# GETTING UNSTUCK

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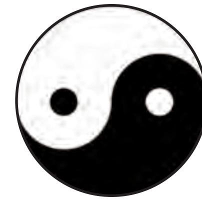
## UNRAVELING THE KNOT OF DEPRESSION, ATTENTION, AND TRAUMA



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C/R

# DEDICATION

This work of so many years could never have been possible without the unstinting support and encouragement of my wife Dr. Roslynn Glicksman, whom it is simply impossible to thank adequately.

I am also grateful to my parents, and to all the other members of my extended family whom I have studied carefully over the years to learn just how it is that smart, hyperactive people make their way in the world.

Finally, if predictably, I need to thank the many hundreds of patients I have had the privilege to treat over the past seventeen years of psychiatric practice. Without their trust and confidence I could never have put together the ideas you will soon be reading.

## TABLE OF CONTENTS

**Chapter 1 The Whats and Whys of Being Stuck page 1**

Who Should Read This Book ............ *page 2*
What's Inside This Book ............ *page 2*
My Intentions with This Book ............ *page 3*
The Three Conditions............ *page 4*
- Attention Deficit Disorder
- Depression
- Dissociaton

Running the Numbers ............ *page 8*
A Broken System ............ *page 9*
Professional Confusion ............ *page 9*
What's Really Going On ............ *page 10*
The Three Remedies ............ *page 12*
- Information
- Medicatio
- Integratio

**Chapter 2 Stuckness page 15**

Alberto: ADD and Dissociation ............ *page 16*
Boris: A Complex Depression ............ *page 22*
Cathy: Dissociation, Depression, and ADD ............*page 23*

**Chapter 3 Attention Deficit Disorder page 29**

Badly Named and Poorly Defined ............ *page 30*
Toward a Better Definition ............ *page 31*
Executive Functioning ............ *page 34*
Disorganization: A Surmountable Delay ............ *page 36*
Underreflective Equals Hyperactive ............ *page 37*
Motivation and Attention ............ *page 38*
Definitions and Beyond ............ *page 42*
- ADD Is about the Structure of Time
- ADD Is about the Disparity Between Conceptual Abilities and Performance Abilities
- ADD Is about Difficulty Getting Comfortable
- ADD Is about Controlling the Level of Stimulation
- ADD Is about Compensating for Other Deficits and Difficulties
- ADD Is about Insecurity and Self-Doubt
- ADD Is about the Struggle for Intimacy
- ADD Is a Conflict Amplifier
- ADD Is about Difficulty with Authority
- ADD Is about Solving the Puzzle of Life

**Chapter 4 Depression page 57**
Mood Versus Illness ........ page 60
The Four Depressive Systems ........ page 62
• Type I Norepinephrine/Stress Depressions ........ page 63
• Type II Serotonin/Hereditary Depressions ........ page 64
• Type III Dopamine/Pleasure Depressions ........ page 66
• Type IV GABA/Bipolar Depressions ........ page 67
Depression and ADD ........ page 69

**Chapter 5 Dissociation page 75**
The Effects of Trauma ........ page 76
The History of the Selves ........ page 79
Left-Brain Selves and Right-Brain Selves ........ page 81
Trauma and the Integration of the Left and Right Brains .. page 85
Brain Integration and Human Potential ........ page 88
The Dissociation Subtypes ........ page 89
• The Split Between Reason and Emotion
• The Split Between Reason and Behavior
• The Split Between Reason and Sensatio

**Chapter 6 Hypnosis and Self-Hypnosis page 97**
A Brief Example of a Trance ........ page 98
Trance: Uses and Properties ........ page 99
Trance and Stuckness ........ page 100
Hypnosis or Self-Hypnosis: Which Is for You? ........ page 101
Self-Hypnosis ........ page 102
The Great Divide: Those Who See Versus Those Who Feel ........ page 103
The Four-Step Process ........ page 104
The Felt Sense ........ page 107

**Chapter 7 The Treatment of Dissociation page 109**
Inner-Child Exercises ........ page 111
• The Case of R. ........ page 115
• Variations for the Less Visual ........ page 117
• The Case of W. ........ page 118
Inner-Parent Exercises ........ page 120
• Three Parental Journeys ........ page 124
• A Basic Inner-Parent Exercise ........ page 131
Inner-Guide Exercises ........ page 133
• The Case of Q. ........ page 135
• General Considerations ........ page 137
Psychoeducation and Integration ........ page 141

**CHAPTER 8 The Treatment of ADD: Executive Functioning and the Management of Time and Task page 145**
Time Maps ........ page 147
Pessimistically Planned Transitions ........ page 150
The Request-Handling Algorithm ........ page 153
The Daily Time Map ........ page 155
The Weekly Time Map ........ page 156
The Monthly Time Map ........ page 158
The Two Little Guys ........ page 160
A Case of Poor Time Management ........ page 161
Time Maps and The Inner Selves ........ page 170

**CHAPTER 9 The Treatment of ADD: Trance, Meditation, and Brain Training page 173**
Medication ........ page 173
Trance ........ page 177
Meditation ........ page 179
Other Brain Training ........ page 181
Creating Your Own Brain Training ........ page 185
Putting It All Together: Controlling Your Mental States page 186
Love as a Brain Enhancer ........ page 189
Therapeutic Trance for ADD ........ page 189
• The Wanting Machine
• The Bull's-Eye
The Case of V ........ page 192

**CHAPTER 10 The Treatment of Depression page 197**
Bipolar-Spectrum Disorders ........ page 198
• Manic-Depressive Disorder
• Cyclothymia
• Intermittent Explosive Disorder
Serotonergic Disorders ........ page 203
• Seasonal Affective Disorder
• Female Hormonal Depression
• Social Phobia
• Obsessive Depression and Obsessive-Compulsive Disorder
Dopamine/Pleasure Depressions ........ page 228
• Denial-of-the-Self/Under-“Fun”-Ded Depression
• Post-Substance-Abuse Depressio

Norepinephrine/Stress Depressions ................................. *page 233*
- Panic Disorder and Anxious-Agitated Stress Depression
- Post-Traumatic Stress Disorder

**CHAPTER 11 Dr. Don's Dreams page 247**

The Problems...................................................................... *page 247*
The Solutions..................................................................... *page 250*
A Training Program
A Rational Syste
A New Subspecialty
A New Educational Approac

**Appendix I Cathy's Trance page 255**

**Appendix II B.'s Trance page 261**

**Reference by Author page 275**

**Reference by Chapter page 279**

**Index page 283**

CHAPTER 1

# The Whats and Whys of Being Stuck

*What does it mean to be stuck?*
Being stuck means not working.
Being stuck means not moving.
Being stuck means not growing.

Being stuck means feeling frustrated, unsatisfied, unfulfilled, lost, confused, blocked.

It's not that stuck people don't have any idea what to do about their being stuck. Stuck people know what to do. They just can't get themselves to do it.

Being stuck does not result from ignorance. Rather, it results from a lack of self-control. It results from not doing what should be done, and from doing what should not be done. It results from problems with focus and planning and execution. Stuck people are inefficient. They function below their capabilities. They don't maximize their resources or opportunities. They can't seem to plan or follow through when it comes to the behaviors required to move forward in life.

No one likes to be stuck, although an awful lot of people are stuck. If you're stuck, you most likely want to change. You most likely want to get going, working, moving, growing.

Hence the title of this book: *Getting Unstuck*.

## WHO SHOULD READ THIS BOOK

If you are an educated individual — a college graduate, say, or a person who has studied and mastered moderately challenging academic material — and yet, even after considerable intelligent self-examination and reasonable efforts at obtaining professional help, you remain stuck and confused, then you should read this book.

If you are a professional of almost any sort – a social worker, psychologist, therapist or counselor, teacher, coach, cop – and you work with good-hearted, well-meaning folks who seem to be trying hard but just can't get anywhere, then you should read this book.

If you are the parent, the spouse, the partner, the lover, the sibling, the colleague, or even just the good friend of a stuck person, then you, too, should read this book.

If you fit into any of the above categories, you will want to read this book because inside it you will find, for the first time in a long time, some straight answers about what's really going on with us in this fast-paced, complex, unforgiving world, and what we can and should be doing to help ourselves.

## WHAT'S INSIDE THIS BOOK

Inside this book, you'll find discussions about what I call the four threes:

- Three conditions
- Three remedies
- Three journeys
- Three tools

The three conditions are depression, dissociation, and attention deficit disorder (ADD). In my practice, I have found that these three interconnected conditions are the primary causes of people becoming stuck.

The three remedies are information, medication, and integration.



The three journeys are three types of guided visualization (inner child, inner parent, and inner guide). They can be used to heal the effects of all sorts of trauma on the ever-developing organization of the self.

The three tools are time maps, pessimistically planned transitions, and request-handling algorithms. These are techniques for time and task management.

## MY INTENTIONS

I began to write this book – perhaps almost a decade ago – out of a wish to train other mental health practitioners in the use of the hypnotherapeutic techniques I had been customizing for my patients with ADD and depression. Once the book began to take shape, however, I found myself using it routinely to speed up my work with my patients. I've been giving it to my patients in various forms for five years now, and I have no doubt that it accelerates their progress enormously. It provides an organizational overview both of the problems that they bring to me and of the solutions I am prepared to provide.

Fundamentally, this book is designed to assist in the quest for a more satisfying and productive life. It's a book about what gets in our way as individuals, as professionals, and as a society and culture, and about what we can do to remedy it. Specifically, it's a book about the complicated relationship between three different conditions that influence human experience — depression, ADD, and trauma — and ways to deal with them. The central contention of this volume is that “being stuck” is an end state that is common to all three of these disorders, and further, that effective treatment depends entirely on separating out and addressing all the components that are present at any one time.

The three conditions operate at three different layers of causation: Attention is neurophysiological, having to do with the structure of the brain; depression is biochemical, having to do with wear and tear at the neurotransmitter level; and trauma is dissociative, having to do with the storage and flow of information within the structures of the self.

In addition to guiding and informing individuals who suffer from any combination of the three conditions, my wish and my mission are to influence my profession, to change how we, as a society, approach these issues. Therefore, you will find herein a subtler and more useful way of looking at attentional issues in mental health (ADD is still both underdiagnosed in adults and simplistically and/or ineffectively treated in all age groups), as well as an emphasis on the interactions between the different conditions and the different levels of causation. At the end of the day, my wish is to attempt to redress the unfortunate disintegration of medication and therapy, to influence how practitioners are trained, and, at the very least, to spread these ideas and practices as widely as I can. I believe Americans are waiting impatiently for an approach to their mental problems that makes sense and that works.

It is not at all accidental that in this book, I discuss the three conditions together, something that, to my knowledge, has never been done before. For the past decade, I have been a specialist in the treatment of adults with ADD. At the same time, I have treated a large number of patients with depression who were sent to me by the insurance companies with which I participate. Many of the people who came to me for help with ADD were also depressed, and a large number of those who suffered from depression also had ADD — ADD that almost never had been properly diagnosed or treated. Both these sets of patients often had underlying post-traumatic dissociations.

When we compare the three conditions, we see that their clinical presentations are often strikingly similar — so similar, in fact, that the conditions are often confused for one another. The three conditions, by different mechanisms, all lead to the same condition of being stuck.

Let's take just a moment to compare the three conditions.

## THE THREE CONDITIONS

### Attention Deficit Disorder

What is now called attention deficit disorder is a hardware problem, an inherited neurophysiological condition that is estimated



by authoritative sources to affect 3 to 7 percent of the population. Although ADD is usually associated with children, it is being increasingly recognized as a widespread problem among adults as well. The three classic symptoms of ADD in children are distractibility, impulsivity, and hyperactivity. In adults, the hallmark symptoms also include procrastination and disorganization. Probably ADD can be more accurately described as an inherited relative underactivity of inhibitory centers in the front of the brain. This means that people with ADD who need to focus on an attentionally demanding task may have difficulty turning off or preventing the activation of competing areas of the brain. This translates in practical terms into a tendency toward underreflectiveness, a preference for action, and a delay in the development of executive functioning.

Executive functioning is defined as the ability to plan across time in order to optimize outcomes. Poor executive functioning is the most common presenting complaint of adults with ADD (read inherited under-reflectiveness). ADD is extremely variable in its presentation, in the degree to which it impairs any given sphere of life, but difficulty in executive functioning, problems with planning and follow through, should always raise our suspicions that attentional problems may be present even if previously undetected.

Although official estimates vary, I have come to believe that the prevalence of ADD has been grossly underestimated. I see attentional issues as an iceberg, more than half of which is still submerged below the surface, unseen, undetected, and unaddressed. This is for two important reasons: (1) because the condition is poorly named, and (2) because hyperactivity can be invisible. The disorder is poorly named because many people have no absolute deficit in attention. Rather, they have a problem modulating their attention — that is, turning it on, keeping it on, and turning it off. Many people with ADD focus quite well, just not selectively or consistently enough to please everyone they need to please.

When I say that hyperactivity can be invisible, I am making another very important point. If, in ADD, inhibitory systems in

the brain are relatively underactive, it follows that some other part of the brain in going to be underinhibited, or overactive. The question is which part.

When the underinhibited part of the brain involves verbal or gross motor activity, ADD is recognized fairly early. However, if it involves systems that are tactile, visual, musical, sexual, emotional, or something else more internal, the patient will very rarely be diagnosed, but the effect on the development of adequate executive functioning may be the same.

Consequently, attentional disorders are like an iceberg. I believe that their prevalence is closer to 10 to 12 percent than the 3 to 7 percent usually discussed. In addition, I believe that since ADD is an inherited set of nervous system tendencies, it cannot be cured. People with ADD, especially those who do not know themselves well, quite often become stuck. Fortunately, the effects of ADD can often be mitigated almost entirely by a judicious combination of wisdom, medication, and the acquisition of compensatory skills.

**Depression**

Depression, also called affective disorders, is the label we commonly use to connote neurotransmitter disorders, which are metabolic or biochemical disorders of the brain. It affects an estimated 20 to 25 percent of the population.

Bipolar disorder, obsessive-compulsive disorder (OCD), and many of the anxiety disorders, as well as the more obvious depressive conditions are all neurotransmitter disorders. These are all wear-and-tear problems, a little like running out of brake or transmission fluid in a car. They are biochemical imbalances in the brain caused by some individualized combination of poor lifestyle, stress, and hereditary susceptibility. Any of these conditions can also alter attention, but they also show themselves in a range of other changes in things like sleep pattern, appetite, energy level, and nervous and emotional reactivity. Depression is an enormous cause of being stuck. Again, fortunately, if it is properly diagnosed by subtype (there are four major types), it is almost always reversible with medication and/or therapy.



**Dissociation**

Dissociation is the way in which a wide range of traumatic childhood experiences are stored and expressed in adulthood. It has to do with the ability of the brain to perform more than one function at a time and to vary and adjust the flow of information about these functions in and out of the conscious awareness. Dissociative disorders are not widely understood, but they are extremely common. We know that extreme trauma can profoundly affect individuals. The post-traumatic stress disorders (PTSDs) of combat troops and September 11 survivors are examples. The category includes not only people who were overtly battered or sexually abused as children, but also those who were more subtly but still chronically traumatized, such as the children of alcoholics, drug addicts, or mentally ill parents; the children of bitter divorces or frequent relocations; and people who grew up with Asperger's syndrome, ADD, or learning disabilities. What become dissociated are what are commonly called the left (verbal) brain and the right (visual) brain.

What we know nowadays is that persistent childhood trauma interferes with the natural process of learning how to manage consciousness and self-consciousness; creating, if you will, programming problems in the brain that affect the way individuals learn to process information and organize the self and the mind.

Throughout history, every culture, to a greater or lesser degree, has recognized the dual nature of the human mind — the rational versus the emotional, the judging versus the experiencing. In modern times, we recognize that this duality has a basis in the left and the right hemispheres of the cerebral cortex. The essential difference between the two hemispheres is in how they process and store information. The right brain is primary, experiential, before words, visual, bodily, emotional, pattern-seeing, in the moment. The left brain, which comes into play later, is verbal, planning, naming, labeling, comparing, judging, one step removed from experience. In order to become most fully human, our best selves, we must integrate these aspects of the mind/brain, these two selves. When children are taught to reject or despise

themselves, for whatever reason, that process of integration is disturbed and altered. The flow of information back and forth between the planning left brain and the feeling/doing/knowing right brain becomes stilted and inefficient.

Dissociation — the divorce of intent from action, of the left brain from the right brain — is a concept central to the understanding of being stuck. Although dissociation in its more obvious forms (for example, traumatic amnesia, battle fatigue, and dissociative identity disorder, which is also called multiple personality disorder) is a widely recognized syndrome, it is usually overlooked when diagnosing and treating adults who can't get things done. Many adults who are correctly diagnosed with ADD suffer less from the underlying neurophysiological problem than from the dissociative effects of a lifetime of interaction with a world that is not in sync with their rhythms or methods of relating. It is this consistently negative and variably but persistently traumatic interaction that interferes with their ability to master and integrate the various parts of the self. As already mentioned, ADD is only one of many traumatizing childhood experiences that can create dissociation and "stuckness."

## RUNNING THE NUMBERS

If you find yourself remaining stuck even after considerable intelligent self-examination and reasonable efforts at professional help, the chances are exceedingly high that you are suffering from one (and probably more than one) of the three extremely common conditions we have been discussing — depression, ADD, and dissociation. When I say that the chances are exceedingly high, I am not exaggerating. In my perhaps biased view, at least 10 percent of the population is affected by attention deficit disorder as I define it. Neurotransmitter abnormalities, commonly known as depressive and anxiety disorders, collectively affect 25 percent of the population. Dissociative disorders, caused by a myriad of conditions and situations, altogether easily affect 25 percent of the population. Add up those numbers and, even accounting for overlap, you'll see that it's safe to say that more than one in three Americans are affected by one or more of these three conditions.



These are pretty astounding numbers when you think about them. If we extrapolate simply from figures of 10 percent for ADD and 25 percent for neurotransmitter abnormalities, we come up with 2.5 percent of our population having ADD and depression. That's 7.5 million Americans. But in reality, it's way more than that, because ADD leads to depression, and ADD leads to dissociation, and dissociation leads to depression as well. When all is said and done, tens of millions of Americans suffer from some combination of these interacting conditions.

## A BROKEN SYSTEM

Unfortunately, the mental health system is just as fragmented as the patients it seeks to treat. Therapists largely are neither prescribers nor diagnosticians. Prescribers are primarily general practitioners and the overwhelming majority of psychiatrists don't even do therapy at all anymore anyway. Nowhere nearly enough psychiatrists are being trained, and those that are being trained are not being trained broadly enough. Although it is possible to receive skilled treatment for depression with both medication and therapy, the therapist and the diagnostician/prescriber usually are not the same person. Treatment for dissociation is provided largely by hypnotherapists, who neither prescribe nor diagnose, and has been focused almost exclusively on the more severe cases-post-traumatic stress disorder (when the acute trauma occurred in adulthood), and multiple personality disorder (when the acute trauma occurred in childhood). Almost no literature at all exists on psychotherapy for adults with ADD, and the literature that does exist on children and adolescents with ADD focuses almost exclusively on medication.

## PROFESSIONAL CONFUSION

What is obvious is that confusion about stuck people is pervasive. Doesn't everyone have trouble getting things done? Doesn't everyone have trouble with self-control? Most stuck people are half-convinced themselves that they're just lazy, selfish bastards who need a good kick in the pants. Does ADD even exist? If so,

exactly what is it? Should medicine be used? Under what circumstances? What else can be done? Is there a specific effective treatment? Is therapy just more coddling?

The whole thing is a mess. Excellent treatments do, in fact, exist for a wide range of aspects of mental functioning. It's just exceedingly difficult to know how and where to find it.

To illustrate the point, consider the following exchange. In June 2000, *The New York Times* ran an article discussing the heightened awareness of attentional difficulties in adults and describing some strategies for coping with ADD in the workplace. It defined the syndrome as a biochemical imbalance that results in six symptoms-procrastination, impulsiveness, disorganization, hyperactivity, lack of motivation, and inability to manage time.

Within days, a cranky psychiatrist shot back a plaintive response in which he labeled the condition as merely a collection of bad habits that, if legitimized as a diagnosis, would surely lead to wholesale drug dependence and the collapse of the mental health reimbursement system.

Perhaps I'm overstating the letter writer's positions. I apologize if I am. But, if nothing else, this exchange taken from the pages of the gray lady demonstrates vividly how confused and conflicted we are today about the diagnosis and treatment of attentional problems and of stuck folks in general. First off, *The Times* was mistaken in a very important way when it labeled ADD as a chemical imbalance. Depression is a biochemical imbalance that can, sometimes at least, be rebalanced. ADD is something else entirely. It is a neurophysiological condition, an inherited variation in brain structure. Although it can be made virtually invisible by medication or the acquisition of compensatory skills, it can never be cured because it is not an illness.

## WHAT'S REALLY GOING ON

If the aforementioned psychiatrist is any indication, it's no wonder that so many stuck people have difficulty finding sympathetic, let alone effective, treatment. I'm not sure exactly how



classifying a very common set of human problems as bad habits helps people to function better. The above psychiatrist was mostly wrong-headed, and what's worse, his letter was unconstructive. (What does he propose to do for the folks with “bad habits”?) In any case *The Times* article does nicely summarize, with its six symptoms, pretty much what I am trying to get at by using the umbrella term “stuck.”

ADD is real, that's for certain. I know because I have it, because my children all have it, and because I have seen thousands of people with it over the past decade. It's easy to talk about bad habits or bad character. It's easy to call people lazy, selfish, unmotivated, irresponsible, or unreliable. What's more useful is to start with the idea that, given the opportunity, most people want to do well, to “be good.” If they're not doing well, there's a reason, and if we want to help them do better, it behooves us to find out what that reason is. To do that, we need to abandon old approaches that just don't work. We need to start dealing with the complex layers of causation that make people stuck.

Getting unstuck involves looking at the complex weave of depression, ADD, and dissociation. Three factors that operate at three different levels and that all must be examined if a speedy and effective treatment is to be devised. These factors can appear in isolation or in various combinations, sequentially or simultaneously, confounding both psychiatrists wedded to an ADD diagnosis and those biased against it — and disappointing patients who seek their help. No wonder so much confusion and controversy surround effective treatment for dysfunctional adults.

What we are about to discuss in this book is not the treatment of three separate conditions. Rather, more accurately, it is the treatment of seven different conditions:

- Post-traumatic left-right brain dissociation (henceforth referred to simply as dissociation)
- Biochemically-based neurotransmitter disorder (henceforth referred to simply as depression)

- Neurophysiologically-mediated attention deficit disorder (ADD)
- ADD plus dissociation
- Depression plus dissociation
- ADD plus depression
- ADD plus depression plus dissociation

## THE THREE REMEDIES

### Information

The past thirty years have witnessed enormous progress in the field of psychiatry in accurately defining treatable clinical entities. We now know a great deal about the nature, course and treatment of most common conditions, and I believe that it is of vital importance to a successful treatment that this information be shared with the patient. Large parts of this book are my efforts to put together in one place the materials that I thought would help my patients better understand their conditions. Chapters 3, 4, and 5 contain a great deal of what I try to explain to my patients about their conditions so that they may most effectively assist in their treatment. Throughout the text are references to books that I have found especially useful. These books are collected in a Reference List at the end of the text. Please consider *Getting Unstuck* a starting point in your exploration of these topics, and read for yourself the books in the "Recommended Reading List" that apply to you the most. All of the books to which I refer have much greater depth that I can convey in my brief references, and all will reward further reading.

### Medication

Medication for ADD is actually a relatively simple issue. Two medications (Dexedrine and methylphenidate. both in a multitude of preparations) account for the overwhelming majority of prescriptions. Three other drugs, two of them also antidepressants (Strattera, Wellbutrin, and desipramine) make up almost all



the rest. Medication for the full range of neurotransmitter, depressive, and anxious disorders is a much more complicated issue. I commonly use a palette of as many as fifteen to twenty drugs.

Depression continues to be ineffectively treated for two common reasons. First, some or all of the depressive subtypes that may be present in a person at any given time are inadequately identified or addressed, and second, the effects of attentional issues on the nature and course of the depression are inadequately appreciated.

Medication is, of course, rarely the only answer, but resisting its role is equally futile. Much wonderful therapy — directive, interpersonal, eclectic, or psychodynamic — is wasted when it is performed on folks whose neurotransmitter problems are interfering with their ability to turn thought and conversation into action. I have repeatedly witnessed what I call the slingshot effect — when bright people with a lot of therapy under their belts finally get a sufficiently subtle diagnosis that allows the prescription of the proper mix of medications, and boom, they take off like rockets because now, they can finally use all that great stuff they've been learning and talking about all that time.

By the time you finish reading this book, you should be able to easily identify the various medication-responsive neurotransmitter-based symptom clusters (there are four major types), and just as easily see the presence of prefrontal cortex-mediated underreflectiveness (ADD) in its many disguises.

### Integration

What I believe distinguishes my approach from many others is my emphasis on right-left brain integration as a complicating factor in the treatment of both depressive and attentional disorders. All human beings struggle with the challenge of integrating their left and right brains. The same right-brain utilization techniques that can be used to change the course and the effects of various mental and nervous diseases and emotional disturbances (the traditional bailiwick of psychiatrists) are the very stuff of the human

potential movement in all its varied glory, the very tools of personal growth that have been sold by one wise man or another, from Tony Robbins to Werner Erhardt, from Krishnamurti to the Bhagwan Shree Rashneesh to Norman Vincent Peale and back again. It's all the same stuff. It's all yin and yang. It's all always about integration of the parts. Always.

In the second half of this book, after we have spent some time defining and describing the three interwoven conditions, we'll look at a range of exercises designed to move along this universally human process of learning to makes our parts work as a whole, and we'll see how they can assist us in addressing these oh-so-slippery reasons for being stuck.

At the end of the day, what I am hoping for is that you, the reader, will find in this book a better way of thinking about, analyzing, and ultimately treating the factors that are keeping you stuck. I am hoping that this volume will be the impetus for a grand collaboration between patients and their therapists, between teachers and their students, between the members of all sorts of families, and that they will give the book to each other and try to use the ideas found within it to spur each other forward in the never-ending quest to be more completely themselves.

Let's move on and see just how this works.

Order the full book at TheAttentionDoctor.com

## CHAPTER 2

# STUCKNESS

### CHAPTER OVERVIEW

**Stuckness: A General Profile**

You don't take care of yourself physically, occupationally, financially, socially, or emotionally.

You know what steps you can and ought to take to make your life better, but you don't take them, and you don't know why.

Your emotions get in your way; you lose perspective.

You have an uneasy relationship with time: You can't get organized, and you can't prioritize.

You don't get things done efficiently or at all.

You're not in control — not of your intentions, not of your feelings, not of your relationships, not of your behavior.

***Bottom line: You know what to do, but you can't get yourself to do it.***