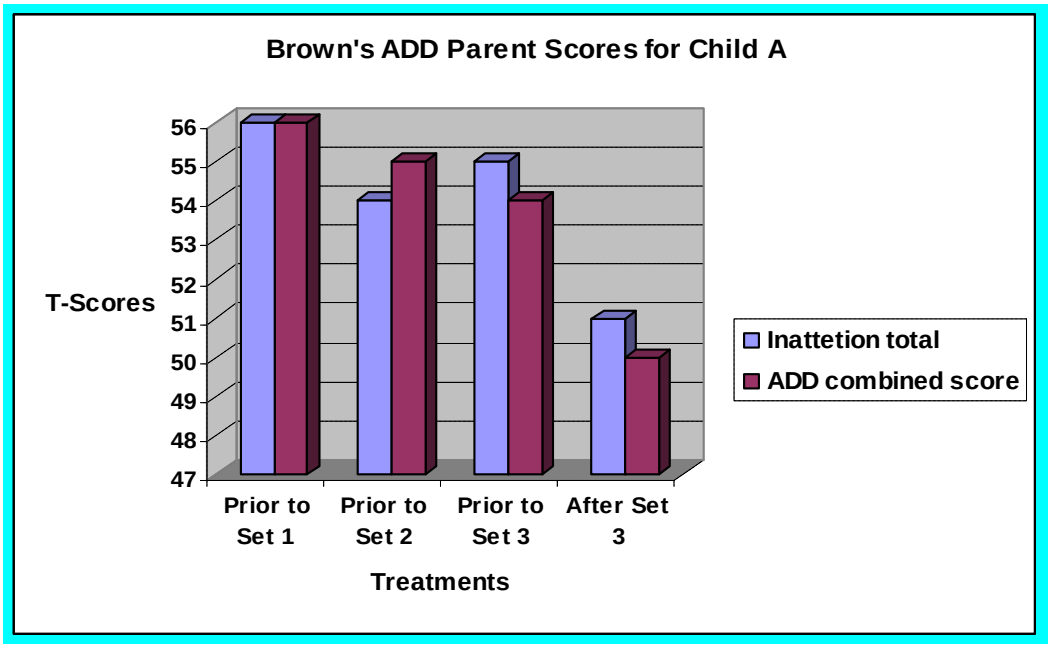

Figure 6a-Parents ADD Scores for Juan

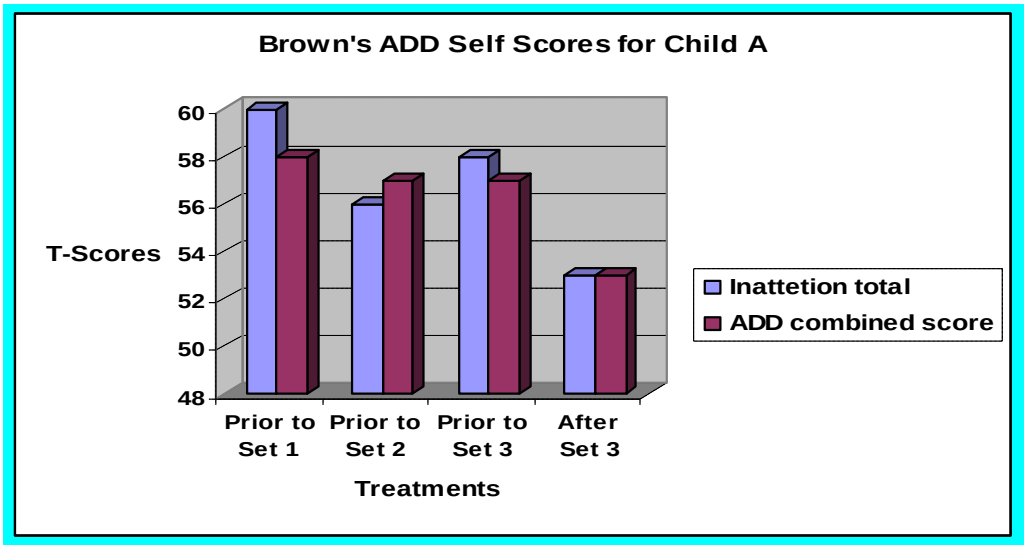

Figure 6b-Self ADD Scores for Juan

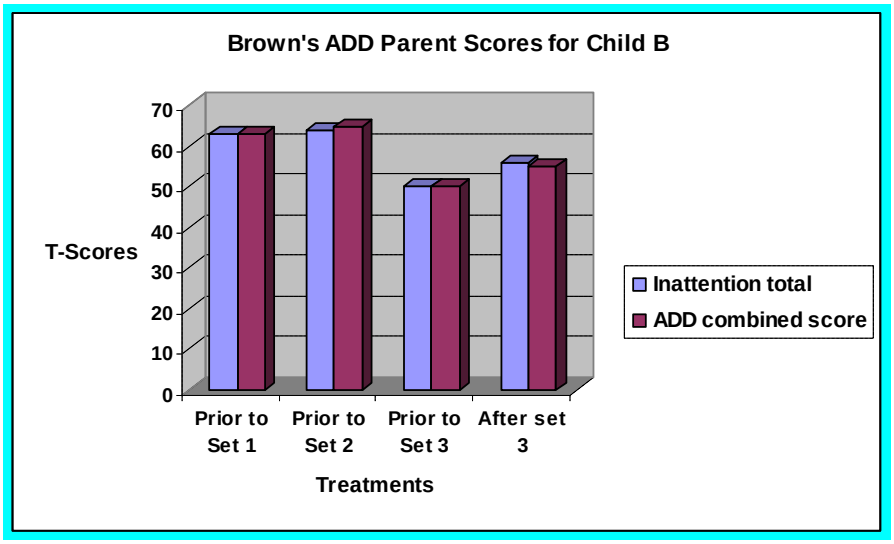

Figure 7a - Parents ADD Scores for Maria

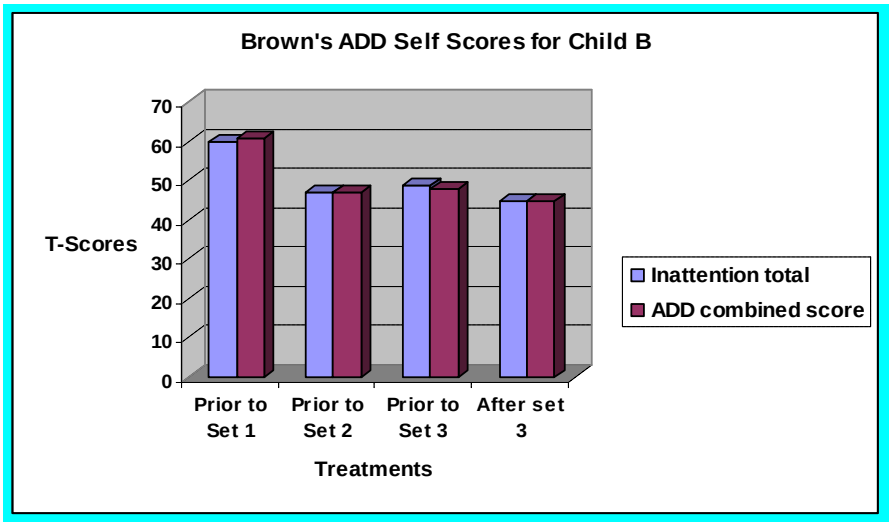

Figure 7b - Self ADD Scores for Maria

Brown Category Scores were also compared to DSM-IV Observations to determine whether there was a significant correlation. Mean scores were compared with the combined DSM-IV categories of Action, Effort, Focus and Emotion, before the first set of treatments and after the last set of treatments.

The mean scores were:

Prior to first set of treatments = 57.1

After last set of treatments = 50.6

The mean scores after the last treatment set were lower than the pre-treatment scores and were below the threshold score of 52. This is interpreted as an improvement in these DSM-IV

areas for both children. This correlation concurs with the observations made in the specific DSM-IV categories. As with the other findings, this correlation needs to be further researched.

The reduction of severity of ADHD symptoms was consistent across the different measures used.

Based on these findings we can therefore conclude that the treatment had a clinically significant positive effect on both children. Further research with a larger sample is needed to confirm the statistical significance of these findings.

7. Discussion

Results seemed beneficial in most areas, especially considering the difficulty of trying to heal children who constantly move and have serious behavioral and learning problems.

The parallel findings of ADHD symptoms in parents and children could suggest a genetic or learned behavioral link. Parental symptoms of ADHD are a common finding in ADHD research.

7.1 Study limitations

A confounding variable was that Maria had a primary condition, neurofibromatosis (NF1) that could cause ADHD symptoms. This meant that SHADE'S techniques might not have worked to their best potential. However, our aim was to explore a process that can help most or all ADHD symptoms, regardless of the primary cause. According to Brown's Scale scores, Maria's Maria's condition improved after treatment. Learning disabilities, with or without ADHD, occur in approximately 40% of individuals affected with NF1. (Pletcher, 2003). Maria does not have mental retardation.

Statistical analyses of the data were not possible due to the small number of subjects and measures in this pilot study.

There was a need for greater consistency in what was measured, as some data collection inconsistencies occurred during some of the video observations and RFI readings. For example, some electromagnetic frequency points around energy field were recorded twice instead of once. Although these occurrences were infrequent, strict recording RFI procedures must be carried out in the main study. A second observer will be present to take random readings to ensure there is no observer error in both RFI recordings and Video observations.

Future studies can be strengthened by scheduling the first set of measures well before starting the study and repeating them at least 1 month after treatment, and then maybe every 2 months after that, to provide an insight into how permanent the improvements in the condition are.

Ideally, each series of treatments should have been five sessions, rather than two of four and one of three. Based on previous experience, it was felt that this would have given the best chance of a positive outcome during each series of treatments. A longer gap between each series of about two weeks would have been preferred, which, based on experience, would have provided a better opportunity to assess whether the ADHD may have returned and if so, to what degree. This was impossible, due to time limitations of the family and the researchers.

Maria moved excessively and constantly throughout most of the treatments, making it difficult for the healer to heal and to take accurate measurements reflecting the healing, rather than their movements, which could have affected the outcomes. Wanting to go the toilet, hunger, thirst, being too hot or too cold, and things in pockets to play with, were all sources of distraction that should be addressed prior to treatment in future studies. Because of this, and the probability that other ADHD children could be even more extreme in these ways, it might be useful to teach the parents how to heal their children at home, using the ABBF Healing System (5.3.5), while the child is sleeping.

Although relaxation is considered safe, in rare cases someone may become more, not less, anxious during the process due to potential for a heightened state of awareness of distracting extraneous sensory perception such as hearing or feeling more when becoming quiet. There are also very rare reports of pain, palpitations, twitching, or crying due to extraneous sensory perception during relaxation and healing processes, creating deeper inner awareness of physical and emotional issues. These should be explained as potential norms prior to any relaxation. Anyone with schizophrenia and other psychoses (thought disorders that distort reality) should avoid relaxation techniques.

Our aura charts showed the ADHD brain is overactive in many areas. During meditation, meditators usually become more alpha dominant. Research has showed ADHD children as having a preponderance of theta, and a meditation study had significant positive outcomes with ADHD (Arenander and Sheppard*)*. As SHADES had similar positive results to meditation, it is possible that the ADHD child needs to attain a more focussed state of alpha.

It seems likely that, if the brainwaves could be adjusted to within a normal range, then ADHD would be reduced. For example, if an ADHD child has an abnormal preponderance of theta, then a meditation procedure to create fast beta could be introduced.

Because of our hypothesis that different brain states/waves may be needed for different ADHD children, there is potential for frequency healing to be used in specific ways. For example, someone with a preponderance of alpha may need a stimulating red, the opposite of alpha to balance the brain state, whereas someone who is in beta may need a relaxing violet.

Finally, it should be noted that for the duration of the current study the healer was ill with a chronic chest infection, which may have to some extent adversely affected his ability to channel appropriate energy.

7.2 Recommendations

7.2.1 Further SHADES exploratory pilots

Due to the large numbers of ADHD children, it is recommended that parents are taught the CBRC method (5.3.4) and/or the ABBF (5.3.5) system in small groups of 10-12, and then apply the techniques at home. Assuming that efficacy and effectiveness can be demonstrated in a more rigorous trial, this option could be very cost-effective.

7.2.2 CBRC method

Parents can learn to use the CBRC method in a group situation, by watching the therapist apply the system to their children during a half-day session. They can then apply the process for themselves and their children at home, to benefit the whole family. The parents would return the day after the teaching to discuss how they applied the system the previous night and the following morning. Thereafter, parents and children would return weekly for a period to be decided, in order to assess improvements in sleep or ADHD patterns. This would also provide a support group facility.

Establishing regular bedtime rituals by using the CBRC method may facilitate sleep onset, as well as better quality and longer sleep. All ADHD children should be carefully assessed for sleep problems, which, if present, need to be addressed regardless of whether or not they are the root cause. A paediatrician can assess the type of sleep disorder e.g. sleep apnea. A sleep method can help with developing good sleep habits and rituals. Because many ADHD children have difficulty keeping to a regular bedtime, calming themselves or settling down, teaching children with ADHD how to self-relax and fall asleep can be essential. Setting an alarm clock to remind the ADHD child to start the bedtime ritual can help them keep to this routine.

7.2.3 ABBF System

It is recommended that the parents of ADHD children attend a half-day group session on how to use the ABBF System. They would then apply the techniques on their children while they are asleep. This would have the advantage of healing ADHD children while they are still and not constantly moving around, thus making the healing potentially easier to achieve. Weekly follow-up sessions for the parents would assess their progress and adjust the techniques where necessary.

In order to help concentration, parents could introduce a reward system, such as coloured stars or some other incentive, whenever the child responds well.

The ADHD child should be made comfortable before the treatment, including ensuring there is no need for toilet, food, drink, or playing with toys in a pocket. The child should be comfortably warm.

7.2.4 Further assessments

Future studies can assess collateral conditions that are commonly associated with ADHD other than those in Brown's Scales, such as potential symptoms of anger, violence, inability to sleep sufficiently or adequately, depression, asthma, more or less energy in day, sadness, fear, headaches or other pains, asthma, allergies or skin problems.

Measures need to be found to assess erratic breathing, oxygenation, physical tension, mental stress, and to test how the methods used in SHADES affect these symptoms.

Specialist forms should be developed to assess aspects of ADHD relevant to the proposed SHADES research. These will include an Initial Interview Form, and sessional Visual Analogue Scales.

Brown's Scales and RFI may confirm if frontal lobes or inhibitory mechanisms of the cortex may be dysfunctional. If so, techniques could be developed to direct appropriate treatment to a relevant area.

7.3 Conclusion and way forward

There appear to be limitations and gaps in orthodox medicine's and CAM's treatment of ADHD. Treatments are either potentially damaging, have little effect on more severe ADHD cases, or are very expensive financially.

Our exploratory pilot adopted a mix of quantitative and qualitative measures. It also used triangulation wherever possible to establish trustworthiness by showing parallels between the various measures, which increases the study's validity.

This exploratory pilot has shown that a systematic approach with unique healing techniques together with combined breath control, physical relaxation, and mental calming, could fill the gaps in the therapies of orthodox medicine with fewer negative side effects and greater efficacy and effectiveness rates for ADHD children.

8. Post-treatment interview with parent

> *Only the father was present for this interview. He commented that doing the breathing technique with both children before going to bed helped them sleep better. Previously, his daughter had rarely slept through the night. He also commented that his son was performing better at school. Both children seem to him to have more energy. Overall he was pleased with both children's progress in the home and school. He also requested that should we do another study he would like to volunteer his children to be treated by Dr Sweeney further.*

9. Broader effects of healing for ADHD

Equally important, with current pressures on health care budgets, these specialist techniques appear to be significantly cost-effective, especially as parents can be taught to do the processes themselves at home. With current annual stimulant drug costs for a UK ADHD child population of 65,000 estimated at £632 per child, if either the CBRC method or the ABBF system can be shown in future studies to cost our estimate of £480 per child, this could have a financial saving of about £9 million for the UK government and up to about $550 million in health care costs in the US annually.

Because there appear to be no past or current studies on this systematic approach to ADHD, the way is open for further more stringent studies and a PhD research project to prove or disprove these apparently significant outcomes.

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