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FROM
PARKINSON'S

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RECOVERY FROM PARKINSON'S

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“It is hoped that the offering of the following pages to the attention of the medical public, will not be severely censured. He... [the writer] considered it to be a duty to submit his opinions to the examination of others, even in their present state of immaturity and imperfection.”

James Parkinson
Member of the Royal College of Surgeons

Preface to *An Essay on The Shaking Palsy*, 1817

Acknowledgements

Thank you Steve, my beloved husband and professor of English, for thousands of hours of proof-reading and making me into a writer.

Take a bow, members of the Santa Cruz PD Treatment Team: Dr. Chris Ells DAOM, LAc, Laura Walter LAc, Rebecca Weinfeld LAc. We've jointly treated PD patients and puzzled, even agonized over them for nearly fifteen years. In this book, I use the word "I" in many places where I might have used the words "we, the Team." This way, I get the blame, if any. But in truth, you three deserve much of the credit. This project could not have happened without you. This is *our* book. Double thanks to Chris, jet-setter, who also works half the year at the Amsterdam branch of the research project.

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And to Dr. Kenneth V. Thimann, senior professor of biology and world renowned researcher, who solemnly, cryptically, warned me in 1973, when I was a college sophomore, that someday, when I, with others in my wake, came to a deep chasm, I would have to dare, against the warnings of others, to take an impossible, flying leap over to the other side. "Don't be afraid," he said, "At that moment, angels will carry you." He continued: from the other side, I would be able to see the way safely through the chasm and could instruct the others, waiting back at the other side, how to follow. But the leap itself would bring me a joy that those who merely followed could never know. His words came back to me many times during this project. I now pass this warning and advice along to all who hope to move forward in research.

Thank you to my father, who was always proud of me. He developed and taught a method of conceptualizing electricity and magnetism as mechanical analogs, and vice versa, thus helping post-WWII aeronautic research engineers feel as comfortable creating and designing with invisible electrons as they had been with nuts and bolts. My work follows in his steps. He played the harmonica.

Thank you to my mother, who loved me dearly and laid so many crucial foundation stones.

For your "sudden shafts of wisdom, dispelling error accumulations of countless centuries," thank you, Paramahansa Yogananda. For concrete moral support and approval when I needed it most, thank you, Sri Daya Mata.

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Introduction

Welcome!

I'm an acupuncturist.

In 1997, I first noticed weird electrical patterns in three Parkinson's patients. After they unexpectedly recovered, I struggled for more than a year to build a hypothesis that might account for these improbable changes.

I sought out more Parkinson's patients and formed a group of interested colleagues. We ended up with a concept that integrated the bio-electrics of Asian medicine and the chemistry of a neurological pathology. The concept applied to Parkinson's but also to any illness that has even a slight electrical or thought wave component. Any illness that is affected by mood, by weather, or by electromagnetic forces might be better understood with this method of integrating Asian and western medicine.

I nervously wrote up an article and sent it off to the *American Journal of Acupuncture*, our top Asian medicine journal of the day. The editor, B.G. Grace, told me, "I think the reason I started this journal, more than twenty years ago, was to someday publish this article." She added, "Be careful. You're going to meet hostility and overwhelming curiosity. Get an unlisted phone number immediately." (She was right on both counts.)

She continued, "You only get one shot at something as outrageous as this. If nay-sayers can prove one *small* point wrong, your entire argument will be thrown away and you won't get a second chance, ever."

She ended by saying, with regard to the multi-billion dollar a year Parkinson's drug industry, "They're going to have to kill you."

A few months later, an advisor, Dr. Fred Jones, former professor of medical research at the medical school in Rochester, New York, read through some of my notes and marveled, "This has implications for a better understanding of cancers, as well as Parkinson's." He added jokingly, "They're going to have to kill you."

I understood the need to get all my proof-ducks in a row before brazenly announcing I'd found the cause and cure for Parkinson's. The proofs might take years. But I felt an urgency to get the word out. I wanted *everyone* with Parkinson's, as soon as they were diagnosed, to know that they *might* recover.

I made the decision to put all my findings on the Internet, for free, to publish only in Asian medicine journals, and not make any press-releases. Sure enough, thousands of people with Parkinson's have found my material. No neurologist has ever contacted me, except for one with Parkinson's disease.

I was supremely grateful for the go-slow approach when I realized, several years into the Recovery Project, that people who already had brain damage from anti-parkinson's medications could be seriously at risk if they healed from the physical injury holding the Parkinson's electrical pattern in place. We saw psychotic breaks, institutionalizations, and fatalities in those people who recovered who had been taking the medications. When I understood the degree to which

these people were not good candidates for recovery I was extremely grateful that we had not “gone public” yet with our findings: hundreds of thousands might have been injured or died.

A few years later, Richard McAndrew wrote a novelette, *Strong Medicine* (Oxford University Press). The royalties are generously dedicated to our non-profit Parkinson’s Recovery Project (pdrecovery.org).

This fictional murder mystery features a female acupuncturist/Parkinson’s researcher in Santa Cruz – my hometown. Early in the story she is killed by what turns out to be a drug company hireling; her cure for Parkinson’s disease threatened the profits of the drug firm.

My adult children were appalled by this book.

I was gratified. Maybe my work is so bold that I *do* need to die for it. If so, I have now been murdered in fiction. With that bit of karma thus resolved and my ducks finally swimming in order, I am safe, now, to blazon forth to the world the good news about Parkinson’s disease.

I can now say, just as one must be able to say in order to recover from Parkinson’s, “I am safe, now, after all.”

Janice “J.J.” Walton-Hadlock, February 24, 2013

“Although, at present, uninformed as to the precise nature of the disease, still it ought not to be considered as one against which there exists no countervailing remedy.”
— James Parkinson, 1817¹

CHAPTER ONE

A CURABLE ILLNESS

Idiopathic Parkinson’s disease is not – and never has been – an incurable illness. Parkinson’s disease has a definite cause. Effective treatment for Parkinson’s disease requires removal of the cause. It’s that simple. When the cause is removed, the symptoms of Parkinson’s vanish.

This book is a how-to for people who intend to recover from Parkinson’s. It includes *many* case study examples. For medical professionals and researchers, this book explains the causal mechanics of Parkinson’s disease. For anyone who is interested in a modern explanation of how micro and macro bio-electrics and bio-waves influence body chemistry, brain mechanics, and gene expression, this book is an introduction to those ancient Asian medicine principles.

An electrical disorder

The secondary cause underlying both idiopathic Parkinson’s disease and psychogenic parkinsonism is a perfectly normal electrical circuitry *ordinarily* used by the body, very briefly, in times of dire physical injury or imminent death.

In people with Parkinson’s, this circuitry is running constantly.

This electrical circuitry, ordinarily, is used only when the body needs to shift into the neurological mode that is used for dire trauma: a mode called dissociation. If the person survives and the trauma is resolved, the body’s electrical circuits should quickly shift back to patterns that drive the more common neurological modes of parasympathetic (awake and calm), sympathetic (“fight or flight”), and sleep.²

This dissociation circuitry is the secondary cause of Parkinson’s disease, and causes the symptoms of Parkinson’s, including the inhibition of dopamine release. In a person who

¹ Parkinson J. *An Essay on the Shaking Palsy*. Sherwood, Neely, and Jones, London, 1817. page 56.

² Some psychologists consider that the immobility of dissociation, or TI (tonic immobility) is an extreme type of sympathetic nervous system response. However, the electrical circuitry of the biologically dissociated state is *extremely* different from that which drives sympathetic mode. Also, unfortunately, both biologists and psychologists use the term “dissociation,” but it means very different things in these two fields. More on this in chapter three.

uses the dissociation for decades, the long-term inhibition of dopamine release leads to gradual dormancy of many of the dopamine-producing cells in the brain's *substantia nigra*. However, these cells are not dead: within a few months after recovering from Parkinson's disease, dopamine levels become high enough that a person never again "runs out."

The *primary* cause, the exact thing that *triggers* the varying degrees of chronic dissociation, and which must be healed in order to allow the electrical circuitry of dissociation to cease, varies in the *exact* anatomical and/or emotional trigger from one person to the next, but usually fits into two basic categories: 1) an unhealed foot and/or ankle injury, often dating from childhood and/or 2) a highly specific form of mental conditioning.

In a majority of the hundreds of patients with Parkinson's that we, the members of the Parkinson's Treatment Team, have worked with, *both* of these triggers have been present.¹

Dissociation

The attributes (heart rate, breathing rate, circulatory shift, etc.) of dissociation mode are recognized in western medicine. The specific electrical currents that drive this mode, currents that flow just under the skin and which can easily be felt by hand, were recognized and written up more than two thousand years ago, in Asian medicine.

The shifts in the under-the-skin electrical currents that occur during dissociation mode cause many well-known alterations in body regulation, including the release of endorphins (pain inhibitors), reduction of blood pressure (which can help prevent excessive loss of blood and/or internal bleeding), and shunting blood away from the skin and organs into the spine and brain. This neurological mode directs a body-wide, last-ditch attempt to keep the heart and brain alive in the face of severe, possibly mortal, trauma.

In this mode, a person does not feel his *own* physical or emotional pain. He may be deeply concerned for the pain of others, but he has a somatic, "in the flesh" numbness for himself.

In this mode, a person may have trouble initiating certain types of *imaginative* thought – including imagining the *sensations* of movement. (In people with Parkinson's, brain scans have revealed that it is the movement imagining area of the brain, a dopamine-activated area, which is inhibited, despite the person's mental instruction to move.) In dissociation, the inhibition of movement imagining prevents dopamine-based motor function, and therefore, movement is inhibited *unless* the person institutes an adrenaline override. (The British word for adrenaline is epinephrine.)

As an aside, adrenaline-based motor function is activated in a completely different manner than dopamine-based motor function. The former is a response to mental commands. The latter creates movement via *imagining* the *sensations* of movement.

¹ The website for the Parkinson's Treatment Team is www.pdtreatment.com. Before visiting this site to make an appointment for treatment or to discuss treatment please read this entire book. Most people do *not* need professional help in order to recover from Parkinson's disease. The goal of the treatment team is to help people understand that, in most cases, they can recover on their own. The treatment team does *not* accept patients who have not read the entire book *on their own*. Reading this book *on behalf* of an elderly loved one who may or may not be interested in doing the work necessary for recovery is *not* the same as having the patient read and understand the material himself. The last chapter of this book has information about what kinds of patients are best suited for recovery using our findings.

More on this, later. This is just an introductory chapter. Every concept mentioned in this first chapter will be addressed in full in a later chapter.

The above dissociation-mode changes *automatically* occur in response to excessive bleeding, excessive perforation of the skin, and nearly any condition in which death might be imminent.

In this state, if he is conscious, a person may perceive himself as if he is outside of his physical body – hence the name of this condition: dissociation.

(This is *not* the same meaning of “dissociation” that is used in psychology, where the word “dissociation” is used to mean the compartmentalization of specific thoughts *away* from normal consciousness.)

A layman’s terms for the symptoms of dissociation is “shock.”

If a person survives the injury or trauma, the electrical circuitry might quickly revert back to the electrical schemas that drive the “normal” (sympathetic, parasympathetic, or sleep) modes. Or it might revert slowly. If the body has a back and forth tussle between the states of dissociation and sympathetic, parasympathetic, or sleep, we also refer to the symptoms of that tussle as “shock.”

The electrical patterns of dissociation are supposed to run for a very short time – just long enough to “cling to life,” as it says in the ancient Chinese medical scripture, the *Nei Jing*.¹ Either the person dies from his trauma, or his heart and brain are kept alive and well while his body negotiates the trauma and begins to stabilize.

The electrical circuitry that controls the various neurological modes can be easily felt, by hand. It flows through the fascia just under the skin. It flows in fascia in other locations as well, but for our purposes – detecting the electrical flow that maintains Parkinson’s disease – we’re only concerned with the currents that lie directly under the skin.²

Learning to feel these currents is easy and requires only a few weeks of training, if that.

As already mentioned, the *non-stop* running of the dissociation circuitry can be set in motion in either of two ways:

1) A significant foot or ankle injury that remains unhealed. The static from injury or incompletely healed injury causes a fairly small electrical aberration. Over decades, this aberration can grow in size until, due to its location at the crucial terminus of an electrical

¹ The *Su Wen* book of the *Nei Jing*, chapter 13 verse 9; *A Complete Translation of the Yellow Emperor’s Classics of Internal Medicine and Difficult Classics (Nei-Jing and Nan-Jing)*; translation by Henry C. Lu, PhD; International College of Traditional Chinese Medicine of Vancouver, 2004. This verse lists the four neurological modes (sometimes translated as “four phases” or even “four seasons”).

² The relatively new, western medical term for fascia, or “fascial tissue,” is “extra-cellular matrix.” Only recently have western researchers discovered that the “extra-cellular matrix” seems to provide a substrate that supports tissue and conveys electromagnetic instructions to these tissues. For thousands of years, acupuncture has been used to make corrections in the electromagnetic signals of the extra-cellular matrix, in order to correct the behavior of aberrant cells and organs.

circuit on the foot, it eventually sets in motion a circuit aberration that *mimics* the electrical pattern that occurs during dissociation.

Many people with Parkinson's recall a childhood foot injury from which it was necessary to *psychologically* dissociate, at the time of the trauma. Because of failure to "return to the trauma" and deal with it at a later date, a condition of localized, ongoing psychological dissociation was established: therefore, the injury was never able to *completely* heal. The unhealed injury eventually sets in motion a body-wide dissociation-like electrical flow.

2) A person with very strong mental focus and will power can successfully command himself, in the face of a specific trauma, to not feel his own physical or emotional pain in a general sense, rather than a localized sense. This instruction, once set in motion, may remain in place until such time as the command is rescinded.

If not rescinded, the instruction, remaining in the subconscious mind, may then activate itself, automatically, on an as-needed basis, in response to subsequent pain or wariness.

A *powerful* mental command to feel no pain causes the body to lurch into the neurological mode of dissociation, the mode in which a person feels no pain.

Although the initial mental instruction may have pertained to a highly specific physical or emotional trauma, the brain, unless subsequently *instructed* to *stop* using mentally-induced dissociation, might *stay* in dissociation mode *or* might develop a habit of shifting into dissociation mode during *any* situation that might be remotely risky or unpleasant.

Many people with Parkinson's recall issuing themselves a command to "feel no pain," many decades prior to the onset of Parkinson's. In several of my cases, the patient has even recalled staring at himself in a mirror when he issued this command – creating a somewhat self-hypnotic condition. Others have no recall of ever issuing such a command – until after they have recovered.¹

Simultaneous access to dissociation and sympathetic mode

So long as dissociation mode is running, it prevents or minimizes access to parasympathetic mode and the concomitant release of brain dopamine.

However, *sympathetic* mode might still be used. For example, a person who receives a shock-inducing injury might still be able to run from on-going danger, as long as necessary, before arriving at a place "safe enough" to go into full shock mode (collapse and withdrawal). In other words, in the face of real danger, the immobility of *moderate* dissociation can *easily* be over-ridden via sympathetic (emergency) mode's adrenaline. The body is designed that way.

¹ Oddly enough, most of our patients with Parkinson's, even though they attest to a "high level of pain tolerance" for injuries or emotional pain, *are* able to feel, and suffer from, specific types of pain: back pain, sciatic nerve pain, tooth pain, and pain from tension in the muscles. It may be that these types of pain are not considered by the brain to be directly related to *dangerous*-type pain, and so do not fall under the jurisdiction of the dissociation instruction. This may be a fruitful avenue for future research.

A person who activates a chronic condition of dissociation can maintain motor function by also activating chronic use of sympathetic mode. Over the long term, by maintaining a mental state of chronic urgency alongside the numbness of chronic dissociation, a person can behave in a manner much stronger, smarter, faster, *and* more wary or alert than the average person. He uses adrenaline, not dopamine, for all *motor* function, while maintaining the physiology of calm, endorphin-produced detachment from his own physical or emotional *pain*.

Chronic use of sympathetic mode

However, the ever-changing brain develops based on the instructions (mental preoccupations) it is given. If a person must use sympathetic mode's adrenaline in order to keep moving (because of dissociation mode's inhibition of dopamine), his sympathetic mode's accompanying mental habits will grow steadily stronger in the areas of wariness, alertness, and anxiety.

Most of our patients, those who initiated a mental instruction to “feel no pain,” have been able to move, for decades, in a manner that they thought was normal by keeping themselves in sympathetic, “fight or flight” mode, for most of their waking hours.

We know that people with Parkinson's have been chronically using only sympathetic mode because when they recover from Parkinson's, their mechanics of movement feel *extremely* different from what they have used for decades – sometimes since childhood. In the words of one amazed recovered patient, a lifelong athlete, who was experiencing dopamine-based movement for the first time since she was five years old: “Is *this* how easy it's *always* been for everyone else to move?”

Also, based on what we have seen in recovered patients, it appears that the subconscious mind, when using dissociation mode, *automatically* invokes the premise that it is putting the owner's life on hold (making the person numb) in order to *save* that life. Many newly recovered patients, even before we learned of the dissociation connection, spontaneously used the phrase “not going to die” in the first few days following recovery. For example: “These last few days, I just feel more relaxed about what happens; after all, it's not like anyone's going to *die* if I make a mistake.” For them, “not going to die, after all!” is a stunning epiphany; it is not their long-time, habitual way of thinking.

Varying degrees of dissociation

A person can use varying *degrees* of dissociation. The instruction to dissociate might *not* be *all* dissociation, *all* the time: we've seen that some people instruct themselves to automatically divert into various degrees of dissociation on an as-needed basis. The instruction becomes subconscious and thus automatic. A “normal person” (one without Parkinson's) uses primarily sympathetic mode during times of stress, not dissociation.

Again, after a person has empowered himself to *consciously* activate the dissociation mode, his *subconscious* mind might then apply the shift into dissociation whenever he feels *any* negative emotion.

Oppositely, in the decades prior to the appearance of Parkinson's, the subconscious mind *may* have been able to easily *stop* the dissociation now and then, when things were running smoothly: when he was able to feel temporarily safe.

In-depth interviews with patients suggest that *some* people with Parkinson's disease have always been able to turn off the dissociation during various "safe" activities or locations, as indicated by memories of bursts of "effortless" movement or memories of sensations, feelings, and thoughts characteristic of parasympathetic mode – a mode that does *not* operate during dissociation.

In highly specific situations, they might have been able to move effortlessly, which is to say, normally, using dopamine, even as the Parkinson's was slowly, invisibly encroaching. These moments or even hours might have occurred while, for example, playing the violin, or when visiting the stamp museum, or every year on their birthday, or in the company of a specific childhood friend. These "safe" times, if any, are different for every person. For example, some people with Parkinson's are symptom-free during sex. Others find that their symptoms worsen during sex. It all depends on how the person defines "safe."

As Parkinson's worsens, even the "safe times" might cease to be safe, and then these times will also cease to be symptom free.

Others have *no* recollection, or only very early childhood recollections, of the sensations of "effortless movement" or perception of expansion in the chest in response to beauty, to name two behaviors associated with parasympathetic mode.

No two people with Parkinson's behave in exactly the same manner. No two people with Parkinson's have the exact same symptoms, nor do symptoms develop in the same sequence or in the same time frame. The enormous variability of symptoms, even the manner in which symptoms vacillate in severity from day to day, and hour to hour, suggest that a highly *personalized* control mechanism is at the helm, responding to the thoughts employed by the consciousness. But the pilot, the subconsciously established tendency to use dissociation instead of sympathetic (fight or flight) mode to deal with fear and pain, is working behind the scenes – hidden even from the conscious awareness of the person with Parkinson's.

Again, the dissociation instruction may *initially* be an intermittent device, or it may be a most-of-the-time coping mechanism. But eventually, over decades, through habitual use of the sympathetic mode override, the brain may begin to perceive everything as risky, and adopt dissociation with an adrenaline override as its *primary* behavioral mode.

This is *not* when Parkinson's symptoms become visible. Symptoms finally become visible when it becomes too much effort to sustain a convincing sense of urgency, the source of the mentally-induced sympathetic mode override. When the adrenaline levels drop, the long-hidden symptoms of dissociation are exposed.

Foot injury and dissociation from pain

Some people with Parkinson's have *both* an unhealed foot injury and a feel-no-pain mental posture. This just makes sense: if a person has created an impervious-to-pain attitude, subsequent injuries may not be able to be fully addressed, and therefore might not fully heal.

Nearly everyone bangs his feet around, smashes his toes, or sprains his ankle. So finding an unhealed foot or ankle injury in a person who deals with pain by making himself impervious to (and therefore unaware of) it should not be too surprising. In fact, a *majority* of our patients (ninety three percent) have the combination: a long-unhealed foot injury *and* a mentally induced ability to be impervious to pain.

Whether the patient has only dissociation from an injury, or mentally-induced dissociation from a generalized ability to feel pain, or both, by the time the Parkinson's symptoms are apparent, the electrical circuitry is running vigorously in the patterns identical to those that drive dissociation mode physiology, including inhibition of dopamine release to the movement, or "motor," imagining area.

TREATMENT

Treatment might involve hands-on physical support of the injured foot or ankle area and/or instruction for the patient on how to change his way of dealing with fear and pain.

Treatment of injury

The hands-on treatment that we use for injuries from which a person has dissociated is Forceless, Spontaneous Release, or "FSR," a type of Yin Tui Na (Chinese manual therapy). This extremely slow, supportive method of holding an injury might be referred to as "be a human ace (elastic) bandage for an hour at a time." Treatment sessions typically last an hour and can be performed daily or weekly until such time as the injury begins to heal. The responses that occur when the injury begins to heal are distinctive. They are described later in this book.

A family member or friend can easily administer treatment. Full instructions on this technique are provided, for free, on the website of the Parkinson's Recovery Project: www.pdrecovery.org.

There is no need for "professional" treatment, except in rare cases where thick wedges of scar tissue are causing electrical blockages. In these few cases, one or at most three sessions of acupuncture can easily remedy the scar tissue blockage. Instruction for acupuncture treatment of scar tissue is available on the website of the Parkinson's Recovery Project. Be forewarned: most acupuncturists have never learned how to most effectively use acupuncture to treat scar tissue. *Tracking the Dragon*, an acupuncture text available for free download at www.pdrecovery.org., teaches everything one needs to know about these techniques.

Treatment of body-wide dissociation

The psychological re-training, if needed, requires that the person stop using dissociation in response to fear. This re-training requires the same level of intensity that is necessary to stop smoking or to quit any long-term habit that was *initially* gratifying.

Most people with Parkinson's are not able, effectively, to consciously "tell themselves" to stop using dissociation, because they have learned to dissociate *subconsciously*. Instead, a person who wants to change his subconscious thinking patterns must command himself to cease *cultivating* or *listening to* all fear- or wariness-based thoughts: he must force himself to admit that, in truth, he is safe.

Of course, after he has recovered, he can indulge in fear again, but he will be able to do so using sympathetic mode – the correct mode for dealing with fears.

Half-hearted or part-time attempts at fearlessness will not work to rid a person of the chronic conviction that he is, somehow, still at risk, any more than a attempt to quit cigarette smoking by cutting back a few puffs per day will work.

We all know how most people actually come to stop smoking: stopping occurs when a person becomes utterly fed up with his smoking habit. At that *moment*, often induced by angry frustration, he tells himself with a particular type of liberating, utter, *joyful* conviction that he is through with smoking. Period!

At that moment, his *mind* is altered by his statement: his subconscious habit ceases to be a driving force – his habit has been moved from the mind’s “active list” to the realm of memory. At this moment, or soon after, he realizes he is now a non-smoker. He then goes through some “process” or method that he has selected, and attributes his cessation to the successful process, or else he simply stops smoking. And he remains a non-smoker: his self-identity changed in the *moment* when he made the decision.

We have seen that this situation is an absolute parallel to recovering from the mentally-induced chronic dissociation that can cause or contribute to Parkinson’s.

For those people with Parkinson’s who have a mental habit of body-wide dissociation (as opposed to having *only* a foot injury dissociation), we have seen that their recovery is preceded, *in every case*, with a powerful statement to either their own mind or to the heavens that proclaims, in essence, “I’m safe, after all!” followed by, “So I won’t be doing that any more.”

It is *not* the trembling that they are “not doing any more.” It is *not* the Parkinson’s that they are “not doing any more.”

The thing that they are not doing anymore is thinking of themselves as perpetually at risk, or choosing to play dead in times of emotion. What they are not going to do any more is respond to fear and pain by pretending to be numb. If and when they do find themselves at risk in the future, they will admit it, and deal with it like a normal person: they will use sympathetic mode. And when the clear and present danger/pain has ended, they will go back to relaxation and enjoyment of life.

As with a smoker, these statements regarding “Not going to be this way any more” usually occur after a person with Parkinson’s has become *fed up* with trying to use will power to *control* his mind or to *control* his Parkinson’s symptoms in various ways. This can be difficult, because people with Parkinson’s often have a highly developed ability for mental control. But this is a situation in which their *accustomed* form of mental control is *not* going to work.

Initially, most patients in our program try to “control the mind” by *forcing* themselves to feel calm. Calmness thus attained might provide a very short-term cessation of symptoms, but it will not get rid of the underlying premise: “I am at risk.” Imposing calm *over* fear does not provide a lasting fearlessness.

When the person with Parkinson’s finally admits that he’s actually safe *already*, he doesn’t need to *impose* calmness – he is *naturally* calm, or as calm as he *wants* to be, *because* he is inherently safe: he is not at risk in any way.

Typically, in the moments just before a person recovers his capacity for dopamine release, he is surprised by the statement that erupts from him. He is surprised by the power or the joy that suddenly wells up in him. He is often surprised because the words that he utters might not make “literal” sense in the context of Parkinson’s, or of fear.

For example, phrases that patients have suddenly found themselves exclaiming include these two disparate statements: one patient unexpectedly found herself commanding to the universe, “I *do* want to live! I *do* want to live!” Another patient found herself overflowing with the more lengthy, “I’m truly grateful for the Parkinson’s: I’m safe now because I have surrendered my life over to You (within a religious context); I finally understand *You* are in charge; not me. I’m safe and can live fearlessly.”

Within moments of producing their unrehearsed declarations, the above two patients began experiencing the unexpected and unique sensations associated with dopamine release.

Although the two sample statements above seem to be utterly unrelated, and *not* related to getting rid of fear *or* recovering from Parkinson’s (in the latter case, just the opposite), they are both declarations that the person no longer sees himself at risk, and therefore, no longer needs to protect himself from anything: he is safe – he is ready to “come back to life,” *whatever* that life might hold.

When a person admits that he is no longer at risk of clear and present danger – and only then – will biological dissociation turn off.

Once the dissociation mode has been turned off, the person has a *choice* as to whether or not he will ever embark on an episode of dissociation in the future. In our limited experience, after turning off the long-running episode that led to Parkinson’s, many patients have been so relieved to feel alive again that they do not ever go back to using dissociation as a method for dealing with pain or fear. Others find themselves subsequently having Parkinson’s symptoms that come and go, depending on their mood.

Most of our patients have been willing to let us work on their feet but have been highly reluctant to decide that they are, in fact, safe. Instead, they have long trained themselves to think that their own wariness is the thing that is keeping them safe, and any reduction in wariness will necessarily *put* them at risk.

In order to recover, they need to admit that ultimate “safety” *cannot* be obtained through dissociative mode risk assessment and mental wariness. They must come to agree with the idea that life is, or appears on the surface to be, inherently risky... but that this level of risk is OK, it is natural, it is even a *good* thing.

Most patients come to this decision by using either a philosophical or a spiritual understanding that affirms that their heart, or their consciousness, or their soul, is safe, even *if* the body or emotions are hurt, even if the body is *killed*.

It doesn’t seem to matter *why* one decides that he is willing to, once again, risk the unknowns of life. He might do it in *spite* of the seemingly random risks inherent in living. *Or* he might decide he is ultimately safe because there *are* no untoward risks – only cause and effect or karma or “the inevitable”. The exact reasoning behind making this decision isn’t significant. What is significant is the decision to stop being wary, fearful, or afraid. He can make this decision *because* he *is* no longer in a condition of clear and immediate risk, after all.

The decision will be made with the joyful vigor that comes from using heart-driven emotions. The decision to fall back on the heart might be a response to being frustrated, *or* being on the cusp of a spiritual transformation *or* being in some other state, any state, that calls for *change*. Whatever the mental state is that finally decides to let heart-based

confidence deal with it, rather than letting the ego-based fears/mind run the show, doesn't really matter.

In every case, the patient's heart can reassure him that he *is* once again safe. As an aside, most of our patients with Parkinson's have no idea what the word "heart" means, in this context, even though their health practitioners, spouses, and friends know perfectly well. This meaning of "heart," a very literal one, is discussed later.

The patient's brain, in response to his heart's assurance, "We're safe now," a statement for which it has been anxiously waiting, will then instantly turn off the dissociation and protection that the brain loyally has kept running in the background – ever since it was first told to do so.

One of the natural features of the state of dissociation is that it does not terminate until the person (or animal) determines that he is now safe from the recent trauma. In some humans, especially those who have intentionally decided to be numb to pain, this determination of having become safe might never occur: the dissociation will then, correctly, run indefinitely.

RECOVERY

In either of the above two scenarios that can lead to Parkinson's (dissociation from a foot/ankle injury or dissociation from pain in general), when the circuitry is lastingly restored to normal (either parasympathetic mode, sympathetic mode or a blend of the two modes) the rigidity of Parkinson's *ceases*.

Recovery from rigidity

When the dissociation-type electrical pattern ceases, dopamine release is *instantly* possible. In a few *moments* after deciding that he is "safe, after all," a person who'd had Parkinson's will feel more supple, less rigid. He will usually remark that he feels "lighter" – less affected by gravity. Suddenly, smiling and certain other motor functions may be automatic. To the degree that muscle atrophy allows, motor function will be effortless, or "light-feeling," and driven by dopamine-based *imagining* of the sensations of movement, as opposed to the adrenaline-based, mental-command driven motor function that the person with Parkinson's may have used for most of his life.

Much of the anxiety and *stiffness* of Parkinson's may disappear *instantly*.

Upon recovering from the dissociation mindset, a person might experience almost instantaneous return of *ease* of movement, which might include a more relaxed voice, stride, looser handwriting and other motor functions that had been lost to rigidity-type symptoms (as opposed to atrophy-type symptoms). These functions might all return quickly, within a few minutes or a few days.

Again, because many people have trouble grasping how quickly this change does occur, it might be only a matter of *moments* or minutes for the disappearance of some of the symptoms that were driven by rigidity or a sense of "heaviness".

Recovery from weakness

Weakness may remain, in certain muscles, because of atrophy. In fact, as *rigidity* and a sense of gravitas (undue heaviness) disappears, underlying muscle weakness may become more *apparent* than before.

A few months may be required for full restoration of the facial muscles, biceps and other muscles that had become atrophied or numb.

Sometime after the rigidity goes away, it can seem (feel) as if the tissues holding the *brain* in place, a holding pattern brought about by long-term “trauma!” tension around the brain (more on that later), “let go.” The brain seems to shift position. After the sensation of the brain physically moving, the tremor, if any, ceases.

Recovery from dopamine insufficiency

A few months may be needed before the dopamine-making capacity is restored to the levels where a person *never* “runs out.” Prior to that time, a person who has recovered from Parkinson’s may experience absolutely normal movement for hours or even weeks at a time, and then, usually in response to extended exertion or extremely hot or cold weather, his capacity for physical movement will “shut down” for a bit. He may be utterly unable to initiate movement for ten minutes or maybe even an hour. After this resting time, during which the brain will have had a chance to re-circulate its dopamine, repositioning it for re-use, the person springs back into normal movement again. These episodes decrease over time. Within a few months, these brief “stoppages” cease altogether.

However, these episodes of immobility are extremely different from the rigidity that characterizes the “frozen” behavior of Parkinson’s. These “low dopamine” moments are periods of deep calm and relaxation. They can feel more as if one’s body is *softening*, as if gently dropping off to sleep, even as the mind remains perfectly at peace: awake and curious. In other words, the mental processes are still dopamine-dominant, but the dopamine levels are not quite high enough to cross the motor function threshold. This phenomenon is *utterly*, different from the mind-set and motor capability during a “freezing up” episode of Parkinson’s disease.

Of course, if a *true* emergency presents during an episode, the person can *always* move using the newly-unpleasant adrenaline override.¹

This phenomenon adds to the strength of our hypothesis.

¹ I inserted this bit of detail here, in the first chapter. I’ve had many patients who weren’t sure they wanted to recover from Parkinson’s because of my mention of these very short periods of “down time” that *might* occur early in recovery. I am including the bit about accessing the adrenaline override in this first chapter, instead of putting it in the logical place, in the chapters on recovery symptoms, because of this fairly common fear.

For readers who do *not* have Parkinson’s, it may seem impossible that a person would choose Parkinson’s disease over the possibility of a few fleeting interludes of immobility during recovery. But for a person who has, even subconsciously, built a mental life predicated on preparedness for danger, the idea of even short periods of immobility is terrifying. This fear, of course, makes even the *anticipation* of the eventual immobility of late-stage Parkinson’s particularly horrible for people with Parkinson’s.

Autopsy studies *do* show a *decrease* in the actively “dark” (dopamine-producing areas) of the *substantia nigra* in people with Parkinson’s. But the areas that are no longer darkly pigmented are still a healthy grey: these cells are not dead.¹

The cells have become “re-undifferentiated.” They resemble the immature cells of a fetus, cells that have not yet received instructions as to how they should specialize.

Following recovery, the demonstrated increase in dopamine production over time, based on steadily increasing duration of dopamine-using motor function, adds to the known fact that these cells are not *dead*, and suggests that they were merely dormant (no longer producing dopamine) because of lack of demand for dopamine.

This particular recovery phenomenon suggests that the dormant areas in the brain are absolutely able to resume their dopamine-making capability in response to re-activation of the neural mode that calls for dopamine. This also suggests that, over a few months, these cells substantially increase the amount of dopamine kept “in reserve.”

Inhibition of dopamine release is *normal* during dissociation mode. Adaptations in the brain, including increase and decrease in cellular activities – based on ongoing usage or non-use in specific locations – are a *normal* process for the very plastic brain.

Recovery from the parkinsonian personality

Also contributing to our hypothesis is the almost immediate alteration in the “Parkinson’s personality” that occurs after recovery.

“For nearly a century, it has been suggested that Parkinson’s disease could be associated with a specific personality type. The parkinsonian personality has been described as compulsive, industrious, introverted, morally rigid, punctual, serious, stoic, and quiet....studies have indicated that Parkinson’s disease patients score lower than controls on a personality trait called novelty seeking which, according to Cloninger’s theory, is the temperament trait primarily modulated by dopamine.”²

These adjectives are just a bit different from the ones I would use. And there are always exceptions to the classic Parkinson’s personality – particularly among the five percent who have *only* an unhealed foot injury and no body-wide dissociation – but the above description meets the case closely enough for this introductory chapter.

Almost *immediately* following recovery, as marked by a lasting shift out of the electrical pattern of dissociation, these personality traits, if present, melt away or become modified. Within a few hours, or in some cases even minutes, the person becomes far more easy-going, less judgmental of *himself*, more curious, playful, and prone to laughter. For example, he may quickly lose his long-term morbid fear of being unpunctual or terrific fear of getting lost while driving.

¹ “Curing Parkinson’s Disease in Our Lifetime: part 3”; Abraham Lieberman, MD; *Parkinson Report*; Fall 2000, Vol. XI, issue 3; National Parkinson Foundation, Inc. p. 10. Note: this is a *very* conservative publication. This article states, in the opening paragraph, “In Parkinson’s disease (PD) ...although dopamine is depleted, the cells in the striatum are *preserved*. This is unlike the PD-like disorders where, in the striatum, the dopamine content is decreased and the cells are lost.” [Italics are mine.]

²“Personality traits and brain dopaminergic function in Parkinson’s disease”; *Proceedings of the National Academy of Sciences USA* 98:13272-7; Valtteri Kaasinen, MD, PhD et al; 2001.

Recovery from tremor

As for the long-time vibrations *inside* the brain, what you might call the “internal agitation” or “internal tremor” that *drives* the visible tremor, those vibrations were present long (usually decades) before the tremor became outwardly visible. These vibrations usually cease very soon, a few hours or a few weeks, after the electrical circuits become restored to “normal.” Just prior to the cessation of this internal tremor, a person might experience a sensation as if the two hemispheres of his brain are *palpably* shifting relative to each other, and may feel as if the room is spinning. After this “head re-alignment,” the long-term “trauma!” holding-pattern that had developed in the brain is gone. The tremor stops.

When this occurs, the sensation is glorious: the unaccustomed *internal* stillness is so peaceful that it may even cause the person to wonder if he has suddenly died. If so, he soon realizes that he is still breathing and concludes that he is still alive, but in a very different way from how he *has* been “living” for much of his life. Soon after this event, the visible tremor also ceases, permanently.

The above sequence of events, events which occur during recovery from the internal tremor, is a glaringly different set of sensations from the *temporary* stopping of tremor that might occur in response to various methods of physical or mental relaxation, or sleep; conditions that allow the physical tremor to *temporarily* abate while the inner tremor continues.

Time frame for recovery

On the one hand, those people with Parkinson’s disease (PD) who have merely sustained an unhealed foot injury for decades by psychologically dissociating *just* from the sensations of the injury at the time and never bothering to re-associate, are usually fairly easy to treat. Their injury causes an electrical pattern that mimics that of dissociation, thus causing the physical symptoms of Parkinson’s, but they are not emotionally attached to the wariness that usually triggers this electrical pattern: they do not consider themselves to be at risk with regard to anything other than the specific injury. They usually recover very quickly from all the symptoms of Parkinson’s when their foot heals, usually within a few weeks or a few months.

On the other hand, those people who have told themselves that they are impervious to pain, in general, thus invoking actual, biological dissociation, can be easy to treat or difficult, depending on how willing or able they are to be rid of the self-induced command, issued many years previous, that allowed them to trigger some aspects of body-wide dissociation mode.

This is a deeply complex issue, and the use of the word “willing” in the previous paragraph is not a reflection of weak will on the part of the patient – just the opposite. The difficulty is, often, that the person has learned to make his *adrenaline-based* will power extremely strong, in order to keep moving.

Changing this habit of using adrenaline-based will power requires will, but of a very different sort – it requires a realization that he *is* safe and no longer needs to use his adrenaline-based will power for purposes of self-protection. His change is going to involve turning *off* his habit of using *adrenaline-based* will power to “control” his life.

However, so long as he perceives himself to be at risk, he must necessarily rely on adrenaline. This is why the acknowledgment of being safe and the subsequent turning *off* of adrenaline-based will power always precedes the burst of glorious conviction and exclamation – coming from the long-dormant joy and *dopamine*-based will power – that heralds the cessation of dissociation.

It can be *extremely* difficult for a person who has spent his life being subconsciously wary to *joyfully* accept the realization that he is “now safe, after all.”

The mental conversion from fear of pain to generalized fear

The dissociation may originally have been triggered by a desire to feel no pain. But long-time use of dissociation with a sympathetic override leads to the brain being dominated by sympathetic mode thinking: fear and wariness. In order to turn off the *dissociation*, a person must declare his resolution to reject any and all thoughts of fear – *including* fear of pain. Either that, or admit that he isn’t in any fear or pain at the moment, or if he is, he wants to feel it and deal with it – and he can do so because he is now *safe*.

Proving recovery

Plenty of people have recovered after having been given a diagnosis of “incurable” Parkinson’s – including many people who have never been aware of *our* findings. In these modern times, you can read their blogs on the web.

Very often, their recovery procedures just happened to have included some therapeutic processes that addressed their old foot injuries. Often, they also did some “personal growth” work, either philosophical or spiritual, that helped them get over their feelings of constant wariness and sense of not being safe.

These people have made conjectures as to which of their sometimes multitudinous therapies gave the pivotal push. But without an understanding of the actual body mechanics involved in causing Parkinson’s, they have not been able to determine *which* of their therapies were causative in restoring them to health, and why their recovery cannot be universally replicated.

In our research program, from 1998 to the present time, we’ve seen many people recover from idiopathic Parkinson’s and psychogenic parkinsonism. Some recovered quickly and easily.

These people often came to us with multiple confirmations (two or more neurologists), of Parkinson’s disease.

We have also received emails from people who we have never met or worked with who wrote to say, “Thank you, I have recovered from Parkinson’s disease by using the free information on your website.” Some emails go into details. Some say nothing more than the above. Most of the emails are from people who received hands-on, therapeutic help from friends and family: people with no professional training who figured out how do the therapy by using the information on our website.

These emails confirm that people can recover *without working with a health professional*.

Support from neurologists

When patients have recovered, their neurologists have consistently dismissed their obvious recoveries by stating that their patients had obviously been “misdiagnosed” or else were neurotic or psychotic (manifesting psychogenic parkinsonism).

One neurologist of our experience, a Parkinson’s specialist, stated in his patient’s notes that he didn’t know why this patient had *pretended* to have Parkinson’s for six years.

Hostility from friends and employers who think they have been duped by a recovered patient because he must have been pretending to have “incurable” Parkinson’s disease in order to get sympathy is *not* an uncommon response.

We know of only one neurologist who recognized that his patient did, indeed recover from idiopathic Parkinson’s.¹

Considering the scorn heaped on people who do recover, by doctors and “friends” who assume the patient must have been pretending or was just a “head case,” the bravery of those few who have “gone public” with their stories is all the more inspirational.

But the scorn is also understandable even if it is not merited: if a person recovers from Parkinson’s disease after going through what the general population cynically views as “getting a bit of foot massage” and “getting over his attitude of being unsafe,” (or, more common, “Finally got over himself”) the world does *not* stand up and applaud.²

And yet, any person with Parkinson’s who *does* go through the steps required during recovery is worthy of the highest admiration.

Not everyone has recovered

We’ve seen *many* people who didn’t want to have Parkinson’s any longer, but who also didn’t *want* to, or could not bring themselves to do away with their long-term ability to feel no pain. In the words of one of these patients: “The whole point of life is to avoid pain. No way am I going to *purposely* make myself able to feel pain.”

These people, like most of our patients with Parkinson’s, have become highly prone to anxiety and fear: they particularly fear the pain that they *might* feel if they do away with their ability to be numb. This fear is genuine. It overlies a genuine, subconscious fear of

¹ Howard Shifke recovered from Parkinson’s. His neurologist is the only doctor we know of who is willing to state that Howard did have PD and did recover. Howard Shifke has a blog about his recovery. I rarely use patient’s real names. In this case, because he is not my patient and because he has a public blog, I can use his name. Most patient names in this book are pseudonyms.

² I often receive queries from people I’ve never met asking: “What can I do to repay you? I used your information and recovered from PD.”

I always reply, “Please make a blog or webpage about your recovery and post it.” However, from what I can tell, most people do not take this very public step.

Oddly enough, many people who spontaneously recover from cancer have done so by visualization, prayer, and other “non-medical” therapies. These people are praised. But so far, when a person with “incurable” Parkinson’s overcomes his disability by doing the extremely difficult work of literally changing the way he uses his brain, he will not receive the same praise as the person who changed the way he uses his mind in order to overcome his “incurable” cancer. Maybe it’s because cancer cells can be seen in the lab work, and the electrical forces that cause Parkinson’s cannot.

imminent death, even though this fear is not apparent until after recovery, when the patient laughingly points out, with regard to some new laxness in his behavior, “Well, it’s not like anyone’s going to *die*...”

Overturing a lifelong attitude of subconscious wariness via a powerful *conviction* that one is, in fact, safe, can be *hard* to do.

It is *highly* understandable that a person with these conscious and subconscious leanings might be terrified, even unable, to joyfully manifest the mental changes required for recovery. After all, his subconscious mind is silently telling him to “play dead and do *nothing* that might be perceived as incorrect, on penalty of death”: a condition even more dire than mere Parkinson’s disease.

Of course, although dislike of pain is a natural human instinct, the natural way to deal with pain is to treat it, if and when it might occur, and assuage the pain with comfort from self and others. The natural way to deal with danger is to *act*: “fight or flight.”

It is *not* natural to make oneself numb for a lifetime, so as to avoid the risk of experiencing pain or death. But this argument makes no sense to a person whose subconscious, due to long-term use of dissociation, truly has come to believe that he is barely clinging to life as it is.

The point here is that it can be very difficult to “face up to one’s foot injury” or “change one’s mind-set.” *Many* of our patients have struggled for years before either successfully recovering, recovering part-way (a condition in which many of their symptoms completely disappear but episodes of body-wide rigidity and immobility may come and go depending on mood or external circumstances, a condition that we refer to as “partial recovery”), or giving up on the idea of recovery.

Impetus behind the Parkinson’s Recovery Project

I have seen people recover from Parkinson’s.

The first three of them were patients of mine who “accidentally” recovered from Parkinson’s in response to treatments for other physical problems – foot problems – which, at first glance, had *nothing* to do with dopamine-producing cells.

– I only mention the dopamine-producing cells because, in western medicine, since the 1960s, inexplicable dormancy of dopamine-producing cells in the brain was widely considered to be the source of Parkinson’s disease – and I bought into that hypothesis as quickly and unquestioningly as all my fellow medical students.

After my own observations, I got online and learned of other people who had recovered. Their treatments often had included, tangentially, some form of treatment that brought energy and/or awareness to the feet. These recoverers tended to attribute their own recovery to their simultaneous use of more esoteric, even mystical treatments. This is only natural: why should awareness of, or energy in, the foot have anything to do with Parkinson’s? The commonality of the foot aspect jumped out at me: gently bringing the patient’s subconscious attention to the unhealed foot injury was the treatment I had given to my own patients who had then immediately recovered from Parkinson’s disease.

The problem of body-wide dissociation only became apparent later, after many patients *partially* recovered following healing of their foot injuries, but were still able to slide in and out of abject parkinsonism in response to various fear triggers.

The curiosity aroused by my own three recovered cases in 1997 and 1998, and the findings of other recoveries from this “incurable” illness, spurred me into research directed at finding both a consistently effective treatment *and* the cause behind all cases of idiopathic Parkinson’s disease. I wanted to know *why* the treatments had worked.

When, after nearly fifteen years, we could finally put all the pieces together, including the dissociation circuitry, we had figured out why people were recovering from Parkinson’s: we’d figured out what causes it and how to reverse it.

Support from western medical research

Only after knowing what to look for was I able to find western medical research that supported my work.

In 2001, a researcher had published a paper after using the relatively new SPECT scans, scans that use radioactive dopamine molecules to observe dopamine activity in the brain. Previous studies had shown decreased dopamine-related activity in the *motor* area in people with Parkinson’s. This researcher was expecting to find diminished dopamine activity in other areas of the brain – areas responsible for behaviors associated with the “Parkinson’s personality.” This finding would be consistent with the prevailing theory of “diminished dopamine production.”

However, what he found was significantly *increased* dopamine-related activity in a non-motor part of the brain: the right caudate nucleus. The right caudate nucleus “classifies stimuli into categories”.¹ This brain area helps decide if something is dangerous or safe.

Based on “diminished dopamine” Parkinson’s theories of the 1970s, this researcher had logically assumed that *diminished* dopamine levels were causing the PD personality traits such as harm avoidance and diminished “seeking” behaviors.

He found the opposite.

He found *increased* dopamine activity – even higher levels of dopamine activity than are seen in healthy people.

The higher than normal levels of dopamine activity were in the part of brain that assesses things – for example, deciding what is safe or not safe.

This article concluded, “It is possible that that there is a unique disturbance of circuitry in Parkinson’s that could explain the paradoxical, highly significant relationship between harm avoidance and dopaminergic function in the caudate.”²

¹ “The roles of the Caudate Nucleus in Human Classification Learning”; *The Journal of Neuroscience*, 16 March, 2005, 25(11); 2941-2951.

² “Personality traits and brain dopaminergic function in Parkinson’s disease”; *Proceedings of the National Academy of Sciences USA* 98:13272-7; Valtteri Kaasinen, MD, PhD et al; 2001.

“The personality type does not seem to be dopamine dependent [due to lower levels of dopamine]. Harm avoidance score [of people with Parkinson’s]... had a “paradoxical, highly significant positive [larger amount] correlation with the ¹⁸F-dopa uptake in the right caudate nucleus. ...The major finding of part II [of the study] was the unexpected, highly significant positive correlation between right caudate ¹⁸F-dopa uptake and TCI [Temperament and Character Inventory] harm

Again, the research showed that people with Parkinson’s disease have *higher* levels of dopamine activity in this part of the brain than people who don’t have Parkinson’s.

The caudate area shares information with the precuneus area of the brain.

The precuneus connection

The precuneus area assesses information in terms of “how does this affect *me*?” This is subjective, rather than objective analysis, and includes risk-to-self evaluation.

The precuneus is also the

area that overrides conscious instruction for motor function, when motor inhibition is called for. This can be considered a function of the “subconscious” mind.

For example, in one research study using brain scans on hypnotized subjects, the precuneus area was shown to override conscious mental instructions to move an arm. The motor imaging area, necessary for dopamine-based motor function, became linked to signals from the precuneus, instead of linking to signals from the frontal lobe’s center of consciousness.

In this research, a person had been hypnotically told that his arm was “too heavy.” Then, when he tried to lift his arm, his precuneus area became unusually active while, simultaneously, the motor area became inhibited – in spite of the person’s vigorous, conscious mental instructions to lift his own arm.

In this research using brain scans to look for the mechanism behind hypnotic inhibition of motor function, “The right motor cortex prepared itself as usual to tell the left hand to move. But the cortex appeared to be ignoring the parts of the brain it normally communicates with in controlling movement. Instead, it acted more in sync than usual with a different brain region called the precuneus. That was a surprise...It’s as if, while under hypnosis, the motor cortex ‘is connected to the idea that it *cannot* move (the hand) and so it doesn’t send a message to move.’ ”¹

These seemingly unrelated bits of research actually show a connect-the-dots relationship between Parkinson’s (in which the electric circuits run as if in dissociative mode), the Parkinson’s personality (elevated energy spent in risk assessment and wariness – a characteristic of dissociative mode), and a mechanism by which dissociation can inhibit motor function (precuneus inhibition of the motor area if it is “not yet safe” to move – “not yet safe” being a characteristic of the immobility induced by dissociative mode).

Combined with our own research, particularly the symptoms that occur during recovery, the evidence powerfully contradicts the theory that Parkinson’s is *caused* by diminished function in dopamine-producing cells.

The body’s efficient decrease in the number of dopamine-producing cells begins to look like yet another side effect of the PD brain becoming locked into a pattern of biological

(Continued from previous page) avoidance in Parkinson’s disease.” This research was done on *unmedicated* patients. In other words, there was *more* dopamine than expected in the right caudate area – there was only less dopamine in the motor *imaging* area.

¹ “Brain scans show how hypnosis can paralyze a limb”; *Neuron*, Yann Cohan, June 18, 2009, as quoted in *USAToday*, June 24, 2009.

dissociation – a pattern in which dopamine use is extremely limited - allotted primarily for analysis (dissociation mode’s particular form of immediate-danger assessment), rather than being used for parasympathetic mode motor function.

This fits beautifully with our findings: people with Parkinson’s do have a “unique disturbance of circuitry,” a chronic electrical pattern that happens to be a perfect match for the circuitry that occurs during life-threatening trauma: the circuitry of (biological) dissociation – a condition in which mobility is inhibited and cannot be initiated until there is no longer a clear and present danger – although the immobility can be overridden, temporarily, using adrenaline, by an occasion of true emergency.

People recover from symptoms of Parkinson’s disease as soon as they stop using dissociation mode and resume use of the “normal” modes, the modes used by the living: parasympathetic and sympathetic.

After more than a decade of observing, working with hundreds of people with Parkinson’s, and beholding successful recovery in many of them and definite, steady improvements consistent with “partial recovery” in many more, my research team feels confident that we have unlocked the mystery behind the cause and successful treatment of idiopathic Parkinson’s disease.

Important aside

Our findings do not apply to drug- or toxin-induced parkinsonism: the Parkinson’s-*like* paralysis or tremor caused by cell death from drugs or toxins. People who have drug- or toxin-induced parkinsonism do *not* have dissociation-mode electrical patterns flowing in their bodies. They will *not* benefit from the treatments that we have developed.

Also, some very elderly people, people who have diminished mental focus, and/or who are not prepared to do the very hard work involved in developing a new personality may not be good candidates for recovery. To learn more, see chapter twenty-six.

Research results

The results of fifteen years worth of explorations, mostly spent working on ways to help people speed up “learning to be safe,” do not lend themselves to graphs or meaningful “statistics.” We have only worked with approximately three hundred people, no two of whom had identical symptoms. Even the term “worked with” needs definition, since most patients have only visited our offices for one to three weeks, and maintained communications, if any, via infrequent emails.

In about ninety five percent of cases, recovery required patient-initiated changes in thinking habits. These changes ranged from discovering and overthrowing unacknowledged fear-based thought habits, to modifying “moral” convictions such as “God *wants* me to suffer so that I can be more like Jesus.”

The need for extremely individualized attitudinal or ethos changes makes it hard to determine, *statistically*, whether or not we’ve discovered a “consistent cure.” Whether a given individual fully recovers – as opposed to *partially* recovers (recovers from injury but not mindset, with residual mood-triggered symptoms) – ultimately hinges on a deeply personal *decision* to change one’s manner of thinking. In terms of proving whether or not Parkinson’s is “curable,” the data we’ve generated says “yes, but recovery is not guaranteed for any given individual.” The pertinent numbers and data are offered up in the last chapter.

Summary

This chapter was a mere preamble.

The following chapters expand on all of the above with full details. This book shares the findings of the Parkinson's Treatment Team of Santa Cruz regarding the *causes* of idiopathic Parkinson's disease and psychogenic parkinsonism, its *treatment* and the utterly unexpected *symptoms of recovery*.

“Often the hands will solve a mystery that the intellect has struggled with in vain.”

- Carl Gustav Jung

CHAPTER TWO

A FOOT MYSTERY AND THE BIRTH OF A PROJECT

I’m a professor of traditional Chinese medicine. I teach acupuncture, channel theory, and the “light-touch” manual therapy known as Tui Na (pronounced to rhyme with “Way, Ma!”). I also have a private medical practice, in which I use, as needed, the various techniques of Asian medicine that are allowed under my license’s scope-of-practice laws.

Over the course of twelve months, in 1997 and 1998, I happened to have three patients who all had the same, fairly rare, irregularity in the electrical currents in their legs. In each of these three, the same major current in the leg was flowing *backwards*. Coincidentally, each of them also had symptoms of early-to-moderate Parkinson’s disease.

These subcutaneous currents are very easy to detect. By holding one’s hand about a quarter inch above the patient’s skin, one can quickly determine which direction the currents are moving.

Of course, I knew perfectly well that I could not hope to make a dent in their Parkinson’s disease symptoms: the conventional wisdom held that Parkinson’s was an incurable illness and I assumed the convention was correct.

But with each of them I hoped to do something about their leg numbness, or their arm pain, or their other symptoms which I assumed, in my ignorance, *weren’t* a part of their Parkinson’s disease.

Their electrical irregularities all seemed to be held in place – or possibly caused – by old, unhealed foot injuries. These injuries, including displaced bones, were clearly obvious to my hands, if not my eyes.

My visual sense is very poor: my eyesight was in the “legally blind if uncorrected” category ever since grade school. Possibly a heightened sense of touch is one of my natural compensations.

At any rate, my hands quickly discovered obviously aberrant channel Qi flow as well as bone/tissue displacement *and* severe rigidity of certain joints in their feet. I inquired about possible foot injuries. In two of the cases, traumatic foot injuries had occurred in childhood. In the third case, there was no recall of any foot injury – until the foot began to heal.

In hopes of restoring their foot and leg electrical systems back to a healthy state, without paying any attention to the “incurable Parkinson’s” symptoms, I treated their foot

injuries with a gentle holding technique that the Chinese medical tradition refers to as *Yin Tui Na*.

Yin Tui Na refers to bodywork techniques that are extremely gentle and subtle. For example, the extremely gentle, “modern” technique of craniosacral therapy would be considered a *Yin* form of bodywork. Oppositely, *Yang Tui Na* is strong, powerful, or at least visible. For example, modern techniques of manual therapy such as Rolfing, bone cracking-type chiropractic, and overt medical manipulation such as popping a displaced shoulder back into its socket are all *Yang Tui Na*.

I did *not* use acupuncture on these patients. The strictures of Asian medicine are very clear: one does not increase the energy in an electrical system that is running backwards.¹

Happily, when the displaced bones and soft tissues in these patients gently drifted back into place in response to the *Yin Tui Na*, and the foot injuries began to heal, their legs’ electrical currents spontaneously straightened out by themselves, with no need of manual encouragement or acupuncture. That was OK with me.

But their Parkinson’s symptoms quickly disappeared.
This unsettled me more than a little.

I had to assume that all three of them had been misdiagnosed. I could see no reason that an unhealed foot injury should be able to cause dormancy of the brain’s dopamine-producing substantia nigra cells. At that time, the dormant-or-dead brain cell theory was the only player in the research on Parkinson’s disease. I couldn’t figure out why an unhealed foot injury could possibly be related to the brain changes that were seen in autopsies of people who’d had Parkinson’s.

Today, at the end of the first decade of the twenty-first century, top researchers in the field of PD are beginning to suspect a psychological component to account for the mood-related ebb and flow of symptoms and the high degree of placebo susceptibility in people with Parkinson’s. But when I started this project, a purely mechanical explanation, extrapolated from toxin-induced brain damage and parkinsonism in recreational drug users, was the model for *all* people with PD.

By the end of the *twentieth* century, it had been proven that cell death *did* occur in people with toxin- and drug-induced parkinsonism *but* that people with idiopathic Parkinson’s disease did not have cell death.

¹ The exact translation from the Chinese is, “Never tonify an excess condition.” Backwards-flowing currents, also referred to as “Rebellious Channel Qi,” are considered a form of “excess.” Any needles inserted into a channel with backwards flow will *increase* the amperage of the problematic flow, causing immediate, “electrical shock” type of pain – and very likely worsening the problems.

Treatment, in such a case, requires that the blockage that’s causing the electrical obstruction and subsequent backwards flow first be removed. Only then can needles or other stimulants be applied – and then, only if necessary. Very often, when an obstruction is removed, the currents immediately resume flow in the correct direction. No acupuncture needling is then needed, or advisable.

In idiopathic, or classic, Parkinson's, many of the striatal cells had reverted back to a more basic form of cell, a cell that was not geared up for producing dopamine, but certainly not cell *death*.

In other words, idiopathic Parkinson's is a *completely* different syndrome from the fairly modern "cell death" problem that can be caused by certain toxins and drugs. Even so, the older neurologists, in general, still tend to think of Parkinson's disease as a problem related to cell *death*.

As an aside, because animals do not get Parkinson's disease, all "animal model" research on Parkinson's is done on animals whose brain cells have been killed. In other words, the animal-based research does not relate in *any* way to people with *idiopathic*, or what you might call "classic" Parkinson's disease. Much of this research is directed at protecting brain cells from death – which does not apply in idiopathic Parkinson's. Or it is directed at stimulating the brain to make new dopamine cells, which also does not apply for people who have perfectly good brain cells – but who are accessing a mental mode that prevents *usage* of these brain cells. The brain cells in Parkinson's that have reverted back to "neutral" cells have reverted because they were *not being used*. Growing new cells will not cause people to think differently – hence, the new cells will not be used any more than the old cells were used.

Researchers cannot create, in animals, the conditions that lead to idiopathic Parkinson's: animals cannot *choose* to dissociate (play dead) so as to present a calm exterior. Therefore, animal research on Parkinson's does not provide *any* information that can be translated to the human model.

Parkinson's is a purely human disorder. For that matter, it is a disorder that afflicts, primarily, extremely intelligent, highly focused humans who are capable of "tuning" out that which they do not want to deal with. Much more on this, later.

The three musicians

I had no idea, at the time, of the significance of all three of these patients being professional, full-time musicians. At that time, many of my clients were in the music community, a community that included the local university and the larger community of musicians in San Jose, just over "the hill" from Santa Cruz.

I was to learn, as I worked with hundreds of people with Parkinson's over the next ten years, that ninety-three percent of my patients with Parkinson's had a particular emotional attitude towards pain – a numbing one – that allowed their foot injuries to remain unhealed. But in about five percent of my patients, including most of those patients who were professional *musicians*, this particular attitude was *not* present.

Knowing what I know now, it's clear that such an attitude of numbness will probably *not* be strongly present in people who used the physical sensations of their heart and chest to direct their musical emotions. I did not yet know about the physiological linkages between a) the brain's melody-line recognition area in the frontal lobe, b) the mood and self-assessment areas of the brain primarily located in the precuneus region, and c) the role of the pericardium (connective tissue around the heart) in influencing the sensations of expansion and contraction of the heart/chest in response to joy or fear, respectively.

I didn't learn about these connections until, in 2002, I stumbled across the relevant music-brain center research in a context completely removed from Parkinson's disease.

But the majority of my patients did *not* heal as quickly as the musicians.

I only mention this here, in this early chapter, because I don't want the reader to be thinking, "Parkinson's is merely the result of a foot injury! Oh joy! Parkinson's is easy to cure!"

The problem, or cause of Parkinson's, even in people who have "only the foot injury," is *not* the unhealed foot injury, per se.

The underlying cause is psychological. In the case of the three patients mentioned already, the psychological trigger was the decision to not acknowledge the foot injury.

Since that time, the psychological trigger we've found in all people with Parkinson's is based on a decision – usually a very necessary decision, at the time – to not acknowledge pain. As mentioned in the first chapter, these decisions usually fall into three categories.

1) The person did not dare to acknowledge the pain of a specific injury (usually a foot or ankle injury). Instead, he chose to dissociate from the specific injury, but retained his overall ability to feel physical and emotional pain. We've seen this in approximately five percent of our patients.

2) All our *other* Parkinson's patients, had decided, in response to some physical or emotional trauma, usually severe, that they did *not* feel their own somatic pain, period.

3) The third category is the most common: a person in this group has *both* of the above situations: he may have decided to dissociate from his ability to feel his own physical and/or emotional pain *and* may also have a foot injury from which he has previously or subsequently decided to dissociate. Or he may have triggered the overall dissociation in response to the foot injury. This category covers approximately ninety three percent of our patients.

Of course, if the person hurts his foot *subsequent* to having already decided to dissociate from pain, then of course the foot injury will simply be included in the overall dissociation. Either way, the foot injury will be unable to heal.

In any of the above three situations, the long-term consequence of such a decision, a decision that might have been life saving, at the time, can be the development of the electrical flow that resembles that of dissociation and which also causes the symptoms of Parkinson's disease – including the inhibition of dopamine release.

A later chapter will explain the exact electrical pattern of dissociation, and why a foot/ankle injury, in particular, can eventually cause changes that mimic that pattern.

Getting back to the musicians, the *reason* their foot injuries had not healed was, in every case, a highly localized (foot only) dissociative attitude towards the injury. Due to this localized, highly specific dissociation from the injury, the injury had never healed. They did *not* have pervasive dissociation.

"Localized" means, in this context, "only with regard to the foot and/or ankle injury." "Pervasive dissociation," in this context, refers to a mental posture that holds one pretty much impervious to the sensations of one's own physical and/or emotional pain.

Please note – my wording says “one’s own pain.” I am *not* saying these patients were not feeling and compassionate to *others*. A person might be *extremely* compassionate when it comes to others – and still be numb to his *own* physical and/or emotional sensations of pain.¹

Over the years, I have learned that a body-wide, or “pervasive,” dissociation from one’s own pain was, in *most* of my Parkinson’s patients, so utter that for much of their lives they had never perceived normal somatic (flesh and blood) responses to physical or emotional pain. These Parkinson’s patients did not recover as quickly as my first three. This diminished degree of somatic awareness is very different from my first three PD patients and my few subsequent patients, about five percent of the total, who were also very sensitive and open to experiencing physical or emotional pain, who *did* recover easily and quickly.

The *majority* of my Parkinson’s patients proudly acknowledged their “high tolerance for pain,” including an *absence* of the physical pains that usually accompany emotional trauma. In addition, most of them protested vigorously that they could never admit to being safe because “no one is ever safe! Only idiots think that they are safe!” The significance of this attitude did not become apparent for nearly a decade. But almost from the start, we noticed that people, who are highly resistant to the idea of terminating their dissociation often take much, much longer to completely recover.

Had my first few Parkinson’s patients been of this latter type, the Parkinson’s Recovery Project might never have come into being.

Providence sent me, for my first three PD patients, professional musicians. They all lived and worked via the sensations of the chest, or heart, which is to say, they were all able to use parasympathetic mode: they could attune their awareness to the sensations produced in the heart area. They had not dissociated from their hearts.

Even as I write this, I am aware that many of my patients who *have* dissociated from their ability to feel their own physical and/or emotional pain, despite the fact that they tend to be *highly* intelligent with powerful verbal skills, nevertheless have extreme difficulty in understanding paragraphs such as the previous. They can read the words, but they are not able to relate to what I am describing.

This makes perfect sense: their subconscious brain is following long-established instructions to “keep me safe.” Anything that might end the dissociation, including information about how dissociation works, can be perceived as a threat. The mind responds to this threat by being “unable” to understand the arguments in favor of ending the dissociation.

¹ The expressions I use, “feel one’s own pain” or “feel one’s own joy” are inadequate English phrases for what I am actually trying to describe. We have no word or phrase in English for the sensations of the chest, or heart, that most humans use to resonate, wordlessly, with life’s experiences.

In many languages, there is such a word. For example, in Spanish, the term “*espírito santo*” (sacred breath, or sacred vibration) means this very thing. So does the Chinese term “*Kai Xin*” (literally, opening up and growing bigger – like the expansion of a blossom – in the heart).

If you ask a Spanish speaker to explain *espírito santo* he will most likely *not* give you a verbal definition. Instead, he will most likely perform a gesture, repeatedly placing his hands on his heart and then moving them outwards, as if demonstrating an expansion in his chest.

These sensations are the ones turned off when a person is in dissociation mode. The absence of these sensations lies at the root of the somatic numbness.

One patient said, “I know all the words you’re using, but my brain won’t let me make sense of them; it’s as if my brain is making a wall that prevents me from understanding your words.”

Others have told me that they’ve read all my material, every word, except for “the unimportant stuff.” When I ask which parts were unimportant, they always say: “All that *heart* stuff.”

So I ask my readers with Parkinson’s to bear with me if they are not familiar with the sensations of expansion or vibration that most people experience in their heart area when they are relaxed or joyful. But this subject *is* important, and will come up later, in more detail.

The discovery of an absence of sensory heart-awareness in most people with Parkinson’s *may* seem merely tangential. However, it was crucial in figuring out the emotional/mental processes and the neurological modes that are causative for Parkinson’s. More than any other PD symptom, this finding helped us connect the backwards-flowing energy that appears in people with PD and the dissociation mode situation. This, in turn, has been crucial in figuring out how to turn off the dissociation.

My first three Parkinson’s (PD) patients, all of whom recovered very quickly, *did* know what is meant by “heart feelings.” In fact, two of them had always referred to it as “Russian soul” and were mildly surprised to learn that people of other nationalities also felt such a sense of almost-physical response and life-instruction coming from the heart area.

Again, these three had only a localized dissociation from a specific injury. They had not dissociated from their ability to feel physical and emotional pain, in general.

This type of Parkinson’s is *usually* very responsive to treatment. Recovery can be very rapid.

A bit more about the heart

The heart-area sensation that is used by most humans to assess how they “feel” at any given moment, or how they “feel about” certain things – and which is used by musicians in a very technical way because the heart connects to the melody-line recognition area in the brain – is very different from the absence of or intermittent allowance of heart-area sensation that one finds in the majority of people with PD.

In my limited experience, *most* of my patients with Parkinson’s, those people with some degree of *body-wide* dissociation from physical and/or emotional pain, have long thought that the phrase “feelings of the heart” is a purely metaphorical phrase!

When I try to explain to *these* PD patients that “feelings of the heart” is a reference to actual, physical, perceptible sensations in the chest that vary according to one’s physical state or one’s emotions, they usually have no idea what I’m talking about.

Their spouses usually know what I mean by the phrase. Their health practitioners usually know. But *most* of my PD patients have had *no idea* that most of the world’s poetical or spiritual references to “the heart” are references to tangible, perceptible sensations in the chest that occur in response to joy, peace, pain, or fear.

Then again, some of my patients do *remember* a time when they knew what that meant – but they have no idea how to re-learn those feelings.

Other patients who have *no* idea or recollection of what is meant by “feelings of the heart” or “sensations in the heart area” – often doubt that there *is* such a thing, aside from poetical and metaphorical usage.

But in-depth information about heart-feelings will come later. This chapter needs to share the mystery of my strange foot and electrical findings in my first three PD patients.

I merely went into the details above to make sure that the reader understands that my first three patients were in the easy-to-treat category: psychological dissociation from a specific injury, with *no* overall (body-wide; pervasive) habit of dissociation from the ability to feel one’s own somatic physical or emotional pain.

Moving right along, the *electrical* variations I saw in these three patients are found in everyone with Parkinson’s – whether or not their dissociation is merely localized or body-wide.

Electrical variations – a bit more about dissociation

The electrical patterns that I’d perceived in the legs of my first three PD patients are a perfectly standard physiological variation; a variation that occurs, correctly, in people who are in a state of physical or emotional numbness following shock, excessive loss of blood, or nearly any near-mortal injury.

This electrical condition, which is normal but which should ordinarily be very short-term, causes symptoms that, for the short-term, resemble all the symptoms of Parkinson’s disease, including rigidity, poverty of movement, soft voice, tremoring, and the inhibition of dopamine-release in the brain.

What I learned through thousands of hours of interviews with my patients is that this electrical state can also be set in place, and sustained long-term, by a single episode of very intense, almost self-hypnotic, mental instructions to “feel no pain.”

But that bit of biology will be gone into in great detail in a later chapter. I will just mention here that the biological phenomenon of dissociation is well known. I studied it when I was in medical school, in the basic physiology class.

– What wasn’t mentioned, in that class, was the physiology involved in *exiting* from this short-term condition. It turns out, if a person *survives* the near-mortal injury, his body then must do a bit of work to *terminate* these life-preserving electrical patterns and resume normal (parasympathetic and/or sympathetic) electrical patterns.

This “work” involves mental focus on danger assessment, the decision that one is safe, followed by a *deep* breath and exhalation, and a shudder or shaking that runs from the head down to the spine. The shudder resets the body back to parasympathetic mode, ending the biological dissociation.

This exhale-shudder phenomenon has been very well studied in post-trauma research. More on this, later.

As mentioned earlier, the symptoms that occur during the survival-mode time and during transition back to normal electrical patterns are collectively known as “shock.”

The symptoms of shock are well known to practitioners of western medicine. The electrical patterns that trigger them are not.

What was also not so well known, when I started the Parkinson's project, is that a person with a very high ability to focus his consciousness can induce physiological symptoms of dissociation and the matching dissociation-type electrical patterns just under the skin. Our many research experiments have confirmed this possibility. And what seems to be happening in many people with Parkinson's is the establishment of the condition in such a manner as to be sub-consciously self-sustaining for a lifetime.

Channel Qi

Before going any further, it's time to briefly introduce the concept of channel Qi. An acupuncturist calls the energy that flows in all the body's skin-deep, easily-detectable-by-hand electrical currents "channel Qi."

In Asian medical school, working from texts, we primarily memorize the channel Qi flow patterns that occur when a person is awake, *perfectly* relaxed, and in perfect health. These patterns make up the twelve "primary" and eight "extraordinary" channels. We also learn a few of the variants ("channel divergences") that can occur when a person moves into various applications of sympathetic mode. But in acupuncture school, for the most part, we don't even discuss the electrical flow shifts that necessarily occur during sleep or in response to near-mortal injury.¹

In the next few years, I was to discover references to these rarely-studied (in modern times) neurological mode-channel Qi shifts, in modern translations of the most ancient book of Chinese medicine, the two thousand year-old *Nei Jing*.²

¹ In the twentieth century, channel theory has been denounced and even outlawed by the Chinese government, mainly because it has been a source of mockery from western scientists. Because most of the modern English language acupuncture texts are translated directly from the Chinese government-approved versions of the ancient classics, channel theory has nearly vanished from twenty-first century study of Chinese medicine. The applications that *derive* from channel theory, such as acupuncture, have been practiced, of course, right along, but there was a period in modern China when you might go to prison for publicly expounding on channel flow patterns in anything other than a historical context. I have been fortunate enough to meet, and even work with, with one of the world's leading exponents of channel theory, Dr. Wang Ju-Yi, a Chinese doctor who is now in the U.S., and thus able to speak freely about channel Qi. At a lunch with Dr. Wang in 2008, when I asked him for an update on the current status of channel theory in China, he told me that you would no longer go to prison for saying that channels exist. On the other hand, no one would want to talk about channels any more – in the modern Chinese medical community, they have ceased to exist.

By the way, channels are sometimes referred to as "meridians." I don't care for this terminology: meridians are *imaginary* lines, such as the lines we superimpose upon the globe in order to break it up into theoretical, uniform latitudes. The paths of channel Qi are *not* imaginary, nor are they uniform: they are not "meridians."

²In the *Su Wen* portion of the *Nei Jing*, chapter 13 verse 9, reference is made to the four main neurological modes as manifested in the electrical channels (in this chapter, the characters that are currently translated as "channels" are actually characters that represent "*color* Qi" – a reference to the light wave-based electromagnetic energy and electricity in the flowing channels). In western medicine the four modes are: parasympathetic; sympathetic; dissociation or (Continued on next page.)

I also discovered that the very specific electrical-flow patterns that *correctly* occur in response to near-mortal injury, such a channel Qi flowing *backwards* in the Stomach channel, were a *perfect match* for the electrical flow in *all* my patients with *correctly* diagnosed idiopathic Parkinson’s disease or psychogenic parkinsonism.¹

Again: the electrical flow patterns that are *supposed* to occur, for a short time, in people in the throes of biological dissociation are present in all people with idiopathic Parkinson’s disease or psychogenic parkinsonism. That’s it for the subject of channel Qi, for now.

And now, a word about the medications of Parkinson’s disease: the same providence that sent me three musicians who were in the “easy recovery” (localized, highly specific dissociation) group, also took care that these patients were not yet taking antiparkinson’s medications. Had they been medicated patients, the course of this project would have been

(Continued from previous page.) near-death; and sleep. In the *Nei Jing*, these four modes are referred to the “four seasons” that keep man “close to the Divine” (parasympathetic), enables man to “flee from danger” (sympathetic), “cling to life” (dissociation) and...there is nothing descriptive mentioned about the fourth mode, sleep. Curiously, the benefits of sleep are not described in the translations that I have found. It may be that the benefits of sleep were too obvious to be described, or may have been removed, over the centuries, by careless transcribers or by students who did not consider sleep to be a medical situation.

This particular translation is from *A Complete Translation of the Yellow Emperor’s Classics of Internal Medicine and the Difficult Classic*, by Henry C. Lu, PhD, published by the International College of Traditional Chinese Medicine, Vancouver, BC, Canada, 2004. In keeping with the tradition for quoting scriptures, bibliographic references are made to the chapter and verse, rather than the page number. This allows for referencing in various editions.

¹ Misdiagnosis is a large problem with Parkinson’s disease. Autopsy findings suggest that thirty percent of PD diagnoses are incorrect. In my own practice, I have seen a similar percent of patients who had been told they had Parkinson’s when, in fact, they obviously did not. In my experience, most of the misdiagnoses have occurred due to a misunderstanding of the nature of the Parkinson’s tremor.

For example, I’ve seen misdiagnoses of PD given to patients who develop tremor from their new asthma medications, even though they have *no* other PD-like symptoms and their asthma medications have the *common* side effect of causing tremor. Some people have been misdiagnosed with PD because of an “active” tremor (as opposed to a resting tremor) coming from their ongoing heart pathology. I’ve seen the tics and muscle spasms from excessive doses of stimulant medications misdiagnosed as the “tremor of Parkinson’s.” Sometimes weakness is diagnosed, incorrectly, as Parkinson’s disease. Conditions such as parasupranuclear palsy (PSP) and multiple system atrophy (MSA) do not have the “look” of Parkinson’s, nor do they respond to L-dopa, but are sometimes misdiagnosed as Parkinson’s disease.

Asthma, heart disease, and syndromes such as PSP and MSA do *not* cause the electrical patterns of dissociation. All the patients I’ve seen who were obviously, glaringly misdiagnosed, did *not* manifest electrical patterns consistent with dissociation.

I would suggest, for more accurate diagnosis of Parkinson’s, that neurologists learn to detect the direction of channel Qi flow in their patients. It’s quick and easy to learn. And it’s more accurate than the “educated guess” method currently employed.

very different. The medication complication did not arise until I started looking further afield for more people with Parkinson's.

The birth of a research project

After my first three patients with symptoms of Parkinson's seemed to recover from PD in response to having their foot injuries treated, I was strangely compelled to investigate further.

I recruited volunteers from the local Parkinson's support group: I offered the members with PD a free acupuncture or Yin Tui Na session if I could first examine their feet.

I got a dozen recruits.

They all showed evidence of an unhealed foot injury. They all manifested backwards-flowing Qi in the Stomach channel on the leg on the side of the body that first manifested symptoms of PD.

This group had very different results from the first three. For one thing, they were all taking antiparkinson's medications. They all experienced dramatic changes in their symptoms after their foot injuries began to heal, but after the foot injuries healed and they found themselves unable to decrease their *highly* addictive antiparkinson's drugs, they also experienced horrible, sometimes fatal effects of severe overmedication.

Although they all attempted to reduce their medication, few of them were able to do so safely, or within a safe period of time. "Safely," means, "without dying." "Safe period of time" means "prior to recovering from Parkinson's."

Some, *following their doctors'* advice, stopped the medications too abruptly (over a period of a few days), and died within the month of sudden-onset neuroleptic malignant syndrome (in which the body's autonomic regulation system for all automatic functions such as breathing, temperature regulation, and heart rate goes haywire). We were to learn, over the next few years, that safe reduction of the medication may require up to a *year* or *more* of very slow decreases in dosage.

All of the patients were assured by their MDs that there was no problem about the medications – they could be reduced or stopped at any time, if the patient recovered from Parkinson's disease. These doctors were extremely misinformed. The manufacturers of these drugs include warnings that these drugs must be stopped slowly because of the risk of neuroleptic malignant syndrome, nearly always fatal. I was to learn that most of the younger MDs, at least in my community, were unaware of this warning.

Other patients, while slowly (over months, not days), safely, decreasing their dosage, experienced – too soon – the fateful brain shift away from the dissociation pattern. The brain shift occurred while they were still medicated.

If they were still taking the medications, even at a greatly lowered, seemingly ineffective dose, when they experienced the dramatic mood and movement shift, referred to previously as "lightness" and "ease of movement," that occurs during the rapid (a matter of minutes, or days, at the most) recovery from the electrical patterns that cause Parkinson's, they were quickly swept up in a psychotic, drug-induced frenzy.

A person who does not have the dissociation-due-to-injury pattern characteristic of Parkinson's or of latent, pre-Parkinson's, *cannot* withstand the highly addictive, mind-

altering chemicals such as L-dopa and methamphetamine (yes, one of the “MAO inhibitors” used to treat Parkinson’s is better known as methamphetamine) that allow a person with PD to over-ride his own dissociation and switch – against his own subconscious will – into parasympathetic mode.

Within seventy-two hours of recovering from Parkinson’s my still-medicated patients were either drug-crazed and merrily increasing their drug dosages by the *hour* or they were starting to experience the drug-driven psychotic breaks that would put them in mental institutions, strapped down to prevent the violent thrashings being caused by their now-excessive drug levels – from drugs which, if stopped too abruptly, could very possibly cause neuroleptic malignant syndrome, and death.

Meanwhile

Around the same time that I recruited the volunteers from the local Parkinson’s support group, I started, with the help of several friends and a Parkinson’s patient, the non-profit Parkinson’s Recovery Project.

A small group of local acupuncturists and a few of my students at the acupuncture college joined the project.

From 1998 to the end of 2002, we ran a free clinic at the acupuncture college where I teach. All patients were treated, for free, once a week, for an hour. We collected a tremendous amount of data about people with Parkinson’s. We also collected possibly the world’s richest treasure trove of real-time data about the dosing of dopamine-enhancing medications.

In particular, we discovered the time frames for brain responses to dose increase or decrease: approximately ten to fifteen minutes after ingestion, L-dopa (in the form of levodopa/carbidopa) or the various dopamine agonists (dopamine imitators) begin to penetrate the blood-brain barrier. Once inside the brain, they begin to act in mere seconds in the motor area of the brain. It takes several minutes to affect the conscious emotion area. In the limbic area of the brain, the deep center that regulates basic functions such as breathing and temperature control, dopamine levels come to equilibrium with the blood levels after ten weeks of steady exposure.

It is limbic area dopamine that needs to be filled up before a person starts showing the *full* effects of the medication at any given dosage.¹

These are very different numbers from the “six-hours of effectiveness” or “twelve hours” (depending on the drug) that are found in the books – numbers that are based on the half-life of the drugs in the *bloodstream*, and which have very, very little to do with the level

¹ Indeed, the manufacturers of these drugs make the point that full benefit of the medication might not be apparent for ten weeks. MDs who have no understanding whatsoever of how the drugs work in the brain sometimes give patients L-dopa to “test” for Parkinson’s. When patients do not have a response within a few days, these under-informed MDs usually increase the dosage, rapidly, often going far beyond the *highest* recommended dosage, until the person begins to manifest nearly instant benefits from the drugs. This results in a) people with Parkinson’s being prescribed medication at excessively high levels even if they are in very early stage Parkinson’s and b) people who *do* have an immediate response to the medication (suggesting an already high level of dopamine in the limbic area – and therefore *not* a person with Parkinson’s disease,) being told, incorrectly, based on a quick response to L-dopa, that they *do* have Parkinson’s.

of the drug inside the brain. Because of the brain's highly selective membrane barrier and the brain's highly limited ability to dismantle these drugs, a huge discrepancy can exist between the amount of drug that's floating around in the *blood* at any given time and the amount that's accumulating in the *brain*.

We also discovered a way to calculate the time spans for dose effectiveness, the timing and dosages related to drug-related "On-Off" phases, the relationship between dosage, timing, and dyskinesia and, most alarming of all, the tragic realization that any person who had taken the drugs for more than a few months appeared to have permanent symptoms of drug-induced parkinsonism – genuine brain damage and cell death, even if we successfully treated their injuries and their *idiopathic* Parkinson's responded to treatment and cleared up.¹

I have written about these findings in *Medications of Parkinson's Disease: Once Upon a Pill*.²

By the end of 2002, by collecting thousands of hours of patient dosage and symptom data, we had a far better understanding of how these medications worked than anyone else in the industry. I can make this statement because, according to the drug industry and the medical profession, the effects of these drugs were, and still are, "unpredictable."

We, however, became able to predict, to within a matter of minutes, when a given person's dosage would "kick in" or when the dyskinesia would start, if at all. We were able to successfully predict, to within a week, when a drug-weaning, previously mild-mannered patient would attack his spouse. We found that we could predict fairly well the bouts of violent drug withdrawal symptoms including terror and shaking (it starts between twelve to twenty days after a ten-percent dosage reduction, and worsens for the next five weeks before leveling out and finally easing up after ten weeks). And so on.

Based on our hypotheses, we were able to predict what would occur, and when, if our patients made changes in their drug doses – *or* if they stayed on them at a particular level while they began recovering.

Our hypotheses were more valid than those of the drugs' manufacturers because *ours* allowed us to make predications that had an uncanny accuracy.

Interpretation of data that allows one to make accurate predictions is one of the definitions of science. Using hypotheses based on four years of working very closely with patients who all charted, for years, their individually determined (or MD determined – usually fatal) dose changes (mostly reductions), and symptoms, we attained that level of data interpretation.

¹ Drug-induced parkinsonism is significantly different from idiopathic Parkinson's disease. For example, a person with idiopathic PD can move perfectly normally in a true emergency. Also, a person with idiopathic PD will have symptoms that ebb and flow depending on emotional state or adrenaline levels. And of course, a person with idiopathic Parkinson's has the easily detectable channel Qi aberration in his legs. None of these signs and symptoms are present in drug-induced parkinsonism – a condition that is, at the present time, incurable.

² *Medications of Parkinson's Disease: Once Upon a Pill* is available for free download at www.pdrecovery.org. This book has everything we learned about the medications, safe methods for modifying doses to get rid of or prevent dyskinesia, and our hypotheses about dopamine uptake and release in different brain areas, based on a four-year study.

In late 2002 we made the decision that we could no longer work with any patient who had ever taken dopamine-enhancing drugs or supplements for more than three weeks. We had seen too many deaths, too many psychotic breaks, too much agony.

I wrote up everything we knew about the medications in the above-mentioned book, put it on the non-profit's website, and made a fresh start on our research, working with and using data from unmedicated patients only.

Meanwhile, although *unmedicated* patients were still fairly *uncommon* at that time, we'd had some. Of the unmedicated patients, five more had completely recovered. Several had dropped out after just a few treatments, because of the impossibility of recovery and the pointlessness and "wasted time" involved in receiving ludicrous treatment such as foot-holding for a brain cell-death problem like "incurable Parkinson's."

Still, all the recovered patients remained symptom free, requiring no more treatments. But I am getting ahead of myself.

By 1999, I had published my foot-related findings in a few articles in journals of Chinese medicine, and established a website to post my research and share the techniques of Yin Tui Na with interested parties.

One of the fascinating issues that arose in response to this information was anger directed at me, via the internet, because I was suggesting that people with Parkinson's had, by dissociating from their injuries, somehow played a role in developing their own illness. I was "blaming the victims."

This next somewhat lengthy section will explain a bit about this issue. I want to include this here, towards the beginning of the book, because it can be a red-button issue for some people.

Blaming the victim – an aside

My findings make *many* people foaming mad. "How *dare* you blame the poor person with Parkinson's for causing his own illness! How *dare* you say that a person's dissociation from an injury is at the root of this terrible illness – as if the patient has brought this on himself!

That's what people who *don't* have Parkinson's often say.¹

¹ Currently, "blaming the victim" of an illness is politically unpopular, and in some cases even illegal. For example, as doctors, we are not allowed to blame smokers for illnesses that develop because of their smoking. We must verbally pin the blame on the cigarettes and the tobacco companies, not the smoker himself. Suggesting that the smoker played a role in developing his smoking-related problems, rather than being an innocent victim, puts the doctor at risk of being successfully sued for malpractice.

For that matter, we are now legally susceptible for punitive actions if we *tell* an obese patient that, technically, he is obese; such wording may hurt his feelings and automatically carries an implication that he is responsible for any weight-related problems. Again, it is "blaming the victim," and can lead to a successful lawsuit.

Then again, *most* people who *do* have Parkinson's who have communicated with me have said or written words to the effect of: "It's as if you were writing about me, personally. It's uncanny: I never thought anyone knew what it was like to be me, but you nailed it. I even remember when I set this whole thing in motion. Thank you!"

I get a similar response from spouses or very close friends of people with Parkinson's: they are amazed that I can write so accurately about the personality and quirks of their loved one with PD.

But they needn't be amazed. A person who has lived much of his life in dissociation mode, while using sympathetic mode to over-ride the immobility aspect, often thinks and behaves in a *highly* predictable manner.

Ironically, he often feels very much alone and individualist – and believes that no one else can know how he thinks or feels. This is actually part of the dissociation pattern of thinking.

The hundreds of people with Parkinson's who I've met or who've written to me, admittedly a self-selected group, have been *almost* uniform in their acceptance of my hypotheses and conclusions. They are particularly excited because my explanations fit, exactly, the way that they have felt inside for a long, long time – and match up with the way they think.

I have, of course, also received some hostility from a very few people with Parkinson's. It has usually come from people who are taking medications. They usually say my work on unmedicated patients is clearly "made up," or "impossible" because "*everyone* who has Parkinson's disease is taking the medication."

This is not correct. Although, in litigious America, patients are encouraged to take medication as soon as possible, possibly to relieve the MD of any responsibility for the patient's subsequent health issues, the doctors in most nations are more cautious, waiting for as long as possible to start people on drugs which cause brain damage, personality change, and have a short number of years of effectiveness regardless of when they are started. Also, many people delay, or never start, taking the drugs because they can cause changes in personality and thought processing, to say nothing of the hideous side effects that begin when drug effectiveness wanes and dosages are upped.

Many people, especially those who take the time to investigate the adverse effects, delay taking the medications for as long as possible.

In addition to those who have accused me of inventing all my research because "everyone who has Parkinson's is taking the medications," I also read one online critique of my work, by a person who said he had Parkinson's and was taking medication for it, in which he accused me of "blaming the victim" in order to get rich. Considering that all my writing and research, everything I've learned about Parkinson's and how to treat it, has always been offered for free, on the web, with *no* remuneration coming to me, this last remark seems poorly thought out. But then, the drugs do interfere with a person's ability to think clearly.

As an aside, one of my patients was a neurologist. He told me that the western explanation of Parkinson's disease didn't actually make much sense and certainly didn't match the way he felt. He said that my findings made perfect sense and described him from

head to foot. I asked him if he would tell his colleagues that he was working with an acupuncturist. He said no: he would be fired from his teaching position if his colleagues ever learned that he was working with me – a practitioner of *alternative* medicine.

Back to blaming the victim: many people with Parkinson's do not consider that I am blaming them – just the reverse. They consider that my work and its explanation for the “Parkinson's personality,” described in chapter one, provides a helpful explanation for their personality, as well as their symptoms – and a path to recovery.

Then again, some people with PD do *not* see themselves in the extended description of the Parkinson's personality that comes later in this book. These people also tend to be in the five percent who have *not* developed a feel-no-pain attitude – the ones who have dissociated only locally, from a specific injury.

Even *they* will say that my explanations make perfect sense, and my descriptions of the *physical* sensations of Parkinson's do match perfectly. The area in which they usually *disagree* is that they feel they do not match the personality profile for body-wide feel-no-pain. Of course they don't: the people with only local dissociation don't have the personality that develops in response to body-wide dissociation.

Again, being redundant here on purpose, not everyone with Parkinson's disease developed the syndrome for the same reasons. People who have *not* dissociated from their overall ability to feel their own physical and emotional pain, a minority of people with Parkinson's, will *not* match the fairly specific personality profile of those who have.

The former might still have Parkinson's, but they won't have the profile that fits the majority of people with PD – people who *have* dissociated from their ability to feel their own physical and emotional pain. And even in the subset of people who have dissociated from their over ability to feel their somatic pain, there is a wide range in the *degree* to which the personality symptoms manifest.

A further aside: psychogenic parkinsonism – the two percent

And in case you are wondering about the missing two percent (five percent have only a foot problem, ninety three percent have both a foot problem and body-wide dissociation), those are the people who have a feel-no-pain attitude but have *no* foot injury.

This condition is correctly referred to as psychogenic parkinsonism. Psychogenic parkinsonism *also* happens to be the western medicine term that is applied to anyone who has symptoms of Parkinson's disease who “spontaneously” ends up recovering. Most western doctors use this term pejoratively, to explain away what could otherwise be a nasty case of misdiagnosis. In other words, if a person is diagnosed with PD and then recovers, the MD dismisses the person as merely having had psychogenic parkinsonism (translation: a head case who never *actually* had Parkinson's).

Even so, since this term, psychogenic parkinsonism, has already been coined, and since Parkinson's always does have *some* psychogenic component, we've kept this convenient term but have gotten rid of the pejorative overlay. We now use the term to help differentiate between PD symptoms brought on by unhealed foot injury and the identical PD symptoms brought on by a “feel-no-pain” attitude. We refer to the former condition as injury-

based Parkinson's and the latter as psychogenic parkinsonism. When people have both processes going on, we just say that they have both. Most people with PD have both.

In other words, it's time to throw away the moldy term "idiopathic Parkinson's," which means "Parkinson's of unknown origin."

Back to the point of blaming the victim

As for the hypotheses presented in this book, including the personality profile for people who have dissociated from feeling, most of our Parkinson's patients have agreed with them – and even agree with the idea that their *own* attitude towards pain or to specific traumatic events *has* been causative for developing this syndrome. In other words, most people with Parkinson's are able to easily accept the idea that they have played a role in triggering their own illness – even though their well-meaning friends are often appalled by the idea that I could dare to "blame the victim."

We, in our research, have seen people recover, completely and permanently, from Parkinson's, by correcting their own attitudes or psychological posture towards either an injury or towards body-wide dissociation. Therefore, I feel that people with Parkinson's should be informed of this possibility – despite the ill will directed at us by those who feel we are blaming the victims.

Getting back to the research trajectory

As my curiosity about the Parkinson's foot injury connection became an obsession, I acquired more private patient subjects, in addition to the first dozen volunteers and the people coming to the free clinic.

These subjects were almost all taking antiparkinson's drugs.

I was spending one hour per week with each of my private Parkinson's patients. The treatments were free.

But I wasn't just *treating* them: I was interviewing them: inquiring into their childhood; habits; likes and dislikes, their attitudes towards pain and physical sensation; towards challenges; towards others; towards their spouses; their parents; their children; their work; values; spirituality; their initial attitude upon being diagnosed, anything and everything.

I wrote up everything they said, and was filled with a deepening concern as I realized that their similarities extended far beyond the presence of unhealed foot injuries and backwards-flowing channel Qi in their Stomach channels.

All my Parkinson's patients were *highly* functional people. Nearly all were deep, analytical thinkers. Many of them were leaders, in their own way, or self-employed. They all had a strong moral compass and a stoic side that allowed them to succeed where most others probably would have failed.

The personality similarity was worrisome: I wanted the cause behind Parkinson's disease to have a simple solution: the foot injury.

Worse yet, the people who *recovered* had all experienced similar alterations in personality. They became more easy-going – less fearful, less obsessed with being perceived as "correct" or "punctual," less afraid of getting lost while driving.

They even became more fanciful: they were once again able to imagine shapes and faces in clouds, after not having been able to do so for decades. They were able to sit calmly and experience simple enjoyment in their surroundings – whatever their surroundings – while doing nothing, or nothing much. Most had not been able to do this for many decades.

For example, a very recently recovered patient telephoned me to explain why she was already twenty-five minutes late for her appointment. “I’m down at the beach, watching the seagulls. I realized I’ve never really sat and watched seagulls before. So I decided to blow off my appointment. I mean, what the heck. It’s not like anyone’s going to die.”

The reader who does not have Parkinson’s may not appreciate the significance of the above. But I’m pretty sure nearly everyone with Parkinson’s who reads the above will have thought, “Oh no! How thoughtless! If I ever recover, I sure hope I never get that way!”

But I was thrilled to hear those words from her: now I could be certain she had recovered.

The above patient, prior to recovery, had embodied the extreme punctuality and highly-developed sense of personal responsibility that characterizes most people with Parkinson’s. She was *never* late. She *always* showed up. She was extremely organized and reliable.

A week after the above seagull episode, she laughingly told me that she had called a friend back east and casually mentioned that she wasn’t sure what she was going to be doing in the upcoming fall. Based only on this casual statement, her friend, who didn’t know she’d had Parkinson’s, had become extremely alarmed and asked her if she was OK.

Prior to recovery, this patient had *always* known, in perfect detail, what her upcoming plans were. When she casually mentioned that she hadn’t made any firm plans for the fall, her friend was alarmed by her drastic change of personality.

These personality changes were troubling to me. Adding personality to the mix was going to complicate everything. But maybe the personality was a side-effect of the foot injury. Maybe this would turn out to be simple, after all. Maybe the personality shift was caused by the resurgence of dopamine. Or, what seemed just as likely, was the dopamine release occurring *because* of the shift in personality? In either case, we weren’t dealing with dead brain cells and incurability.

And whatever we were able to prove or not prove, in this research project, I loved these people. I felt as if I had finally found my “tribe.” Aside from their having Parkinson’s and me not having it, I felt as if finally, I had met my brothers. As I learned more and more of their personality traits and they began to open up to me and trust me, I found that I shared many commonalities with, had an understanding of, these people’s motivations and deepest secrets. I understood these people better than I understood my colleagues, my fellow churchgoers, my family, my closest friends.

Spouses of several of my patients even felt a bit jealous at the way in which their stoic, deeply private spouses with Parkinson’s opened up to me, and I to them. It was as if there was an almost automatic bond of between me and so many of them.

So I shouldn’t have been so surprised.

But less than one year into the project, as I was still puzzling over the finding that all my PD patients had an unhealed foot injury and backwards-flowing channel Qi, together with an uncanny similarity in personality and an analytical manner for perceiving the world that I could personally relate to, I was shocked when a colleague who was very familiar with the project mentioned my own condition of Parkinson's disease. He assumed I knew of my condition, even though, so far as he knew, it wasn't "common knowledge."

I was stunned. I told him he was mistaken. I didn't have Parkinson's disease. Surely, if I had Parkinson's disease, I would have been the first person to know it. Bah.

If I did in fact resemble a person with Parkinson's, it was only "doctor's disease" – a psychosomatic imitation of symptoms based on spending too much time studying a given illness.

“Weep, my child. For he who is without tears has a grief that never ends.”

- Mexican proverb

CHAPTER THREE

FOUR NEUROLOGICAL MODES

Before I can continue with the trajectory of the research project – and with my analysis of my own physical symptoms that seemed to resemble Parkinson’s – some additional information about the “autonomic nervous system,” the neurological and endocrine systems that regulate our core functions, needs to get laid out. This chapter will quickly review the points made thus far and then dive in a bit deeper.

As previously noted, people with idiopathic Parkinson’s disease (PD) *and* psychogenic parkinsonism (as opposed to those with drug- or toxin-induced parkinsonism) all have a particular electrical pattern running throughout their bodies. This pattern is a *normal* feature of a rarely triggered neurological mode called “dissociation.”

As also noted, the field of psychology also uses the term “dissociation” to describe a completely different phenomenon: the compartmentalization of specific memories, in order to keep them away from normal consciousness. This is *psychological* dissociation.

The *original* use of the word “dissociation” had to do with social groups, particularly religious groups. When one left his previous religious group, he was said to have disassociated from his church.

Today, the words dissociated and *disassociated* (extra syllable) are used interchangeably, and the most *common* modern usage of “dissociation” refers to psychological dissociation.

But in this text, the less common, neurological-mode meaning of the word “dissociation” is what I am referring to, unless otherwise specified. I may even refer to this mode as *biological* dissociation, as well, if there is any risk of ambiguity.

The four modes

We have four autonomic neurological modes: parasympathetic, sympathetic, sleep, and dissociation. When physiologists or animal behaviorists use the term “dissociation,” they refer to the most rarely used of the four autonomic neurological modes.

At any given moment, a person’s body automatically chooses the neurological mode, or *combination* of modes, that is best suited for the activity and mindset of the moment, as well as the current external circumstances.

The neurological mode(s) of the moment determine heart rate, breathing rate, neurotransmitter levels and blood distribution patterns, and other physiological functions for that moment.

The parasympathetic/sympathetic spectrum

Parasympathetic mode, the dopamine-driven mode, occurs when a person is awake and peaceful, or joyful. Sympathetic mode is popularly known as the “fight or flight,” or “adrenaline-driven” mode. Most people, during waking hours, are using a blend of parasympathetic and sympathetic modes.

For example, if a person is driving in dense traffic (a sympathetic mode function regulated by adrenaline) while eating (a parasympathetic mode function regulated by dopamine), he is simultaneously using nerves, blood supply patterns and neurotransmitters characteristic of *both* parasympathetic mode and sympathetic mode.

The blend of parasympathetic and sympathetic occurs along a continuum: one end of the continuum is pure parasympathetic. The other end is pure sympathetic. Along the middle stretch of the continuum, moving away from parasympathetic, are the states of a decreasing percentage of parasympathetic behaviors and an increasing percentage of sympathetic.

Parasympathetic

As a person feels more content or more joyful, his heart rate and breathing grow slower. His body’s neurological systems move closer to the parasympathetic end of the continuum and further away from the sympathetic end of the continuum. At the parasympathetic end of the spectrum, his digestion works the best, and his thoughts are calm and pleurably focused. He may be deeply sensitive to the aesthetic (heart-feeling) qualities triggered by sounds, sights, tastes, smells, and the sensations of tangibles – including the sensations inside his own body that occur in response to emotions.

At this parasympathetic end of the spectrum, a person is best able to notice how his heart feels: he is able to feel a vibratory sensation of expansion in the chest in response to beautiful music or a rainbow; he feels his heart area swelling in response to the laughter of a young child, or swelling and ebbing while watching the ocean waves – as if feeling an echo of the wave movement within his own chest.

Dopamine is the dominant neurotransmitter of this mode.

The *vagus* nerve, a long, meandering cranial nerve which, when stimulated, *invigorates* digestion and *quiets* the heart and lungs, is the predominant nerve of this mode.

The channels that are charted in most books of Chinese medicine show the paths in which channel Qi flows when a person is in pure parasympathetic mode.

At the parasympathetic end of the spectrum, a person can *feel* the tightening of his heart when something fearful occurs – and his body slides towards sympathetic mode. As the body moves towards sympathetic, the ability to feel the heart-area sensations diminishes: awareness shifts away from the heart and relocates in the brain.

Sympathetic

As one becomes fearful, he moves away from the more parasympathetic end of the spectrum and closer to the more sympathetic. Again, the sympathetic mode is popularly nicknamed the “fight or flight” mode.

Adrenaline, also called epinephrine in the British system, is the dominant neurotransmitter of this mode.

In sympathetic mode, the sensory nerves do *not* evaluate sound, sight, taste, smell, or touch in terms of how they stir the heart. Instead, all sensory input is *mentally* evaluated in terms of risk. The brain takes charge, and the heart feelings are put on hold.

The *spinal nerves* are the dominant nerves of sympathetic mode.

The spinal nerves, triggered by negative and self-preserving thoughts, quicken the heart and lungs, and *inhibit* the digestive organs. These nerves trigger the opposite functions of the vagus nerve.

When a person’s consciousness moves towards fear and away from feelings such as contentment, fulfillment, security, or joy, adrenaline levels increase and dopamine levels *decrease*.

Because this is so crucial, I repeat: when a person slides towards the sympathetic end of the continuum, his sensory function shifts over to brain awareness, rather than heart awareness. As a person becomes more fearful, his visual, auditory, smell, taste, and touch sensations are processed increasingly by the brain, instead of the heart.

When one is *predominantly* in sympathetic mode, nearly all sensory input is assessed in terms of the mind’s survival-based and/or ego-based thoughts: “How will this affect me?” and “How should I think about this?”¹

“Normal” channel Qi routes, the ones that are learned in schools of Chinese medicine, are the routes that occur during parasympathetic mode. The channel Qi changes that occur as a person moves further towards sympathetic and away from parasympathetic are described in the Chinese classics under the heading of “channel divergences.”

The sympathetic mode divergences

The first channel Qi divergence described in the classics describes the main shift into sympathetic mode: an increase in energy to the Bladder channel (which lies directly over the spinal nerves); the subsequent increase in amperage to what the Chinese call “Kidney,” a

¹ In addition to the various studies done by the medical profession, the United States military has also researched the shifts in consciousness and sensory perception that occur when one is at the far sympathetic end of the continuum. These findings have contributed to a better understanding of the altered thinking in soldiers during raids and explosions, and the altered thinking that occurs in police during fast-speed car chases, to name just two examples. These tests confirm that people think differently and use different parts of their brain during emergencies. People in hyper-dangerous situations, who have shifted to almost *pure* sympathetic mode, are guided by the ego-protecting precuneus area of the brain – their carefully learned training often is disregarded. They do *not* use the consciously directed frontal lobe. Often, they are literally unable to hear real-time instructions from supervisors.

To look up some of the extensive research this subject, search words might include “adrenaline; brain response; or brain during emergency.”

term that includes both the kidney and the adrenal gland (the adrenal gland sits directly atop the kidney).

The adrenaline released via this channel divergence then “strikes the heart” (elevates the heart rate).

This is also a good western description of the physiological changes that occur as one moves into sympathetic mode, as well as a description of the shift in the flow of channel Qi.

More to the point, it is the changes in the flow of channel Qi that *trigger* the subsequent changes in the physiology. Western medicine considers all the sympathetic mode changes to be chemically driven. However, the driver that actually sets the chemical changes in motion is the shifts in electrical currents: shifts that are driven by thought waves, and which occur as rapidly as thought itself.

After the fear is ended, as a person relaxes, he quickly moves back towards the more parasympathetic end of the spectrum.¹

¹ The nomenclature can seem contradictory. We tend to think of “sympathetic” as meaning “feeling sympathy for.” This is *not* the derivation of this word usage. The word “sympathetic” was first applied to nerve responses back in the days when Galvani (1737-1798) was famously applying electrical stimulation to dead frogs, creating a muscle response in the frogs’ legs. This word usage of “sympathetic” for the spinal nerves first appeared in English in 1769, by Johnstone. He referred to the nerves that relayed an electrical trigger to the muscles as “sympathetic” nerves, because they performed an action in *response* to, or “in *sympathy* with” stimulation. From the *Oxford English Dictionary*, 1982, p. 3207.

When other regulatory nerve systems were discovered – primarily, the vagus and other cranial nerves, these were incorrectly assumed to run automatically, as opposed to the sympathetic nerves, which required direct electrical stimulation. These other systems were lumped together and labeled “parasympathetic nerves.”

A century passed before an association was made between these nerves and the emotional states of relaxation and fear that determine which sets of nerves will be stimulated. The “secretions” of the adrenal gland were not isolated until 1895. The discovery of dopamine only occurred *very* recently, in 1957, and its association with the parasympathetic system is only just becoming recognized – in sync with the discovery that the commonality of all the addictive drugs – cocaine, alcohol, nicotine, methamphetamine, and heroin – is that they *are* addictive because they all elevate dopamine levels.

As an aside, high school students, since the mid 1990s, learn in health class that dopamine is the commanding neurotransmitter of pleasure and addiction. Yet I have met MDs who, as recently as 2002, were unaware of this, even to the point of defiantly insisting that dopamine-enhancing antiparkinson’s drugs are *not* addictive. (It has since been proven that they are. See: “Levodopa and the Progression of Parkinson’s Disease,” *New England Journal of Medicine*, Janice Walton-Hadlock, Vol. 352 No. 13, March 31, 2005 p. 1380.)

In 2012, researchers at New York-Presbyterian Hospital/Weill Cornell Medical Center published a paper with the old-news “revelation” that dopamine-agonist drugs cause withdrawal symptoms similar to those of cocaine withdrawal. “For the first time, researchers have defined this phenomenon, which they call dopamine agonist withdrawal syndrome (DAWS)...” The study was supported by the Parkinson’s Disease Foundation, and published in *Archives of Neurology*, Dr. Melissa J Nirenberg, Jan 11, 2012. The press release for the study, put out by the hospital, screams, “In World First, Researchers Identify and Define Dopamine-Agonist Withdrawal Syndrome (DAWS).” Nearly a decade earlier, in 2003, I discussed this syndrome in my book on dopamine-enhancing drugs. And even then, this phenomenon would not have surprised *any* high school students of my acquaintance.

Somewhere in the middle

The Chinese, in ancient times, by noting the electrical channel Qi shifts that occur in the various neurological modes, were able to describe four distinct modes. In western medicine and in the field of psychology, only two modes, parasympathetic and sympathetic, are recognized. The neurological modes of sleep and dissociation are completely ignored, even though changes in nerve behavior, neurotransmitter release, and organ function are drastically altered during these two latter modes.

In addition to ignoring two critical modes, the western thinking with regard to these modes is only recently starting to recognize that a person is usually in multiple modes at any given time.

Even in the second half of the twentieth century, doctors still assumed that only one mode could be active at any given time. This very limited, mechanical thinking about neurological modes is still reflected in common speech: A person will say, “Oh, he’s in fight-or-flight mode,” as if a person was in *either* parasympathetic, or sympathetic, but never both. When I was taking medical classes in the 1980s, this was still being taught.

Happily, now in 2012, the young MDs are being taught that *two modes*, parasympathetic and sympathetic modes are *usually* both in use at any given time.

However, the incorrect idea that only two modes exist is still deeply entrenched.¹

Most people, while awake, are almost always somewhere in the *middle* of the parasympathetic/sympathetic spectrum. It is *extremely* rare for a person to be in *purely* parasympathetic mode or *purely* sympathetic mode.

Most people, most of the time, are somewhere nearer to the middle of the neurological continuum: they are in a blend of parasympathetic and sympathetic systems: both dopamine and adrenaline are coursing through the body; the heart beat and breathing are noticeable, but modest.

When I was taking medical classes for my Master’s degree in 1989, dopamine was considered merely a “relaxant.” This determination was made because dopamine “relaxed” the “tension” of Parkinson’s disease. Now we know that dopamine is not a relaxant – it is a stimulant, and together with adrenaline, they make up the top two “system leader” neurotransmitters. Back to nomenclature: dopamine regulates the *parasympathetic* system – the system used when one *truly* is able to feel sympathy.

¹ Some researchers are now aware that certain behaviors, such as feigning death and passive avoidance, are actually different from the “normal” parasympathetic and sympathetic behaviors. Brain analysis shows that these behaviors are regulated by the “dorsal motor nucleus” of the vagus nerve. This is a different nerve area from the part of the vagus nerve that regulates gastrointestinal sensitivity and perceptions of calmness and joy, as well as social communication.

But because the vagus nerve does play a role in these behaviors, they are considered part of the parasympathetic system. This section of the brain does rely on channel Qi that flows in the normal direction.

But dissociation, in which a person is neither “feigning” nor “avoiding,” is an utterly different mode. In dissociation, a person is actively probing the place between living and dying. In Parkinson’s, he is probing that place while simultaneously trying to maintain the appearance of normalcy.

To understand Parkinson's disease one **must** understand that the body and mind can simultaneously use aspects of multiple modes.

To understand the four modes better, and appreciate that most of us are *not* in just one mode at a time, consider how one would behave if in *only* one mode or another.

Pure parasympathetic

In *pure* parasympathetic mode, exclusively parasympathetic with no other modes engaged, a person will have no sense of ego, extremely minimal, extremely slow and nearly undetectable heartbeat and minimal breathing, and a highly intensified awareness of heart-based sensory experience, even *highly* direct “intuitional” experience.

In the ancient Chinese lore, this is the mode that “is valued by Gods because it is in tune with the Divine being.”¹

Pure sympathetic

Oppositely, when a person is in *pure* sympathetic mode, he may be unable to hear anything or perceive anything other than his own internal voice telling him how to act in the moment. In this state, normal physiological limits and sensory input can be overridden: a person can easily lift a car to save a child trapped under a tire; he can flee for miles on a broken leg and never feel the pain of the injury; he can perform tragic feats of mayhem with no awareness of the possibility of consequences.

A step beyond pure parasympathetic

If a person is able to attain and sustain a state of pure parasympathetic mode, he is in a position to transition to another state altogether: the “breathless state”, or what is sometimes called the state of “perfect communion with soul.” This may seem an arcane or even pointless subject for discussion in a book on Parkinson's disease, but understanding this mode is critical to the PD discussion.

In this state, just beyond *pure* parasympathetic mode, one consciously and *joyfully* disconnects his awareness from the *physical* sensations of his own body.²

He is able to shift his awareness over to the vibratory phenomena that exist just under the surface of physical phenomena. This is an *extension* of the heart's sensitivity to vibratory phenomena as, in this state, the objective awareness of vibrations cease to be polluted by the *brain's* interfering subjective interpretations of “how does this affect me?”

In this state, one's awareness of self switches from awareness of physical existence to awareness of the vibratory forces that create the illusion (atoms and molecular structure) of matter. In this state, profound physiological changes may occur: one's breathing may cease; the heart beat gently ceases for however long one chooses – minutes, hours, or days; one's

¹ *Su Wen*, chapter 13-9. Translation by Henry Lu, PhD.

² Note the use of the word “joyfully.” This is very different from the grim determination used by people who, from fear of pain, command themselves to be numb. But many of my patients with Parkinson's have imagined that their numbed, joyless state of dissociation from physical sensation is a spiritual move towards the much lauded state of Divine communion. Much, more on this, later.

heart *awareness* continues, however, and becomes attuned to the electromagnetic vibrations *behind* the seeming physical reality of matter.¹

In this state, through tuning one's awareness as one tunes a radio, one can pick up on, or "know" any vibration in the universe. In this way, the great saints, sages, and mystics of every faith, can feel (know) "the falling of a bird in the distant forest" or "hear" the voice of Love (Wisdom) that permeates the universe.

Which neurotransmitters are dominant in this condition? An absence of neurotransmitters, an absence of chemical influence, in general, marks this highest state of consciousness.

What emotions characterize this state? An absence of *emotionalism* (the ego-based emotions of fear, greed, lust, and so on) and *perceptive awareness* of calm, peace, joy, and even bliss.

The channel Qi flow, in this state, comes to a halt: the electrons are converted to their vibratory (electromagnetic) equivalent. It is *this* mode, actually, even more than mere "pure" parasympathetic, which "is valued by Gods because it is in tune with the Divine being."

Most people never experience the bliss of pure parasympathetic nor the opposite - the overwhelming, almost hypnotic, self-preservation commands of pure sympathetic. Most people are always moving back and forth along the middle of the spectrum, somewhere between the two ends.

As we experience relative degrees of relaxation or fear we move first one way, and then the other, along the spectrum, but we usually stay somewhere in the blended zone.

Sleep

In sleep mode, both adrenaline *and* dopamine levels drop very low. Although dreams can trigger the release of tiny amounts of these movement-activating neurotransmitters, causing the dreamer to move or mumble, neurotransmitter release is generally low during sleep, in healthy people.

During sleep, both the spinal nerves and the vagus nerve are fairly inhibited.

During sleep, the channel Qi shifts dramatically away from the "awake" patterns: Qi flow through the brain is deflected away from the frontal lobe (director of conscious thoughts and actions) and shunted into the lower parts of the brain *and* up and over the *top* of the head.

In a healthy person, the body's thoughts and electrical currents move towards the parasympathetic end of the spectrum before transitioning into sleep mode.

¹ The breathlessness state and the absence of physical movement described above is *not* the ultimate state of soul awareness, but it is close. In the *highest state* of soul communion with, or disappearance into, Universal Love, one can move the physical body freely and behave with the appearance of normal physiology, even while perceiving all matter in *either* its vibratory form or its material form – as one chooses.

But if the subconscious mind is not at peace, a sleeping person can manifest some sympathetic mode patterns – some might be strong enough to cause disturbing dreams, movement, or calling out in one’s sleep. Sometimes, if the sympathetic electrical patterns are strong enough to override the sleep patterns, a person can lie in bed, awake, maybe even unable to close his eyes. Even so, his body may be somewhat limp. His body is in a combination of sleep and sympathetic modes.

Dissociation

Dissociation mode is the least used mode, and only kicks in during highly specific conditions: mortal injury, severe loss of blood, excessive perforation of the skin, and/or during the transition to death...or when one successfully commands oneself to be numb to his own physical and/or emotional pain.

In dissociation, the mode of “last-gasp attempt at death-prevention,” heart rate is *greatly* reduced, breathing rate is *greatly* reduced, blood pressure becomes very low, blood is pulled away from the skin and shunted deep inside to the spine and brain. All of these changes serve to prevent the further loss of blood and maintain blood and oxygen supply to the heart and brain.

In this mode, adrenaline and dopamine release are both severely inhibited. A surge of endorphins is released, creating physiological numbness.

The skin can become cold, and the body may curl up slightly into a fetal position. The person, whether conscious or appearing to be unconscious, may perceive himself from a location that seems to be outside of his own body: hence the name, “dissociation.”

For a good visual image of dissociation, think of the possum that curls up, looking dead, at the first sign of danger. The possum does not “pretend” to be dead. He cannot help himself. He simply isn’t designed for the “fight or flight” of sympathetic mode. Except for conditions in which he is defending his young, he is uniquely hardwired to slide automatically into dissociation at the first sign of danger.

Another common example of dissociation that many of us have seen occurs when a cat catches a mouse. When the cat’s claws perforate the mouse’s skin – a significant level of skin perforation can trigger dissociation mode – the mouse becomes rigid, and appears dead: his breathing becomes imperceptible, and his tiny claws curl in in what looks like the rigor mortis of death.

If the cat was hunting for sport, and not hunger, he may bat the rigid mouse around for a few minutes and then, becoming bored, depart in search of livelier prey. About ten minutes later, the mouse will come out of his dissociated state, using the following sequence: his brain will be extremely active in the danger assessment area. If he can see the cat, smell the cat, hear the cat, or if any other sensory signal indicates that he is not safe, he will not be able to institute the deep breath and shudder. When, at some point, his danger assessment determines that no risks are present, he will take a deep breath, shudder from his head all the way down to his tail, (thus resetting his body to his usual blend of parasympathetic and sympathetic modes), and scamper off.

A person, when in *full-blown* dissociated mode, becomes very still, even rigid. The fingers curl in, the skin temperature drops and the body assumes a mild-to-full blown fetal posture, similar to the hunched posture of Parkinson’s disease. The release of brain dopamine and adrenaline is inhibited.¹

This mode is *usually* of short duration. Either the person dies from the trauma or his condition becomes somewhat stable. If and when his brain’s danger assessment activities come to the conclusion that he is no longer at risk, his body will come out of the dissociated state: he will exhale deeply, shudder or tremble, and then shift out of the dissociated state. If his trauma was severe, he may go through various “shock” related symptoms, such as trembling, poor temperature regulation, inhibited digestion (including nausea or vomiting), and so on, as his body adjusts back towards the more customary neurological modes: parasympathetic (not fearful), or sympathetic (“fight or flight”) or, most likely, a blend of the two.²

Channel Qi in dissociation mode

The channel Qi pattern for dissociation mode is drastically different from the other modes. In this mode, the Stomach channel’s Qi, which normally courses *down* the face and the front of the torso into the antero-lateral part of the legs and into the feet, *reverses direction*: it runs *up* the leg towards the head. At the chin, it shunts up to the forehead and flows into a channel that ordinarily runs at high levels during sleep (the Gallbladder channel). This results in a through-the-head pattern very similar to the sleep-mode pattern. Like the sleep-mode pattern, this circuitry greatly inhibits the release of both adrenaline and dopamine.

But bear in mind, normal sleep mode results from the normal diurnal clock surge in channel Qi in the Gallbladder channel, a surge that occurs every twenty four hours. The surge in the Gallbladder channel that occurs during dissociation is the result of backwards flow of the Stomach channel – an *extremely* different mechanism.

Meanwhile, in the other channels, especially the front midline (the Ren) the channel Qi can become difficult to detect. The channel Qi becomes concentrated in the spine, but

¹ The endorphin release and cessation of physical and emotional pain during skin perforation-induced dissociation is the reason for “cutting.” In the first decade of the twenty-first century, “self-cutting,” (making shallow cuts in the skin with a razor blade), experienced a wave of popularity among young people seeking an opioid-like high. The neurological responses from cutting are similar to those from using opioids such as heroin, but cutting is much more affordable, more private, and usually much safer. However, it is possible to accidentally overdose: too much cutting can cause a level of endorphin release high enough to stop breathing – just like an overdose of opiates. The emergency-room treatment is naloxone – the same treatment used for opiate overdose.

² Often, when recovering from a near-death experience, a person slides first into a fairly pure parasympathetic condition, prior to resuming his normal balance of parasympathetic and sympathetic. This phenomenon is often seen in hospitals where the person “restored to life” is temporarily in a state of joy and/or peace – perceiving everyone and everything as beautiful and perfect.

even here, the flow can become somewhat inhibited – the channel Qi may move slowly, if at all.¹

The Du channel, which flows directly over the spine and into the head, becomes profoundly altered. The energy in this channel prepares to transition away from its charged-particles (such as electrons) basis and begins conversion into electromagnetic wave forms. This is a transition that is completed at the moment of death, but the process can be partially performed even while a person is still alive.

In the classic texts of Chinese medicine, this process is referred to as “the Du channel can serve as a reservoir for the channel Qi.” In other words, the Du channel becomes a sort of holding tank: energy will resume its charged-particle attributes if the person survives the trauma. If the person dies, channel Qi energy will complete its conversion into wave-based forms prior to departing the body for good.

While dissociated, a person usually perceives himself as if he is located outside of his body: as his energy converts to a wave basis, his self-awareness is less connected to his physical form.

The other changes that occur in channel Qi flow during dissociation will be described in a much more detail in a later chapter, as part of a full discussion of Parkinson’s disease symptoms.

Dissociation is a subset of sympathetic? Wrong.

As mentioned in a footnote in chapter one, some psychologists consider the immobility of dissociation to be just another aspect of sympathetic mode.

By feeling the electrical currents that run just under the skin, one can determine that dissociation is *extremely* different from sympathetic mode.

For example, as one moves from highly parasympathetic towards a greater degree of sympathetic mode, his electrical currents bypass, to a corresponding degree, the gastrointestinal organs and increase the amperage of their flow to the heart and lungs. And while doing so, they still run in the *correct* directions.

Depending on which body parts call for an increase in energy, the currents will run with increased amperage in selected body parts, on an as-needed basis.

In the first moments of being startled, while the person (or animal) might be “frozen in his tracks” (a startle response), the currents that run down the sides of the back experience a huge surge in amperage – but the currents are still moving in the *normal* direction. This surge, although it might manifest as the pause before flight, is not immobility. During this pause, the body is preparing for a subsequent surge in the legs, arms, or other muscles, as

¹ One of my textbooks for acupuncture students, *Tracking the Dragon*, has exercises for learning to feel, by hand, the alterations that occur during various neurological modes. To practice feeling the patterns that occur during dissociation, one student feels the channel Qi while his study partner imagines his arm is being pulled off by a tiger. The shift in the channel Qi is usually very dramatic. The tiger-imagining partner can often feel the somatic numbing and mental alteration that is triggered by this dissociation-inducing exercise. This book, which teaches beginners, including non-acupuncturists, how to feel channel Qi, is available from the website of the Parkinson’s Recovery Project: www.pdrecovery.org, on the publications page. The chapters that apply to treating Parkinson’s are available for free download.

needed, to support running, flailing the arms, or whatever actions must be taken for self-defense or protection.

This additional support to whatever muscles need energy will be provided via currents that are running in the *normal* direction.

Oppositely, during dissociation, currents run *backwards*. This condition of backwards electrical flow is utterly different from the circuitry of parasympathetic, sympathetic, or sleep.

Backwards flow in the electrical systems of the body is used in preparation for death or suspended animation, while trying to figure out if death can be postponed, or when the body needs to induce immobility for reasons of severe injury.

The backwards flow of energy during dissociation is *not* a mere hypothesis: the electrical circuits that flow just under the skin – and the *directions* in which they flow – can easily be felt by hand by most people after a few hours of training. Examining these currents is an extremely objective, not subjective, activity.

Pure dissociation

In *pure* dissociation, a person is rigid, and seemingly unconscious – like the mouse that appears cold and lifeless.

However, this is not the only form that dissociation can take: dissociation can be moderate, as well as full-blown. Also, just like parasympathetic and sleep modes, dissociation can combine with sympathetic mode patterns. Dissociation can even be masked, or overridden by sympathetic mode behaviors, even while some of the characteristics of dissociation remain in the background.

For example, if a person breaks the large bone of his leg, he will be inclined to lie motionless, or maybe quivering, in pain. His body will become somewhat curled up, he will feel disinclined to move – to the point that he might even feel slow and move only with care and difficulty. Endorphins will be released, inhibiting the otherwise overwhelming pain signals. His heart rate, after the moment of the initial panic, may be slowed. His breathing may be very slow and shallow. His skin may become sweaty and cold. After a few minutes, he may even feel strangely detached from his physical body. His brain's dopamine function is only minimally available for motor function: however, dopamine activity *increases* in the danger assessment part of the brain. This is a moderate case of biological dissociation, or “mild shock.”

However, if the above person has broken his leg while being attacked and is *still* under attack, and if he needs to run for a mile on his broken leg in order to flee – he will be able to do so: his body will use a combination of dissociation mode and sympathetic mode – until he gets to a situation in which it is safe to become immobile.

During this “run for life,” the electrical currents in the Stomach channel of the broken leg will still be running backwards. The muscle rigidity triggered by backwards running currents will allow the micro muscles in the vicinity of the bone break to tighten down like a rigid cast around the broken bone, holding the pieces somewhat in place.

Meanwhile, leg muscles directed by other channels, channels that are still running in the right direction, will “splint,” or “take over the job,” for the leg muscles that are

temporarily out-of-order due to backwards-flowing channel Qi. In this manner, a person can run for miles on a broken leg while fleeing from danger.

An example of splinting gone out of control manifests in people with advanced Parkinson's. After *decades* of backwards-flowing Qi in the Stomach channels and the ensuing rigidity and lack of mental control in these channels, a mental command to "walk forward" will cause all the functional muscles of the leg to kick into gear: and the person finds himself walking backwards. When the muscles on the anteriolateral sides of the leg have become nearly useless, due to the rigidity induced by backwards-flowing channel Qi in the Stomach channel, the only muscles able to respond to the "walk forward" command are the muscles on the medial sides of the legs and the backs of the legs. And so despite thinking "walk forward!" the person finds himself walking backwards.

But I am getting ahead of myself. This aside was to provide an example of how a person may be able to get motor function in some areas, using sympathetic mode, even while other parts of the body are being held immobile by backwards-flowing currents characteristic of dissociated mode.

So, a person can flee from danger while carrying a potentially mortal wound – using sympathetic mode to mask the ongoing dissociation mode. Once he gets himself to a safe place, once he no longer needs to run from outside dangers such as a predator or other danger, the sympathetic system turns itself down. The symptoms of dissociation that were present, but which were being masked by sympathetic mode, then manifest more fully: the body becomes somewhat immobile and the brain is highly focused on danger assessment. The underlying dissociation is no longer masked by the adrenaline override of sympathetic mode.

So long as an injured person is conscious, sympathetic-mode movement, which is to say, adrenaline-based motor function, can almost always mask, or override, the immobility of dissociated mode, even if other aspects of dissociation such as emotional numbness and backwards-flowing channel Qi in certain channels are present. This allows movement (fight or flight) to an even gravely wounded body.

Dissociation's electrical patterns

The dissociation patterns are *extremely* different from the usual electrical patterns that flow under the skin, and are very easy to feel. As noted earlier, when a person is using dissociated mode to a significant degree, the Stomach channel may seem to be missing, or may even flow *backwards*.

Even for a novice at feeling channel Qi, one who doesn't know *which* direction the currents are supposed to flow, and therefore doesn't know if the current is flowing backwards or not, it's still easy to tell if the currents of a fellow human are running in the dissociation pattern: those currents feel unpleasant. The dissociation patterns of current flow just feel *wrong*; when you detect them in another person, they might even, in severe cases, make your skin crawl or make your hairs stand on end.

When detecting the flow of a patient's channel Qi, even if one doesn't know which direction the energy is *supposed* to flow, the backwards-flowing or back-and-forth energy of dissociation *sometimes* gives off a strange, unhealthy-feeling electromagnetic field. If the

energy is missing altogether, it can *sometimes* feel positively creepy to the person assessing the channel Qi; it can seem as if the person's flesh is somehow dead.

The various blended modes

Sympathetic mode can blend in with any of the other three modes.

For example, a person who is awake and somewhat relaxed is still almost never in *purely* parasympathetic: his ego- or fear-based thoughts keep him in a *blend* of parasympathetic and sympathetic mode.

A sleeper with excess activity in his subconscious mind might find his quality of sleep diminished by the intrusion of sympathetic mode thoughts and electrical patterns *blending* with his sleeping patterns.

A person who is dissociated and awake will often manifest a *blend* of dissociated and sympathetic modes.

Living long-term in a dissociation- sympathetic blended mode

In the case of Parkinson's disease, or in any a person who is using the dissociation mode because of severe trauma or in order to prevent awareness of his own physical and/or emotional pain, concomitant use of the sympathetic mode allows physical movement – of the type that occurs with adrenaline, not the dopamine-based type of movement.

In a person with a blend of dissociative and sympathetic modes, the dissociation mindset and the release of endorphins may render the person impervious to the physical and emotional pains in his own body. Meanwhile, the sympathetic mode's release of adrenaline will enable him to be highly alert, possibly even hyper-vigilant.

Such a person, by virtue of his powerful adrenaline “override,” undiluted by dopamine, can come across as stronger, faster, and more analytical than a person who is merely living with a “normal” blend of parasympathetic and sympathetic. He will also come across as far less susceptible to physical and emotional pain than the average. His brain functions, his thoughts and his emotions, will be colored by his dissociation, however. His brain and thoughts will also be steadily, ever-increasingly influenced by chronic over-indulgence in sympathetic mode.

So if and when his adrenaline levels *drop*, from lack of mentally-induced urgency, he will find that movement can be difficult. He will also find that he has become habituated to wariness-based thinking.

Although the effects of dissociation vary from person to person, depending on the intensity of the dissociation and the triggers for the dissociation, a person who is living in a blend of dissociative and sympathetic modes might perceive himself, or parts of himself, as being separate from his physical body.

Because of the dissociation, he might not be able to form positive mental images at will – unable to imagine the faces of his loved ones, or imagine the sounds of their voices. He *probably* cannot *imagine* the physical sensations of his own physical movements: he moves by mental command – a very different form of movement from that directed by dopamine. He

might not be able to *imagine* light permeating his body, or at least not in injured areas, if any.¹

He might have no perceptible *heart area* response to external stimuli such as music, lovely art, or even loved ones – he may only be capable of a mental response.²

And when a person becomes firmly unable to feel pain, he also becomes unable to feel the presence of calm, peace, and joy – all of which are *feelings: sensations*.

The long-term development of Parkinson's disease

Long before a person develops Parkinson's disease, he has already dissociated from either his injury (psychological dissociation) so that it doesn't heal – and then the unhealed mess causes an electrical disarray that resembles the patterns of dissociation mode, *or* he has dissociated from his ability to feel physical and emotional pain (he has managed to trigger trauma-type, biological dissociation). Either or both of these two types of dissociation might have started in the *childhood* of a person who much, much later finally develops Parkinson's.

However, the dissociation does not slow him up at the time it is first invoked. At the time, he merely overrides the dissociation with adrenaline, and goes on his merry way –

¹ There will be much, much more about this symptom later. For now, let me expand on it via an example: one of my patients was a playwright and screenplay writer. He could mentally picture whole scenarios, from the backdrop to the facial expression of every actor in his plays. He could not, however, visualize light in his own body. When asked to visualize his body as being full of light, he protested strongly. He insisted that it was impossible for him to do such a thing. Finally, after months of coaching, while still insisting he couldn't do it, he did it. At the same moment as he was able to imagine light in his elbow, he inexplicably started weeping. He then cried for almost ten minutes: big, wrenching sobs.

On the other hand, one patient had gone to a hypnotherapist prior to her diagnosis to understand why the left side of her body wasn't working. With the guidance of the hypnotherapist, she *was* able to mentally create a picture of the inside of her body. The right side was gleaming and functional. The left side was filled with rotting timbers and stagnant water. She was unusual in that she was able to see anything; most of our PD patients can't even imagine any image or activity going on inside their most affected body areas and are terrified even to take a mental look. This patient was *not* able to alter the mental image using hypnotherapy. We have seen that hypnotherapy is *not* able to make a lasting change in people with Parkinson's. The hypnotherapists have all wanted to make an overlay of health and brightness in the body, without first getting rid of the underlying dissociation – which leaves the Parkinson's in place.

² I recall one spouse complaining about her husband with PD having no heart awareness. "When we went to Florence, he never even saw Michelangelo's statue of David."

"Yes I did! I was right there with you!"

"You never saw it," she shrugged.

I joined in, "I remember seeing that statue! You turn the corner and there it is, at the far end of the hallway, and even at that distance, the beauty and power pouring out of that statue takes your breath away; I was stunned! I'd seen pictures of it, but the statue itself, oh! Such a *feeling* emanating from it!"

"Well, I don't know about that, replied the husband. "But it was very accurately carved. I remember admiring the accuracy in the fingers."

The wife continued, "Like I said, he never *saw* it."

maybe even stronger and more focused than before, thanks to the increased levels of adrenaline.

The Parkinson's disease, which is to say the *obvious* physical changes that occur during dissociation, doesn't begin to appear until the person is no longer able to summon up enough mental reasons for the stream of adrenaline that allows him to override the dissociation. When a person who has dissociated from a foot injury or who has locked his heart into a state of constant dissociation can *no longer* mentally create a constant sense of emergency, symptoms of Parkinson's will begin to appear.

For many people with Parkinson's, this diminishing ability to create an adrenaline override comes about when some long-maintained fear is resolved: the youngest child graduates from high school; the mortgage is paid off; the hated uncle finally dies; and so on.

When the fear that a person used to keep himself strong, via adrenaline, is diminished or laid to rest, the symptoms of Parkinson's can begin to become apparent.

Meanwhile, the *habit* of perpetually dwelling in heightened alertness (the sympathetic mode mindset) may linger: anxiety, also known as pointless mental worry *unaccompanied* by enough adrenaline to do anything *about* the worry, very often accompanies the appearance of Parkinson's symptoms.

But I am getting into deeper waters.

This chapter is merely meant as the briefest of introductions to the four neurological modes, and the ways that they can overlap.

Where Asian medicine comes into all this

As noted earlier, each of the neurological modes creates a highly specific electrical pattern throughout the body, including in the detectable electrical flow in the tissues just below the skin. By learning to feel for these patterns, a health practitioner can ascertain just what modes the patient is using at the moment, *and* even discern if two or *more* modes are being used, simultaneously, even if each one is being applied in various, *localized* body parts.

As mentioned earlier, the “primary” channel Qi flow patterns, as taught in schools of Chinese medicine, are the ones that occur when a person is in parasympathetic mode.

Also mentioned earlier is that shifts in consciousness, such as the shift towards fear, can cause divergences from the “primary” flow patterns. These consciousness-based shifts are well-studied and predictable, according to the little-studied ancient classics of Chinese medicine. Shifts into fear, sleep, or dissociation lead to specific changes in the flow of channel Qi. These are “standard” shifts, and are considered healthy, or at least normal. Such changes are *not* considered pathological.

However, other triggers can also lead to alterations in the flow of channel Qi. People with pathogen-based illness, injury, significant scar tissue, emotional problems, or psychological dissociations that prevent sensory awareness of some body part, will manifest *pathological* divergent variations in their electrical currents, variations set in motion by the pathology. These pathological, aberrant variations can be *very* different from the four, “standard” variations that accompany the four neurological modes: unique in each person.

By feeling, with one's hands, the variations in a patient's currents, one can *know* that, contrary to modern western thought, a patient is rarely in only one neurological mode: "only parasympathetic," "only sympathetic," or "only dissociated." We can ascertain, by simply feeling the electrical currents that run just under the skin that, for example, even if *many* of the patient's currents are flowing in the parasympathetic pattern, other body areas *can* be simultaneously manifesting electrical diversions to supply sympathetic mode needs, or presenting aberrant (pathological) patterns in localized areas.

These aberrant patterns may be due to injury or localized infection. They can even be snatches of sympathetic, sleep, or dissociation flow patterns that got "stuck" and have failed to shift back to parasympathetic when the emergency, the sleep, or the dissociation was over.

Such flow patterns (divergences into modes other than parasympathetic) might have been needed in response to some crisis, but if some sections of the flow *failed* to switch back to parasympathetic when the crisis ended, they might now be causing physiological pathologies.

Restoring harmony

The basic goal of Asian medicine treatments is usually expressed as "restoring harmony." Harmony, in this usage, actually means, "getting all the channel Qi to flow in the patterns of parasympathetic mode." Very few acupuncturists have learned this. They often parrot the word "Harmony!" and leave it at that.

This understanding is also expressed, by practitioners of Chinese medicine, as "Go through: no pain; No go through: pain." In this phrasing, "Go through" means: the channel Qi flows in the correct patterns for parasympathetic mode – the patterns we learn in school. "Pain" refers to anything that is not beneficial for humans. "Pain" can refer to maladies ranging from allergies to cancer, from the flu to schizophrenia.¹

The electrical patterns that run just under the surface of the skin are extremely easy to feel by hand. At the acupuncture school where I teach, most students, within a few hours of attending the Advanced Channel Theory class, can start to feel the sensations given off by these currents. Within a few weeks, they are usually able to pick up on subtleties that allow them to distinguish between the currents running just under the skin, deeper currents that run

¹ Many *modern* acupuncturists, *especially* most China-trained acupuncturists, do not think in terms of channels, even while intoning the classic rubrics such as "Go through: no pain." This is a political situation. As mentioned earlier, Channel theory was denounced and discarded by the communist leaders of China. Most people who learn Chinese medicine today learn how to correct aberrations in the channels via acupuncture, but they do not even realize that this is what they are doing: they are locked into vague vocabularies such as "restoring harmony" via common combinations of acupuncture points that *might possibly* be helpful to help resolve the patient's problem, without understanding that the purpose of the acupuncture needles is actually highly specific: the restoration of the parasympathetic channel Qi pattern.

The medicine has become, to a great extent, formulaic: for syndrome "X", use this treatment "X," and hope it works. The changes that occur in response to the treatments, changes that restore health by correcting the flow of channel Qi, are often not recognized by modern acupuncturists as having *anything* to do with channel Qi. As one giddy acupuncture professor of my acquaintance happily, but incorrectly, proclaimed, "Acupuncture is so cool! No one knows what's going on, but you stick needles in, and *sometimes* it really works!"

in the muscular fascia, and the deepest currents that run through the fascia that covers the bones. So these currents are *not* arcane or hard to detect.

Most animals are extremely sensitive to these currents: when an animal knows to lick another animal or human “just where the problem is,” it’s because he’s picking up on the highly obvious (to him) electrical static that occurs in any place where injury, cellular aberration, or localized infection is causing static-rich aberrations in channel Qi flow. Humans, too, have an innate ability to easily discern these static-discharging problem areas – but our cultural upbringing usually inhibits our ability to be consciously aware of them.

Wrapping up the discussion of the four modes: feeling the channel Qi is the fastest and most accurate way to determine which modes a person is in, and which parts of his body are in which modes.

And though I’ve said it before, I’ll repeat it yet again:

The body-wide electrical flow patterns of dissociation are a perfect match for the electrical flow patterns that can be easily detected in people with Parkinson’s disease.

“Cry out! Don’t be stolid and silent with your pain. Lament! And let the milk of loving flow into you.”

- Rumi’s “Cry Out In Our Weakness” (Bark’s translation)

CHAPTER FOUR

FEELING NO PAIN: A FEW CASE STUDIES

To demonstrate what I mean by unhealed foot injury, dissociation from a localized problem such as a foot injury, and body-wide dissociation from the ability to feel the body, I’ve selected a few representative case studies. All names have been changed.

Katya

Katya, age 56, was my very first patient with PD symptoms. She came to see me for gallstone troubles. After terrifying, brutal experiences with obstetric doctors in her native Russia in the 1970s, she was determined to avoid all MDs. Therefore, she had never seen a doctor about her increasing immobility, legs that felt like wood, gnarled feet that stuck to the floor, cogwheeling wrists and ankles, slow fingers, increasingly hunched posture, loss of vocal volume and loss of sense of taste and smell.

I learned of these problems as I used Asian medicine to treat her, successfully, for gallstones. She mentioned her slow shuffling walk and the profound rigidity in her legs and torso, both of which she could overcome for a few steps by using sheer will power, when she needed to. But what worried her even more was what she called “the woodenness” of her legs.

I hadn’t started this study yet, and Parkinson’s wasn’t on my radar. Besides, she didn’t have a tremor. In medical school, I’d learned that tremor was an integral part of PD. I have since learned that between 15 to 35% (depending on who you read) of people with Parkinson’s do *not* ever develop a tremor.

Had I known she had Parkinson’s, I most likely would have done the modern Asian medicine treatment for Parkinson’s disease: acupuncture needles in the scalp. This very modern treatment, which only provides short-term (one or two days) relief from symptoms and which does *not* slow the progression of the syndrome, was designed to conform to the modern *western* understanding of Parkinson’s – the idea that Parkinson’s is caused by insufficient dopamine-producing cells in the brain.

At the time I met her, my knowledge of modern Asian medicine would have pointed me in this direction only.

After inserting acupuncture needles to treat her for gallstones, I was exploring the bones of the leg and feet to see if there was a reason for the “wooden” feeling in her lower limbs. I found an area on the foot that was deathly rigid, absolutely devoid of vibration and

responsiveness. Because Katya was quite afraid of having her feet touched (a not uncommon PD characteristic), I used the extremely firm, supportive, slow-moving technique of Forceless, Spontaneous Release (FSR). This technique is a type of Yin Tui Na (Chinese light-touch manual therapy). This technique enables the practitioner to support an injured area without intruding on the patient's desire to not be touched or "messed with." The technique is so non-threatening that Katya, like many recipients of FSR, ended up dozing, even though I was touching her off-limits feet.

With a very firm grip on her feet, I *slowly*, almost imperceptibly, worked my hands over her right foot, the more rigid foot, only moving my hands on to a new place after the area being held finally made some small reflexive response.

My hands came to a complete halt when they arrived at the strange deathlike feeling in the center of her right foot. I held that spot. I did nothing at all. I just held her foot with one hand at the top of the arch and the other on the sole directly beneath the arch, in the area of the acupuncture point known as ST-42. I sat there, holding this area, for about fifteen minutes, while I contemplated this unusual deathlike sensation in her foot. Or maybe it was forty-five minutes. I can lose all sense of time when I am sitting, supporting an injured area.

However long it was, her foot eventually began gently shaking. The bones under my hands began to jostle and vibrate. And then Katya, still deep in her dozing, began to murmur softly in her sweet Russian-accented English.

"She was wading in the Volga River. She wasn't supposed to be there. Her grandmother told her never to go down by the river. She was wading in the river. She hurt her foot. It was very bad. She wasn't supposed to go down to the river. She wasn't supposed to go there. She was only five years old. She hurt her foot in the river."

Tears rolled down her cheeks. Her foot shook and her body shook. Her breathing shook as she whimpered. I continued to hold the place on the foot for over an hour. After the treatment, we discussed the long-forgotten injury.

Katya had *psychologically* dissociated from the injury so utterly that, even in her dozing memory of the event, she spoke about the injured child in the third person. She could not admit, in the beginning, even in her subconscious, that *she* was in fact the child with the injury. Consciously, as we spoke, she did recall the event. The faint but distinct scar where she had sliced her foot open was visible, in a good light, on the bottom of her foot. But her dissociation from her guilty secret was so complete that, even in her sleep-talking, she had attributed the entire event to "that" little girl. It is no wonder Katya's body had not been able to address that injury.

Little Katya had already learned to maintain a vise-like mental grip on her thoughts and emotions prior to the foot injury: at age three, she saw her father taken at gunpoint, at night, from the family home and killed in the street outside by army soldiers. Her mother had died violently at the hands of soldiers when she was two years older. She was then raised by her epileptic grandmother whose seizures terrified her and who she was careful not to disturb in any way for fear of bringing on an epileptic event.

Katya was a brilliant and talented woman who had overcome terrific obstacles in her life. Her ability to leave the past behind and keep her heart open, her "Russian soul," as she called it, was crucial to her success in her very rewarding life as a professional musician and conductor.

Over the next few months, Katya completely recovered from all her symptoms of rigidity, foot and leg numbness, and poverty of movement.

Katya *had* dissociated from her foot – a psychological dissociation from one body part. She had *not* dissociated from her overall ability to feel. She had *not* invoked biological dissociation to prevent her from feeling other somatic pain.

She was highly sensitive to heart-area responses, which helped her in performing her music work.

Hjalmar

Hjalmar, when asked about history of injury, whispered with pride, in his muffled PD voice, “I’ve never been hurt. Never!” During his intake interview, he had already told me that he’d served in the Navy for many years and had seen active duty in the Pacific during WW II. His nickname from his lumberjack days was ‘Give ‘Em Hell’ Hjalmar.

Hjalmar’s eyes twinkled with an L-dopa glow and allowed him a jaunty bearing despite his otherwise inexpressive face, his walker and his shuffle. I was endeared to him from the start. It seemed incredible to me that he had *never* been involved in some sort of horseplay or risky event that might have caused an injury.

He was sixty years old. He’d been diagnosed with Parkinson’s disease seventeen years earlier. His head was scrunched down on his torso and his hands were useless flapping fins. His voice, when available, was a gasping whisper. His right foot was a shapeless, purple-gray mass. His drug-induced overconfidence resulted in his general refusal to use his walker, so he shuffled along *without* it, falling down several times a day. His knees were at least twice as wide as healthy knees, the result of thousands of falls, which he always broke by dropping to his knees. “Nope,” he whuffed. “Never been hurt.”

This got my curiosity up. “No broken bones? No surgeries? No black eyes? No falling off a bicycle? Sprained ankle? Whiplash? Car accident? Tripping in a gopher hole? No one ever pulled a chair out from under you?”

1998 Christmas photo: heavily medicated, smiling as broadly as possible. Note hunched posture.



“Nope!” Proud defiance beamed forth from the twinkling, L-dopa drenched, eyes, which sat, ludicrously, in that utterly expressionless face.

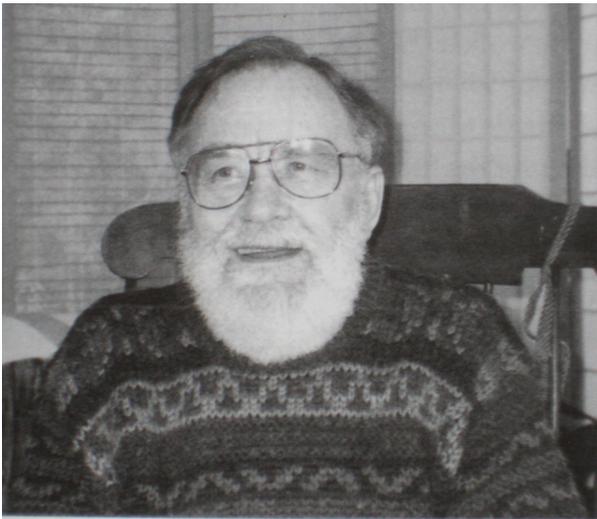
He was a Lutheran minister. His utter inability to smile was one of his earliest symptoms. His parents were actually relieved when they learned that he had Parkinson’s disease, and therefore wasn’t stony faced from depression: “We’re so glad it’s just PD. We’d feared you’d lost your faith.”

After the fourth session, as his shapeless, doughy foot began to respond to the FSR, he cleared his throat. “Now, when you asked about injury,” he whispered, “you might have been thinking about the time I got hurt when I was three years old. I forget exactly what the situation was, but my granddad was visiting. Maybe I took a pretty bad fall or something, because I remember my granddad put my arm in a sling. I don’t recall exactly what it was, I

think I hurt my arm and my shoulder, and maybe my leg and my foot. It must have been pretty bad for them to put my arm up like that.”

A few weeks later he recalled another severe foot injury from falling off a naval cruiser ladder with his foot caught in a rung. This injury had badly twisted his foot and ankle, but it had never hurt.

The next week, he reported that a few days after the most recent Yin Tui Na foot-holding treatment, a dark bruise had appeared on his right foot. But more interestingly, two bruises had appeared on his right arm as well. We conjectured that, when the foot injury got dislodged and released that ancient memory of injury, the body then spit on its hands, hauled up its slacks and decided to take care of the other injuries to the body that were lurking: a sort of package deal. At any rate, his rigid, flipper-like hand became much more flexible shortly after that visit, even as his foot began the long road back to health.



Hjalmar's childhood

Hjalmar was outgoing and chatty, but he stiffened perceptibly when I asked about his childhood. He told me there was nothing to talk about there. “I’ve come to terms with it,” is all he would say.

Hjalmar’s wife interrupted: “What about your mother?” She turned to me and continued, “Cold as ice. She was so cruel to those kids. We don’t even like to talk about it. But there’s a story there, if you want it!”

2001. (No longer medicated) Note the ability to smile. Improved posture: head is farther back, centered over the shoulders.

I never did probe for details. It was telling enough that my simple question, “How was your childhood?” evoked such a response. As I got to know them better, both Hjalmar and his wife alluded, many times, to the heartless “parenting techniques” that Hjalmar’s mother had enforced.

As I worked with Hjalmar over the next few years, observing him as he tried to reduce his antiparkinson’s medications, I concluded that he had been dissociated from his foot, but *not* from his over-all ability to feel.¹

The last time I visited Hjalmar, in 2005, in a nursing home, he cheerfully brought his hands together, prayer-fashion, and touched them to his forehead to greet me. His hands, previously useless “flippers,” came graciously up to his forehead in the traditional Hindu

¹ For more about this case, please see “The Use of Yin Tui Na and Stomach Channel Acupuncture Points in the Treatment of Facial Immobility in Parkinson’s Disease”; *Journal of Chinese Medicine*, (the peer-reviewed, “highest eagle” English language journal of Chinese medicine); Janice Walton-Hadlock; Vol. 69; June 2002; p. 43.

salute. He no longer had idiopathic Parkinson's disease, but his brain damage from decades of taking L-dopa left him unable to care for himself in many ways.¹

Norm

Although sometimes an injury is remembered, or partly remembered as with Hjalmar, the injury history just as frequently remains as a sealed book. Norm never did remember what he had done to his right foot that caused it to be rigid, unable to bend at the ankle or even the toes. He had never even thought that it was strange that his feet moved like robot feet, unflexing in any part.

He grew up in the Midwestern U.S. and he had run cross-country in school. He'd been very good at sports, so we concluded that his foot had probably not always been so rigid. But by the time he came to me, shortly after his diagnosis at age 48, there was no question that there was something strange about that foot. He guessed that the rigidity had come on slowly, through the years. His best guess remains that it was the high school broken ankle, sustained while running cross country, and which hadn't been a problem, which had caused his foot to become, to use his neat simile, "stiff as a board."

He did allow, "I don't think about my feet much. My feet hurt all the time, sure, but I try not to think about them. Feet aren't very nice, after all." It was the first time I had heard that feet weren't very nice, so that stuck with me, but later I wondered which came first, the injury, which caused him to conclude, eventually, that "Feet aren't very nice," or the idea of feet not being nice, so that when he hurt his foot he hadn't wanted to dwell on the injury. I never went deeply into this with him, but it was a curious sentiment coming from a golfer and tennis player whose feet had served him faithfully for so many years.

Norm came to Santa Cruz three times a year for treatment in our program. He stayed for a week each time. He was treated for at least two hours a day while he was here. It was three years before Norm's big toe suddenly was able to move, following a relaxation and startling rotation of his 1st metatarsal. A few days after that, another bone shifted and his second toe was able to move. A few days later, his entire foot could flex and extend.

During those three patient years, he continued to fly to Santa Cruz from across the country. I asked him if he was discouraged at how long it seemed to be taking. Those feet were the most rigid of any feet I've ever seen, before or since. In reply to my question, he said, "Waal, ah figure there's Plan A and there's Plan B. Y'all are Plan A. And there ain't no Plan B."

So Norm stuck it out. More than three years after he started coming to Santa Cruz, he could once again play tennis and go for long walks.

After his cement-like feet finally became flexible and pain-free, Norm continued to be severely disinterested in being able to feel or be aware of the rest of his body. He wanted his body to be functional, but he didn't want to have to think about its existence. He was adamant that he did not want to work on anything having to do with emotions.

Even though he regained his ability to walk and play tennis, his right arm tremor never did go away. When I asked him, many times, if he wanted to keep working with me to

¹For more about Hjalmar's experiences with drug reduction, a two-year battle that nearly killed him, please see *Medications of Parkinson's Disease or Once Upon a Pill* by Janice Walton-Hadlock. Find "Hjalmar" in the index. Available at www.pdrecovery.org.

see if he could get rid of the tremor, he always said, “No, I don’t need that arm. I use my left arm now.” He refused to discuss the matter.

After he was once again playing golf and tennis, I asked him, on his way out of my office, to use his trembling right hand to carry the small airline pillow that he always brought with him. He was somewhat puzzled by the request. As soon as I put the pillow in his right hand, he transferred it to the left hand. I asked him to put it back in his right hand. He did so, but within moments it was back in his left. I asked him to concentrate hard on holding the little pillow in his right hand. He found it amusing that he didn’t seem to be able to leave it in his right hand.

He tried very hard to keep the pillow in his right hand, but it was hard for him to simultaneously walk and hold the pillow in his right hand. Still holding the pillow in his right, he got out the doorway of my office with *great difficulty* and approached the few stairs that lead down to the parking area. He was baffled by the stairs. He turned to me, pillow in right hand, and asked me in all seriousness, “What am I supposed to do?”

I told him that he was supposed to go down the stairs. He asked, “How?”

Remember, he was once again playing tennis. Movement, including stairs, was *not* a problem for him – so long as his trembling right arm could be ignored.

I told him to just go down the stairs one at a time. This problem with stairs was utterly unexpected. He stood at the top of the landing. Slowly, with his wife’s help, he negotiated a few steps. After several steps, he was breathing hard and sweating, and looking desperate. He switched the pillow to his left hand and easily finished going down the steps.

When he got to the bottom of the steps, I asked him to please put the pillow back in his right hand until he got in the car. He did so, and approached the car. He got to the door of the car and again became baffled. He had no idea what to do next.

I told him to open the car door. He looked painfully confused. He started to reach for the car door with his left hand – the hand that he’d been using for several years now – but with the pillow in his right hand, he couldn’t figure out how to simultaneously push the door handle release and also pull the door open. He struggled with the door for several seconds, then gave up: he put the pillow in his left hand and, with his left hand, opened the car door.

I asked him to put the pillow back in his right hand after he got the car door open. With the pillow in his right hand, he could not figure out how to get into the car.

After that, I never met with him again. His wife emailed me several times: his right arm tremor continued to get worse, to the point that it seemed as if his right hand was shaking his whole body. He sent his love, but he did not want to do anything that might involve working on emotions having to do with his right arm.

The last I heard, he decided to try antiparkinson’s medications to help with the tremor. He tried all of the various drugs, and none of them helped. Just the opposite. They rapidly made the tremor *worse*. After experimenting with various agonists and L-dopa, his tremor became a monster: violent dyskinesia rather than tremor. He had gotten no relief from the drugs; instead, they made him violently dyskinetic within a matter of days. When he quickly stopped taking them, his symptoms of tremor became impossibly violent.

As an aside, this violent agitation in response to having taken the drugs is a common adverse effect, once the Parkinson’s patient’s injuries are gone. This suggests that there are

chemical differences in the brain between injury-induced Parkinson's, which allows a person to somewhat safely take the medication, and purely mind-induced Parkinson's, which Norm still had.

For more on this subject, please read *Awakenings*, by Oliver Sacks. This book describes some of the shocking, excruciating symptoms, including violent super-tremor and even fatalities that developed in patients in the early days of L-dopa research. These unbelievably violent symptoms started when a person took the drug, and *worsened* when the person *stopped* taking it. Many of Sacks's colleagues condemned him and refused to believe that the physical atrocities described in his reports could even exist – until they saw actual video footage of these patients. In my book *Medications of Parkinson's, or Once Upon a Pill*, I describe symptoms that developed in my recovering, medicated PD patients that exactly matched the “impossible” symptoms that that Sacks had described.

In all the years that I knew Norm, with his gentle, loving smile and his gentle, polite drawl, his response to my medical inquiry, “How are you feeling today?” was always the same: “I don't know. I never really think about how I'm feeling.” Probing with more specific questions could never elicit any answer other than “I'm fine” or “I don't know.” Norm's wife used to laugh, “Don't ask him how he's feeling. He never knows what to say!”

Norm was supremely disinterested in learning how to feel or be aware of his right arm. More accurately, he *feared* such feeling and awareness. Although his structural symptoms of Parkinson's rapidly evaporated after his foot recovered, Norm's fear, tremoring, and dissociation from his right arm – and from the ability to *feel* his body – continued to worsen.

With what I know now, I can say that Norm had both a foot injury and a body-wide dissociation from being able to feel. When the foot injury healed, many of his symptoms went away, but the tremor and uselessness of his right arm remained.

This pattern, in which tremor remains even after many Parkinson's symptoms disappear, is extremely common in those who have both a foot injury and a body-wide dissociation from feeling, after the foot injury is healed. We refer to these patients as having partially recovered. A more technical diagnosis would be that their idiopathic Parkinson's is gone, but psychogenic parkinsonism remains.

As an aside, I eventually discovered that many of my Parkinson's patients, if asked to imagine their body, or imagine their body filled with light, are only able to mentally construct some portion of their body. Sometimes an arm or leg or one side of the body is missing. Just as often, the entire body is dark. Any attempt to mentally fill the body with light may be met with feelings of revulsion, fear, or utter refusal on the part of the imagination.

I had to wonder if a person who has actually *lost* a limb but who still, now and then, imagines using the limb or who feels phantom pain in the missing limb is a mentally more complete person than a person who, terrified of acknowledging a body part, lives in ever-increasing fear of that body part or fear of pain, or dissociates from the sensations of his body.

The former still has a complete body image; his consciousness is healthy even though the physical limb is lacking. The latter has an unhealthy consciousness: his conscious mind can only perceive his body or some part of his body as if it is standing outside himself. He is

terrifyingly incomplete – even though his *subconscious* mind must know that he *does* have a body, and probably also knows that his body is still wracked with pain from some unhealed injury.

Norm had dissociated from his foot. He had *also* dissociated from his ability to feel any physical or emotional pain, and was positively hostile towards the idea of acknowledging the presence of his right arm. Although he recovered from many of his symptoms when his foot healed, he was disgusted by the idea of feeling his body, or even imagining light in his body. So far as I know, he never recovered from his increasingly violent tremor.

Gabriella

I had been holding Gabriella's foot once a week for an hour, for about three months. Her previously numb foot had already gone from pale purple gray to a nice pink. She'd had horrible pains in her feet when feeling first returned to them. She said it felt as if "every time I've ever walked barefoot over sharp rocks, showing off that I didn't feel anything, well, now I'm feeling every one of those rocks."

I was holding her foot when she started having excruciating pain half-way down her tibia (the bone on the front part of the lower leg). Within a day after the tibia pain began, it was crippling. She was unable to walk. Pain pills didn't touch it. After two weeks of her calling me every day, screaming into the phone that she was in agony, it suddenly occurred to me that she must have broken her leg. I asked her to go to the hospital and have it X-rayed.

Sure enough, the tibia was broken clear through and displaced. The radiologist told her, "You should have come in two weeks ago, when you broke it." He told her that two weeks worth of healing had already occurred at the broken ends.

Gabriella told him that if it was broken, she had broken it seven years ago. Seven years ago, she had been carrying her baby while hurrying across a busy thoroughfare, dodging traffic. She suddenly saw that she was about to be hit by a bus. She had made a flying leap to the sidewalk and just missed: her leg, right at the point of the broken bone, had crashed into the curb. The baby had flown from her grip and landed in the shrubbery. Stenders-by had asked if she was OK. Of course she was OK. She certainly wasn't hurt.

The radiologist told her, "You're crazy. There is no way you could have been walking around on a broken leg for seven years." That radiologist was wrong. I've since known several people with Parkinson's with still-broken bones who've been unaware of the break until they started being able to feel.

It might be significant that, when Gabriella was four years old, her parents decided to get a divorce. Rather than subject Gabriella to the emotional strain of the divorce, they sent her away with no explanation. She had cried about something just before her parents had told her that she needed to go away. She'd assumed that the crying was the reason that her parents put her on the first airplane ride of her life, at age four. The flight took her, unaccompanied, to California, to live for many years with her grandmother, whom she had never met. Gabriella told me that, on the plane ride, she had made a solemn vow to herself that she would never cry again. She'd kept her vow – until starting to work with me.

About a month after arriving in California, four year-old Gabriella was playing in grandmother's back yard. A heavy cement table fell down on her foot. She kept her secret promise. She never cried. Almost thirty years later, I was working with Gabriella's foot injury: an injury consistent with a foot being smashed by a cement table. Soon after the foot

began to experience terrible pain, eliciting screams of fear and agony from Gabriella, she also began to experience her more recent tibial fracture.

When I first met her, Gabriella's PD symptoms were mild, except for her tremor. Most people with PD find that their tremors stop when they fall asleep. But Gabriella sometimes tremored even while sleeping, during her dreams. Her husband complained that he was regularly awakened by what he thought must be an earthquake, but it was only Gabriella, trembling in her dreams.

As an aside, Gabriella was a horse trainer. Three of my first fifty PD patients were horse trainers. I do not live in a particularly horsey area, so these numbers are somewhat curious. These three each said that they got along better with horses than with people. Also, they told me they were not afraid to punch an ornery horse in the ribs if it lashed out with teeth or hooves. "If a horse kicks me, I punch him back. It's just playful. It doesn't hurt. We get along," were typical remarks from these wranglers.

I ran into Gabriella at the grocery store ten years after she had recovered feeling in her foot and leg – and her PD symptoms had simultaneously faded away. She'd had no return of her Parkinson's symptoms. She's still working with horses.

She had been dissociated from her foot injury. She had also been using dissociation since age four, to prevent crying or feeling any physical or emotional pain.

She recovered from both.

She had never taken any antiparkinson's medications.

Chuck

After working with a few dozen people with PD, I thought I had seen feet in every stage of deformity, discoloration, and distortion. But Chuck's right foot was ghastly. When he was six years old, his right foot had been chopped off by a hay mower and then sewn back on. Fortunately the doctors had sewn it back on quickly enough so that the tissues and toes had all survived. The foot had been clumsily reattached in a pair of surgeries that would be considered primitive by today's standards.

After it seemed like the re-attached foot would survive, the doctors did a second surgery. In hopes of giving the foot some flexibility, surgeons harvested tendons from the *good* foot, the *left* foot. They had taken whopping big skin and muscle grafts from his good, *left* leg. When I met Chuck, both of his legs and feet were rigid. Scars seemed to be everywhere on both feet and both legs.

When I met him, Chuck's right leg was an inch and a half shorter than the left; he used an elevated shoe. With the limping and poor surgical alignment, his foot had become increasingly distorted through the years. When I saw him first he was fifty-nine, ten years after his diagnosis with Parkinson's disease. His foot stuck out to the side at a sharp angle; he was using what should have been the proximal (closer to the heel) part of the arch of his foot for bearing the weight that should have been borne by the ball of the foot, to the extent that it was hugely callused; and the outer ankle bone was rotated so that it was at the front of the ankle instead of on the side. The bones had grown into their new positions. His foot had the flexibility of granite.

He hadn't let the injured foot slow him down; one of his favorite pastimes, before the PD, had been hiking. Why not? He had no feeling in his feet so hiking wasn't a problem.

The flow of Stomach channel Qi through the right foot seemed nonexistent. The toes were purplish grey. Some weight-bearing parts of the foot were bright red, as if mildly inflamed. He had no feeling in either of his feet. The Qi in *both* his legs was running backwards. The Qi flow in the left was, if anything, even worse than the right. His Parkinson's symptoms had started and were worse on his left side, his "good" side, the side with the tendon extractions. The right foot was "worse" because it had been usable only as a "flipper" for nearly 53 years.

I had never before been confronted with anything on this scale of physical and energetic distortion.

After more than a year of one-hour-per-week free Tui Na treatments, his right foot no longer jutted to the side. The ball of the foot was weight bearing, and sensation was returning to his toes. After nearly two years, his right foot was nearly correctly shaped and could bear weight in the normal fashion, including on the newly formed callus at the ball of the foot. The callus in the arch was melting away. The bones were reshaping themselves, as evidenced by their obvious changes under the skin. He had recovered sensation in all five toes of the hay mower foot, the skin had good color and even the grafted areas had changed from blue-gray to pink.

To westerners, this sort of rejuvenation may seem impossible. But the electrical patterns that flow just under the skin are connected to the electrical patterns that flow over every cell in the body. The electrical flow over each cell directs the DNA expression in each cell – telling the cell what type of cell it should be, how it should relate to its neighboring cells, and what sort of chemistry it should perform. The channel Qi flow over each embryonic cells determines the DNA expression in the developing organism. As the organism grows very large, billions of iterations of the cellular patterns create and sustain the very large, under-the-skin flow patterns that can be detected by hand.

When my patient's feet began having normal channel Qi flowing over them, and normal cellular electrical instructions deriving from the larger channel instructions, the cells in the foot began behaving appropriately: the bones were slowly reshaping themselves, the tendons and muscles realigning themselves into healthy positions. Bones are always being disassembled and put back together.

Although the body does this work with one calcium atom at a time, over the course of a year, every bone has been essentially rebuilt. The building occurs according to that moment's instructions coming from the electrical patterns on the cell walls. As an example, the random bone deposits that occur in osteoporosis (degenerative, or "old age" arthritis) come about when the energy flow is diminished in the vicinity of the affected joints. With fewer instructions as to the correct placement of the calcium deposits, the new bones gets laid down in a somewhat random manner – creating the painful irregularities seen in arthritic joints.

Getting back to Chuck, Qi started moving correctly over the surface of his feet after less than a year, and motor function in the foot improved accordingly. But sensory nerves in the foot were slower to recover. It was nearly two years before *he* could feel the sensation of electrical current moving through his toe in response to a needle on the jaw at acupoint ST-6.

Chuck regained smoothness of movement and finesse in his left hand. He also regained the ability to smile, a matter of great importance to his six-year old granddaughter.

One point in his case that interested me greatly was that his *left* side was the side that first developed symptoms of Parkinson's. His *right* foot was the one that had been cut off and sewn back on.

Chuck's Parkinson's disease developed on his left side. His severed foot was on his right side. The grafted skin and tendons used in the two repair surgeries had been removed from his left side. Chuck was able to cognize his *right* leg and foot. He had *no* proprioceptive awareness of or ability to imagine his *left* foot and leg.

Chuck had received an enormous amount of love and support after his foot accident. He had been told to be brave and not cry when he had the two subsequent surgeries that mutilated his *left* leg and foot while harvesting skin, muscle, tendons and ligaments. It was his *left* side that he could not bring himself to visualize.

Although *many* of his symptoms diminished, he was unable to significantly reduce his medications. He soon developed symptoms of drug-induced parkinsonism as well as symptoms of severe over-medication.

Chuck had dissociated from his left leg, possibly because of the surgery. He remained dissociated from his left leg, and was unable to be interested in restoring awareness of it.¹

Rebecca

Most of my patients' injuries are less shocking and less obviously traumatic than Chuck's. For some reason I am always drawn to Rebecca's story; Rebecca was just so sweet. She initially had no recall of any foot injury, but during our first session, as I was holding her foot, she drifted off into a sort of reverie and began telling me about her childhood, and, it turns out, her injury.

"My mother had seizures," she told me, "and, you know, I think I was born knowing that I couldn't make loud noises or do anything that might startle Mother. They tell me I was a perfectly behaved little girl, and that it's a good thing, too; any sort of noise might trigger one of Mother's seizures. I was always able to behave, and I never made noise."

At this point, her voice grew softer, and as I continued holding her foot, she continued her story. "I remember it so well now. I remember exactly what I was wearing. It was a green and white striped skirt. I was wearing a white blouse with buttons down the front and a Peter Pan collar. My hair was cut in bangs, straight across the front. I can picture that green and white skirt like it was right here.

"I can just see myself, that day, playing at jumping back and forth over the railroad tracks that ran by, not too far from our house. I wasn't ever supposed to go play by the railroad tracks. So of course, I did.

"I was five years old. I was jumping back and forth, back and forth. And one time, when I was jumping, I missed, somehow, and instead of landing on the bottom of my foot, I came down on the top of my foot. The front of my toes stubbed under and my foot bent right double under me, and my full weight came down on my bent foot so that I was standing on the top side of my toes and top part of the foot instead of the bottom of the foot.

¹ For more about this case, please see "Parkinson's Disease from TCM/Channel Theory perspective: Theory and Case Study"; *California Journal of Oriental Medicine*; Janice Walton-Hadlock, Vol. 12, No. 1, Winter 2001; p. 8

“That foot was bent right double. You wouldn’t think a foot could bend like that, or that a little girl could hurt her foot so badly and not cry, but I always knew not to cry or make noise. Especially if I was doin’ somethin’ I shouldn’t...”

Rebecca had been dissociated from her foot injury. Whether or not she was also dissociated from her ability to feel, I shall never know. She was taking medications, and as soon as she regained feeling in her foot, she began suffering dire effects of severe overmedication and never returned to the clinic.

If a person no longer has a dissociation-type electrical pattern running through his body, the dopamine-enhancing drugs are *ferociously* addictive, and cause very rapid brain change.

Lila

Sometimes, only rarely, in my experience, the injury is almost imperceptible except to a very experienced touch. The cause may remain unknown, as might the emotional reason for the failure to heal.

Lila was a forty-eight year old yoga teacher. She was devoted to healthful habits and yoga exercise, so it seemed strange to her that she was having trouble holding her arms in certain postures, and even lately having trouble getting up off the floor. All her adult life she had worked at keeping every part of her body flexible.

She said that, lately, it was almost as if she couldn’t think of what muscles to use when the time came to get up off the floor.

She did not yet have a diagnosis of PD, nor did I give her one. Instead, after learning about her main symptoms, I asked if she had tremor in her hand. She was a little surprised, but admitted that lately, when she held her arm up to her nose, in certain yoga postures, her right index finger tremored.

She must have thought I was asking random questions when I asked her my usual PD intake inquiries.

Yes, her voice had been getting fainter and raspier, even though she sang weekly in a choir: she was starting to cut back on the solo work due to unpredictable vocal hoarseness. She assumed that, at forty-eight, her voice change was due to aging. I let her keep thinking that. (Four years later, I attended a memorial service at which she did all the solo singing. Her voice had returned.)

Depression? Yes, despite her daily meditations and her wonderful life she was fighting to keep at bay a deepening depression.

I could see that her cheek muscles hung down limply on the right side of her face, making the characteristic PD line along the side of the nose and lips that appears when the ball-of-the-cheek muscles stop functioning.

A quick exam showed me that Qi was running backwards in her right leg.

Unlike most of my patients, her feet appeared to have no flex or extension limitations whatsoever. I could not imagine that there was an injury lurking inside her graceful right foot even though she had early, but classic, signs of Parkinson’s on the right side of her body. However, despite the apparent health of the foot, I held it at the center of the arch, near

acupoint ST-42 for an hour each week for several weeks. I told her only that I was treating the backwards-flowing Qi in her leg.

Despite no obvious sign of injury or a palpable sense of chaotic Qi in the vicinity of ST-42, after several sessions I felt the characteristic static electricity release given off when an injury is present and *acknowledged*, followed by almost imperceptible shaking and vibrating in the foot. At that point, I had a palpable sense that something small, round, shadowy and viscous, about the size of a large pea, was inside the foot at ST-42. Whatever it was, it felt as if it was dissipating as I kept holding the foot.

Next, the bones felt as if they were moving in little circles, as if they were unwinding. If I had to guess, I might say that it was fascia tissue responding to a relaxation of micro-muscle in the area. Nothing was overtly displaced, but some tissue or energy was moving in that foot in response to the firm, nearly motionless holding technique of Forceless, Spontaneous Release (FSR), the style of Yin Tui Na that I use on all my PD patients.¹

During the next few weeks, her right foot became quite painful. She saw an orthopedic doctor who told her that she probably had sesamoid bones (little granular bone bits that sometimes form “spontaneously”) in her foot. He assured her that she would be in pain for the rest of her life. He suggested orthotic support devices for her shoes and told her to avoid walking uphill for the rest of her life.

When I saw her again, the next week, she asked me with some heat, “What, I can walk downhill but never uphill? What sort of nonsense is that? How am I supposed to walk downhill if I can’t walk back by going uphill? Should I find trails and paths that go down but not up? I should restrict myself to flatlands for the rest of my life? That’s ridiculous!”

Since she was one of the patients that did not have a diagnosis, I couldn’t tell her that she was experiencing the classic symptoms of recovery from Parkinson’s, or refer her to my book describing the recovery symptoms. Instead, I merely told her that I’d noticed some tension in her foot that had released, and that possibly there had been an old injury at that site.

¹ I am often asked if I have heard about the newest or latest light-touch therapies. I am familiar with many of the types of light-touch therapies, including “unwinding” – which might be used to describe what happened in Lila’s foot. However, I was not using any special “unwinding technique.” I merely used the word “unwind” in trying to explain Lila’s response to the treatments.

I am intentionally not referring to many particular “named” therapies in this book. Nearly all of the light-touch therapies are based on the exact same principles, even though their “discoverers” create special vocabulary and sometimes even insist that they have “invented” some aspect of gentle support. Also, these “discoverers” sometimes teach the student to be focused narrowly on a particular location or type of tissue that the discoverer has found to be “the key to nearly all problems,” thus preventing their techniques from having an adaptive universality. I prefer to keep the theory more generalized and adapt various supportive holding methods to the needs of the patient. Ultimately, all of the light-touch techniques use the exact same principles.

I have to wonder, what sickness have we incorporated into our society that we need to take classes to learn how to gently hold and support a person who has been injured? All of the light-touch techniques are just stylized forms of firm hugs or gentle “tickles (such as used in Bowen therapy),” similar to the grooming, holding, and licking that “dumb” animals do for themselves and each other. By giving a technique a name, we make it “medical,” and therefore socially acceptable, I suppose. But this process also makes these techniques the domain of those who have the “Special Training.” The truth is, we all have an inherent knowledge of how to do these “newly invented” techniques of supportive holding.

The place where I had been holding was the place that now hurt, after all. I suggested that the pain would go away as soon as the injury healed completely. I asked her to stay in touch and come again in a few weeks.

The pain did subside after three weeks. Her symptoms that had matched the symptoms of early Parkinson's disease began to ease up quickly and then disappeared.

She never had any idea how she had hurt her foot. Her foot had never appeared to be physically impeded in any way. But backward Qi flow originating at ST-42, an acupoint on the mid-foot, had been flowing up her leg, and there had been an unmistakable release of energy and static, characteristics of injury release, from the center of her foot during her treatment.

Lila's case is an important one, for it demonstrates that the bones may be in what appears to be their correct positioning even though some element of retained injury remains in fascia, micro-muscle, or tendons. It is also important because Lila recalled a contented childhood and parents who were supportive and attentive. Lila never remembered any fearful event associated with a foot injury or any reason for inhibiting her pain, although she clearly had had a foot injury at some point and it had failed to heal. She recovered easily, with no emotional outbreaks or any behaviors to suggest that she'd been harboring any body-wide dissociation.

An aside: using physical movement therapies to treat Parkinson's

Her case is also extremely significant because some people who have "spontaneously recovered" from Parkinson's have attributed their recovery to yoga, or Tai Ji, or Qi Gong, or various exercise modalities. And yet, I have worked with people who *teach* yoga, Tai Ji, or Qi Gong who have, nevertheless, developed Parkinson's disease despite years of teaching these classes.

From what I can gather, it's *not* the physical movements of these workouts that prevents or heals Parkinson's. Rather, it's the degree to which the person works at *perceiving* what's happening in his body while he *does* his daily movement drills.

A person who performs what *looks* like perfect Qi Gong, or perfect yoga postures, who is not *feeling via his heart* the sensations in his activated body parts – sensations that should resonate with the heart area, is *not* doing the exercises correctly. In order to perform the essence of any of these Asian movement techniques, one must be focused on the sensations that arise within the body in response to the movements, and enjoy how those sensations resonate with the heart.

If one can learn to do that, then any of these movement practices might serve as a vehicle for recovery from Parkinson's disease, because they all instruct a person to bring his consciousness to various parts of the body, in turn. Oppositely, if one has no idea what I'm talking about in the above paragraph, it might be very difficult for him to recover via one of the movement-related practices, no matter how accurately he performs the postures.

In the case of one woman who wrote up a website because she spontaneously recovered from Parkinson's after taking up Qi Gong *and* having some psychological breakthroughs, she wrote on her website that, after her Parkinson's started going away, she felt pain from a painful foot injury that she had received years earlier, and which she had never taken care of because it hadn't hurt at the time.

She noted that, now that she could feel the pain, she was nurturing the foot, and taking care of it as she should have done at the time of injury. She had greatly enjoyed learning Qi Gong, during the practice of which she learned to focus on how energy *felt* as it moved through various parts of her body. She was not familiar with our work, but her experience supports our findings. She did *not* take up Qi Gong in order to recover from Parkinson's. She took it up because it struck her fancy. And then she “accidentally” recovered.

I suspect that her PD was of the foot-injury type, and not the body-wide dissociation type:

If she'd had the body-wide dissociation type, it might have been extremely unpleasant, or even impossible, to learn to *feel* the energy moving through her body during her Qi Gong practice.

In my own case, I had been doing daily Qi Gong-type exercises for over twenty years – exercises that came with explicit instructions to “move each body part with conscious will, while *feeling* the energy and light in the body part.” I'd been doing that exercise sequence for decades and assumed I was doing it correctly. And all the while, unbeknownst to me, my pre-Parkinson's condition was building up.

Only after I recovered from Parkinson's did I realize that my understanding of “*feel* the body part” had been faulty. I hadn't been feeling it at all – at least not with my heart. I had paid *mental* attention to my body's energy. But I had never “felt” it – never felt it resonate with my heart.

I was stunned, after recovering, when the exact same movements that I'd always done were now accompanied by an entirely new *sensations*.

I suspect that anyone who recovers from PD via Tai Ji, Hatha Yoga, Qi Gong, or any of the movement-based energy awareness systems probably had only a local dissociation from an injury, and *not* the body wide dissociation from the ability to experience somatic feeling.

Again, I know of many people who have gone through the motions of doing these exercises for years – all the while developing Parkinson's disease.

Jake

Jake's situation was the opposite of Lila's. Lila's injury was very subtle. Jake had a history of broken bones, concussions, deep scars: a good sampling of the various injuries that can occur to a person who races motorcycles cross-country.

Jake was only thirty five years old when he came to see us. His face was an expressionless mask. His body was rigid and his voice was a soft monotone.

The Qi in Jake's Stomach channels, in his legs, ran backwards. The Qi that should have been running down his back was nearly impossible to feel. The Qi that should have swept over his head, to his back, and then down to his feet, was running for a few inches in one channel, hitting a band of scar tissue from the stitching up of one of his three very serious head injuries, shunting into a different channel altogether, and then zigzagging over his head into his ears and disappearing into his neck instead of flowing down his back. Qi from another channel on his head, which should have been coming up from his back, was missing

altogether. *None* of the currents on his body were running correctly, or even running more than a few inches before being diverted by electrically impassible bands of scar tissue.

He had thick wedges and thin strips of scar tissue, many from scars that had been surgically stitched up. He had scars on his legs, his arms, his torso, and his head.

Merely holding his feet was not going to get anywhere with him. Even if he had *not* been dissociated from his feet or his ability to feel, his channel Qi would not have been able to flow normally past his collection of scars.

Scar tissue, like rubber, is non-conductive. When channel Qi meets impassible scar tissue, it might run laterally (alongside the scar) until it can flow into another channel. It may dive deep, traveling under the scar and reappearing downstream from the scar, leaving a numb area between the scar and the site of reappearance. Or the channel Qi may dive deep into the muscle layers, never resurfacing, leaving a *substantial* expanse of skin with almost no current. Like rivers and electricity, channel Qi follows the path of least resistance. Scars create terrific resistance.

Jake was a young man with tremendous zest and dynamism, but his lack of a functional electrical system was destroying him.

Before we could even begin working on his feet, every one of his scars was perforated with acupuncture needles. Only after we had created electrically-porous openings in his scar tissue, so that channel Qi might *potentially* flow in the right pathways, did we start gently trying to bring his attention to his feet.

I tested for potential flow by using gold and silver needles. The voltage differential between the gold and the silver will create a small battery effect – a current will flow from the gold towards the silver *if* there is no non-conductive impediment or zone of non-conductivity. *If*, after needling, the gold and silver were able to generate a current that flowed *through* the scar area, then the channel Qi could *potentially* flow. Then he could be treated with Tui Na to bring his consciousness to the area. But if the gold and silver needles placed on opposite sides of the scar were not able yet able to generate an electrical flow through the scar, then he needed more acupuncture in the scar.¹

During his two weeks of being treated twice a day by someone on the PD Team, first with acupuncture, and then with Yin Tui Na on his feet, neck, head, arms, and a few other damaged body parts, Jake's wife observed the gradual return of his facial expression and the budding return of fluidity in his movement. After these two weeks, he had to return home, where his wife planned to continue treating him with Yin Tui Na.

He had not yet decided if or how he was going to deal with his body-wide dissociation from pain, which might have started when he was agonizingly miserable after being sent off to boarding school when he was a young lad. Even so, at least he now had *some* channels on his body that were once again able to flow correctly. Overall, he was physically moving better than before, and he was showing facial expression again.

He had never taken antiparkinson's medications.

¹ For instructions and theory on needling scar tissue – why, when, and how – please see chapters 12 and 13 in the acupuncture textbook *Tracking the Dragon*, Janice Walton-Hadlock, available at www.pdrecovery.org.

I've included this case because sometimes a person *does* need more than just foot holding or a change in heart-attitude. Sometimes a person with Parkinson's has injuries, in addition to foot injuries, that must be attended to by a professional. *Substantial* physical impediments, usually in the form of scar tissue or titanium repair plates, can sometimes prevent the correct flow of channel Qi, and should be treated, if possible.

Of course, it can sometimes be difficult to convince a doctor to remove surgical repair plates, even if the area with the metal is a source of constant tension, pain, torque, or aberrant channel Qi. But scar tissue that is preventing the free flow of channel Qi is a very treatable condition.

Gus

Two years after he was diagnosed, Gus came to the free PD clinic (1998 to 2002) at the local acupuncture college. Gus was treated by Doreen, an acupuncture student.

Gus was 78 years old. We asked him about any history of foot injury, but he had no idea of if, when, or how he might have hurt his foot. During his first treatment session, he wondered out loud what he might have done.

During his second session, while Doreen was holding his foot, he suddenly said, "Ouch! I dropped an ammunition box on my foot right at that spot. It was during the war." He didn't say any more about it.

During the next session, he mentioned the war injury again. Then he started shaking: not in a Parkinson's disease tremoring way, but like someone who is severely chilled. Then his head started to hurt and his stomach was in terrible pain. He asked her to stop working on his foot. He felt nauseous. He began to panic. He lunged up from the treatment table, shaking violently and holding his stomach. There was a look of horror in his eyes. He lurched to the front office and telephoned his wife to come pick him up immediately. After she arrived, he sat for a while in the outer office, clutching his stomach and shaking violently, trying to steady himself enough to walk to the car. He was terrified.

He called Doreen the next day and said that the dizziness, nausea and shaking was getting worse. He didn't think he could come back. Doreen was concerned and called him each day to follow up.

Finally, after several days had passed, he told her over the phone about his foot injury. That day in Japan, during WWII, when he'd dropped the ammunition box on his foot, was the day every single person in his platoon had died except for him. He had been left for dead. He had never talked about it, not even with his wife. He never thought about it. He had not remembered it since the day he was rescued. He didn't want to remember. He couldn't bear to remember. As the sensations in his foot, triggered by Doreen's work, came to the surface, they were accompanied by the heart-searing memories of that fateful day. He thought he would die from the pain and fear.

Over the next two weeks, he discussed his future options with Doreen. He never shared details of the war events. He wanted to know what he could do to stop the memories that were daily overwhelming him. He was *not* afraid of worsening Parkinson's disease. He was afraid that he would keep remembering more and more details. He came to a decision: he would rather have Parkinson's than risk bringing up any more memories. "I'm old," he told

Doreen. “I was only diagnosed two years ago. I may not live too long, and my Parkinson’s is pretty mild. I would rather have the tremor and the stiffness and go out that way. I’d rather live with Parkinson’s than live the last years of my life not being able to escape from the war. My only fear is that, now that you’ve opened that door, I won’t be able to shut it.”

He and Doreen agreed that he had a better chance at re-closing the door to his war-time memories if he did not seek further treatment for his Parkinson's disease.

We heard from him a few years later. His Parkinson’s was worsening *very* slowly. He was taking a very low dose of antiparkinson’s medications but he was already having side effects from the medication: On-Offs, with violent dyskinesia and mindless euphoria during the Ons. He didn’t say anything about his war memories. Because he no longer had a foot injury, he could no longer handle the medications.

Gus had dissociated from his foot injury, and from all his memories of that fateful day in Japan. In this case, his dissociations were *psychological* dissociations – the separation of certain thoughts away from normal consciousness. His actual Parkinson’s symptoms were extremely mild, and he was already in his late seventies when they appeared.

When awareness of his foot injury was restored, via Tui Na therapy, awareness of the war horrors was also restored. Gus had in no way dissociated from his ability to feel, in general. He was a jolly, almost goofy sort of fellow, a real sweetheart. He was not a cerebral type, but was a very warm hearted, “good egg.”

He had never dissociated from his *overall* ability to feel, but he had blocked out all memory of the *day* he’d hurt his foot. Very possibly, if his platoon had not been attacked that day, he would not have dissociated from his foot injury at all. He didn’t seem like the typical Parkinson’s personality.

Victoria

Victoria had feet that were rigid, and the Qi was missing in her feet and running backwards in the Stomach channel in her legs. The right side was slightly worse than the left, and her symptoms were mostly on her right side.

After an hour of holding her feet, they would relax and flex normally. The channel Qi would flow correctly in her Stomach channel. A week later, the feet would be rigid again, and the Qi running backwards.

After many months, during which she felt much better for a day or two after a treatment but then her symptoms returned and over the months, steadily worsened, she happened to tell me about her decision, at age nine, to feel no pain. I had already asked her many times about emotional triggers, and she had always said she was “fine” in that regard.

This time, she mentioned that, at age nine, she had been sent off to summer camp for the entire summer. Unbeknownst to her, her mother was dying of cancer. When she returned from summer camp, her mother was gone. An aunt told her, “Your mother died while you were gone. We all hope you aren’t going to make a scene about this. You are old enough to behave rationally.”

She had felt completely overwhelmed, and decided then and there to show no response to her emotional pain. She told herself to be numb, and she remained unsusceptible to her own emotions ever since. When I met her, fifty-five years later, she admitted that she was unable to feel her own emotions. She was very compassionate, very giving, very

sensitive to the feelings of *others*, and very well loved by her family and friends. She was extremely intelligent and capable. But she was utterly unable to feel anything in her chest that resembled the *sensations* of expansion that come with relaxation or the contraction that comes in response to love or fear, respectively.

I saw her on and off a few times over a few years. She was never able to alter her decision to be numb to pain, a decision that she had long forgotten, and which she only remembered during one foot-holding treatment during which she was profoundly relaxed. She insisted that her emotional stance – of which she was proud – should not have anything to do with her symptoms. She also saw no benefit in learning to *feel* her own emotions, after so many decades of being strong by virtue of not feeling them.

Her symptoms continued to slowly, steadily worsen over the next few years, which is normal with Parkinson’s disease. She eventually stopped coming to see me.

Eleanor

Eleanor was in a similar situation.

When she was six years old, she lost four close relatives – all to heart attacks. She remembers deciding that having a heart was “a dangerous thing.” She decided to “not have a heart.”

“It’s curious – when I was in grade school, I was often told that I was heartless, because I was never emotionally moved by things in the way that the other children were. When the other children said I was heartless, I always wondered how they knew, because of course I had never told anyone that I had decided to not have a heart.”

This patient, like Victoria, was extremely intelligent – and absolutely unable to understand why “turning the heart back on” might be a good thing. Her only bothersome symptom was a tremor. Her arm and leg rigidity was mild. She wasn’t concerned about her moderately mask-like face. As far as Eleanor was concerned, she had lived a very successful life, in part, by virtue of being unaffected by the emotionalisms that destroyed the happiness of most of the people she knew. She’d also been very upright and intelligent.

She was proud of her stoicism, and if tremor was the price to pay for her toughness, then she would welcome the tremor.

A few years later, as her symptoms continued to worsen, she did return for a few treatments from other PD Team members, but in the end, was unable to see her way to changing her long-held determination to have no heart.

Hannah

After Hannah’s husband of sixty-two years passed away from cancer, Hannah went into mild shock. She had been in complete denial the whole time he was fighting cancer. “He can’t die,” was her simple statement. She was very meek, and had devoted her whole married life to being an unquestioning servant to her mean-tempered husband. Aside from some arthritis in her hip and old age-type high blood pressure, she was perfectly healthy.

Two days after his memorial, to her surprise, Hannah was unable to get up out of a chair without assistance. Her body was hunched severely forward. When she tried to walk, her feet stuck to the floor. She tremored, she had only a hoarse whisper of a voice, her face was an emotionless mask, and her limbs were rigid.

Her daughter asked for advice. I offered her information from my book about Parkinson's medications. The specific material I gave her explains how to ease the symptoms of short-term dopamine insufficiency, symptoms that occur during drug withdrawal from dopamine-enhancing drugs – and which can occur during shock.

These techniques are simple. They include staying bundled up, keeping the feet very warm, eating frequently and eating rich food such as salmon or avocados, keeping music going (music such as classic waltzes or positive, major-key singable songs), and other tips on keeping a person's autonomic system stable until it sorts things out.

Within three weeks, after Hannah slowly became able to accept the shocking fact that her husband had indeed died, her PD-like symptoms were gone.

Hopefully, any MD could tell you that what Hannah had was sudden-onset psychogenic parkinsonism. You might also say that she'd had a severe emotional shock, or if you wanted to be more technical, you might call it short-term dissociation due to emotional trauma.

Comparing cases of psychogenic parkinsonism

The two previous subjects, Victoria and Eleanor, also had psychogenic parkinsonism, but they shared two important differences, when compared to Hannah.

First, their decision to be numb had been a very conscious decision because they had determined to not show their pain. Second, they had been able to put an adrenaline over-ride in place that had enabled them to be highly functional and cerebral – which they loved – even though they had diminished ability to feel calm, peace, or joy. Victoria and Eleanor had slow-developing psychogenic parkinsonism. This syndrome is, at first glance, indistinguishable from idiopathic Parkinson's. The correct diagnosis can only be attained if one takes the time to find out the *cause* behind the dissociation.

Summary of the above case studies

All but the last three of the above cases had unhealed foot injuries.

Of those with foot injuries, most had made a decision to “not feel” their foot pains at the time of injury.

Some, in addition to having a foot injury, had dissociated from their ability to feel pain, in general.

Victoria and Eleanor had *never* hurt their feet. But they *had* decided to dissociate from their ability to feel in order to deflect an overwhelming amount of emotional pain. They had dissociated from their ability to feel, while nevertheless keeping their memories intact.

Oppositely, Gus, the WWII veteran, had *psychologically* dissociated from an *event*, so that he couldn't remember it. Due to dissociation from the event, his foot injury, received that day, did not heal. But as soon as the event was brought to his attention, via FSR on his foot, he *did* feel the foot injury, and remembered the other events of the day.

And *unlike* all the other cases described, he didn't know *how* to make the pain go away. He *wasn't* able to dissociate from his heart-feelings. He was flung into a nightmare, and *couldn't* escape the physical and emotional pain. He didn't know how. In his case, the dissociation-type electrical pattern in his legs was being caused by the unhealed foot injury, even though he had not dissociated from his ability to feel pain per se.

These cases may seem very dissimilar, especially for a person with Parkinson's who is trying to decide if he "matches" any of these cases. But despite the variations, all these cases have an underlying similarity: their coping mechanism resulted in a channel Qi flow pattern that matches the pattern for biological dissociation – the condition that occurs during severe trauma and which has symptoms that resemble those of Parkinson's disease.

Whether the dissociation was psychological and localized, and related to "tuning out" a specific injury, *or* came about via a mental (which is to say, psychological) instruction for body-wide numbness to physical and/or emotional pain (in which case subsequent foot injuries – which are common – would of course fail to heal), *or* was brought about by separating the memory of some event away from normal consciousness (an act known as psychological dissociation), thus preventing the healing of a foot injury that occurred during the event, *all* of these cases involve some form of psychological dissociation.

And all of them directly or indirectly will eventually cause the channel Qi to flow in the pattern that ordinarily occurs during trauma-based, biological dissociation – a pattern that can be easily detected in everyone with correctly diagnosed Parkinson's disease.

And in all of the cases in which the person *terminated* his particular form(s) of dissociation, his symptoms of idiopathic Parkinson's also ceased.

As a further aside, while discussing their various foot symptoms, *many* people with Parkinson's told me that they had intuitively felt that their mobility problems somehow stemmed from their feet: feet that were, in many cases, misshapen, discolored, numb, or stinking with fungus-infected toenails, in *addition* to containing an unhealed injury.

Many had even mentioned the foot connection to their doctors. They had been assured by their MDs that such a notion was purely wrong. In the words of one local neurologist, "There's no *way* that something that happens to your foot can affect your brain – and the *brain* is where Parkinson's is."

“Oh what a gift the giftee gi’ e us, to see ourself as others see us.”

- Robert Burns

CHAPTER FIVE

DOCTOR’S DISEASE

This chapter gets back to the narrative of my own diagnosis. Now that you’ve had an introduction to neurological modes and a collection of case studies under your belt, we can return to the situation that closed chapter two, with my colleague implying that *I* had Parkinson’s. He hadn’t actually said, “You have Parkinson’s!” What he said was, “Are you trying to tell me that you have Parkinson’s?”

I had merely been discussing some of the more obscure PD symptoms, and referring to my own physical, idiosyncratic behaviors that were similar to those of my patients, in order to demonstrate the symptoms.

I replied, “No, of course I don’t have Parkinson’s disease!” And we dropped the subject.

But his words opened up a line of thought that had never occurred to me.

Very quickly, I responded to his “diagnosis” in the same manner that most of my patients had initially responded to a diagnosis of PD: while assuming the diagnosis was wrong, I nevertheless found myself sliding into a highly negative mindset: I was obsessed with envisioning a rapid decline into utter immobility. In my mind’s eye, I was already in a wheelchair.

As I realized that I was doing this, I was also delighted to realize that my behavior was so predictable. Not yet appreciating that *many, if not most* people with Parkinson’s are *extremely* susceptible to suggestion and placebos, while considering themselves to be highly analytical and therefore *not* susceptible to placebos, I marveled at the way in which my *reaction* to my diagnosis was uncanny in its similarity to the diagnosis-reactions many of my patients had described to me.¹

¹ Many research projects looking into the placebo effect have used people with Parkinson’s as the subjects. These studies use people with advanced Parkinson’s, those who have “On/Off symptoms.” On/Off means, when their medications kick in, they can move, when the medications wear off, a few hours later, they become rigid until they take the next dose. Their ability to move goes On and Off, depending on the time they took their last dose.

When such patients were secretly given dummy pills as substitutes for their usual medications, they were able to move normally after the usual twenty minutes of waiting for the pills to kick in, and the benefit of the dummy pills lasted just as long as a dose of the real medication.

Many, many placebo experiments have been done using people with PD: it’s easy to see if the patient is responding or not to the placebo: either he can move or he can’t.

What many placebo researchers possibly don’t know is that most people with PD are *highly* susceptible to suggestion. Because people with PD tend to evaluate (Continued on next page.)

And *even* as I nurtured an image of myself utterly immobilized with Parkinson's, I simultaneously assumed that my diagnosis was incorrect: *if* I was manifesting some symptoms of Parkinson's, it was merely the result of "doctor's disease."

Doctor's disease

Doctor's disease is a phenomenon experienced by many students in medical school in which healthy learners find themselves experiencing the symptoms of whatever illnesses they happen to be studying at the time.

Upon being diagnosed, by my colleague, with Parkinson's, I decided to prove that what I had was merely doctor's disease: a psychogenic illness that would go away as soon as I stopped dwelling on it. To prove this to myself, I made a list of all my Parkinson's-like symptoms and the dates when I had first noticed each of them.

I had been doing the project for less than a year. If all my symptoms were less than one year old, my symptoms were purely psychological, and would go away if I stopped focusing on Parkinson's.

By now I had a much more detailed awareness of actual PD symptoms than many neurologists: my detailed interviews with so many patients had led me to realize that dozens of unrecognized or "anecdotal" symptoms were actually quite prevalent in Parkinson's disease.

As I wrote up the list of the starting dates of my own traditional and anecdotal PD symptoms, I realized with dismay that most of my symptoms had manifested, at least to a small degree, several years *prior* to the starting of my Parkinson's project.

For example: the tendency for my arms to assume a bent-elbow, waist-high position despite my constant pushing them back down had been going on for several years.

The hunched posture that I was constantly correcting had been a problem for at least five years.

The increasing difficulty in turning my head to look behind while driving had been getting much worse over the last few years.

The feeling of muscular oppression in my chest when doing light chores that required lifting my arms over my head, such as taking down a shower curtain, had been "normal" for me for more than a decade.

For at least the last five years, if I sat too long on the sofa, at night, I needed a family member to pull me up to get me "going" again. Considering I was, at that time, a runner

(Continued from previous page.) everything according to imperfect sensory cues that are processed by the mind and by the dictates of the subconscious, rather than relying on the ultimate verities of the heart, they are extremely easy to fool. At the same time, they usually think that they are *less* susceptible to mental manipulation because they perceive themselves as less vulnerable to *emotionalism* than the general public. But emotionalism and mental manipulation are two sides of the same coin: they are both conditions in which the ego-based question "how does this affect *me* or my long-cherished thoughts" is used as the basis for all evaluation. Even when emotionalism has been diminished, ego-based thinking is still highly susceptible to suggestion, and highly resistant to the idea that this is the case.

doing daily 10K runs in the woods, this should have made me worry, but I just assumed it was a normal stiffening up during inactivity of any person in her forties. Which, in hindsight, makes no sense at all: I’m now sixty, and I don’t have trouble initiating getting off the sofa.

The numbness in my toes and the weird sensations in my legs when I lay down at night, as if my legs were made of static-charged wood, had been intermittent, but had been occurring for over a decade.

A very slight shuffle of my right foot, causing my right heel to wear down so much faster than my left, had been slowly, slowly worsening over twenty years.

For the last year or so, my arm swing was sometimes erratic, impossible to coordinate, but this problem usually only started up after half an hour of running. I mostly ignored this increasing *inability* to make my arms swing, but if and when I thought about it, I attributed this problem to “too much exercise.” Which makes no sense at all.

I’d even had an episode of full-blown festinating gait. Although I attributed my fall to “losing my focus due to mental preoccupation,” I had actually festinated and, as my steps got closer and closer together and I was unable to lengthen my stride, my upper body lurched forward until I had finally fallen, face down, spread-eagled while jogging out along a mountain road.

As for my very small tremor, which only recently had started to be more of a constant, I had always attributed that to the intensity of my personality – I could always control it if I needed to, using various tricks. One of my best was my clever habit of holding a pen in my gently trembling hand so that, at work, when I was stressed and therefore most likely to tremor, I appeared to be merely tapping my pen, impatiently, on my clipboard. I had been doing that since medical school, more than a *decade* earlier.

And I recalled a fellow student once taking me aside and telling me that I needn’t look so dour while listening to a patient’s history. I had been surprised. I always took special cares to plant a smile on my face lest I lapse into what was becoming a tendency to look “too serious.” “Why are you frowning?” had become a common question from friends. This too had started more than a decade ago – while I was still in medical school.

Since that time, the “look” had become more problematic, especially on the right side of my face. All my problems were on my right side. My first act, every morning, before brushing my teeth, was to hook my fingers into the corners of my mouth and pull my face into a smile. I had told myself that this was just the typical scowl-y look of old age, and had attributed nothing ominous to my right-sided facial droop.

OK. I made my list and rechecked it. Something was seriously wrong here.

If this were merely doctor’s disease, my symptoms would have started within the last year – when I started the Parkinson’s project. Many of these symptoms, though extremely mild at first – probably not even noticeable to someone who wasn’t medically self-analytical – and only recently becoming harder to shake, went back a decade or more.

This was not doctor’s disease.

I had all the symptoms of classic, idiopathic Parkinson’s and, like my patients, my symptoms had been slowly, steadily developing for a long time – years – until now they were finally diagnosable – obvious to someone with very little training – as Parkinson’s disease.

I assured myself, brightly, that I didn't need to worry. I had seen people recover from this illness. Possibly, I too would recover. And then I was overwhelmed by an inner voice pointing out that I would be the one who *didn't* recover.

I had *no reason* to think that anyone might *not* be able to recover, and yet, those were the very words of my inner voice.

At this early stage in my research, it had *never* occurred to me that some people wouldn't recover. If there was an effective treatment, it should work for everyone, right?

And yet, here I was, suddenly certain that I would, of course, be the one who couldn't recover.

And the uncanny thing was, I had heard this *exact* same response from nearly *all* my patients. Even though some people had clearly recovered, most patients assumed that those recovered ones had been lucky. "I'm different. I probably won't be one of the lucky ones," was a common theme among my as-yet unrecovered patients. That, and "Well, in *my* case, I *can* recover, but it's going to take a *long* time..."

It was as if they knew, somehow, that their own case had to be different; *they* were different, and what happened to other people didn't apply to them. Other people might recover easily – this suggested that *other* people's Parkinson's was the result of something fairly insignificant – some darned foot injury. But their *own* cases, well, that was different. Recovering was going to be a *real* struggle for them, because their problem was more profound. Somehow.

Up until now, this negative attitude had really bugged me. And here I was, indulging in the *exact* same thoughts as most of my patients – illogical, negative thoughts – just like the ones that deeply irritated me when they were presented by my otherwise intelligent, analytical patients.

And so, after two days of uncharacteristically dwelling on the sudden sadness of life and sinking into the gloom of a future of inevitable unhappiness, all the while maintaining a superficial smile, I decided to grasp at a straw. I was going to do something different from what my negative patients were doing.

As a medical professional, a primary care provider, I had long disdained the self-pitying attitude that *some* of my patients, Parkinson's and non-Parkinson's alike, embraced. I *had* seen that patients with a mature attitude, ones that accepted the ups and downs of life as learning opportunities, did far better with their problems. Whether or not they recovered from whatever was afflicting them, their attitude of gratitude enabled them to have a better life than was had by those who wallowed in despair.

Over my years as a doctor, I had developed a secret wish: I wished that all my patients would take the time to find at least one reason to be at least a little grateful for *something* about their illness and their life challenges.

So I decided that I was going to be one of those patients that I admired. I was going to be grateful for my illness.

My very loving and extremely intelligent sister, Lendie, once told me, “When difficult circumstances come, try to imagine the kindest possible explanation: the kindest explanation is the one closest to the truth.”

Armed with the above, and fortified with decades of spiritual training, I marched myself into my meditation room. I told myself that I wasn’t going to leave the room until I was truly grateful for something having to do with having Parkinson’s disease.

It was the middle of the afternoon.

But before I can explain what I did next, and what followed, it will help if the reader knows a little more about acupuncture channels. Here’s why: my knowledge of channel theory enabled me to make sense of what was happening to me during, and after, my diagnosis and recovery. Nothing else would have allowed me to make sense of it.

By sharing the following section on channel theory, you will be able to see my physiological changes, before, during, and after recovery, in the way I was seeing them – in a way that made perfect sense.

Also, channel theory can be important to know about for a person who intends to recover. Very often, having a friend who has mastered the art of feeling channel Qi (this can take several hours, but isn’t particularly tricky) can be extremely helpful if/when a person slides into partial recovery.

“It is by virtue of the twelve channels that human life exists, that disease arises, that human beings can be treated and illness cured. The twelve channels are where beginners start and masters end. To beginners it seems easy; the masters know how difficult it is.”

- The Chinese medicine classic, Spiritual Pivot, chapter 17¹

CHAPTER SIX

CHANNEL THEORY

Channel theory is a crucial part of Asian medical theory. It turns out also to be the key to understanding the anatomical changes that occur in a person with Parkinson’s disease.

In order to *recover* from Parkinson’s disease, one doesn’t need to understand channel theory. To figure out what causes Parkinson’s and what were the common treatment denominators of the many people who had “miraculously” recovered, some knowledge of channel theory is needed.

For those readers who do want to understand what’s going on in people with Parkinson’s and what’s changing while they get treatment or alter their thinking patterns, read the channel theory information in this chapter and the next five short chapters. If you don’t want to know, you can skip these chapters – and still recover from Parkinson’s.

But first, one thing needs to be clear.

¹ The translation is from *A Manual of Acupuncture*, Peter Deadman and Mazin Al-Khafaji, 1998. *The Spiritual Pivot* is thought to be approximately 2000 years old.

The words “Spiritual Pivot” refer to the transitions in which wave energy becomes physically manifest as force-carrying particles (tangibles) (facing away from God, or Yin) and oppositely, particles revert back to waves (facing towards God, or Yang). Energy pivots back and forth between these two states. These transitions are directed by consciousness, both Universal and human.

In quantum physics, we say that the appearance of an object (whether it is perceived as a wave or a boson (charge-carrying particle), or its color shift, and so on) depends on the perspective of the viewer. In other words, these “transitions” are not so much transformations of substance, but transformations of perspective.

If one’s consciousness is facing towards the *origin* of the universe, towards Love or the Divine or whatever you wish to call it that drives the creation of the universe, the universe appears very different than if one’s consciousness is focusing on the tangible, created aspects of the universe. One’s perspective is a matter of choice, ultimately. This is the fabled “spiritual pivot.” Facing towards the creation is also known, in the east, as “the way,” or “the Tao.”

Channel theory is not the same as acupuncture

Channel theory is a keystone of Chinese medicine.

Chinese herbology, acupuncture, moxibustion, energetics (such as Tai Ji or Qi Gong), and dietetics are merely the five main applied-treatment *branches* of this medicine. Channel theory is the *basis*.

Even so, a person who studies acupuncture may have NO understanding of channel theory beyond the first semester beginner's lesson in which the locations of the historical channels are memorized, together with a sampling of some historic mentions of "divergent channels." The student may never learn – and the acupuncture teacher may not know, what channels are, how they work, the mutual influence of channels with mind and chemistry, or even what "divergent" means, in this context.

Oppositely, a person who studies the ancient Chinese classics and appreciates the metaphysics as well as the physics and medicine of these treasures may have a deep understanding of channel theory – and may *never* have studied acupuncture.

Acupuncture is *not* synonymous with Chinese medicine. Channel theory is. However, most "practitioners of Chinese medicine" are acupuncturists: they have learned, primarily, acupuncture techniques. They do *not* have to pursue an in-depth study of the classics or the roots of the medicine. In the USA, the various state boards that license acupuncturists do *not* require the study of channel theory beyond the memorization of some of the historical channel locations.

Again, most acupuncturists are *not* knowledgeable about channel theory. Although there are wisps of budding interest in channel theory in the *west*, most China-trained acupuncturists and herbalists consider channel theory to be an outdated historical concept.

Also, acupuncturists are *not* trained in the various neurological modes as they relate to channel Qi flow patterns. Most of them have *no* idea that channel Qi flows differently ("diverges") in different modes. They do not *need* to know this to practice acupuncture.¹

Most acupuncturists have little or no experience in feeling the channels for diagnostic purposes.

Finally, most acupuncturists are not trained in Yin Tui Na, the treatment techniques that we use in treating Parkinson's. Although many acupuncture boards require that students take one or two Tui Na classes, most schools offer Yang (vigorous, manipulative) Tui Na, because that is the main style that is taught in China today.

¹ As an example of how poorly trained many acupuncturists are with regard to the neurological modes, the *California Journal of Acupuncture and Oriental Medicine* once published a major article about "fight or flight" sympathetic mode – and referred to it as fight or flight *parasympathetic* throughout the article. None of the peer reviewers, who we can assume are all acupuncturists, caught the error before it went into print. The journal is widely read, and frequently discussed, at the acupuncture college where I teach. Not one of my colleagues – *professors* – mentioned this glaring error.

Therefore, assume that most acupuncturists are not pre-qualified to help a person who wants to use our findings in order to recover from Parkinson’s disease. Yes, an acupuncturist might be able to learn everything that is needed, but so can nearly anyone who is capable of sitting still for half an hour at a time – the length of time of the average, at-home therapy session.

Yin Tui Na is not rocket science. It does not require *any* medical training. Just as many people have recovered from Parkinson’s after having their feet held by a spouse or friend with no medical background as have recovered after getting some Yin Tui Na treatments from the PD Treatment Team of Santa Cruz. Maybe more.

I’m hammering away at this because no matter how many times I’ve written that we use channel theory to *understand* Parkinson’s and Yin Tui Na to *treat* Parkinson’s, I receive a steady stream of inquiries from people asking me to recommend an *acupuncturist* in their area so that they can recover from Parkinson’s.

An acupuncturist will probably not know anything at all on this subject.¹

Also, we of the PD Treatment Team get frequent requests asking for referrals for “trained” Yin Tui Na specialists, even though we have always pointed out that performing Yin Tui Na is about as sophisticated as doing an imitation of a human ace bandage. No, we don’t give referrals for practitioners who are “experienced” in this very simple-to-learn technique.²

INTRODUCTION TO CHANNEL THEORY

In the first chapter, I referred to the currents that run amiss in Parkinson’s as “circuits.” The Chinese medicine name for these circuits, “channels,” was introduced in the second chapter, together with the word for the energy that flows in them, “channel Qi.”

What are channels made of?

Channels are the pathways of electricity-like currents that circulate over every cell and which also, in huge multi-celled organisms such as humans, collect via billions of iterations to form large rivers of current in the fascia just below the skin. The energy in the channels is referred to as channel *Qi* (pronounced *chee*).³

¹ Even worse, many acupuncturists are mistakenly taught that Parkinson’s disease is a form of Liver-Wind (sudden onset, unpredictable movement such as stroke or sudden spasm brought on by irregularity in the Liver channel Qi). The treatments that they are taught for PD are relaxation-type treatments that may provide mild relief for a few hours or a few days, but will *not* slow the progression of Parkinson’s, and may possibly accelerate it, as will be explained in a later chapter.

² A textbook on Yin Tui Na is available for free download on the publications page of the Parkinson’s Recovery Project website: www.pdrecovery.org.

³ For now, consider Qi to mean “energy.” “Channel Qi” is the electrical and electromagnetic energy flowing over the outside of cells’ outer membranes: the energy that regulates the chemical switches of inner-cellular functions in all living systems.

Qi means the *exact* same thing as, and is *derived* from, the much older Sanskrit (the language of ancient Hinduism) word pronounced *chee* and (Continued on next page.)

In a living person the largest, closest-to-the-skin paths of electricity-like channel Qi *tend* to flow in specific, detectable routes through the body's tissues. Its flow in the fascial (fascia-based) tissues that lie just under the skin can be felt, by hand, by holding the hand close to, a quarter to half an inch away from, the skin. These currents can be felt through clothing. Like radio signals, the waves given off by the currents are *not* impeded by shirts or trousers.

The channels only exist when moving current is present. A dead person, a person in whom no energy is flowing, has no channels, and no channel Qi.¹

(Continued from previous page.) spelled *Chit*. (The “t” at the end is only pronounced when Chit is followed by a vowel.) In Vedic (ancient Hindu) philosophy, Chit is one of the three attributes of God. For example, “Sat-Chit-Ananda” (Wisdom (or Consciousness)-Manifested Energy-Bliss), is one of the more common definitions, or “names,” for God.

While there are few books explaining the meaning of the *Chinese* word “Qi,” other than saying it is a mysterious, un-definable force, there are *thousands* of essays, many in English, explaining the physics and straightforward ramifications of *Vedic* “Chit,” all of which mesh perfectly with our most modern understandings of modern physics and quantum theory – and the Chinese “Qi” is pronounced the exact same way and means the exact same thing.

Qi and channel Qi are defined in depth in my acupuncture textbook, *Tracking the Dragon*, Available at www.pdrecovery.org. or from the publisher, Fastpencil.com

¹ When western scientists first learned of channel theory, they were highly dubious. One doctor famously did a careful dissection of a corpse and announced that there was no evidence of any structures that corresponded to the description of the primary channels. Therefore, channel theory was, for nearly a century, mocked and reviled. Channels *still* cannot be detected in a corpse: when the body is dead, no electrical currents flow.

Since the late 1970s, some western researchers have been preoccupied with proving the western hypothesis that acupuncture channels are derivatives of the nervous system. While some studies have shown that the nervous system can be, in fact, affected by stimulation of the channels, and anesthetized nerves are not responsive to acupuncture, no studies have been able to prove that channels need the nerves in order to exist. The Asian theory would say that even single-celled organisms have channel Qi flowing over the surface of the cells – and single-celled organisms do *not* have nerve cells.

Nerve structures develop in very large organisms in *response* to instructions provided to the cellular DNA via the channel Qi. At the smallest, cellular levels of channel Qi electrical flow, the flow influences DNA expression and the formation of cellular structures and specific types of cells, including nerve cells. Even though a few experiments are finally being designed to look for Qi flow patterns that are not directly related to nerves, these studies are few and far between. There is simply not much profit to be made in objectively proving the existence of channels.

As an aside, the existence of acupuncture *points* has been objectively proven: machines can easily detect decreased electrical resistance in the skin at the locations of the known acupuncture points. In fact, my first experience in receiving acupuncture was from an MD who used one of these machines to locate acupoints on me. He had not memorized the general vicinity of the point locations or learned to hone in on the *exact* location by a trained sense of touch. Many MDs call themselves acupuncturists after taking a few weekends of basic theory. Back to the main point, machines have *not* yet been developed to locate the *directional* vectors of moving energy that *connect* those points.

The best way to feel the *directions* of the currents that run in the channels remains the *seemingly* subjective method of feeling the Qi by hand. It is quite easy to learn. It is like learning to differentiate the difference between the feel of velvet when stroked with the nap and against the nap.

Detecting the flow direction and amplitude in these channels is easy. My students at the local acupuncture college usually begin to master the process within about five to six class hours. The sensations given off by the flow of channel Qi are distinct, and very objective. All the students, after a few weeks of practice, can precisely detect the pathological channel patterns on a given patient even when they are told nothing about the patient in advance and are instructed to write up their findings without discussion with the other students.¹

Is channel energy the same as electrical energy?

In opening this chapter, I carefully referred to “paths of *electricity-like* currents...”
Now I need to explain why channel Qi isn’t *exactly* the same as electricity.

When we deal with electrical currents in inanimate objects, such as car batteries or toasters, all we really care about is the movement of electrons, and maybe the electromagnetic waves that generate or are generated by the electron movement.

But in living systems, we contend with more than just electrons. So, unless you’re a physics fan and already know about the five kinds of force-carrying particles, grab a cool drink, pull up the footrest, and settle in. I’m about to dive into a bit of esoterica on the subject of waves and their partnered force-carrying, moving quantum bits. This may seem off the subject of Parkinson’s, but an application for this information will appear in chapters eight and nine.

Waves and bosons

Electrons are just one type of force-carrying particle. There are five types of these particles, and they each behave a little differently. These particles are generated by, and can generate, in their turn, five distinct types of waves. For example, we generally think of *electrons* (one of the five types of force-carrying particles) as being paired with *electromagnetic waves*. We think of photons as being paired with light waves. There are three other kinds of waves and matching, or paired, particles, as well.

While western researchers sneer at this subjectivity, which turns out to be quite objective, since all students are able to feel the exact same thing, I am reminded of a cartoon strip in which Doonesbury character Alex tries to assess the electrical engineering professors at the colleges to which she is applying. She asks them this question: “Two black boxes, each hiding an internal circuit. Using workbench tools, how do you tell which is the current source and which is voltage?” Several teachers are stumped. Finally, one professor gives her the correct answer: “Well Alex, they’re Thévenin and Norton equivalences, so tools are useless. You’d have to hold the boxes in your hand. Since the current source has a resistor, it’d be warmer.” (From the cartoon anthology collection, *Heckuva Job, Bushie*, G.B. Trudeau, Andrews McMeel Publishing, Kansas City, 2006, p. 223.)

At this stage of scientific research, electricity-measuring tools have not yet been devised that can determine the *direction* of Qi flow amidst the various bits of electrical forces that can be detected just under the skin. At the present time, if you want to detect the dynamic flow of Qi, workbench tools are useless; you have to feel it with your hand.

¹ Most acupuncture schools do *not* teach this ancient art. But feeling for aberrations in the body’s electrical currents helps immensely in diagnostic pinpointing. At the acupuncture school where I work, I teach a two hours-a-week, eight-weeks *optional* class in this skill.

The five type of waves are referred to in the Indian (Vedic – more than three thousand year-old) physics as 1) Thought waves (similar to sound waves, but they don't need a medium through which to travel. And despite the use of the word “thought,” these “Thought” waves are *not* electromagnetic brain waves, they are waves generated by pure consciousness.), 2) Movement waves, 3) Light waves, 4) the waves that generate Gaseous matter (in which electrons become paired with protons, neutrons, and other quantum bits), and finally, 5) the waves that generate the forces that allow for Solids.

In modern quantum physics these waves have been given new names. Names that, to my mind, are less meaningful than Sound, Movement, Light, Gas, and Solid. And in quantum physics, their paired particles are called bosons, in honor of Dr. Bose, the Nobel prize winning physicist from India. Still, despite the varied nomenclature, the five types of wave/particle phenomena have been recognized in times both ancient and modern.

In the Ancient Vedas, these five types of waves and their paired bosons are collectively referred to as the Five Elements, sometimes translated as the Five Phases, and also by the name the Great Elements. The Elements are poetically named Ether (thought), Air (movement) Fire (light), Water (gas) and Earth (solids) – in that order. In Chinese medicine, they are referred to as Five Elements, and are named Wood, Fire, Earth, Metal, Water – in that order.

The five kinds of *waves* created in each of these elements also have their own names. For example, the type of waves formed by the Element of Ether are Sound (consciousness) waves. The Element of Fire creates what we call Light waves.

The five kinds of *bosons* that are generated by the five kinds of waves also have their own names. For example, the bosons, or force-carrying particles formed by light waves are called photons. The bosons formed by the propagation of “Water” (gas-forming) waves are called electrons. The bosons formed by waves of Sound are known as Higg’s bosons. And so on.

Ignore the details. The main idea is this: five types of waves, five types of particles. Each type is a condensation of the previous type.

The sequence of creation

Sound (consciousness) waves are the first type of waves to form, in the creation of the universe. The subsequent types of waves are each condensations of the preceding type. Sound waves condense to form Movement waves, Movement waves condense to form Light waves, and so on.¹

So a wave and particle of a *solid*, the fifth, and densest of the five Elements, contains within itself condensed forms of Sound, Movement, Light, and Gas-forming waves.

¹ In the beginning was the Word... Many scriptural references note that the first aspect of creating a tangible universe is the manifestation of “Sound,” or waves of consciousness, also known as The Word, the “sound of many waters,” the *manifest* consciousness of the Universal intelligence. The “sound” produced by the Sound is described as, and named, “Om.” The word Om has many derivatives, used by the various world religions: Aum, Hum, Amin, Amen, and Tao (from “Da Om,” meaning “Great Om”). In scripture as in physics, Sound waves come first; only after Consciousness creates the Sound waves can those waves then condense into the other forms of waves, those of movement, light, gas and solids.

This is why, when we break up an atom (an atom of a *solid*), the break-up releases “Gas” (electrons from non-solids which are paired with protons and such), Light, Movement, and Sound waves.

Comparing inanimate and living systems

When we run electrical currents through the toaster, we are only concerned with moving the electrical *charges* of the photons (light-wave generated bosons) that lurk within electrons (gas-wave generated bosons). We don’t really care that some Sound waves, and Movement waves are tucked *inside* the electrons, moving in the wire, as well.

But in living systems, the currents are highly specific as to which kinds of waves and force-carrying particles are dominant in any given circuit at any given time.

For example, each of the five senses is influenced by a specific type of wave. We *hear* sound waves. We *see* light waves. We *feel* (perceive touch sensations) movement waves. We *smell* waves that generate the electron-proton relationship (waves of the Gas element). We *taste* waves that create the forces that bind solids (waves of the Earth element).

The neurons (brain nerves) that process each of the five senses respond primarily to one type of wave and its specific type of paired boson.

So, it isn’t just “electricity” that’s moving in the channels. It’s highly *specific* blends of the five types of waves and bosons that moves in each of the channels.

Which comes first, the wave or the boson?

The other way in which the stuff moving in the channels differs from the current generated by your car battery is that living systems exist *first* as wave systems. The wave systems then determine the boson patterns that create and sustain the seeming *tangibility* of matter, including “living” matter.

When a living system dies, the two denser wave forms flowing through the channels (the gas and solids waves) convert back into the “lighter” wave forms from which they were made. Then, the three “lighter” types of waves – thought, movement, and light – separate from the body. But they remain united, as the astral form of the previously-living thing.¹

In other words, the *idea* of our existence, or soul, together with our thoughts (right or wrong) or what you might call our personality, exists before the physical body makes its appearance, and stays together after death, as well.

The assembly and maintenance of the body, from the earliest beginnings as a single cell, is driven, not by inanimate electrical currents, but currents that are created and driven by the waves generated by the perfect thought wave idea of our existence *and* by our personal, idiosyncratic habits and our adopted thought vibrations – thoughts and habits that might be either right or wrong (in tune with nature or out of tune).

¹ This is why a person loses weight, a few ounces, at the moment of death.

In living systems, instantaneous pivots between the wave forms and the boson, or material, forms, help create and maintain a seemingly “real,” materialized *manifestation* of the unique idea and the personality glitches that vibrate behind each individual.¹

Let’s call it electricity

Now, having said that, it’s still going to be easier if I just talk about channel Qi as “electricity.”

After all, many aspects of channel Qi flow behave like electrical currents: the channel Qi is subject to resistance; it follows the path of least resistance; it can “short circuit” into other, nearby channels if its own route is blocked; it is influenced by nearby and by parallel currents;

The currents that run in the channels are unidirectional: *direct* currents rather than household-type alternating currents.

Chicken and egg constructs

In my limited experience, western medical practitioners try to understand Asian theory using 18th century western medical constructs: constructs that are archaic in light of western physics but which still dominate western clinical medicine.

The clinical western medical model tends to turn a blind eye to the new findings in modern physics, and quantum theory in particular. Even the 20th century paradigms of western medicine hold that the *structures* of the body – nerves, organs, blood vessels – must be creating and determining the paths and modes-of-effectiveness of any electrical currents that might exist in the body.

Further, they tend to insist that, if any electromagnetic waves exist alongside of the currents, they are the *result* of the currents – currents that are generated by chemistry in the cellular structures. There is no “which came first, the chicken and egg” mystery in western clinical medicine: the structure is assumed to be the dumb template on which chemical and electrical events, even thoughts, are generated.

This is why the western medicine paradigm is regularly challenged, shocked by, and knows not what to make of studies proving that the mind influences the body’s chemistry or, most recently, that the brain is grown via thoughts, and not the other way round.²

¹ In Asian physics, the wave precedes, and can exist without, the boson. In the west, the general public assumes the opposite: we are taught that moving electrons are the source of electromagnetic waves. While western physics gives lip service to the idea that electromagnetic fields and their paired moving electrons are “equal and simultaneous,” nevertheless when teaching the subject in high school, the material is presented, for the most part, as if the moving electron comes first, and its electromagnetic waves follows. This yields an incorrect impression of the nature of matter.

In ancient, eastern physics, it was recognized that, in the big picture, the waves, or fields, come first, and discreet “chunks” of force-carrying particles (the building blocks of matter) may, or may not, accompany those fields. Advanced western physics now admits this to be the case, but high school and basic college physics is still taught *as if* matter precedes and creates waves.

² The leading *research* by MDs in the field of brain creation has not yet made its way into *clinical* (applied) medicine. Researchers are only rarely clinicians. (Continued on next page.)

Oppositely, in Asian medical philosophy, both Indian and Chinese, we recognize many *mutual* effects: waves, including thought waves, brain waves, and heart-generated waves, and currents, and cellular and organ structures all act on and influence each other.

Waves are generated not only by thoughts but also by the various chemical (and therefore electrical) structures and reactions in the body). Currents are directed by the waves *and* by the local chemistries, but also drive the DNA expression and trigger most chemical reactions. The cells and organ structures (created based on the instructions provided by *both* the currents (or “channel Qi”) and the materials provided by the structures (cellular chemistry, including DNA) produce wave signals that add to the mix.

Working together, the somewhat *stable* electrical properties of physical structures of the body *and* the electromagnetic waves with their fast-as-a-thought ability to *change or influence* moving electrical currents, provide both stability and dynamism to the underlying electrical nature of the chemistry of living systems.¹

The wave aspect of a person, not the chemistry, is the *ultimate* driving force behind the ever-changing structures and molecules that make up a person’s physical being. The full collection of waves – including thought waves, the waves generated by the channel currents, the waves generated by the organs (such as heart waves) and the waves generated by the chemistry of the cells – directs the currents of Qi in the large channels and in the cells. These currents then influence thought processes, organ function, and cellular performances.

Continued from previous page.) Some newish books on the subject include *The Brain that Changes Itself*, by Norman Doidge MD; Penguin books; 2007 and *The New Brain*, by Richard Restak M.D.; Rodale; 2003.

¹ To help explain how the currents can direct the cells, consider that the channel Qi flowing over the individual cells directs the cellular chemistry and DNA expression.

“DNA expression” is a term that refers to chemistry building activity in small sections of the huge DNA molecules. Small sections of the molecule are called on now and then to manifest a few of the thousands of bits of genetic instructions that reside on the DNA molecule. Most of the DNA’s molecules are inactive at any given moment. When a bit of the DNA *is* being used as a template for building a specific molecule, we say that bit of DNA is “expressing” itself.

Electrical charges that bathe the outside of the cell – the nano-scale manifestation of channel Qi – contribute to the regulation of chemical activities in the cells, including expression of the cell’s DNA. These extra-cellular charges can be considered the smallest branches of channel Qi, *deriving* from the large rivers of channel Qi that flows under the skin; or they can be seen as the *building* blocks of those rivers. In truth, it works both ways.

To appreciate just how small the channels can be, consider the one-cell organisms; in single-celled organisms, their surface-of-the-cell electrical patterns *are* their “channel Qi:” their shape- and function-determining electromagnetic structure.

Back in 1970, during a Biology 101 exam, I was completely paralyzed by the question: define homeostasis. The question filled me with awe. I had no idea how I could explain, in words, the miracle of homeostasis. I remember sitting there, anguished, because, (Continued on next page.)

(Continued from previous page.) though I knew the answer that the teacher wanted, I knew that homeostasis was something much grander than the feeble definition he’d given in lecture. But I could not find the words. I left the space blank. Just now, as I wrote the text associated with this footnote, I realize that I have finally answered that question to my satisfaction... somewhat. I’d love to go on, but believe it or not, I’m trying to keep it short, here.

The whole thing is very circular.

But if it's circular is it reasonable to ask which comes first: the waves or the matter? The ideas or the hard stuff? This is the chicken and the egg question.

The "Starting Point," if you will, is the initial waves of creative Consciousness – the *idea* of the chicken. Even so, the constructs in the body, established by those waves, influence, in their turn, the "subordinate" waves.

But after a living system has assumed a material form, then injury, illness, toxins, or thinking that is wrong can cause detrimental changes in the cells and larger structures. "Wrong," in this case, means not in harmony with Universal Law, including laws such as "For every action there is an equal and opposite reaction" or "the law of gravity."

These detrimental changes can then cause changes in the electrical currents that flow over these cells and structures. Iterations of these changes can, potentially, bring about changes in larger and larger streams of channel Qi flow.

These changes, in turn, bring about changes in organ function and in *organ*-based wave patterns. These changes can even bring about changes in the large rivers of channel Qi that flow under the skin, and in one's brain patterns. From there, these alterations can bring about changes in one's thought waves.

Fighting back against pathologies

The extent to which illness or injury can change one's thought waves depends on the opposing vigor with which one mentally resists yielding to the waves, or as they are popularly called, "vibrations," of illness or pathology. The ability to oppose changes in thought waves in the face of insult and injury depends on the strength of one's consciousness, one's sense of Self (soul).

Ironically, in order to maintain his composure and self-control, or in order to survive near-death, a person with Parkinson's has opted for dissociation, a psychological stance that *denies* him full awareness of his physical body (his self), as well as his heart-guided Self.

Thus, he renders himself *less* able to consciously *feel* the pain and the eventual pathological changes set in motion by his ignored injuries or emotional traumas.

He *cannot consciously* resist the damaging physical and mental changes caused by his injury or his indulgence in chronic dissociation because he cannot *feel* the injury because he is *choosing* numbness.

He may summon up his will power in the struggle to keep functioning *in spite* of worsening illness and injury, but so long as he is dissociated from his ability to *feel* his ongoing physical or emotional pain, he cannot summon up the consciousness that will trigger a *healing* process. And so long as he is dissociated, he cannot easily summon up the consciousness that helps to end the habitual dissociation.

He *can* end the habitual dissociation, but not by using his mind-created thoughts – he must use a parasympathetic-mode *realization* in order to reconfigure his thoughts.

This is exactly the same mechanism by which a person suddenly realizes that he is, in fact, a non-smoker, or a non-drinker, or the conqueror of any pernicious habit. He must identify, not with his established electromagnetic *habit* patterns of wrong thoughts of helplessness, but with the idea of his underlying Self. That underlying *basis* for the person's

very existence never had an illness or a bad habit. Those bad habits or wrong thoughts were laid down on *top* of the waves of Self. But they can never actually change the underlying thought that created the Self. The realization, or one might even say remembrance, of one's true nature (one's soul nature) is able instantly to institute *correct* thinking or habits, thus turning off and even destroying the electrical waves behind the stodgy mental habits that have held him prisoner.

In summary, the flow of channel Qi in the body, while obeying the laws of electricity, is far more than just a mindless flow of electrons.

And what is “channel *theory*?” It is the theory that the healthy body and all pathological conditions in the body derive, originally, from waves and currents. All pathological conditions are best treated, ultimately, by optimizing the waves and currents of the body so that they most closely conform to the idealized wave of (the very thought that creates) that body.

This conformity, when the very *idea* that creates the individual matches up with the waves and matter that are *materializing* the individual, with no overlay of wrong habits or ego-based, incorrect thinking, is the “harmony” that practitioners of eastern medicine often talk about.

“The river glideth at his own sweet will..”

- William Wordsworth’s “Lines Composed Upon Westminster Bridge”

CHAPTER SEVEN

THE CHANNELS INVOLVED IN PARKINSON’S

Some more basics of channel theory

The *main* “channels” of Chinese medicine, the ones memorized by acupuncturists, are the swaths of charged currents running through the fascia just under the skin.

These currents have enough force that they can be felt by simply holding one’s hand directly over the course of the current. It takes a bit of training to feel them, but not much. Nearly everyone can learn to feel the current in the larger channels.¹

¹ When I teach students to feel these currents, they can often feel them within a few minutes of receiving instruction. It takes much longer, usually several weeks, for them to start to trust what they are feeling. I have found that the easiest way to help them learn to trust their perceptions is to have a group of students all feel the same patient’s channel flow and write down what they perceive without telling the other students. Later, when they compare notes, they are amazed that they have all felt the same things, including the same aberrations in the exact same locations. This confirmation lends a sense of objectivity to their as yet “unproveable” measurements. In my years of experience, I have only had a few students who did not quickly learn to feel the flow of Qi.

Possibly because of the very small amperage of the currents and waves that constitute the channel system, these electrical forces that course over the body have been, until recently, utterly disregarded in western medicine. This is starting to change, as the significance of micro-currents is exploding in our faces.

We now have tiny computer chips that can almost fit on the head of a pin – and these chips contain micro-electrical systems. In the world of computers, we see very small electrical forces directing very large and complex systems.

Even ten years ago, the general citizenry might have expressed disbelief that micro-, even nano-electromagnetic signals might be elegantly regulating the tiny electrical bonds that hold together the chemistries of the body. Today, in the extremely small world of computer chips, we see how a one-electron switch triggered by a wireless signal can direct an entire cascade of information to move in a particular direction. This makes it easier to understand how, in a biological system, the electric fields generated by the currents running throughout the body, and the currents generated by fields and wave patterns, including heart and brain waves, might send significant signals to tissues and chemistries in the body.

Until very recently, most MDs assumed that crude chemical interactions, rather than subtle electrical ones, determined all cellular functions. Even into the late 1990s, many older doctors assumed that the extremely large electrical impulses that run along the nerves were the *only* electrical processes in the body!

Just a few years ago, in 2001, a middle-aged neurology professor sharing a table with me after a wedding got up angrily from her seat and announced that she refused to sit at any table with me or ever speak to me again. This astonishing explosion occurred (Continued on next page.)

Channels have width

The electricity in our homes flows in very limited pathways: wires. They are practically perceived as being one-dimensional. The flow of Qi in the channels is not limited in this way.

The main channels have significant *width*, even though they are no *deeper* than the very thin swaths of fascia through which they flow.

The main channels are described as distinct from each other, but in fact they sidle up against and touch each other along their long sides. For example, the three channels that all flow up the arm are each wide enough that they touch, and even mingle, at their edges.

Although popular maps of the channels often portray the channel Qi as running in a thin line, like an electrical wire, this traditional depiction is artistic liberty, not a realistic portrayal.

There is *no* area on the surface of the body that does *not* have channel Qi flowing under the skin. Still, along the *midstream* of each channel, the sensations of channel Qi are strongest, and are thus easiest to track by hand.¹

The twelve primary channels

Chinese medical theory breaks the channels down into two types: Primary channels and Extraordinary channels.

The twelve primary channels are made up of three currents that run from the upper torso/armpit area *down* the arms towards the hands, three that run *up* the arms from the hands to the head, three that run *down* from the head to the toes, and three that run *up* from the toes towards the upper torso/armpit area.

These currents are bilaterally symmetrical: each channel on the left side of the body has a matching one on the right side. Therefore, one might say that there are actually twenty-four primary channels, if counting the lefts and the rights separately.

All of the twelve primary channels flow sequentially: channel one flows down into the hand where it flows into (becomes named) channel two; channel two flows up the arm to

(Continued from previous page.) when, in response to her asking me how acupuncture worked, I started to explain that acupuncture manipulated electrical currents in the body, currents much smaller than those used by nerves. She bristled. Possibly she had expected some esoteric statement about Qi that she could laugh off. She loudly refuted my statement. I cheerfully reasserted it. She stood up from her assigned seat, announced loudly, “Nerves are the only part of the human body that use electricity! I refuse to listen to this.” and stomped off.

Maybe she had forgotten that there is almost *no* chemical process in the body that is *not* electrically driven. At the time this hostile response took place, the research on bio-electrics had been making strides for over a decade, but this professor at a highly respected medical school was clearly unaware of it.

¹ Some Chinese researchers in the field of scalp acupuncture claim that the effectiveness of their treatments disproves channel theory, because the scalp points do not necessarily lie directly on the thin lines used in the modern drawings of the channels. Although they are politically correct in wanting to dismantle channel theory, their premise is wrong: there is *no* location on the body that is not supported by channel Qi – despite the thin-line drawings.

the head where it becomes known as channel three, and so on. The twelfth and final channel flows into the first one and the whole cycle starts over.

You might think of the twelve primary channels as one long looping sequence of current. But it’s not so simple. Remember those Five Elements – five types or phases of waves and force-carrying particles? Each of the twelve channels carries, predominantly, *one* of the five Elements. For example, the first channel carries, predominantly, a wave construct known as “Metal” Element” (a condensation of waves and bosons of three lighter Elements: sound, movement, light,). The third channel carries, predominantly, “Earth” Element (a condensation of waves and bosons of the Metal Element: sound, movement, light, *and* the gas generating characteristics of “Metal”).

This doesn’t matter at all to the treatment of Parkinson’s disease, but in case you were wondering, there are reasons that the twelve “primary” channels have distinct names even though they all run in one continuous circuit: different sections have different relationships with the various Elements.

All the primary channels have many points of intersection with other channels and with the extraordinary channels. At points of crisscrossing channel intersections, channel Qi flow is influenced by several factors: it will flow into whatever pathway offers the least resistance while simultaneously being under the influence of the particular element that dominates in that channel, as well as being influenced by thought waves and the physical and chemical structures of the body. In other words, when a bit of Qi in the 3rd channel intersects with the route of the 2nd channel, on the face and on the neck, the *type* of Element that predominates in that channel keeps the 3rd channel moving along in its path, and lets the 2nd channel also continue on its way, fairly unmolested by each other. In this manner, the channels can share information (be somewhat influenced by intersecting electromagnetic signals), but can also maintain their own integrity.

Channel names

The name of each Primary channel reflects an internal organ that is located near the course of the channel or along a branch of that channel. For example, one of the smaller branches of the Stomach channel diverges from the main, skin-level portion of the Stomach channel and flows into the stomach. This branch contributes to the development and function of the stomach. Therefore, this channel was named “Stomach channel,” even though it begins at the eye and ends at the toes.

Three of the Primary channels play a large role in Parkinson’s disease: the Large Intestine channel, the Stomach channel, and the Gallbladder channel. These three will be described later in this chapter.

The eight extraordinary channels

Three of the eight “extraordinary” channels, The Du, the Ren, and the Dai, carry a blend of all five elements and can disperse channel Qi of various elements into the primary channels, as needed.

In addition to providing channel Qi in the zones over which they flow, these three extraordinary channels can also serve as feeder lines for the primary channels when, due to injury, illness, loss of limb, or change of neurological mode, the regular path of a primary channel requires some extra back-up channel Qi or a storage zone for surplus channel Qi.

(The Dai and the other five extraordinary channels do not play a significant role in Parkinson's, and will not be discussed.)

The Du and the Ren are pertinent to this discussion. They run, respectively, 1) up the back and through the head to the forehead and 2) up the front of the torso. They are named 1) the Du (usually translated as "Governor," meaning second in command to the King (soul, or heart) which is the Infinite Divine manifesting as individualized consciousness), 2) the Ren (usually translated as "Conception" but more accurately translated as mother, or humanity, or Infinite Divine manifesting as matter, as opposed to manifesting as thought). The Du and Ren channels play a role in Parkinson's, and will be discussed a bit later.

Acupoint names

The acupoints, the locations on the body that are used most often in acupuncture, are named, in English, with a channel name and a number. The numbers are assigned in sequence, starting at the origin of the channel. For example, in the case of the Stomach channel, which flows from the face to the feet, the first named point, "Stomach 1," is near the eye, at the beginning of the channel, and the last point, "Stomach 45," is on a toe at the end of the channel.

In writing, the channel names are usually abbreviated. The point named "Stomach 1" is usually *written* ST-1. In speech, the point names are *not* abbreviated into initials. For example, ST-1 is *not* called "S" "T" "one." When spoken, the points are called by the full name of channel plus number: for example, "Stomach one."

In Chinese, the points are not numbered; they each have poetic names that relate more to the probable healing function of the acupoint than to a channel. The "probable" healing function has to do with the odds being good that a given health problem is often, though not always, caused by an electrical glitch at that particular location.

THE PATHS OF THE CHANNELS

The diagrams in the following section show the parasympathetic mode paths of the Primary channels that are most deeply involved in the pathologies of Parkinson's disease. You don't need to memorize these paths. Just get a general sense of them, and notice that they flow in a *specific direction*.

Again, these drawings show the channels as they are taught in acupuncture schools – parasympathetic mode. This is how they flow when a person is awake, in perfect health, peaceful or joyful, and fearless.

The channels flow very differently in each of the different neurological modes.

The Large Intestine channel

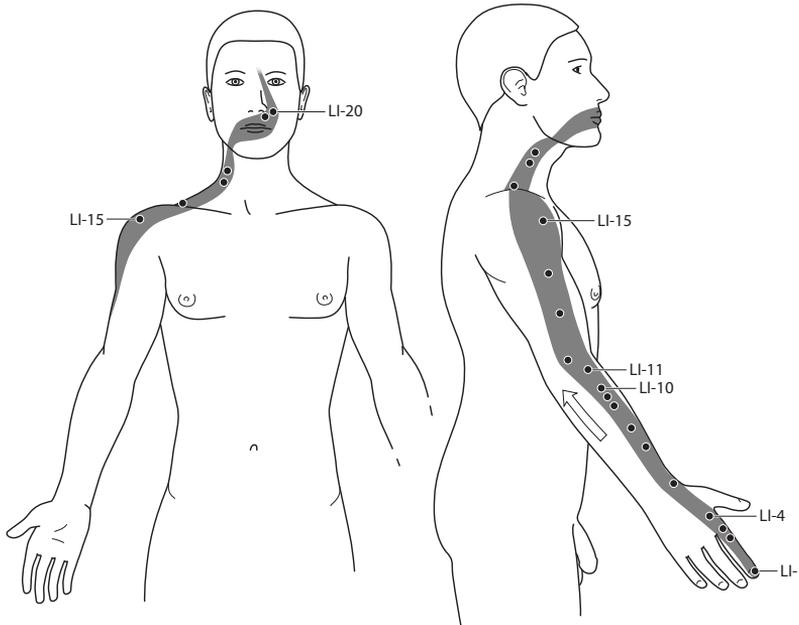


Fig. 7.1 The normal (parasympathetic mode) flow of the Large Intestine channel

The Large Intestine channel flows from the tip of the index finger up to the side of the nose on the *other side* of the face. From there, it connects with Yin Tang, the point between the eyebrows (Yin Tang is shown on the map of the Du channel.)

From Yin Tang, the current flows back down the face in the pattern known as the Stomach channel. Notice that the *right* Large Intestine channel crosses over to the left side of the face. So, the *right* Large Intestine channel will next flow into the *left* Stomach channel, and vice versa (see Stomach channel, Fig. 7.2). This left-right cross-over helps drive the left-right coordination between the arm swing and the leg stride.

The arrow alongside the drawing shows the *direction* of current flow: from the fingers to the head.

The Large Intestine channel is abbreviated LI.

The Stomach channel

The Stomach channel begins at Yin Tang, the forehead point between the eyebrows. The Stomach channel then runs down along the eye's inner canthus (meeting point of the upper and lower eyelid). It then runs down the center of the cheek, spreading out widely over the cheekbone and narrowing again as it passes the corner of the mouth, loops around the upper and lower lips, and then resumes its path down the face, from the corners of the mouth down to the jaw. (Note: the branch that loops around the mouth is shown on the next page.)

The current then travels over the lower jaw, down the side of the neck, and over the collarbone towards the nipple.

The channel follows the mammary line (where a row of nipples would be located if we were dogs, and not humans) until it comes almost to the bottom of the ribcage. Around the level of the fifth rib, the channel travels medially (towards the center line, or midline, of the body), drifting a bit closer to the midline but still continuing its downward (towards the feet) flow. When the Stomach channel gets to the pubic bone, it flows laterally (towards the sides of the body, away from the midline) over the inguinal groove towards the front-side of the hip.

From the hip, the Stomach channel flows down the anteriolateral (front-outer) side of the leg, over the center-front of the ankle, directly over the highest point of the dorsum of the foot (over the arch of the foot) and then the channel branches. One branch goes to the second and third toes. Another branch flows over to the medial side of the big toe after which it reverses direction, heads back up the leg, and is known as the Spleen channel. There are numerous other branchings and bifurcations along the Stomach channel, but the main path and its branching on the foot are the most important for understanding Parkinson's disease.

There are two symmetrical Stomach channels, one on the left and one on the right. Only the right side Stomach channel is shown in Fig. 7.2.

The Stomach channel is abbreviated ST.

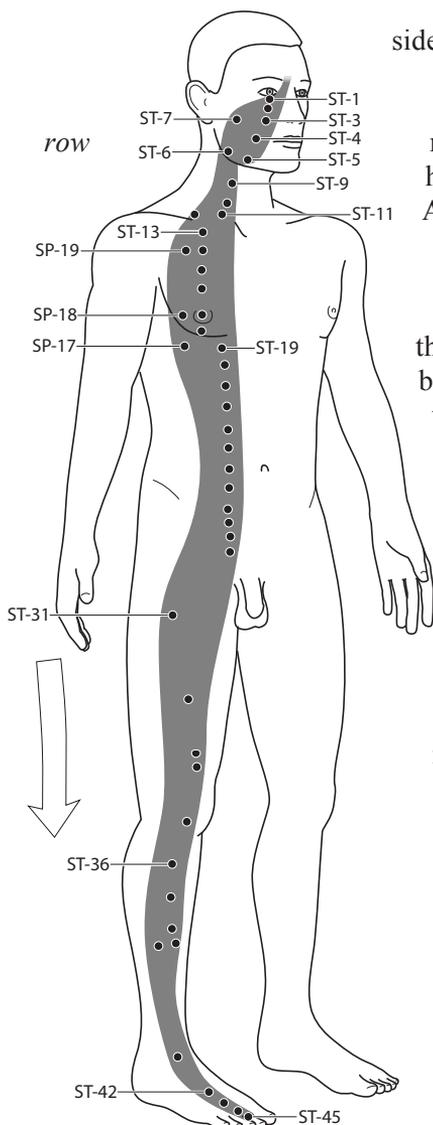


Fig. 7.2 The normal (parasympathetic mode) flow of the Stomach channel

The “lip-skirting” branch

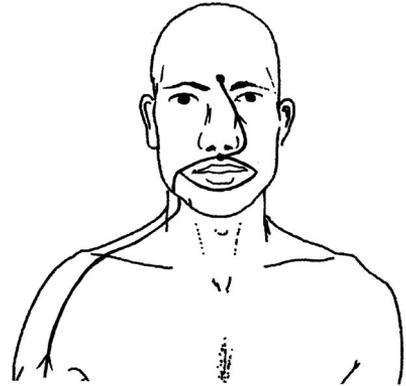
In addition to the main paths of the Large Intestine and Stomach channels, a “branch” of these channels flows around the lips, helping to integrate the left and right sides of the body. Electrical current in this branch flows in an alternating fashion, flowing first from left to right, and then, a moment later, from right to left – so long as a person is awake.

The driver of this back-and-forth motion, the determinant for the speed of the back and forth shifts in the current is, in part, the arm swing. The tempo of the arm swing influences the surges in the Large Intestine channel, which flows up the arm and into the Stomach channel. The Stomach channel surge is thus influenced by that tempo.

Also note, in the drawing below, that this branch allows the Large Intestine and Stomach channels to intersect with points on the midline of the upper and lower lips: points that are crucial to driving the Du and Ren channels.

Fig. 7.3. Detail of the Large Intestine channel showing the branch that usually flows around the lips.

Only the right side LI channel is shown, with its cross-over to the left side of the face.



As an aside, in acupuncture schools, the channels are usually memorized via traditional *line-drawings*: thin lines connecting the dots of the acupuncture points. Most of the drawings in this chapter are “wide” drawings. They show the *actual* paths and approximate widths of the channels.

On this page, for clarity, I’ve used the “thin line” style of drawing the channels.

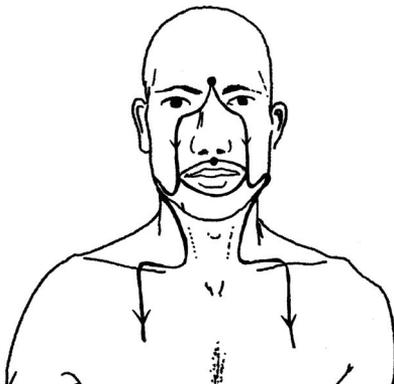
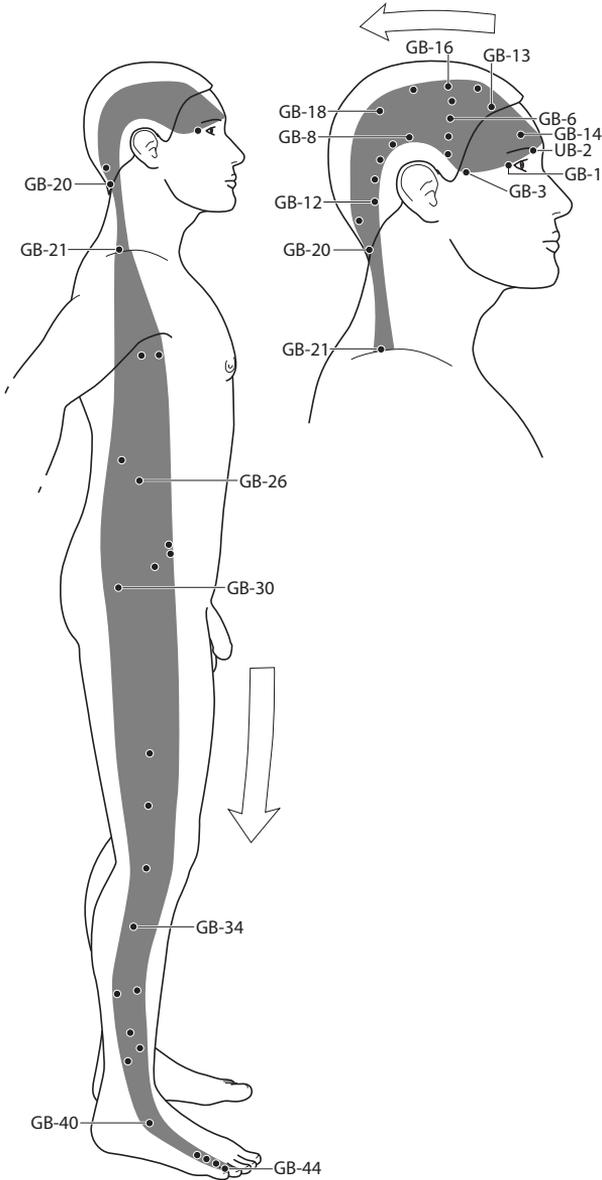


Fig. 7.4 Detail of the face portions of both the left and right Stomach channels, including the “lip-skirting” branch, showing the intersections with Yin Tang, on the forehead, and Du 26, on the upper lip.

The Gallbladder channel



The Gallbladder channel, like all the channels that flow from the head to the toes, begins at Yin Tang (on the forehead. See Fig. 7.6.)

Just as the Stomach channel was just a renaming of the arm's Large Intestine channel, after the latter arrives at Yin Tang and changes direction, so the Gallbladder channel is the renaming of the arm's Triple Burner channel. The Triple Burner channel is not germane to a discussion of Parkinson's disease, and will not be addressed.

The Gallbladder channel is abbreviated GB.

Fig. 7.5 The normal (parasympathetic mode) path of the Gallbladder channel

Two of the extraordinary channels: the Du and the Ren

The Du channel

The Du channel, usually translated as “The Governor,” flows from the anus, up the spine to the top of the neck, through the center of the head (following the brain stem), emerges at the front of the head at the point between the eyebrows, “Yin Tang,” and flows down the midline of the face to the upper lip and into the mouth. A branch of this channel runs over the top of the head.

The Du channel regulates energy in the spine and brain, and in the midbrain – and regulates the release of dopamine.

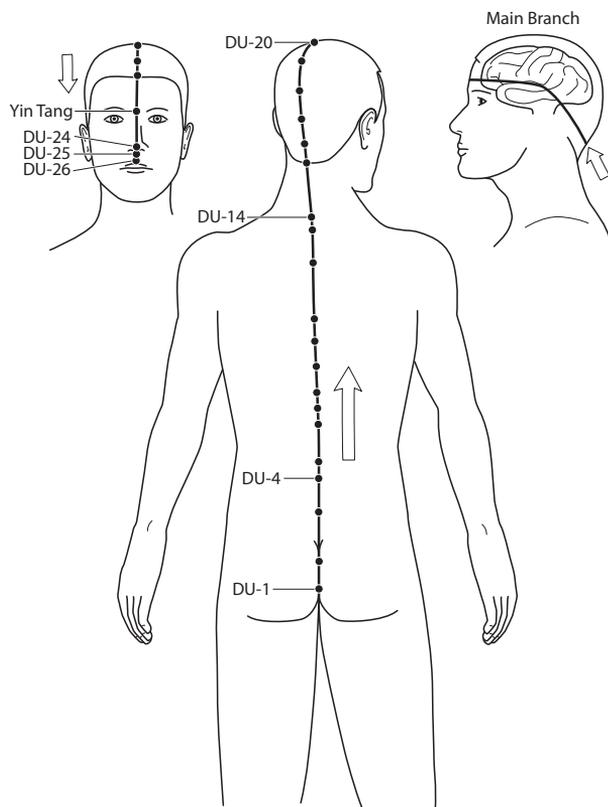


Fig. 7.6 The normal (parasympathetic) path of the Du channel

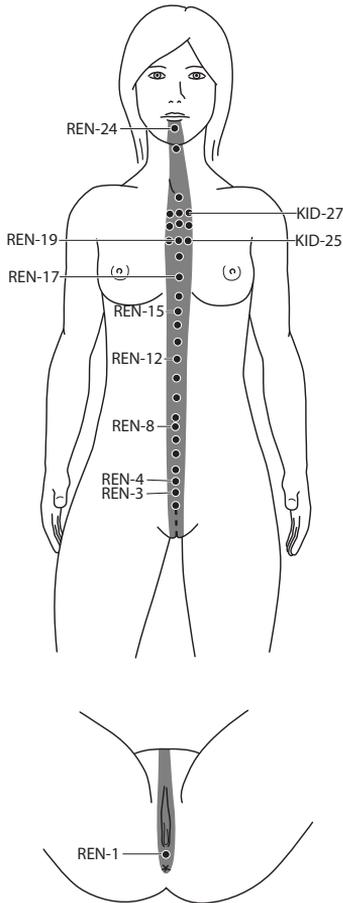
Dopamine? I’ll bet you thought I’d completely forgotten about dopamine, and maybe even Parkinson’s disease. Be of good cheer: the channel theory portion of this book is nearly finished. The subject of Parkinson’s will soon be foremost, again.

The energy in the Du channel keeps the brain and spinal currents alive. If the neck is broken so that the Du channel is severed, death or a serious brain-body disconnect will ensue. Protection of the Du channel plays a large role in the electrical changes that occur during dissociation due to near-mortal injury or due to any other cause.

In the upcoming explanations of what goes awry in Parkinson’s disease, the head portion of the Du channel, in addition to the Stomach channel, will be referred to *many* times.

The Ren channel

The Ren channel, usually translated as the “Conception Vessel”, flows from the anus to the front of the body, up the midline of the front torso, up the midline of the neck and over the midline of the lower lip and then flows into the mouth.



Note: the drawing of the Ren channel, on this page, uses the “wide” channel form of illustration. The drawing of the Du channel, on the previous page, uses the “thin line” style of illustration.

Most Chinese medicine textbooks use the thin line style. This style suggests that channels are wire-thin, almost one-dimensional lines of current. This is not anatomically correct. The “wide band” style of illustration is more accurate: it suggests that the channels cover a fairly broad swath.

Fig. 7.7 The normal (parasympathetic mode) path of the Ren channel

These two channels, the Du and the Ren, flow from the anus, up the back and front sides of the body, respectively, then flow into the mouth and gastrointestinal tract, and back out the anus.

The Du and Ren channels in embryonic development

In the earliest stages of the human embryo, and even in very primitive multi-cells organisms (those with enough cells to form a spherical blastula), the Du and Ren channels exist. When even a very tiny, multi-celled spherical organism has become large enough that the inner cells can no longer easily get access to oxygen or food, or dispose of their waste,

those inner cells die. This creates a hollow space in the center of the sphere. The hollow assumes a tube-like shape. This shape, a sphere with a hollow tube down the center, is called a blastula.

After the formation of the blastula, the electrical (channel Qi) currents that run up over the outside of the sphere also run down through the center of the tube – flowing over the surface of the cells that form the sides of the tube. The current running down through the tube in the middle of the sphere pulls fresh water and food into the tube, supplying the central cells. The same current, as it flows out the bottom of the tube, carries water-borne waste away from the organism’s center.

After emerging from the bottom of the tube, the current then travels back up the outside of the sphere of cells, to the top, and back down again through the tube.

Very large organisms, such as worms, are still essentially just tubes. Currents flow over the sides of the worm, into the mouth, through the gut, out the anus, and back up the sides.

Gigantic organisms such as humans are basically modified worms. We still have a large current that runs up our front and back and down into our mouth, out the anus, and back up the front and back sides to the mouth.

All of the “primary” channels, the channels that create the arms and legs, derive from and make contact at several points with the Du or Ren channels.

The Du channel in the various neurological modes

As mentioned several times, the paths of the channels, as drawn above, are the “classical” paths, and show how the channels flow when a person is in parasympathetic mode and in perfect health. The following discussion will give an example of how channel Qi flow changes in the various modes.

Parasympathetic

The Du channel runs through the head and helps regulate consciousness.

During pure parasympathetic (calm and awake) mode, the head portion of the Du channel runs as shown in Fig 7.6 – straight through the midbrain, emerging back out to the skin at Yin Tang, a point also known in the east as the Third Eye and/or “the star that shines in the east.”¹

The center of the frontal lobe, just behind Yin Tang, is the center of human will, Self-aware consciousness, and spiritual perception. It is best accessed when one is in pure parasympathetic mode.

¹ The “east” is the front of the head. The back of the head, the occiput, is the west. The word “occiput” derives from the word that means “west,” as in “occidental.”

When the biblical magi said they’d followed “the star that shines in the east,” they were saying, modestly, via this common metaphor, that they had followed their divinely inspired intuition, which is accessed by focusing the consciousness at the Third Eye, the center of conscious will and spiritual perception.

Sympathetic

As one shifts towards some degree of sympathetic mode, the portion of the Du channel that flows through the head is, to a matching degree, diverted away from the midline and shifted towards the sides of the head, towards the precuneus area (to the sides of and just behind the frontal lobe). The precuneus area of the brain assesses information in terms of “What does this mean to *me*,” or “How does this affect *me*?”

As one moves away from parasympathetic and indulges more in sympathetic mode – which stems from ego-based and fear-based thinking (one and the same) – energy in the precuneus area of the brain is increased. Oppositely, clear (truly objective, in terms of Universal Wisdom) thinking is diminished.

Sleep

During sleep, amperage in the head portion of the Du channel is greatly diminished. Much of the channel Qi in the head portion of the Du channel is rerouted so that it runs from the back of the neck, over the *top* of the head (not through the *midbrain*), and into the point between the eyebrows.

Dissociation

During a mortal injury, much of the channel Qi from all over the body collects in the Du. In the Du, some of the channel Qi converts from formed, force-carrying particles into wave form. Then, depending on the mental state of the individual, the channel Qi may collect at the very top of the head, or at the back of the neck, or in the area just posterior to the heart – positioning itself to make the final exit from the body (death). Notice that all these locations are posterior (towards the back side of the body) relative to the midbrain. Similar to sleep mode, the channel Qi does not flow in significant amounts through the midbrain and into the frontal lobe during full-blown dissociation.

When, during dissociation from shock or severe trauma, the Du channel does not flow through the frontal lobe, loss of consciousness can occur. When the Du channel does not flow through the portion of the mid-brain that houses the substantia nigra, the release of dopamine is inhibited. When the Du channel flow is reduced, dopamine release is reduced accordingly.

As mentioned in chapter three, most of the time these modes are not all-or-nothing: depending on the degree of dissociation and the degree of sympathetic override, a person who is somewhat dissociated may have *some* amount of frontal lobe access, or *some* amount of dopamine release, even if certain areas such as the movement imagining area is blocked off.

However, over decades of dropping into or staying in some degree of dissociated mode, the channel flow pattern of dissociation increases in amperage in response to frequent or habitual use.¹

The newest brain research proves that the brain grows based on how it is used. Use of dissociation mode makes the brain develop more in the dissociative areas such as wariness,

¹ Modern research confirms that the brain gets “better” at (devotes more circuits to) doing whatever we regularly ask it to do. It also reduces or gets rid of circuits and cells that are barely used or not used, respectively. But most cells, cells with DNA, always retain the *potential* to re-establish previous functions.

and diminishes brain access in the areas that are the domain of parasympathetic function such as relaxation, dopamine-based motor function, and trust.

These brain changes are, of course, reversible. They change again if a person changes his thought patterns again.

But even in modified dissociation, during which a person *overrides* the physical paralysis of dissociation by using sympathetic mode thoughts, the Du channel does *not* flow through the area of the brain that regulates *imagining* motor function (a dopamine-dependent function) for any body parts from which a person has psychologically dissociated.¹

Very mild – and temporary – dissociation: an example

During *mild* dissociation, such as occurs when swimming in a frigid mountain lake (you don’t get *used* to the cold, you *dissociate* from it), much of the channel Qi that is not being used to drive motor function will divert into the Du channel and bide a while, until the swim is over. The portion of the Du that runs through the head will be shunted heavily into the sides of the brain – away from the midbrain – so that the sympathetic mode can commandeer the muscles during this time.

After the swim, the person will shiver until, after warming up for a bit, he affirms that everything is OK, after all, and then he’ll take a deep breath, exhale, shudder, and the channel Qi will be jerked back into the parasympathetic mode pattern (or more accurately, a blend of parasympathetic and sympathetic). The dissociation pattern ceases when parasympathetic mode kicks in.

Many, many people have experienced, and can recall, this sequence: cold water swim; get out of water but still shivering; decide I’m OK now; deep breath; shudder; calm (no shivering). Most of my *Parkinson’s* patients *cannot* relate to this description: I’m OK now; deep breath; shudder; calmness. Their spouses can, their health practitioners can. The eyes of most of my PD patients actually glaze over when I start to describe this sequence.

Strengthening the habit of using Yin Tang

As noted, during severe trauma or severe injury, the Du channel does *not* flow to the center of the frontal lobe, the region of the third eye. This Yin Tang area is *only* served by the Du channel when a person is using some amount of parasympathetic mode.

However, if, via spiritual training, a person has learned to keep his focus on the third eye *despite* challenges, including mortal injury or pre-death, he can keep his channel Qi moving in the parasympathetic pattern. He can prevent any channel Qi from diverting into the “Uh oh! How does this affect *me*” area of the brain (the precuneus). He may then *consciously*, in attunement with Universal Wisdom, choose what he shall do with his Du channel energy as he calmly, joyfully, prepares to take that energy with him in his final, *conscious* exit from the body – or recovers *consciously* from his injury or trauma.

¹ As noted earlier, functional (real-time) brain scans of people with PD have shown the inhibition in this motor imagining part of their brains. This inhibition occurs even when they give mental commands of “Move” to a rigid body part. Also, the “conscious” instruction area shows decreased activity while the precuneus area (the area used in self-conscious (ego-based) assessment and hypnosis) shows increased activity.

Staring at the third eye

A surprising number of my patients with Parkinson's have spent years doing applied spiritual practices. Many have done yoga or other meditative practice. Some have, for many years, included focusing on the third eye, or "Yin Tang," as a part of their meditation practice.

Curiously, they have never been able to attain the joy that is ordinarily attributed to these various practices.

After recovering, the forehead gazers, and I must consider myself a bona fide member of this group, have realized that, although we might have spent countless hours holding our eyes physically focused on the midpoint of the frontal lobe, as instructed, our *thoughts* were snugly ensconced in the precuneus part of the brain, asking ourselves, "How'm I doin'?"

We had been busily assessing or analyzing our "spiritual" practice via the ego. We'd been *thinking* instead of feeling. No wonder we hadn't *felt* the joy in our hearts that is normally associated with this practice.

Chapter closing

You don't need to memorize the paths of the channels in this chapter. The most important thing to get out of this chapter is the idea that electrical flow in the healthy body occurs in a fairly specific pattern and in a highly specific direction.

Also, the channels are not distinct, separate bits of energy. The channels are actually parts of a continuously circulating electrical current. For example, you have seen how the channel Qi of the Large Intestine channel flows up to the face, across the upper lip and up to the forehead. And when this current changes direction and flows down the face towards the legs, the downward flowing portion of the Qi flow is named the Stomach channel.

The names change; the channel Qi never stops. One channel flows into the next, and from there into the next, and the "last" of the primary channels flows back into the first – and all of them derive from and constantly mingle with the great streams of energy in the Du and Ren.

And as demonstrated in the quick discussion of changes in the Du channel during different modes, when variations arise in the flow of a channel's Qi, the physiology – the blood flow and activity level – in the areas that receive increased or decreased channel Qi is altered accordingly.

“(The fourth) change of colors ... is valued by gods because it enables us to stay close (cling) to life.”¹

Nei Jing, classic of Chinese medicine

CHAPTER EIGHT

CHANNEL QI DURING DISSOCIATION

The previous chapter, by way of introduction to channel Qi variations, described some of the ways the Du channel changes during various neurological modes. Actually, *all* channels change their flow patterns in each of the four neurological modes.

The channel maps in the previous chapter showed how the channels most involved in Parkinson’s flow while a person is in parasympathetic mode – awake and free from fear.

This chapter will explain how those same channels flow when a person slides into dissociation mode.

Again, the changes that occur in channel Qi during dissociation create a perfectly normal pattern – one that can help save a life. It is usually a very short-term pattern.

The patterns seen in this chapter also happen to be the exact same patterns that can be detected in a person with Parkinson’s disease – where they have become chronic.

Dissociation and the Stomach channel

When a person slides into dissociation, the Stomach channel is the channel most *obviously* affected (obviously discernable by hand). It doesn’t matter if the move towards dissociation is due to near-mortal injury, loss of blood, excessive perforation of the skin, because one’s “time has come,” or because one is choosing to be numb to his own physical and emotional pain: *when dissociation kicks in, the Stomach channel becomes altered.*

Even in very mild dissociation, or mild shock, as opposed to a complete state of immobility and loss of consciousness, the Stomach channel Qi may manifest its “backwards” pattern: its dissociation pattern.

During *parasympathetic* mode, the Stomach channel flows from the eye down to the toes, as seen in the previous chapter.

¹ Su Wen, chapter 13-9, from *A Complete Translation of the Yellow Emperor’s Classics of Internal Medicine and the Difficult Classic*, by Henry C. Lu, PhD, published by the International College of Traditional Chinese Medicine, Vancouver, BC, Canada, 2004. Some translations use the word “cling” instead of “stay close to.”

Dissociated mode, which is a last-ditch attempt by the body to stay alive in the face of mortal wounds, lets us “cling to life.”

But during dissociation, the Stomach channel Qi runs backwards – from the mid-foot up to the chin. There may be no Stomach channel Qi at all in the 2nd and 3rd toes or on the front of the face.

Staying away from the Du channel: the Stomach channel shunt

During dissociation, when the backwards-flowing Stomach channel Qi gets to the jaw, in the vicinity of ST-6, it is shunted up to the side of the head, to acupoint ST-8.

ST-8 is *not* on the path of the normal, parasympathetic flow of the Stomach channel. ST-8 is used only when the Stomach channel is flowing backwards.

ST-6, on the lower jaw, acts as a safety shunt. This shunt prevents Stomach channel Qi from flowing backwards over the face and going *backwards* into the Du channel.

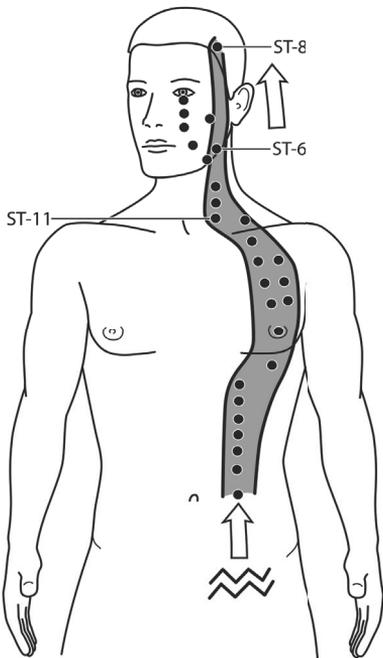


Fig. 8.1 *Stomach channel Qi flowing backwards, towards ST-8 and the head portion of the Gallbladder channel, during dissociation.*

In Fig 8.1, the large arrow on the side of the head demonstrates the direction of the Qi flow in the head portion of the Stomach channel during dissociation. Compare this flow with the correct flow of the Stomach channel, in Fig. 7.2 in the previous chapter.

The zig-zag lines merely indicate that the entire length of the Stomach channel is not shown.

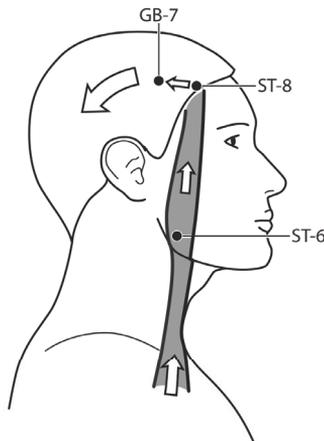


Fig. 8.2 *Stomach channel Qi flowing into the Gallbladder channel.*

The arrow on the side of the head shows the location and direction of the Gallbladder channel. The charge that builds up at ST-8 can short-circuit into the Gallbladder channel in the vicinity of GB (Gallbladder)-7.

As shown in the previous chapter, the face portion of the Stomach channel intersects the Du channel in two places: the upper lip and the forehead, at Yin Tang. *If backwards-*

flowing Stomach channel Qi started to push the *Du* channel in a backwards direction, the person might die.

The *Du* channel is crucial for maintaining life and consciousness. The head portion of the *Du* channel *must* run in the correct direction: from the back of the head towards the front of the head.

The power in the *Du* channel can be *reduced* without the person dying. For example, its amperage is *reduced* during sleep, anesthesia, or during dissociation. When it is reduced, it still flows gently in the *correct* direction. For the *Du* channel, reduced flow is OK. Backwards flow is not.

The *Du* channel must *not* run backwards. If it does so, a person can quickly become unconscious. If the head portion of the *Du* channel runs backwards for an extended period, the person can die.

And so the shunt on the back of the jaw, in the vicinity of ST-6, automatically shunts any backwards-flowing Stomach channel Qi up to ST-8, out of harm's way, so that the *Du* channel never intersects with backwards-flowing channel Qi.

Acupoints ST-6 and ST-8 are something like electrical capacitors: the channel Qi can build up at ST-6 or at ST-8.

If the static builds up at ST-6, alongside the lower back molars, a lower back molar pain may develop.

If the static builds up at ST-8, a headache on the side of the head may ensue. In a case of mild dissociation or mild injury causing Stomach channel Qi to back up, the headache caused by a build up of static electricity at ST-8 may be sufficient to get the person to go lie down and rest.

Ideally, the jaw pain or headache from such a build-up will cause the person to lie down, process the situation, and resolve it by relaxing and switching over to parasympathetic mode. This allows healing to begin in the troubled area. As soon as sufficient healing has occurred, enough so that the Stomach channel can flow correctly again, the pain will cease.

As soon as the cause of the backwards flow of Stomach channel Qi ceases, the Stomach channel Qi will *immediately* resume its flow in the correct direction. Any build-up of static at ST-8 will disperse by flowing back down to ST-6. When the injury begins to heal and/or the dissociation ceases, any channel Qi at ST-6 will resume running down the neck and into the torso, into the usual pattern of the Stomach channel.

Many people with Parkinson's have been subject to pain in a lower back molar that can't be explained by x-ray or relieved via surgery. In some patients, the pain is chronic. In others it comes and goes. Not everyone with Parkinson's has this "inexplicable" lower jaw pain. Of those who do, it goes away when the Parkinson's symptoms cease.

Also, if and when too much channel Qi builds up at ST-8, on the side of the forehead, the Stomach channel Qi "shorts out" (spills over) into the nearby Gallbladder channel on the side of the head. When this short circuit occurs, a person *may* experience a momentary flash of electrical charge as the channel Qi surges into the Gallbladder channel in the vicinity of GB-4.

In some people with Parkinson's, this "short circuit" may occur frequently, creating a *small* buzzing sensation on the side of the head during times of stress.

In others, this short-circuit was a one-time, *highly* charged event, after which, Stomach channel Qi is steadily shunted into the Gallbladder channel. For some of the latter, the one-time, powerful, long-lasting shunt is highly memorable. It sometimes occurs during one's late teens or early twenties. Some people with Parkinson's, though not a majority, recall such an event. This short circuit has been described to me in various ways, by various patients: "it was a zap, or "a buzz," on the upper side of the head, or "a spinning inside my head."

Others have said that it seemed as if the room was spinning, or as if the brain was in an altered state for a minute or so. After this highly charged event, the internal tremor is usually up and running, so that a person never really feels quite so relaxed as he used to, even if his Parkinson's tremoring is not going to appear until several decades in the future.

This event, the "brain-spin shift" that sets up the internal tremor, should *not* actually occur during a short bout of dissociation – the normal process of "shock." This event only occurs when the Stomach channel has been shunting far too much channel Qi, *for far too long*, into the Gallbladder channel on the side of the head. During recovery, many people experience a room-spinning sensation as if one hemisphere of the brain is re-orienting back to normal, followed by cessation of internal tremor. This recovery phenomenon allows me to hypothesize that, many years prior to the appearance of Parkinson's, the steady, excess flow of channel Qi into the head at this area forces a specific current, or possibly the entire brain hemisphere, into a position more posterior than normal.

One of my Parkinson's patients remembered this moment clearly: he was in his teens, riding his bicycle, when his brain seemed to go into a spin. He "came to" a good half mile farther down the road, with no recall of having bicycled the last half mile. He had previously told no one about this mind-lapse, but had jokingly referred to it, in the privacy of his own mind, as "my abduction by aliens."

In my own case, I vividly recall the moment, when I was seventeen, when the laundry room began spinning violently. I clung to the washing machine, hanging on until the room stabilized. I never gave it another thought, until after I made the list of all my own life experiences that might shed some light on my development of Parkinson's disease. I, too, had never told anyone about that singular moment.

One of my patients told me that at her baptism, when she was eight days old, the preacher nearly dropped her head-first into the basin. He grabbed for her foot and caught her in time. She swung for a moment, suspended by the fierce foot-hold. Her grandmother told her, several times, "You were a wonderfully calm baby up until that moment. And ever since then, you've always been somehow agitated, as if you never got over that slip."

Then again, many people with Parkinson's have no recollection of such an event, and have never felt any sort of pressure, tingling, buzzing, or other irregularities on the side of the head in the vicinity of ST-8.

It seems that this short-circuiting “zap” may occur after a very short period of time of backwards-running channel Qi, if the severity of the injury and the dissociation, and therefore the severity of the build-up of static, is high and of rapid onset.¹

On the other hand, the zap may occur after several years, or even decades, of channel Qi becoming increasingly stymied by an unhealed injury, scar tissue, or other blockage on the Stomach channel. In the latter case, when the energetic confusion in the vicinity of the blockage becomes, over time, severely altered, *eventually* backwards channel Qi flow offers less resistance than correct channel Qi flow.

In this case, decades may pass before the shunt from ST-8 into the Gallbladder channel occurs – and it may be remarkable when it happens, or it might occur unnoticed if it happens during sleep. If it happens during sleep, the person might never know that it happened until, during recovery from Parkinson’s, the affected brain hemisphere physically switches back into its correct position – an unmistakable sensation – unless, again, that process occurs during sleep.

More on this subject, later.

* * TIME OUT FOR MORE CHANNEL THEORY * *

Each of the primary channels, in turn, experiences a two-hour (approximately) increase in amperage every day. These increases drive many of the “diurnal” (internal clock) physiological events that so mystify western physiologists.

For example, the Lung channel (channel #1) experiences a surge in amperage from 3:00 a.m. to 5:00 a.m., as it flows down the arm to the hand. Next, the Large Intestine channel (channel #2) has a surge from 5:00 a.m. to 7:00 a.m. as it flows up the arm, to the forehead. The Stomach channel (channel #3) surges from 7:00 a.m. to 9:00 a.m. as it flows from the forehead to the toes.

And so on.

The Gallbladder channel (channel #11) has a surge between 11:00 p.m. and 1:00 a.m. This surge at approximately 11:00 p.m. is crucial in helping a person fall asleep.

Remember, the mighty Du channel roars up the spine and through the midbrain, maintaining consciousness. (See Fig. 7.6, p. 111.) While coursing through the midbrain, this current passes right through the substantia nigra, home of the brain’s dopamine supply. This current is responsible for stimulating the release of dopamine. This current also maintains wakefulness and self-conscious awareness.

A small branch of the Du runs over the top of the head, but during wakefulness, this amount of current in this branch is not as great as the amount running through the middle of the brain.

In order to fall asleep, this power in the head portion of this current must be greatly diminished.

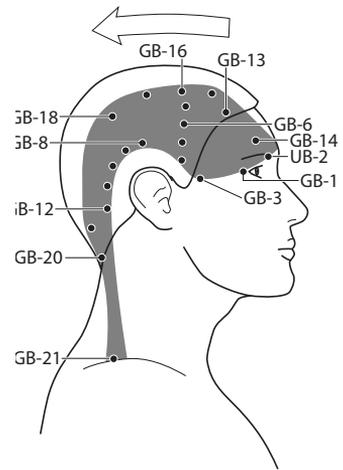
¹ I had one patient, with only local dissociation from a foot injury and no overall dissociation, who experienced this localized buzzing on the side of his head every work morning, as he had his breakfast consciously steered himself (via dissociation) for another day at work.

Review: using the figures below, recall that the Du channel and Gallbladder channels run in opposite directions.



Fig. 8.3 The head portion of the Du channel runs through the center of the brain, from the back of the head to the front of the head, through the brain stem and midbrain. (See Fig. 7.6)

Fig. 8.4 The head portion of the Gallbladder channel runs along the left and right sides of the head. It flows from the front of the head to the back of the head: the opposite direction of the Du channel. (See Fig. 7.5.)



When the Gallbladder channel experiences an increase in amperage at around 11:00 p.m., running the *opposite* direction of the Du channel’s current, the power in the Du channel is diminished.

This is a basic tenet of physics – the power and direction of a given current will influence the power and direction of a nearby current.

At approximately 11:00 at night, the *increase* in Gallbladder current causes a *reduction* in the power of the Du channel. When the Du channel is significantly decreased, consciousness ceases. A person falls asleep. Dopamine release is automatically inhibited. Awareness of the body is severely diminished. (We stop feeling, smelling, tasting, seeing, and hearing during sleep.)

When the Du is significantly diminished, thoughts are inhibited. As thoughts become inhibited, the *fear*-based thoughts that trigger the release of adrenaline cease: adrenaline is no longer released.

When sleeping, levels of dopamine and adrenaline levels both drop. We cease to move.

During sleep, we are relaxed, not rigid: channel Qi throughout the motor areas is greatly diminished and motor-driving neurotransmitter levels are very low. *Even so*, the channel Qi is still going the right *direction* in the various channels, such as the Stomach channel. In this way, among others, sleep and dissociation are very different.

When a person nods off at nighttime and channel Qi is greatly reduced in certain parts of the body, where does it go? The channel Qi that isn't being used during sleep, such as the channel Qi for the digestive organs, is coursing through the Gallbladder channel, directing an enormous amount of housecleaning in the liver and gallbladder organs.

During sleep, we do not feel ongoing physical or emotional pain.

Of course, if a person is fearful, the sympathetic mode can over-ride the sleep mode. If a person has a running train of fear going through his mind, his sleep will be poor, and he may startle at noises, smells, or other stimuli. He will be able to feel his physical and emotional pain as he tosses and turns on the bed, half-awake or even fully awake.

But assuming that one has slept well, approximately six hours later, at around 5:00 a.m., the Large Intestine channel has a surge in amperage. This surge causes a boosted level of LI channel Qi to flow along the upper lip – where it intersects with the Du channel. This blast of channel Qi provides a “wake-up” call to the Du channel. Next, the Large Intestine channel wends its way up to the forehead, where it intersects the Du channel again, at Yin Tang, the point between the eyebrows. This second intersection of the LI and Du channels gives yet another boost to the Du channel. During “Large Intestine channel time,” the increased amperage of this channel slaps the Du channel for two hours with a hefty blast at both these locations.

The Du channel, thus stimulated, begins flowing with steadily increasing amperage until it attains its normal “awake” level once again – ready to start a new day.

A so-called “branch” of the arm's Large Intestine channel is said to “connect to the large intestine organ.” The branch in question is the vagus nerve. This surge in the Large Intestine channel across the upper lip wakes up the Du channel, which in turn wakes up the vagus nerve. This nerve stimulates the intestines, which have been dozing, getting them ready to move the bowels and make way for breakfast.

Next, from 7:00 a.m. to 9:00 a.m., the Stomach channel gets an amped up level of channel Qi. The Stomach channel, like the Large Intestine channel, traverses the lips, intersecting the Du channel. Just like the LI channel, the surging Stomach channel merrily whacks the Du channel on the upper lip and at Yin Tang, further rousing the Du.

By the time 9:00 a.m. rolls around, the Du channel has been getting nudged for four hours with an elevated level of stimulation from the Large Intestine and then the Stomach channels. By approximately nine in the morning, a person's Du channel is vigorously up and running. The diminished level of Qi in the Du channel that was induced by the increase in the Gallbladder channel at around 11:00 p.m. the night before, is ended.¹

¹ These times are approximate. They vary according to the hours of daylight. In the classics, this bit of channel theory is called the Law of Midnight/Midday. This subject is discussed in depth in *Tracking the Dragon*. These hourly shifts in channel Qi can also be overridden by, what else, the sympathetic nervous system. Thus, although every system in (Continued on next page.)

As an aside, if a person uses *only* sympathetic mode to drive his thoughts, there may be no “slow, gentle wake-up” for him. He may awake with a start as his brain switches directly over from dozing sleep into alert, sympathetic-mode consciousness. This “on alert” mode of waking up happens to be the norm in most of my patients with Parkinson’s disease.

Instead of waking slowly, lying in the bed noticing that sensation and awareness is returning to his toes, sensing the feel of the sheets on his skin, he may immediately think, “What day is it?! What am I supposed to be doing today!” With sensory functions ignored, his mind racing at full speed, in sympathetic mode, he may bound out of bed, or at least lay in bed trembling as he worries about organizing his day most efficiently, or some such set of thoughts.

* * END OF CHANNEL THEORY TIME OUT * *

As noted, during dissociation, the backwards-running channel Qi in the Stomach channel is shunted up to the side of the head. From there, it short circuits into the Gallbladder (GB) channel. This causes increased amperage in the Gallbladder channel any time the dissociation is activated.

Increase in the Gallbladder channel’s amperage = decrease in the Du’s

This *increased* amperage in the GB channel during dissociation causes a *decrease* in the amperage of the Du channel – just like the Du decrease that occurs *normally* at night, which induces sleep and which inhibits the release of dopamine.

Remember, during *sleep*, despite the absence of dopamine, muscles remain relaxed. In sleep, channel Qi is going the correct direction.

It is *not* the absence of dopamine that makes muscles rigid – it is the *backwards* flow of channel Qi in the arms and legs – a dissociation-specific pattern. Rapid-onset rigidity is the *correct* muscle response to the backwards flow of channel Qi.

The almost instant tightening up of muscles in response to backwards-flowing channel Qi is a biologically protective mechanism: if a limb is severely injured or severed, so that channel Qi cannot flow through and begins flowing backwards, the muscles in the area automatically tighten up. This tightening restricts further blood loss in the injured limb. Muscle rigidity, by clamping down the muscles, also limits the movement of any displaced tissues, including bones, thus preventing them from becoming further displaced. Backwards-flowing channel Qi is *supposed* to make the underlying tissues become rigid.

In a situation of dire injury, a person will still be able to move, but only by using adrenaline. Dopamine release is correctly inhibited.

Remember, if a person is in sleep mode, the *decrease* in dopamine makes muscles become limp, not rigid.

(Continued from previous page.) the body might cry out for sleep at around 11:00 p.m., excessive mental activity – or habit (the realm of the subconscious, driven by the sympathetic nervous system – can prevent a person from falling asleep even though the channel Qi is coursing through the Gallbladder channel in the go-to-sleep pattern. By using adrenaline, one can prevent his body from *responding* to the diurnal shifts in channel Qi – or even prevent the shifts from happening at all.

As an aside, the reason that dopamine-enhancing drugs allow a person with PD to move is those drugs alter the *thought* processes: the surge of dopamine created by the drugs over-rides the person's dissociated attitude and *forces* the person into parasympathetic mode, a mode in which one *can* use the motor-imagining area: an area usually forbidden during dissociation. With mood-altering drugs flooding his brain, the person feels *safe enough* to move. He might not be giddy with happiness, but his brain can register "safe." By temporarily inhibiting the dissociation-inducing thoughts, the drugs allow the brain to execute parasympathetic-type movement instructions.

Just as a person on methamphetamine, a dopamine-enhancing drug, might become so fearless that he dives to his death out of the tenth story window, certain that he can fly, a person with a severe injury is able to feel quite fearless (extreme parasympathetic mode) when under the influence of mind-altering, dopamine-enhancing drugs. In this drugged state, he can move easily even though his muscles are still fairly rigid. If you feel the leg muscles of a medicated person with Parkinson's, the stony rigidity is still present in the muscles. The dopamine doesn't "loosen" the muscles; it allows a person to access motor function in *spite* of the rigid muscles.

Dopamine-enhancing drugs *don't* deliver "much-needed dopamine" to the muscles; they create drug-induced signals of safety or fearlessness so that a person can move in spite of himself, in spite of his unhealed injuries, and in spite of his dissociation-inducing attitude.

Returning to the main discussion, during dissociation, if the person is able to remain conscious, *adrenaline* may still be released, even if dopamine release is inhibited. Adrenaline allows movement even in rigid body parts.

If a person who is dissociated has fear-based, sympathetic-mode inducing thoughts, his body may release adrenaline to override the immobility brought about by dissociation's inhibition of dopamine, inhibition of the motor imagining areas, and other brain functions that are correctly inhibited during dissociation.

The addition of Stomach channel Qi (from the backwards Qi shunt) to the Gallbladder channel Qi already flowing in the Gallbladder channel increases the overall amount of channel Qi in the head portion of the Gallbladder channel.

The increased amount of channel Qi pouring into the Gallbladder channel then decreases the amperage in the Du channel.

This Rebellious-Qi induced combo – an increase in amperage in the Gallbladder channel and matching, simultaneous reduction in Du channel amperage – can lead to beneficial immobility or somnolence. This enforced immobility or sleepy state can be an important factor in healing, following a severe, life-threatening injury.

For example, when a person breaks a leg, the resulting Rebellious flow in his leg's Stomach channel Qi will end up at ST-8, and then zap into his Gallbladder channel. This, in turn, will inhibit, somewhat, the Du channel. The inhibition will cause him to be able to rest deeply. Between the chemical release of endorphins, triggered when channel Qi flows interiorly along the spinal portions of the UB channel, and the electromagnetic sedation of the Du, the injured person may almost feel somewhat sedated, in spite of the significant injury in

his leg. So long as he feels safe, so that he doesn't have to activate an adrenaline override, he may remain in this "sedated" state for as long as necessary.

He may feel this way until the break in his leg is healed enough that channel Qi can once again go through – a matter of a few days, or a few weeks, depending on the degree and location of the break.

Following a severe injury on one side of the body, such as a leg-break, *if one is in a safe place*, one may experience a period of diminished interest in physical activity, a somewhat inhibited appetite, and an increased ability to doze. This "partial sleep" state is created via the *partial* Du channel inhibition that comes about when there is a surge of current on only *one* side, left or right, of the Gallbladder channel. The effect of the Gallbladder channel on the Du is only "half-strength" if the injury only occurred on one side of the body. The channel Qi on the *uninjured* side of the body may still be running somewhat normally. So the Du channel will be running at half strength.

Then again, if a person is in danger or is fearful immediately following the leg-break, his body will shift into sympathetic mode. In sympathetic mode, the elevated adrenaline levels will allow him to override the partial-sleep type symptoms of dissociation mode. A person can run for miles on a compound-fractured leg, if he is in mortal fear. Only when he gets to a safe place will his channels cease to flow in the sympathetic pattern. Then, his adrenaline levels will drop. After the adrenaline is neutralized, he can succumb to the brain-altering effects of Rebellious channel Qi in the Stomach channel shunting into the GB channel – he can rest deeply.

We see this behavior in injured animals in the wild.

The Stomach and Large Intestine channels during dissociation

The most significant of the many shifts that occur during dissociation is the backward-flowing Stomach channel shunt into the Gallbladder channel, which causes increased power in the Gallbladder channel and, therefore, diminished power in the Du channel, which causes, in its turn, a reduction in dopamine release and a reduction in mobility.

But other changes occur, as well. In parasympathetic mode, the Stomach channel, as it flows down the front of the neck, intersects the Large Intestine channel as the latter makes its way towards the face. But when Stomach channel Qi is flowing *backwards*, it creates a difficult-to-bypass glitch for the Large Intestine channel at that point of intersection.

The Large Intestine channel Qi *cannot* flow easily past this point of intersection when the Stomach channel is flowing backwards. Instead, the channel Qi in the arm portion of the Large Intestine channel is turned back, at this point on the neck. The backwards-flowing channel Qi in the Stomach channel acts as a channel blocker to the head-bound portion of the LI channel.

This leads to two situations: the face has an absence of channel Qi in the areas where the LI channel would have gone. In the arm, the LI channel Qi flows backwards, or back and forth, or in some manner that diverts the channel Qi away from its normal flow pattern: from index finger to the face.

The correct muscle response to backwards-flowing channel Qi

Backwards-flowing channel Qi sends “be rigid” instructions to underlying muscles. Muscles that underlay the Stomach and LI channels become rigid when the channel Qi above them runs backwards.

During profound dissociation, in which the body assumes a somewhat fetal posture, it is the backwards-flowing channel Qi in the legs and the front of the torso (Stomach channel) and arms (Large Intestine channel) that renders these areas somewhat rigid, so that the body pulls in tightly.¹

The Ren channel during dissociation

During dissociation, the Ren channel (Fig. 7.7), which runs up the front midline, becomes very weak, or stops running entirely. The Qi that normally runs in the Ren channel, coursing upwards along the front of the body, from the anus to the lower lip, stays deep inside the body during dissociation, moving into the Du channel and converting into wave energy.

The Ren channel is easy to feel.

It is also very easy to feel a diminishing or an absence of channel Qi in the Ren channel when a person slides into dissociation.

In response to dissociation-triggering thoughts, the flow of Ren channel Qi, in many, if not most, Parkinson’s patients, will almost instantaneously decrease, or stop.

The chin tremor that can occur in Parkinson’s is related to the cessation of Ren channel Qi.

¹ We call this the fetal position. The fetal position is caused by a peculiar flow pattern in the Stomach and Large Intestine channels during gestation. The stomach and bowels of the fetus do not function. Instead, the fetus receives nourishment directly into the bloodstream from the mother. If these channels *were* functional during gestation, the fetus would have stomach and bowel movements, extruding waste into the amniotic fluid, thus filling the lungs with muck and preventing breathing after birth. The “fetal” position, with the body curled up, is caused, in part, because the Stomach and Large Intestine channels do not have “normal” flow until birth. (Continued on next page.)

During dissociation, these same channels are also altered, creating rigidity in certain muscles that leads to a fetal-type posture. The same thing occurs in old age, when the Stomach and Large Intestine channels weaken, and the posture becomes “pulled in”. These two are also the channels that shut down first when a person’s body is preparing to die or is in severe dissociation.

These two channels are considered the channels of “Life-is-Present!” (*Yang Ming*, “brightness of the sun) as opposed to all the other channels, which run whether or not a person is born yet – or is heading towards death. *Yang Ming* is also a popular “good luck” name for businesses, in China. This subject might lead to a discussion of whether or not the fetus is also somewhat mentally and physically dissociated from his body – able to observe his world, his mother, himself, from outside the womb, if he so chooses. Is he hovering between the world of physical tangibility and a more subtle, vibratory realm, or moving back and forth between the two. At will? Somewhat impervious to pain, if he so chooses? Who knows. If the fetus is in a somewhat dissociated, or you might say pre-death/pre-life condition, it may even be able to *consciously* decide whether or not to self-terminate or to go through with the “body experience.” Many interesting philosophical points arise.

In a baby, a sudden shock such as a loud noise can often produce tremoring in the baby's chin. A baby does not have the presence of mind and strength of mental focus to think to himself, "I'm safe, after all," thus restarting the flow in the Ren channel.

We instinctively hold a chin-tremoring baby to the left side of our adult chest – just over our heart. The baby's heart will soon begin to resonate with the "It's OK" frequency being given out by our much larger adult heart. The baby's heart then resumes the "It's OK" frequency in his own heart. When this happens, the baby's Ren channel Qi resumes normal flow, and the chin tremor stops.

Feeling the flow of Ren channel Qi is a convenient way to see if a person's thoughts are triggering dissociation or not. This Ren channel shut-down, like the backwards flow of channel Qi flow in the legs, comes and goes as quickly as thought.

When dissociation mode kicks in, the Ren channel flow may be instantly diminished, maybe even to the point where it cannot be felt.

Backwards Stomach channel, healthy Ren channel

Even if a person has an unhealed foot injury, he might still have access to heart feeling. In this situation, which we've found in about five percent of our patients, the Stomach channel Qi will be running backwards, but the Ren channel will still be flowing. A person with this situation might be able to perceive heart-expansion feelings in response to the usual emotional stimuli, such as majestic music, visual beauty, and so on, even though his legs are starting to feel wooden or rigid.

Even so, after enough years with an unhealed foot injury, the Ren channel flow may become reduced as a *side effect* of the alterations in the Stomach and Large Intestine channels.

In this case, a person has an ongoing unhealed foot injury, and this injury has generated an aberrant channel Qi pattern in the leg that is shunting into the head and triggering a Gallbladder response that *mimics* the electrical patterns of dissociation. This electrical pattern then can affect the thoughts, moving them in a sympathetic mode direction and, eventually, possibly following the brain hemisphere shift, into a dissociated format. From there, the dissociation type thoughts lead to diminished flow in the Ren channel.

Oppositely, a person who has a severe trauma that legitimately triggers dissociation, or has mentally induced a generalized, or "body-wide" condition of freedom from pain, will *typically* have greatly reduced flow of Ren channel Qi.

Quick review: primary dissociation (where the dissociation is activated by severe trauma or a mental attitude of feel-no-pain) causes the Ren channel to diminish, and almost immediately the Stomach and Large Intestine channel Qi flow becomes backwards, back-and-forth, or seemingly gone altogether.

Secondary dissociation, in which a long unhealed foot injury eventually sets in motion the Stomach and Large Intestine backwards-flow patterns that *mimic* dissociation, can eventually create alterations in thought patterns. These alterations, in turn, lead to dissociation-type inhibition of the Ren channel: two routes to the same conclusion.

The inhibition of flow in the Ren channel can be used diagnostically, to help confirm a diagnosis of Parkinson's, just like the backwards flow in the Stomach and LI channels.

Inhibition of the Ren, like alterations in the Stomach channel, can also be used to detect the patterns that arise during partial recovery. Partial recovery occurs when the foot injury heals and channel Qi *can* once again flow merrily all the way to the foot when a person is feeling safe *but* slides into dissociation-type flow in response to any sort of fear-based mental trigger.

For readers who have PD who are saying to themselves, “Well of course, a person has to be able to slide into dissociation if there's some problem!” let me reiterate: the normal, healthy response to fear is sympathetic mode, not dissociative mode. A healthy response to fear is an increased heart rate, increased breathing, and increased blood pressure. A healthy response involves running away, fighting back, or at least getting one's dander up. Playing dead is *not* the healthy response to fear, unless one is a possum.

I have been asked by members of the Parkinson's Treatment Team to repeat the above statement, enlarge on it, and put it in bold typeface.

The normal, healthy response to fear is sympathetic mode, not dissociative mode. A healthy response to fear or pain is an increased heart rate, increased breathing, and increased blood pressure. A healthy response involves running away, fighting back, asking for help, or at least getting one's dander up: some form of action. While immediate expression of the sympathetic response might not always be practical, the pent-up energy of this response should be allowed to release itself as soon as a safe time arises.

Playing dead (dissociation) is *not* the healthy response to fear or pain. It is a very special response that a few extremely intelligent and focused people have figured out how to use in order to make themselves numb. However, they have not figured out how to make themselves *stop* using it. Like other methods of increasing the level of endorphins or opiates in the body, non-emergency use of this neural mode is addictive.

Again, the Ren channel is also an indicator of dissociated mode. With some patients, the shift in channel Qi is easier to feel in the legs. In others, it might be easier to feel in the Ren channel.

Both the Ren and Stomach channels, and to some extent the Large Intestine channel, will respond to mental, or role-playing instructions that activate dissociation mode by diminishing, stopping or even reversing their flow of channel Qi.

The other channels during dissociation

All the other channels are also affected, primarily by becoming greatly diminished in amperage. To the degree that one is dissociated, the channel Qi flow is diminished in most of the primary channels. Much of the diverted channel Qi flows into the torso- and neck-portion of the spine. Once there, the particle portion of the channel Qi converts into wave form, to ride out the trauma – or to prepare for an exit from the body.

This decrease in channel Qi in the skin and in the extremities can make a person's skin very cold to the touch.

The portion of channel Qi that converts to pure wave form is no longer “channel” Qi. It is the *non-material* basis of a person’s identity. In this form, the energy is not necessarily tied to the body. These waves of energy can become centered *outside* of the body. This allows for the experience of perceiving one’s own body from *outside* the body.¹

Dissociation and endorphins

When channel Qi flow dives deep within, to the spinal portion of the Du channel, it triggers the release of endorphins from the spinal nerves, at the place where the spinal nerves emerge from the spinal column, near the base of each vertebra. These opiate-like chemicals inhibit the perception of pain. For this reason, together with the alteration of consciousness to outside of the body, mortal wounds are painless.

The time frame for switching into dissociation: instant

As for the speed at which this switch to dissociation can occur, the Stomach channel - Gallbladder channel shunt and the Ren channel inhibition can be activated in the blink of an eye. When I am doing diagnostic work, trying to determine if the person is using his mind to flip himself into dissociation, I often get the patient to relax by telling some ridiculous joke, or I say something soothing to distract or relax the patient. *If* the patient’s Stomach channel begins to flow in the correct direction during distraction or relaxation, (which means that there is not, or is no longer, an injury-based blockage on the foot) I might then say something negative, such as “Uh oh...!”

If the patient has the habit of dissociating in response to negative thoughts, fears, or anxieties, the channel Qi in his Stomach and Ren channels will *immediately* begin running backwards, or feel as if it has stopped running altogether, in response to my simple “Uh oh...”. *Immediately*.

Anyone reading who does *not* have PD might be wondering how a body-wide neurological shift can occur so quickly. It’s easy. The shift is driven by thought waves. Thought wave patterns can change as quickly as thought. These waves then alter the currents.

Waves affecting currents is not theoretical: it is basic physics. This is similar to the way that wireless radio waves can be picked up by and then direct the currents that run your computer. In a living system (a living body), the wave-altered currents then alter the performance of underlying muscles and organs and regulate the release of appropriate neurotransmitters.

¹ This situation is similar to the condition produced when “knocked out” by chemical anesthesia. Anesthesia is *not* similar to sleep. It is more similar to dissociation. Chemical anesthesia causes powerful reversal of Stomach channel Qi: aspiration of vomit is one of the risks of chemical anesthesia. During complete chemical anesthesia, the body can become very cold, especially the extremities. Also, some people experience alert consciousness during anesthesia, but they perceive events as if the center of awareness is located *outside* of the body. For example, they may observe their own body, and everything else in the room, from a vantage point behind the doctor or even from the ceiling. In this state, no pain is perceived.

People hovering on the brink of death may also experience events as if they are located outside of their physical body. This is due to the same channel Qi redistribution and conversion into wave-form that occurs during dissociation.

Then again, anyone who has or is familiar with the Parkinson's-related tremor will already know just how quickly a body can go from "not trembling" to "rapidly trembling." A person with PD might be resting, tremor-free, when he first wakes in the morning. But as soon as his mind turns to "Uh oh! What am I supposed to do today?" Or "What shall today bring?", a full-blown tremor can suddenly appear. The tremor rapidly appears, or magnifies, in response to any simple statement or thought that carries some negative implication: it happens at the speed of thought.

In people with Parkinson's, the transition into dissociation is often, though not always, accompanied by a *sideways* flicker of the eye. This weird sideways eye flicker may have been noticed, for years prior to diagnosis, by the spouse or very close friends of the person with Parkinson's. In the early days, when a person's Parkinson's symptoms still come and go, before they become almost permanent, the sideways eye flicker often immediately precedes the hard-eyed (somewhat stony-faced) look that many people with Parkinson's disease use whenever they are being "mentally strong" or focused. Some spouses know this look as the glazed "I'm not listening to you anymore; my inner self is a thousand miles away" look.

But my point here is only that this transition can occur almost instantly – as quickly as an eye flicker, or as quickly as a thought. When the thoughts waves switch over to the realm of dissociation, the appropriate channels *immediately* switch over, triggering the physical manifestations of dissociation.

Tremor and dissociation

Tremor is a normal behavior. It commonly occurs after a person has experienced shock or dissociation. After the shock is over, as the person's danger assessment area begins to think that maybe everything is OK now, he may tremor.

Tremoring gets the person's conscious attention. The correct, healthy response to observing oneself trembling is to quickly assess the physical danger of the situation. If the danger has passed, a person will take a deep breath, and then let a "re-adjusting" shudder travel from his head down to the bottom of his spine.

This shudder turns on the vagus nerve, which regulates the parasympathetic system.

After the deep breath and the shudder, the parasympathetic nervous system begins to kick in, the dissociation stops, and the trembling stops.

A person may tremor following an intense sympathetic mode experience, as well as a dissociation-sympathetic mode experience.¹

¹ Sometimes, the tremor might be delayed until such time as it is "safe." For example, when my husband had his oral examinations for his Master's degree, he did just fine. Hours later, after he got home and relaxed in his chair, he suddenly felt weak in the knees and started to tremor, just for a moment. He quickly did a mental assessment, took a deep breath, and shuddered, and the trembling stopped.

He'd been walking around all day in a state of mild dissociation with a sympathetic mode override. When he got home, the tremor began. He only "shook off" the fear mode, literally, when he got to a "safe" place – in this case, home.

Many people with Parkinson's are not even safe when they are at home. Their minds have determined that there are no safe places. Then again, (Continued on next page.)

Examples of shuddering

The cold lake example was introduced in the previous chapter, but here I expand on it.

After swimming in a very cold mountain lake or ocean, a person may experience strong shivering or tremoring after getting out of the water.

While swimming in alarmingly cold water, the blood is shunted deeply interior – the same shunt that occurs during dissociation. The swimmer might think that his body has become “used” to the cold water... but that thinking would be wrong. The body does *not* become accustomed to the cold – the body shifts into a temporary state of dissociation so that one can’t *feel* the cold. In this state, the swimmer becomes numb-ish as his blood is shunting deep into the body, away from the skin – a condition similar to that which occurs during dissociation.

However, because he *wants* to stay alert and keep swimming, nothing could be easier: he instructs himself to keep moving. His body slides into a combination mode: dissociation with a sympathetic mode override. In this mode, he has adrenaline galore, and he is numb to the icy cold. He can swim, for not *too* long, in alarmingly cold water and even enjoy the experience..

But when he gets out and his adrenaline levels drop, his body may exhibit powerful tremoring. It does this to get his attention. The thought occurs to him, “I’m tremoring; I must be cold.” He takes steps to remedy this cold: he either wraps up in a blanket or stretches out in the sun.

Soon enough, warmth returns – but the tremor is still going.

And then, a moment comes when the realization hits: “I’m still tremoring, but I’m actually OK now.” After all, the cold is no longer pervasive, sensation is returning to the limbs, the sun’s warmth is causing blood to return to the skin.

No longer feeling dangerously cold, he registers the thought, “I’m OK now.” As soon as he registers this thought, “I’m OK now,” he *instinctively* takes a deep breath and shudders from his head down to at least the torso, if not the bottom of the spine. This physical jerk as the base of the skull triggers the vagus nerve to kick back in. The vagus nerve stimulates the flow of the Stomach channel – in the correct, head-to-toe direction.

As soon as the mind determines that the body is safe, after all, and the deep breath and shudder turn the vagus nerve back on, the tremoring stops. If the cold was severe, two or even three deep breaths and shudders may be required.

The dog beach

Tango was a good-natured dog. At the local dog beach, he had many doggie friends. One day, a new dog, a half-wolf mix, ran up to Tango and behaved as if about to attack. Tango was stunned into immobility. The hair stood up on Tango’s back as he stood there, stone rigid, while the owners of the new dog ran up and apologized, and removed their wolf-mix from the scene.

Tango still stood there, in mild shock. Then, he shuddered from nose to tail, and started to walk away. His legs were so stiff he could barely walk. After a few steps he stood

(Continued from previous page.) I’ve had a few patients who always stop tremoring and can move somewhat easily after, say, 6:00 p.m., when sitting in their barcalounger, “done for the day.” I have one patient who can always move normally when she’s doing the laundry.

still again, planted his feet in the sand and shook himself *hard*, really hard, a couple of times. He panted for a moment, and then pranced off.

Shudders in people with Parkinson's

Going back to the example of the cold-lake swim: if the person with PD *does* remember experiencing the very common “cold water swim” situation, or other shudder-inducing situations, he assures me that he can no *longer* do a shudder. Even if he remembers doing it the past, a person with Parkinson's is usually *adamant* that he can *not* shudder, now. And he is correct.

I often have PD patients *try* to shudder, as if they are snapping themselves out of the tremoring from a bad chill. They usually are *completely* unable to make themselves move in a convincing shuddering fashion. They don't seem able to even *imagine* how one would go about starting a shudder. They can't imagine which muscles might be involved.

Of course not!

Remember, the shudder, and the parasympathetic restart is *not supposed* to occur so long as danger is still lurking. So long as the cat is nearby, it is not safe for the mouse to shudder – the shudder would bring dangerous attention to him. He cannot shudder until his brain gives the “all clear.”

So long as a person is thinking that he is in danger or needs to be wary, his brain will not, *can* not, give the necessary instructions to shudder.

The shudder is instinctual, somewhat involuntary. It only occurs *after* a person has affirmed that he is “OK now,” or “OK, after all.”

Summary

Trauma can lead to highly specific changes in channel Qi flow that support the neurological mode called dissociation.

When the trauma is ended, a person may begin to tremor, signaling that the body is ready to terminate the dissociation, if the mind is able to determine that the situation is, once again, safe. If the situation is deemed safe, the person shakes off the tremor and the dissociation. Channel Qi immediately begins to flow in parasympathetic and/or sympathetic mode, again. The tremor ceases.

If the person's assessment of the situation is “I'm OK, now,” he will take a deep breath, shudder, and terminate the dissociated state.

Dissociation causes inhibition of dopamine release and other overt physical changes, all of which happen to match the symptoms of Parkinson's disease. **Dissociation is not supposed to stop until the traumatized person, or creature, determines that he is, once again, safe enough to come back to “life.”**¹

¹ This chapter has only discussed the most basic alterations in channel Qi that occur during dissociation. In fact, because severe injuries can induce this condition, complete with aberrant flow of channel Qi in the exact location of the injury, *or* the condition can be mentally induced with particular attention to some body part that seems to be dangerous or in danger, almost any place on the body can experience dissociation-type channel Qi flow even if the rest of the body is running normally – or oppositely, the mind can be inducing a dissociation channel Qi pattern in much of the body, but allowing for normal Qi flow in some body part that for, whatever reason, is deemed “out of danger.” (Continued on next page.)

(Continued from previous page.) The mind plays a huge role in this, and so it's impossible to say exactly how any given person's channel Qi will flow once he starts using dissociation as a coping mechanism.

The *Nei Jing*, the classic scripture of Chinese medicine, does not even begin to describe the possibilities of dissociation-based channel Qi disruptions. Instead, the *Nei Jing* describes only a few of the more common, standardized channel Qi divergences, such as those that occur in the UB (spinal nerve-regulating) channel during body-wide sympathetic mode.

Even so, included in the divergence section of the *Nei Jing* are references to conditions that manifest in dissociated mode, such as "the Du channel serves as a reservoir for the channel Qi."

Most of this chapter was extracted from chapter eight of an acupuncture textbook on channel theory: *Tracking the Dragon*. The *Dragon* textbook goes into the flow patterns of dissociation, and the flow patterns of all four neurological modes, in great depth. The book includes many demonstrative and even fascinating case studies about the mind's ability to create a *localized* neurological mode. These case studies were left out of this book because they do not feature Parkinson's disease, per se, even though they do help illustrate the degree to which mental behavior can determine physiological changes, including highly localized ones.

“All healthy people are healthy in the same way; all unhealthy people are unhealthy in their own way.”

A paraphrase of Leo Tolstói’s opening line of Anna Karenina

CHAPTER NINE

WHEN CHANNEL QI GOES AWRY

So far, the discussions of channel Qi have covered how the channels are *supposed* to flow.

When channels are running perfectly, in the parasympathetic mode pattern or in the sleep pattern, all the body systems can grow, maintain, die, or respond correctly to external changes, in an optimal manner. That’s *perfect* health.

Sometimes, for short periods of time, the channels need to flow in predominantly sympathetic mode, or even in the dissociated mode. That’s still pretty healthy, overall.

But sometimes, the flow of Qi goes wrong: it can get distorted, obstructed, or it might even get stuck in a pattern that is not appropriate for the neurological mode of the moment. The result is illness or pain.¹

It is not uncommon for a person with Parkinson’s to have, in addition to aberrant channel Qi flow from injury and/or a dissociative attitude, a few additional channel Qi aberrations. This can occur because a dissociative mindset can prevent a person’s mind from knowing that a given part of the body needs healing, or needs a corrective nudge in the channel Qi.

This chapter explains just a few of the basic ways in which channel Qi flow can go amiss: disruptions, obstructions, and “stuck” patterns.

¹ I mentioned earlier that the Chinese maxim for stating this is “No go through: pain. Go through: no pain.” Although my professors stated this maxim to me nearly every time I asked a question about theory, I had no idea what they were talking about. Not until nearly a decade after graduating from Asian medical school did I realize what this statement actually meant: if channel Qi is flowing correctly, in parasympathetic mode, the body will manifest health. If channel Qi flow in some person is “not going through”, which is to say inhibited, obstructed, or flowing in any direction that is not consistent with the wave pattern of the *original*, perfect idea that created that person’s soul, the result will be “pain”: sickness, poor health, pain, moodiness, wrong thinking, shortened lifespan.

I think the reason that it took me so long to understand this maxim is that no discussions of channel theory were raised during the years when I was in school. My China-born and -trained professors had been taught that, officially, channels were only an historical superstition. Because, as a westerner, I only heard the words of the above maxim and had nothing to connect it to, it was meaningless. Nevertheless, I heard it a *lot*. It wasn’t until I studied channel theory that I began to understand this maxim.

Channel disruptions

The flow of channel Qi can be disrupted by illness, injury, toxins, or negative thought patterns.

These channel Qi disruptions *usually* go away by themselves when the illness plays itself out, the injury heals, the toxins are cleared out of the body, or the negative thoughts are removed.

If, however, the irregular channel Qi patterns that developed fail to “snap out of it,” the faulty flow patterns *might* continue, from sheer habit, even after the illness, injury, toxins, or bad mood is over. This can lead to a chronic condition in which “nothing is wrong” according to western medical tests, but the person’s health is nevertheless diminished.

Acupuncture can often help in such circumstance, especially if the problem is just a left-over channel Qi aberration from illness, toxins, or injury. It might even be safe to say that this is the main type of problem that acupuncture can help with.

But if the channel Qi disruption was caused by electromagnetic waves generated by negative thinking – and if that negative thinking was self-induced and is still ongoing – the acupuncture will not be able to make a lasting change in the situation until the thinking is straightened out.

Negative thinking – an aside

There are several kinds of negative thinking, according to Chinese medicine principles. Some cases of confusion and negative moods or attitudes are brought on by “externals” such as fever, pathogens, toxins, injury, low blood sugar, high blood pressure, and so on. Very often, the negative thoughts go away when the underlying, causative problem goes away.

In other cases, a person might *choose* to fill his mind with ego-centered thoughts that are fearful, lustful, jealous, critical of others, and so on. In Chinese medicine, these are called “internally-induced” types of negative thinking, and are referred to classically as the Seven Pernicious Emotions.

For example, *short-term* numbness, as a way to deal with life-threatening pain, is a beneficial form of channel Qi alteration. Oppositely, cultivating the idea that the best way to deal with all physical and emotional pain, or even potential pain, is to become numb, is *not* beneficial. This type of thinking is an “internal” source of negative, or wrong, thinking.

This kind of thinking can increasingly cause the channel Qi to flow in the pattern of dissociation mode – a pattern that causes all the symptoms of Parkinson’s disease.

Negative thoughts influence the flow of channel Qi. If negative thoughts are self-cultivated, no amount of acupuncture or any other treatment will get correct the flow of channel Qi so long as the negative thoughts are in force.¹

¹The opening chapter of the Nei Jing, the most ancient book of Chinese medicine, is devoted to this principle. Western medicine is beginning to recognize the deleterious effects of self-induced, or “internally caused” wrong thoughts.

For example, researchers, including Dr. David Burns, MD, have found that the most effective treatment for depression requires the patient to observe his thoughts, learn to recognize the thoughts that are most closely linked to depression, and learn to replace those specific thoughts with carefully designed alternative thoughts – thoughts that give rise to (Continued on next page.)

If a person is filled with negative thoughts by choice, or because he will not bother to carefully regulate his own thoughts, working to keep them positive and uplifting despite challenging circumstances, there is no *lasting* way to help him with medical conditions *caused* by those thoughts.

Other sources of channel disruption

Other disruptions occur after channel Qi has *temporarily* diverted into the sympathetic mode, sleep mode, or dissociation mode pattern, and for some reason failed to revert *back* to parasympathetic mode when circumstances allow. In these cases, a person may develop physical, emotional, or mental problems from the channel Qi becoming stuck in an inappropriate pattern.

For example, a person who is under tremendous stress may find himself unable to let go of the sympathetic mode channel Qi patterns even when the stress is off. In a circular fashion, the stuck channel Qi can make him feel stressed, which leads to stress-related thoughts. These thoughts, in turn, lead to stress-type channel Qi flow.

This type of channel Qi problem can lead to chronic disorders. This type of problem is *sometimes* very easily corrected with acupuncture.

Of course, if negative mental thinking has been self-nurtured and maintained, as can occur in the case of long-term stress, that must first be corrected.

Then again, in some cases, the channel Qi corrections temporarily instituted via acupuncture *might* allow for clearer thinking. *If* the patient is inclined to adhere to these “corrected” thoughts, the treatment benefits *may* be lasting.

Channel obstructions

Sometimes channel Qi flows aberrantly because it cannot traverse a gap in broken or torn tissue or cannot pass through some non-conductive material such as scar tissue.

In these cases, the flow diverts around the gap or the blockage.

Blockage makers

A short and incomplete list of channel blockers includes scar tissue, muscle tension, swelling from sprain or other injury, bone displacement, a twist in the connective tissue, mucus (which is non-conductive) and other channel Qi diverters, including mentally induced blockages such as selective dissociation from some body part, or of course, body-wide dissociation.

Scar tissue, with its rubber-like mass of short, crisscrossing fibers, is an example of non-conductive tissue. Channel Qi must divert around scar tissue, *if* the scar is blocking a channel. On the other hand, if a scar runs parallel to the course of a channel, it may not block any flow at all.

A channel Qi diversion around a blockage can easily be felt by a trained hand.

(Continued from previous page.) the chemistry of contentment or happiness. Just studying this process does not get rid of depression; the person has to actually do the work of changing his thought habits.

This process is called “Cognitive Behavioral Therapy.” It works better than drugs, and is currently considered the only *lasting* way to cure depression induced by *willful* incorrect thinking.

Diverting around a blockage

After being diverted, Channel Qi *might* resume its normal pathway a short distance downstream from the scar tissue, broken bone, or other impediment.

Sometimes, if the scar traverses a wide area, the channel Qi gets shunted into the path of a nearby channel. In this case, if the nearby channel is flowing the same direction as the blocked channel, the displaced channel Qi may or may not resume flow in its own, correct channel after it gets past the blockage. If the channel Qi does not, at some point, flow back into its own channel, significant weakness, numbness, or pathologies may develop along the portion of the channel that is “downstream” from the blockage, which has minimal or no channel Qi flowing in it.

However, even if channel Qi is diverted into the path of another channel, the flow pattern *might* self-correct somewhere downstream of the blockage. Remember, channel Qi is not brainless electricity; Qi flow patterns are stabilized by the body’s chemistry and structure and by the mind’s brain waves. These forces can help channel Qi to resume its correct pattern after getting past the trouble spots. Also, throughout the system, smaller “connecting channels” link the main channels. These connectors can bypass or help correct small channel Qi glitches.

So the diverted channel Qi might resume running correctly somewhere further downstream of the blockage, or it may remain in a neighboring channel into which it was diverted.

In the latter case, the amount of Qi in the original channel is reduced, downstream from the blockage, and the amount of Qi in the neighboring channel is increased – and possibly confused: each channel’s electrical vibratory patterns are specific for one of the five electron movement variations (see Chapter 6, Channel theory, p. 96).

In some cases, some portion of the diverted Qi may run deeper into the body via a “connecting” channel rather than running laterally into a nearby, skin-deep primary channel. This submerged Qi is often able to resurface near the skin farther downstream into the original channel. In this case, the Qi may continue to flow correctly for the rest of the length of the channel, but the amount of Qi flow may be diminished in the area *immediately* downstream from the blockage.

Then again, if a channel is blocked and the nearby channel into which it flows is running the *opposite* direction of the diverted channel, the diverted current changes its direction, and flows along with the nearby channel’s current. (If this occurs, the neighbor current will be somewhat modified by this addition, but for now I’m introducing general principles, not the fine details.) In this case, the *diverted* channel Qi is not able to resume its correct path farther downstream. The area downstream from the diversion might feel fairly empty, containing only small additions coming from auxiliary sources.

In treating people with Parkinson’s, *sometimes* we need to treat their scar tissue, if any, using acupuncture. This is only the case if the scar tissue happens to be obstructing a

channel. While a majority of our PD patients have *not* had channels obstructed by scar tissue, we have had *some* patients who needed to get their scar tissue broken up.¹

Blockage at the end of a channel

If any of these blockers occur at the *end* of a channel, the channel is not able to divert around the problem area and regroup farther downstream. In such a case, the blockage may become complicated.

For example, if the channel Qi cannot regroup and continue flowing into the *next* channel in the normal sequence, the *next* channel will have a deficiency near its beginning. Also, the stymied channel Qi may overflow laterally or *back up* in a manner that causes more problems than just a simple, short-distance diversion.

Therefore, a channel blockage at a channel terminus is particularly problematic. If the blockage persists for a long time (years), the channel Qi flow pattern may become highly distorted in the vicinity of the blockage.

Over time, the distortions themselves can contribute to a form of electromagnetic blockage.

At some point, as the channel Qi flow at the terminus becomes increasingly stymied, the electrical resistance in that end-part of the channel begins to build. Channel Qi, like electricity and water, will flow in the path of least resistance. If the resistance at a channel terminus becomes too large, the Qi in the channel will begin flowing in whatever direction offers the least resistance – even flowing backwards.

Although the standard terminology is “backwards” (“Rebellious” is how it is often translated from the Chinese) the actual movement of “backwards” Qi can be either backwards, back and forth in a rapidly alternating movement, or seeming to disappear altogether.²

Increased resistance at the end of a channel can eventually cause channel Qi distribution *higher up* the channel to divert into another channel, or to flow backwards. And then, moving still farther upstream on the channel, the channel Qi might flow backwards or divert, until the entire channel is moving “Rebelliously.”

Once things begin to go awry, flow patterns become unpredictable: they can go awry in *lots* of ways. All bets are off. Anyone with antique, easily blocked household drains in a two-story house knows what I’m talking about.

¹ Much more on the subject of scar tissue, including how to quickly and easily treat it with acupuncture, is included in the book *Tracking the Dragon*, available at www.pdrecovery.org.

² The idea that currents can run backwards is presented in the oldest book of Asian Medicine, the hoary *Nei Jing*. Rebellious Qi was translated as “Retrograde” (backwards) Qi in the first English translations. Now, “Retrograde Qi” is the common translation in England. In the U.S., “Rebellious Qi” is the more common (and more physically *and* metaphorically correct) translation. Physically, being retrograde just means you’re going against the inclination. But channel Qi always flows in the path of least resistance, so it’s never truly retrograde. Metaphorically, rebellion is a destroyer of the *staus quo*. Backwards-flowing channel Qi, as occurs with dissociation mode, can lead to Parkinson’s disease, a “destroyer” of health.

Since the body is actually *designed* to easily accommodate backwards flow in the Stomach channel, during dissociation, it may be that Rebellious Qi in the Stomach channel falls into place more easily than Rebellious Qi in other channels.

Blockages on the foot

During normal footsteps, the bones that form the arch of the foot freely move up and down. These wedge-shaped, so-called “cuneiform” (wedge) bones are able to move towards the sole of the foot and towards the “top” of the foot, as needed, as the foot flattens and arches.

The relative freedom of movement in these joint articulations means that, during a foot injury, these bones can move quite a bit.

A close-up view of three channels on the foot

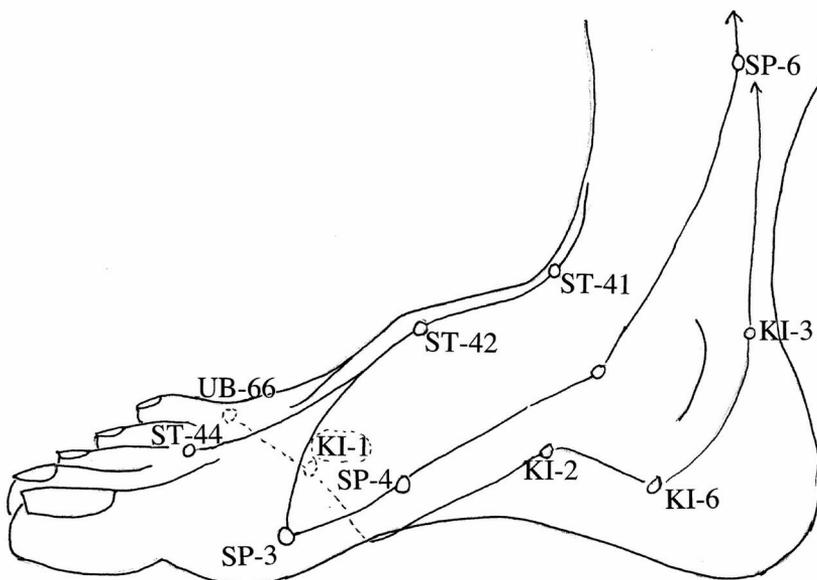


Fig. 9.1 Correct channel Qi flow in the foot of the Stomach, Spleen, Urinary bladder and Kidney channels, and some key acupoints of the foot. The dotted lines signify locations on the underside of the foot.

A blow to the ankle, the toes, the sides of the foot, or almost anywhere on the foot, can result in displacement of these cuneiform bones.

If a person twists his ankle, there is a good chance that his middle (also known as 2nd, or intermediate) cuneiform bone, in the center of his foot, is also going to twist, or move so far out of place that it can't slide back, or the fascia around that bone is going to get in a twist as the bone is thrown out of place and then rebounds back towards its correct setting.

The end or “exit point” of the Stomach channel proper lies directly over the middle cuneiform bone of the foot, at acupoint ST-42.

Notice ST-42, at the “high spot” (directly above the highest point of the arch) of the foot. At this point, ST-42, the channel bifurcates into two lines of current. Channel Qi flows

both towards the toes (ST-44) and *also* over to the Spleen channel at acupoint Spleen 3 (SP-3). In parasympathetic mode, more of the Stomach channel Qi flows to the tips of the second and third toes. In sympathetic mode, more of the Stomach channel Qi flows directly to SP-3. In dissociation mode, it goes to neither: channel Qi from the cells of the foot flows *backwards* up the Stomach channel.

Next, notice the dotted line, which indicates channel Qi flowing on the *underside* of the foot. This line shows how the channel Qi flows from the Bladder channel (at UB-66, on the smallest toe), underneath the foot, to the first point on the Kidney channel, Kidney 1 (KI-1), on the sole of the foot, and then continues up the Kidney channel.

The most important point to note on the above Fig. 9.1 is ST-42. This is the location of energetic disarray and unhealed foot injuries or some residue of unhealed foot injury in the vast majority of the Parkinson's patients that we have seen.

This location, ST-42, is highly significant.

As already mentioned, this is the area that is very likely to be distorted following a blow *anywhere* on the foot or ankle. This location also happens to be the terminus of the Stomach channel.

Again, when obstructions occur somewhere in mid-channel, the channel Qi can flow around the obstruction and pop up farther downstream.

When an obstruction occurs at the end of a channel, the channel Qi cannot necessarily “find its way” into the next branching of the channel. The possibility for channel Qi confusion is heightened when the blockage occurs at the endpoint of a channel.

ST-42 is the end of the Stomach channel. If an injury prevents the flow of channel Qi past ST-42, the channel Qi will either divert into some other nearby channel, following the path of least resistance OR the channel Qi will become stagnant in the area.

If Stomach channel Qi does become “stagnant,” as they say in Chinese medicine, some amount of Stomach channel Qi may back up towards the ankle.

Although these electrical aberrations may begin on a modest scale, over *decades* they can snowball and become extremely significant. In the case of an unhealed injury that jams up the flow at ST-42, the roadblock can eventually lead to backwards flowing channel Qi in the entire Stomach channel, including the forehead shunt into the Gallbladder channel and the simultaneous diminishing in power of the head-portion of the Du channel.

This injury-based aberration creates a pattern exactly like that of dire-injury dissociation, except that it is a lasting pattern, rather than the normal, short-term dissociation pattern that goes away as soon as the trauma has stabilized.

What's in a word?

When considering the various ways in which channel Qi can go awry, probably the most dire way is “Rebellion.”

The word “rebellious” is significant. Rebellion, in China, is considered the most dangerous of all political situations. In rebellious times, the political system is overthrown.

Chaos and death ensue. No good can come of rebellion. During profound dissociation mode, life itself may be “overthrown:” the soul must leave the body.

We learned about Rebellious Qi in our Asian medicine classes. I had been taught mild examples of systems running backwards: a cough is a quick spasm of Rebellious (backwards) Qi in the lungs. Burping is Rebellious Qi in the stomach.

Never were we taught that an entire channel might run backwards. Of course, channels were no longer significant, when I was in school.

And yet, the very name “Rebellious Qi” suggests that Qi moving backwards might be far more dangerous than a mere cough or a burp.

When I noticed backwards-running Qi in my PD patients and then discovered all the pathologies that derived from it, I only then began to understand the power and danger of “Rebellious” channel Qi. A channel running backwards occurs when life itself is about to be overthrown. Rebellion indeed!

As noted earlier, for Chinese political reasons, channels no longer exist. Therefore, the theory of Rebellious channel Qi no longer applies to the flow of the channels. Instead, “Rebellious Qi” now refers *only* to hiccups and coughing: situations that might better merit the title Pesky Blurps of Backwards Qi, but certainly not the terrifying title of Rebellious Qi.

It was not until I stumbled across backwards flowing Qi in an entire electrical channel and saw the dire repercussions of this phenomenon that I came to appreciate the wisdom of the ancients. When they named the phenomenon of backward-running channel Qi “Rebellious Qi,” they knew what they were talking about.

Parallel currents

Not only can channels go awry – their waywardness can then influence other channels.

Any basic physics class, in the electricity-and-magnetism semester, teaches that parallel electrical currents influence each other: alterations in one of the parallel currents will bring about an alteration in the other current.

When a person has aberrant channel Qi on one side of his body, left or right, two things happen:

1) an aberrant channel Qi pattern on one side of the body will be reflected on the matching channel on the other side of the body.

In other words, the healthy side will become somewhat modified so that it *somewhat* matches up with the sick side.

2) the “correct” flow of channel Qi on the healthy side of the body will help to modify the irregularity that has developed on the sick side.

This bilateral system of mutual modification allows the injured or ill side of the body to nevertheless maintain *some* semblance of the healthy pattern, even though the channel Qi is obstructed. This mutual influence of paired electrical currents helps get the channel Qi back into its correct position as soon as possible, instead of becoming random. The disadvantage is that both sides are somewhat incorrect, but that’s still better, for a living system, than having one side that’s become utterly random.

This is one of the many advantages to bilateral development in living systems.

We see this in people with Parkinson's: if there is a foot injury and backwards-flowing channel Qi in the Stomach channel on *one* side of the body, the channel Qi on *both* sides of the body may feel somewhat backwards or “not right.”

Even so, the injured side usually feels *more* “wrong” than the channel Qi on the healthy side. The healthy side may feel only moderately altered.

In *some* cases, the injured side is going backwards and the healthy side is going in the correct direction, but with little strength. In other cases, the channel Qi on the injured side seems to be completely missing, and the channel Qi on the non-injured side is merely going backwards.

Again, once things run amiss, all bets are off. The body will do its best to correct for electrical problems, but it still must obey the laws of physics – *particularly* if a person is dissociated.

After all, it is only in parasympathetic mode, when a person's thinking is in tune with heart, or “close to the Divine,” that he can effectively use the concept of “mind (Divine awareness) over matter.”

Sympathetic mode's “mind” uses “brute force, or *grim* will over matter,” a very different principle, indeed.

This phenomenon, in which one side's channel Qi is more deranged than the other side's, is very common in Parkinson's disease. The symptoms of Parkinson's reflect this: the symptoms are usually worse on the side with the unhealed foot injury, or on the side of the body from which the person has psychologically dissociated. This is helpful diagnostic information.

In our patient notes, we often make a note of the Side of the body on which Symptoms First Appeared (SSFA). Hands-on treatment is then directed towards this side.

Stuck channels

In Parkinson's disease, the channels have become stuck in dissociated mode.

They may be stuck because of an unhealed foot injury from which a person has psychologically dissociated.

They may be stuck due to habitual negative thinking such as “I still need to be guarded,” “I'm still injured,” or “I'm not safe.”

They may be stuck because *both* of the above situations are ongoing.

In some people with Parkinson's, aberrant channel Qi flow is also being held in place by scar tissue that is significant enough to block crucial channels.

This discussion of how channel might go awry or become blocked just brushes the surface, but it's enough to for our purposes: beginning to understand Parkinson's disease.

“The grand aim of all science is to cover the greatest number of empirical facts by logical deduction from the smallest number of hypotheses or axioms.”

- Albert Einstein

CHAPTER TEN

SYMPTOMS OF PARKINSON'S DISEASE:

LOCATION, LOCATION, LOCATION

Just before my four-chapter digression into channel theory, I mentioned the lists that I had made of my patient's Parkinson's symptoms, and the list of my own symptoms. These lists proved crucial in helping to figure out the underlying cause of Parkinson's.

As also mentioned, I had seen some people recover from Parkinson's but had no explanation for why an unhealed foot injury could cause Parkinson's, or why holding the foot injury might allow the foot to start healing, let alone have the Parkinson's symptoms melt away.

But one thing was certain: the symptoms I was seeing in my Parkinson's patients, and the symptoms in myself, which were consistent with a diagnosis of Parkinson's, could *not* all be explained by the current paradigm for Parkinson's, the “diminished dopamine” theory.

The western medical view of Parkinson's disease

The Big Four

Parkinson's disease is usually diagnosed on the basis of four physiological traits: poverty of movement (slowness), rigidity (stiffness), postural instability (poor balance, including walking or falling backwards), and tremor.

In order to be diagnosed with PD, a person must present with three out of the above four traits. If only two of the traits appear, postural instability *cannot* be one of the two.

However, as any neurologist knows, many, many illnesses have at least two of the above traits and are *clearly* not Parkinson's disease.

Many a person with only stiffness, or with just tremor, has shown up at the doctor's door fearful that he has Parkinson's, when it is obvious to any diagnostician that the person does *not* have PD.

Parkinson's disease, while defined by the Big Four traits, above, also has a very specific “look” based on those traits showing up in certain muscles and not others. For example, in Parkinson's, the “frozen facial expression”, typically worse on just one side of the face, from the eyebrow, down, is the result of *limp*, or *flaccid* muscles, not rigid ones. This limpness does *not* affect the muscles of the forehead. Very often, people with

Parkinson's have learned to use their perfectly healthy forehead muscles to manifest facial expression.

Oppositely, The *rigidity and tightening (opposite of flaccidity)* of the neck's sternocleidomastoids muscles causes the head to be pulled forward and makes it difficult to turn the head to the side.

The *flaccidity* in the foot causes foot drop and shuffling.

The *rigidity* in anteriolateral sides of the legs, above the ankle, makes it *difficult* for a person with Parkinson's to initiate forward movement in the leg, or to turn to the side that's primarily affected.

In other words, people with Parkinson's do not have flaccidity and muscle atrophy, or its opposite, rigidity, in *all* muscles – they have flaccidity in very specific muscles and rigidity in other, very specific muscles. The highly specific locations of flaccidity and of rigidity, give Parkinson's disease its unique “look.”

A problem with the western dopamine theory

If the actual problem were dopamine insufficiency and subsequent motor inhibition, *all* the muscles would be inhibited in the same way: they would *all* be limp and soft, as the muscles are during sleep, when neurotransmitter levels drop steeply.

The highly specific locations of weakness and of its opposite, rigidity, prove that Parkinson's is *not* a syndrome primarily caused by body-wide dopamine insufficiency.

(In fact, even my PD patients who are MDs *have* noticed these inconsistencies, even to the point of saying, “What I have doesn't feel like it's coming from the current hypotheses about Parkinsons!”)

Also, if the loss of dopamine-producing cells was the underlying cause of Parkinson's, the overall symptoms would not ebb and flow depending on how safe or happy the patient feels at a given moment – which they do, in *most* people with Parkinson's.

No matter how severe a person's Parkinson's becomes, his symptoms almost always have a range of severity on any given day, or moment, and that range is utterly mood dependent: if the person feels safe, he can move better than when he is feeling anxious, fearful, nervous, afraid of being judged, afraid of making a mistake, afraid of running late or, let's just say, in any way “not safe.”

The Big Four characteristics of Parkinson's haven't been modified in nearly two hundred years. But as I worked with my patients, I was accumulating a highly specific list of symptom locations. This was a different way of looking at the problem, compared to the over-all view that James Parkinson's had taken back in 1817, when he wrote *The Shaking Palsy*.

I was generating a list of symptoms that was highly location specific – and highly specific as to the nature of the symptoms: whether they were symptoms of weakness and atrophy *or* symptoms of rigidity.

I was also helped, in this process, by the fact that I was starting to recover, myself. I admit, I have skipped over the part of my own story that tells about my treatment and

recovery. I will get back to it. But that story will make more sense if the reader knows a bit more about Parkinson’s symptoms.

I was able to distinguish between problems of rigidity and problems of weakness all the more clearly as my own symptoms began to go away. This also enabled me to ask the right questions of my patients, both when I was treating them, *and* when they were recovering.

But prior to my own diagnosis and recovery, I was utterly unable to understand why the treatment of a foot injury could cure Parkinson’s disease. One afternoon, I just happened to be describing the symptoms of Parkinson’s to my very patient husband. By chance, I happened to describe all the symptoms in terms of location, starting at the head and going down to the toes.

By the time I had finished, I was staring, dumbfounded, into space.

“*All* the symptoms of Parkinson’s disease are located on the Stomach channel! The minor, side symptoms are all located on the Large Intestine channel! None of the other channels are affected!”

That was the moment that I gave up trying to fit all the symptoms of Parkinson’s disease into the “modern” (1960s) idea of mere dopamine insufficiency.

In retrospect, it was obvious. But considering how brainwashed I had been to think of Parkinson’s as coming from the middle of the brain, it’s not surprising that the location of PD symptoms along the length of the Stomach channel had never entered my mind even though I was treating problems at the foot end of the Stomach channel.

But it was by thinking in terms of the whole Stomach channel that I was able to see that somehow, the Stomach channel entered into the mystery.

I did not put together the link between the neurological mode of dissociation and its backwards flow of channel Qi in the Stomach channel for nearly eight years. But making a map of Parkinson’s symptoms is the thing that first put me on the track of understanding the cause and cure of Parkinson’s disease.

Making a map of symptoms

I replaced the Big Four’s *generalized* symptom descriptions with the exact locations of these symptoms. In other words, I made a list of specific PD symptoms and draw up a matching “map” of the locations of the symptoms.

For this task, I used the symptoms of my early- and mid-stage Parkinson’s patients and, in medicated patients, ignored symptoms that were obviously related to adverse effects of the drugs and which are opposite from the descriptions of Parkinson’s disease (for example, the *excessive* drug-induced movements known as dyskinesia).

I replaced the general term “poverty of movement” with the exact locations of poverty of movement symptoms in my early-stage PD patients.

I replaced the general term “rigidity” with a list of the specific locations in which rigidity most often appeared.

For tremor, though it may eventually become system-wide, I used the most common starting locations of PD tremor.

As for postural instability, this is a body-wide problem that develops later, because of *slowness* of the balancing response. It is not actually a separate problem.

Parameters

I did not use for my research any people who had a significant, known medical situation in addition to their Parkinson's symptoms. People with a history of stroke, heart disease, or anything that might confuse the data were not included in the research.

No two are alike

When perusing the following map of Parkinson's symptoms, remember this: no one PD patient will necessarily have all of the symptoms described in this chapter. At his time of diagnosis, he may have only a few symptoms. The symptoms of Parkinson's disease usually develop gradually. At first they may even be intermittent.

Some of the symptoms may begin years, even decades, prior to an official diagnosis of PD.

In the following maps, the symptoms are listed in head-to-toe order alongside drawings of the Stomach channel and then in finger-to-head order alongside a drawing of the Large Intestine channel.

Key to the map:

- The hollow circle indicates Parkinson's symptoms recognized by western medicine.
- The filled-in circle indicates Parkinson's symptoms that are fairly common, or at least not uncommon, but which are often unknown to western MDs.

Letters preceding the symptoms refer to:

A = muscle atrophy, weakness, or numbness

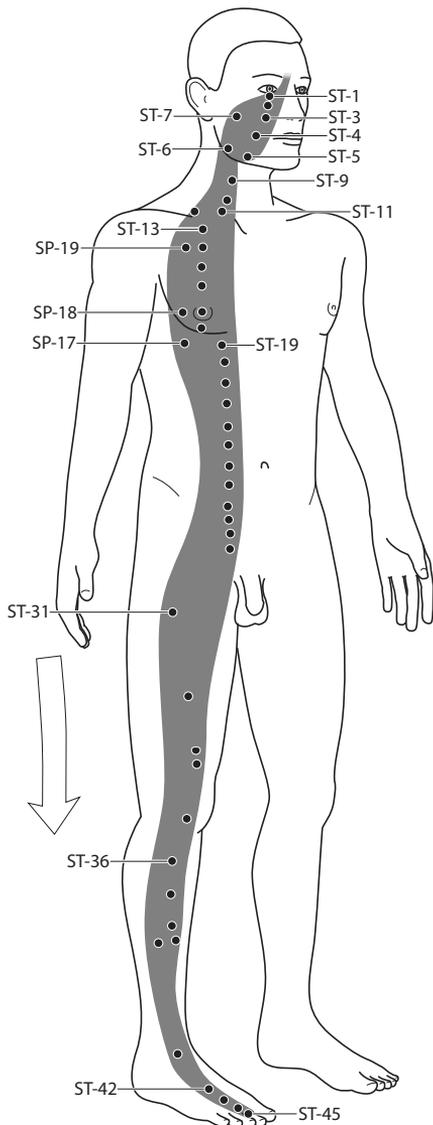
R = rigidity or tension

D = dissociation (symptoms characteristic of trauma-induced biological dissociation)

SSF A – Side (left or right) where Symptoms First Appeared

STOMACH CHANNEL SYMPTOMS

- **A.** (**A** = atrophy) Minimal or slow eyelid blinking; sagging lower eyelid.
This symptom, and nearly all of the face symptoms, are usually worse on the Side of the body where Symptoms First Appeared (**SSFA**).
- **A.** Overuse of the eyebrow and forehead muscles to portray facial expressions – due to lack of sensation in the cheek and eye muscles.
- **A.** Sinusitis, various problems with the sinuses, including severe snoring and even sleep apnea.
- **A.** Seborrheal skin on the side of the nose or cheeks (due to poor circulation and numbness).

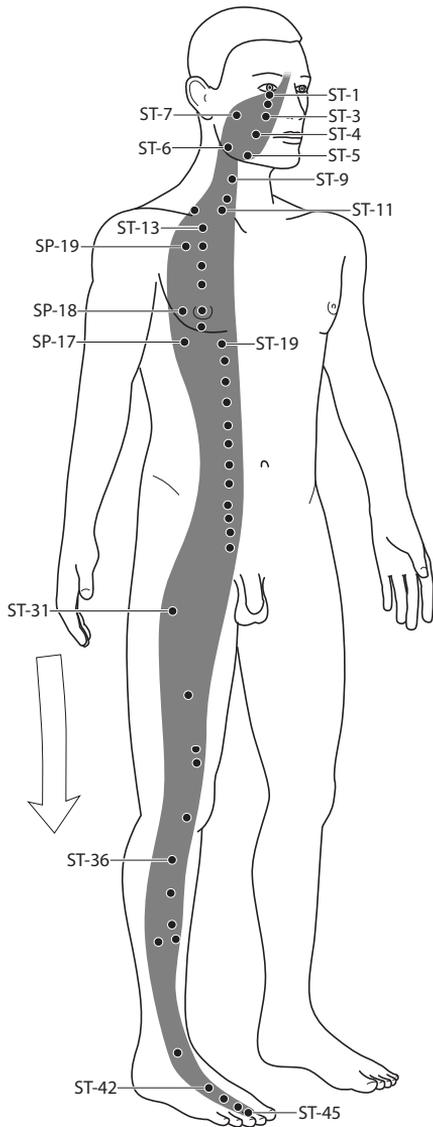


- **A.** Loss of sense of taste or smell.
 - **A.** A feeling of deep cold inside the cheek.
 - **A.** A groove on the face on the **SSFA**, running from the side of the nose to the side of the mouth due to atrophy of the buccinator muscle.
 - **A.** When attempting to smile, a flatness in the “apple” of the cheek (the muscle that bulges outward along the top of the cheekbone during a smile).
 - **A.** A sensation as if the roof of one’s mouth is sinking down into the mouth at the back of the mouth, as if the sinus bones are collapsing downward inside the face.
- **A.** Inability to lift the corners of the mouth when smiling.
- **A.** Inability to realize whether or not the facial muscles are not actually moving when consciously attempting to smile.
- **A.** Following a conscious smile, the face reverts back to a stony expression.
- **A.** Poor lip control; numbness of the lips; drooling.
- **D.** Poor swallow reflex.
- **A.** Teaching oneself to consciously exhale before putting food in the mouth and not breathing once food is in the mouth to avoid a tendency for food to slide down the airpipe when chewing, often many years prior to diagnosis, due to increasingly inhibited swallow reflex.

- **D.** Aspiration pneumonia from food going down the wrong way.

This ends the facial and swallow symptoms. Notice they were all caused by atrophy, weakness, or numbness, or were characteristic of dissociation.

In the next section, from the back of the jaw to the top of the foot, all the symptoms will be characterized by tension and/or rigidity (**R.**).



- **R.** Pain that comes and goes in the back lower molars on the SSFA, and/or intermittent pain in the lower back teeth on the side of the body that has the foot injury – a pain for which dentists can find “no reason.” This is the location of the shunt at ST-6 that sends channel Qi up to the forehead instead of letting it flow over the face. (One patient said that her lower molar on that side had “no root at all.” Her dentist had *never* seen that before in a patient.).
- **R.** Spontaneous spasming in the throat for no apparent reason, choking or coughing from “nothing,” choking or coughing from saliva, choking easily when eating, spasms in the throat: **R**
 - Hunched posture, head pulled forward due to tension in the sternocleidomastoid muscles of the neck.
 - **R.** Choked off voice, soft voice from tension in the throat muscles.
 - **R.** Difficulty turning the head from side to side.
 - **R.** + **D.** Orthostatic hypotension (low blood pressure, insufficient blood supply to the head when standing up from a sitting position) This is probably due to the pressure on the carotid sinus in the neck. The rigid tissues of the neck press on the

carotid sinus, sending a false “high pressure” signal to the sinus. The body correspondingly lowers the blood pressure. This symptom, orthostatic

hypotension, is also commonly associated with adrenaline insufficiency as well as shock (dissociation).¹

- **R.** Discomfort, even a feeling of suffocation or panic, due to pressure from rigid muscles over the chest and heart if doing an activity in which the arms must be raised over the head: for example, while taking down a shower curtain, getting plates down from a high shelf.
- **R.** Pain or tingling between the shoulder blade and the spine when trying to sit up very straight with the shoulders back for any length of time, especially on the SSFA. These muscles are accustomed to being pulled laterally by chronic tension in the muscles of the chest.
- **D.** Either a “cast-iron” stomach or a hypersensitive one with tendency to nausea (vagus nerve inhibition, a characteristic of dissociation).
- **R.** Difficulty turning over in bed at night, or turning from the waist due to muscle tension down the abdomen.
- **R.** In some women, extremely deep, pathological abdominal stretch marks that formed during pregnancy from an utter failure of the skin to stretch
In one case, many years prior to her diagnosis with PD, a patient had experienced failure of the uterus to expand during her second pregnancy, necessitating a Caesarean section for a baby of low birth weight. Her first child had been carried to term in a fully expanded uterus.
- **R.** Pain in the groin, especially on the SSFA: R
- **R.** Lack of hair on the legs along the Stomach channel, even if the rest of the leg has a normal hair pattern, especially on the SSFA; a variant of rigidity.
- **R.** Extreme hardness in the anteriolateral muscles of the upper and lower leg. Many people with PD point with pride to this wooden section of flesh, assuming that it is hard because it is supremely toned muscle. The energy movement and tone in these muscle groups, however, suggest woodiness rather than healthy tissues.
- **R.** Festinating gait due to inability to sustain repeated lifting of the rigid thigh.
- **R.** Difficulty in moving to the side, turning to the side while walking.
- **R.** More difficulty in turning to the SSFA than in turning to the other side.
- **R.** A sensation described as “woodiness,” “weirdness,” “buzzing,” “emptiness,” “something irritating under the skin,” “something not right” referring to the sensations in the anteriolateral portion of the legs.

These feelings can be constant, but they especially might be felt at the end of a long day of standing.

- **R.** Cogwheeling (jerkiness during rotation) in the ankles. The “cog” is at the Stomach channel point of the ankle and may also occur at the nearby Gallbladder channel point at the ankle. Like most symptoms, cogwheeling is usually worse on the SSFA.

¹ Many people with Parkinson’s are proud of their low blood pressure, never realizing that it is a part of their Parkinson’s pathology.

That ended the jaw to top-of-the-foot symptoms. Notice: they were all caused by rigidity or else were characteristic of the nerve alterations that occur during dissociation.

In the following section, from the top of the foot to the toes, all the symptoms will again be characterized by atrophy, weakness, or numbness (the letter **A**), except for a few that are directly related to injury itself or a channel short circuit. Unless it says otherwise, symptoms will be more severe on the SSFA.

- **A**. Foot drop (toes seem to drag along the floor, foot doesn't "lift" up).
- A sensation of tingling or buzzing that comes and goes in the medial ankle – on the Kidney channel. This ankle sensation can be so strong that one is prompted to pull down the sock and stare at the ankle, looking for the source of the irritation: The cause is a **short circuit** that occurs when the blocked Stomach channel flows medially into the nearby Kidney channel, causing symptoms of excess amperage in the Kidney channel.

Severe vascular irregularities, varicosities, and skin staining may occur on the medial ankle – on the Kidney channel – especially on the SSFA: This is caused by channel Qi spilling over into the Kidney channel because of blockage at ST-42.

- **A**. Misshapen feet or toes.
- **A**. Grey or purplish cold feet or toes.
- **A**. Veins on the dorsum of the foot, especially on the SSFA, do not run down to the toes. Instead, the veins form a loop just distal to ST-42 (at the center of the foot).
- **A**. Tendency for cramping in the sole of the foot due to no muscle function in the opposing muscles on the dorsum of the foot.
- **A + D**. Toes curling under the sole of the foot due to no muscle function in the opposing muscles on the dorsum of the toes. Also a characteristic of dissociation.
- **A**. Severe bunions and other displaced bones: **A** (This can be due to unhealed injury as well as muscle atrophy.)
- Smaller foot on the SSFA. The foot on the SSFA might be from one half to two full shoe sizes smaller than the other foot, due to muscle tension holding the **injury** in place. The foot often lengthens out as the foot relaxes, following healing: muscle tension from protecting an unhealed injury.
- **A**. Toenail fungus, especially in the three medial toes due to inhibited circulation and numbness.
- **A**. Distinct toenail ridges that run parallel to the moon of the toenails.
- **A**. Inability to separate the 2nd and 3rd toe.
- **A**. Numbness on the medial side of the big toe (acupoint SP-3), or poor response when a needle is inserted at SP-3. Needling this point *should* be breathtakingly painful in a healthy person.
- **D**. Lack of proprioception in the feet and toes, inability to know where the toes are if shoes or slippers are on. Proprioception is the ability to feel the location and actions of a body part without looking at it.

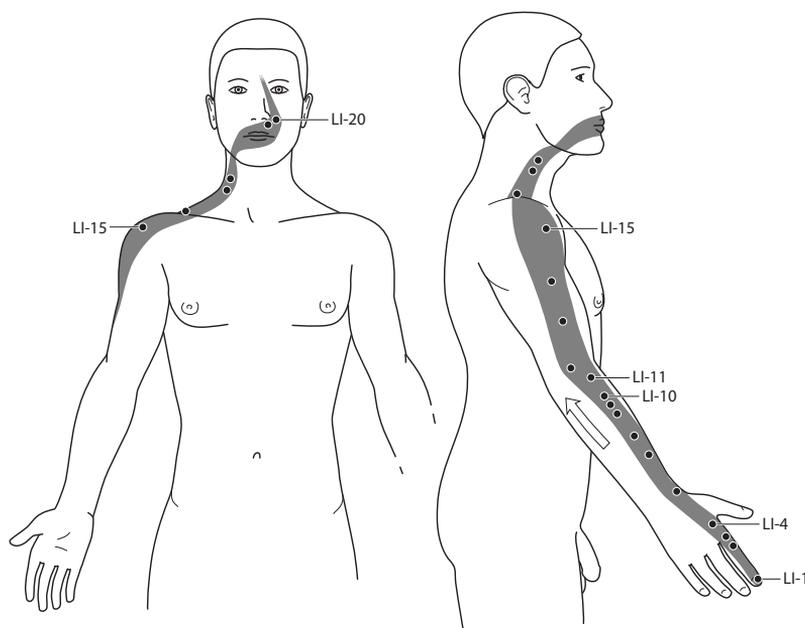
For an example of poor proprioception in advanced Parkinson's, a person might not be able to know where his feet are once they are hidden from view by his

shoes. This can make full insertion of the feet into the shoes very, very difficult. Likewise, when putting on long sleeves, it may impossible to know “what to do” with the hand as soon as it becomes hidden from view inside the sleeve.

Large Intestine channel symptoms

The next section discusses the symptoms of Parkinson’s disease relative to the Large Intestine channel.

The following symptoms in the arms, from the wrist to the shoulder, along the Large Intestine channel, are characteristic of rigidity. Symptoms in the hands are from atrophy. Symptoms are usually worse on the side where symptoms first appeared.



- **D.** Lack of proprioception in the hands and arms.
 - **A.** Poor small motor skills: cutting food, picking up small things, doing buttons.
 - **A.** Slow “finger tap.” When tapping the thumb with each of the other four fingers on the same hand, in turn, the normal “quickness” of this job might be hard to achieve: the tap will be slow and weak.

Also, repeatedly tapping the index finger on the thumb will be slow, and the ability to tap may peter out altogether after several, or several dozen, repeated taps.
- **A.** Micrographia. If micrographia is present, a person might also have upper arm soreness during handwriting. It feels as if he is using the rigid upper arm to make the lettering instead of just using the very small, atrophied muscles in the hand and wrist. Inappropriately performing this small motor task with the large motor muscles causes the already rigid bicep area to tighten up even more, causing pain.

- **R.** Cogwheeling (jerkiness during rotation) at the wrist. The cogwheeling is most pronounced at the Large Intestine channel's intersection with the wrist.
- **A. + D.** Pill-rolling tremor.
- **A.** Atrophy of the muscle between the thumb and index finger, the muscle that bulges up as it pulls the thumb over to the 2nd metatarsal bone. Note, this muscle is not on the Large Intestine channel – this muscle is the location of one of the bridges by which channel Qi flows from the Lung channel into the LI channel. When LI channel Qi is running backwards, this bridge cannot be used, and the muscle in this area atrophies.
- **R.** Severe rigidity in the bicep. Sometimes the bicep muscle dwindles away so that there is no muscle in that location – but it was never atrophied in the sense of limp – it was rigid as it dwindled over the years.
- **R.** Lack of arm swing.
- **R.** Prior to diagnosis, when arm swinging is/was still possible, a person may have a tendency to swing the arms in a peculiar manner, maybe using the pectoral muscles instead of the bicep, with a side to side motion instead of the more normal front to back pattern, or with the hands turned inward or outward.
- **R.** Tendency for the arms to be crooked at the elbow when the arms are at rest, with the hands resting on or near the waistline.

The following symptoms on the *face* portion of the LI channel are characteristic of atrophy, weakness, or numbness. This is because the Large Intestine channel is not able to travel to the face. The absence of channel Qi leads to the following:

- **A.** Loss of sense of smell.
- **A.** Diminished facial expression.
- **A.** Poor lip control, numbness of the lips, drooling.
- **A.** Seborrhoeal skin along the side of the nose.

Symptoms that can occur on both Stomach and Large Intestine channel

- **D.** history of cancer, melanoma, lipoma, moles, or tumor along the Stomach channel or Large Intestine channel. These develop at the site(s) of injuries that cannot heal due to dissociation and/or backwards flowing channel Qi.

Summary of the location and type (atrophied or rigid) of symptoms:

As seen by the above list, the Stomach and Large Intestine channels are the *locations* of nearly all the symptoms of Parkinson's disease.¹

¹ The exception is the problems that arise on the medial ankle along the Kidney channel. Technically, the medial ankle symptoms are not on the Stomach channel. But by feeling the channel Qi, it becomes apparent that the medial ankle symptoms occur when Stomach channel Qi, unable to move past the obstruction at ST-42, diverts into the Kidney channel, in addition to backwashing up the Stomach channel. This excess condition, in which Stomach-type channel Qi sloshes into the Kidney channel, can lead to medial ankle conditions such as electrical sensations of pain, varicosities, and discoloration. These medial ankle symptoms are all located in the area where the Stomach channel can short circuit into the nearby Kidney channel. This short circuit on the ankle occurs in the vicinity of acupoint KI-3.

Bear in mind that, in an *absence* of channel Qi, the muscles are merely limp, and where channel Qi is running *backwards* the underlying muscles are rigid.

Again -

No channel Qi: limp

Backwards channel Qi: rigid

As discussed earlier, during normal dissociation from severe injury or shock, which is time-limited, backwards-flowing Stomach channel Qi is shunted up to the *side* of the head, and so does *not* flow over the face. Also, the Large Intestine channel is not able to flow over the face. Therefore, there is an *absence* of Stomach channel and Large Intestine channel Qi on the parts of the face served by these two channels. During shock, or dissociation, the facial muscles become expressionless due to the lack of normal channel Qi from these two channels.

Compare this with Parkinson’s. During Parkinson’s, one sees the exact same absence of channel Qi on the face. However, shock is fleeting, Parkinson’s is *chronic*. The *chronic* absence of channel Qi from the Stomach and Large Intestine channels leads to atrophy and/or numbness of those facial muscles.

During normal *dissociation*, Stomach channel Qi runs backwards from the mid-foot to the back of the jaw. The muscles that lie under the Stomach channel become *rigid* until the dissociation stops.

Compare this with Parkinson’s. During *Parkinson’s*, the muscles that lie under the chronically backwards-flowing Stomach channel, from the foot to the back of the jaw, become chronically rigid.

During normal *dissociation*, there is an absence of Stomach channel Qi from the mid-foot to the toes.

During *Parkinson’s*, there is the same absence of Stomach channel Qi from the mid-foot to the toes. This chronic absence leads to atrophy and/or numbness in that distal part of the foot.

During normal dissociation, Large Intestine channel Qi runs backwards, from the shoulder to the fingers. The muscles that lie under the Large Intestine channel become rigid until the dissociation stops.

During Parkinson’s, the muscles that lie under the chronically backwards-flowing Large Intestine channel become chronically rigid.

A discussion of the symptoms of Parkinson’s disease

Some people do not like the “list” format. Lists can be tedious.

And yet, it can be important to know the full complement of Parkinson’s symptoms. In the first place, knowing all the symptoms can help a person begin to recognize that he is recovering – which helps him feel safe.

Second, knowing the symptoms can sometimes help a person who has been misdiagnosed realize that he doesn't have PD. Oppositely, it can convince a person who is resisting a correct diagnosis of Parkinson's.

The following section presents most of the same material that was on the list, but in a more chatty, "paragraph" format.

Also, the paragraph format allows room for some of the interesting side-notes to be included.

If you are already convinced that the symptoms of Parkinson's disease do in fact match the symptoms of dissociation, and also match with the channel theory understanding of dissociation, you can skip the next section.

On the other hand, if you want to learn additional details about the more obscure symptoms of Parkinson's, then refresh your glass and settle in for a little bit more light reading.

On the face

On the face, the Parkinson's symptoms, symptoms of atrophy, weakness and numbness along the Stomach channel, are due to the absence of Stomach channel Qi. You will recall that, during dissociation, the backwards-flowing Stomach channel does *not* travel up the front of the face, but is shunted from the back of the jaw up to the forehead along the side of the head to ST-8. From there, it shorts into the GB channel and reduces the Du channel amperage.

As for the face portion of the Large Intestine channel, as the channel flows up the arms towards the face it isn't able to get past the spot on the neck where the backwards-flowing Stomach channel creates an obstruction.

Little or no channel Qi flows over the muscles of the face during dissociation. In the areas normally traversed by the Stomach and Large Intestine channels, the muscles are limp. They droop. The *lower* eyelid on the side where the PD first appeared often hangs limply, sagging lower than the other eyelid, exposing more of the eyeball on that side of the face. This can make the eye on the SSFA appear larger than the other eye. (The *upper* eyelid is regulated by the Urinary bladder channel, and is usually not affected.)

If these muscles *were* rigid, like the rigidity that pulls the arm into a bent-elbow position, the cheeks would be pulled tight, and the mouth would be locked into a hideous grin, the ghastly grin of rigor mortis. If the eyelid was rigid, it would be pulled tightly up into place, giving the illusion of the eyelid being shut, not open.

From the jaw to the top of the foot

From the corner of the jaw, at ST-6, on down to the center of the foot at ST-42, the symptoms are caused by *rigidity* along the path of the Stomach channel. This is the area where the Stomach channel runs backwards during dissociation.

The neck is pulled forward from the tension in the sternocleidomastoid muscle. Turning the neck is very difficult; to look behind, one must turn the whole body, because the neck is locked into rigidity.

The whole torso is hunched forwards, because the muscles on the front of the body, along the Stomach channel, are very rigid, compared to the relatively relaxed muscles along the back side.

The legs are pulled up tightly. In bed, at night, it can be extremely difficult to lie with the legs straight out beneath one or, even more difficult, with the legs posterior to the torso, such as occurs when one stretches languorously. This “pulled forward” leg tends to allow the psoas (inside the hip) muscle to tighten up. This, in turn, pulls the leg somewhat medially, which is seen in advanced Parkinson’s. The tightened psoas also makes it very difficult to turn to the side while walking, particularly to the side more affected.

The rigidity in the muscles of the leg contributes to the weird feeling in the legs, as if the legs were wooden or filled with static electricity.

From the top of the foot to the toes

The toes are often numb. People with Parkinson’s often cannot separate their toes, especially the middle toes. Many of them have assured me that *no one* can separate their toes, even if they have seen their spouses and children separate their toes.

Many people with Parkinson’s have severe toe fungus. This fungus, which is always present in *everyone*, creates the “white” portion of the nail (not the moon, but the part that extends away from the skin. The very thin reddish line, just between the white nail and the pink of the nailbed is caused by the body’s immune response, constantly repelling any attempt on the part of the fungus to move into the yummy area of the nail bed.

The white of the extended nail is white because fungus is eating away at the clear nail, leaving an uneven under-surface and white, crumbly debris.

In Parkinson’s, the extreme numbness in the toes prevents the body from being able to maintain an immune response in one, two, or even all of the toes, although usually it is the medial toes, the ones fed by the Stomach channel, that are most affected.

Circulation in the toes is usually very poor. It is not uncommon for the large veins of the feet to make a semi-circle on the top of the foot, instead of a fan shape that collects from all the toes. The toes can be susceptible to cold, and it is not uncommon for people with PD to have Raynaud’s syndrome (hands and feet that are extremely difficult to warm up, once they become cold).¹

All of the above are symptoms of atrophy and lack of circulation in the feet – indications that channel Qi is *absent*.

The arm, from the fingers to the shoulder

The arm along the Large Intestine channel, from the fingers to the top of the neck, is rigid. The arm is often bent at the elbow because of the constant tightness along the bicep line.

The fingers may be rigid, as well. The backwards-flow channel Qi does not back up and flow backwards into its source channel, the Lung channel (which flows down the arm from the torso).

¹ Nearly 90% of my Parkinson’s patients have had problems with cold. The other 10% seemed to have problems with heat: they got overheated very easily. I did have one patient who never seemed to notice whether it was warm or cold out. His wife said that, in their forty years of marriage, he had never remarked on the ambient temperature, even though his feet were always “slabs of purplish-gray ice” and his skin was often very cold to the touch. When he recovered from Parkinson’s, he started complaining to his wife for the first time that the house was either cold or hot.

When a channel *begins* at the fingers or toes, any backwards-flowing channel Qi will be able to discharge out through those fingers or toes. In the case of the Large Intestine channel, this backwards-flowing channel Qi can discharge through the index finger, and sometimes the thumb.

Atrophy of the first dorsal interosseous muscle

The hand might also manifest atrophy in the location where the Lung channel is supposed to cross over into the Large Intestine channel; the muscle that bridges the distance between the thumb and the index finger on the back of the hand (the first dorsal interosseous muscle.) This is the muscle against which many writers rest the shaft of their pens. This muscle becomes extremely atrophied during Parkinson's, especially on the side of the body that first showed symptoms.

This muscle is in the location where the Lung channel should be able to cross over to (and become) the LI channel. However, since the LI channel is running backwards, the Lung channel Qi cannot flow into the path of the LI channel. Instead, the Lung channel Qi is discharged out the tip of the thumb, or flows into other channels on the hand.

This flow pattern is also characteristic of dissociation – a condition in which the channel Qi does not flow normally into the index finger; a person who has just ended a dissociated state or shock may need a minute or two before his fingers resume their normal ability to grip: picture a person who's just had a bad shock trying to hold a pencil and repeatedly dropping it.

Physical symptoms characteristic of dissociation that are not on the Stomach or Large Intestine channels

By now, you are practically an expert on the Stomach and Large Intestine channels, in sickness and in health.

But you may have noticed that *some* physical symptoms of Parkinson's were not included on the above lists or paragraphs.

These symptoms, although physical, are more closely related to the brain's shut-down of certain nerves during times of dissociation.

For example, one of the first nerves to get shut down during dissociation is the vagus nerve: a cranial nerve that regulates digestion. The entire digestion system is shut down during shock or dissociation. This is why people under anesthesia or in shock (dissociation) may tend to vomit if there is food in their stomach. Also, the bowels barely move, if they move at all. Which brings us to another common symptom of Parkinson's:

- **D.** Chronic constipation – a type of constipation that does not respond to laxatives, or the opposite: a long-time tendency to very loose, poorly controlled stools, even prior to the diagnosis of Parkinson's (vagus nerve inhibition, characteristic of dissociation).

Another nerve that is often shut down during dissociation is the nerve that carries bladder signals to the brain. When you are nearly dying, the body has more important things to do than deciding whether or not it's time to urinate. And so we see this symptom of Parkinson's:

- **D.** Either the ability to hold the bladder for an alarming number of hours, sometimes urinating only once or twice a day, if that, or else the opposite; chronically frequent, scanty urination (bladder nerve inhibition).

The Gallbladder channel

Mention must be made of the Gallbladder channel symptoms that occur in a small percentage of PD patients. Possibly, this material belongs elsewhere, inasmuch as it does not relate directly to dissociation. But this section is too small to merit its own chapter, and it *is* related to symptoms that develop on a specific channel. So here it is.

The leg portion of the Gallbladder channel runs adjacent to the leg portion of the Stomach channel.

Sometimes, in addition to symptoms along the Stomach and Large Intestine channel, a person with Parkinson’s may exhibit symptoms of backwards-flowing channel Qi in the leg portion of his Gallbladder (GB)channel.

An unhealed *lateral side-of-the-ankle* injury can sometimes cause backwards-flowing channel Qi in the GB channel.

Also, an unhealed *side-of-the-hip* injury can sometimes cause a significant blockage in the flow of GB channel Qi.

We’ve seen that people whose tremors first appeared in the leg, instead of the hand, very often have an unhealed injury in the hip and/or leg/ankle portion of the GB channel, *as well* as a blockage in the Stomach channel.

In people whose Parkinson’s tremor develops in the legs first instead of first appearing in the hand, moles, tumors, or cancers may develop along the Gallbladder channel, particularly in the hip, lateral side-of-the-knee, or lateral ankle area, in the years prior to their diagnosis with Parkinson’s. In my patients with this leg-tremor-long-before-hand-tremor scenario, they tended to have developed symptoms fairly young, in their thirties to fifties. I had one patient with this situation who was only twenty-eight. ¹

¹ In my first year of research, I had three patients whose tremoring had first appeared, intermittently, many years prior to their diagnoses of Parkinson’s, but in the leg, not the hand. In two cases, they had experienced tremor in the leg during stress, starting as early as high school, even though they were not diagnosed with PD until middle age. I became obsessed with figuring out why they had started with leg tremor instead of hand tremor. Also, these patients had not responded by recovering quickly even after their foot injuries healed. Obviously, something was still out of whack. Noticing that their Gallbladder channels Qi still ran erratically, I finally tracked down an unhealed injury in the hip joint of one of these three patients. A few days later, when I saw the second one, he also had an unhealed injury in his hip. In the first two, I noticed large moles on the skin in the vicinity of the hip injury. Moles often develop on the skin in the vicinity of erratic channel Qi, such as occurs following an injury. The moles usually remain even after the injury heals. In this way, moles can reveal a history.

Excited, I telephoned the third “leg tremor came first” patient. She’d always been oblivious to pain. She hadn’t remembered her ankle injury, received while skiing, until the ankle began to heal. I assumed she wouldn’t remember any hip injuries, so instead, I asked her if she had a mole on her hip.

“No,” she replied, emphatically.

I asked her if she was positive that she had no mole on her hip. She was adamant. There was no mole on her hip. I begged her to go look in a mirror, maybe she had never seen it, but I was certain that she had to have a mole on her hip.

Exasperated, she said, “No I do NOT have a mole on my hip. I know this for a fact. I *used* to have a large mole on my hip, but I had it removed *years* ago.” (Continued on next page.)

(Continued from previous page.)

Also, a person who has received injuries in areas other than the channels of the Stomach, Large Intestine, or Gallbladder, who has chosen dissociation as the way to “deal” with those injuries, may still be manifesting unhealed injuries in those areas.

In some cases, the person will be able to recover from Parkinson’s more easily if those injuries are addressed. They are easy enough to discover: the body will feel unusually rigid in those areas that have a dissociated, unhealed injury.

In some patients, until these injuries have healed, they cannot feel safe enough to turn off the dissociation. Remember, they have dissociated because they understand themselves to be at great bodily or emotional risk.

Then again, some people, upon deciding that they are “safe, after all,” thus turning off the dissociation and recovering from Parkinson’s, then spontaneously become aware of unhealed injuries in various body parts. These areas may be suddenly painful. Memory of the “forgotten injury” may come flooding back.

These areas, now that the consciousness can attend to them, begin healing on their own, just as they would in any healthy person. These injuries may be painful enough that the patient begins reaching for the aspirin bottle and thinking of ways to ease or treat the pain, but finally, the injuries are on the right track. No longer in suspended animation, they are ready to heal.

Summary

Healthy use of full-blown dissociation creates a *temporary*, highly specific pattern of channel Qi flow in the body. This pattern causes specific areas of numbness and/or weakness and specific areas of rigidity and/or tension.

These patterns cause the body to curl up in fetal position and become fairly motionless until the danger has passed or death has occurred.

Parkinson’s, or you might say “chronic” dissociation, is linked with a long-term specific pattern of channel Qi flow – one that causes specific areas of numbness and/or weakness and specific areas of rigidity and/or tension.

The PD patterns match perfectly the channel Qi patterns that occur during dissociation.

This chapter only addressed the *motor* symptoms of Parkinson’s and how they compare to *motor* function during dissociation.

The next chapter is where the *really* fascinating material begins: the body-wide and mental symptoms of dissociation, and the parallels in Parkinson’s disease.

I was ecstatic. Scientific findings lead to the ability to make accurate predictions. The next week, I found, and treated, her unhealed hip injury.

“Truths suppressed lead, disconcertingly, to a host of errors.”

- Paramahansa Yogananda, Autobiography of a Yogi

CHAPTER ELEVEN

BODY-WIDE SYMPTOMS OF PARKINSON'S DISEASE

Many symptoms of Parkinson's are body-wide, as opposed to being located on a specific channel. These body-wide symptoms can include behaviors, attitudes, sleeping patterns, and so on.

Many doctors are oblivious to these symptoms because they are not in the Big Four: rigidity, poverty of movement, postural instability, and tremor.

However, these body-wide symptoms are just as much a part of Parkinson's as the obvious, physical problems – maybe more so.

The body-wide symptoms help confirm that Parkinson's disease is a syndrome triggered by chronic use of dissociation mode.

The following list is the result of working closely and consulting with hundreds of people with Parkinson's and their spouses and/or good friends.

As in the previous chapter,

- A hollow bullet indicates a symptom that is recognized by western medicine.
- A solid black bullet indicates a symptom that we have noticed with great frequency in our Parkinson's patients, but which is not recognized by western medicine. These also happen to be symptoms that go away when the person recovers from Parkinson's.

Note: most of these symptoms start at low levels, or come and go. As the Parkinson's disease progresses, they become more severe or more constant.

Also, and you just knew I was going to say this, no two people with Parkinson's have the exact same symptoms and the exact same personality. We're looking at generalities here.

Body-wide and/or behavioral symptoms of Parkinson's

- Constant assessment of one's own behaviors or the behaviors of others.
- Constant assessment and or evaluation of what is going on around one, or “what needs to be done,” by oneself or by others.
- Fear of anxiety or stress-inducing social interactions (this trait often becomes stronger as the other symptoms, especially tremor, worsen.).
- Strong aversion to highly charged emotional situations, particularly situations involving anger. This is often a life-long pattern.

- High aversion to being in the vicinity of people who are being overly assertive, threatening, or who might become angry.
- Fear of cold, fear of getting cold feet, extreme difficulty in warming the hands or feet, even Raynaud’s syndrome. This problem of temperature regulation is a very common dissociation symptom. Even the basic Red Cross course warns about the problems of temperature regulation during shock and post-shock. Although about 90% of my patients get cold very easily, the other 10% tends to get overheated.
- Fear of being vulnerable, or being perceived as “weak,” “pathetic.”
- Fear of seeming not in control: strong desire for self-control or situation control.
- Movement initiation: as the Parkinson’s progresses, initiating movement becomes more difficult. For example, a person might need to increasingly *command* himself to move, or mentally command himself to swing his arms. As soon as the mental focus shifts away from the movement, the movement may come to a halt.
- Tendency for extreme punctuality from fear of being perceived as irresponsible (late). (I have had only *one* PD patient who ran late. She was chronically late – by up to an hour or more, every time. She continued to be chronically late even after she recovered. She was unique in my experience. She was also one of my professional musician patients, and her personality did not match the standard Parkinson’s personality.)
- An extreme dread of making a wrong turn or becoming lost while driving. A majority of my PD patients, before seeing me for the first time, drive to my office the day before the appointment to make sure that they know just where to park and to make sure they don’t fly into a panic/rage by getting lost looking for my office on the day of the appointment. None of my other (non PD) patients that I know of, in all my years of practice, have done this.
- The “Parkinson’s personality” (as noted by some western researchers) Briefly, the “Parkinson’s personality,” as described in chapter one, may include harm avoidance tendencies, particularly emotional harm, unusually strong will power, and intensity of purpose.
- Depression. The depression may have been kept at bay during most of one’s life by a determined effort to stay busy in an “important” way, or by creating a constant sense of “emergency.”
- An unusually high capability for strength, speed, and stamina in his pre-PD years. My patients have been ace fighter pilots, marathoners, highly successful business people (usually self-employed), and leaders in their fields, whatever those fields may have been.
- Inability to cry on behalf of one’s *own* physical or emotional pain, especially during youth, although they might, in adulthood, have learned to cry at movies, or cry for joy, or cry for situations *other* than their own physical or emotional pain.
- Dislike for anyone, even a spouse, to see and/or touch the feet. Fewer than half of our patients have had this trait. However, in those who do have this trait, their fear may be severe.
- Aversion to or difficulty in visualizing, imagining, or even pretending to imagine either one’s entire body or certain body parts, as being filled with light.

- Difficulty in perceiving (somatic feeling) that all of one’s body parts are part of the actual, physical body. When imagining body parts from which one has become dissociated, those body parts seem to be floating just outside of the physical parts, or jutting away from their physical counterparts.
- Aversion to *imagining* that one’s own limbs, or entire body, are actually located inside of one’s limbs or physical body. Asking a person with Parkinson’s to imagine that his own limbs are located within his actual limbs can, in some cases, evoke responses such as “That’s disgusting!” or “That’s terrifying.”
On the other hand, during therapy, the realization that one’s limbs *are* perceived as being outside of one’s physical body is sometimes greeted with mild amusement, or even surprise upon learning that this is abnormal.
Again, biological dissociation gets its name from the manner in which a person perceives himself as outside of, or dissociated from, his physical self.
- Difficulty in feeling one’s heart expanding or contracting in response to beautiful or negative thoughts or experiences.
- Very high capacity for analytical intellect.
- A long-time absence of joy, absence of ideas as to what might bring joy.
- Inhibition of specific types of imagination. A person with Parkinson’s might not be able to mentally imagine the faces of loved ones, or the sounds of their voices. He might be able to daydream in black and white, but not in color. He may not be able to imagine “faces” in the clouds or leaves on trees, and other forms of creative imagining.
- Increasingly prone to imagining worst-case scenarios. Often, a person with Parkinson’s prides himself on his constant wariness, even if his constant anxieties are considered excessive or pathological by others.
- Imagines himself to be the only one “keeping everything working and/or safe,” either in the family or at work. As a corollary, often considers himself to be surrounded by people who are lazy, stupid, or who just “don’t get it.”

Discussion of the above list

The symptoms listed above are all characteristic of dissociation and/or the “safety assessment” that occurs in the brain *following* the onset of biological dissociation.

Safety assessment

If mouse dissociates, following perforation of his skin by the claws of a cat, he will not be able to “snap out of it” until his brain determines that he is once again safe. If there is still any smell of a living cat nearby, the mouse must stay dissociated. If there are any sounds of the cat, the mouse must stay dissociated. If the cat is visible, the mouse must stay dissociated.

The brain of the immobilized, dissociated mouse switches into an intense “safety assessment” mode. Even though the mouse might appear to be cold and rigid – might even appear to be dead – his brain is working hard at detecting anything that might be dangerous.

Only when the mouse’s brain receives no signals that might be interpreted as *immediate* danger is the mouse then able to tremor, take a deep breath, shudder and spring back to life.

The mouse is not able to project and think “logically” about what does and does not constitute safety. Animals do *not* assess safety in terms of *potential* dangers. They are only concerned with clear and present danger. If there is no clear and present danger, they revert back to the business of living.

Animals do not get idiopathic Parkinson’s disease.

Humans, however, especially highly intelligent and highly focused humans, can get “stuck” on the idea that they aren’t *yet* safe enough to come back to life – and maybe never will be.

Many of my Parkinson’s patients agree that they have lived with a heightened “safety assessment mode” for much of their lives.

The brain grows better at doing whatever it is asked to do. People with Parkinson’s tend to be extremely intelligent, to begin with, with highly focused will power. As they become chronically stuck in “safety assessment mode,” their own brain, performing as per request, pushes them to become steadily *more* analytical and judgmental of everyone and everything, while all the while growing in wariness and anxiety.

Though I am getting ahead of myself, the problem for most people with Parkinson’s (the ninety five percent who have mentally-induced biological dissociation), the reason that they have not been able to “snap out” of dissociation is that they have concluded that life itself is *potentially* dangerous.

Therefore, they *cannot* conclude that the danger has passed. They cannot conclude that they can safely resume living *fully*, using all their sensory functions via parasympathetic mode.

This sense of ongoing danger can border on the ridiculous.

I recall a single week in which three different patients, at different times, in trying to explain to me why life was constantly dangerous and why it would be foolish to let their guard down, each said: “Life *isn’t* safe. What about Hitler?”

I confess, when I heard for the third time this exact same, highly inapplicable argument in favor of lifetime-dissociation, I exclaimed, exasperated, “I’m really tired of hearing about Hitler as a reason to be always on guard. *Please* choose something else!”

The patient, completely missing the point, immediately provided me with several *other* reasons why it was smart to never let one’s guard down – why it was smart to never “come back to life.”

But in other cases, the reason for wariness has been tragic, at least at the time the dissociation was initiated. In many cases, one can *almost* understand why a person has chosen to go through life unable to feel his own heart. It *almost* makes sense that he will not, cannot, allow himself to experience sensory experience via the heart. It *almost* makes sense that he doesn’t desire to know what joy is, if feeling joy means also feeling such intense pain.

But then again, even while such a state of suspended animation, thinly disguised by a sense of urgency and adrenaline, prevents the sensations of *immediate* pain, it also can lead to

the long-term physical and emotional pains of rigidity, immobility, tremor, and the indignities and agonies of Parkinson’s.

In the big picture, it’s a poor trade-off.

A personal aside

I know that in my own case, prior to recovery, I had spent most of my life, starting in my teen years, unable to understand why “everyone” craved happiness. I thought that anyone who used pursuit of happiness as a motivator was stupid; all my study of philosophy showed that happiness, outside of spiritual bliss (unimaginable), was never lasting, anyway.

I did *not* yearn for joy. In my defense, I had no idea what was even meant by the word “joy.” I certainly did not recall ever feeling it, except on two distinct, fleeting occasions: once, while sitting on the beach in the afternoon, it seemed as if the heavens opened and my heart was flooded with joy. The skies, the sands, the sea all sparkled. The other time, after climbing to the top of a tricky rock, I felt a strange sensation come over me. I did not recognize it as “joy” until years later, after recovering from Parkinson’s.

I assumed joy was a reward, issued after the fact, for a life well lived. I also assumed that joy was evidently pleasant, from what I’d heard of it, but I was also suspicious of the concept. I partly assumed that the desirability of joy was based on the opinions of those superficial and/or stupid people who went around wanting to be happy. I really had no interest in it. I know this sounds strange but, prior to recovering, this is how I thought.

I craved *safety*: physical, moral, financial, intellectual, and social safety. I wanted to play by the rules – the rules that *I* approved of. I didn’t give a darn about following most social rules. I was pretty sure that following my own rules was my best shot at attaining this “safety” I craved, this “goodness.” Considering all the philosophy I had ingested, I should have realized that there *is* no such thing as safety in the above categories. If happiness is fleeting, “safety” is even more so.

However, I realize in retrospect that my brain was being *correct* in pursuing this mode of thinking, because I had instructed myself to be numb: dissociated from my physical body. In the big picture, this thinking was *not* correct with regard to being alive. But it was biologically correct for a person who imagined himself to still be at risk of “present and immediate danger.”

I *did* experience a relief from my constant state of wariness when I lost myself in playing violin or piano, or singing. When playing music or singing I felt a lifting of the constant mental oppression that I thought of as “intelligence,” “focus,” or “getting things done.”

In the years just prior to the obvious symptoms of Parkinson’s, I *had* noticed a tendency towards depression. I consciously countered it by singing. I had a few short, swingy or highly rhythmic songs that I could always rely on to help me snap out of it when I found myself sliding into unwarranted gloom. I would launch into “Blackbird, Bye-Bye” or other hits from the 1920s and ‘30s at the least sign of depression.

And even as I write this, I can hear a few patients saying, “Your observations do not apply to me: I *do* enjoy life. I have fun doing [insert some amusement here].”

In a very small percent of my patients, this statement is correct: about five percent of my PD patients feel expansion of the heart – actual joy – in response to many activities, and

they direct their lives on the basis of what gives them this sensation of joy. They *also* are able to feel joy whether or not they are doing the activity.

But in most cases when a patient with PD has insisted that he enjoys life, it turns out that what he enjoys is the *stimulation* – the adrenaline jag – created by some activity. The *intensity* of his preferred activity may be able to temporarily divert him from focusing on wariness. A person with Parkinson's will often find this intensity of activity to be pleasurable because it creates a diversion. But very often, the person does not perceive actual, heart-felt *joy* from the activity.

Then again, as noted in previous chapters, many people with Parkinson's *do* have highly specific activities that make them feel good. Whether or not the person with PD is conscious of the fact, these are activities that subconsciously have been deemed "safe." The person will feel good while doing these activities, and may even be able to move almost normally during these times. However, when "the spell is broken" or the safe activity is over, the Parkinson's is right back in place.

But I digress.

Some other characteristic symptoms

Sleep

Sleeping with Parkinson's

During most of the day, a person with PD will have an elevated level of channel Qi in the Gallbladder channel on the side of the body that has an unhealed injury, and a normal level of the other side of the body.

This unbalanced flow through the brain may contribute to internal agitation that is felt by a person with PD. Certainly, when 11:00 p.m. rolls around and *both* sides of the brain have an increase in amperage, the agitation is often reduced. A spate of deep sleep may ensue.

Many people report that, in their pre-Parkinson's years, they fell asleep hard, no matter what was going on or what they were doing, at around 10:30 or 11:00 p.m.. In advanced Parkinson's, the rigidity, the tremor, or the anxiety, may prevent sleep.

Again, many people with pre-PD or early stage PD sleep very well from around 10:45 p.m. to 1:30 a.m. This is significant. This is the time of day when the Gallbladder (GB)channel is *supposed* to be running at a high level. In Parkinson's, this channel runs at a high level all day long – at least on the injured side of the body. The nighttime increase in GB channel Qi can create a *uniformity* of channel Qi through the head which can be very relaxing.

The "fatigue" of Parkinson's, which worsens as the PD progresses, may be subclinical during the day; situations that produce a sense of urgency can cause the tiredness to momentarily recede. Because of this fatigue, which is caused by wanting to collapse into the state of immobility that a person experiences when he is in shock, a person with PD may sense a constant internal battle between alertness, restlessness and fatigue. He may draw upon his strong will power to get through the day, sometimes creating mental situations of

emergency, fear of failure, or even fear of disappointing someone in order to produce enough adrenaline-based drive to keep going.

The time of greatest discord is often between 7 a.m. and 9 a.m. Seven to nine in the morning is the Stomach channel time of day. At this time of day, overall energy of a person with Parkinson’s might be either at its height: he may be at his most dynamic and high-powered or, oppositely, it may be at the lowest level: he may be utterly unable to get up and get going.

Sleep and dissociation

A person who has been traumatized may need lots of sleep. He may be able to sleep very deeply. Then again, if he does not feel he has arrived in a safe place yet, his sleep might be uneasy – sympathetic mode can override the patterns of sleep mode.

Susceptibility to addiction

Addiction and Parkinson’s

A few other curious symptoms of Parkinson’s can be attributed to dissociation, as well. For example, a person with the type of Parkinson’s disease that comes about from dissociating from the heart may find that he is not susceptible to addiction. “Addiction” refers to changes in the brain that occur in response to an excessively high level of dopamine. Some examples of substances that elevate dopamine levels are nicotine, methamphetamine, opiates, alcohol, and cocaine – and of course, most of the antiparkinson’s drugs.

Because a person with Parkinson’s may have shut down his brain’s dopamine system, his use of many substances that are ordinarily addictive will *not*, at low levels, cause his brain to register an excessively high level of dopamine. Therefore, his brain will not undergo the addiction-type changes that would ordinarily occur from cigarettes or mere cocaine.

As an aside, many of my PD patients have pointed with pride to the fact that they were able to stop smoking cigarettes, or even stop using opiates or cocaine, with no trouble at all. They have all attributed this ease of stopping to their “high degree of will power.” They are incorrect. The reason it is easy for them to stop using addictive substances is that, due to their chronically low dopamine levels, their brains have never undergone the changes that occur during addiction.

We have seen that *recovered* patients are *extremely* susceptible to addiction. Their “superior” will power disappears when their Parkinson’s disappears. Once they cease dissociating from their physical sensations, they often have the will power that one might expect from a child. If their Parkinson’s-inducing mental state began when they were six years old, for example, they may find that they have the will power and emotional maturity of a six-year old.

They usually “grow up” fairly quickly. Even so, it can be fascinating to watch a person recovering from Parkinson’s quickly blossoming and “growing up” out from what appears to be mildly arrested emotional development. And he may never have the “superior will power” of Parkinson’s ever again. Just the opposite. He may find himself to be refreshingly emotional and vibrant.

Addiction and dissociation

Doctors know that a person who uses powerful opiates to deal with extreme pain will not become addicted to the opiates. So long as the patient only uses the opiates when his pain is severe, he will be able to stop using the opiates without undergoing drug withdrawal. Oppositely, if he continues to use the opiates after the pain becomes “liveable,” he is very much at risk of becoming addicted.

During episodes of severe pain, most people turn off the parasympathetic mode, and survive, one breath at a time, in sympathetic mode or in dissociated mode, or in a blend of the two.

In this condition, one is not easily susceptible to addiction – just like in Parkinson’s disease.

This is just one more way in which Parkinson’s resembles a dissociation-sympathetic blend.

Tremor

Tremor and Parkinson’s

In Parkinson’s disease, when tremor first appears, it may seem to be in “just the fingers” or “just the legs” or “just the lips.”

In fact, the tremor is not occurring in those places: the tremoring is occurring in the brain.

The parts of the body that manifest the tremor, in the early stages, are those areas that have become so numb or atrophied that there is only minimal physical control in those areas. *Conscious* control of those areas is minimal. As a person loses awareness and control of these areas, those areas will eventually begin to move, helplessly, in time with the tremor in the brain.

Intentional movement can make the tremor stop, temporarily, because the consciousness being directed to the atrophied body part allows for a very small amount of temporary neural communication with the area.

As the body gradually becomes increasingly numb, not under conscious control (dissociated), the tremor is able to manifest through an increasingly larger number of body parts. As the Parkinson’s worsens, and the patient responds to this worsening by dissociating more completely (because dissociation is increasingly the answer to *all* physical problems that suggest vulnerability), the person’s proprioceptive relationship with his physical body becomes increasingly distant. As conscious awareness of the body’s somatic sensations decreases, the brain-driven tremor is able to activate shaking in an increasing percentage of the body.

Even so, the tremor typically is worst along the Stomach channel and Large Intestine channel. Sometimes, if the person also has a side-of-the-hip injury, the leg portion of the Gallbladder channel, from which the brain has dissociated, may also manifest the brain’s tremor.

As a curious aside, we have noticed that people with injuries on both feet, or both ankles, *particularly* if they hurt both feet at the same time, tend to not have tremor, and tend to not have as much internal agitation, or internal tremor, as those Parkinson’s patients who have unhealed injury primarily on only *one* side of the body.

One explanation for this arose after noticing the bizarre experience that occurs during the recovery of many patients, patients *with* tremor: a sensation as if one hemisphere of the brain is shifting position. This brain shift has been mentioned before. The sensation can feel as if the room is spinning, or as if the inside of one’s brain is moving, as if the physical brain is rotating so that the side where symptoms first appeared is literally moving, moving anteriorly (towards the front of the head), back into position. A few patients have felt more as if the brain is “dropping down.” Following the sensation of brain realignment, the tremor stops.

It does almost seem as if the injury-based shunt that carries Stomach channel Qi into the Gallbladder channel, on the head, also serves to tilt the affected brain hemisphere backwards or creates an electrical pattern “tilt.” This “brain tilt” may be the mechanism that creates un-evenness between the hemispheres, which leads to the electrical static that drives the tremor. This may be a fruitful avenue for future research.

Certainly, after a breath-taking sensation that feels as if a brain tilt is correcting itself, the tremor stops. Utterly. It’s gone, for good. It’s not gone because the person has made himself calm. It’s gone because it’s gone.

One of the most glorious sensations that occurs during recovery from Parkinson’s is the cessation of the tremor. As mentioned earlier, the unexpected internal stillness is so shocking, most people wonder, for a few moments, if they have died. They have become so accustomed to relating a trembling brain with alert consciousness that, when the trembling stops, they aren’t certain if they are dead or alive.

Within a few moments, of course, they realize that they are still breathing, and therefore, still alive. Those first few moments of non-tremor are glorious and feel like an altered state of mind.

Tremor and dissociation

As has already been discussed, tremor is a normal part of dissociation. When a person is out of immediate danger, the body begins to tremor. This is a signal to the owner of the body that he is still “holding his (metaphorical) breath.” He needs to take a deep breath, exhale, maybe even make a buzzing sound with his lips, and execute a shudder, or shake, that runs from the head down the back, maybe even all the way down to the tip of the tailbone.

Based on our experiences with people recovering from Parkinson’s, it may be that dissociation, the normal, severe-injury type of dissociation, sets in motion a process in which one side of the body is slightly more affected than the other: and one hemisphere of the brain would get shoved backwards a little more than the other, slightly less affected, side. This would allow for a mild misalignment of the two brain hemispheres. Then, when it’s time for the dissociation to end, the misalignment in the brain sides triggers a tremor. The shudder-and-shake that ends dissociation may *physically* snap one out of the tilt. This might be another subject for further research.

At any rate, sometime following the dissociation-ending exhale and shudder – it might be minutes, it might be weeks – the brain feels as if it’s become re-aligned. The tremor stops almost instantly.

Personality

The subject of the personality changes that can occur due to chronic use of dissociation is fascinating and vast. This is a subject worthy of an entire book. For now, in this book, it will be easier to discuss this subject, necessarily briefly, in the section that deals with recovery symptoms.

After all, it is only after recovering from Parkinson's, when the personality traits characteristic of Parkinson's wonderfully, gloriously disappear, that one is able to realize that something so complex as an entire "dissociation personality" does in fact exist – and can go away when the dissociation ceases.

I will only say, for now, that the personality traits and the disappearance of these traits following recovery, are far too similar, from one PD patient to the next, for it to be raw chance. Also, these behavioral traits do match up with the thinking processes that are part and parcel of dissociation and of the sympathetic-mode override.

A lengthy aside: Parkinson's and genetics

The very large identical twin studies done in the late 1990s showed that an identical twin of a person with PD is *less* likely to develop PD than the national average, thus proving that genes are *not* causative for Parkinson's. However, it has also been noted that many people with Parkinson's share some fairly uncommon genes. It has also been noted that Parkinson's seems to run in families, even though identical twins tend to not *both* get PD.

Running in families

The attitude that pain must be hidden, and that a person is weak and flawed if he shows his pain, tends to be a socially-learned behavior. In those cultures that consider showing pain or emotion to be a weakness, we see a higher percentage of people with Parkinson's. This "family-learned" attitude can create the impression that "Parkinson's runs in families," even though Parkinson's has been *proven* to not be genetic, in a Mendelian sense.

However, even in families that embrace the "hide your pain" philosophy, an identical twin has a unique situation. Usually, one identical is the dominant; the other is subordinate. Even in the most rigid of emotion-suppressing families, the intimate relationship between identical twins can provide a loving, comforting, even confiding relationship for the subordinate twin, who can go to the dominant twin for succor. The subordinate twin is thus able to express fear and pain instead of suppressing it or dissociating from it. The dominant twin, however, may have no one to turn to, and may need to put on the "stiff upper lip."

In my own very limited experience with identical twin cases, only the emotionally dominant twin has had Parkinson's – the other does not.

Parkinson's and intelligence

It may well be that the genetic similarities that are found in people with Parkinson's are related to the *high IQ* of people with Parkinson's, and/or the spiritual fervor of people with Parkinson's.

I have never met a slow-witted person with Parkinson's disease. I do not think that a dull-witted person would be capable of the level of analytical mental processes and mental

focus that are necessary to maintain biological dissociation for the long-term in the absence of clear and present danger.

Parkinson’s and genetics

These genes for intelligence may allow the powerful mental focus that is necessary in order to invoke and maintain a lifelong subconscious instruction to dissociate from physical and emotional pain. These genes may contribute to the mental prowess that *allows* a person to dissociate, and even to the spiritual fervor to which many people with Parkinson’s attribute their “choice” of being “unaffected by pain.” But even the geneticists agree, these genes do not *cause* Parkinson’s, *per se*.¹

The study of this field, in which genes are recognized as contributing to some *leaning* or *attribute*, which then makes a person more or less *capable* of having a tangential condition, is called “epigenetics.”

For an example of epigenetics, a strong ability for mental focus might be necessary for a person to be a good music composer. But the genes that allow for that mental focus might just as easily be applied to the study of architecture, or the application of mental dissociation. Or not used at all. Merely having the genes that allow for strong mental focus will not necessarily cause a person to become a composer. Nor will these same genes necessarily cause a person to make the choices that are necessary to create Parkinson’s disease. But if he decides to take the dissociation route, those genes might help him to be *very* good at maintaining that decision.

I repeat: people with Parkinson’s may all have genes that allow for intensity of mental focus, but a person *can* have intensity of focus *without* developing Parkinson’s. For that matter, a person can have genes that will allow for intense mental focus and choose not to use that capability at all. How a person’s life unfolds depends on how a person chooses to *use* his potential genetic capabilities. Genetic potentialities, *in most cases*, do not in and of themselves determine our destinies.

Spiritual fervor

Which leads us to the next commonality for people with Parkinson’s disease: strong spiritual leanings, though not necessarily associated with a religious denomination. Oddly enough, religious fervor, long thought to be the result of highly personal, individualized behavior, has been proven, via identical twin studies, to be genetically driven.²

¹Using identical twin studies to track genetic traits, researchers have discovered that intelligence is more closely related to genetics than it is to parenting or environment. This might include the high level of intelligence required to mentally invoke and sustain the dissociation characteristic of Parkinson’s. Another common trait in people with Parkinson’s, spiritual fervor, has also been found to be genetic. A disproportionate percentage of my Parkinson’s patients have a deep spiritual fervor. In some, their fervor is a deep personal secret. In others, it is overt. Many of my patients have been stunned to learn that they are not my first patient with Parkinson’s who is a priest, nun, professional religious, or who has spent time in a monastery, nunnery, or ashram.

² “Another [identical twin] study showed that the strength of an individual’s spiritual fervor was significantly shaped by heredity, though one’s choice of affiliation – whether to become, say, a Methodist or a Roman Catholic – was not.” From “A Thing or Two About Twins; *National Geographic*; Jan. 2012; p. 58. If one understands the continuing-wave nature behind the principles of

Most of my Parkinson's patients strive intensely to embody "doing what's right." They tend to be "above" the lesser "weaknesses" such as overindulgence in smoking, drinking, and so on. They also *tend* to be fairly judgmental towards those who do not have as high a level of will power as themselves.

Many consider themselves to be very spiritual, even if not religious: they consider service to others, selflessness, detachment from materialism, and even asceticism to be *extremely* important.

Many of my patients have been religious professionals: priests, ministers, rabbis, nuns, and monks of both eastern and western religions. *Many* of my patients have told me that, in their teen years, they considered a monastic life.¹

reincarnation, it becomes very easy to appreciate that a person with lifetimes of spiritual seeking behind him will be best suited for a body with a genetic code that "fits" with the particular wave signals that arise from lifetimes of spiritual practice. Based on this, one would *expect* a link between spiritual fervor and genetics. We inhabit those genetics that best fit our already very specific, individual wave properties – properties created in large part by past-life actions and thoughts.

¹ A Hindu monastic swami once told me that people with Parkinson's disease are very advanced souls who have temporarily lost their way – taking a side trip into trying to control their own fate. A Tibetan monk stated that people with Parkinson's are living in their heads; they have forgotten that God is also in their bodies. (Continued on next page.)

I have discussed the spiritual aspect of their lives with hundreds of people with Parkinson's and with their family members. Some of these long talks have gone late into the night.

The insights from people who have *recovered* from PD have been especially enlightening. Most recoverers have thought deeply about the personality changes that they experienced during recovery. I have written up the following conceit (extended metaphor) to summarize the brutally honest self-analysis and conclusions that arose in these many talks:

People with Parkinson's have spent lifetimes climbing up the steep mountain of self-discipline, seeking God attunement. They have spent lifetimes practicing mind over matter and denial of the flesh. As they've climbed higher and higher up the spiritual mountain, they've felt a growing detachment from the body, and from the people in the metaphorical valley below. Increasingly, they have come to view those who were not working at seeking God as being earthy, bawdy people, larking about in childlike ignorance.

After lifetimes of diligent practice of spiritual disciplines, they have developed tremendous mental powers of concentration, superb physical control and strength, the capability to detach themselves from the sensations of the body. Without realizing it, they began to take pride in these accomplishments. They came to feel that they were somehow different from or superior to the less powerful people. When pride came, they not only become isolated, they lost their sense of spiritual direction. They tried to use their hard-won capabilities to fend off the freezing loneliness of their high spiritual altitude.

They magnanimously serve others from their state of spiritual elevation even while they feel apart from them. From high on their metaphorical mountain of spiritual attainment, they become responsible, they take charge, they pridefully give blessings to the underachievers, the incompetent people below. But in the loneliness and emptiness of their attainments, they remain assailed by their infinite fears – they have separated themselves from others, and they have separated themselves from God.

They have forgotten that attunement with God is most easily found via the low-lying paths of humility, devotion, and the trust in God that brings spiritual fearlessness.

And so, by virtue of the Divine laws of cause and effect, they eventually develop this fitting illness. The symptoms of this illness are the logical conclusions of what they have long sought: they

Many, if not most, of my PD patients, when asked what gives them joy, answer, often wistfully, that making *others* happy gives them joy.

When asked what someone might do for him to make *him* happy, or what makes his own chest expand with joy, his own heart thrill with happiness, many of my patients have thought for a long time before replying something to the effect: “It’s been so long, I don’t remember,” or “I don’t really feel joy;” “I don’t know;” and even “I don’t think I even know the meaning of the word.”

Since joy is the essence of the spiritual life, there is a certain irony here...

Possibly the most significant of the “personality-related symptoms” is the way that symptoms come and go, diminish and intensify, depending on the person’s moods and surroundings.¹

Causal commonalities

Not all our patients have the same story line for their childhood, but a majority have shared stories of parental coldness, loss of loved ones at an early age, or family pressure to not show emotion or pain. Also, many have a history of a dangerous or highly painful accident that occurred in a setting in which it was not physically or socially safe to

have denied the senses of the body for lifetimes, and so the senses become stripped away: taste, smell, and touch are all lost. Their mental determination to be unmoved by worldly events results, eventually, in an illness characterized by inability to participate in the world.

Finally, when they can no longer dress themselves, feed themselves, clean themselves, explain themselves, or even blink their eyes in wordless communication, they may realize that they are physically dependent for every aspect of life on those very people that they once spurned: the common people down in the vale.

Eventually, after repeated lifetimes of struggling against the symptoms seen in Parkinson’s disease, they *will* learn to accept, with humility and gratitude, the ministrations of the kind members of the community. Their minds will someday let go of their fear and pride. When this happens, they will suddenly behold God all around through their remaining senses of hearing, sight, and intuition.

They will hear God’s love and sympathy in the gentle patient words of the people who care for them. They will perceive in their heart the good intentions of God flowing to them through the actions of the helpful people of the valley. They will see that the very bodies of even the most unsophisticated people of the valley are condensations of the light of God. The spiritual seekers had never been alone on their mountain after all: God was always there. And that mountain that they thought they needed to climb?

There never was a mountain. That was their own conceit.

¹ When I say “come and go,” all time frames are possible. Mentally-induced conditions may appear only during times of particular stressors, and may last a few minutes, a few days, a few months, or years. Or a few seconds.

I have had many patients whose Stomach channel Qi *usually* ran backwards. But in response to a joke or limerick, their Stomach channels *instantly* ran perfectly normally – so long as they were laughing. The instant they finished laughing, the channel Qi would revert to a dissociation pattern. One of these patients frankly admitted that she enjoyed being emotionally “turned to stone” because it made her feel safe. Of course, she regretted that it was causing her legs to be rigid, but she couldn’t let go of her idea that “something bad might happen if the numbness wasn’t there.” Only when laughing was she able to temporarily forget about her anxieties, and use her legs somewhat normally.

acknowledge the injury. In many cases, being injured could provoke hostility from the parent(s).

In the above paragraph, I am trying to be calm and objective. The truth is, many of the childhood stories I've heard from patients have been heartbreaking. But this introductory book is not the place to dig into those details.

I first began to wonder about the significance of this after my first three Parkinson's patients *all* answered my not uncommon (in Asian medicine) intake question about childhood with an unexpected coolness.¹

Many of my patients have made a connection between some specific terrifying childhood memory or a heartless style of parenting, in general, or even the fairly common cultural admonition to "don't show your emotions" and their preference for maintaining an arms length distance from their own heart's emotions. Many of them consider the practice of biological dissociation, for anyone who is *capable* of doing it, as a *sensible* response to problems they just can't "deal with."

It *does* make a certain kind of sense, and yet, dissociation was never intended as a long-term biological mode. In the short term, it can be a lifesaver. As a long-term way of "living" however, staying in a state of pre-death has many drawbacks.²

Cyclical symptoms

I will close these chapters on body-wide symptoms with one of our most bizarre observations. People with idiopathic Parkinson's disease have a twenty-three day cycle of movement ability, during which movement goes from good, to bad, and back to good again over twenty-three days. A person with Parkinson's will usually go from a very good day or days, during which he has a great attitude and feels at the top of his game, and slowly slide, over the next eleven days, down into a pit in which he may be certain that he has never been so rigid (or negative, or tremory, or whatever his current, worst problem is). Then gradually,

¹ Regarding this diffidence in talking about childhood, the intake scenario usually ran something like this: "...and what about your childhood? Anything interesting that you think might be of significance?" The patients often replied to my query with more or less the same words, while becoming distant for the first time: "I don't think we need to discuss that. I've worked that out."

Being a doctor, I've grown used to people at least trying to answer my medical intake queries. This evasion on the part of so many people with Parkinson's when I asked about their childhood certainly piqued my curiosity. And yet, others were not shy at all; they told me stories of hair-raising violence and cruelty. Of course, not everyone had a horror story from his immediate family or a childhood that called for a high level of stoicism. (Continued on next page.)

Some of the people with Parkinson's *were* from happy homes – but often they recalled some injurious event during which they were *badly* shocked or scared, or had to put up a strong face, or had no one to turn to for comfort during the singular episode.

The main point here is, no two people with Parkinson's are exactly alike. And yet, there are so many similarities in how they've chosen to respond: too many to ignore.

² Sri Daya Mata, spiritual leader of the international yoga community founded by Paramahansa Yogananda, addressed this subject in "satsanga"; a question and answer session. She was asked, (I paraphrase) "People say that we are never given more trials than we can deal with, but that's not true. I've known people who fell apart from their challenges."

Sri Daya Mata replied, "That's because they *didn't* deal with them."

over another eleven days, he will cruise back up to the top again. The complete cycle lasts twenty-three days. And then it starts again.

The most uncanny thing about this cycle was that all my patients were on the *same* twenty-three day cycle. My patients all had a “good day” on the same day, and eleven or twelve days later, they all had their worst-ever day, and then, by day twenty-three, they all had a “good day” again.

The incredible thing was that this cycle did not just happen to my patients in my office, in my hometown. It was happening to all the patients around the world who were in email contact with me.

Before I realized that there was a cycle, I was often remarking to my family, over dinner,

“I’m really excited: everyone is doing much better today.”

A week and a half later, I’d be saying, “Everyone is much worse today, I don’t know what I’m doing wrong. Maybe I’m a fool for trying.” And then a week and a half later, I would be rapturous with glee because “*Everyone* is doing so much better!”

My son finally pointed out that I’d been doing this up and down cycle for over a year, and that it was impossible that “everyone” was doing poorly or that “everyone” was doing well. Surely I was exaggerating.

I wasn’t exaggerating.

I went through my charts. I went through the emails that had been sent to me from people I knew *and* from people that I had never met. Sure enough, there was a consistent, twenty-three day cycle in people with Parkinson’s from around the world, even if I’d never met with or emailed with them before. In fact, I suddenly saw that I tended to get the most emails at the apex and nadir of the cycles.

This was unbiased reporting: the emailers who had never met any of us on the team were *not* being influenced by me or by anyone in the project.

The other thing that was quite strange was that, since starting this project, there were a few times that the low in the cycle was extremely low or the high was extremely high.

I recall that all my patients experienced a *severe* low in the first week of August of 1998. Another one occurred towards the end of January in 2000. I have not tracked enough of these extremely powerful lows and highs to detect a pattern. I did not share this information with patients at first, because I feared “contamination” of my research data.

But once I had several years of data, I did present this information about the twenty-three day cycle to patients so that they could keep their chins up when they found themselves having a rough week or so.¹

The influence of whatever it is that drives this cycle ceases when a person recovers from Parkinson’s disease. The physical symptoms of Parkinson’s *and* the emotional

¹ Several friends of the project have tried to research the probable cause of this worldwide cycle. The only astronomical event with a twenty-three day cycle that might possibly be driving the pattern is a star in our galaxy that emits a strong radio wave in a twenty-three day cycle. This is not a biorhythm pattern. Biorhythms begin on the day a person is born. Therefore, there are 365 potential starting dates for the biorhythm cycles. But all PD patients seem to be stuck in the same cycle. It may be that, when they shut down their heart, they fall out of their native biorhythm and into a sort of default cycle that can be influenced by strong atmospheric phenomena.

symptoms of Parkinson's (if any), the negativity, wariness, self-pity and/or fear or shame of self-pity, and anxiety, were all influenced by the twenty-three day cycle.

However, the physical and emotional symptoms of *recovery* were not influenced by the twenty-three day cycle. The pain and tingling in injuries that were healing, the ability to taste and smell, to sleep long and deep, to cry, the changes in self-awareness and the new found ability to feel one's own heart's responses were *not* influenced by the twenty-three day cycle.

Summary

Many of the "body-wide" or "personality" symptoms, such as inability to cry or fear of being perceived as weak in any way, are closely related to the mental states that occur during dissociation, where being stoic, unnoticed, or motionless, might make the difference between survival and death.

Other symptoms can be seen as the inevitable side effects of keeping the brain in an attitude of chronic danger assessment.

Still other symptoms, such as the sleep patterns, derive from the channel Qi shifts that occur during dissociation.

As I sit here, plunking down the words for this chapter, pondering on my patients, their seemingly wide range of symptoms and the underlying similarities of their symptoms, I realize that this chapter could go on for hundreds of pages.

In chapter one, I promised that I would write up everything I know about Parkinson's disease. I must fail on that score. If I wrote up *everything* I've seen that might be pertinent to the Parkinson's personality, this chapter would end up as a whole 'nother book.

I have to laugh. Prior to recovering, it would have been painful, maybe impossible, to write the above paragraph. Failure to make good on a promise would have been breaking one of my rules.

“Color-energy and pulse are valued by the Gods, and they were taught by the teachers of former times.”¹

- Nei Jing, Spiritual Pivot, chapter 13-5

CHAPTER TWELVE

DIAGNOSING PARKINSON'S DISEASE

Start with a good diagnosis

Recovering from Parkinson's is pretty much a do-it-yourself job, or at least a do-it-at-home-with-a-friend job. Professional help is not required.

It can be helpful to be certain of your diagnosis. Then again, we've seen that receiving a confirmation of “incurable Parkinson's disease” from a neurologist often throws a person into a tailspin, with extremely rapid acceleration of symptoms. If a patient learns that this syndrome is curable, the accelerated symptoms often vanish. The patient reverts back to his previous, milder level that he manifested prior to diagnosis. So we must weigh the balance between the worsening of symptoms that can be brought on from the stress of getting a diagnosis against the importance of *knowing* whether or not a person actually has idiopathic Parkinson's. Then again, if the person already has a diagnosis, there is no harm at all in confirming it with the idea in mind that it is a curable syndrome.

As for the statement that this is a do-it-yourself job, consider the following three points:

Point one: healing from the injury

Nearly anyone who can sit still for half an hour at a time can master Yin Tui Na, the hands-on part of the recovery process. This means that a person with Parkinson's should be able to find someone, a friend or family member, who is willing to put in a few hours to learn what's involved. That person can then provide the supportive holding of Yin Tui Na to the injured foot or ankle of the person with Parkinson's.

If no friends or family members are available, it's possible that a massage therapist who specializes in light-touch therapy, or a craniosacral therapist, will be willing to learn how to do the hands-on treatment.

For complete instructions on Yin Tui Na, an entire book, packed with photos, is available for free at the website of the Parkinson's Recovery Project: www.pdrecovery.org.

The title of the book is *Yin Tui Na: Techniques for Treating Injuries and Parkinson's disease and Any Dissociation Injury*.

¹ Color energy refers to light waves, electromagnetic energy: channel Qi. Assessing Channel Qi and pulse were two diagnostic tools in ancient times.

Please don't write to us asking if there's a trained Yin Tui Na specialist in your hometown area. This is like asking us if there's anyone in your area who knows how to hold hands.

In general, people do not "train" in this type of work because it is about as basic as holding a crying child until he stops crying. If a person can hold a crying child, he's already mastered Yin Tui Na. Admittedly, *not* everyone has the patience to hold a crying child. Even so, holding a crying child is *not* something for which anyone needs training.¹

Point two: healing from the dissociation

The far more important part of the work, learning how to stop dissociating and dwelling in the land of chronic danger assessment, must be done by the patient himself, and no one can do that for him. Only the person with Parkinson's can make the *decision* to stop the dissociation. We've had patients who've tried counseling, hypnotherapy, and so on, to no avail. Everyone who has recovered has realized that they needed to decide that they were safe. No support from "professional healers" has done the trick. For that matter, therapists who want to "dig in and find out root causes" tend to make the person worse – more anxious, more on the lookout for even more things to be anxious about.

Even so, even though the patient must do-it-himself, advice on how to approach the business of turning off the dissociation is provided in a later chapter.

Point three: getting a good diagnosis

Before even starting out with the Yin Tui Na or trying to switch the tracks of one's mental train, it's a good idea to make, or confirm, the diagnosis of Parkinson's disease. That, too, is a do-it-yourself job. In fact, you are more likely to have a solid diagnosis if you do it yourself – with the help of a friend – than if you rely solely on one neurologist.

¹In answer to a frequent question, "Can I do Yi Tui Na on myself?", I provide the following: I received an email from a person who had been diagnosed with Parkinson's disease by several neurologists. She moved several times, and each new MD confirmed the diagnosis. She wanted me to be clear on the point of several confirming diagnoses because she had recovered, using our methods.

She was living in a remote area in the Midwest, where she had gone to care for her aged (Continued on next page.)

father who was in failing health: her father could not possibly do Yin Tui Na on her.

She treated herself by sitting on her own injured foot. She found a way to sit on the foot that was supportive and soothing to the foot.

For the fear-based dissociation, she found it soothing to press her thumbs hard against her sternum. She sat like this every day, putting gentle pressure on her foot and pressing thumbs against her chest to help her feel her heart. Feeling the heart is a trait of parasympathetic mode. She recovered completely. She sent only the one email to introduce herself, to tell me that she had completely recovered, and to share that it is possible to treat oneself.

Another sometimes-effective way to address the foot injury is the Chinese art of Qi Gong, which loosely translated might be called "Paying attention to and moving your own body's energy around." Some people with Parkinson's have healed their foot injuries by consciously feeling the sensation of sending joyful energy through their foot, every day, for many months. Most of my patients have *not* been able to do this effectively because they are not able to even imagine that energy, and especially not joyfully.

Do-it-yourself diagnostics

Confirmation by a neurologist

If one, or possibly two or more, neurologists confirm that the collection of symptoms is probably Parkinson’s, the next step is to have someone feel the channel Qi in your legs, torso, and arms.

Feeling channel Qi

Learning to feel channel Qi is easy. Instructions on feeling channel Qi are provided, for free download, on the website of the Parkinson’s Recovery Project: www.pdrecovery.org.

This free material consists of the first chapter and the channel maps from the book *Tracking the Dragon: Advanced Channel Theory – An Acupuncture Text*. This is all the material needed in order to master feeling channel Qi.

You will need to enlist a friend or family member. It is nearly impossible to feel one’s own channel Qi. Frankly, if you are one of the few people who *can* accurately detect aberrations in your own channel Qi, you probably don’t have Parkinson’s, because one characteristic of Parkinson’s is lack of sensory awareness of electromagnetic wave patterns, such as the sensations of wave expansion in the heart, in one’s own body.

Have your friend or family member read the material in chapter one of the above book, and then have him practice feeling channel Qi on a few different *healthy* people before attempting it on you.

Have him practice for several hours, maybe over the course of a week, or so.

Your friend should notice, on the channel maps, the *correct* directions for channel Qi flow.

The friend should focus on feeling the following channels:

The channel Qi on the leg portion of the Stomach channels – both sides.

The channel Qi on the torso portion of the Ren channel.

The channel Qi on the arm portion of the Large Intestine channels – both sides.

After a week or two of practicing feeling channel Qi, your friend will probably say that he isn’t sure of what he’s feeling, and he doubts that he will ever learn to feel channel Qi. But, after he’s felt other people’s channels over a period of a week, or so, then let him feel the channel Qi in you, in the three areas listed above.

Even if he thinks he hasn’t been feeling anything in those healthy people, he will most probably be able to notice that *your* channel Qi feels different – *if* you have Parkinson’s disease.

If you do have Parkinson’s, and he feels your Qi in the above channels, It is highly likely that he will say, “I’ve forgotten what I’m trying to feel! I don’t know what I’m doing.”

This is because, even though he didn’t feel “anything” on the healthy people, he was picking up on signals. Those signals are unremarkable because they are perfectly normal. But when he tries to feel the channels on a person with Parkinson’s, the sensations will be so weird, or so diminished, or so intuitively wrong, that his first assumption will be that he’s “forgotten” what he’s trying to do, or that “I can’t feel *anything*.”

If this occurs, the “problem” isn’t with your friend’s skill set. The problem is with your channel Qi. Still, at this point, it might be helpful for him to practice again on a few healthy people and come back to you again.

If he notices that your channels feel “different” from the healthy people he has practiced on, or he can’t feel them, or he feels them going the “wrong way, “ then your diagnosis is confirmed.

You have Parkinson’s disease.

It’s really very simple.

Do not expect to find an acupuncturist who is trained in the art of feeling channel Qi. Most schools of acupuncture do not teach this art. In China, as mentioned in earlier chapters, channel Qi doesn’t exist, and has been made illegal. China-trained acupuncturists and doctors are *not* taught to feel for it.

In my many years of teaching this art to people with no medical background, I’ve only met one person who truly couldn’t feel anything, even after working on it for several hours. He mentioned that he was also taking antidepressant medication. I do not know if his drug use was impeding his ability to feel channel Qi. I only mention it. Most people start recognizing what they are feeling within a week or two of taking a two-hour class and doing a spot of practice at home.

Self-diagnosis: if you are not diagnosed by a neurologist

If you are not working with a medical professional but suspect that you have Parkinson’s disease, please read through the chapters on physical locations of PD symptoms and body-wide symptoms. Note any symptoms that might apply.

The symptoms you have might be obvious or they might be very very mild. You will *not* have all the symptoms listed in that chapter.

To make a diagnosis of Parkinson’s you need to have at least one symptom in three of the four categories. Remember, the four categories are poverty of movement, rigidity, tremor, and postural instability (walking backwards or losing your balance.)

If you have several symptoms in only two of the categories, you might still call it Parkinson’s disease – but in this case postural instability cannot be one of the categories.

For example, a person might have several symptoms of poverty of movement (slowness in tapping the fingers together, slowness in rotating the wrist, etc) and several symptoms of rigidity (difficulty in turning his neck and twisting his torso).

In this case, even though he doesn’t have tremor, he can still justify a diagnosis of Parkinson’s disease because he has more than one symptom in two categories – and neither category was postural instability.

The presence of a tremor does not prove a diagnosis of Parkinson’s disease. Remember, between 15 and 35% of people with Parkinson’s do *not* have tremor. The number range depends on who you read.

Also remember, lots of people have tremor who do *not* have Parkinson’s.

You are looking for a package of symptoms, unique to yourself, but similar enough to other people with PD in terms of the symptom locations and whether or not the symptoms are slowness or rigidity in the correct location, so that you can be lumped in with all the other people who have various symptoms but share the diagnosis of Parkinson’s.

Remember, a person with Parkinson’s will *not* have all the symptoms in the chapter describing the location of symptoms. He may only have a *few* symptoms. He might *not* have the “frozen facial expression.” He might *not* carry his arms bent. He might *not* have a hunched posture. He might *not* have tremor.

Everyone with PD manifests different symptoms, and manifests them a bit differently.

If, after checking your symptoms against the descriptions in chapters ten and eleven, you decide that you do, in fact, have Parkinson’s, then have a friend check the direction of movement in your channel Qi.

Diagnosing what type of Parkinson’s: injury-based or mentally-induced

After confirming a diagnosis of Parkinson’s, the friend who is feeling the channel Qi might want to see if your channel Qi can normalize in response to mood changes.

If the Parkinson’s electrical pattern – the dissociation pattern – is being held in place by an injury, the channel Qi will not alter much in response to mood. If the electrical pattern is primarily mood-induced, it will ebb and flow, and maybe even run correctly now and then, in response to mood. A joyful mood will cause the channel Qi to run correctly. Fear, negativity, apprehension or emotional numbness will make it run backwards.

By the way, it is *not* normal for channel Qi to run backwards when a person is fearful or apprehensive. A normal response to fear is use of the sympathetic mode, in which channel Qi is somewhat shunted away from the digestive organs and sent, in even higher amperage than usual, directly to the muscles that are needed to combat the danger, or flee. In sympathetic mode, the amperage in some channels shifts, sending more energy to the heart and lungs, for example, and to whatever muscles might be needed in the ensuing struggle. But even as the areas of higher amperage move around, the channel Qi still flows in the normal *directions*.

If your friend notices that your channel Qi is flowing the wrong way, or is missing, or erratic, have him do some mood alterations tricks: have your friend tell you some jokes – the sillier the better. If, in response to the dumb jokes, the Stomach channel Qi on the legs begins flowing normally, (similar to how it flows in a healthy person), then you are dealing with a case of mentally-induced dissociation with little or no foot-injury component.¹

¹ The joke that I usually use is this: “Have you heard the one about the bishop and the lady sword swallower?” If the patient’s channel Qi is in dissociation mode *only* because of a mental attitude, then, in response to that question, the channel Qi will very likely start running correctly – unless they’ve heard that one before. I never need to actually tell the whole joke. Channel Qi changes occur almost immediately in response to one’s mental state. Even the anticipation of something funny is usually enough to switch a patient’s mental wariness. The (Continued on next page.)

If the Stomach channel Qi on the legs runs backwards even when the patient is laughing and happy, you are probably dealing with a situation that involves an unhealed foot or ankle injury.

If there is a foot or ankle injury, the patient may very likely *also* have mentally-induced dissociation, as well, but you will not be able to diagnostically isolate the two forms of dissociation, at first.

After the foot injury has been treated and the Stomach channel Qi on the leg runs perfectly normally under certain conditions – for example, if the patient is laughing and/or singing – and disappears or runs backwards when he stops laughing or singing, or disappears when you say “Uh oh...” to the patient, then you will know that he still has mentally-induced dissociation even though he no longer has the injury-induced dissociation.

PD diagnosis: bits and pieces

The rest of this chapter is just a collection of bits and pieces of PD diagnostics-related information.

When experts disagree

There is no “hard” test for Parkinson’s. A doctor’s diagnosis of Parkinson’s is an educated guess, and is not necessarily correct. Approximately thirty percent of people diagnosed with Parkinson’s whose brains are eventually autopsied show no indication of a reduction in the number of dark (*nigra*) cells in the substantia nigra. Technically, this means that they were misdiagnosed, and did not ever actually have Parkinson’s disease.

For an example of how difficult it can be to get a “firm” diagnosis, one of the very largest drug studies ever conducted for antiparkinson’s medications was the Eldopa study of 2001. The patients had early stage Parkinson’s. Nearly two hundred people were used as subjects in this study.

To make sure their study was valid, six top neurologists, all Parkinson’s specialists, were recruited to confirm that all of the subjects did, in fact, have Parkinson’s disease.

Interestingly, very few of the subjects had *unanimous* diagnoses. In the end, the researchers had to accept subjects for whom a *majority* of the six neurologists could assign a diagnosis of Parkinson’s disease.

So don’t get too alarmed if you have doctors that disagree, or if your findings don’t agree with your doctor’s. Unless you are using channel Qi diagnostically, diagnosing Parkinson’s disease, especially in the early stages, can be very tricky.

Blatant misdiagnosis

We have seen a fair amount of this.

We have seen people who, prior to knee or hip surgery, could move and walk normally. Immediately following the surgery, they have been unable to move the “repaired” joint, or unable to move or walk normally. All of their post-op movement problems have been

(Continued from previous page.) above “joke” is courtesy of P.G. Wodehouse, who uses it in just this manner inasmuch as he never actually tells the joke. I doubt that there is any more to this joke than the introductory question.

dismissed by their surgeons as Parkinson’s disease. The surgeons typically say, “There’s nothing more I can do for you: you developed Parkinson’s; you’ll have to work with a neurologist.” This is shameful, but it happens.

Tremor-related misdiagnoses

Some people are told that their asthma medication-induced tremor is Parkinson’s. Some people are told that their active tremor is proof of Parkinson’s, even if there are no other symptoms. (Parkinson’s tremor is nearly always a resting tremor, not an active tremor.)

Many medications, particularly medications that alter brain neurotransmitters such as antiparkinson’s medications or SSRIs, can cause tardive tremor. Tardive means that the tremor might show up later on. For example, with many drugs that cause tardive tremor, the tremor shows up long after the person has *stopped* taking the drug – maybe years, maybe decades. We know of no treatment for drug-induced parkinsonism.¹

Tremor can be caused by heart problems or blood sugar regulation problems. There are genetic forms of tremor.

Essential tremor.

One issue that does arise fairly often is the diagnosis of essential tremor. Essential tremor is a condition with a tremor that resembles the resting tremor of Parkinson’s but presents with no other Parkinson’s-like symptoms.

A really good neurologist, one who knows that Parkinson’s worsens quickly in response to the mental fear induced by a correct diagnosis, and who knows that the medications have a very limited period of effectiveness, may tell a person who has early stage Parkinson’s disease that he merely has essential tremor.

This is good medicine. There is, or used to be, nothing to be gained by telling a person he had early stage Parkinson’s. And there was *much* to lose.

¹ In 2001, an older physician friend who works at a Veteran’s Administration hospital told me that, when he was much younger, about four percent of his elderly patients had Parkinson’s disease. This is about the national average for people over seventy years of age. However, when the WWII Air Force pilots started to get into their senior years, nearly all of them were diagnosed as having Parkinson’s, or a Parkinson’s-like tremor. As he put it, “I would walk into a room with all these Air Force vets sitting around, and they’d *all* have tremors going.”

He was intrigued. A bit of digging uncovered the information that nearly all of the ex-pilots had been required to take methamphetamine during their long, war-time flights. This drug was used to help them stay awake for extremely long periods of time. Fifty years later, nearly all of them were developing a tremor.

We now know that methamphetamine, like most dopamine-enhancing drugs, causes long-term brain damage, including damage that causes drug-induced parkinsonism, and its tremor. This is an example of *tardive* (delayed onset) drug-induced tremor.

More recently, in 2012, I learned from a psychologist who works at a VA hospital that many, if not *most* of the vets he sees have symptoms of drug-induced parkinsonism, but in the cases of the younger ones, it’s almost always tardive effects of having used the mind-altering, dopamine-enhancing drugs such as “ecstasy.”

As noted previously, our methods do not help people with physical brain damage from the use of mind-altering drugs.

However, there is now an effective treatment for Parkinson's (the treatment provided in this book). Hopefully, over the next few decades, doctors will be more judicious in giving a diagnosis of essential tremor if what they are seeing actually is, or even might be, very early stage Parkinson's. Even though this book shares an effective treatment for Parkinson's disease, one may as well recover sooner rather than later. Then again, if a patient is quite elderly and clearly not inclined to do the sometimes challenging work of recovering, it might be better that he be given the diagnosis of essential tremor, if his movement symptoms are slight. He may well live out the rest of his life with no significant motor problems, and he will not suffer the steep decline that typically occurs immediately following a diagnosis of Parkinson's disease.

True essential tremor usually does not present with backwards-running channel Qi in the legs. However, it *may* present with backwards running channel Qi in the Ren channel and/or the Heart channel, on the arms.

Essential tremor may behave very differently from the tremor of Parkinson's.

The tremor of Parkinson's is a "resting tremor." In the early stages, at any rate, a PD "resting" tremor only occurs when the person's arms (or legs) are at rest. Movement of the limbs stops the tremor, temporarily. For example, even if the hand is trembling, if the person reaches out for a book, the tremor will stop during the reach. It will not resume until the hand is again at rest.

As the Parkinson's progresses, the tremor may start to occur even when the limb is being used. Because the tremor occurs along the Large Intestine channel, specific movements that require the use of the muscles along this channel will be more likely to trigger the tremor than movements that use other muscles.

The arm movements that are most likely to trigger tremor are those that bring the hand up towards the face: brushing the teeth, eating, and drinking. These types of hand-towards-the-face movements are most difficult to make, and can often cause the most violent manifestations of a Parkinson's tremor, even while the arm is moving.

Other tremors

Many of the *non*-Parkinson's tremors are "active" tremors: they occur when a person is actively extending the arm or leg, or is using strength in some muscles of the arm or leg. Still other types of tremors are constant, whether or not a person is resting or using the limbs in questions. Many drug-induced tremors are of the constant type.

Treatment of essential tremor can be very challenging: in some cases, it appears to be the result of heart dissociation from trauma, just like with Parkinson's – but without the leg component and the full-body dissociation. I have not seen enough cases of essential tremor to speak knowledgeably in this area.¹

¹ Although some modern acupuncturists incorrectly consider tremor to be a form of "Liver-Wind," tremor is historically considered a form of Heart Yin or Heart Qi deficiency. "Liver-Wind" is the description of sudden, unexpected, even violent movement, such as sudden muscle cramp or stroke, or some other internal condition that leaves a body part paralyzed or cramped. Inexperienced acupuncturists, incorrectly assuming that the repetitive, predictable tremor is a type of "sudden or unexpected change in motor function," jump to this (Continued on next page.)

Using mechanical tests

During the early years of the twenty-first century, some doctors embraced the newest technology, PET and even SPECT scans, to get a more “hard proof” diagnosis for PD. However, many senior neurologists had patients with *normal* PET scans (showing no alteration in dopamine uptake) who were also confirmed to have PD by multiple doctors. And oppositely, some people with “suspicious” PET scans, scans that showed reduced dopamine uptake and should therefore indicate Parkinson’s, had no symptoms whatsoever of Parkinson’s disease.¹

Because these tests proved so unreliable, they have fallen somewhat out of favor.

The traditional brain scan

A doctor will usually order some sort of brain scan, either a CT or MRI, if a person has parkinson’s-like symptoms. This test is NOT done to confirm a diagnosis of Parkinson’s disease. A brain scan *cannot* show Parkinson’s disease. The brain scan is used to *rule out* tumors, bleeding, and other brain problems.

If the scan *doesn’t* show any visible problems, and the patient has poverty of movement, *or* rigidity, *or* tremor, and maybe postural instability, and has the classic “look” of Parkinson’s (somewhat inhibited facial expression, *or* slightly hunched posture, *or* bent arms bent, etc), the doctor will usually diagnose Parkinson’s disease for lack of anything more specific.

Then again, if he’s a very wise doctor and the patient’s symptoms are primarily tremor and the other PD symptoms are still only moderate he may diagnose essential tremor even though he knows that he is looking at early Parkinson’s disease. He can then change the diagnosis to Parkinson’s at a later date when the movement problems become more obvious or chronic. In this way, the doctor can delay the rapid worsening of symptoms that usually occurs after a patient is given a diagnosis of Parkinson’s. This extreme, rapid worsening occurs, for the most part, in those whose Parkinson’s is driven primarily by dissociation rather than injury.

Next, some patients doubt their doctor’s correct diagnosis of PD because their symptoms are not constant: their symptoms ebb and flow, depending on mood and situation. But this changeability is *characteristic* of Parkinson’s disease. Even so, a good doctor,

(Continued from previous page.) conclusion. I have seen many people with Parkinson’s whose acupuncturists have wasted their time and money unsuccessfully treating them for Liver-Wind.

¹ PET (Positron Emission Tomography) and SPECT (Single Photon Emission Computed Tomography) scans use radioactive forms of dopamine. The activity levels of dopamine in the brain can be observed by tracking the radioactivity. Using western radiology theory, *reduced* uptake of the radioactive dopamine on the side of the brain that regulates motor function on the side where symptoms first appeared *is interpreted to* indicate Parkinson’s disease. Actually, all it shows is reduced uptake – the conclusions one can draw are shaky. Reduced uptake *might* occur because a person already has enough dopamine, or because a person is in a neurological mode that doesn’t take up dopamine. And if you think about it, *if* Parkinson’s was actually caused by reduced dopamine *production*, the brain side that is less functional due to this decreased dopamine production should be *more* eager to pick up the introduced Dopa, not less. If the brain was wanting dopamine in the motor area on that side, an *increased* uptake in radioactive Dopa would be observed, not a decreased uptake.

familiar with the progression of Parkinson's and its "incurability," might try to buoy confidence by saying, "It's not Parkinson's: after all, your symptoms come and go." If he says this, what he really means is: "In order to let you maintain your quality of life, I'm not going to call it Parkinson's...yet."

An aside: getting on the medication right away

Following the negative brain scan and a diagnosis of Parkinson's disease, *if* the patient's doctor is in the USA, he may tell the patient to get on the drugs immediately, even if the PD symptoms are minimal.

This is either because the doctor is ignorant about the brain damage caused by the meds, or is fearful of lawsuits (a legitimate concern), or simply because this is what he was taught in school.

In the USA, if a patient is not prescribed the meds immediately, and subsequently stubs his toe on a crack on the sidewalk, the toe-stubber can sue the doctor. The thinking here is, "If I'd been taking the medication, I wouldn't have stubbed my toe."

I repeat, in the USA, doctors offer their PD patients medications at the first sign of any Parkinson's symptoms.

In other countries, countries that are less sue-happy, doctors usually ask their patients to wait as long as possible before starting the medications. The medications, if taken cautiously, at the modest levels suggested by the manufacturers, become useless after about five to ten years. "Useless" means, in order to get any benefit, the patient must take the drugs at doses so high that the side effects (painful spasms, flailing, Ons and Offs, alternating euphoria and great fear) are often worse than the symptoms of Parkinson's.

Since the turn of the millennium, as American doctors have gotten more cavalier about prescribing, using higher doses to start, and quickly upping the dosage to levels that are actually warned against by the manufacturer, the drugs now, at these excessive levels, have an average effective run of only two to five years before the side effects become oppressive and the drug benefits minimalized.

If your doctor says that the drugs should be started right away, because they *slow* the progression of Parkinson's disease, get a different doctor: your doctor is either knowingly lying to you or, more likely, is *extremely* misinformed.

Then again, it might not be the doctor's fault. At various times, various drug companies have promoted their latest antiparkinson's medication by saying it "might" or "seems to" delay the progression of Parkinson's disease. These reports get lots of attention. Well-meaning doctors are happy to have something to offer their patients that will slow the progression. Several years usually pass before these spurious claims are disproven, and by then, doctors have grown accustomed to prescribing the new drug – and very often do not keep up with the news that a particular claim about "slowing the progression" has been soundly disproved.¹

¹ This footnote is an excerpt from *Medications of Parkinson's: Once Upon A Pill*, by Janice Walton-Hadlock:

"Doctors tend to prescribe in their "familiar" zone, rather than basing prescriptions on the latest research. At the sixth International Congress of Parkinson's Disease and Movement Disorders,

various papers were read, all proving that using dopamine agonists instead of L-dopa as the first course of treatment, or as an adjunct in combination with reduced levels of L-dopa, was much safer, provided better coverage of symptoms, and greatly extended the effective years of the medication (the time period before the drugs developed adverse effects). At the close of the conference, after the reading of all the papers, the doctors in the audience were asked to indicate, by a show of hands, whether or not they would be willing to consider using the safer drugs or modifying their prescriptions of L-dopa, substituting, where possible, the agonist drugs which had been proven, in test after test, to be safer and more effective.

“A majority of doctors in the audience raised hands to indicate preference for continuing to initiate treatment of PD with levodopa – the treatment that had been proven most damaging – rather than start with one of the new agonist drugs.

“This trend is well recognized by people who research what happens to medical research. It has been estimated that, barring the vigorous advertising efforts of pharmaceutical companies, it usually takes about twenty years for new research to actually become part of clinical medicine, part of the “standard of care.””

The following excerpt is from “Levodopa and the Progression of Parkinson’s Disease,” *New England Journal of Medicine*, Janice Walton-Hadlock, Vol. 352 No. 13, March 31, 2005 p. 1380. The excerpt is from my rebuttal of a previously published article touting research sponsored by a pharmaceutical company. The company, in response to increasing studies showing that their drug, levodopa/carbidopa (L-dopa) was addictive and caused brain damage, claimed it had research “proving” that the drug slows the progression of PD: My rebuttal of their claim showed *how* the results were intentionally skewed to make it falsely *appear* that L-dopa has a slowing effect on the progression of Parkinson’s disease – and the higher the dose, the more slowing:

“This research study actually disregarded their *own* radiology reports proving that the brains of people with higher doses were *more* damaged.

“To get the results they wanted, they assessed the subjects’ motor function a mere ten days after withdrawing them from medication that they’d been taking for a solid year. It’s been known for years that it can take up to ten weeks for the levels of pharmaceutical dopamine in the brain to be “washed out.” The drug company that sponsored the study actually had the nerve to say that they waited a full ten days to allow the dopamine to be flushed from the system – implying that they had waited longer than necessary to run the follow up tests. In other words, the subjects’ brains were still swimming in medication at the time of the “post-drug” assessment.

“They also put all the subjects back on the medication immediately after their day-ten assessment. They knew full well that fatal, neuroleptic malignant syndrome from over-fast stopping of this medication can kick in by day twenty – long before the drugs are *completely* washed out of the brain’s limbic area.

“This study was undertaken – by the company that makes the medication – to counter the growing conviction among doctors and researchers that the medications were actually accelerating the progression of the illness.”

As noted in the first chapter, we will not work with medicated patients.¹

Using antiparkinson's drugs to form a diagnosis

Using antiparkinson's drugs to "prove a diagnosis" of Parkinson's is very common and ludicrously inaccurate.

The drugs used for Parkinson's are mind-altering drugs, mood drugs. They can obliterate pain and make a person feel physically light on his feet.

People who do *not* have Parkinson's usually get a very big mood boost from the antiparkinson's medications, and can often move more easily, almost immediately after starting the drugs. This effect is similar to that of a person who says he can't dance but, after having a few drinks, can "trip the light fantastic."

A person without Parkinson's who is unable to move from the pain of a botched hip replacement might be able to move very easily after taking one or two doses of a dopamine-enhancing drug. Of course, when the drug wears off, the pain will be back, and possibly worse. But his doctor might well say that his response to dopamine proves that his condition is Parkinson's disease. We have seen such patients.

Of course, within a very short time people who don't have Parkinson's but who use these drugs develop the hideous side effects, and then it's too late to help. Their brains have been damaged beyond likely repair – and they may need the medication for the rest of their lives to override the effects of the drug-caused brain damage: drug-induced parkinsonism.

– *Dum spiro spero: So long as I breathe, I hope*

There is always hope. I will *never* say that a person *cannot* recover from drug-induced brain damage. One patient, Gertrude, who is discussed in chapter nineteen, did regain normal motor and mental function ten long years after stopping her medication. Even so, the other patients in our very limited experience have not been able to regain normal motor or mental function following a period of extended use of antiparkinson's drugs.

Oppositely, people who actually *do* have Parkinson's *might or might not* notice any benefit from the medications at all, for the first week or so, or even the first two months. They might not notice a benefit in motor function until after the limbic area of the brain gets topped up, a process that can take up to ten weeks. The manufacturers of the basic L-dopa drug say as much in their instruction insert: full benefit might not be apparent for up to ten weeks.

After the basic operating system of the brain has become "topped up" with dopamine, then motor function will be able to go on and off in quick response to any given dose of the drugs. This process is explained fully in *Medications of Parkinson's: Once Upon a Pill*.

Then again, some people who do have *very early* Parkinson's, in which the limbic area is not as denuded of dopamine, do have a *somewhat* quick response to the medications.

In many of these cases, the weirdness of the false joy produced by the drugs and/or the dopamine's powerful stimulation of the vagus nerve, causing stomach or digestive activity beyond a level acceptable to the person with PD, leads many people with very early

¹ To learn more about this policy, please visit the website of our research project, www.pdrecovery.org. There is a link for medicated patients on the homepage, and an entire book, *Medications of Parkinson's: Once Upon A Pill*, available for free download.

Parkinson’s to stop taking the antiparkinson’s drugs after a few weeks. They might or might not resume the drugs when their symptoms gradually worsen.

By the way, the drugs enhance speed of movement and reduce rigidity. In *some* people, the drugs also temporarily inhibit tremor. In many, many people with Parkinson’s, the drugs do *not* inhibit the tremor, especially after the tremor has become body-wide. In some people, the drugs amplify the tremor.

In our limited experience, most people who do manage to safely get off of dopamine-enhancing antiparkinson’s medications have tremoring that is far worse than the tremoring they started with, even if they are only on the drugs for a few weeks or so. I have seen this repeatedly.

These days, I don’t *see* it, because I no longer work with medicated patients. But I still get the emails. They usually begin: “I didn’t believe you when you wrote that taking the drugs for even a short time will cause the tremor to be much greater when one stops the drugs. My tremor became much worse within just a few weeks of taking the drugs my doctor prescribed: the tremor used to be small, and it would come and go. Now, it is now violent and persistent. My whole body shakes.”

A person in this situation now has both idiopathic Parkinson’s disease *and* drug-induced parkinsonism: a daunting combination.

Tremor is listed as an adverse effect of all the dopamine-enhancing antiparkinson’s drugs. In other words, the makers of these drugs recognize that the drugs can cause, or worsen tremor.

I’ve gotten a bit far from the original subject of diagnosis. I’ll just say that using the drugs to “test” for Parkinson’s only happens when a doctor doesn’t understand how the drugs actually work.

Diagnosing recovery

As you will read in the chapters on recovery symptoms, body areas that were numb may be temporarily painful – a situation extremely similar to the temporarily painful recovery from frostbite. Body areas that had been rigid may become limp. So a person who is recovering from Parkinson’s may have better sleep and might feel light in his body and heart, but he might at the same time be feeling quite a bit of pain and be limp as a dishrag, especially in the legs.

This leads a person to question what is going on.

The two questions that usually arise are:

- 1) Am I actually recovering?
- 2) Did I ever have Parkinson’s to begin with?

If you had several symptoms of Parkinson’s from at least two categories, *and* if your Parkinson’s has been confirmed by checking the direction of channel Qi flow in the legs and noting that it was flowing backwards, and *now*, following treatment, the channel Qi is consistently flowing correctly, you have good answers. Yes, you did have Parkinson’s. Yes, you are recovering.

However, many people who begin to recover are then told by their neurologist that they never had Parkinson's disease: they must have been misdiagnosed.

Because of the new symptoms of limpness in areas that, in Parkinson's, are supposed to be rigid, the doctor might change the diagnosis to "multiple system atrophy." We've also seen recovering patients "re-diagnosed" with parasupranuclear palsy. In either case, the doctor will eventually be proven wrong, because you will also recover from the recovery symptoms.

But you can't blame him for guessing: he probably has never seen a person recovering from Parkinson's disease and does not know what the recovery symptoms look like.

If the patient is in partial recovery, which means that he might be moving much better than before – so long as he's feeling safe – but might still have tremor, maybe even all the time, then the doctor may very likely change the diagnosis to "essential tremor."

If the diagnosis is changed, the doctor will very likely say that the *Parkinson's* diagnosis had been *wrong*.

These changes of diagnosis do *not* mean that the patient didn't have Parkinson's disease. The patient *did* have Parkinson's disease. However, in the western medical system, Parkinson's is defined as incurable. Therefore, if a person's symptoms begin to diminish, that person's diagnosis *must* be changed. He can't have had Parkinson's, by definition: Parkinson's is incurable.

Hopefully, this definition will be changing sometime in the next few decades. Until then, we will continue to have patients sending us frantic emails saying, "My doctor said I never had Parkinson's at all! I've wasted all this time doing FSR (the type of Yin Tui Na we use) and I never even had Parkinson's. By the way, I still have a tremor, should I keep getting treatments?"

If I get this type of email, I ask a few questions. I usually learn that the diagnosis was changed because the person is now moving far, far better than before, possibly has restored facial expression, and so on.

In other words, they are recovering. If they are recovering in response to treatment that brings one's attention to an unhealed foot injury, that person *did* indeed have Parkinson's disease, prior to recovering, but his treatment has been effective. Seems logical, doesn't it?

But the power of an "official, *doctor's* diagnosis" can sweep away all logic. When a patient's doctor says, "You never had Parkinson's after all," the patient, in our experience, tends to believe the doctor.

As for the patient's question of whether or not to continue FSR treatment, this raises an extremely important point.

The answer is no. FSR will no longer help you: your foot/ankle injury is gone. You are now moving much better. Congratulations. But if your movement symptoms are easing up, and you are getting better, *but* you still have tremor and you freeze up, maybe even worse than before, in response to fear or negative thoughts or situation, you are still sliding into mentally-induced dissociation instead of using fight or flight mode to deal with your fear. You still have a mental habit of using biological dissociation: *a habit that needs to be*

destroyed if you are going to recover. You still have idiopathic Parkinson’s disease, even though your doctor is puzzled by the improvement in some aspects of your *motor* function. For example, you may be able to smile again, which may puzzle the doctor. But if you still have rigidity in other areas, or episodes of immobility or tremor, and the channel Qi is running backwards in your legs while this is happening, you still have Parkinson’s disease.

In this case, you are still using biological dissociation – but you are using only the mentally-induced form, instead of the combination that you used previously.

At this point, you *can* stop doing the FSR. There is no point in doing any more foot massage. Your foot injury has healed. Congratulations!

Your job, now, is to change the way you use your mind; all the foot massage in the world isn’t going to help you one bit from here on out.

A few other diagnostic possibilities

Some patients have scar tissue so deep or so extensive that the scar tissue is forcing the channels to reroute.

In these cases, the channel Qi might be doing anything, including running backwards.

Treatment, in these cases, should include acupuncture needling. One or two treatments are usually adequate to restore current flow through the scar area.

Instructions in needling scar tissue are included in chapters twelve and thirteen of *Tracking the Dragon: Advanced Channel Theory*. These chapters are oriented towards professional acupuncturists, and are not available for free on the website. However, a hard copy of the textbook can be ordered from the website.

Please do not write to me asking for names of acupuncturists who are experienced in needling scar tissue. Some schools teach these skills, others do not. The skills are easy to learn, and any acupuncturist can quickly master the techniques by working from the text.

If there is no acupuncturist in your area and your friend has determined that your legs’ channel Qi is rerouting because of problematic scars, you may have to travel outside of your immediate vicinity to find an acupuncturist. Ask around; go online. I cannot recommend people. In most countries, acupuncture is considered a form of medicine, and can only be practiced by someone who is licensed. This is one of the few aspects of treating Parkinson’s disease that cannot be done at home, by a friend or family member.

Most people with Parkinson’s do *not* have *channel-blocking* scars.

Even if a scar is big and thick, it might not be blocking a channel. If a scar runs parallel to a channel, it might not be blocking it. If a scar bisects several channels, going perpendicular to the channels, then the odds are good that the scar is blocking the channel.

Regarding surgical scars: whenever possible, good surgeons try to stick to the recommended surgical lines, when cutting. These are directional lines for various body parts that have been determined to cause the fewest post-surgery problems.

Curiously, these lines correspond to cuts that run parallel to the channels! Hmmm.

Some patients, not many, have bone displacements in areas other than the feet that are so severe that channel Qi is running in a pattern of biological dissociation or running

erratically. This displacement might be in the cranial bones or neck, spine, shoulder, hip, arms or legs. In other words, it might be anywhere. These displacements can quickly be discovered by checking for the flow of channel Qi and comparing the flow to the maps in the appendix of *Tracking the Dragon* (free). If the channel Qi is making some divergent path rather than sticking to the healthy, “normal” path, it might be helpful to hold the vicinity of the channel Qi divergence, using a supportive, FSR hold. If the area feels unnaturally rigid, then this is an area that might benefit from treatment.

In cases involving the head, neck, or spine, areas that must be handled with extreme caution and respect, treatment by someone trained in craniosacral therapy can be very helpful. Look in the phone book, or go online to find a therapist. If a trained therapist simply cannot be found, the same Yin Tui Na that was done on the feet can be used in these areas with displaced tissues and erratically flowing channel Qi. The practitioner should work even more gently than he did on the feet.

The book on Yin Tui Na, on our website, has instructions and photos for holding and helping all the various body parts, including head, neck, and spine.

Some people have muscle spasms that are causing neck or spinal displacement. The book on Yin Tui Na has instruction for treating some of these types of muscle spasms.

As you will read later, it is usually not necessary to track down any and all old injuries – when the patient stops dissociating, the body will be able to quickly recognize those injured areas: they will hurt. The patient will *want* those areas supported or treated. As they heal, any limping or motor hesitancy that had been caused by those injuries will cease.

Using channel Qi flow to predict Parkinson’s disease

The question arises, “If a person has backwards-running channel Qi in the leg portion of his Stomach channels, does this mean he is going to get Parkinson’s someday?”

Not necessarily.

A person with a badly sprained ankle, a foot injury, a leg break, severe knee pain, and so on, might be experiencing the perfectly normal reversed channel Qi flow that occurs with significant injury.

A person who is still in shock from some trauma may have backwards-flowing Qi in his legs.

However, channel Qi should *not* flow backwards except under highly specific circumstances. If any person is unaware of any health problems or very recent trauma and yet he has chronic backwards-flowing channel Qi in the legs, it merits a bit of assessment: by doing Yin Tui Na, one can tell if all the bone articulations in the feet and leg are working correctly.

If injuries can be detected, it is fine to treat them. If the injuries were the only thing causing the PD-inducing backwards channel Qi flow, the channel Qi might then immediately begin to flow correctly, and the Parkinson’s channel Qi pattern will begin to ebb.

If these other injuries are treated but the channel Qi still runs backwards any time the patient is feeling some anxiety or wariness, he will need to work on his mental stance.

If the legs present no indication of injury and all articulations feel healthy but the Stomach channel Qi is running backwards, try telling the patient a joke or two. If the channel Qi corrects itself and runs normally, and then, a few minutes later reverts to running backwards again, the person may be dealing with a short-term emotional trauma from which he is dissociating.

If this is the case, and if the person has no outward signs or symptoms of Parkinson’s disease, wait a few weeks and check the channel Qi again. If it has returned to normal, then don’t worry about it.

If there is no indication of injury, and if after several months pass this person’s Stomach channel Qi in his legs is still running backwards, his health is not optimal. He might be at risk for Parkinson’s disease at some distant time in the future. This person will be better off if he can pull out of dissociation mode, and resumes using a healthy blend of sympathetic and parasympathetic modes: the modes of the living.

Misdiagnosis

Then again, if a person comes to our clinic because he or his doctor thinks he has Parkinson’s disease, and if this person does *not* have backwards-running channel Qi anywhere in his body, we try to determine what he *does* have.

Also, we have seen quite a few people who have been told by an MD that they do *not* have Parkinson’s – but they come to see us anyway. They are hoping we will confirm a diagnosis of Parkinson’s “because you’ve found a way to treat *that*,” and there’s no way to treat the diagnosis (whatever it is) that my doctor says I have. These people usually do not have Parkinson’s disease.

We’ve also seen a sprinkling of people who clearly do not have Parkinson’s but who have *self*-diagnosed themselves with Parkinson’s based on a collection of symptoms that might or might not resemble, slightly, the symptoms of Parkinson’s disease.

For these cases, we still take the time to try to figure out what they do have. We must use various diagnostic skills. These skills include feeling all the channels, taking a lengthy history, including history of drug use, and using tongue and pulse diagnostics as taught in Asian medicine.

Often, if the patient does *not* have Parkinson’s disease, we *are* often able to come up with a better-fitting diagnosis and come up with a treatment plan.

Our methods for treating Parkinson’s cannot help a person who doesn’t actually have Parkinson’s.

Even so, in these cases of misdiagnosis, we often can, and do, help these people. But any *good* doctor or acupuncturist or osteopath should be able to treat these problems - or at least give a better diagnosis. But I’m not going to discuss that. The focus of this book is on Parkinson’s disease.

“Love demands the reassurance of touch. Most fights are really protests over emotional disconnection. Underneath the distress, people are desperate to know: Are you there for me?”

- Sue Johnson, *Psychology Today* Jan 1, 2009

CHAPTER THIRTEEN

TREATMENT FOR PARKINSON'S DISEASE: ADDRESSING THE UNHEALED INJURY

To recover from Parkinson's, a person must recover from the mental attitude of dissociation, an attitude that, in most people with Parkinson's, allows retention of unhealed injuries. But in some cases, particularly cases where the dissociation is *only* with regard to the injury, and is not systemic, just bringing the patient's attention to the injury can end the dissociation and end the Parkinson's symptoms.

Therefore, when a patient comes to us with Parkinson's, we address the unhealed injury.

We do provide some suggestions for getting started on the mental change, particularly if it seems that the person has body-wide dissociation, but there is not anything we can actually *do* for the patient in this regard: he must do that work himself. Even so, in a few patients, the process of learning to feel the dissociated injury can sometimes provide impetus for doing the more challenging work of overturning a long-term attitude of dissociation.

This chapter will address treatments for the physical injury. Suggestions for changing the mental attitude will come in a later chapter.

The unhealed injuries of Parkinson's disease can respond to nearly any therapy that brings the patient's attention to the injured area. This chapter will describe, briefly, a few named techniques that have been effective.

Not everyone with Parkinson's is suited for all techniques. Techniques such as Qi Gong or yoga, which require a person to concentrate his consciousness on how a particular area *feels*, may be helpful for a small percentage of people with Parkinson's, however, they will be *not* be helpful for about ninety-five percent of the people with Parkinson's.

In our Recovery Project research, we use FSR techniques, a type of Yin Tui Na (therapeutic holding). Our reason for using these techniques is they seem to be the most universally acceptable to people with Parkinson's – they work even on people who have difficulty perceiving life-force energy in their own bodies. Happily, it is also a technique that nearly anyone can quickly master, making it possible for people to be treated by friends or family.

Movement-based therapies: do-it-yourself treatment

Qi Gong, yoga, and Tai Ji are all movement-based therapies which, *if done correctly*, can be used to bring healing to a dissociated injury.

I know of three people who have recovered from Parkinson's disease by using the Chinese art of Qi Gong, or "life-energy control," together with a deliberate change in their mental approach to life.

Many, many schools of Qi Gong exist – anyone who becomes a "master" of Qi Gong can make up his own school, or format. The techniques in the nearly unlimited number of schools vary in terms of the sequence and mental imaging used to move life energy around. Some schools also use vocalizations to stimulate the energy of sound waves in the body. But they are all the same in that they are methods to help a person increase his sensory awareness and control over of his body's energy – usually the channel Qi energy.

Of the three I know people who used Qi Gong, each one used a very different type, or "form," of Qi Gong.

In doing Qi Gong, a person physically and/or mentally sends some aspect of energy – light, warmth, breath, sounds, or the electrical sensations of channel Qi – into various parts of the body, in a specific sequence. These sequences are referred to as "forms."

Some forms are very simple: a person feels or imagines light or some other type of energy flowing through the body in the same sequence as the paths of the channel Qi. This method ensures that every part of the body gets some momentary attention.

Other forms might get energy moving through the body by imitating the movement of some wild animal. One of my teachers taught "Wild Crane" Qi Gong. Doing this form, one flapped the arms, strutted with the legs, and stimulated all parts of the body by imitating the movements of a wild crane, while intensely *feeling* the life-energy as it powered the various movements.

Other forms of Qi Gong, particularly "medical Qi Gong," focus on a specific anatomical area, one that has a medical problem. The person directs his consciousness to that area and moves the muscles in that area, keeping his consciousness focused like a laser on the area – while *feeling* what the energy is doing inside that area and maybe visualizing light in the area, "breathing" into the area, feeling warmth in the area, or whatever is taught in that particular school, or "form." The goal here is to bring the consciousness to an area that is being ignored by the body by *feeling* and *paying attention* to what's going on.

As soon as the consciousness is able to truly *feel* what's going on with the energy in the area with a health problem, the consciousness usually will automatically trigger the processes that bring healing into the area.

The principle here is that the body knows how to heal itself. Humans, because of their capability for ignoring problem areas or ignoring their physical bodies altogether, develop unnatural health problems.

A dog might lick a wounded area until it stops giving off the static associated with "channel Qi not flowing through correctly." A human, given the same static problem, might simply dissociate from the area and go his merry way – and the injury remains unhealed or creates derivative problems, until such time as the consciousness resumes awareness of the injury – if ever.

Again, using Qi Gong to recover from Parkinson’s disease only works in people who are able to imagine and *feel* light and energy moving throughout the body.

One of the three people I know of who recovered from PD using Qi Gong did *not* use Yin Tui Na or other foot therapy techniques. She had very early stage Parkinson’s. One used Qi Gong exclusively. The other two used both Qi Gong *and* Yin Tui Na.

However, *very* few of the people we’ve worked with have been able to feel, visualize, or otherwise “move” their life-energy. Many have actually spent years doing Qi Gong, and never even realized that they were glossing over their foot regions, or doing the Qi Gong completely wrong (not *feeling* the energy).

It is characteristic for most people with Parkinson’s to have difficulty in feeling life-force energy.

In my own case, I had done a fifteen-minute, Qi Gong-type of morning exercise for more than thirty years – and the whole time I was developing Parkinson’s disease. Only after I recovered, when I did the emotional shift described in an upcoming chapter, that I started *feeling*, actually perceiving the energy in my limbs during the exercises. Only then did I realize that I had never actually done the exercises correctly: like most people with Parkinson’s who practice these exercises, I had simply been going through the motions.

Despite years of training, during which I was regularly told that the whole point of these exercises was to consciously control and *feel* the energy, its movement, tension and or relaxation, I performed the exercises perfunctorily, as if the point of the movement was to be symmetrical, rhythmic, strong, and so on.

I was performing the movements as if I were looking at myself doing them, rather than *feeling* how my heart awareness resonated with the sensations of what was going on with the energy in my limbs while I was doing them. I did feel the results of what I was doing, to a degree, but it was only after I recovered that I realized I was missing a huge component of what is meant by *feel*. After all, if you don’t know you’re missing something, you don’t know that you’re missing it.

During all those long years of dutifully doing the exercises, I was not *able* to drop into the parasympathetic mode’s sensory perception of *feeling* myself doing the exercises via the heart’s sensory perceptions – which is the whole point of Qi Gong. I did the exercises in the only way I knew how: using sympathetic mode. Even as I was doing the exercises, I *evaluated* my performance as I performed it; I didn’t perceive it with my heart.

After recovering from Parkinson’s, I was stunned to learn how different it was to do these exercises in parasympathetic mode. There is no way I could have done these exercises correctly prior to my recovery. I simply was not able to understand what was meant by “send your conscious *perception*” or “*feel*.” I thought I knew, but I didn’t.

The same holds true for yoga, Tai Ji, and other movement arts: a person with Parkinson’s is very likely to misunderstand the entire point of these movement-based exercises.

For example, in yoga, a person doing the Lion’s pose should be child-like: he should pretend he is a lion, he should feel in his own heart how the heart of a lion feels when he opens his mouth wide and roars.

In all my decades of doing yoga, prior to recovering from Parkinson's, I thought the purpose of the Lion's pose was to open the mouth wide and stimulate the facial muscles.

The same holds true for the Triangle pose: one should have fun while feeling "triangular," feeling what it's like to have the body aligned in these triangular shapes.

A person is wrong if he thinks that the point of yoga is getting the body lined up just so, and the muscles moving just so, and the symmetry just so. The exercises are a structured way of having fun, of playing with the body, of keeping the consciousness focused on exactly whatever the body is doing and noticing how it *feels* in the heart to do these movements.

The original purpose behind the Asian movement arts

The various Asian movement exercises are actually a part of the Asian spiritual traditions: before one can sit motionless and focus the consciousness like a laser, it's a good idea to "get out of the head." One can *most* easily leave behind the kaleidoscopic whirl of the restless mind by spending a bit of time focusing on the parasympathetic, heart-based perceptions of the physical body. I emphasize parasympathetic, because sympathetic mode awareness of body sensations keeps a person locked into his mind as he mentally assesses his movements.

As one moves the body in parasympathetic mode and brings the attention, laser-like, onto the perceptions of electrical energy within the molecules of the moving flesh, the mind becomes primed for meditation: focused on something other than one's thoughts and worries.

Immediately following the movement exercises, one begins the deeper level of his spiritual practice. He can bring that highly focused, parasympathetic mind into the stillness of meditation, the observation of the breath, the deep wells of heart-felt prayer, or into whatever realm his practice takes him.

Whatever form of one-pointed meditation a person practices, he will be able to slide into it more quickly if his meditation is preceded by a short period of highly focused physical movements, movements that pleasantly draw the awareness away from worries and anxieties, and create a parasympathetic mode focus point for the mind.

But *most* people with Parkinson's, about ninety-five percent, in our experience, cannot do this: due to their dissociation, their minds are *necessarily* lodged into danger assessment and some degree of physical numbness. They can go through the motions of movement-type exercises, but they can't actually experience parasympathetic mode *feeling* of the energy, or imagine it, or visualize it (in the injured areas, anyway), or in any manner bring their consciousness to bear on areas from which they have dissociated.

Manual therapies: receiving treatment from another person

Going online, you can find stories of people who have recovered from Parkinson's using various light-touch techniques. These techniques have all sorts of names, but the principles are the same: gentle, non-threatening methods of bringing the patient's attention to bear on the area in question.

In the field of Chinese medicine, *all* light-touch techniques fit under the umbrella heading of "Yin Tui Na."

Forceless, Spontaneous Release, or FSR

The Yin Tui Na technique that we use is FSR, we being the members of the Parkinson's Treatment Team of Santa Cruz. This book has already introduced this technique, referring to it as being a "human ace, or elastic, bandage" for the unhealed area.

Although this technique is extremely simple to master, I have written a book on the subject for acupuncturists who want to understand the underlying mechanisms, the most comfortable positions to sit in while doing it, and so on. The book is titled *Yin Tui Na: Techniques for Treating Injuries of Parkinson's Disease or Any Dissociated Injury*.

This book is available for *free* download at www.pdrecovery.org. It can also be purchased in hard copy from Fastpencil.com.

People living overseas who want to avoid the high shipping costs of getting the hardcopy from the US can order the book through their nearest Ondemand books distributor. This is a print-on-demand program that can be found in many university bookstores around the world, as well as in an increasing number of independent bookstores.

If you are planning to provide hands-on therapy for someone with Parkinson's disease, please read the above book.

Historical note

This book, the one you are reading now, *Recovery from Parkinson's*, used to contain all the pertinent information on FSR. This book started as a short collection of my observations on Parkinson's. It was barely fifty pages long. The title was *Recovery from Parkinson's*. I posted it, for free download, on the website of the new and hopeful Parkinson's Recovery Project.

Every few years, I added more material. At some point, I started using different titles on each edition so that readers could know if they were reading the most up-to-date information. One of the titles, *Almost Icarus*, was quickly abandoned: too few people had ever heard of the Greek anti-hero, Icarus. Another update of this book, the one that preceded this edition, was titled *Trouble Afoot*. *Trouble Afoot* was released in 2005. By that time, the book with "everything we know about Parkinson's" had grown to be a monster: it ran to more than 700 pages.

In this (hopefully) final edition, I've been able to reduce the size of this book. Part of the page reduction came from putting all of the treatment technique information into a separate book: *Yin Tui Na: Techniques for Treating Injuries of Parkinson's*. (published by and available directly from Fastpencil.com, 2012.) I put nearly all of the channel theory into another separate book: *Tracking the Dragon* (Fastpencil.com, 2010).

Both of these books, originally written up for people with Parkinson's, are now in use as textbooks for acupuncture students.

For this edition of this book, I've finally reverted back to the original title: *Recovery From Parkinson's*.

An excerpt

The following is excerpted from *Yin Tui Na: Techniques for Treating Injuries of Parkinson's Disease*, page 3. The following may seem a bit redundant, since I've already shared some of this information. But I am excerpting straight from the book to show the general tone of its instruction.

Overview of the techniques we use

The first technique discussed in this book, Forceless, Spontaneous Release, or FSR, instructs in a certain *tempo* of treatment (slow), amount of *pressure* applied with one's hands (firm), and a *lack* of intention that the practitioner brings to the treatment. The physical and emotional support provided by this technique can help bring a patient's attention to an injured area so that healing can begin.

FSR can be performed almost anywhere on the body that has unhealed injuries. In people with Parkinson's, the legs, feet, and ankles are areas that nearly always call out for treatment.

This technique does *not* apply particular vectors, directions of movement, to the patient. However, corrective movement in twisted or displaced tissues often occurs, spontaneously, as the patient responds to the firm support. This technique can also be used diagnostically, to detect injuries and holding patterns.

The second technique discussed uses very gentle nudges to suggest directional movements in muscles that have become stuck in a particular holding pattern. The examples of this technique included in this book show applications for the rotational joints of the hips and shoulders, but this technique of gentle nudges can be used in almost any body part that has become locked up. This particular technique does not have a name. It uses the tempo and support principles of FSR, but has intentional movement.

The third technique, craniosacral therapy, is a method for improving and regulating the flow of cerebrospinal fluid via correcting displaced cranial and spinal bones or micro-muscle holding patterns in the joints of these bones. To assist in healthy movement of cerebrospinal fluid, gentle, directional pressures are applied at the various cranial and spinal joint articulations. The vectors for the induced movements at these articulations are highly specific, and are aimed at maximizing the openness of these joints.

This book describes the hand positions and a few of the vector directions most commonly used in craniosacral therapy. However, in treating injuries from which a person has become dissociated, or in people with PD, we combine the very specific hand placements of craniosacral therapy with the FSR tempo, degree of hand pressure, and the *lack* of direction and intention, as opposed to using the usual craniosacral therapy directional forces.

The "minimal," directional nudging used in most styles of craniosacral therapy is, very often, perceived as manipulative and threatening by many people with Parkinson's.

Finally, this book teaches an extremely gentle, or "Yin" technique for releasing psoas muscle spasms – a spasm that is not uncommon in people with Parkinson's disease. Many techniques have been developed for releasing psoas muscle spasms. The particularly Yin method that we use, which people can even do on themselves, gets less emotional resistance from people with Parkinson's than the more traditional but brutal, sometimes even pain-inducing, methods for releasing these spasms.

A brief introduction to Forceless, Spontaneous Release

The Forceless, Spontaneous Release technique is *extremely* "Yin": passive, firm, often motionless, with no "intention" on the part of the practitioner.

The technique consists of this: the vicinity of the patient's unhealed injury is held firmly between the two hands of the therapist, which have been firmly placed on the skin or the clothing on opposite sides of the injured area.

The *two hands don't do anything* except hold, firmly, until such time as the patient's subconscious starts to feel safe enough to pay attention to the area being held, at which point the patient's injured area starts to *move on its own* – often in motions suggesting the (long-delayed) follow-through response to the original injury or motions that suggest relaxation of long-held tension. During these movements, the therapist keeps his firm, supportive hands (usually the palms) pressing on the patient's skin or clothing, while allowing his hands to be carried along by the spontaneous movements being made by the patient.

That's it.

Sounds too simple? Much of this book is spent explaining what is meant in the above paragraph by terms like “firmly,” “don't do anything,” “move on its own,” and all the other terms and questions that arise when doing this extremely non-invasive work on a person who has dissociated from an injury, thus preventing that injury from completely healing.

Again, the above book is available for free download from www.pdrecovery.org. or from Fastpencil.com

Which patients should get FSR treatment?

Anyone who is planning to recover from Parkinson's disease.

As mentioned in an early chapter, my first three Parkinson's patients, who unexpectedly recovered, did so in response to nothing more than simple FSR.

As noted at the beginning of the chapter, even in people with both mentally-induced dissociation *and* a foot injury, we do Yin Tui Na on the injury.

Very often, when the patient re-associates with his foot, he finds himself feeling a new openness in his heart, as well. Sometimes, by turning off the dissociation from the foot injury and helping the foot to heal itself, the patient is able get a glimpse of what parasympathetic mode feels like. The “lift” that can occur after the foot injury begins to heal can sometimes last up to a week or more, during which time the person may have almost no symptoms of Parkinson's, or might start having the recovery symptoms.

If, after this “honeymoon,” his symptoms return, he can appreciate that his body is now physiologically *capable* of normal function, but his mind still needs some corrective measures.

“I can think as clearly and realistically as the next person, so if what I am telling myself is irrational, why does it seem so right?”

Feeling Good, the new mood therapy, Dr. David Baker, MD

CHAPTER FOURTEEN

NO MORE NEED FOR YIN TUI NA

Most patients who experience a decrease, or even a cessation, of symptoms due to channel Qi being able to flow correctly after healing of their injury very quickly resume their Parkinson’s symptoms.

Within a few hours, days, or weeks or so, not trusting, or even alarmed by, their new ease of movement and heart-based feelings, they *increase* their mental wariness and their reliance on dissociation: a purely mental process that *prevents* lasting recovery.

Within a day or two, or maybe a week, a long-time habit of mental wariness usually instructs them to establish an even more vigorous condition of dissociation – even though the foot injury is now gone.

Some degree of mental wariness might have preceded the injury – and been a factor in preventing the injury from healing.

Or the mental wariness might have been installed at the time of injury – *because* of the injury.

The mental wariness, however installed, will have increased over time, because that is the nature of brain training. We get better at that which we practice.

But even so, the foot injury was “helping out.” The backwards flow of channel Qi in the Stomach channel, held in place by the injury, was assisting the brain in maintaining dissociation mode behavior and thinking.

When the foot injury is healed, the brain will need to *increase* the amount of negative thinking that it was using in order to sustain the instruction issued so long ago: feel no pain.

This can lead to the installation of *very* bizarre, highly illogical new reasons for not being safe. Examples of this are in the chapters on recovery symptoms, chapters twenty through twenty-nine.

Repeat:

If a person feels “light” and “happy” and “all the symptoms are lessened [or gone]!” for more than a few hours following a foot treatment or subsequent to the healing of the foot injury, and then the Parkinson’s symptoms reappear, the symptoms are due to mentally-induced dissociation. In particular, tremor may reappear a few hours, days, or weeks later, in response to some small negative thought, even though the arms might continue to be more relaxed or the face more expressive. If this is the case, then he still has mentally-induced

parkinsonism. An MD will still refer to this as idiopathic Parkinson's (Parkinson's of unknown origin). We might refer to it as psychogenic parkinsonism. The point here is, the person is still manifesting Parkinson's, by whatever name, *even though he no longer has dissociation held in place by a foot injury.*

In these cases, the foot injury has been acknowledged, the injury in the foot is beginning to heal. The foot is no longer playing a part in maintaining the Parkinson's symptoms of dissociation.

There is no point in treating the foot any more.

The thought or thoughts employed to ramp the Parkinson's back up, the thought that causes the reversion into post- foot-recovery, *purely* mentally-induced dissociation, and all the symptoms of Parkinson's, might be very small.

A thought such as: "I'll bet I haven't really recovered yet – that was too easy" can easily trigger enough anxiety to cause increased dissociation. If one has trained himself to jerk into dissociation at the first sign of risk or anxiety, this simple, negative thought should – according to established habit - bring all the symptoms right back. But with the foot injury gone, the brain might discover that it needs some *extra* negativity to create a strong enough state of dissociation. The brain will cheerfully supply the materials: more negative thoughts and a firmer grip on the brain connections that cause dissociative mode.

The PD symptoms, or *some of them*, might then quickly return and even *worsen*.

“But everyone responds to fear...”

Most humans do *not* dissociate in response to some negative thought. They lurch into sympathetic mode: fight or flight. The “fight” portion refers to physical, dynamic activity, not mental defensiveness, and “flight” also refers to some sort of physical, dynamic behavior. A person may use that “fight” response to bang on the piano, yell at the kids, or write an angry letter to the Times, rather than punching.

But he does *not* play at being emotionally dead while engaging in mental loops.

Mental loops are a part of the dissociative mode's pattern. Correctly used, these mental activities are used, during dissociation, to categorize external stimuli to determine when it is safe enough to end the dissociation.

When a healthy person comes across potentially fearful or painful situations, his blood pressure rises and/or he gets physically protective, defensive or steamed up. This is the opposite of the withdrawal into “be numb,” a mode that a person with Parkinson's has taught himself to do.

The whole problem is that a person with Parkinson's has cleverly figured out *how* to make himself numb on command, and he's instructed himself to do so in response to anything even remotely related to risk, fear, or pain.

This is not a healthy way to deal with trouble.

Channel Qi

When a person has an episode or two of feeling lighter or having decreased symptoms, this is the point at which it may become important to have someone on hand who understands a bit of channel theory, and who is able to detect the fluctuations of channel Qi.

A spouse, friend, or health practitioner who has learned how to feel channel Qi can be of service at this point.

If

I repeat: *if*, after the foot injury released and the foot readjusted itself and began to heal, and the channel Qi *has* been able to flow correctly down the leg and over the foot, and all symptoms of Parkinson's were gone for a few hours, or a few days, or a few weeks, but the symptoms – or *some* of them – return less than before or worse than before, or become intermittent, psychogenic parkinsonism is probably the cause.

Most PD patients, when this occurs, conclude, “The foot isn't healed yet!” Or “*Another* injury must still be lurking.

Now, here's the thing. The person has already experienced a brief time of not being dissociated, as evidenced by the feelings of lightness and absence of symptoms.

If other significant injuries are still lurking, possibly an old hip injury or a neck injury or some other problem, the newly “recovered” patient will soon be able to *feel* those injuries. After all, he's no longer dissociating, so he'll be able to feel. I repeat: because he has stopped dissociating, his body will be able to feel other injuries. It may take a few hours, or a few days, for the other injuries to be noticed, but when they are noticed, the mind may well decide it needs to dissociate *anew* because of these injuries.

This is very different from dissociation that has been induced by an injury-based electrical pattern stemming from the center of the foot that happens to *mimic* the channel Qi pattern of dissociation. This new version of dissociation is mentally induced, triggered by the subconsciousness in a re-invigorated attempt to maintain dissociation.

The patient may also (decide to) dissociate anew because, with the foot injury-based dissociation gone, he is now starting to feel some old, forgotten *emotional* pain – some pain from which he had previously dissociated.

When the dissociation held in place by the foot injury is gone, the new non-dissociation mode will be challenging. Injuries and old emotions will start to register. These pains and emotions probably will not be fun.

If the patient has not yet decided to *never again* use dissociation as a mode for dealing with pain or fear, he will probably slip into the mindset of dissociation again at the first possible sign of danger.

Increasing the mental grip

In some cases, the other injuries (non-foot or non-ankle injuries) might be in locations that will not *ordinarily* lead to Parkinson's disease: because of their locations, they don't physically cause a reversal in the Stomach channel's Qi flow.

However, if the person has a mild habit of mentally-induced dissociation, a habit that was *supported* by a dissociation-mimicking blockage in the foot part of the Stomach channel,

he may well fall back on this mental habit even after the foot or ankle injury has begun to heal. And the level of the old mental habit might not be enough. With the foot injury now healed, the person might need to invoke a *stronger* mental level of dissociation to keep himself from feeling pain or fear.

The trick, at this point, is to determine whether or not the person has some injury that is still physically impeding the flow of channel Qi, or whether the “return of Parkinson’s” is now a purely mental condition.

In our limited experience, most people whose Parkinson’s “returns” after a few hours or a few days are responding to a mental component, at this point, rather than a physical one.

These patients usually do not *want* this to be the case. They usually will insist that they need more physical support, more foot holding, more FSR.

FSR is not going to do them any good, at this point. The remaining problem is in the mind – but they usually will not accept this unless it can be *proven* that they are mentally creating the dissociation. This is where it becomes helpful to have a friend or partner who can feel the channel Qi, and who knows what it’s supposed to feel like in a healthy person.

Here are the two key points:

1) Mentally inducing the dissociative mode causes the channel Qi to *instantly* flow backwards – to flow just like it does in Parkinson’s disease.

2) If the channel Qi *can* run correctly, *however briefly*, the foot injury is no longer a physical impediment to the flow of channel Qi.

As we say in Chinese medicine, if the problem is constant, and stays in one location, it is a *physical* injury (“Blood stagnation”). If the problem *can* come and go, or move around being now in one place, now in another, it is a Qi problem. Qi problems, particularly those that come and go, or move around, are usually coming from the emotions and/or the mind.

Chinese medicine recognizes that problems that can come and go aren’t being caused by a physical injury.

A person with Parkinson’s will very likely ask, at this point, “Then how can a person with Parkinson’s disease move perfectly normally during a true emergency?” Easy. A person with Parkinson’s can move perfectly normally when he uses sympathetic (emergency) mode to override the dissociation. As mentioned many chapters ago, Parkinson’s symptoms begin to appear, not when a person first dissociates, but when a person can no longer manage to summon up enough sense of real and present emergency to keep overriding the dissociation.

Yin Tui Na, including FSR, is used for treatment of *physical injury*. If there is no longer a physical injury that is significant enough to cause channel Qi blockage, there is no point in doing hands-on work.

Feeling the channel Qi

Feel the Stomach channel Qi in the leg(s) of the person with Parkinson's. If it is going backwards, back and forth, or missing altogether, make a few jokes and see what happens to the channel Qi. If it begins flowing correctly when the patient laughs, there is *no* physical blockage in the foot: there is *no* need to do hands-on treatment.

If the channel Qi does not flow correctly in response to jokes, try physical influences that typically are able to calm the patient: have him sing a favorite bit of music, or give him a neck massage, or have him practice his deep breathing exercises.

If, in response to these relaxation techniques, the channel Qi begins to flow correctly in the legs, there is no longer a significant blockage in the foot, if there ever was one. You can conclude, under these conditions, that the person's Parkinson's symptoms are being caused by his thoughts: he is sliding into dissociation from a long habit of using dissociation mode in order to avoid fear or pain. If the channel Qi is *capable* of flowing correctly in the legs, there is no physical blockage: there is no reason to do hands-on treatment.

If the channel Qi continues to run backwards despite all calming treatments, the foot might need more work *or* the patient might be so guarded because he prefers his condition to be physical, rather than mental, that his own mind will sustain the dissociation no matter what. His fear that you will "discover" that his problem is purely mental can be a great enough fear that he will not be able to relax while you are feeling the channel Qi in his legs.

That's OK. Hold his foot for half an hour, and he will relax, or even fall asleep. At this point, you, the health practitioner (or spouse or friend) can let go of his foot for about fifteen minutes, and test it again.

Why wait fifteen minutes? The channel Qi will sometimes run correctly, very superficially, because of the mere presence of your hands. The currents in the patient might run through your hands, as a form of diversion around the blockage. In this manner, a very superficial, short-term appearance of correctly-flowing channel Qi might occur in the patient's skin simply from proximity to the highly conductive skin of the practitioner's.

That's why it can be important to wait a few minutes, even up to ten or fifteen minutes, after you've let go of the sleeping patient's old injury site, before you check the channel Qi again.

Now, if, while he is sleeping, the channel Qi can run perfectly correctly, then he does not have a physical impediment: there is no need to do hands-on therapy.

Do be aware that the level of channel Qi flow in the legs is always diminished during sleep – but the *direction* of channel Qi flow in the legs, in a healthy person, is never *backwards*.

Don't "lead" the channel Qi

It is extremely important that you, the spouse, friend, or health practitioner, not "lead" the channel Qi. If you run your hand over the person's leg in the direction that you think the channel Qi should go, and you aren't being careful to *not* influence his channel Qi, his channel Qi *may*, for up to a minute, *superficially* flow in the direction that your hand has gone, whether or not there is a blockage.

The greater part of the art of feeling channel Qi includes learning how to not influence the channel Qi even as you are detecting it. To this end, it can be helpful to learn this art with a friend. You and your friend can try feeling the channel Qi on a third person, and each one notice any changes in channel Qi flow that are triggered by your over-aggressive “feeling” of the channel Qi, if any.

Sometimes, the practice “patient” can tell you right out, “I can feel what you are doing.” If the patient can tell that you are feeling his channel Qi, then you are influencing, rather than detecting, his channel Qi.

To be sure that you are not influencing the patient’s channel Qi, try to learn how to hold your hand in one place and notice the movement going on under your hand. Then, let your hand be carried by the channel Qi and notice where it takes you. Don’t *ever* move your hand in the direction that you *assume* is the correct one: the patient’s channel Qi will automatically, superficially, momentarily, follow your hand. After one strong pass of your hand, you won’t be able to tell what the patient’s *own* channel Qi was doing prior to your influence.

Practice this on a healthy person first: in a person with Parkinson’s, you might not be able to let the channel Qi “carry” your hand in some direction. If a person has Parkinson’s, the channel Qi in his legs might be impossible to feel, or it might be going back and forth, or backwards.

So practice on a healthy person so you’ll know what channel Qi movement *should* feel like. And if the channel Qi in a person with Parkinson’s *ever* starts to feel like *that*, to feel the way it should – assuming you haven’t just created that channel pattern, temporarily, by your unintended influence – then there is no longer a physical injury, and there is no longer a need for hands-on therapy.

But the foot is still stiff!

One of the basic symptoms of dissociation mode is a decrease in circulation in the extremities. It is normal, during dissociation, for the feet to become cold and, in some cases, for the muscles of the foot to tighten up. The toes might even curl under.

This toe curling is *not* necessarily a “normal” symptom of foot injury, but it is very much a *normal* symptom of dissociative mode.

In other words, once the injury has resolved, foot rigidity, *especially* if it is variable, is not coming from injury – it is coming from the play-dead response (dissociation). A lasting cure for the foot stiffness will *not* come about by doing hands-on therapy on the foot: the problem is in the mind.

Again, if the patient’s foot stiffens up now and then, or relaxes during a treatment but stiffens back up after a few hours or days, or at the first sign of negative thinking, this does *not* indicate a foot injury, but it *does* indicate psychogenic parkinsonism.

For example, I had one patient whose feet relaxed during treatments, but which stiffened up again whenever she thought about shoes or had to put her shoes on. Her cruel mother had had a shoe fetish and owned many hundreds of pairs of shoes. As a young child,

my patient used to think bitterly to herself, “You should love your own children more than you love your shoes...”

When I first met her, her foot was clearly injured: the bones were displaced. It was only after the foot healed that she started getting stiff foot and curling toes in response to thoughts of shoes or putting her shoes on in the morning. She wanted me to continue working on her feet – but holding her feet never led to any improvement in the situation, other than a short term relaxation that would be gone within a day or two.

A patient whose legs and/or feet stiffen up, even though they can be, or have been, relaxed for a short while, will usually insist that he needs foot holding because his Parkinson’s is still coming from his foot rigidity. But in fact, the situation is just the reverse: the foot problem is now coming from his mentally-induced parkinsonism. All the foot holding in the world is not going to solve this problem.

Secondary injury

Sometimes, however, the channel Qi *is* being stymied by a secondary injury. The most common location for a secondary injury is the hip, in the vicinity of the Stomach channel or nearby Gallbladder channel. In a few cases we have also seen neck, shoulder, or head injuries, usually in the vicinity of the Stomach channel, contributing to the physical mimicking of the dissociation pattern. It *might* be helpful to treat these injuries using FSR.

If such an injury is suspected, just hold that area using FSR. If the area seems unnaturally locked down or has limited range of movement, there may well be an injury there.

If you, the spouse, friend, or health practitioner, are not sure what the normal range of movement should be for a hip or neck, practice FSR in these locations on a few healthy people first, and then try it on your Parkinson’s patient.

Scar tissue

Scar tissue, if it is blocking a channel, can also be a physical impediment and might need treatment. If a person has significant scarring, it might be best to visit an acupuncturist who has trained in treating scar tissue. If the acupuncturist is not trained in this art (very few are), introduce the acupuncturist to the book, *Tracking the Dragon*, available via www.pdrecovery.org.

If the acupuncturist insists that there is no need to ever put a needle through the scar itself, find a different acupuncturist, if possible, or request that he make an exception in your case.

Refusal to acknowledge psychogenic parkinsonism

Some patients are so determined that their problem *must* be purely physical, rather than having any mental or emotional component, that they go on a never-ending search for “one more injury.” They will keep discovering, remembering, and wanting you to hold an unending stream of injuries, including a prick on the pinkie finger or a bump on the buttocks.

These patients need to be reminded that the whole problem, ultimately, is mental. Remember: the foot injury did *not* cause the Parkinson’s. Psychological *dissociation* from the foot injury prevented healing – and that *inability* to heal eventually led to the Parkinson’s.

The unhealed injury allows the channel Qi in the vicinity of the injury to get convoluted, over time, to the point where the channel Qi mimics the channel Qi pattern of biological dissociation. But the problem, from the start, was the psychological dissociation from the injury – which set in motion an electrical pattern that mimics that of biological dissociation.

Many people have recovered with *no* foot treatment whatsoever – even though they *still had* an unhealed foot injury. These people recovered after deciding to change their way of thinking.

As soon as they stopped using dissociation as a self-protection mechanism, their symptoms of Parkinson’s ceased. A few days or weeks following their recovery, they often noticed that they were experiencing a *lot* of foot or ankle pain.

They have subsequently healed from the injury – just like any healthy person heals from an injury. They have sometimes even recalled the incident that caused the injury, but that’s not crucial to recovery. All that’s needed is to have a good laugh over it and say, “I’d completely forgotten about that injury. I’d better put an elastic support bandage on it, it feels so sore and weak [or swollen or whatever].” Or they go in for an x-ray, or they get some massage on the injured area.

And then the injury heals up *all by itself*, just as nature intended, because the person has stopped using dissociation as a coping mechanism.

So if a person gets caught up in thinking “There must still be one more injury preventing me from healing,” remind him that the mind is where it all starts. If he fixes his mind, he will recover and his injuries will take care of themselves, for the most part. They may require a little support, or in the case of scar tissue, some working over, but no more than any normal injury would require.

If he *doesn’t* fix his mind, his subconscious, working from previous instructions to stay dissociated, will even be able to invent *false* memories of injuries, if he gets desperate enough (fearful that he will have to stop dissociating).

A clearer picture of the mental tricks that can be played by people who are trapped in dissociation will come from reading the chapters on partial recovery.

At this point, the astute reader might be saying, “If a person can recover completely by shifting his mind, why bother doing the FSR at all?”

Good question. Very good question.

And here’s the answer: even though most of our patients have slid back into the habit of wariness and the habit of dissociation, the temporary (a few hours, days, or weeks) cessation of Parkinson’s that *can* occur in response to getting rid of the foot injury can serve as a sudden shaft of wisdom: recovery is possible.

Given the pessimism that most MDs bring to the subject, it can be wonderfully liberating for the patient to have his own interlude, however brief, during which he realizes that he doesn’t have an “incurable” condition.

A person with Parkinson's who has heard about the recoveries of others but who has nevertheless doubted that his *own* recovery is possible (this doubt is a normal consequence of excessive wariness) might be able to cling to the *fact* that he *did* move perfectly normally for a short while. This fact can give him the positive push that will help him work at overcoming his mental habits.

Also, the returning symptoms may well be slightly different. For example, the tremoring might be over a larger area, but the arm rigidity might have disappeared. This serves to prove that a change-up *has* taken place. Such a change can help diminish the power of the word "incurable."

Of course, this fact of change can also alert a subconscious that has been instructed to "never again feel pain." This fact *might* then push that subconscious to create new and more powerful negative thoughts in order to keep the dissociation in place.

But for all that, the *fact* of a temporary respite from symptoms helps expose the real problem: the mental attitude.

Again, *if* a person recovers from the foot injury but maintains or even *increases* the intensity or the frequency of his mentally-induced dissociation and wariness, the *memory* of his abrupt, glorious shift into normalcy – even if only temporary – can sometimes serve as encouragement during the other, more important phase of treatment: getting rid of the mental decision to stay in biological dissociation.

Again, an *increase* in mental wariness may become necessary because the foot injury, which was helping maintain the dissociation, is now gone, and so the mind has to maintain the dissociation all by itself, with no help from the injury.

In summary

If the person slides back into experiencing symptoms of Parkinson's after a short period of lightness and decrease of symptoms, which is to say, slides into what we have named "partial recovery," then the most challenging and noble part of recovery can commence: removal of the habit of the dissociation and/or the mental instruction that got the dissociation going in the first place.

“I have sworn upon the altar of God eternal hostility against every form of tyranny over the mind of man”

Thomas Jefferson

CHAPTER FIFTEEN

TREATING MENTAL HABITS OF DISSOCIATION: INTRODUCTION

Thomas Jefferson’s words appear to be directed towards political tyranny. A deeper study of his life and words suggests that he understood self-induced mental tyranny to be more insidious and more difficult to fight than mere political tyranny. A victory over mental and emotional tyranny is more important, and more rewarding.

Every person who has *recovered* from body-wide, mentally induced biological dissociation (heart-based sensory numbness and immobility) has done so in a flash – a moment.

Lasting recovery is *not* a process – it is a decision.

In each person who has undergone the healing mental alteration, there has come a moment, a shining moment, when he either becomes fed up with his attempts to be in control, or he surrenders control of his life to a higher power, or he experiences some other emotion, such as amusement, calm, or joy as he realizes that he has incorrectly been trying to control his portion of the universe so as to stay “safe.” He decides to *stop* using his mind in the way that he has been: using it to protect himself via freezing up. He decides to stop living his life in the way that he has been: mentally, rather than viscerally. He decides, in that moment, to allow himself to feel the roar of life inside his body.

The roar of life

This roar is enormously powerful, but it does not derive its power from ego-based thinking. It is the power of life-force, itself.

When a butterfly emerges from its chrysalis, it must use a tremendous amount of energy. If a well-meaning human helps the butterfly by opening the chrysalis for him, the butterfly will not live. He will not have enough energy to fully open his wings and fly. In order to prepare himself for the job of life, the butterfly must experience the surge of power that he brings into himself as he fights against the chrysalis, breaking it apart.

In order for a rose to bloom, the petals inside the bud must push and press against the tough outer sepals. This push comes from the same life-force energy that fills the butterfly during his fight to be freed from his chrysalis cage.

In both cases, this energy derives from pure joy: the joy inherent in life-force. This energy is *not* based on ego-based thoughts. Even though the butterfly is *not* going to live for very long, even though the rose, once open, will soon fade, the energy is not withheld. The energy expresses itself with no thought of the future.

This is the energy that is being subconsciously *suppressed* in most people with Parkinson's disease.

By the way – when I have read the above to people with Parkinson's, sitting in my office with their health practitioners and spouses, the practitioners and spouses nod their heads, “Yes, yes!” The person with Parkinson's usually sits there with a blank look on his face, trying to make sense of the above words.

This life-force energy might be suppressed because the person with Parkinson's wants to be strongly in control of his emotions or his sex drive. Or it might be that he doesn't want to feel pain, or be made fun of. Or maybe he's decided that he's safest, or the world is safest, if he suppresses this power. Or maybe he's just listening to wrong thoughts.

For whatever reason, he's decided that staying in a dissociated state, to some degree, is the smart thing to do. And staying in this state automatically turns off, to a matching degree, the ability to invoke this life-power except during life-threatening emergencies.

And this mental state expands itself over time! What might have started as the ability to use dissociation to stay “calm” when facing a specific trauma eventually becomes a generalized immobility when facing all the vicissitudes of life.

The semantic problem is, *true* calm comes from knowing that one can safely *feel* one's traumas and *process* them – and move on. The time for processing trauma is when it is safe to do so. A person with Parkinson's has never gotten around to feeling safe: his own mind has been instructed to never allow the possibility.

When recovery occurs

In every case we've seen in which a person with the psychogenic pattern recovers from Parkinson's, there has been a moment when the person simply decided he's safe now, after all.

The process by which a person decides this varies from one person to another.

For example, a person might become overwhelmingly fed up with his years of lying to himself about not being “safe enough.” At that *moment*, provoked by the honest rage or genuine amusement he feels towards his own false thoughts, he invokes the joyous roar of Universal Love he has long denied himself. He allows the power of his heart to burst forth and declare its righteous indignation or loving forgiveness at the trick his own mind has been executing on his own subconscious. This might manifest as yelling out loud, even shaking a fist at the heavens or, oppositely, crying with joy, or simply stating the sudden realization “I'm alive! I'm safe!”

In that moment, he recovers.

Or the person might suddenly, sheepishly admit that a higher power has always been keeping him safe, but due to a stubborn dislike for experiencing any negative emotion, the person has held himself aloof from feeling too much. As soon as he admits that he's actually

been safe right along, he might be filled with a tidal wave of joy. This might physically manifest as overwhelming static flowing over the body, taking form as waves of gratitude and whispers of “Thank you! Thank you!”

Or the person might experience something completely different: the calm *decision* to just sit back and allow himself to *feel* the power of energy coursing through his body – after which he admits, it *is* safe to do so, despite previous mental instruction not to. And he recovers.

So the decision might be made with a flood of gratitude, a burst of indignation or laughter, some mood that rejects fear and embraces joy. This new awareness might not appear suddenly, unheralded: in some cases, this wisdom slowly snowballs over several weeks or months before it erupts in the *sudden decision* that everything’s going to be OK now: it’s safe now. Or it might be *anything* that combines deciding it is now safe with the flood of heart energy that makes obvious *why* it is safe: it is safe because the heart energy, the energy that drives life, is *always* safe, that’s why.

It’s impossible to guess how this change of mind will occur in any given person. Each person with Parkinson’s has created his own story to keep himself half-frozen. So every person gets to out-grow this habit in his own way.

However the decision starts, whatever the dominant emotion that is activating the flood of life force, the decision consists of choosing to defer to the heart, for a change, instead of the ego. Once it is able to listen to the heart or let energy pour through the heart, the mind can admit that it *is* safe, after all.

The heart’s wisdom then automatically rescinds the *mind’s* long-established instruction to the subconscious: “We’re going to die! Keep us safe or we will die.”

If the person allows a strong enough surge of life force to flow through at this time, and *if* he goes through some sort of realization that includes deciding not to play the dissociation card ever *again*, except during death, or appropriately dire circumstance, then this particular episode of dissociation will be concluded. Those patterns will actually be turned off, as if they were destroyed. It feels great. This is the moment when the epiphany “Hey! I don’t *have* to be like this!” appears.

If the person decides that he feels safe in that moment, but he reserves the right to slide back into dissociation any time he wants to, in the future, he will find himself sliding into partial recovery at the first hint of negative thinking. In partial recovery, the person may find that he can move perfectly normally when he wants to, and freeze down hard (manifest any or all of his symptoms of Parkinson’s) any time he’s confronted with something he doesn’t like.

Because of these episodes, he will usually say that he still must have PD (“I *knew* recovery couldn’t be *that* easy!”) and will refer to the frequent episodes – even whole days – of normal movement as “accidentally forgetting to have Parkinson’s disease for a while.”

Following this transitional moment when the dissociation is turned off for good (until the next time the person decides he should play numb because he’s afraid of feeling pain), he

may have a glorious experience of parasympathetic feelings – colors are brighter, movement is effortless, and so on.

In cases where turning off the dissociation has been lasting, it was fairly common for the person to experience an epiphany shortly after turning off the dissociation, an epiphany such as “What the heck, it’s not like anyone’s going to *die*,” or “It’s OK to be vulnerable!” or “All along, You were there,” or “I had the ability to heal myself!”

Oppositely, in those cases where the Parkinson’s reappears within a few hours, days, or weeks, the thoughts were more likely to have run along the lines of “I guess this is the last time I’m ever going to feel really good,” or “I will always remember this day of wonderful movement as the Last Hurrah, and then my Parkinson’s will return.”

In these latter true-life examples, the patients allowed themselves to wallow in habitual negative thoughts despite their *complete* cessation of symptoms, and their Parkinson’s came back *exactly* in the manner and timing anticipated.

Staying safe

Dissociation cannot stop until the dissociated animal determines that he is safe. This is a basic biological tenet of dissociation.

A person who has created a mind that is always circling the wagons, running the war room, or in some other fashion mentally devising ways to stay safe, is doing these things because he has decided that he *cannot* be safe unless he is always on guard. Also, if he decides he is safe, the dissociation will end, and the old, long-suppressed pain will begin! He doesn’t want that. And so the mental games go on.

The problem for most people with Parkinson’s is that, in order to sustain both the dissociation (which keeps them from feeling physical and emotional pain) *and* the sympathetic mode adrenaline (which enables them to move despite the dissociation), they’ve learned to maintain both a conviction that they are not yet out of danger *and* a heightened sense of urgency.

People with Parkinson’s have learned to brush their teeth using adrenaline. They tie their shoes using adrenaline. They are *accustomed* to being highly alert. Their *overactive* wariness or anxiety does not seem unnatural to them. To them, their heightened wariness seems intelligent, logical and, in many cases, even morally superior to the incautious, even devil-may-care attitudes of “ordinary people.”

One patient said to me, with regard to his very intelligent bunch of hard-working co-workers, “Everyone I know is an idiot!”

I gently suggested to him, “If everyone you know is an idiot, what does that say about *you*?” He replied, “It means *I’m* smart enough to *know* that they are all idiots.” And he was genuinely sincere. It wasn’t so much that his co-workers had low IQs. Their problem was they allowed themselves to *feel*, and they weren’t *constantly* alert to potential problems regarding anything and everything.

His attitude is not present in everyone with Parkinson’s, but neither is it unusual.

Many people with Parkinson's have been told over and over, by loving friends and spouses, that they need to "get over" their hyper-elevated sense of being the only person keeping everyone safe, or the only person keeping everything from going to hell in a handbasket.

But the person with Parkinson's is often thinking to himself, "Phooey! If it weren't for *my* vigilance or hard work, or superior drive, or superior intelligence, or ____ (insert your own virtue here), everything would fall apart."

These kinds of mental attitudes are so common in people with Parkinson's that they are a feature of the "Parkinson's personality."

It is only by understanding the role of psychologically induced biological dissociation that we can begin to recognize the relationship between Parkinson's and an attitude that results from decades of mental hyper-vigilance, of always being on the lookout for danger – and decades of wondering as to why other smart people aren't doing the same.

– Again, this mental posturing does not apply to *everyone* with Parkinson's disease. About five percent of our patients with Parkinson's do *not* fit this model. The rest, however, do.

We've worked with many people who very much want to recover from Parkinson's, but they are terrified to abandon their mental "alertness" or mental "prowess." In some dark reach of their minds, they are certain that their mental wariness is the only thing that's kept them alive, or successful, or safe for so long.

However, a person with Parkinson's needs to bear this in mind: until the brain determines that the situation is once again safe, a person cannot return to "normal" life. He must increasingly live in the land of almost-mortal injury, the land of the nearly-dead.

But he can never know that he is safe by using *mental* constructs to do so. He has created enough "unsafe" scenarios that he will not be able to override them with his mind. His mind can create reasons to be unsafe as quickly as his mind can create reasons to be safe.

Albert Einstein famously said, "we cannot solve problems using the same kind of thinking we used when we created them."

Most of my patients have wanted to use their minds to "solve" the problem of their refusal to use their heart. None have succeeded. The ones who have recovered from Parkinson's have allowed themselves to use their own hearts to override the mind. For those readers who don't have Parkinson's, you may know exactly what I mean. For my readers with Parkinson's, who probably don't know, you can substitute for the word "heart" for the word Love, God, grace, the name of some saint, sage, or prophet that is synonymous with love, or any word that you equate with the Power or Wisdom that guides the universe and transcends death.

The heart has the "legal" (biological) right and the ability to override anything set in motion by the conscious mind, including subconscious habit.

The irony here, as I'm sure you've already noticed, is that we access "heart" *not* by mental thoughts, but by feeling.

So a person who is going to recover from Parkinson's is going to have to become so fed up with listening to his anxious mind, or so ready to turn control of his life over to a higher power, or so willing to feel life force that he will, against his better *rational* judgment, allow his heart's wisdom to rise up and take charge of his mind, destroying the mental habits that create this illness-producing situation.

Relaxation isn't the answer

Cultivating or allowing a joyful surge of life force is the exact opposite of what most people with Parkinson's work hard at, prior to recovering. Most of my patients, anyway, have tried to deal with their Parkinson's symptoms by finding ways to *relax almost to the point of sleep or feigning death*: deep silence, deep breathing, massage, the "Corpse" pose in yoga, anything that stops sensory input.

Cessation of sensory input gives the sympathetic mode fewer triggers for fearful thoughts. But these calming techniques will never get rid of the mindset behind the Parkinson's.

The goal in recovering from Parkinson's isn't to *temporarily* stop the rigidity or the tremoring by tuning out all external stimuli.

The goal is to once again be able to experience noise, colors, thrills, anger, or any sort of passion, by using either sympathetic mode or parasympathetic mode – the way living people do.

The goal is to be able to be immersed in life and respond to life like ordinary, healthy people – either with physical lashing out of anger or self-defense (sympathetic mode) or the belly laugh and/or sweet tears of compassion for one's *self* that comes with wisdom (parasympathetic).

You don't *ever* want to respond to potential pain or danger by playing dead – unless you are actually in the throes of mortal injury or act of dying. If you are, then fine, dissociate until it's safe to either die or live. But if you're actually capable of life, then don't play dead.

Of course, no one with Parkinson's is in *utter* dissociation. Utter dissociation leaves a person appearing lifeless. People with Parkinson's have some *degree* of using dissociation as a response. They also use sympathetic mode, although their "fight" activities are often mental and verbal, rather than physical. They also, some of them, use parasympathetic mode, during activities that have been labeled "safe." If they are in the five percent with no mentally-induced biological dissociation, they may use parasympathetic even more often, as they will have more "safe" activities.

Still, using *any* amount of biological dissociation, pre-death, as a way to get through the day, as a way to be "safe" from the potential risks of life, is no way to live.

So, even though most of my patients are trying to fix themselves by looking for some way to calm themselves down, what we've figured out is that they need to do just the opposite: they need to get emotionally *fired up* about their own inability to control their own minds. They need to allow, maybe, a flood of gratitude to whatever mystery in the universe has always been there for them, keeping them safe. Or maybe a return to normal life will come amidst a storm of resentment against their self-instilled mental squatters (negative

thoughts). Whatever method occurs, it will *not* be the “relaxation” techniques pursued by most people with Parkinson’s: *techniques that allow the deathly calm of a physical body in suspended animation to co-exist with a mind focused on wariness.*

The next chapter shares a collection of mental exercises that can be used to attain this state of “fired up.” Having already said that recovery is a decision, not a process, these steps are nevertheless a process that can help a person *realize the extent* to which his automatic (subconscious, self-programmed) mind has taken over his own conscious mind.

The powerful heart emotions, ranging from indignant rage to surrender and humility that will eventually arise from the *frustration* and *discouragement* of doing these “positive mind” exercises with *no lasting result* is what will lead to the awareness that one does, in fact, have a weird subconscious negativity in control of the mind. This realization, or admission, leads to the *decision*, the powerful, brain-altering decision, to end the dissociation via the overriding power of the heart.

This heart power is a power that was always there, right along, like Dorothy’s magic red slippers that finally carried her back home, away from the world of Oz. She’d been wearing those slippers during all her attempts to figure out a way to get home, but she didn’t use them – she kept looking, pointlessly, for outward means of help.

This heart power has been there right along, and the person with Parkinson’s knows it. But the subconscious mind, instructed to “feel no pain,” has kept this knowledge hidden and squelched, in order to be “safe.”

When a person is ready to live again, as opposed to being safe, he just needs to build up a head of emotional steam in his heart and give his heart free rein. The heart will automatically know what to do. Using the unpremeditated, spontaneous, joyous language of the heart, the wayward brain will be issued the commands that will bring it to heel.

The heart already knows what these commands are. The brain has already been instructed, from the beginning of the dissociation, to *not* know. The heart, ever-patient, ever-loving, has politely played along. The heart was never diminished in any way by the mind’s shenanigans or dissociation commands. The heart, or maybe I should say the Love that keeps the atoms of the body in place and which is most feel-able in the vicinity of the heart, is still right there, ready to act – if and when called upon. It can wait, patiently, for an eternity. It is never “too late” to recover.

The epiphanies

Many people who have recovered have experienced epiphanies, bursts of sudden wisdom, such as “No one’s going to die after all” or “It’s OK to be vulnerable!” They usually insist, incorrectly, that they recovered because they “realized” these uplifting thoughts.

Wrong. They did *not* recover because of these words of wisdom. They realized the wisdom *because* they recovered.

Soon after recovery, within a few weeks, or sometimes within milliseconds, of turning off the dissociation for good, they were able to feel the truth in fairly obvious, even banal but nevertheless uplifting, bytes of wisdom that had been hidden from them because of their previous mental attitude.

The ugly truth of the matter, one that is a bit hard for some recovered patients to accept, is that the moment of recovery occurred when they “gave up” trying to be in control, or got sick and tired of staying wary, or done with listening to their self-created stream of constant anxieties, and decided to overthrow their ongoing mental system of self-governance and instead, turned all *control* over their lives to something “good” and “worth living for”: a higher power; their heart; possibly personified as St. Francis; Krishna; Buddha; Jesus, Allah; the Father, Divine Mother; or some personal relationship with a teacher or guru; *whatever* is their perceived source of goodness. That control *includes* the responsibility for keeping one safe. In other words, the *Goodness* of the universe is in charge of maintaining ultimate safety, not the ego-based mind.

Our patients with Parkinson’s who recovered did *not* recover because they were intellectually exposed to some great truth. They know those truths perfectly well. Sometimes they have served as teachers of those truths even while they were insidiously developing Parkinson’s. (Many of my patients, of every faith, have been religious instructors.) But they don’t know how to *live* those truths.

They recovered because they stopped hiding behind a wall of fear. As soon as they dismantled the wall, the truth was right there, like it always had been.

When you read on the web the stories of people who recovered because of some vitamin product or specific physical technique, read their stories more closely or contact them and question them. You will discover that they’d been taking the miracle vitamins for months or years with no result, or they’d been doing their mystical breathing technique for a very long time, with no result.

But at some point, they just decided to defy their inner voice of negativity, side with joy, instead, and have dared to live again. And a few moments later, they realized that they had changed – their Parkinson’s was gone or going.

Very often, they are understandably adamant that the vitamin, the physical technique, or some external substance, was the critical thing that finally conquered the Parkinson’s. If they had been assuming right along that the Parkinson’s was caused by some *externally* imposed enemy, that PD was brought upon them by something *outside* themselves, then they must logically conclude that some *external* weapon such as a vitamin or some specific movement was what vanquished the enemy. But they are incorrect.

(Except for those who completely recovered when their foot injuries began to heal. In those cases, the problem *was* simply an external injury combined with a psychological dissociation from *just the injury*. But that’s a very small percentage of patients.)

Oppositely, several of my patients, after recovering by changing their thinking and *without* resorting to external aids have said laughingly, “I feel so stupid. I’ve just been doing this to myself with my own mind!”

The odd thing is, prior to recovering, these very people would have fought against anyone or anything that implied that they were “stupid.” After recovering, when they are no

longer “at risk” of unendurable pain from the negative judgments of others or their own judgments, they can laugh at themselves in a whole new way.

Recovery can be humbling and simultaneously delightful. Feeling safe enough to really live is a glorious – and a humbling – feeling.

Where are all the recovered people?

I am often asked, “Where are all the recovered people? Why don’t your patients go on nation-wide TV to proclaim that they have recovered?”

There are several reasons. The first is that anyone who recovers is immediately presumed to have been misdiagnosed. Parkinson’s, these days, is *defined* as incurable: if you recover, you didn’t really have it, you were just a head case, a crazy person. Whether you recovered when your well-known, lifelong foot injury was healed or when you instituted a heart-/mind shift, your Parkinson’s was still a case of misdiagnosis. According to our modern medical principles, foot injuries or moods (dissociation) shouldn’t alter the capability for neurotransmitter release in the brain.

Another reason is that most people who recover do so after realizing that their negative, self-protective attitude has gotten out of control and taken over their life – and they managed to put a stop to it, thus recovering. This is a weird thing to confess to the newspapers; it can be hard to admit.

Exorcism

Yet another reason that recovery isn’t something that people necessarily want to blow their own horns about is that, in a few cases, the recovery was just “too weird to talk about.” A few recovered patients have felt as their recoveries occurred after giving permission for their hearts to exorcise – a strong verb, but an accurate one – some pernicious thought-energy from their minds. Just imagine how that would play on national TV!

But exorcise is the right word, in some cases. The negative thoughts or fears can seem to almost have a “life of their own.” Many people have noticed, when they really start working at changing their thinking, that it seems as if there’s an alter ego inside the brain that is sabotaging everything they do that is positive.

This vicious, pro-active negative thinking might have been self-created, or implanted by a parent or a social constraint or – who am I to decide – imposed by a tramp soul that was squatting in a patient’s mind.

Of course, in the big picture of universal cause and effect, or you might say of karma, however it got planted in the mind or even invited into the mind, the problem, which is to say the “voice of fear” or “evil voice,” was *originally* self-created.¹

¹ As an aside, in every case, responsibility for welcoming these wrong thoughts or squatters *must* ultimately fall upon the patient himself. So long as he wants to point a finger of blame, he is ignoring the laws of physics, the laws of action and reaction. He is denying the fact that at some point in time, possibly a point long-obscured, possibly in a previous life, he *chose* to initiate some line of wrong thinking. Subsequently, this placed him in a life situation – a family, a trauma, a backdrop of unpleasantness – that would tempt him to acquire his mental habit of living with biological dissociation. (Continued on next page.)

While on the subject, I've had patients who didn't like the idea of trying to retrain their thinking because "it almost feels like there's another personality inside me, fighting with me, when I try to change. It scares me. It makes me feel crazy. I don't like confrontation. I'd rather have Parkinson's than deal with all this."

But getting back to the main point, a person who feels that he needed to "exorcise" bad thoughts coming from what felt like a weird voice in his head, a voice that had taken on a life and personality of its own, that person is not going to go on national TV and say, "I recovered from Parkinson's! I did an exorcism and now I'm all better!"

I'm sorry, but even if that's how it felt to the patient, and it worked, his proclamation will *not* be met with loud hurrahs and celebration. He will be dismissed as a *serious* nut case who "only" had psychogenic parkinsonism.

Continuing on the subject of "going public" with news of recovery, consider this: the "roar" of righteous joy that a person feels when turning off the dissociation is exactly the same kind of powerful surge of self-assertion that occurs when a person successfully decides to stop smoking. It's a decision.

A person *should* be praised when he stops smoking. It's a powerful decision in favor of self-assertion versus habit. But it's not national news. And at least a smoker has some physical evidence of change: there used to be cigarettes around the house and now there are not. When a person with Parkinson's recovers, he's a nut case because he evidently never really had Parkinson's.

(Continued from previous page.) Until a person admits that *he* was the one that originally started this trail of events, allowing the wrong thinking or the wrong "energy" to enter or start functioning, he does not have the *authority* to *change* his mind and command the negative thoughts to leave. So long as he is an innocent victim, he is powerless to change.

I've had two patients who, on their own initiative, each independently came up with a simple, layman's ceremony that they described as "exorcism." Immediately following the ceremonies, one recovered and the other was suddenly very nearly recovered, with most of his symptoms vanishing.

In a third case, the patient was lied to by his inner voice: "You can't make me leave because you invited me in!" The opposite is actually the case: "Because I was the one who invited you, I am the one who can cast you out. I'm in charge here."

Whether the patient's own mind is playing tricks on him, or an actual evil spirit with a consciousness of its own is involved, is of *no* interest to me. What is of interest is all religions teach that that no thought or negative emotion can stay in a person's mind if commanded to leave by the heart-will (soul) of the person.

Tangentially, even in cases of people who recover from schizophrenia, another "incurable" illness from which twenty-five percent of patients eventually recover, those who do recover say that they had to make a firm *decision* to stop giving attention or credence to their closest thoughts – their inner voices. And eventually, those voices, when truly ignored and/or cast out, do go away. Learn more in *A Brilliant Mind*, Sylvia Nasar's biography of John Nash, Nobel prize winner in economics and a person who had to greatly humble himself in order to recover from schizophrenia. He recovered by willfully deciding to ignore his inner voices and trust the minds of others – less brilliant than himself – to guide his actions until the "demons" of schizophrenia were gone.

Recovering from Parkinson's does *not* occur when a person insists on using grim determination to get a death grip on what he thinks must be an externally induced incurable illness. It occurs when a person allows his powerful, loving heart energy to terminate his mind's clever, fairly paranoid trick of using dissociation rather than dealing with life. On the surface, this is not really the stuff of national heroism.

To *my* mind, this *is* heroic work. I have the highest possible awe and respect for any person who changes himself for the better. Still, prime-time television audiences are not ready to understand why an illness that can be reversed by a *decision* is even a "real" illness.

I recall one of my patients suddenly smacking himself on the head in a gesture while saying, "How can I have been so stupid!" He then said to me, amazed, "I did this to myself! I did this to myself!"

He was being completely honest.

The above is a discussion that went somewhat far afield from the question, "Where are all the people who've recovered from Parkinson's?" But getting back to that point, how many people are willing to go on national TV and say, "I recovered from Parkinson's after admitting that being numb isn't a good way for me to pretend that I'm in control of my life..."? Not many. Especially if they can be certain of being pronounced "misdiagnosed," or "crazy," and "certainly never had *real* Parkinson's."

An honest admission of "How I Recovered From Parkinson's" will involve an honest admission that the PD was pretty much self-created, in most cases.

Therefore, we are not going to see people singing their own praises of how they *actually* recovered from Parkinson's any time soon. At present, illnesses that derive from inappropriate mental behaviors are sneered at: "It was all in your head" is an insult, not a compliment.

For example, even though addiction causes neurotransmitter changes (just like Parkinson's), it is only recently that we use a vocabulary that allows addiction to be viewed as a genuine illness, and not just a "lack of will power."

Our society does not yet appreciate that overcoming a *mental* attitude or *mental* habit is one of the most challenging goals a person can set for himself.

Most of our patients who have recovered have done so after attuning themselves with a higher truth, one that transcends death, in order to bravely stop using mental attitudes that pretend to hold death and danger at bay via keeping the person paralyzed and/or numb. Just try playing that out in the national media.

I am certain that, in the centuries to come, we will begin to recognize that *all* illnesses have *some* mental component. And the self-protective mental attitudes that we create to keep ourselves "safe" are some of the most difficult to overcome. After all, they often include the concept that removal of the protective attitude will cause pain, or even death.

I do realize that the above may anger many people who do *not* have idiopathic Parkinson's disease: they will call this "blaming the victim."

I also know that my patients know just what I'm talking about. Which doesn't make it easier for them to let the heart rise up and re-assert itself. But they know just what I'm talking about.

Even though they understand me very well, many, if not most, of my patients usually want to argue with me about the need to stop the dissociation. They feel that there *should* be some way they can recover fluidity of movement while still maintaining their mental inhibition of heart feeling. They usually *love* to argue. They are usually *very* good with word-based logic, and are reluctant to admit that some doctor – such as myself – can't come up with a *word-based mental* system for altering the brain patterns that they have set in motion, thus somehow allowing themselves to have it both ways: a body directed by life force, while numb to physical and emotional pain *and* having a mind directed by the clever ego.

But this is impossible. Remember: dissociation inhibits the release of dopamine.

What dopamine release is not

Many a person trying to recover simply cannot understand that parasympathetic mode and its concomitant dopamine release is *not* the result of getting what he *wants* (often translated as "being happy.") Likewise, dopamine release is *not* the result of retreating or hiding in the calm that borders on falling asleep. Dopamine release is *not* the result of suppressing or stifling the emotions in order to present a calm face to the world. Dopamine release is *not* the result of achieving "safety" by acting on fear-based impulses for self-protection. Dopamine release is *not* the result of receiving praise from others. It is *not* the result of attaining victory or success.

The one exception (there's always an exception, isn't there?) to this "success" rule is: dopamine release occurs when a person succeeds in vanquishing his ego and surrendering (being obedient to) the instructions given to his heart by the universe. Will power is *rightly* used when it is applied to performing the instructions of the heart and keeping the mind ever attuned to the heart.

Success, in this sense, has nothing to do with, is the opposite of, ego-based success.

What dopamine release is

Dopamine release occurs when a person feels safe enough to be unguardedly alive – which includes being alive to risks, frustrations and failures: in other words, safe enough to be alive *no matter what* happens.

Dopamine release occurs when a person *expects* to experience the joy of being alive *whether or not* he gets to do what he wants – whether he wins or loses, whether he's calm or dynamic.

Summary

If a person wants to recover from Parkinson's, he needs to stop trying to find safety in playing dead, and start living.

Wrong approach: *Crawl into your wounds to discover where your fears are. Once the bleeding starts, the cleansing can begin.*

Tori Amos

Right approach: *Help! Thanks. Wow...*

Anne Lamott

CHAPTER SIXTEEN

TREATING MENTAL HABITS OF DISSOCIATION: TECHNIQUES

First, get rid of negative thoughts.

Chronic, negative emotions such as anxiety, fear, resentment, jealousy, and so on, are not objective realities. They are the result of negative, often fallacious (based on fallacy: illogical or half-logical), thoughts.

Since the days of Freud, psychologists have wrongly assumed that emotions are the logical – and therefore “true and correct” – results of past hurts. The assumption has been that, by uncovering “hidden” emotions one could “resolve them” via expressions of bitterness or sadness or more negative thoughts, and thus move on to health.

Modern research shows that the opposite is true. Our thoughts, in the form of subjective opinions, create our emotions. Our opinionated *thoughts* create the physical symptoms that we call emotions. Emotions are a side effect.

We are able to decide what kinds of thoughts we will have. We *choose* our thoughts.

The “radio transmissions” of our thought waves trigger specific chemistries and physiological behaviors: what we call “emotions.” Elevated blood pressure is a response to angry thoughts; inhibited joy and lifelessness is a response to depressive thoughts. Tremors, as people with worsening Parkinson’s know, are set in motion by anxious or fearful thoughts.

We have the innate ability to *decide* what thoughts we are going to cultivate and harbor. In order to recover from the mental aspects of Parkinson’s, a person needs to retrain himself to stop cultivating thoughts of “needing to be good,” fear of incompetence or disapproval, helplessness, resentment, or whatever negative thoughts he uses to “drive and sustain” himself. He must replace those carefully nurtured, deeply loved, highly damaging “precious” thoughts with positive thoughts that more accurately reflect “truth”: the nature of the universe and basic physics.

Only when a person with Parkinson’s has retrained his thoughts so that he is no longer oppressed by self-pity, determined to be impervious to pain, or whatever his particular specialness is, will he be able to say to himself, with any degree of believability, “I’m safe, now.” In order to turn off dissociation, a person must decide that he is safe. That’s a biological fact.

In order to learn more about retraining your thoughts, please read *Feeling Good*, by Dr. David Burns, the Stanford researcher and “father” of modern cognitive behavioral therapy. This book is easily available on Amazon. Hundreds of variations of his research have popped up, but his book is the simplest, most basic, and cheapest.

His work is directed towards attitudes that lead to the emotion of depression. The underlying emotion of most people with PD is fear, with depression being only secondary. But people with Parkinson’s are very smart, and can easily adapt his depression program to address their own wrong thinking patterns.¹

Second, do not suppress your emotions

It is not healthy to suppress emotions. After negative thoughts have triggered negative emotions, and those emotions have led to physiological changes such as elevated heart rate, higher blood pressure, pain in the heart area, butterflies in the stomach, and so on, it is a bad practice to pretend that those symptoms don’t exist.

Do not suppress your emotions.

Suppression of negative emotions leads to a thousand variations of illness. If a person has negative emotions, he should express them in ways that are safe, kind to others, and as healthy as possible.

Example: something has made you really angry? Go run a mile. Go surfing. Most of all, *refuse* to dwell on the thing that made you angry. Let go of it. Do *not* take it out on your nearest and dearest; do not take it out on a stranger.

You get to *choose* what kinds of thoughts will reside in your mind. You should be always the master of your thoughts, not the hapless victim of a runaway mind.

The *wise* person is always working to regulate his *thoughts* and *opinions* so that negative emotions do not arise in the first place. If and when they do arise, he expresses them in a manner that helps him move forward. And he does not dwell on that which caused a

¹Cognitive behavioral therapy was developed by Dr. David D. Burns, MD in the late 1970s. Hundreds of variations of this type of therapy have branched off from his original, brilliant work, but I find his original work to be the most all-purpose. “Cognitive behavioral therapy” simple means “learn to recognize and get rid of the incorrect thought patterns (cognitive behaviors) that, by their very nature, make a person physically or emotionally sick.”

I *highly* recommend that people with Parkinson’s who are embarking on recovery familiarize themselves with the material in his book *Feeling Good*. This book is primarily about treating depression – a condition that inhibits the release of dopamine, which, in turn leads to worsened depression, which further inhibits the release of dopamine. But many of the principles apply to the self-perpetuating, distorted thought patterns of people with Parkinson’s, as well. The cognitive distortions that he refers to as “mental filters” and “should” patterns have been particularly common in my patients with Parkinson’s.

Please read his book, *Feeling Good*, and *practice* the simple mind-retraining that he explains. While practicing these steps may not turn off your *idée fixe* that you are “not yet safe,” or “it’s a smart idea to be stoic and numb to pain,” such practice will make more clear to you the extent to which you are actively feeding your dopamine-release inhibition via your thoughts. This, in turn, may help you more quickly get to the point of being fed up with your own inability to be in control of your thoughts – leading to the forceful, *joyful* expulsion of your idea of being “not safe”, thus affirming that you are safe – and ending your use of dissociation mode.

negative emotion. As soon as he catches himself getting caught up in a pointless, negative thought stream, he stops himself and institutes a stream of healthy, positive thought.

Third, admit you are safe

Once you begin to work at being aware of your negative thoughts and are working to consciously replace them with positive thoughts, there are lots of ways to tell yourself, “I’m safe now!” which, in turn, terminates dissociation mode.

If you do *not* learn to get a grip on your thoughts and work to patiently retrain them, the suggestions in this chapter will give only short-term relief. You will find that you are only able to “stay safe” for a very short period of time. Your well-trained negative thoughts will come rushing back as soon as you let your guard down, and your Parkinson’s symptoms, driven by your favorite negative emotion, and complimented by your continuing use of dissociation, will return.

The cyclical nature of Parkinsonian thinking

A person with psychogenic Parkinsonism has adapted the use of dissociation – a rarely used neurological mode, a mode that should only be used when nearly dead – to help him suppress any expression, or even conscious awareness, of his pain and/or his emotions. This is typically initiated by giving himself a command to “feel no pain.”

In order to comply with the command, his body automatically uses dissociation – the “play dead mode” – to suppress his physical or emotional pains.

Then, in order to *maintain* the dissociation, his obedient subconscious sets in motion a steady stream of negative, fearful thoughts that carry the underlying subtext “you are not yet safe: if you let down your guard, you are at risk of great pain, even death.”

The subconscious assumes that these thoughts must *not* be allowed to stop. If the person with PD stops having the fearful thoughts, he will have to admit he is safe. If he admits he is safe, the dissociation will turn off and he will be vulnerable to pain. This is no good: after all, he has previously commanded the subconscious to help him stay safe and feel no pain.

So, with the help of the subconscious, he develops some stream of false, fear-based thinking. This enables him to feel “not safe” and thus maintain the dissociation. However, it also causes his mind, eventually, to be obsessed with negative, anxious thoughts. These thoughts create negative emotions – complete with the painful *sensations* of negative emotions. These emotions are suppressed (not healthy!) because he is using dissociation to make himself numb.

At some point, the negative thoughts, coupled with his inability to *process* the fearful emotions produced by these thoughts, are mentally overwhelming. They are no longer tricks that help him stay stoic – he starts to *believe* that the negative thoughts are *truth*. As the Parkinson’s symptoms worsen, the negativity can become obsessive. He *has* to retreat deeper into rigidity and numbness (dissociation) or the pain from this negativity (emotion) would become too overwhelming.

Meanwhile, the dissociation tremor is a biological signal saying, “Could you please see if it’s OK to be safe yet? Can we stop the dissociation?”

Of course, the answer, driven by negative thoughts, will be “No!”

And at this point, even the tremor makes him scared, and so he adds the “tremor that naturally accompanies fear” (a common, ordinary tremor) to the dissociation tremor, thus *worsening* the tremor situation.

At this point, he is in a downward spiral. Until he turns off the instruction to feel no pain, or admits that he’s now safe, he cannot get out of this spiral. His symptoms will continue to worsen, and he will worry about this (creating more negative thoughts), the worry will make painful emotions and he will work harder than ever to play dead in order to not feel these pains. He will throw himself into “relaxation” methods that resemble lifelessness or deep stillness (playing dead). These games will *never* lead to a lasting benefit. The long-term goal must be feeling good, feeling safe, even when *active*: even when *alive*.

If you are planning to recover from Parkinson’s disease, please take the time to learn about methods such as cognitive behavioral therapy for changing your thought processes – and then get to work on doing it. Plus, it’s time to admit that you actually *are* safe enough to stop freezing up as a response to anything that you don’t like. It’s still OK to have dislikes – but respond via sympathetic mode, not via dissociation.

Ideas for breaking the negative thinking cycle of Parkinson’s

The following is a collection of general ideas that you might use, in addition to cognitive behavioral therapy. Not every one of these ideas will “sit right” with every person. Some have religious overtones. Some do not.

In my limited experience, those people who have experience in some spiritual pursuit seem to do better at embracing the principles behind these ideas. This may be because a person who has been practicing modifying his thoughts in order to be more in tune with a great spiritual teaching or teacher has already been working, to some degree, on disciplining his thoughts. In modern lingo, he’s been practicing cognitive behavioral therapy.

Then again, those who have come to me saying, “God wants us to suffer” or “I deserve to suffer,” tend to be incapable of doing any significant amount of self-help work.

1. Statement of fact: I’m safe enough to come back to life

The following section shares several ways to tell yourself that you are safe enough, now.

1a) You can allow some higher power to be in control of your life. If the higher power is in control, keeping you safe, then you can let down your guard and don’t have to keep yourself safe anymore.

The “higher power” doesn’t need to be some traditional religious figure. It can be anything from the Light behind all creation (physics), the basic laws of cause and effect (aka the laws of action and reaction), to The Force of the Jedi Masters (George Lucas). It can be John Paul II, the late pope, who had Parkinson’s disease.¹ But it has to be something more powerful than yourself, and it has to be something fair, and something that is inherently good, or loving.

¹ A catholic nun with advanced Parkinson’s gave up control of her ego and surrendered care of her life over to John Paul II and recovered overnight.

You can stop believing in this higher power as soon as you've turned off the dissociation, but if you've gotten yourself into a condition of circular, self-perpetuating fear in which it's impossible for you to be safe, you may well need something outside yourself to snap you out of it.

1b) If you don't like the higher power idea, you can tell yourself (repeatedly, until you admit that it's true), that you are choosing to be joyful, strong and ready for *action* anytime you feel fear. This is the opposite of choosing to dissociate. Practice: alternately pretend you are feeling fear and freeze up. Then, pretend you are feeling fear but you are going to power through it with joy. If you have a higher power that you trust, you can imagine this power right beside you, keeping you safe and filling you with joy.

1c) You can just admit that you are safe, after all, and that you are no longer going to use dissociation. This can be hard, because the mind will give you a lot of back chat if you don't have something else, such as your heart or a sense of joy, lined up to take the place of the dissociation.

1d) In addition to the re-training techniques of cognitive behavioral therapy, one can use spiritual affirmations or any type of self-help retraining techniques. Practicing these methods is a particularly helpful first step for people with Parkinson's who aren't sure that they are, in fact, dissociating from their heart or their ability to relax, even though their friends and loved ones say "Boy, you sure fit the description of a person who has dissociated from the heart!"

An uplifting affirmation can serve as a litmus test for negative thoughts. If the positive affirmation is quickly countered by thoughts such as "Yeah, right; this can't possibly work," then you know you've got some real problem thoughts.

Observing one's own thoughts with regard to "I am feeling safe no matter what!" can be an eye-opening process for a person with Parkinson's who has dissociated from the heart but is in denial about it.

Many people will not be able to decide that they *can* be safe even when they realize the extent to which they have become prisoners of their self-created negativity and its resultant fear. I have worked with many such. But learning to recognize that the negative thoughts are there, and *realizing* how powerfully they have taken hold, can sometimes inspire a person to gather up his heart forces and either issue a heart-based (soul-directed, and therefore joyful) command, "I *am* safe!" while destroying the negative mental habit either by chipping away at it, or by blowing it up all in one shot.

Or the realization might inspire a person to turn the mess over to a higher power. Or laugh at himself and stop doing it.

Through whichever method the person admits he is safe, the dissociation stops. If the person has been firm in his resolution to not use dissociation any more, and he has started overhauling the negative mental stream that caused him to think he *needed* dissociation to cope with the negative emotions his thoughts were creating, then he's about to recover from the psychogenic factors that can cause Parkinson's disease.

2. Banishing the negative thoughts

After this initial stab at admitting that, in fact, you are safe enough to come back to life, you may find it helpful to *exorcise* any habitual thoughts to the contrary – and there might be lots of them.

Although the work of cognitive behavioral therapy can make a huge improvement in a person's thinking, sometimes it is just not enough. If a person has essentially hypnotized himself with a command such as "We shall feel no pain!", then some stronger medicine might be required.

In such a case, I like the word "exorcise." "Exorcise" suggests calling up your own forces of good to expel negativity that has got you in its grip.

You must consciously, powerfully, banish the thoughts that are keeping your locked into negativity. More on this will be shared a bit later in this chapter.

3. Recognizing when you're more dissociated than usual

If your symptoms are somewhat variable, ask a friend or spouse to *tell* you every time your face freezes or your eyes glaze over, and you retreat into a particularly "safe" or "frozen" place. I call these phases, when a person's eyes glaze over and they stop being able to hear what people are saying, "special deeps."

Having these episodes, if any, pointed out to you is similar to the list-making aspect of self-awareness/cognitive behavioral therapy in that it helps you, the patient, acknowledge the frequency with which you divert into an altered state (alternate personality), an altered state that uses a *deeper* degree of dissociation than usual. This deeper state usually features even less sympathetic mode than usual, and often has weird mental instructions such as "Tune them out! Don't listen to them, they don't understand."

Spouses are usually the best at recognizing when a person slides into this state. They often know very well about your tendency to glaze over and emotionally disappear when something is happening that you don't like. All they need to do to help you is say, "You're doing it right now!"

It may be helpful for the spouse or friend to look for the eye flicker that occurs in many – but not all – people with Parkinson's as they shift over to the personality that is "safe via dissociation." It is often, though not always, a *sideways*, darting eye movement, such as is used in the movies to suggest that a person is being untruthful or evil.

Some patients have learned to recognize when they are doing this, after their use of the altered state is pointed out to them.

Like the self-awareness steps in item 1d, above, this awareness will *not* fix the problem, but may open a person's eyes to the *extent* that he's using a weird mental state (*high* level of dissociation with almost no sympathetic override).

It's not the dissociation comes and goes: the dissociation is always there. But usually there's some amount of sympathetic mode override. The "special" deeps, supported by self-created mind games, is what your loved ones notice when you glaze over and seem to have "stopped listening" or "gone into your own private world."

Hopefully, if you have PD, you will be *alarmed* to realize the extent to which your own subconscious slides into an even more utterly dissociated state, or altered personality state. If a loved one can point these episodes out to you, you may begin to recognize when you do this. You *may* become more motivated to take charge of your own personality and consciousness instead of being a hapless puppet.

Realizing that you are sliding into a weird psychological state without *conscious* control can be a rude awakening. You don't *want* to be sliding into an altered state without even knowing you are doing it. When you become aware of what you are doing, you will hopefully begin to *resent* that your subconscious mind, with its ego-driven negative habits, has gotten out of hand. You will want to regain control of your own mind.

In order to regain conscious control, you must turn off the mental story line that drives you to dissociate. In order to turn it off, you must admit that you're now safe.

4. Get fed up or see the humor

Repeated half-hearted assurances of being safe will not work, but becoming fed up with your own failure to take control of your mind, or even the recognition that your mind is playing games, *may* help a person build up a head of steam that can generate a powerful, heart-based JOY-FILLED (not angry) victorious assertion that destroys the habit and/or turns the mess over to a higher power in one swift stroke.

5. Practice being conscious of the sensations of movement

You might be able to *correctly* practice some Asian movement technique such as yoga, Tai Ji, or Qi Gong. When I say correctly, I mean actually *feeling* light and energy in whatever part of your body you are working on. When you dare to feel your body, you *might* feel *safe* enough to let yourself feel your heart, as well. Deciding that you are safe enough to feel with the heart will automatically turn off the dissociation.

One problem with this method is that many people with Parkinson's go through the motions of these arts and never actually *feel* the body, and don't even realize that they aren't feeling.

Also, some people are able to trigger awareness of and healing in their *injuries*, via these practices, but are *unable* to overcome the heart dissociation while using them. They might recover from many of their PD symptoms, but other symptoms will remain or pop up during times of stress. These people remain "partially recovered" until such time as they stop using dissociation mode altogether – a process that requires a person to decide that 1) he is safe and 2) he doesn't need to use the frozen, emotional lock-down trick any more.

6. Turning off the dissociation mechanically

Shudder and exhale deeply. This is a movement that spontaneously occurs when a person has decided he is safe. Most people with Parkinson's cannot perform this movement because their body biologically, automatically, *inhibits* this motion if there is imminent danger.

Even so, immediately after doing any or all of the above exercises, give a shudder and exhale with relief. It may feel very unnatural, at first, but at some point, your brain and body might, in a moment of feeling safe, be able to perform this physiological act that turns off the dissociation and resets the body into parasympathetic mode.

It may take hundreds of attempts, but don't give up. Any time you feel that you are *no* longer in imminent danger, try to do this move. If you can do it, you have turned off the dissociation – at least temporarily.

If the dissociation returns – and your subconscious may think that it's supposed to reinstate the dissociation, you will have a better understanding of what you're fighting. You

will affirm, exorcise, and stay aware of your thoughts with a new level of intensity and joyful determination.

As Pogo famously said in the cartoon strip by Walt Kelly: “We have found the enemy, and he is us.”

7. Don't dig for dirt

Something to NOT do: don't worry about remembering the specific incident that started you down this path. That will not help you. Don't waste time trying to remember why you dissociated in the first place. The *ego* loves these sojourns through the mind, but they aren't going to help you admit that you're actually safe, now, *and* you probably won't find what you are looking for.

Remember, the whole *point* of dissociation is that you can't remember the problem until such time as you are safe, and have been safe for a while – long enough to get back into normalcy for a while.

You might *never* recall the specific thing that made you dissociate, or you might remember it a few days or a few years after you finally decide you are safe. Deciding you are safe – no longer in clear and present danger, and no longer needing to use dissociation again even if a situation should arise in which you are in danger – is what you need to work at.

(If and when you recall the thing that terrified you into a pre-death state, you can do whatever you need to do to get over it: face your fear, forgive the perpetrator, mentally let go of the incident, or physically purge yourself somehow. Let go of it, get over it, and move on.)

Your *ego* will say, “You need to figure out what started this!” But your ego is a liar. Your ego knows perfectly well that you can't figure that out – because you've psychologically dissociated from it (compartmentalized it away from normal consciousness).

No matter how often I say this, a good percentage of patients say to me, “If only I could remember what started all this...” and put off getting to work on doing something productive. (The others have some *known* reason for clinging to fear, and they usually cherish this reason, considering it perfectly good justification for going through life half-dead. Oddly enough, when they recover, it turns out that the *remembered* reason isn't the actual reason, at all. A previous, *forgotten* fear started them down the path of dissociation. Subsequent fears are then remembered and cultivated; they are used as helpful evidence that the person isn't safe.)

People who insist that they need to “get to the bottom of this” don't understand or don't choose to accept that their brains are going to keep that information locked up until such time as they are safe. In those people with Parkinson's whose subconscious has taken over, this “If only I could remember what started it all” is a tricky, sneaky ploy on the part of the ego to keep the person distracted from the fact that he is actually safe already. Remember, the ego, via the subconscious, has desires of its own, and one of them is the desire to be in charge. Staying dissociated from the heart is one of the best tricks the ego can employ in order to stay busy and in charge.

In a few cases, when patients have been consciously cultivating self-pity or resentment over a well-remembered incident, they say, “I know why I *have* to be this way: in my childhood I experienced (insert your special event here) and I will *never* be able to get over it.”

Either way, whether the origin has been hidden away or some old painful event is right out there in the open and lovingly nurtured, dissociation has been employed to make it less painful, and dissociation cannot be turned off until a person decides he is safe. In either case, the heart has become shut down and the ego is now in charge.

In classic literature, this theme is known as “The evil minister to the king: the evil one who usurps the power of the throne.” The king is the heart. The evil minister is the ego. In the case of Parkinson’s, the evil minister has co-opted the subconscious and told it to dissociate (numb the heart) until such time as the person is safe from *any and all* dangers, even future dangers – a time that will never come. The ego will continue to build on old fears and/or create imaginary and future dangers forever – because this move will keep the ego in control.

Remember, actual dissociation is only supposed to stay in place until the real and present mortal danger has passed or the person is dead: a very short time, indeed.

It is the *undisciplined*, out-of-control ego that has modified the rules to say, “Stay dissociated until all possible danger is gone forever!”

The problem is, we are *never* going to be safe from *any* and *all* dangers. The *undisciplined* ego knows this, and uses this little lie in order to allow the ego to stay in charge indefinitely.

When you are using dissociation, you are not using your heart – in many ways, the heart is perceived as the opposite, even the enemy, of the *undisciplined* ego.

Oppositely, the heart has no enemy. The heart loves the ego in the way the mother loves her fractious two-year old child even while the two-year is screaming “I hate you, mommy!” The *undisciplined* ego resents, fears, or even hates the heart – just like many a two-year old in mid-tantrum.

Remember, we should use dissociation only during times of genuine mortal distress, when we are on the cusp of death. *At all other times*, dangers should be dealt with using sympathetic mode (fight or flight).

Spiritual superiority

In our experience, many a person with Parkinson’s feels superior to the average person *because* he (the person with PD) doesn’t react to danger in the same way as the hoi polloi: the “lower man” usually uses very physical flight or flight behavior. The person with PD tends to respond *mentally* or *verbally* and dissociates from physical feelings and often concludes that this is a sign of spiritual superiority.

Dissociation, when used to lie to oneself in order pretend that one is numb or has no negative emotions, is just the opposite of spiritual superiority. Because dissociation works by temporarily turning *off* a person’s ability to use his heart as a decision maker, it is the opposite of spiritual.

When trying to recover, do not underestimate the challenge. In deciding to turn off the use of dissociation and admit that you are safe, you are embarking on an inner battle with your own ego. Your ego knows you very well, and will use every trick. However, your heart

can vanquish all ego tricks in the blink of an eye. But the heart, being wise and good, has excellent manners: it never speaks until spoken to, and it never interferes until called upon to do so.

8. Have some fun with this

Make up your own system! Do anything you want that makes you admit that you're actually safe enough to use the three normal modes: relaxed, fight or flight, and sleep. The suggestions above are just a few of the methods you might consider, a sampling of ways to get you started on admitting that you are safe.

A four-part exercise for getting annoyed at your Parkinson's mindset

Because many of our patients have wanted a *specific* set of things to “do” to get started on changing their mental processes, we've developed a sequence of exercises. The rest of this chapter shares this sequence.

The following is a four-part collection of very specific mental exercises, to be done in the order presented. These exercises are based on the principles discussed above. They may provide a jumping off point for the person who has read all of the above and doesn't know where to begin.

The four parts of this sequence are derived from well-known, all-purpose self-help exercises. They have been modified for people with Parkinson's.

As noted in the previous chapter, these exercises probably will *not* work to get rid of your negative thought habits, particularly if you installed them via some form of self-hypnosis. What these exercises will do is make you realize just how powerfully disobedient your own mind is. This should make you get fed up, or laugh, or something in between – an emotion. Then, when you realize what a monster you've created and you are truly ready to change, you will take steps: you will act on that emotion in a productive manner.

Each person who has recovered from Parkinson's has “taken steps” to wrest back control of his own mind. These steps are very individual. They flow, automatically, from the heart of the individual. We cannot write up the “steps” that any given person “should” take. However, a later chapter shares some case studies that demonstrate examples of the individual, heart-based “moments” in which people have unleashed their hearts and suddenly recovered from the mental basis for Parkinson's.

Part 1: The peace and harmony prayer

Visualize your own brain and mentally surround it with divine light. Then deeply implore, “Lord” (or Love, Universal Goodness, Buddha or Buddha nature, Allah, Brahma, Jesus, Divine Mother, or whatever serves as your personal favorite expression of the Universal Love that transcends death), “fill my brain with peace and harmony, peace and harmony.”

Repeat this over and over, for about a minute: “Peace and harmony, peace and harmony. Fill me with peace and harmony, peace and harmony...”

Afterwards, visualize your own heart surrounded by the divine light and pray, “Lord, fill my heart with peace and harmony, peace and harmony” for about fifteen seconds.

If you are able to use your imagination enough to pretend that your heart has a little mouth, and that mouth is saying the words, it can be very helpful. Many people with Parkinson's have difficulty in creating fanciful mental images, and might not be able to imagine a little mouth on their own heart.

If you wish, when you have finished the above, you may also visualize your brain resting inside your heart. You might need to imagine your heart as being larger than it actually is in order to make the brain fit inside of it. Imagine a pool of light surrounding your heart.

Observe your brain in this setting. If your mental image of your brain changes shape, that's fine, continue to observe it, while saying, "Lord, fill this brain with peace and harmony."

As an example of the brain changing shape, one patient who did this found that her "brain" changed shapes, quickly transforming into a series of ferocious and dangerous animals, and ending up being a very sweet black and white spaniel. Feel free to let your imagination, if any, run wild. You'll be safe – it's all happening in your heart.

Part 2: Statement of gratitude and taking charge

After a few days, or as soon as you feel that your mind's resistance to peace and harmony is diminishing, add the following affirmation after practicing the peace and harmony prayer. In this affirmation, your heart is making a statement to your brain:

"Thank you for many years of service. I *am* safe. You will now stop this protection. I am in charge again, and I will keep us both safe."

Sit calmly and notice how you *feel* in your chest, in the heart area. Don't pay attention to thoughts: this is a time for noticing how you *feel*.

Again, if possible, imagining a little mouth on your heart might be helpful.

Part 3: You are not welcome here

If, while trying to concentrate on how you feel, your brain gives you any backchat, which it probably will, say firmly to those negative thoughts: "You are not welcome, and you must leave."

Repeat this affirmation three times and then immediately begin part four.

Part 4: A Positive word

Pick a simple and familiar *positive* word or extremely short phrase, and say it over and over. Examples of a positive word or phrase are "love," "Om (or Om-Tat-Sat)," "God," "Allah O Akbar," "Shalom," "Lord," "Gurudeva," "Hail Mary full of grace," or any extremely simple statement or word that you associate with unequivocal *goodness*. Continue stating this affirmation for a minute, or until your brain stops making arguments and you start being able to pay attention to how this affirmation makes you feel in your heart area.

Keep your chosen phrase simple, and stick to the same one for the most part, rather than playing around with something new every time.

This simple affirmation will give extra oomph to your assertion that the negative thoughts are not welcome and must leave.

The prayer is a way of demonstrating to yourself that you are no longer enthralled (in thrall) by your brain's self-created endless stream of negative or fear-based thoughts.

Discussion

The above may seem extremely simple.
But just try it.

You will probably find that it is nearly impossible to shut off the endless stream of arguments that your brain is using to keep you safe. During the peace and harmony prayer you might find yourself looking at the clock. During the affirmation you might find yourself worrying about the plumbing or resenting your in-laws. It will be very hard to stay focused on these simple, *goodness*-related activities.

That's the whole point of these exercises.

These exercises provide a way to make you start to be circumspect about your own thought processes. By doing these exercises, probably somewhat unsuccessfully, you become *confronted* with the fact that your own brain has gone out of control: it is in a constant scurry, creating an endless keeping-me-safe monologue that will not stop *even when you tell it to*.

History of the affirmations

The PD Team did not create the techniques in the previous chapter. For the most part, they are modifications of other, sometimes famous, healing techniques.

Giving credit where credit is due

The first exercise, **Part 1**, the Peace and Harmony prayer, is a somewhat famous prayer for dealing with a person or situation that is causing you long-term distress. You picture the other person (or the barking dog, or whatever) in light, say the prayer, and then do the same for yourself. Eventually, by practicing this, you can modify your own thoughts and even the thoughts of the other person. This prayer is astonishingly effective at reconciling difficult situations.

I learned of this prayer from Swami Brother Bhaktananda, who learned it from his guru, Paramahansa Yogananda.

Many years ago, in our research, we started using the heart/brain modification of this prayer. We found that our Parkinson's patients could become extremely peaceful, so long as they were relaxing in the office doing the prayer. Very often, they would walk around the office, at the end of the session, saying, "I'm better! The Parkinson's is gone!"

However, as soon as they left the office, they snapped right back into negative thinking and their symptoms would return. The thoughts usually consisted of variations on "This can't possibly work" and "Don't listen to them (the Parkinson's Treatment Team), they don't understand."

We also tried using a visual of the mind floating in a rippling lake of light. But we found that visualization was very difficult for most of our patients. Even for those people who

could visualize, the benefit was only temporary. The point of the exercise was to get in touch with the feelings of the heart.

Of course, after doing this exercise, patients employed the same kinds of negative statement as soon as they left the office, and the Parkinson's symptoms returned promptly.¹

Before explaining why these techniques don't actually work, and why they can be as dangerous as the other, various "relaxation" methods often used by people with Parkinson's, I'll finish sharing the sources for parts 2, 3, and 4.

Part 2, the affirmation, "Thank you, and I'm in charge here now," is derived from the collected statements that have erupted from people in the moments during which they recover from Parkinson's. At the moment of recovery, people tend to feel an upwelling of gratitude and safety, as if they have just handed the reins of their protection over to something within, or something vast and beyond. This affirmation, featuring "Thank you" and "The heart is in charge, now," reflects the sort of thing people say upon recovering. So by practicing saying it, you are actually practicing for the attitude you will have after you recover. This can be reassuring – your mind knows that you will not fall into a bottomless pit after you recover, you will have a new attitude, not an absence of attitude.

And this brings us to **Part 3**: you are not welcome and you must leave. This technique is possibly the most important part of the sequence.

As soon as you say, "Thank you brain, but the heart's in charge here now," the brain will start telling you all sorts of reasons why this is not possible, or why this is a bad idea. This is when you have to assert yourself.

The statements, "You are not welcome," and "You must leave" are derived from a very basic, layman's-level exorcism affirmation. It can be used for any negative situation, thought, or "energy" that is imposing itself on someone against that person's conscious will. It can also be used, out loud, against houseguests who have overstayed their welcome, and party crashers.

It is a very powerful and effective statement, and must be used with focus and conviction.

There can be no negotiations, no explanations, no accusations.

If backchat starts up, refuse to listen to it – same as you would with the unwanted houseguest. Stand up for yourself. You do have power. You don't have to play dead anymore.

¹ I mention this one technique that we tried and abandoned so that I could bring up the subject of Heartmath (Childre and Martin). For the most part, the popular Heartmath techniques do *not* help people with Parkinson's: just the reverse. Most of their techniques wrongly assume that *any* decrease in sympathetic mode automatically shunts a person into parasympathetic. This is a nice generalization, but one that does not hold true for people with Parkinson's. In particular, their devices for measuring heart/brain synchronicity have been detrimental for our patients. It turns out that heart-brain synchronicity is easy to attain while dissociated. Some of the Heartmath work, by training a person to exit sympathetic mode, actually helps train a person with Parkinson's to be *more* utterly locked into dissociation mode – the opposite of what people with Parkinson's need. And our patients tend to enjoy doing the device-driven Heartmath "work" because they are so *extremely* good at it: good at playing dead.

The brain will want to talk this over, but you are in charge and you don't want to hear it. Remember: no negotiations, no explanations, no accusations. Pure and simple, "You are not welcome, and you must leave."

The brain will try in every possible way to dissuade you from being serious about this statement. The brain will argue, it will want to discuss things, it will think up excuses. All these ploys fit under the heading of "backchat."

The brain's strongest argument will be that this eviction is a sneaky, and probably evil, way to take over control of the mind, and you are going to be sorry, and maybe even dead, or at least in pain. It may even say, "You asked me to be here, so I have the right to stay!" Your brain will know all your weaknesses, and will use them against you.

This is why, after you say, "You must leave," your next action must be **Part 4**: repetition of a word that, to your mind, is associated with utter goodness.

This technique is ancient, and can be found in every major world religion. It consists of keeping the mind focused on something that is identified with goodness, so as to keep the mind *away* from thoughts that are not identified with goodness.

This repetition assures your mind that the "You are not welcome" command" is *not* in league with the forces of darkness, if any. This powerful, simple, laser-like focus on something good and positive is a way of saying to the mind "This command banishing you is a part of my attunement with something good. It's OK. In fact, by this attunement with my innate goodness or my choosing goodness, I'm *safe*."

This will be very hard for the mind to accept. After all, the mind has been told that keeping you safe is *its job*.

In the end, your mind will refuse to comply with your instructions.

And that's the whole point. Your own brain will refuse to comply with your own instructions. After all your hard work, your focused peace and harmony prayer, the light and the ripples in the chest, the affirmation that you want the brain to stop doing this protection act, the expelling of the negative thoughts and the repetition of a word related to something outside yourself and/or inside yourself that is good, after all this, there's a good chance that your own brain is going to completely ignore you when you tell it that its creations, its negative thoughts, are not welcome.

That's when you will *start* to realize what a monster you have created. You may start to become discouraged. And then, if you think it through, this is when the seeds of righteous indignation or the seeds of surrender-to-goodness, or the seeds of whatever is going to inspire you to overthrow your brain, are planted. This is a good thing, despite what your brain says.

Doing this sequence of exercises should take about three minutes, or less. This sequence of exercises should be repeated five times per day, *minimum*.

This means that a person should spend a total fifteen minutes per day on these exercises, or a bit more, if desired. And it costs nothing. There is no reason not to do these simple exercises.

Even so, you will be surprised at how your mind finds time to do everything but focus on these exercises.

You might need to keep this up for several weeks, maybe even a few months. Or maybe only one, high-powered session will be enough.

If it takes more than one session, and it probably will, then day after day, week after week, as you continue doing all these prayers and affirmations and statements aligning yourself with goodness, and your own mind continues to ignore your very specific instructions, those seeds of frustration begin to germinate.

The heart will speak

In the end, your frustration with your lack of self-control and your growing awareness that you have done this to yourself – after all, these are your *own* thoughts that are disobeying you – will lead you to rescind the dissociation instruction using the only tool that can handle the job: your heart. If you don't like the word "heart," use "your trust in Love" or "Trust in a higher power."

By whatever name, your heart will lead the charge.

If you were to try to put into words that which the heart is saying, you might say that your heart was roaring "By the joyful power vested in me, I declare myself safe and ready to go back to life!"

Or you might find yourself, at the other end of the spectrum, with a heart that seems to sweetly whisper, "Thank you! Thank you! You have always been there, keeping me safe. I was never *unsafe*. I don't need to pretend any longer that I am not safe. Please, Lord, turn off (or destroy) my wrong habit."

Or your heart might be proclaiming or murmuring something in between.

Whatever your heart comes up with will be the right thing. And it will be somewhat unique. The words that others have used to translate their heart's feelings at their moment of recovery might not do a darned thing for you.

Crediting another source

I've credited the source for each of these individual techniques. We've used all of them, individually, on many, many people with Parkinson's, and have seen the unexpected consequences and distortions that have been created by the minds of our patients when the techniques are used individually.

The source for the idea of putting all these well-known, ordinarily effective techniques into a sequence was two-pronged.

Prong number one

For the first prong, I had been studying the techniques used for people who get "stuck" in post-traumatic stress disorder. In particular, I was reading yet another book by

Peter Levine, PhD, the father of modern thinking on trauma resolution. After all, my patients do seem to have developed dissociation in response to trauma. But I found myself, as before, saying to myself with each paragraph: “Parkinson’s patients *don’t* have this characteristic; they *don’t* have that symptom; they *don’t* have these thought sequences.”

People who develop post-traumatic stress disorder tend to be very right brain, very holistic in a sensory way. Brain scans show that they remember their trauma in a visual or visceral way. Brain scans show that people who have been through the exact same traumas but do *not* develop PTSD remember their traumas in a *verbal* way.¹

As a quick generalization, people with Parkinson’s tend to be very left brain, very word-based, very able to organize and compartmentalize thoughts and experiences via words: the kind of people who do *not* develop post-traumatic stress disorder.

And yet, my patients had been traumatized, and I was hoping that Levine’s work with trauma might be helpful, even if a different part of the brain was involved. I was looking for some cross-over trauma treatment method based on Levine’s right-brain work that might process the trauma that had been tucked away into the left sides of my patients’ brains.

Research in the field of treating trauma increasingly confirms that the body must be made to physically respond to the suppressed trauma, while being supported by some form of physical and emotional comfort – such as the FSR that we were already using.

But for years, we’d seen that the Yin Tui Na only went so far. Most of our patients, after a temporary respite from Parkinson’s symptoms following the FSR induced healing of their injuries, threw themselves back into Parkinson’s when they next came across any situation that made them self-conscious, anxious, angry, or whatever. After that, with the injury now gone, they might not have PD all the time, but they still had it whenever they considered themselves at risk. And as they became aware that they might slide into PD at any moment, this *fear*, the fear of the PD resurfacing, quickly became its own *constant* trigger for even more magnificent symptoms than before.

But Levine seemed so adamant: the trauma must be confronted if you want to get rid of it. It finally hit me: in a few of our patients, the trauma was only the injury. But in most cases, the trauma was, for the most part, the *lies* inflicted on the conscious mind by the subconscious mind, lies needed to maintain “not safe.” For that matter, being “not safe” forever is traumatic in and of itself.

So in addition to any injuries and emotional traumas, my patients had then added another layer of trauma: telling themselves that they were better off if they were numb (not truly alive) or that they would never, ever, be safe. That was, in itself, a traumatic event. The conscious mind was being steadily, relentlessly traumatized by itself.

The brain, or mind, needed to get some support so it could confront the fears sown by the long-term lie, “We’re better off being numb; we are never going to be safe.”

All the techniques we’d ever used to reconcile the heart and brain only worked until the patient experienced some new negative emotion: a condition in which he didn’t feel safe. As soon as there was *any* negative emotion, the dissociation returned. In other words, the

¹ Ruth A. Lanius et al., “The Nature of Traumatic Memories; A 4-T fMRI Functional Connectivity Analysis,” *American Journal of Psychiatry* 161, no. 1 (January, 2004); 36-44, as explained by Dr. Temple Grandin in *Animals in Translation*, Scribner, 2005; p. 194.

heart could comfort the brain, and the brain could feel safe for a short while, but that temporary security, in and of itself, did not turn off the underlying dissociation.

Prong number two

The second prong that led to this chapter's sequence of exercises came after pondering the above, long and hard. Though I had been fully recovered for more than a decade, myself, and was beginning to understand the problem, I was no closer to a solution that might be helpful for people who had not yet recovered. I perfunctorily turned to my meditation room.

After a quiet session of meditation and prayer, not dwelling particularly on the problem, I suddenly knew that not one, but a specific sequence of techniques, was needed.

To my surprise, what appeared to my heart's understanding was a sequence of exercises that does *not* work to end the lie "I'm not really safe yet," but which *does* makes clear to the patient the true nature of his problem: his mental lies.

This, in turn, leads the patient to overcome his problem on his own. I had long known that, more than anything, most of my patients nurtured the desire, "I'd like to be able to fix this on my own." This solution fulfilled that yearning.

For more than a decade, I had entered into or ended my prayers and meditation sessions with a plea for a technique that could end the mentally-induced Parkinson's symptoms – something that replicated the process that had occurred in those people who had successfully, completely recovered. I'd had hunches, hunches that had led me to direct my patients in each of the techniques in this chapter. Some patients had done some of these techniques for months, even years.

But when the benefit of each technique eventually proved short-term, and I, in prayer, demanded anew an answer for my patients, the answer that *always* appeared in my heart was the frustrating assurance: "They have to do it themselves."

I did share this aggravating bit of insight with a few patients, and one patient, in particular. She was a patient for whom I spent countless hours in prayer. Every few weeks I would say to her, "The answer still comes to me, 'She has to do this yourself.' Do you have any *idea* what that means?"

She would give me the no, and we would proceed with the weekly FSR session, providing temporary comfort and relaxation to whatever part of her body was particularly stiff that week.

And came the day, maybe because I finally asked the right question, when I got a different answer. I asked, "How can my patients' minds heal from the traumas of deceit that have been imposed upon them by themselves?"

The answer arrived: the preceding series of techniques, parts 1 through 4, done together, in a specific order.

This chapter tells the exact steps that were given to me in prayer, together with the caveat: "These techniques will not solve the problem. They will only serve to reveal to the

person exactly what the problem is. He can then choose to invoke all the power of his heart to override his own bad habit, or not.”

So that’s where this sequence of techniques came from.

An aside: calming techniques can be dangerous

The techniques in this chapter are extremely different from the calming techniques that most of our patients love: techniques such as massage, sleep, or stony silence. A bit of explanation is due.

Over the decades of experimenting with *powerful* calming techniques, we slowly were forced to admit that these techniques, done alone, were just as pointless, even a bit detrimental, as the relaxation methods that our patients dearly loved, which they sought out, and each of which *did* work, for a short while, until the patients learned to distrust them *because* they worked.¹

For example, we started out with a collection of famous heart-relaxation exercises. *Because* these exercises worked, and the brains of our patients were temporarily lulled into feeling safe while doing the heart exercises, the patients very soon, within a few weeks, learned to be particularly *wary* of doing anything involving the heart.

In one experiment that went weirdly awry, we had patients pretend that their heart was sealed in a steel box, with no way in or out. After about half a minute in the box, we’d tell them to let the heart out. They would usually experience a few moments, or even minutes, of parasympathetic sensory function: colors were brighter; sounders were sweeter. The whole point of the exercise was to help them realize that parasympathetic mode was good, enjoyable, and safe.

Instead, we found that, to a man, they came back us the next week saying, “I *like* this exercise [for a change]. I practiced all the time! I’m getting really good at shutting my heart in a box!”

When we pointed out that the purpose of the exercise was letting the heart *out* of the box, they would *completely* ignore us. They’d found another cool way to feel safe, and they *loved* it.

These are intelligent people. They knew perfectly well that the point of the exercise was to learn that they were safe in coming *out* of their self-imposed boxes. But they *loved* getting into those boxes.

As an example of learned wariness, one patient felt relaxed when his knee was held by his wife. But a week later, holding the knee didn’t work. The wife “figured out” that

¹ Most of the “official” acupuncture treatments for Parkinson’s are treatments to induce calmness. A colleague of mine, a renowned Chinese acupuncturist who specialized in neurological conditions, confided to me that it seemed as if his treatments on people with Parkinson’s calmed them down for a few days, but in the long run, over a year or two, their symptoms seemed to accelerate faster than the PD symptoms in untreated people. After observing the changes in my patients, drastically different from the results he was getting, he stopped treating people who had Parkinson’s, and sent them directly to me.

holding his elbow worked to calm him and stop the tremor. A week later, the elbow didn't work. But he could still relax if she held his ankle. A week later, the ankle was no good.

Each time he thought he'd found "the place," his body would quickly determine that being held at that place was not safe – it was dangerous, *because* it made him relax. Then, the patient would need to find yet another place that the brain hadn't yet grown wary over. The same thing occurred with these heart-and-brain exercises.

As the patients started being able to relax by tentatively working with their hearts, they quickly learned to be extra wary when any "heart nonsense" was suggested.

We realized that the peace and harmony type of exercise would not work as a stand-alone technique.

We also had patients use the "Thank you, I (the heart, Love, the Divine Will, etc.) will be in charge now" as an isolated affirmation. The problem with this one was that patients, for the most part, did not have a sense of what their heart was, what it felt like, and what it meant to say that the heart, an unknown quality, was in charge. They were additionally frustrated because their friends, spouses, or health practitioners (people who weren't as "smart," according to the person with Parkinson's) understood perfectly what is meant by the "feelings of the heart" or "using the heart."

Therefore, this affirmation was only effective with people who already had a strong sense of "heart." Remember, the whole point of this project was to find methods that helped *everyone* with idiopathic Parkinson's, not just the small percent (about five percent) who already had some kind of heart-awareness.

By putting the first exercise (Peace and Harmony) together with the heart's command to the brain to stop "keeping us safe," we had a slightly better response. People can more easily accept the idea of the heart being in charge *if* they've spent some time imagining the heart in a safe context.

Even so, the benefit was only temporary. As soon as the exercise was over, the patients' *minds* got cracking again, thinking of an infinite number of ways to find safety in physical strength, social status, financial security, moral purity, or whatever the patient had decided was the key to "being safe." The heart went to the back burner, to be used "only during heart exercises."

As for the next exercise, part three, telling these thoughts that they are not welcome and must leave, that has been extremely hard for *many* patients. They have pleaded with me that they do not want to do this.

For example, "These are *my* thoughts! They deserve to *live!*" and "Can I put these thoughts in a special box in my mind so I can have them when I need them, rather than banish them?" are just a few of the passionate arguments people have offered in favor of hanging on to their negative thoughts. Some of the arguments for clinging to negative thoughts have bordered on the genuinely insane.

These patients are very sincere. They do *not* want to get rid of their steady stream of self-protecting mental activity. Deep inside, their subconscious mind is doing exactly what it

was commanded to do, so many years ago. The mental wariness is just one component of an utter, hypnotic level of obedience. The brain is doing exactly what it has been told to do. Until the subconscious is relieved of responsibility, it will fight *to the death* to do its assignment correctly.

The subconscious mind does not *want* to get rid of its negative thoughts. The subconscious mind has been commanded to keep up the wariness until such time as the person is *safe*.

So what can a person do? He has to keep saying, “You are not welcome here; you must leave,” and then *immediately* immersing himself in some word or very short phrase that he knows, beyond all question, is aligned with goodness, and thus, with safety. By using these words, the brain has a harder time presenting the argument that this banishment is an evil trick, a *bad* thing.

The subconscious mind is somewhat flummoxed by these conflicting ideas: you (the negative thoughts) are banished *and* I’m focused on something that is truly good and beneficial right now. So I don’t need you, (the negative thoughts) anymore.

The subconscious has to really struggle with this seemingly conflicting approach. It is doing what it has been told off to do, after all. But here you are, telling it to go away. It cannot go away. You told it to be there, talking to you about potential dangers, keeping you safe. It cannot go away. The mind finds itself in an uncomfortable position, and its favorite defense – rationalizations, also known as “backchat” – seems to be unwanted. The mind is in a bind.

Remember, with ordinary hypnosis, the hypnosis can be ended by when the “authority” that gave the instruction rescinds the command. But in the case of the amateur self-hypnosis sort of situation imposed by the person with Parkinson’s, the mind has literally created a monster: it has gone beyond the original command and created a self-sustaining instruction so that the instruction cannot be rescinded even if the original command is remembered and withdrawn.¹

¹ We humans are special because we alone, among the earth animals, can create whole worlds in our mind and circumspectly observe them even while participating in them. As they say in Hinduism, we can be the maker of the thing, the observer of the thing made, and *be* the thing that is made. While the other animals have a self-protective function in the brain (ego), man alone is able to create a whole story line around his ego and even pretend that he exists separately from the Universal Will.

If you don’t like the idea of Universal Will, substitute for that phrase “the physics laws of cause and effect” or “for every action there is an equal and opposite reaction”. By “Will,” I’m simply referring to “the way things do work in this universe.”

Humans *can* give birth to thoughts that conflict with the ways things work in this material universe. For example, mermaids that sing like humans but breathe underwater don’t really work, but we *can* mentally create them.

This creative ability gives “birth” to what might metaphorically be called a “son” of man’s consciousness: man’s mentally created ego-based thoughts and ideas. In the biblical story of Abraham, God asks Abraham to “kill his son” (his ego-derived fantasies that exist somewhat outside of the basic universe as created by Divine Law. Abraham is so attuned with the Divine that he is perfectly willing to live without his own, ego-based creations and ego-centric interpretations of the universe. God, or the

The original instruction has moved ahead and created children of its own. To get rid of the whole mess, one must use a method of wider scope than merely retracting the original instruction: one must step away from the mind and allow the soul (or heart, or superconscious, or whatever you prefer) to destroy the entire dissociation habit: a habit of looking into the now-warped mind in order to determine whether or not one has finally attained “safety.”

The next section illustrates calling on this “larger” force.

The Sorcerer’s Apprentice

An image from Walt Disney came to my mind one day while working with yet another person who wanted to recover from Parkinson’s but who couldn’t bring himself to get rid of what he calls his “war room”: his out-of-control fear-mongering thoughts; his loyal “servants.”

The image was from the Disney movie, *Fantasia*, a short section based on Goethe’s poem, “The Sorcerer’s Apprentice”. This section features Mickey Mouse, the apprentice, who is tired of swabbing the floors.

Mickey enchants (hypnotizes) the mop so that *it* will wash the floors while Mickey relaxes. Soon, the floor is clean but the mop is still bringing in buckets of soapy water and dumping them onto the floor.

Mickey doesn’t know how to stop the mop!

He tries to negate the spell, but that doesn’t work (maybe because he still doesn’t really want to swab the floor himself). He tries various charms, similar to what he used to create the spell, but they don’t work.

The water can’t drain away fast enough. The water level is rising! Mickey tries everything to stop the mop, but can’t end the spell. He breaks the mop handle in two. The two pieces quickly turn into two mops, and the bucket brigade continues twice as fast as before.

Mickey chops the mop to smithereens. All the bits turn into full size mops, and they step up the pace. Hundreds of buckets, torrents of water! The palace is nearly flooded and the apprentice is about to be swept into a monstrous whirlpool when the Sorcerer looks in.

With a raise of his eyebrow and a casual flick his wand, the Sorcerer vanishes the water and the hundreds of enchanted mops. Mickey returns, sheepishly, to washing the floor with his single mop.

This is a beautiful metaphor for the trouble that people with Parkinson’s have gotten themselves into. They’ve figured out how to put themselves into a land somewhere between living and dying, they don’t know how to get themselves out, and all attempts at stifling their self-created fearful thoughts merely lead to a burgeoning of new fearful thoughts.

My patients often say to me, “If I could just remember how I got into this mess, I could fix it.”

Universal Creative Force, then says, “Good. I was just making sure. Go ahead and continue to have fun with your conscious mind. You don’t actually *need* to kill your ideas, you just need to be willing to kill them if they start coming between you and me (telling detrimental lies and causing you to live in disharmony with Universal Love).”

This is not true. They really, really want it to be true. But they can no more stem the flood of self-created negative thoughts than Mickey can stop the mop.

Essentially, they want to use their mind – their best friend, the thing that keeps them safe – to turn off these mind-created thoughts. That will not happen.

Everyone who has recovered from Parkinson’s has done it when they experienced a moment of realization in which they have turned control of the situation over to their heart and suddenly realized that they are OK, after all: they *are* safe.

Note my use of the words “experienced” and “realization” in the preceding sentence. Neither of these words is being used in the sense of “a thought.” The experience is a heart-felt one. Not a thought. The realization is a heart-knowing. Not a thought.

The sorcerer, representing the Divine, the Heart, Wisdom, Goodness, is needed to step in and override the mess created by Mickey’s half-baked understanding of magic and self-determination.

In a case where the mind itself is the problem, the heart is the only thing that can remove, in the twinkle of an eye, the mess that the mind has created within itself.

The prayers, affirmations, and commands written up in this chapter probably will *not* get rid of the Parkinson’s disease.

What they will do, if practiced as if your life depended on it, is prime you. They will drive home to you the degree to which your mind is no longer under your control. When you finally begin to see just how utterly your out-of-control negative thoughts are making an anxiety-driven half-dead out of you – a nearly paralyzed half-dead – you will *decide* to make a change. Your method doesn’t matter. You might become filled with the power of righteous indignation and joyously banish the wrong thinking. You might sweetly, happily “surrender to a higher power.” You might do something in between, something to which your heart guides you.

Your heart will know what to do if you give it free rein.

Whatever your PD-conquering emotion is, it will be something other than the long-term refusal to feel safe which has increasingly been your master.

The power of your emotion is the thing that will open your heart

Many people with Parkinson’s fear the enormous tide that accompanies emotions. Many have spent a lifetime “mastering” (suppressing, lying about) their emotions. Ironically, they find themselves possessed by anxiety, the sister-emotion to fear, the most primitive of all the emotions.

People with Parkinson’s need to learn that certain emotions are OK. The emotions that can power a person through to recovery are good emotions: the joy of humble, wisdom-directed self-determination, the love of life, the compassion that arises from feeling in

harmony with the universe. And all of these emotions can pack a wallop of power. Good power.¹

No matter *which* direction you go, whether cauterizing your brain cells of bad habits with the wisdom, or casting out your wrong thoughts with joyful, righteous indignation or melting with sweet gratitude, when you finally allow all the *power* of your long-stifled heart to suddenly well up within you, proclaiming that you are safe now, your self-induced long-term dissociation will be able to turn itself off. And then... the Parkinson's disappears.

If the Parkinson's was being held in place by the mind, the matter is closed. If the body has unhealed injuries from which the mind had dissociated, the injuries will soon become apparent: they will hurt. The body will be able to make an intelligent response to these pains: there might be swelling, bruising, and so on. A person might need to take an aspirin or two, or seek out a chiropractor, or wear an elastic bandage for support. But the injuries will be apparent, and they will heal in the way that normal, cared for injuries do.

FSR might be beneficial, at this stage, but it will probably not be *necessary*. The main reason for the FSR, you will recall, is to bring one's attention to the injury. If the overriding dissociation is gone and an injury is still present, the attention will, soon enough, automatically be attracted to the unhealed injury: healing will commence.

¹ As a quick aside to the inevitable backchat from my readers with Parkinson's: there are good emotions and negative, or as we say in Chinese medicine, "pernicious" emotions.

Some teachers distinguish between the two by calling the former "emotionalism." Emotionalism is ego-based twisting of emotions. Examples of emotionalism are jealousy, lust, greed, sloth, selfish desires, anger from the thwarting of selfish desires, and so on. Emotion, pure emotion, such as love, compassion, and so on, exercised while in parasympathetic mode, is good. Emotions only go "bad" when they are controlled by the ego (sympathetic "what's in it for me" mode, or dissociation, "Am I safe yet?" mode).

“Hypnosis is first and foremost a self-accepted journey away from the reality of the moment.”

- Encyclopedia of Mental Disorders

“Yackety yak! Don’t talk back!”

- The Coasters

CHAPTER SEVENTEEN

BACKCHAT

If you try doing the exercises in the previous chapter, you will see very quickly that your ego is not going to take this lying down.

Even as you are trying to do something perfectly safe, like imagining your own mind held in light, with blessings of peace and harmony, you will quickly see that your mind starts running off on unnecessary, unwanted tangents. You might be able to discipline your mind a little, the first few times you do the peace and harmony prayer, but after that you’ll notice that you are trying to do the prayer with half your brain while simultaneously nattering away at yourself about this and that.

This realization may be the fastest way to begin to recognize that you’ve got a problem: your rogue mind (directed by habit and enforced by the ego and the subconscious) is running the show and ignoring instructions from the head office (conscious mind).

Some people have found that, with steady practice, they have been able to resume control. They can slowly build a mental platform of genuinely feeling safe. Their symptoms are lessened after they practice the exercise, and they move steadily towards the decision that will end the dissociation.

But for most people, these exercises make them feel as if they are going crazy – as if there are weird personalities in their head, or even demons. This is often due to insufficient conviction while saying: “You are not welcome and you must leave” (part three of the exercises).

The brain often responds to this exercise – or any one of the exercises – with false arguments or distractions that prevent your convictions from getting a foothold. I refer to these arguments and distractions as “backchat.” One of my colleagues refers to it as subterfuge.

Sometimes, the backchat is alarmingly frank. As mentioned earlier, one patient, while doing part three, the “exorcism” part, heard an inner voice proclaim, “You invited me here, so you can’t throw me out!” Needless to say, the patient was startled. Sad to say, he also *believed* that sneaky, lying voice. Remember, the ego knows you better than anyone, and will use the arguments for which you are most likely to be susceptible.

Other forms of backchat are more subtle. The following is an example of backchat performed before the person even *started* doing the exercises.

When I asked one patient, while in my office, to try part four, picking a single word that represents, to him, Goodness, he said, “I’m really into *grace* right now. The grace of God.”

I said, “Great. For your affirmation, after you’ve thanked your mind and told it to turn off the protection because your heart will now be in charge, and you’ve evicted the negative thoughts that are used to keep you dissociated, just say ‘Grace, grace, grace’ and enjoy the gentle feeling in your heart that arises from immersing yourself in the word ‘grace.’”

My patient replied, “I have a better idea; I’ll say ‘I can choose to open my heart to the grace in the universe.’ I like that.”

I replied, “You’ve just missed the whole point of the affirmation.”

I then pointed out to him that the affirmation is one or two or three words that refers to something good that is outside of, and more powerful than, the ego-based mind.

His modification of the one-word affirmation was a statement that *he* was in charge (rather than the Love in the universe), and that he was going to mentally *choose* to open his heart, *when* so inclined, so that some universal grace might be admitted – when he gave it permission. With the insertion of a few clever words, he’d perverted the whole intent of the affirmation so that it was now about himself and his continuing ability to maintain control over his own heart.

Again, the point of the affirmation word in part four is to focus outside of oneself, on something wonderful that exists outside of, and is larger than, oneself.

Never underestimate the wiles of the ego.

Another patient, in response to the suggestion that the exorcism be followed by a simple word or phrase that brings one’s focus onto something of pure goodness, said, “I know, I’ll sing my favorite spiritual chant.”

She then launched into an insipid, sing-song rendering of a song that she had clearly sung thousands of times, “I’m placing flowers at the feet of the divine Mother...”

I asked her to stop, and then said, “If your exorcism works, and the negative energy leaving your body takes the form of a hideous monster, with jagged fangs, and he’s angry at being exorcised and he’s going to attack you, is that what you would come up with to protect yourself? That little song?”

She exclaimed, “No! I would yell ‘God! Help me!’”

I answered, “Then that’s what you might say when you need a “positive word” to keep your focus on the goodness in the universe that is keeping you safe from all the monsters in your head – monsters that you’ve created. ‘God! Help me!’ sounds more like ‘a few, positive words’ that can keep you focused on something greater than yourself.”

She was very reluctant to accept this idea. She argued, “But I can’t go around yelling at God to help me all day long.” (I was not trying make this patient a believer in God. At our first meeting, she identified herself to me as a God-based spiritual *instructor*.)

I agreed that she couldn't go around yelling out loud at God *all* day, and pointed out that she only needed to do it *mentally*, for a few moments, five times a day, until she got sick and tired of doing it with no result – at which point she could ask her heart, or her God, or whatever she trusts to be good, to take charge of her life and make her safe.

Then, as soon as she admits that she's completely, unequivocally safe, the dissociation can turn off.

After that, she can go back to being a healthy person so long as, in the future, she uses sympathetic mode when she's scared instead of playing dead when she's scared.

She looked dubious. She preferred the song. Several times, later in the session, as I was explaining things she disagreed with, she automatically whimpered that same song. I asked her if that song was helping distract her from what I was saying – was she using the song as part of her “zoning out: playing dead”? That song was the vocal equivalent of sticking her fingers in her ears and singing, “I'm not listening...”

Although she seemed very intelligent, she insisted that a *spiritual* song – a song with *spiritual* words – could not possibly be used as a ploy of the subconscious.

I reminded her of that great commandment – don't ever take the name of God in vain. “In vain” means “without success.” This commandment means, among other meanings, “don't ever use the name of God in a sing-song, repetitious, mindless manner.

She was using that song as “backchat.”

When you use the simple, positive word, or you might refer to it as calling out to God, or goodness, or The Force, or whatever it is that *you* call out to when you are in mortal peril, call it out as if you mean business. That's how you need to call out when you are proclaiming your positive word.

As if you mean it.

Patient results

Do not be fooled by the seeming simplicity of these exercises. They are powerful, and focused on goodness. Below, some quotes from patients after doing the exercises for a *week* will demonstrate how powerful they can be.

Bear in mind as you read these emailed patient reports, they were writing to me prior to my recent decision to include the word “exorcism” in this book. I did find it interesting that, with no such word or related vocabulary on my part, many people who tried the exercises came up, on their own, with the word “demon” to describe the powerful thoughts against which they were struggling.

“Am I going crazy?”

“I'm experiencing a *terrible* week. Realizing that I'm not in control does not seem to be a liberating experience for me. The exercises started out easy as described and got difficult, now impossible, with worsening tremors, palpitations, suicidal thoughts and despair. I feel like my whole world has imploded [because of these exercises] pushing myself three or four times every day to a crisis point in the hopes that some words will come to me to snap me out of this trance or whatever it is.

Instead, I find myself losing heart for this process and having these frightening suicidal ideas. I have been pleading with the Universe to help me find the voice and words to end the dissociation – to no avail. If I try to calm myself, am I just feeding the demon? If I do nothing then it's like giving up – so what do I do?

My family and friends think I'm crazy. Having these reactions [to simple affirmations] makes me wonder if they are right."

I wrote an encouraging reply, and she answered, "Thank you for your immediate reply. I didn't realize until I read it that I was expecting you to cut me loose – tell me that I didn't really want to recover and should go elsewhere – talk about a negative thought!

"It's funny, but at one point, I did wonder if the Universe was helping me to deal with what I was going through, in answer to my prayer, but I guess I was so frightened that I didn't really believe that."

As an aside, a few weeks later, this patient finally got up the nerve to verbally stand up to her brothers, who had been demanding that she take antiparkinson's medication. After this act of self-confidence, she started having periods of much easier movement in response to the exercises – interspersed with the old rigidity whenever her thoughts went into the old downward spiral.

"It's like a holy war"

Another patient wrote: "I have been doing the exercises every day, several times a day, for two weeks. I have some resistance to the terms at times but I just ignore that or adapt it to more Buddhist terms, but essentially I find the exercises so far have been very effective. I must say I am feeling more peace and harmony in my head and heart...I'm even getting a more stable *feeling* of safety, a sense of spaciousness that is real Refuge at my heart. And for periods afterwards I feel that...haven of safety pervading myself and everything. I'm amazed at how my Guru is listening and responding, even to so-called non-Buddhist "prayers"!

He continues, "At times I feel a demonic surge of distraction or rebellion coming from a more sub-conscious place, vehemently trying to sabotage, especially when the going is good. It's like a Holy War, one side giving up the selfish life and relying wholeheartedly on my Guru where all happiness and goodness come from, or ME staying in charge with my bitter, terrified mess but at least holding on to 'power'."

These simple exercises, three minutes of positive thinking practiced five times a day, were able to provoke the tempests of emotion suggested in the above two emails within just a few weeks of starting in on them.

I have no idea if the first writer feels affiliated with any religion. The second writer is a Tibetan Buddhist with long experience in meditation and self-analysis.

While on the subject of spirituality, I will also quote a third patient who never did try the exercises: "If I have to believe in any kind of spiritual angle in order to recover, I'd rather have Parkinson's disease!"

She only contacted me once, accused me of pushing a spiritual agenda, and I never heard from her again.

Fearful of a lurking spiritual overtone

Just in case you are suspicious of anything smacking of spiritual or esoteric endeavor, please know that everything I'm offering here can also be understood in non-religious terms such as love, grace, and basic high school physics. It's just easier to use a spiritual vocabulary. Spiritual vocabularies were developed for the express purpose of helping us learn to listen to our hearts and turn off our egos – so the spiritual terminologies are very convenient – but not necessary.

Many of my patients have recovered with no overt “spiritual” overtones showing up at all. Then again, most of these patients were still in very early-stage Parkinson's disease. The ones with more advanced Parkinson's have usually felt some sort of spiritual tug during their recovery.

Also, consider this: if your brain is telling you to avoid anything that suggests a positive outlook, such as is offered by many world religions and non-denominational self-help programs, is it possible that this avoidance is being prompted by your self-serving ego?

Eye movement and mental backchat

It is not uncommon for a person with Parkinson's, during the course of everyday conversation, to indulge in verbal “backchat” with a loved one or health practitioner as to why something has to be done “his way,” to the point that he finds himself backed into an utterly illogical statement. At this moment, he feels he is in danger: rational thought is at odds with his “stay safe” argument.

This stand off is very difficult to describe, but close friends and spouses of people with Parkinson's will know what I'm talking about.

Very often, when this occurs, when the person with Parkinson's is at risk of having his argument shot down for being illogical or, God forbid, incorrect, the eyes of the person with Parkinson's will dart quickly from side to side.

Immediately after this movement, the eyes will have a fixed, slightly glazed look. Of course, some people get the glazed look without doing the eyeball movement. Once this “look” is in place, the person with PD will have no problem in presenting some utterly illogical, self-preserving statement with no realization whatsoever that he is making no sense. He may be able to tune out the other person altogether even while pretending to be listening.

This is a fascinating process. I can only make conjectures as to what is technically going on in the mind of the person with PD when this occurs, but I suspect it is akin to a psychological state named “dissociative identity disorder,” previously known as Multiple Personality Disorder. I would really love to have some brain scans showing what is happening during these moments.

Many spouses and friends have observed the darting eye movement and/or the temporarily glazed eyes, together with the realization that all meaningful communication has ended: the person with Parkinson's has become a brick wall until such time as danger he perceives has passed.

I suspect that, in these moments, which sometimes last until the other person has left the verbal battlefield, the person with Parkinson's is delving into a slightly different

personality at this point: a personality that presents a calm face to the world while being *unable* to logically process the words of whomever he is speaking with.

I recall that, prior to my own recovery from Parkinson's, when confronted with these situations, I was able to enter into a state where my own mind was able to tune out the other person's words. If a person was saying things to me I didn't agree with, for example, "You *think* too much!" (a common criticism of many people with PD), I would switch into a state in which a monologue featuring self-protective advice ran in my head, side by side with the words of the person with whom I was speaking. The monologue ran something like, "This person doesn't really know. He doesn't understand. Pretend to be listening. Do not be affected by what he is saying. He can't be trusted because he doesn't know..." and so on.

I sometimes busied my mind with counter-specifics such as "It's impossible to think too much! He's just jealous because he's not as smart as me." In general, my stream of thought was designed to negate or block any thoughts that might interfere with my own personal thinking. And I was very, very good at it.

Since recovering, I am able to actually listen to others and consider what they have said – even if it contradicts my thinking – without immediately saying silently to myself that the other person doesn't know, is ignorant, doesn't understand, and/or how I personally am an exception to whatever they are discussing.

I mention this mental defense trick because this is also a form of backchat.

"But a busy mind is normal!"

Because a surprisingly large percentage of my PD patients have some background in spiritual seeking and meditation, they often say something along the lines of, "But everyone has a monkey mind [thoughts that run out of control, undisciplined backchat], but not everyone has Parkinson's disease. So why do I need to get rid of *my* errant thoughts?"

People who don't have Parkinson's will have already figured this out, but people with Parkinson's usually cannot understand things that they have purposely trained themselves to not understand; so for my patients, here goes.

Most people have thoughts that keep themselves somewhere on the continuum between parasympathetic mode (relaxed and calm) and sympathetic (fight or flight). Most people have no capacity for and no interest in turning off their own somatic awareness.

People with Parkinson's have trained their mind to use thoughts that keep them somewhere on a continuum between dissociation (nearly dead) and sympathetic (fight or flight).

There's a significant difference there.

Turning off thoughts in order to feel calm or joy: normal people

When most people are *able* to turn off their endless thoughts (usually ego-based, and therefore sympathetic mode-based), they decrease their use of sympathetic mode and, by *default*, effortlessly drift into the relative peace and calm of increased parasympathetic mode.

For example, most people who start to practice a little meditation find the process a little bit peace-inducing, even if they can't keep it up for very long due to their poorly disciplined mental habits. This is the whole point of most spiritual exercises: getting people out of sympathetic mode so that they automatically relax into parasympathetic.

But people with Parkinson's might practice meditation techniques for years and *never* experience the joy or peace of meditation. Instead, they might find their meditation time spent in a fierce battle with their undisciplined thoughts, with self-chiding for their inability to "do it right," and a preference to just go to sleep. Even if they *can* turn off the sympathetic mode nattering voice, they are not allowed to enter into parasympathetic mode because they have not yet decided that they are "*truly*" *safe*. They haven't yet turned off the dissociation, therefore they cannot really get into a significant degree of parasympathetic – at least not enough so that they *feel*, or feel *good*. And they might have one really strong reason or a bazillion assorted reasons why they might *not* be safe.

Again, when many people with Parkinson's *do* manage to calm the mind, they are *not* moving into parasympathetic (unless they happen to be doing a "safe" activity at the moment). Instead, when they decrease sympathetic mode, they usually move, automatically, towards a deeper level of dissociation or shift towards the sleep mode, the unconscious mode.

If they *have* managed to slide towards parasympathetic mode, it may be a very guarded, minimal degree of parasympathetic.

If they *can* temporarily control their negative thoughts, using mantras, massage, or meatballs, their sympathetic mode anxiety decreases, but they do *not* experience the normal shifts associated with increased parasympathetic mode: joy, increased *pleasant* sensory awareness such as colors becoming brighter than usual, hearing that switches target (for example, stops picking up on traffic noise and instead notices the sweet bird song), a stronger awareness of heart-feeling than usual, and/or a stronger sense of heart-based poetry and/or internal music.

So, in answer to the question, "Everyone has restless thoughts, what does it have to do with Parkinson's," the answer is, "Most people have restless thoughts – thoughts aligned with sympathetic mode as opposed to parasympathetic. People with Parkinson's have aligned their restless thoughts with sympathetic as opposed to dissociation."

"But my thoughts can't be just like those of other people with PD. I'm different."

In case I haven't mentioned it yet, no two people with Parkinson's are the same. They have different *degrees* of using dissociation, different preferences and parameters for when and how much to use dissociation, sympathetic, parasympathetic, and sleep. These modes are not black and white, and they are not a fixed amount. A person with Parkinson's disease is on a slope: his use of the various modes is slowly changing away from parasympathetic, slowly getting too tired to *vigorously* maintain sympathetic, and increasingly caught up in dissociation while insisting "I'm not safe yet."

Parkinson's is *not* a static condition. It is a constantly changing condition, one that worsens steadily over time as the person's coping mechanism (dissociation) creates more problems than it solves, and the person with Parkinson's keeps trying to solve the resultant

problem by getting “even more safe” or using even stronger mental motivators (fears) to keep going – thus compounding the problem.

No two people with Parkinson’s are alike. Some people with Parkinson’s *do* have a few “safe” activities during which they are able to just enjoy themselves – in parasympathetic mode. However, as the Parkinson’s progresses, their ability to “lose themselves” in parasympathetic mode usually diminishes.¹

So please, if you have Parkinson’s, as you read the following, please stop trying to figure out reasons why the following doesn’t apply to *you* because you aren’t *exactly* the same as the descriptions below.²

Instead, try to understand that, with a self-induced mental condition, everyone will have his own presentation, depending on how he established his own ground rules. For a change, try to understand the following as a general principle (parasympathetic thinking),

¹ For example, many of my Parkinson’s patients who want help to deal with their increasing anxiety insist to me that they “used to love music” and “music calms me down.” When I ask if they still listen to music, to take advantage of its calming effect, they usually say no. When I ask why they no longer listen to much music, they tend to give the same answer: “It distracts me from the things I need to think [worry] about.” I ask, “Isn’t that the reason that you *should* listen to music?” and they reply, “Music that tries to calm me down is an irritation: it makes me more agitated because I can’t concentrate on the things I need to be dealing with [my anxieties].”

Music is an irritation when a person is in a high level of sympathetic mode. When a driver becomes lost while on the road, the first thing he does is turn off the music. This makes no sense on the surface. But in sympathetic, flight or flight mode, any sound that might mask danger is automatically perceived as irritating. People with Parkinson’s increasingly lose the ability to spend time in parasympathetic mode, a mode in which music can be pleasant.

Anxiety is a condition in which one has a high level of sympathetic mode thoughts, but a low level of adrenaline for dealing with them – usually because there is nothing, actually, to be physically “done.” Low levels of adrenaline and high levels of sympathetic mode thoughts leads to anxiety – which in itself is worrisome, and leads to further worried thoughts. In a person with Parkinson’s, this anxiety is yet another reason to feel “not safe.” And so the cycle feeds on itself. Meanwhile, the person who wants help for his anxiety reports that he can’t participate in calming activities such as listening to music because the distraction prevents him from focusing on his anxieties – which he needs to do, because he is anxious. This is an example of a seemingly irrational position. But if you start to discuss ways to remedy this situation, the person with Parkinson’s is very likely to dart his eyes quickly from side to side and then reply, with glazed and staring eyes, “You just don’t understand.” No more productive conversation will be possible after this, until the subject has changed and the eyes drift back to a more normal (less fixed, or glazed) look.

² I have *so* many patients who have read my entire book and then said to me something like, “I’m not sure I have Parkinson’s, because a sentence you wrote on page 196 in the second paragraph [or some other highly specific sentence] doesn’t apply to me *at all*. Therefore, your theories don’t apply to *me*. I won’t be able to recover like your other patients. *But* I want you to try to fix me, anyway, because I’m determined to recover. And *I* don’t need to do the mind-changing work because I’m different because...[because I’m religious, or because I’m not religious, or because mom always liked my sister best, or some darned thing].”

This is another form of backchat: the “I’m different from all those other people” argument. This backchat, like all the backchat, is pernicious, fallacious, and generated by the instruction to stay dissociated.

rather than in terms of how it pertains to *you* (sympathetic and dissociated thinking), and try to not argue in defense of your position. No one is watching you read this. You are safe. Just relax and read the following in a detached, loving manner.

In order to recover from Parkinson's, the conscious wariness or negativity of the conscious mind, kept in motion by the subconscious mind, which is motivated by the instruction "stay in dissociation because we're not safe yet" must be turned off via instructions from a higher authority: the superconscious (or "heart," or insert here your own name for Universal Goodness, Soul, Savior, Buddha nature, love of Allah, etc.).

Only a *higher* authority, such as the heart-directed conscious mind, can stop the "Stay dissociated!" command that was issued long ago to the subconscious mind by a terrified consciousness.

So long as you are busy paying attention to the rantings of your frantic mind, you cannot be paying attention to the higher authority, the one that holds the key to turning off the dissociation.

Once you have successfully turned off the dissociation mode by realizing that you are safe and you *can* once again access *parasympathetic* mode, you *can* go back to having a restless mind, negative thoughts, and all the rest – just like "normal" people.

But you will be able to do it the way that other people, *healthy* people, do it: using sympathetic mode. Don't worry: you will still be able to be worried, practical, organized, punctual, and all the other qualities on which you pride yourself. You can also still be paranoid and nasty, qualities of which you are ashamed, if you want.

You aren't going to change all that much, actually. Many people with PD have told me that they are afraid to change their way of thinking. Their reasons range from "I don't know who I'll be if I get rid of my fears," to "If I conquer this, I'll die because my soul will have become perfected."

Both of these lines of thinking, and everything in between, is wrong: just more specious thinking by the canny mind.

You will still be you, warts and all. It's just that you'll experience your personality using sympathetic mode and/or parasympathetic mode, as nature intended, rather than being *compelled* into your behaviors by a cleverly implanted lie: "You are better off if you stay dissociated! Be wary or *die!*"

Of course, if you should choose, at some later date, to decide that the best way to deal with some new pain is to dissociate again, you can do that. Only maybe you'll think twice before doing so. And maybe you'll remember to give an instruction with a limited time duration, such as "I don't want to feel this pain until the weekend."

For now, you just need to turn off the *ongoing*, open-ended instruction that you came up with years ago, one that says: "The best way to deal with pain and fear is to play dead - indefinitely."

You don't need to turn into some sort of empty shell, or a elevated spiritual being with nothing left to live for.

Once you've turned off the ongoing instruction to stay dissociated indefinitely, and decide that you are safe, after all, you can actually resume living. You will resume using the normal neurological modes that everyone else uses. You can still have a restless mind, you can still entertain anxious thoughts, if you so desire. But you can entertain them in sympathetic mode, as opposed to dissociated mode.

This means you'll still be you, but you won't have Parkinson's. For example, if you're using fear-based thoughts while using *sympathetic* mode, rather than dissociated, you can still walk easily and you don't need to tremor.

Won't that be nice? Do you notice how your brain is frantically looking for loopholes in the above section? Those thoughts fit under the heading of backchat.¹

Summary of the techniques

The whole trick is turning off the ongoing instruction, created long ago, that says, "We don't like what is happening! This is going to be painful! Let's be numb!"

To that end, you can practice the four exercises described at the beginning of this chapter. Maybe you'll find your heart opening up and surrendering control to your heart, or to a higher power, as you do the exercises. Maybe you'll find the backchat disappearing when you exercise it. Maybe you'll get sick and tired of not getting anywhere with these exercises, or you'll get terrified by the level of backchat that erupts. But if you stick with it, at some point you'll realize that you *can* command, with your heart, rather than your brain, and your heart will tell your brain that you are now safe.

It doesn't matter which path you take. The great thing is to come back to life, one way or another. As a side effect, the Parkinson's will go away.

I have been on the receiving end of thousands of hours of specious backchat from my patients with Parkinson's. The high level of intellect of most people with Parkinson's would render their backchat delightful, if it weren't for the horrible, even painful, Parkinson's symptoms that are eventually created by this "cleverness".²

The arguments are clever, analytical, and self-preserving. The friends and spouses of people with Parkinson's have known for years that they will never win an argument with a person with Parkinson's – the self-preservation via mental justification instruction is too deeply imbedded.

I realized years ago that no one, no matter how wise, loving, or honest, can win an argument with a person who is willing to be nearly dead rather than be wrong.

¹ My colleagues have various names for backchat, names like "self-sabotage." Many spouses have referred to it using terms such as "a clever answer for everything so that (s)he is never wrong."

² Specious [definition]: showy, beautiful, plausible, seeming to be good, sound, correct, logical, etc. without really being so; plausible but not genuine. Webster's New World Dictionary; 1970.

So if this material seems to be written a little more pointedly than you'd like, please understand that I am trying to break through the defenses of the reader with Parkinson's. I am blunt in hopes that the reader with PD can maybe begin to see himself in a way that will be helpful, rather than in a manner that further propagates the Parkinson's symptoms.

“Your vision will become clear only when you can look into your own heart. He who looks outside, dreams; he who looks inside, awakes.”

- Carl Jung

CHAPTER EIGHTEEN

FULL RECOVERY: A CASE STUDY

Case Study #1: Janice Walton-Hadlock

This case study picks up where we left off in chapter, five, where I was heading off to my meditation room.

I'd been forced to admit I didn't have doctor's disease. I had Parkinson's.

I had *all* the major symptoms of Parkinson's. I'd had many of the symptoms at a low level for many years. They had been getting steadily worse and had recently become slightly apparent to others. For two days, I fell into a deep gloom.

Suddenly, every “abnormal” movement I made was scary. Everything that was physically hard to do, such as turning over in bed or getting up off the sofa when “too relaxed,” was scary. Three days earlier, I'd thought of these difficulties, and even thought of my infrequent, hide-able tremor, as “normal, age-related behaviors.” Now they were symptoms of Parkinson's.

And here is where my recent familiarity with Parkinson's played to my advantage. Unlike many of my recently-diagnosed patients, I knew that what I had was a really, really bad syndrome.

So many of my patients have said, “Well, it's only a tremor” (or whatever mild symptoms were presenting), “and it's not too severe – I can hide it when I need to – so I guess I'm lucky.”

I knew better: I knew exactly what was meant by “Parkinson's is a degenerative disorder.” It means you might only have mild symptoms today, but every day you are going to get a little worse and a little worse and one of these days you'll be helpless and utterly dependent on others for everything.

My volunteer patients had only mild symptoms back when they'd first been diagnosed. Now many of them were taking levels of medication that left them thrashing violently, and even at this level of medication, they were in wheel chairs, unable to walk. My patients' symptoms, all of them, had started off slowly and now many of them were unable to talk, walk, or feed themselves. I knew, at the moment of my diagnosis, what lay ahead, unless I was able to recover.

Therefore, I was more despairing than many of my recently diagnosed, somewhat naïve patients – those who assumed that their mild symptoms weren't really going to be a problem. I think this was helpful in forcing me to take the steps I eventually ended up taking.

On the other hand, I had seen people recover from this illness. Therefore, I should have been less depressed than most people who receive a diagnosis, right? As soon as I was diagnosed I said to myself, “Well, you know this illness is *not* incurable, you've seen people recover.” (I spoke to myself in the second person, saying “You” instead of “Me.” I usually did this. I almost never thought of myself as “me.” This might be related to the pathology of dissociation. On the other hand, it might be the *helpful* circumspection of cognitive behavioral therapy. I'm not going to get caught up in worrying about it one way or the other. I merely mention it.)

Here's where it got weird. As soon as I said to myself, “You've seen people recover,” a voice inside me said, “But you're probably not going to be one of the lucky ones.”

Huh? I wondered where this “not one of the lucky ones” voice was coming from. Like most of the people I've ever met who have Parkinson's, I too have always considered myself pretty capable, master of my own ship, very self-disciplined, able to do whatever I set my mind to. One of my college-days credos was “If other people can do it, then you can, too.”

So where was this “You won't be one of the lucky ones” voice coming from?

Now, the odd thing is, I'd already heard “But I probably won't be one of the lucky ones” a dozen times before...spoken by my new patients.

For some reason, these highly intelligent, highly capable people, people of great resource and will power, were all certain that, when it came to overcoming Parkinson's, they were “different” from my patients who had recovered.

All of them, in fact, were certain that they weren't going to be one of the “lucky ones.” They were going to work with me, they were going to keep a positive attitude, they were going to give it their best shot. But, they were not going to be one of the lucky ones. If they *did* recover, it was going to be *very* hard, and take a *very* long time.

Remember – those first several patients that had already recovered had *not* been trying to recover from Parkinson's disease. I had been treating their other, “non-Parkinson's problems,” in their legs, feet and arms. And then, amazing to all of us, they *accidentally* recovered from Parkinson's. I almost had to wonder – if they'd known their foot-therapy treatments were able to make the PD symptoms go away, would they have been able to surrender so completely during those snuggly ankle-holding sessions? Would they have been able to recover if I'd told them I was treating the Parkinson's disease? Or would they have been more guarded and thus less likely to recover?

Subsequently, I'd treated a few more unmedicated patients with Parkinson's who had recovered, but even so, we hadn't been *assuming* that they were going to recover. It was only when I started having some confidence that people were recovering from Parkinson's, and I was beginning to treat people with this specific goal in mind that I started hearing, “I won't be one of the lucky ones; if I do recover, it will take a long, long time.”

So here I was, knowing better than most what advanced Parkinson's really looks like, so I was desperate. And I was listening to myself produce this offensive, whiny statement that, even if there *was* a cure for Parkinson's, *I* wasn't going to be one of the lucky ones, a statement that I'd heard a lot, and greatly resented, from my own newly signed-on patients with PD.

I let myself wallow in self-pity for two days, until I was lucky enough to remember one of my secret wishes for my patients. I had often found myself saying to myself: "I wish my emotionally negative patients could find *some* way to be grateful for things, even though they are dealing with challenges."

I had long been aware that those of my non-Parkinson's patients who were able to be circumspect and grateful for some aspect of their problems, as opposed to whiny and self-pitying did a lot better in recovering from them or at least suffered a lot less while going through them.

These wiser patients tended to acknowledge 1) some kind of silver lining to every cloud and 2) their own past behaviors had probably contributed to the situation in which they now found themselves.

When my PD patients told me flat out, "I'm *not* going to be one of the lucky ones!" or "Even if I do recover, it's going to take a really long time," I found myself thinking, resentfully, "If that's what you think, then your thinking will make it true."

And here I was, behaving just like those people.

Until I dealt with my bad attitude I wasn't going to waste my time having someone hold my foot injuries, assuming I even had any (I didn't recall the injuries until after I recovered).

First things first. I needed an attitude adjustment.¹

¹ I have already mentioned Cognitive Behavioral Therapy as a potentially helpful tool for someone wanting to recover from Parkinson's. My spiritual training, for over twenty years, had included circumspect observation, objective analysis, and regulation of one's own thoughts, so as to be on the lookout for negativity, self-pity, and so on. This practice, which is a form of cognitive behavioral therapy, was helpful training in my ability to recognize, this day, that "I'm doing something wrong!" when I responded to my diagnosis with uncharacteristic self-pity and despair.

Although I have not spent a lot of text describing Cognitive Behavioral Therapy, this therapy can be crucial in recovering. *I* have not discussed it in detail because this therapy is taught in many, many books, and I am trying to keep this book as short as possible.

Most of the verbal counseling that is provided for patients who come to visit the PD Treatment Team of Santa Cruz is just variations on Cognitive Behavioral Therapy. People with Parkinson's are smart enough to read up on this therapy and do it themselves, without paying others to coach them through it.

This brings up an important point: many times, people contact us because they want us to "cure" a very elderly parent who has been diagnosed with Parkinson's. These very elderly patients are clearly no longer interested in or capable of changing their own patterns of thinking. We try to discourage these people from entering into our program. They have very little chance of success and a very great chance of feeling confused and frustrated.

I marched myself into my meditation room and told myself, “You’re going to stay in here until you’re grateful for everything that God has assigned to you. And He’s going to know if you’re lying.”

I spent some time in the usual ineffective prayers and ritual, because I didn’t know where to begin. So I started with a basic prayer. Then, still not knowing what I needed to do in order to be grateful, and stewing in self-pity, I started reminding myself of all the previous times in my life where my desires had been thwarted. Poor me.

I started musing on my childhood, a period of time most politely described as “walking on eggshells.” As a young child and teen, the explosive madness around me had been unpredictable. At times, rightly or wrongly, I feared for my life.

In our culture, we don’t think that little children truly think of suicide, but one of my most frequent thoughts was “Hang in there, someday you will be dead, and this scenario (my childhood) will be over, and you’ll be at peace.” By the time I was five years old, I had learned that children got to leave home when they grew up, which was a relief. I decided that I could be happy either way – leaving home or dying.

As an aside, and not that it is important, I’m told I didn’t speak until I was four years old. I do not have good recall of the events of my childhood, but I have very clear recall of the sense of being in danger. I was only safe when my father was visibly present.

So there I was in my meditation room, recently diagnosed with Parkinson’s, and I decided to look honestly at this regrettable childhood. Poor little me.

Detour.

The following is a short detour in which I must explain those aspects of my personal philosophy that were extremely helpful in recovering from Parkinson’s disease.

First, you must know, with regard to what would now be considered child abuse, I never said to myself, with regard to my own childhood, “How can anyone treat an innocent child in that manner?”

Many of my patients *have* made this “poor me, I was only an innocent child, treated unfairly” statement with regard to some perceived cruelty in family life or politics, which is why I mention it. Most of these people have refused to consider dealing in a *healing* manner with their past hurts because they have been deeply attached to feeling sorry for themselves and resenting the perpetrators. They say to me things like, “I’ve forgiven that person; I’ve forgiven him every single day for the last twenty years!” This attitude is *not* forgiveness, nor is it helpful in recovering from Parkinson’s disease.

I don’t know how I felt about the “Fairness of Life” as an infant, but I do know that, since my teen years, I have never said, “Oh, poor me, I was an innocent child and yet I was unfairly born into a situation that I didn’t like and this wasn’t fair!” I will explain why in a moment.

For now I will say that life often *appears* unfair, because we do not have the whole story. However, based on my understandings of basic physics, I am certain that, whether we know the whole story or not, we can be certain that life is fair. If anything, the universe is unbalanced in favor of forgiveness.

In retrospect, and from what I've seen in those who have been able to recover and those who are determined to cling to attitudes that prevent recovery, I can say with certainty that my attitude towards the ultimate fairness of life was helpful in my own recovery from Parkinson's.

Because this issue comes up so often with resentful patients or with patients who imagine that their own mental process is somehow unique – who also are unlikely to recover so long as they cling to these fallacies, by the way – let me say that I have spent time with many children and newborn babies, and I have never met an “innocent” child.

Children are born with a past and with certain desires for what they hope to do in any given lifetime. Children *choose* the families into which they will be born – some more deliberately than others.

These choices often have more to do with what lessons we know we need to learn than what we “want”. Therefore, we might be born into a situation that is brutal, but it's the situation we need at that time – and we have chosen it, or those spiritual teachers we love and trust have chosen it for us.

And if you are wondering if this line of reasoning condones abuse, no, this does not in any way condone abuse. Abuse is always wrong. But it does happen, and there is a reason it happens. Either we have universal laws of cause and effect or we do not. If we do, there are reasons for what happens to us.

If we do *not* believe in cause and effect, or the other laws of physics, then we are wise to be in a constant state of fear. (And if there are no laws of cause and effect, or of gravity, or all the other laws of physics, then there is no way to predict what is going to happen if I let go of my pencil – will it fly up? Down? Sideways? Will it disappear?)

But even if we don't like the fact that this universe is built around the principles of cause and effect, laws of action and reaction, it is a real fact. If bad things happen to us, there are reasons for it.

As for staying fearful or dissociated because we don't like receiving our just desserts, that's just not healthy. Better to deal with things than to live in constant dread.

Our bodies do not live well when we are in a constant state of fear. And if we deal with that fear through dissociation, rather than sympathetic mode, we will develop Parkinson's. If we use just sympathetic mode – without dissociation – while choosing to stay fearful, or driven, or perfectionist, we merely develop anxieties and a nasty personality – normal problems, but not Parkinson's.

I am not a fatalist. Just because someone *deserves* a painful comeuppance for some past transgression doesn't mean he *must* experience it: he might, instead, be forgiven by the very person who was “assigned” by fate to administer that punishment.

On the other hand, that person who administers the karmic retribution, acting out of anger or out of ignorance, sets himself up to receive, at a later date, a similar fate.

How can we each contribute towards stopping this very unpleasant but very “fair” bound and rebound of actions? Forgiveness. Forgiveness is the answer.

During a strange, brief experience in my teen years, I unexpectedly beheld a scenario of a past-life action. It accounted *exactly* for some highly specific, highly unpleasant aspects of my childhood. At the time of this experience, I had never heard of reincarnation. I knew nothing, at that time, of the odd “loincloth” clothing, smeared ashes, and jungle-ashram

lifestyle I observed in this unfolding scene, nor did I have, at that time, a philosophy that enabled me to make sense of what I was helplessly experiencing. But as I watched the very brief scene that flashed across my mental movie screen as I stood, frozen motionless, with the breath sucked out of me, in the middle of the kitchen one afternoon after school, I knew I was seeing a memory of myself.

Anticipating the reader's question, I was not sick with the flu at this time, and I did not drink, smoke, or use mind-altering drugs.

From that moment, I was blessed with the knowledge that, however much I might not like it, there was logical *reason* behind the certain painful aspects of my childhood. I was, from that moment, in awe of the perfect laws of cause and effect in the universe. Up until that time, I had thought of cause and effect as mere physics principles, notions that only applied to moving bodies, molecules, atoms, but not to me.

But from this moment, I had to accept that, even if I didn't remember them, the negative actions and thoughts that I had once perpetrated were the initiating forces that led to me finding myself on the receiving end of these same actions and thoughts at some later date.

I might not feel the consequences until many lifetimes later, but when I found myself in a stink, it was because of something I myself had previously set in motion through a wrong behavior.

In other words, there was no sense in being bitter about what happened in my life. Everything was happening for a reason and with perfect fairness. When things happened to me that I didn't like, I had played a causative role in those happenings.

I was to come to understand, much later, that in fact, we *don't* need to suffer for many of our ignoble past actions. Much of what we do in error is instantly forgiven by Love, a poorly understood but highly active force in the universe.

But if we think we are doing something wrong and *choose* to do it anyway, we subconsciously tell ourselves "some day I will have to pay for this." And if we create *that* story, we will have to fulfill that thought when "some day" comes.

The reader does not need to agree with any of my personal philosophies in order to recover.

But, based on what I have seen from working closely with those who *have* recovered and oppositely, with those who have struggled with partial recovery for years while being *unable* to say to themselves "I am safe now," I can see now that one's personal philosophy can be very important in determining whether or not a person can bring himself to recover.

After learning about dissociation and the need for a person to be able to say "I am safe now," I only now understand why my own personal attitudes were extremely helpful in recovering from Parkinson's.

Also, the actions I took after being diagnosed with Parkinson's (deciding to work on my attitude before working on the injury) might not be understandable to the reader unless the reader knows of my firmly held beliefs.

I have no interest in sharing my deeply personal beliefs and experiences with strangers. However, as a scientist, I must include them as possible factors in a recounting of how and why I recovered from Parkinson's, a syndrome whose symptoms are highly susceptible to psychological influence.

This is the end of the “detour.” Back to the meditation room!

There I was, sitting in the meditation room, musing on the worst parts of my childhood, the parts that I still resented. I grudgingly admitted that I’d learned a lot during those years.

I had learned to be emotionally stoic and extremely independent. My childhood experiences helped me develop a supreme disinterest in the self-indulgence and/or lack of emotional control that leads to the expression of extreme mood swings and the appearance of, if not the fact of, demonic possession.

I had learned to be *unimpressed* by and *not* attracted to the allure of inappropriate (ego-driven) use of psychic powers. In many ways, this difficult childhood had given me many useful strengths.

And yet I was resentful. This made no sense. If I had benefitted from a learning experience, I should be grateful, not bitter. Not only that, I obviously had set in motion, by myself, the childhood situations that I had resented so deeply.

I did not know the specifics of how or when I had set each of these situations in motion, but I was utterly certain that I had previously, willfully, set in motion the events I so greatly resented when they boomeranged back at me in the early years of my current life.

So I settled in to my meditation chair more comfortably and said, “Well, I only got what I deserved, and come to think of it, I got it in a way that taught me a lot. Thank you.” I said “thank you” several times, thanking God for my rocky childhood. And I think, for the first time, I really meant it.

I had tried to express gratitude and forgiveness in the past, but it had never seemed crucial. But now I had Parkinson’s. Parkinson’s was a terrible, tortuous way to live. Somehow, knowing that I was facing Parkinson’s disease made it more important that I get over myself and that I stop playing around with my delicious self-pity and my sense of being “different from others.”

I’ll repeat the above because I think it was important: I was facing a terrible, paralyzing illness, and the time for half measures was over. There was no more reason to play mind games with myself. I was in a horrible, terrible situation, and I might as well admit that all my previous resentments, cherished self-pities, and “specialness” needed to be thrown away. They had never helped me, they might be hindering me, and while I still had my wits about me I was going to say “Thank you” to God with all the fervor of my heart.

Why say Thank you to God? Because I hadn’t known, at the time, that my hellish childhood would bring me certain strengths, and at the time, I would have done anything to *not* have had this particular childhood. And yet, a loving Providence had allowed this childhood to happen to me. The Universe knew what I needed; I didn’t. God loved me. He felt everything I felt. If I had suffered, He had been right there, feeling everything I was feeling. He’d been willing to feel suffering, because I needed that suffering in order to...to what. I don’t know. Maybe it was to “work out” my past wrong-doing. But I was certain that there was fairness in it, whatever it was, and it was something I needed. I was going to have to take it on faith, and just be grateful.

Weird.

Which sent my mind flitting forward to my high school days, and my first boyfriend. How I had suffered when we broke up, and he started hanging out with one of my girlfriends! Until that time I had thought my childhood had been the ultimate in pain, but this break up of my high school romance was somehow even more painful. Maybe because the breakup had taken me by surprise: I hadn't had time to brace myself for it and make myself numb.

And then, sitting in my meditation room, realizing I had Parkinson's, I thought, "Ha ha. Truth is, he was kind of a jerk. I'm *really* glad that I didn't marry *him!*" By the time I had Parkinson's, I had a wonderful husband and two ideal children, and a very busy and meaningful life. Why was I still cultivating, *savoring*, the pain of the breakup of a high school romance?

I said, "God, *thank you* for breaking up *that* relationship! I will never waste another minute wallowing in the pain I felt from that break-up!"

I could truly say that I wiped the slate clean of any regrets for *that* incident, and actually felt a bit of that relaxation and amusement that accompanies real gratitude.

Moving right along, I wondered to myself, "Was that relationship so crummy because I needed it in order to appreciate the really good relationships I've had since that time? If so, then *Thank you*, God!" I could actually see the humor in it, and the overarching perfection of a life in which one could be in love with a jerk, the first time around, so that one could appreciate being in love with someone decent later on. And no doubt, the jerk was a karmic repayment...no doubt I had been a jerk at some point in my past.

But this brought my thoughts to a subject about which I was *extremely* bitter.

When I was very young, I yearned for some sort of monastic life, although I didn't know the name for it. I used to hope I could someday live in a prison, because I could so easily relate to the idea of an extremely simple life, with a cot of my own, books to read, time to ponder, and lots of privacy, and lots and lots of silence. Such a life seemed extremely familiar to me, and safe.

Not knowing that such things as monasteries even existed, the best picture of a life of solitude was the prison life I'd seen in a TV show. Of course, as a child, I was unaware that prisons today offer little in the way of privacy or of silence, but still, it was the closest thing I'd heard of that seemed like an answer to the question "What is the best way to live?"

Neither of my parents were affiliated with any particular religion. As I grew older, I read about Catholic monasteries, but I felt no connection to the Catholic church. I also began to have a more realistic understanding of prisons, and so that option was also out.

I grew up about one mile away from a beautiful park/yoga retreat center. I often drove past the grounds on my way to the market, or when doing errands. As I drove past, I often wondered what was hidden behind the tall walls of ivy. Sometimes, one could see the tips of what looked like windmill blades. Other times, the windmill was hidden by the ivy. There were no signs, no parking lot, no way in or out. It was a mysterious hedge that utterly surrounded an acre or maybe several acres, of land.

Years later, when I was already married, I read in a book that this retreat was a world-renowned sanctuary, the repository of some ashes of the Mahatma Gandhi, and it was

connected with a universalist, yoga-based church that had...a monastic order. The monastic order had the exact rules and ideals that I had yearned for all during my childhood.

When I learned, from a book, that this ivy-draped sanctuary was affiliated with the historic swami monastic order, and was open to the public, I telephoned my dad. Did he know there was a garden retreat, open to the public, just a mile from the old family home?

He was shocked. It took several vaudevillian verbal back and forths before I realized that *he* was shocked because I *didn't* know about it. He said, "You've got to be kidding me! I know I went there with each of your sisters. How is it you never went there? It's just the kind of place that you would love!"

I frantically responded, "But how do you get in? There's no sign! There's no entrance! There's no way in or out!"

He paused before saying gently, in a teasing voice that implied as, "You silly goose. I'll use small words so you can understand me."... "You can either walk there, or drive there and park in the big parking lot right off the street, and go in at the front gate: the entrance to the parking lot has a sign right out in front that says "Visitors welcome."

Now, I had been *fascinated* by this ivy-covered place. Deeply drawn to it and unable to figure out what it was. And here all my family members had known about it and had spent time there, had spent hours there, escaping from the insanity of home to enjoy the peaceful lake, the swans, the waterfalls. And I had never heard a word about it, had never seen the signs, had never even seen the parking lot or the gate!

I knew, at this moment, that there had been dirty work afoot. A terrific conviction came over me that my eyes had been veiled, intentionally, by some Force, so that I could not learn of this church, its ashram centers, its monastic orders, until after I was married and therefore ineligible to sign on.

When I read the book and called my dad, I was already married. Sacred vows. I knew then and there that I was going to become a lay member of this church, and I have been a loyal member ever since. It is a non-denominational church, a church that teaches about the universality of love, the truths that bind all the major world religions, and so on. The church teaches methods of healthy eating, exercise, effective prayer, meditation, and the basic how-to-live behaviors that can help a person develop the will power, patience, self-control, humility, generosity, devotion, and so on, that is needed in order to live in harmony with universal truths. Simple stuff. Exactly what I was looking for.

And I would have been a *great* nun.

I would have *loved* being a nun of this order. This was what I'd been looking for my whole life, and someone had intentionally hidden this church from my eyes so that I would not learn about it until I was married and unable to join as a monastic.

I could think of no reason that I deserved this exclusion from paradise. Even if, in past lifetimes, I had been a terrible person, didn't God want me to improve myself now? Wouldn't joining a church and serving God be the antidote to whatever I'd done wrong in past lives?

I could not understand why I had been rudely denied knowledge of this church. As for the *founder* of this church, who had passed on when I was still an infant, I thought I could see his hand behind this tricky bit of deception.

I loved him. I was devoted to him and to everything he had ever worked for. But since I'd first learned of the church he'd founded, through reading this book, I had *never* forgiven him for intentionally denying me the chance to at least apply to be a nun in his order.

Here I was, diagnosed with Parkinson's. Sitting in my meditation room. Remembering that nasty, scheming bit of trickery that had kept me from devoting my life to service and had kept me from the peace of the ashram and kept me away from doing what I just knew I could have done SO well: the simple, quiet nun's life, a life of service and reflection.

And then I started to really think it through.

I had a harmonious, loving marriage with lots of music and laughter. My two children were wonderful people. They had both taught me so much and they were an asset to the world, so far as I could tell. If I had not married and had children, *their* offerings to the world might not exist, or would not exist in the exact same way. How was I to know what the world needed from them, or from my husband? Had my married life been a form of service?

And what about me? Had God arranged to keep me away from this religious order because He had something specific in mind for me that required me to live in the world instead of the cloister?

It occurred to me: the reason might be more than just the great kids and good marriage. Maybe I had to stay "in the world" so I could do my research on Parkinson's. I would not be in a position to be doing this research on Parkinson's if I were a nun.

And suddenly, it wasn't just the Parkinson's angle or the great kids – it was everything. Everything that had ever happened to me in my whole life was connected to some Divine plan: the terrifying childhood that shunted me into emotional numbness (I had already seen an underlying thread of childhood fear and emotional numbness in most of my Parkinson's patients. I could relate to it even though I didn't yet know about the role played by dissociation); no doubt one of my many foot injuries had happened on purpose so that I could develop Parkinson's disease; the husband who had encouraged me to study medicine; the various health challenges of my wonderful children, friends, and myself, challenges that had inspired me to study medicine my whole life, and especially from "outside the box," eventually leading me to a career in Asian medicine.

For one brief moment, I suddenly felt as if I had a glimpse of hundreds of thousands of carefully calibrated "unrelated circumstances" that had brought me to this exact point in time. And in a blaze of illumination, I realized that my spiritual teacher, my guru, my beloved – who I bitterly resented with regard to keeping me out of the ashram (another one of those unrelated circumstances) – had been involved every single step of the way!

Long before I knew of him, or of any specific religious path, he had made sure I injured my foot enough to ensure I would develop Parkinson's.

(Until I discovered his teachings, or should I say, until unknown forces in the universe arranged to have me stumble across them, I was not religious at all: I was a scientist. I am now both.)

Even before I was born, something in the universal order had helped make sure that I would be born into a family where I would learn, the hard way, the qualities that I would need in order to be analytical, circumspect, and unimpressed by physical and emotional hardship and by psychoses – and the qualities I would need to both *develop* and *research* Parkinson's.

As a child, this universal force, which I personified by thinking of it as my spiritual teacher, had kept me *away* from churches. As a teen, when my yearning for monastic life was at its most intense, my teacher literally blinded my eyes so that I could not learn of the nearby monastic ashram.

Such love! Such devotion!

As I looked back over my whole life, I realized my teacher had never left my side. He was in control.

I had always thought that *I* was in control of my life. I thought back over all of my constant, tough mental work, work directed at figuring out how to make my family and friends healthy, safe, successful. I thought about all my pathetic control-freak behaviors. They were laughable, pitiable. My attempts at control were *nothing* compared to the control that the universe had been exerting on every single detail of my life.

What a fool I'd been! I'd always thought I was more in control of my life and my emotions than anyone I'd ever known. But I suddenly saw that the very events that had shaped those emotions had been set up and controlled by vast universal forces that I'd been utterly unaware of! With all my study, and all my "self-control," I knew nothing! I controlled nothing! I was a puppet!

Well. That put a different angle on things. I had to consider this: If my teacher didn't want me in his ashram, it was for some *reason*. There was a reason he had "betrayed" me!

And then, without planning to, I entertained some specific thoughts that, I can see now in retrospect, were the thoughts that probably turned off the "You Are Not Yet Safe" signal in my brain.

Healing thoughts

I thought to myself: "*Everything* that's *ever* happened to me that I didn't like, at the time, turned out to be something that was for my ultimate good. How can my Parkinson's disease be any different?

Everything I didn't like has been deserved – it happened for a *reason*. I've needed to work it through in order to make spiritual progress. How can this terrible illness be any different?

Everything that has ever been hard for me has turned out to be a blessing in disguise. How can this adventure with Parkinson's be any different?

Then my thoughts got more specific. "There's a *reason* I have Parkinson's. There is something I have to work through. Once I've worked through it, that bit of karma will be behind me and I'll be over it. Bring it on! I'm going to have Parkinson's because I deserve it and I need it and I'm going to learn from it and the same universal forces that have guided every minute of my life are going to be there guiding me through this, too. I'm not going

through this alone. I'm going to experience this with my teacher by my side, and I'm grateful to God for everything that's about to transpire. Thank you, God, thank you!

My mind kept rolling through similar thoughts: "My guru knows that I have Parkinson's. He helped set me up so that I would get it, even *giving* me the perfect gift of a hellish childhood. He *wants* me to have it because I need to have it! How strange, how perfect!

Wow! I, like others with Parkinson's, had been singled out for a very powerful, very terrible challenge! Like everything else in my life that I didn't enjoy at the time, this Parkinson's disease is going to be for my ultimate good. It is a blessing in disguise. It is a gift!

At this point, unlikely though it may seem to the reader, I felt a wave of gratitude wash over me. I felt as if I were special to God, I felt, tangibly felt, that I was part of His over-all design. I felt so loved by Him. I burst into tears.

At this moment, I just stopped trying to be in control of my life because I had suddenly seen that it was impossible. I had never understood what I'd been dealing with in this life. I thought I could be in control of what I did and what happened to me. Ha!

The big circumstances of my life, the real nuts and bolts, were *completely* out of my control. They were also completely under control – God's control. I was in good hands. Of course, I could control my *reactions*, my *attitudes*. I could choose to be grateful or I could choose to be bitter. But I could not change the course of the sun, the moon, or the "random" incidences that were in mysterious, perfect fairness, directing the course of my life.

And while basking in this glow of gratitude for all the challenges in my life that I had bitterly resented at the time, and which had clearly been for the best, I started thinking about all the little "coincidences" that had occurred in my life that were like answers to prayers. I started remembering all the little "miracles" in my life, the simple miracles that every one of us experiences now and then.

Not only was I *not* in control, but clearly the Mystery that *was* in control was so generous, so helpful, so miraculous, whenever it was at all possible for it to be so.

I was still crying. I was crying with relief, because I wasn't in control of anything.

As an aside, until age seventeen, I was incapable of tears. A curious incident in high school inspired me to imitate crying, and after I mastered that, I was able to produce real tears – but only when overcome with joy.

A jarring thought hit me. What if these things – all the things that had allowed me to develop Parkinson's – had happened because, even before I'd been born, I had wanted to be useful to God? Maybe I wasn't just a pawn in this game. Maybe I was a volunteer!

Maybe I had come to this world after signing up to do some specific good in the world, and all of the challenges I'd gone through had merely been requirements that needed

to occur so that I could be of service: find an effective treatment for an illness whose time had come. Maybe God had looked for recruits, and I'd raised my hand.

The job would require a person to acquire not only Parkinson's disease, but also a degree in biology, a medical background and, evidently, a connection with Asian medicine, a convenient acupuncture college, a successful business life that would help subsidize the unpaid time spent in research, and a whole collection of other little coincidences that made me the perfect person to get to the root of Parkinson's disease.

Maybe, just maybe, by having this illness myself, and by having all the other ducks in a row, such as the necessary medical training, I would be able to understand Parkinson's and related illnesses in a different way.

The contemporary research MDs were all busy looking at cells and measuring dopamine release, but none of them were asking the real question: what *causes* the body to produce and release dopamine – or stop making it. But *I* was asking that question.

I suddenly saw that my entire life had been a set up so that I could have Parkinson's and possibly advance the understanding of this illness. Not a huge big deal, but maybe it was something that the universe wanted, and maybe, even before I was born in this life, or some other life, I'd agreed to help out. Maybe that willingness to help was what had started the current sequence of events.

- At this point in my narrative, the reader with Parkinson's might be saying to himself, "Well, this doesn't apply to me: I'm not finding a cure for some illness so why do I have to have Parkinson's?" This specious argument is an obvious attempt to avoid the point: you *do* have it for a specific reason. You performed the actions that allowed it to be set in motion. You are not in control of your life. Forces that love you and that are working with you, for your highest good, have arranged, through all manner of delicate, perfect "circumstances," for you to have this illness so that you can learn something, change, and then not have it.

Your recovery is going to make a difference for you and, indirectly, for the entire world. There is no way you will be able to undergo that transformation into a person who's conquered the temptation to cleverly use dissociation to make yourself numb without first having Parkinson's or some similar problem. You *are* a hero, a perfect soul. *And* you currently have Parkinson's. It's crucial to the unfolding of the universe that you have this problem, and that you overcome it. It all ties together, somehow, even though no one can see the all the connections. So please, stay with me here.

My musings continued, through my sobs of gratitude: by having Parkinson's myself, and by having a somewhat unique medical background and all the other prerequisites, I was perfectly positioned to learn more about Parkinson's than anyone had ever been.

How cool was that!

I was no longer thinking of myself as a *puppet* of God – I was a *partner*. I was extremely subordinate, but I was on his team. We *all* are, after all. I'd always *heard* that and *believed* that. But I'd never *felt* that way before – felt it in my heart.

I'd always felt as if I was standing off to the side, just a bit, dutifully loving God, but not actually involved in a way that allowed me to serve him *directly*.

I was floored with humility. Little me acting out a role needed by the universe! Working in sync with something that was "meant to be"?? !!

Well, actually, all of us are. But it's hard for some of us to *feel* the heart truth of that statement even as we give lip service to the words.

Now I was really crying. What an honor. All I could think was, "What an honor! What an honor!" I'm part of something so much bigger than I can ever understand, but I'm a *part* of it.

I no longer wanted to recover from Parkinson's. I was going to have every symptom of Parkinson's to the fullest! I was going to experience Parkinson's in a way that no one had ever experienced it before. I would observe every physical symptom, I would assess every thought that passed through my mind, I would analyze my misplaced spiritual yearnings, I would connect the dots between everything that had ever happened in my life and the symptoms that were starting to paralyze me. I would write up everything, I would be such a good servant! God was in control, I was going along for the ride, and I was going to be a *great* passenger!

In this moment, I felt no fear. I felt as if a veil that covers the innermost workings of the universe had been pulled aside for a fraction of a minute so that I could know that things *were* going According To Plan. I hadn't seen much of the plan. Anything of it, really. I'd only seen enough to know there *was* a plan – and I was not in control.

Still awash in tears, I admitted again that I had *never* been in control. From that moment, I determined that I would never again pretend that I was in control. God was in control; my guru was in control. Fine. I was not. Fine. I determined that, if I ever caught myself trying to influence the course of nature, I would stop in my tracks and turn control over to God. If He told me to do something, fine, I would trust Him. I would no longer trust my own tricky mind to tell me the right thing to do. I would only trust my heart, my love for God.

And then my thoughts took an even weirder turn.

I was perfectly happy, and grateful, that I had Parkinson's disease, and I was prepared to experience Parkinson's to the fullest. I started thinking about all the pain that was going to come to me – the paralysis, the cramped muscles, the loss of every form of personal strength and pride. And then I thought, my ego and my nerves will feel all these things, and my soul will feel them, as well. My soul will not be injured by them, but it *will* experience them. But if my soul is feeling these pains, these sufferings, then the Infinite Eternal – which is connected to my soul and which knows everything - will *also* be knowing these pains, feeling them, and experiencing my sense of suffering.

Oh no! God's creation, Love, all-knowing and all-feeling, is going to be suffering through feeling the pains that I am going to be feeling!

God's Love knows of this pain that I will be embarking on. He will feel every thing that I feel. And yet He is willing to feel all this pain in order that this illness, which will be helpful to me, may occur.

And that's when I really fell apart.

"For God so loved the world..."

I suddenly felt just the tiniest fraction of the love and devotion that permeates the universe. It was a love that allows us to suffer, as we need to in order to work out whatever we *think* need to suffer. Why do we think this way? Because of our past wrong choices that we decided to act on even though we knew they were wrong at the time. Many wrong actions, performed through ignorance, are forgiven. But when we knowingly choose to do wrong or intentionally break some promise we are setting ourselves up to think that we will have to pay for it someday. Our *ego* clings lovingly to the notion that we've done wrong and will have to suffer accordingly. But even so, we're never alone while working out these transgressions of universal law: Love is right there with it. Love feels everything we feel, and suffers when we suffer.

I was so stunned at what Divine Love was willing to put up with – in this case, feeling the suffering that I was going to endure while having Parkinson's – that my gratitude and my sense of being loved and cared for utterly overwhelmed me.

I cried Niagaras. My whole body was crying because there was so much love, and it was right there with me. Everything I'd ever done or felt, everything I'd ever thought about, the Divine had been right there with me, doing it, feeling it, observing my thoughts. I had never been alone. I had never been alone. I had never been alone.

I was cared for. Love was in control.

I was exhausted.

I had said I would not leave my meditation room until I was truly grateful for this unexpected syndrome. I was now beyond grateful: I was looking forward to experiencing life – and Parkinson's disease – to the fullest.

It was the middle of the afternoon. I stumbled down the hall, still crying, and fell onto my bed and dropped into a deep sleep.

When I awoke, I noticed a strange sensation. A tickling “golden” feeling was traveling down my right leg and foot, traveling over the path of the Stomach channel and flowing into the Spleen channel. I had more feeling in my right foot than I'd had in years, though prior to this, I hadn't known that it was numb.

Over the next few weeks I experienced what I have come to recognize as symptoms of recovery. Areas that were numb in my foot and my face had frostbite-like burning and tingling as they came back to life. Areas that were stiff became limp and weak as the rigidity went away. My awareness of my foot continued to increase.

I decided not to ask my son, a brilliant Yin Tui Na practitioner, to hold my foot for me. I wasn't in any hurry to recover, and my heart hadn't told me that I needed to start receiving treatment for the Parkinson's.

Several weeks after the “little episode” in my meditation room, I was out walking in the woods, about a mile away from home. My foot had been mildly painful, lately, but nothing unbearable. Suddenly, a mile from home, my right foot suddenly relaxed completely. It felt as if every muscle in my foot relaxed, the foot became limp and squashy, as if every

bone in my foot had drifted apart from its neighbor. The foot was a flaccid blob of relaxed tissues. It would not support weight. I was out in the middle of nowhere, unable to walk.

Prior to recovering, I would have panicked, or tried to somehow tough it out. Now, I wasn't interested in worrying. I decided that this was unexpected and interesting, and no doubt God knew about it, so I was darned if I was going to let myself worry about it. Considering everything I'd been through in the last few weeks – having Parkinson's, deciding I was honored to have Parkinson's, and then having the Parkinson's start to go away just when I was ready to embrace it – I figured that being stuck in the woods unable to walk didn't even merit a blip on the scale of weirdness or danger.

So, I sat down. I decided to do nothing but relax and enjoy myself. After about fifteen minutes, I felt the bones in my foot shaking and moving around, as if they were adjusting themselves. It was strange, but not unpleasant. After another ten minutes or so, I tried standing up and putting weight on my foot. Ouch! My foot hurt, right in the center, in the area of ST-42: right where it had been smashed by the car door incident when I was a child.

I slowly hobbled home. Over the next two weeks, the foot hurt like the dickens – as it should have done, back when I injured it, but I had not felt any pain at the time. (I didn't want my sister to get into trouble.)

My foot swelled up and developed a huge bruise, and pain consistent with a broken bone. The bruise was similar to bruises that had appeared on some of my Parkinson's patients when their injuries began to heal.

I never did have anyone hold my foot. A few times, between the time of the "little incident" in my meditation room and the complete healing of my foot, I thought I could feel hands of some angel holding my foot, comforting it.

Prior to all these strange events, I had not been in the habit of noticing "angels." For that matter, if a person had told me about his angels I might have rolled my eyes behind his back. My "window of gullibility" had been extremely small. I knew too much.

But since I started recovering it didn't seem to matter so much who or what was alongside me, helping me, or just being with me. It was as if an entire world of loving help was all around me, in the form of visible friends and invisible ones, should I ever need it. That love, those friends, had always been there. I had never been able to notice it, or take advantage of it. I'd been too busy keeping everyone safe: myself; my family; my business; my world. And now I was aware of the love around me because *I* was no longer in control.

In many spiritual paths this admission that one cannot be in control is referred to as "surrender." A common joke for people on nearly every spiritual path is, "Wanna make God laugh?" Make plans!"

I would have to say that most of my PD patients really, really hate the word "surrender." They think it means "giving up." It doesn't. It means admitting that Love is in charge.

One of the most amusing changes I observed right away was my lack of concern as to "what people will think." I was walking towards town one day when I remembered I'd forgotten something. I stopped and turned back towards the house. I suddenly remembered how, my entire life, I was mortified if I had to stop in mid-stride and turn around because "what if someone is watching? What will they think I'm doing?" This may sound ridiculous to the reader (unless he has Parkinson's), but I had sometimes walked around the block in

order to circle back, so that a casual observer wouldn't see me stopping in my tracks and turning back.

Crazy, eh? As I recovered, and observed myself making more and more changes in my behavior, I was able to see the degree to which I previously had been always working to keep myself safe from anyone and anything, including any behavior on my part that might bring up negative thoughts in any random observer.

As for the rest of my recovery, it was pretty much the usual.

A few weeks later, I experienced the weird brain shift that you will read about in a chapter on recovery symptoms. My internal tremor shuddered to a halt. For quite a while, I was very tired in the mornings from 7:00 a.m. to 9:00 a.m..

I experienced pretty much all the usual stuff that happens to people while they are recovering from a lifetime of dissociation.

In summary, I did not have anyone hold my feet.

I did decide that I was safe and had always been safe right along. This does not mean that I felt protected from any potential danger or hardship, but rather that I finally understood that, no matter what should happen to me, it was 1) fair because there was a reason behind it and 2) the Big Picture is based on love.

I was going to die some day, I might die in pain and I might die in poverty, but my soul was going to be OK no matter what, and it would all come out all right in the end. Nothing very profound, you might say. But what made it a potent force for healing was my decision that these simple ideas applied even to me. I wasn't "different" from normal people. *I* was safe, just like everyone else. *I* was OK, just like everyone else. It was safe to get back into living – just like "normal" people do.

From the moment I *felt* these realizations, the dissociation ceased. Over time, I became aware of various injuries and they healed themselves, and that was the end of it.

So there you are: a case study describing one person's recovery from Parkinson's disease.

I confess, I did do one somewhat crazy thing. As I realized that I was recovering and I felt so much more alive than I'd felt for most of my life, I felt just awful that others were still sick with Parkinson's.

I announced to God, "I don't want to recover unless everyone can recover!"

I received an immediate, unexpected answer: "They can. But whether they recover or not is up to them, not you."

I did *not* like this answer. I decided that this was just the usual "spiritual", cryptic mumbo-jumbo that God and the saints like to use when they are being coy and don't want to be too obvious.

(Actually, it's not mumbo-jumbo. It's the frankness and simplicity of God but we perceive it as cagey or evasive because we are usually hoping for a more flattering response.)

I did not like this answer. I decided to defy God and figure out what was involved in recovery so that *everyone* could recover. (Notice that my sudden spiritual insights had gotten rid of my dissociation, but in the big picture of things they had not actually made me much wiser! I was still me, warts and all.)

God knows me pretty well. In retrospect, this was probably the response he expected of me. At any rate, no lightning bolts came down on my head when I shook my fist at the ceiling and repeated, “I don’t *want* to recover unless everyone else can!” I did recover completely. And I still haven’t figured out how to help or get through to those patients who are determined to cling to their use of dissociation while expecting me to heal them by holding their feet.

At this point in time I had not figured out the physiology involved. The physiology of Parkinson’s turns out to involve dissociation, a process that is easily halted if and when a person feels that he is safe enough that he can stop playing dead. I also did not understand that a person can use his own subconscious in such a way that he *intentionally* prevents himself from ever feeling safe enough – thus enjoying the physical and mental benefit from the almost constant use of adrenaline and sympathetic mode (during his younger years) and reaping the dubious emotional benefit of appearing “calm” and “unaffected by emotions.” I also didn’t know how these subconscious habits get better and stronger through practice.

So my saying I didn’t want to get better unless everyone else could, also, was sort of silly. But at the time, I sincerely desired this.

That’s why I started the little project, the Parkinson’s Recovery Project: I didn’t want to recover via some special miracle or favoritism. I’d seen several people – all musicians, as it turned out – who recovered just by having a foot injury receive treatment. I had recovered by getting over my conviction that I was “different from other people” and needed to stay emotionally guarded in order to be safe. But I had many patients whose foot injuries had been healed who were behaving very strangely – making up all sorts of reasons why their improvement had to be a fluke and would not last, or telling me that, in spite of their cessation of some symptoms, they “deserved to have Parkinson’s and shouldn’t really recover.”

I had patients whose foot injuries had recovered but the patients now had symptoms of PD depending on their moods! I didn’t like this.

I wanted, more than *anything*, for treatment of Parkinson’s to be a simple physical treatment with no psychological component. It would just be easier that way. But my own case showed me the opposite: the mental attitude was behind the foot problem. Fix the foot, a person might get somewhat better, but might not completely recover. Fix the mental problem, the person would get better right away and the physical problems, the injury, if any, would take care of itself.

I am not a psychologist. I did *not* want to present PD to the world as a psychological disorder. I was dismayed by what might lie ahead. I also have no desire to be a hero. I like my privacy.

On the other hand, I finally understood that I had to do what my heart told me instead of living via the ego-based intelligence as I’d done for so many years.

My heart told me to keep working on the Parkinson’s and to make public whatever I find. I have done so.

Throughout, I have clung tightly to the words of Mother Teresa of Calcutta, to her response when asked by a cynical reporter, “How can you possibly hope to succeed in helping all the world’s ‘poorest of the poor’?”

She answered, “God does not ask us to succeed. He only asks that we be faithful” (obey His instructions, as received through our hearts).

In my own case, being “faithful” took the form of embarking on more than a decade of research to figure out why the foot injury was able to inhibit dopamine release. Even trickier was figuring out what was going on with the people in partial recovery. They no longer had the foot injury, and sometimes their channels flowed correctly, but the least little thought of danger caused their channels to flow backwards in what I was now calling the Parkinson’s Pattern.

My research team and I worked with hundreds of people who were stuck in partial recovery. We developed various experiments, most of which had to do with sensory awareness, heart feeling, visualization: all the things that are most difficult to do when a person has Parkinson’s disease. I combed the internet nightly for any research that might be related to dopamine, brain-based motor function, altered mental states, the heart-brain relationship, and anything that might touch even tangentially on this subject. I kept compiling notes on my patients, looking for links. Slowly, a picture of Parkinson’s emerged that’s presented in this book.

And speaking of pictures, about three weeks after sensation started returning to my



face and I was able to once again use the muscles of my right cheek, I had my husband take a photo. Quite a bit of muscle use in the right lower eyelid and cheek had already returned, but this photo shows that the lower eyelid on the right is still slightly saggy, making the right eye look larger than the left.

Also, although these conditions had been more severe prior to recovering, this picture shows nicely what I mean by a “groove” alongside the nose on the *right* side, and the flatness of the cheek on that side. In comparison, note the nice “bulge” of cheek muscle, the “apple” in the cheek, on the *left* side.

Fig. 18.1 *early April, 1998*

I wish I had taken photos prior to this partial restoration of facial responsiveness. In my defense, I did not know at the time that I was going to be writing a book or making any serious discoveries.

I should mention, for about a year or two, prior to my diagnosis, one of my first actions every morning, before brushing my teeth, was pulling the corners of my frowning, “frozen,” mouth up into a smile. My frowny face looking back at me in the mirror seemed so “negative.” At the time, I assumed this frown was a normal consequence of aging. Talk about denial...



One month later, my husband took a few photos, against the same wall, at the same time of day, a month later. As before, the sun is coming from the right, helping to accentuate the groove alongside the nose and on the right side.

A slight improvement is evident. The eyelids are more symmetrical and there is evidence of a slight muscle bulge in the right cheek.

Note the new separation between the two upper front teeth. This occurred in a matter of minutes, one evening while I was relaxing, when my upper palate resumed normal muscle tone.

Fig. 18.2 *One month later (early May, 1998)*

If I relaxed my face, letting my jaw droop, the right side of my face and my right upper lip would still become completely limp (lacking in tone).

Fig. 18.3. *(early may, 1998)*



This fourth photo, taken fourteen years later, shows that the improvement has remained, and even improved slightly.

Note the muscle of the *right* cheek that is in line with the “corner” of my mouth, the muscle that forms the bottom of the “bulge.” This muscle did not exist for a year or so prior to my diagnosis.

The symmetry of the left and right lower eyelid muscles has remained.

The hair is a lot grayer...

Fig. 18.4
February, 2013



Getting back to the timeline, more than a decade sped by before my research into channel theory led me to the realization that the “Parkinson’s channel Qi Pattern” was actually something much more universal: the Dissociation channel Qi Pattern.

The channel Qi pattern seen in Parkinson’s was identical to the naturally occurring and *correct* pattern for energy flow when a person was dealing with mortal injury, extreme loss of blood, excess perforation of the skin, and so on. This pattern was related to shock. This was a normal pattern that was a short-term, life-saving pattern that could only be ended when a person or animal was able to affirm, “I have assessed the situation, and I am no longer in danger.”

And then I knew what the problem was for people stuck in partial recovery. Based on our years of research, talking with, doing hands-on work with these people, for thousands of hours, they all had one thing in common. They didn’t feel *safe*. Worse, in *order* to feel even *somewhat* safe, they assumed that they needed to be in control of their lives as much as possible. The way to maintain this control was by freezing up rather than acting out.

They each had what they thought were their own special reasons for not feeling safe, for needing to be in control and for needing to stay in dissociated mode, using mentally generated motivators or fears to maintain enough sympathetic mode override to mask the underlying dissociation. These reasons were based on faulty logic or clinging to situations

that were long gone. These reasons were keeping them locked into a mode that is only supposed to be used by people who are hovering on the edge of imminent death.

Only when they decide that they are genuinely safe even though they are not and never have been “in control” can they turn off the dissociation. And once they’ve done that, they must, in the future, dare to use sympathetic mode – not dissociation – any time they aren’t relaxed. They must use the mode that allows them to fight, flee, act out, and even have somatic feelings of physical and emotional pain – all the things that “normal” people do. And then they won’t have Parkinson’s disease anymore.

I hope the reader with Parkinson’s will not be put off by my case study and assume that a spiritual component is *necessary* for recovery. However, I will say that all the people I know of who have recovered have been willing to at least consider the possibilities of “goodness.” So long as a person *insists* on staying focused on dangers and evil, he is using the part of his brain (the sides) that he has unknowingly trained to inhibit conscious control of his actions and movements. Only if he is willing to keep his focus around to the positive (which automatically shifts electrical currents to the center of the frontal lobe), will he be able to get back in tune with the correct electrical patterns that enable humans to move normally.

Whether he uses his spiritual training to assist in his mental realignment or uses a non-denominational trust in the general goodness of things, or a trust that love *can* ultimately conquer evil – any of which serve to redirect the channel Qi that flows through the brain – is completely up to the person who wants to recover.

“Do this either by work, or worship, or mental discipline, or philosophy - by one, or more, or all of these - and be free...doctrines, or dogmas, or rituals, or books, or temples, or forms, are but secondary details.”

Swami Vivekananda (1863-1902)

CHAPTER NINETEEN

FULL RECOVERY CASE STUDIES, CONTINUED

Case study #2: Gertrude X

Gertrude recovered from advanced Parkinson’s. I met her at a lecture I was giving in Amsterdam.

I was trying to get through to the audience made up mostly of doctors and health professionals that Parkinson’s goes away as soon as a person decides to not use dissociation mode. They kept asking, “How long does it take?”

I replied, “It takes about a minute. But some people wait for years before having that minute.”

None of them liked this reply. Hands were raised, the questions continued, “But how long does the average person take before they have that minute? Is it weeks? Months? Years?”

I said, again, “That’s completely up to the individual. Recovery takes about a minute.”

They still didn’t like this answer. Another attendee asked, “But on average, how long does it take to recover from Parkinson’s?”

I responded by saying, “You clearly do not understand what I am saying. I will answer your question by having someone else answer it. I understand that we have a person in the audience today who has recovered from Parkinson’s disease. I have never met this person, but I’ve heard from her health practitioner, who practices our methods for recovery, that a recovered patient from Germany planned to come to this class in order to meet me.”

I continued, “If some person in this audience has recovered from Parkinson’s, will you please stand and tell us about the MINUTE in which you recovered from Parkinson’s. My audience does not understand what I mean about one minute. I am going out on a limb here by asking this person, about whom I know nothing except that she has recovered, to tell us about the one minute when she recovered from Parkinson’s.”

I scanned the room. No one stood up right away, and the class members were swiveling their heads. After several seconds of silence, a middle-aged woman stood up and said, “You must be talking about me. I do not think my English is good enough to explain.”

I assured her that her English would be great, and could she please share a few words about the ONE MINUTE in which she recovered from Parkinson's.

She got off to a slow start, but her confidence increased as she held the audience spellbound. I paraphrase, keeping as closely as possible to her exact words, as I remember them.

“Before I can explain that minute, I must tell you something.

“I was diagnosed more than ten years ago. I took some medications for a while, but then I found out about the Parkinson's Recovery Project and went through the hell of getting off my medications. That hell lasted a couple of years.

“Brigitta is my health care provider. She did Yin Tui Na on my feet and I began to feel much better. I thought I had recovered. But my symptoms started to come back, especially if I was worried.

“I started to get worse quickly when my marriage fell apart. My husband told me that the young woman who was often at the house was not, what I thought, a friend of my sons. She was his lover. My husband told me that, because I had Parkinson's and he felt sorry for me, I could continue living in the house.

“I moved into the basement. Over many years, my symptoms became constant, as they had been before I healed from the foot injury.

“I kept working with Brigitta. She continued to do Yin Tui Na on the parts of my body that hurt, but the Parkinson's symptoms were constant and the severity kept getting worse.

“My symptoms became very severe. My tremor was violent. My body was very tight, so cramped up, I could barely move. I was in terrible pain most of the time.

“And then came a day, the worst of the worst of the worst.

“My symptoms were so bad, no one was in the house but me, I was terrified. I could not move. But at least, with all of my suffering, until that day, I had never had headache.

“On this day, on top of everything else, I had headache. It was a *horrible* headache, like my head was being pressed in a machine. The pressure was horrible. I thought I was going to die from the pressure. I was desperate. I had been able to be brave through all the terrible symptoms, but now this headache was killing me.

“This is when I had the minute that you are talking about.

“All of a sudden, I found myself screaming. I was shaking my fist at the ceiling, yelling, ‘I DO want to live; I DO want to live.’

In that moment, I didn't care who heard me. I didn't care about anything any more. I don't even know what I meant by “I DO want to live.”

But that is what I said, and suddenly I realized that the Parkinson's was going away. My body was softening up, the rigidity was going away. My tremor started to go away! I was alarmed because I realized that I was going to recover!”

(Dear reader: as an aside, this feeling of shock, even fear, is not uncommon when a person realizes that they are recovering.)

“It will sound crazy, but at that moment, I prayed so hard, ‘Dear God, please let me keep the tremor in one finger so that I will always be able to tell when I am becoming fearful again, so that I can remember to stop my fear.’

“In that moment, I was recovered. That was three years ago, but even today, when I become worried about something, my fourth finger on my left hand tremors for a bit, so I can tell that I am letting myself get worried.

She asked me, “Is that what you mean by ‘the one MINUTE?’”

I said, “Yes.”

The expression “hushed silence” is about right for describing the room. I repeated, “Yes. That is exactly what I am talking about.”

I scanned the audience briefly and then said, “Do you begin to understand what I mean by “Recovery takes about a minute?”

I thanked Gertrude, and we broke for lunch.

The next day, I met Gertrude for breakfast at our mutual hotel. She was so open, so perfectly “normal.”

She explained that she had a tremor in her fourth finger that morning because she had just heard that her adult son, who suffered from schizophrenia, had just started drinking again. She knew that worrying about him wouldn’t help him, but she couldn’t help it. He was the primary source of finger tremor, when she had it. The tremor was tiny, almost unnoticeable. It did not affect her ability to use her hand in any way.

Aside from that, she had *no* symptoms that suggested she’d ever had Parkinson’s.

She told me a little more about her life. It was rather typical for a person with Parkinson’s: the high ideals, very high intelligence, stoic, a stint of living in an ashram in India, becoming a teacher for disabled children, willing to suffer on behalf of others – some fairly typical traits for people with PD.

We had a lot of laughs about our before-and-after PD personalities. We both agreed that life had become much more pleasant and more “honest” when we’d thrown aside the crazy “gotta be perfect, gotta be safe” attitude.

I asked her why she had said, “I DO want to live.” Had she been fostering some suicidal ideas?

She assured me that she had not. There had been no suicidal thoughts. She had been as surprised as anyone might have been to find herself shouting at God, at the universe, “I DO want to live!” Her choice of words was utterly spontaneous, and she could not account for them.

The main thing was, *when* she felt like shouting those words, she did so. At that moment, she no longer cared what anyone overhearing her might think. She had been truly terrified and she didn’t know what else to do. She was in so much pain, and she was

experiencing the worst of the worst of the worst. So she started yelling as loud as she could, yelling that she wanted to live, and her Parkinson's stopped.¹

She laughed, buttered another slice of the excellent bread, and we smiled at each other.

I always enjoy spending time with another person who has recovered from Parkinson's. A wordless understanding passes between. It is a beautiful secret, even though it is right out in the open. It is secret because it cannot be explained in words. It is an understanding full of love.

Case study #3 Viola

After being diagnosed with Parkinson's, Viola decided to pursue Qi Gong. Not because she thought it would bring about recovery, but because she wanted to learn something new. She threw herself into it. She used an approach that is not typical of most of our patients with Parkinson's: she had fun with it. As opposed to many of our patients with Parkinson's who have pursued some Asian movement arts with a grim determination to "do it right," Viola enjoyed the novelty of being in charge of what her own energy was doing. She took pleasure in getting her energy to go in the right places at her instruction. At some point, she was able to make her Qi to flow in the correct manner! At that point, she noticed she was unintentionally recovering from Parkinson's. Just after this, following her recovery realization "moment," she had an epiphany, "It's OK to feel vulnerable!"

In other words, when she got the channel Qi moving the right way (parasympathetic – though she was not using that name for it), the instruction in her brain that was keeping her locked into dissociation was turned off. When she did this, she had the epiphany and realized that she didn't need to be guarded any more. This prevented her from sliding back into dissociation when she finished the Qi Gong session.

She knew nothing of our program.

Some weeks later, she became quite aware of pain in her foot and ankle. She realized that she had an old injury that she'd "never paid attention to at the time."

She gave the injury the attention that any healthy person might, including mentally directing energy to the painful areas.

After that, she had no Parkinson's, and no foot injury.

I enjoy this case study because 1) she knew nothing about our program, 2) like me, her foot injury became apparent *after* the emotional dissociation stopped and the brain circuitry inhibiting dopamine release had already been turned off. In other words, she was once again moving like a healthy person, albeit one with a foot injury.

¹ After lapsing into dissociation, a person is "on hold" while they figure out whether or not they are dying, staying alive, still at risk, etc. Although at this time, I did not understand the role of biological dissociation in people with Parkinson's, I now can see that a statement of "I want to live," given with enough power and determination to get through to the subconscious (which normally runs along mindlessly, using habit to give it its strength) might be enough to turn off the lingering, indecisive state in-between life and death that is characteristic of dissociation. In other words, she's said the perfect thing, without even knowing it. Perfect for her, at any rate. Everyone gets to find their own way through this tricky, self-created mind trap.

She recovered from the dissociation *first*, and then recovered, in a natural manner, from an unhealed injury. This is the opposite sequence of many of our patients who want to work on the foot injury first and then tackle the mental problem.

Not aware that her overall attitude is somewhat *atypical* for people with Parkinson's, she has started a program based on the idea that Parkinson's disease can be cured simply by doing Qi Gong.

I have never met her, but based on reading her writing, she strikes me as typical of the “five percent:” those people who have only dissociated from a foot injury, who recover from Parkinson's as soon as their subconscious attention is directed to the foot.

We know that this method will not actually work for most people with Parkinson's disease: including the many teachers of Qi Gong, Tai Ji, yoga, and other movement arts who have developed Parkinson's disease and been our patients.

However, *if* a person with PD can identify with the *joie de vivre* with which she entered into her Qi Gong practice, then a Qi Gong approach, *any* Qi Gong approach (there are hundreds of schools, but almost all share the same principles) might do the trick for that individual.

Case study #4 Sister Marie Simon-Pierre (real name)

Sister Marie Simon-Pierre is the French nun who became somewhat famous after recovering from Parkinson's, overnight, after praying for assistance from the late Pope, John Paul II (1920-2005).

John Paul II had advanced Parkinson's disease when he passed in 2005.

Sister Marie Simon-Pierre had advanced Parkinson's when she decided to pray to the deceased John Paul II for help. She wrote his name on a piece of paper and put the paper in her pocket.

She did this at bedtime.

In the morning, she no longer had Parkinson's disease.

She had been diagnosed in 2001. She had her “miraculous,” overnight recovery in 2005. Immediately following her recovery, she was once again able to drive a car, walk normally, and return to work.

She has been vigorously interviewed by the proper church authorities.

It seems that her prayers to John Paul II were answered very quickly: overnight. From this we might conclude that, prior to asking John Paul II for help, she was using the more conventional prayers.

It seems fair to conclude also that she decided to make a switch in the essence of her conventional prayers.

I am guessing that, without even realizing what she was doing, she “surrendered” control of her life, for a change. The “higher power” to which she surrendered control was John Paul II.

Maybe she was able to surrender to him because she felt close to him. He had only recently passed, he was very human, very loving, and he’d had Parkinson’s. Maybe she felt that it would be OK to surrender to him, whereas possibly her other prayers had been very sincere, but somewhat formulaic, less desperate and open-hearted. I don’t know. I am guessing here. But it’s what they call in the sciences an “educated guess.”

Her recovery has been regarded as the first of the several “proven miracles” that are needed for the beatification and eventual canonization of a saint.

Oddly (but not so oddly, actually), in 2010, she started having a return of some symptoms. While various doctors have shoved their oars in (insisting that she never had Parkinson’s to begin with) and various church experts are now having to decide whether or not the “miracle status” is threatened, it is not surprising to me that she might be having a return of symptoms.

If she does not understand that she must refrain, from now on, from the temptation of using dissociation to deal with fears and emotions, she is extremely likely to slide back towards Parkinson’s disease.

When a person first recovers, he might feel just glorious, and all his symptoms might seem to be in abeyance. The real trick is to not slide back into dissociation the next time the going gets tough.

If Sister Marie Simon-Pierre was assuming that John Paul II could do all the work and she didn’t need to change the behaviors that contributed to the Parkinson’s, she was wrong. Even if she experienced a “miracle,” via John Paul II or via her active surrender to a higher power, using dissociative mode again as a way of dealing with some new emotional or physical pain can bring all the symptoms right back.

John Paul II

Using the case study of Sister Marie Simon-Pierre gives me an easy segue into the life of John Paul II. Some people have wrongly assumed that a person who is numb to somatic feeling is necessarily heartless and cold to others. This is not necessarily true. It is to one’s *own* sensations that one becomes numb, during dissociation. One might still be able to feel *very* deeply on behalf of others.

During World War II, John Paul II was a teenager. He was Polish. When the Nazis came into Poland, he watched helplessly when, over a few days time, they dragged his father, mother, and then his teenage sister into the street and killed them.

His pain must have been ferocious – or he may have dissociated from his ability to feel that pain. He went on to become a very good skier, an actor, and a priest. He was known for his compassion for others.

But it would surprise no one if he had frozen some part of his heart when his family members were slaughtered. Then again, he may have broken his foot while skiing. If he had become good at dissociating from his heart in time of pain, he might well have easily dissociated from his foot if, in fact, he injured it.

I have no idea, of course. I never met John Paul II.

But I can use him as an example of a person who had Parkinson's, and who might have had a good reason to make himself numb to his own somatic pain, while remaining deeply loving and compassionate regarding the feelings of others.

Even though he did not recover from Parkinson's I'm including this short biography of him here, to explain Sister Marie Simon-Pierre's connection to him. He passed from complications of kidney failure, completely unrelated to Parkinson's disease.

Because of the way antiparkinson's medications addle the brain, the Pope did not use them. Although the medications are prescribed almost like candy in the US, European doctors are much more hesitant to put people on highly addictive, mind-altering, personality-altering medications. The doctors usually suggest that people wait until their symptoms are interfering significantly with their ability to get through the day.

Summary

Towards the beginning of this book, I described case studies in which people recovered after having their feet held. The mental aspect of Parkinson's wasn't present. Then I described cases in which people had their feet held and some of their symptoms went away, or their symptoms started to come and go, depending on their mindset of the moment.

Now, coming full circle, I'm sharing case studies in which people received no support for the foot injury, but recovered by changing their mindset or bringing their sensory, heart-based *feeling* attention to their foot injuries. In these cases, the long-forgotten foot injuries healed up on their own as soon as the mind became aware of them.

This pretty much sums up the rules for recovering from Parkinson's. If you only have a foot injury and are not otherwise dissociated, treating the foot injury will bring about a recovery. We've seen this in about five percent of our patients.

If, like most patients, you have mentally induced the dissociation mode, and possibly due to that, have not been able to bring your attention to a foot injury, you will need to address both of these problems. If you only fix the foot, you will find yourself sliding into partial recovery as soon as your mind realizes that you are now at increased risk of starting to feel.

On the other hand, if you just fix your mindset and end the dissociation, the Parkinson's will cease. Soon, the foot injury will heal up on its own.

The rest of this book describes recovery symptoms.

While it may seem that recovery should be fairly straightforward, it is anything but. For many people, recovery is as baffling, or more baffling, than having Parkinson's disease.

I provide descriptions of the recovery symptoms to help people navigate the strange phenomena that occur during recovery, but also for another reason: the recovery symptoms are one of the greatest proofs of our hypotheses.

The only way to account for the symptoms that occur during recovery is the channel theory presented in the first half of this book.

The western understanding of Parkinson's does not even begin to account for the symptoms that occur during recovery.

Refresh your beverage, take the dog for a short walk, and then settle back in. You're about to read about symptoms that allowed us to discover the actual mechanics behind Parkinson's disease. More than any other information, the symptoms of recovery gave us proof of the cause of Parkinson's disease and the reasons behind its cure.

“There’s nothing either good nor bad, but thinking makes it so.”

Shakespeare’s Hamlet

CHAPTER TWENTY

RECOVERY SYMPTOMS: INTRODUCTION

As people with Parkinson’s recovered from their foot injuries, many of them experienced unexpected, counterintuitive, and even bizarre physical and emotional changes. In the early days of the research, these events became as much a part of the puzzle as the symptoms of Parkinson’s disease. Although the smaller details of these events varied from one patient to another, there was a baffling overall similarity in the changes that they reported to us, week after week.

For research purposes, our earliest PD patients almost never met with or spoke with each other: the probability of research “contamination” from patient-to-patient interaction was unlikely. Furthermore, since our hypotheses as to the cause of Parkinson’s disease had not been formed when the first pioneers began to recover, there is no way a patient could have “guessed” at appropriate recovery symptoms, and no way we could have suggested them. We were as stunned as the patients when one recovering patient after another manifested his own variations on these unexpected symptoms.

We named these events “recovery symptoms.”

When I first started noticing changes in people with Parkinson’s in response to my treating their feet injuries, I had no idea of any theory that might connect the foot injury to the symptoms of Parkinson’s disease.

In the end, the largest single source of information about the cause and development of Parkinson’s disease was the collection of recovery symptoms. The recovery symptoms, together with my understanding of channel theory, provided the clues that allowed us to figure out the processes that lead to idiopathic Parkinson’s disease.

“What the heck?”

The pioneer patients in our project expected any improvement from Parkinson’s to be pleasant. They assumed that recovery, if that was indeed what was happening, would consist of steady, linear improvements in motor function. They assumed, as well, that any benefits would take the form of a “return to the past.” In most cases, this would have meant a return to the previous way of life: high pain threshold; strong will power; adrenaline-activated thought and movement.

What actually occurred did not fit anyone’s expectations. Every one of the pioneers was shocked by the unanticipated, seemingly negative collection of new symptoms that occurred as their feet began to heal.

But as they began to see the positive flip-side of these sometimes painful or alarming changes, they started to appreciate that something incredible was going on: they were truly

recovering from Parkinson's disease – not just feeling better by masking the symptoms. After all, the new symptoms, though weird, were the exact *opposite* of the symptoms of Parkinson's.

The credo of many in this group soon became “I don't know what the heck is going on, but it sure as hell isn't Parkinson's disease.”

Introduction to physiological symptoms

Many physiological pathologies of Parkinson's are apparent whether or not a person is trying to move. For example, coldness in the hands and feet, the numbness or lack of muscle responsiveness in the face and toes, the muscle tension that pulls the neck forward and inhibits rotation of the neck, the forward-leaning, shoulder-hunching tension in the overall carriage, and the steely rigidity in the anteriolateral muscles of the neck and legs, these are all conditions that exist whether or not the person with Parkinson's is trying to execute large motor function (walking or using the arms). For example, if a person with PD has atrophy of muscles along the side of the nose or in the lower eyelid, it will be present to the keen observer whether he is sitting down, lying down, or walking.

Many of these *physiological* symptoms of Parkinson's disease do not change with mood or expectation: they are caused by physical changes that have taken place in muscle tissue, nerve tissue, blood supply, and brain-to-muscle connectivity. These symptoms may *contribute* to the poor performance of certain movements, in the same way that a polio-shortened leg or missing thumb may contribute to poor performance. But they do not *cause* the mood-based variations in poor movement initiation or tremor.

The physiological symptoms are *not* improved by the taking of dopamine-enhancing medications because they are *not* dopamine-related symptoms. They are simply the result of long-term changes in nerve and muscle that result from the electrical disarray that is present in idiopathic Parkinson's disease.

These are the symptoms that clear up quickly if the channel Qi starts going the correct direction.

Introduction to mental/emotional symptoms

In most people with idiopathic Parkinson's, emotional and attitudinal postures that activate bouts of dissociation or keep dissociation constantly running in the background can trigger the *motor* inhibition symptoms of Parkinson's disease.

This inhibition can occur whether or not a person has any sort of foot injury.

Whether people have a foot injury or not, if they have the long-term backwards flow in the their Stomach channel that is characteristic of dissociation, they will have inhibition of dopamine release and therefore they will have rigidity, difficulty with movement initiation, poverty of movement, tremor, and postural instability.

Once a person's channel Qi is physically *able* to flow correctly (no longer any impediment from injury), these symptoms come and go, or vary in intensity, depending on a person's mindset in that moment.

While a person has idiopathic Parkinson's disease, it can be difficult to determine whether or not a symptom is purely physiological or if it is mental. However, during recovery, the distinction often becomes more clear.

Why there is no list of specific recovery symptoms

In 1999, in the first edition of this book, I included a list of recovery symptoms that had occurred in my first dozen patients. Because I was concerned that some symptoms were purely individual, and not characteristic of PD, I never included symptoms on the list until *several* recovering people manifested them.

But once I did list the symptom, such as “tingling, frostbite-like sensations,” I included on the list the specific muscle groups and the exact locations in which people had experienced those symptoms.

As the project grew, I kept trying to update the information, listing additional recovery symptoms as I observed them.

However, I soon found that the more exacting patients that were coming into the program were using this information as a checklist: if their own recovery symptoms were *not* on the list, they panicked.

And sometimes, if a person *didn't* experience all of the items on the list, he was certain that his recovery had stalled.

The panic or worry over stalled recovery often resurrected the old Parkinson's symptoms, or at least some of them.

We did not yet realize that a person who was always wary, always on the lookout for danger would use *any* personal deviation from our lists as an indication of non-recovery or worse.

Now, in this edition, I've deleted the list format. Instead, I want people with Parkinson's and their health practitioners to understand the *mechanisms* involved.

The following chapters list only a *sampling* of recovery symptoms, together with explanations of *why* the symptoms occur.

The tempo of recovery

Physiological recovery: somewhat slow, measured in days or weeks, not minutes

With regard to the *physiological* symptoms (muscle atrophy, poor nerve function, etc.), no one experienced a red-letter day when he woke up and said “Ah! The Parkinson's is suddenly gone! Today is The Day!”

Please remember, there was never a distinct day when the person woke up and *suddenly* had idiopathic Parkinson's disease. The physiological symptoms of idiopathic Parkinson's came on slowly. The physiological recovery also takes some time. Trying to ascertain a single day on which the physical symptoms are gone was as tricky as trying to ascertain the exact day on which a broken bone is healed.¹

¹ Drug- and toxin-induced parkinsonism *can* come on quickly, even overnight. The book, *The Frozen Addicts* by Dr. Langston, MD, describes the immediate or overnight onset of full-blown parkinsonism, complete with utter rigidity and constant tremoring, that occurred in a group of drug users that used a “bad” batch of synthetic heroin. These drug users suffered immediate, irreversible brain damage. Their condition has *nothing* in common with people who develop idiopathic Parkinson's

Once the foot/ankle injury, if any, has healed sufficiently, the *electrical* disarray can correct itself almost instantly and the *electrical* (injury based) trigger for dissociation will immediately cease. However, repairing the damage that this backwards electrical flow has caused during the previous decades can take weeks, even months. It will take time to grow new muscle. It will take time to retrain new nerve connections. It will take time to return to full sensory function.

Mental/emotional recovery: as quick as flipping a switch

The negative emotional and mental patterns of dissociation, patterns that inhibit neurotransmitter release, can come and go as quickly as thought. Many patients have told us that, following a bit of bad news, such as receiving their diagnosis of Parkinson’s disease, they suffered an *instant* decline or rapid daily decline in their ability to initiate movement.

Oppositely, if they felt encouraged by some positive idea, they might have an almost instantaneous, but temporary, improvement in movement initiation or speed of movement; in these cases, their movement almost instantly improved to the extent that their current *physiological* condition allowed. Then again, if they were still plunging into dissociation at the first sign of trouble, as soon as a negative thought arose, the previous level of movement inhibition returned within a few minutes.

How long will the overall process take? How intense will this be?

The amount of time required for healing is variable, and I will *not* make estimates as to how long it might take for any given individual, even if I meet him in person.

I have had patients whose more obvious symptoms of Parkinson’s disease were gone within three to five weeks of the foot injury starting to heal. I have had other patients who were still noticing tiny improvements in motor function a full five years after the injury was healed and the major symptoms of PD were long gone.

In my own case, for example, within half a year, I assumed I had recovered completely because I had no more symptoms. But five *years* after recovering, one day, as I was putting my shoes on, my right leg (the one with more severe symptoms) lifted up and crossed itself over the over left knee in order to facilitate putting the shoe on. Up until that moment, when putting on my shoes, I had always used my *hands* to lift my right leg up and lay it across the opposite knee. It was pure habit. I was amazed to see my leg doing without the help of my hands. This move occurred effortlessly. I hadn’t even thought about it. It made me realize that my use of my limbs was still improving – I was still experiencing changes related to recovering from Parkinson’s disease.

disease. Nevertheless, *The Frozen Addicts*, and the hypotheses contained therein, was the primary source of the “dead brain cell” theory of Parkinson’s. Today, most research on Parkinson’s is done on lab mice that have been given drugs to kill their brain cells. These mice are referred to as a “parkinson’s model,” even though it has since been proven that people with idiopathic Parkinson’s disease do *not* have dead brain cells.

In cases of tardive (delayed onset) parkinsonism developing from use of mind-altering drugs such as methamphetamine and use of pharmaceutical drugs such as some anti-depressant and anti-anxiety medications, the parkinsonism from the brain damage caused by these drugs may come on more slowly – in some cases, over decades. In cases of brain damage from drugs or toxins, the channels do *not* run in the dissociation pattern.

Also, the *intensity* of recovery symptoms varies from person to person. The recovery symptoms are sometimes subtle, sometimes not.

A recovering patient might experience severe symptoms in some muscle groups and have almost no *noticeable* cues as to the changes that were gently occurring in some other body part.

Some people recover from some of the *physiological* symptoms of idiopathic Parkinson's disease, such as circulation and numbness, in a matter of weeks or months but linger in partial recovery for *years* following the physiological recovery.

Linearity

In my original list of recovery symptoms, I listed them in *order* that recovery symptoms had often, but not always, occurred: first, second, and last.

I learned that, no matter how many times I wrote “recovery symptoms did not necessarily take place in this sequence,” most people with Parkinson's panicked if their recovery symptoms were not in the sequence in which they had been listed. I repeat, we were still not aware of the inclination towards negativity and worst case scenarios that many people with Parkinson's had acquired and/or cultivated – that this negativity was a natural result of living with dissociation and sympathetic mode override for many, many years.

Now, there are no more references to which recovery symptoms *tend* to occur first, second, and last. Toes may recover before fingers, or vice versa. Improvement in sensory function may precede the return of easy movement in some body parts, or vice versa. Toes may regain sensitivity prior to recovering full range of movement, or vice versa. Oppositely, facial muscles may show increased movement long before full feeling returns to the face. Or vice versa.

The path of recovery is somewhat, but not entirely predictable, and recovery symptoms do *not* necessarily follow a straight line.

The organization of the chapters on recovery symptoms

Again, no two patients had recovery symptoms in the exact same order. Even so, the recovery symptoms that *tended* to occur earlier are in the earlier chapters of this recovery section and the recovery symptoms that *tended* to occur later on are in the later chapters of this section.

Each chapter has an explanation as to *why* these symptoms occur, a few specific examples of what these symptoms looked or felt like, and an example or two of the fascinating ways in which some patients have used the recovery symptoms to mentally convince themselves that they were getting worse instead of better.

And have I mentioned that no two people with Parkinson's have the exact same collection of symptoms? Each person's recovery was also unique.

“He jests at scars, who never felt a wound.”

- Shakespeare’s “Romeo and Juliet”

CHAPTER TWENTY-ONE

RECOVERY SYMPTOMS: NUMBNESS AND PAIN

Numbness vs. rigidity: a review

Chapter ten had a long song and dance about the *locations* and *natures* of the physiological symptoms of Parkinson’s disease. Now you get the payoff for wading through all that material.

As you will recall, most of these symptoms are located on the Stomach or Large Intestine channel. The *nature* of the symptoms refers to numbness and atrophy, or oppositely, rigidity. Numbness and atrophy are due to an absence of channel Qi. Rigidity is a correct response to backwards-flowing channel Qi.

Recognizing these recovery symptom patterns was crucial in figuring out that Parkinson’s disease symptoms are identical to symptoms of channel Qi flowing in the dissociation pattern for a long time. That was my payoff.

Here’s *your* payoff: differentiating between symptoms due to *absence* of channel Qi and those due to backwards flow of channel Qi will enable you to make sense of recovery symptoms.

When, the channel aberrations resume correct flow, the numbness and the rigidity begin to melt away. It doesn’t matter whether the channel restoration is a response to healing the foot injury or healing the mental-lock keeping one in dissociative mode. When channel Qi begins to flow correctly in the Stomach and Large Intestine channels, numbness and rigidity, if present, go away.

We observed that, in recovering patients, areas that were previously numb became highly sensitive, for a while. Areas that had been rigid became limp, for a while.

This chapter will address the recovery symptoms that occur in body parts where channel Qi flow had been absent or minimal: areas of numbness.

The next chapter will discuss recovery symptoms in areas that had become rigid.

The pain of injury

Our patients with Parkinson’s wrongly assumed that the healing of a foot injury and restoration of healthy Qi flow in the feet should necessarily be pleasant. The *end* result is pleasant enough, but many patients experienced long-suppressed pain while the foot was healing.

The FSR techniques, or any other light-touch massage technique, encourage a person's awareness and even subconscious to revisit a long-ignored injury and thus initiate healing.

When the mind decides to acknowledge an ignored injury, the unexpressed, dormant symptoms of injury may appear. These symptoms may include bruises, tenderness, pain, swelling and even heat.

If a patient's injury had been only a dislocation or sprain, the reawakened pain wasn't necessarily severe. If the reawakened injury was a broken bone, the pain was sometimes considerable.

As patients started experiencing the pain of forgotten injuries, they often said, "My foot hurts! What should I do?"

We were surprised by their degree of fear and by the questions that arose. These people were adults; they should have known what to do to ease the pain of a healing injury.

But even though they might have been capable of helping care for other people who were in pain, recovering patients often had no idea of how to care for *themselves* when they were hurt.

We had to teach them.

How to deal with pain

The appropriate thing to do, we explained, whatever sort of pain occurs, is to treat the injury the way that it should have been treated in the first place: use common sense.

If, following FSR treatment, or a few days or weeks later, the foot hurts, then favor the foot for a few days. Limp a bit. If the foot itches, scratch it. If it wants to be rubbed, rub it. Listen to the body, and give it what it wants. Again, use common sense. Do *not* be stoic.

Treat your "recently" injured foot in the way a well-loved child would treat an injured foot. This may even include (God forbid) asking for and accepting help. If it's a severe sprain or dislocation, you might want to wrap it up or get a little extra sleep instead of going dancing.

In the rare case where it feels like a bone is broken, don't be stoic and force yourself to walk on the broken foot. Use crutches for as long as necessary or even stay home and lie on the couch for a few days. Leave the stoicism behind.

A very quick course in dealing with pain:

Pain occurs when the electrical signals in the body are disrupted. The disruption may come from injury or it may come from mental distress.

Dealing with physical pain

When injured, a person should, as soon as possible, focus his mind on the area that's been injured. Next, he can imagine light, and very gentle muscle tension in the area. In this manner, he tells the brain that this area needs some help.

It can be helpful to hold that mild muscle tension for a count of ten, and then release. Repeat ten times. This takes about a minute or less. I have personally used this technique after receiving a nasty blow or injury, and the results are delightful. In some cases, the body doesn't even need to go through the usual swelling and pain processes, because the brain already knows about the injury. Healing begins immediately.

The idea of sending energy to an injured area is very Asian – this is *not* an American concept. As a child, I was taught avoidance measures such as “Don’t think about it,” “Bang your head against the wall and you’ll forget all about your stubbed toe,” and of course, “Stop that crying or I’ll give you something to cry about.”

Dealing with emotional pain

Fear, grief, rage, the fear associated with physical pain, and even just being startled can disrupt the channel Qi flow through the pericardium, the connective tissue around the heart. The altered pericardial signals send a message to the brain that says, “We are not at peace: something is wrong.”

The brain interprets these signals as various forms of pain. The signals serve to get the brain’s attention, and tell the owner of the body that something is amiss. As soon as the body is able to focus on the pain and correct the electrical signals of the pericardium, the pain ceases, or is greatly lessened.

We correct the destabilized pericardium by surrounding it with a mentally induced, larger-than-the-pericardium sensation of loving protection. This larger field, via resonance, calms the pericardium and brings it back to stability.

An infant is not able to correct the signals in his pericardium. If an infant is startled or in pain, he cries. After the cause of the crisis has been dealt with, the adult calms the crying infant: the adult holds the infant over the left side of his chest. The calm signals from the much larger adult heart resonate with the infant’s heart signals and bring the infant’s signals back to the correct pattern. The infant’s pericardium, or “heart,” is calmed. The pain signal ceases. The crying stops.

Between the ages of six and eleven, a child should learn how to calm himself.

Technically, when a person calms himself, he is reinstating, intentionally, the pericardium signals that he associates with feeling safe and OK. He may also take a deep breath when calming himself, as this helps restore parasympathetic mode function.

Ideally, the child learns to restore destabilized pericardial signals prior to adolescence. The powerful mood swings of adolescence can overwhelm a person who has not already learned how his heart is supposed to feel, when calm, and how to restore his heart to that calm if it gets distressed.

Anyone who has *ever* felt calm has a memory, in his brain, of what “calm” feels like. “Calm” is the above-mentioned loving feeling that we can use to surround the heart and bring it back to stability. As humans, we have the ability to install that feeling around the heart any time we need to – any time we become agitated or in pain. As we restore and then consciously sustain that feeling of calm, or what you might also call a feeling of “goodness,” “soul,” or “something within,” the brain is then able to turn off the Red Alert button. The problem ceases to register in the brain as “pain,” and is converted to mere “sensation.” From here, the body or the thoughts can address the problem in a productive fashion.

In some cases of physical pain, physical contact in the injured area, in addition to mental attention, helps to more quickly restore the channel Qi flow, somewhat. The restoration of channel Qi helps diminish the stress pattern in the pericardium.

Whether the pericardium is calmed by mentally and/or physically holding an injury, if any, or by re-installing a “calm” signal all around itself, thus bringing the pericardium signals back to “All’s well,” the brain is able to note that the pericardium is OK now. Once the pericardium is OK, the brain can turn off the Pain alert.

The pain-inducing situation is then moved from the “Inbox” of the brain, where the flashing light of “PAIN” was grabbing the person’s attention, over to the “work to be done” or the “finished business” part of the brain. At this point, the event can become a memory, and while it still may register as a “sensation” until the healing is complete, the event no longer has the ability to trigger a *distressing* type of “pain” response that unsettles the pericardium.

If the pain is large enough, a person might seek out hugs from another person. These hugs from a calmer person work just like they do in an infant. The close, chest-to-chest contact can help restabilize the chaotic signals in the pericardium of the injured party.

As adults, we have the legal right and the moral responsibility to re-install that remembered feeling of calm in our heart any time we don’t feel good. We can re-install it with the help of friends or by focusing our minds on the remembered sensations of calm and love. Failure to take care of pain, or a preference to cultivate pain, dwell on it, or use it as a sympathy- garnering device is immature.

In our modern, “scientific” culture, children are rarely trained in how to deal with pain. For the most part, children are left to figure it out for themselves. Some do a good job. Many do not.

Many of my patients with Parkinson’s have had almost *no* idea of how to deal with pain. They may not even know what “Calm” feels like. Their emotional maturity, once recovery begins, can be very similar to the emotional maturity they had attained when they first started dissociating. If they first dissociated from pain when they were five years old, they may have the pain-processing skills of a five year old.

This subject could fill a book. But this is enough to be getting on with.

Fear of pain

Because many of my patients had no understanding of how to deal with pain, they were often terrified of it.

Some patients have expressed great fear in anticipation of feeling old injuries. Some were afraid to let us touch their feet.

One person traveled to Santa Cruz to be treated, knowing full well that the treatment consisted of foot holding. But when I asked her to remove her shoes, she balked.

She explained, “Not even my husband has ever seen or touched my feet.” She went back and forth for about half an hour deciding whether or not she could allow me to even look at her feet. Then she made up her mind. No. She left. I never saw her again.

Others were terrified of what they might feel in *general* if they let their guard down. As quoted earlier in this book, one patient explained: “The whole point of life is to avoid pain.”

Those patients whose stoicism was zero or minimal tended to recover more quickly. They sometimes mentioned that they had been very stoic and guarded at the time of injury, or throughout childhood. But if they had learned, in their adult life, that it is good to experience

sensations and that it is not “bad” to feel and respectfully attend to the body’s injuries, they responded more quickly to treatment.

Some of these emotionally mature patients had consciously worked at learning, as adults, that it’s OK to ask for help. A few had even taught themselves how to cry.

The patients who were able to cry and mentally focus on the actual sensations of their own physical and emotional pain had fewer problems figuring out how to deal with any pain or bruising that arose when the foot healing began.

Many patients, when starting treatment, were still proud of their ability to not feel pain. Some had stopped crying in early childhood and had not been able to cry since. Some truly believed that non-feeling or perpetual wariness was superior to acknowledgement of physical or emotional pain. In general, these people needed more time spent in holding their rigid feet or ankles before the injuries “let go” or started to manifest as bruising or pain.

Often, these people were alarmed or anxious when the appearance and sensations of an old injury began to manifest. Although the pains were not necessarily severe, a few even veered into bouts of hysteria and paranoia when confronted with the pain of their old injuries.

Some patients had *no* ability to face pain and process it. One patient had full-blown bouts of hysteria every evening for several months after he started feeling the injuries in his foot. We finally figured out that re-awakening the foot injured had also re-awakened a life-threatening, excruciating groin injury.

Then again, one (and only one) patient, within hours of being *diagnosed* with Parkinson’s disease, developed the same sort of daily hysteria, and it lasted for several months. He developed this hysteria a full month before he heard of our work and started being treated by us. His hysteria finally eased up after many months of foot treatment, psychiatric counseling, prescription-strength anti-insomnia drugs, and homeopathic remedies. In this case, he was not feeling long-suppressed pain. In the face of being diagnosed with a terrible illness, he was unable to control himself any longer, after years of being stoic. In my limited experience, his case was unique.

Eventually, we realized that many people with Parkinson’s literally do not know how to deal with pain or fear. They may have never *learned* the usual pain assuaging mechanisms that young children slowly master during the years from around age three to age eleven (approximately). For many of our PD patients, the only fear- or pain-treatment mechanism they’d ever known was mentally blocking out the pain or fear – pretending that it wasn’t there. The concept of *confronting* fear or *feeling* pain and consciously soothing it and thus neutralizing it was absolutely new to them.

A lengthy aside: pain from other injuries

Some recovering patients experienced pains in *other* parts of their bodies as they began to recover from dissociated foot injuries. These pains turned out to be other injuries that had also never healed. Sometimes the other suppressed injuries appeared at the same time that the foot injury started to show signs of bruising and swelling. Sometimes the other injuries appeared weeks, months, and even years after the foot injury healed.

Very often, the person recalled the incident(s) that probably caused the other re-appearing injury(s). I was told things like: “I’ll bet this hip pain goes back to when I fell two

stories and landed on my hip; it sounded as if a bone had broken but my hip *never hurt*,” or “Oh yeah! Eight years ago, when I moved the stove by myself, I thought I twisted something in my neck and I heard something pop, and my clothes have sat crooked at the neckline ever since, *but it never hurt*.”

Then again, sometimes a patient has had no recall of any injury at all in the non-foot area that spontaneously manifested a bruise or soreness.

It does *not* matter whether or not the patient is able to remember the painful incident. Some patients (especially those that have raced motorcycles) have had so many injuries that there is no way they will ever sort out which incident caused which injury. That’s fine; this lack of memory will not impede recovery.

Some of the non-foot injuries only showed up as faint bruises with no pain. Some were full Technicolor bruises, featuring blues, yellows, and greens, with streaks of fresh red under the skin. Sometimes there was pain with no bruise. Sometimes there was bruising *and* pain.

Although unhealed broken leg bones were relatively rare, the people who had them experienced a tremendous amount of pain and swelling at the site of the break. Sometimes, in cases of very severe pain from a broken leg, body-wide tremor accompanied the pain and shock for a short time – as it should.

Staggered recoveries

Although some patients had arm, leg, neck or head injuries that appeared at the same time as the foot injuries came to the surface, it was more common for the various injuries to show up in a staggered fashion.

Research has proven that a person who receives severe multiple injuries cannot *simultaneously* feel the pain of all of his severe multiple injuries. In these cases, the body seems to “decide” which injury is the worst at any given moment, and addresses that one. When appropriate attention has been given to that worst injury and healing has begun in that most problematic area, a different injury is then able to receive the body’s foremost attention.

A person whose fall down a steep hill has bruised his ribs, sprained his knee, scraped skin from many places and thrown his back out, will know what I am talking about. Even though he may have a general sense that he hurts all over, only one injury at a time will *truly* stand out as being the thing that needs to be addressed immediately in any given moment. And as soon as that particular problem starts to feel better, another injury will move to the fore. It is not uncommon for people with injuries in multiple areas from a really bad accident to spend *months* healing. As soon as the neck pain starts to heal, the hip pain might demand attention. As soon as the hip pain starts to resolve, the knee pain might arise. When the knee healing is underway, the shoulder injury may start to squawk.

In some of our cases, once the patient started being able to tune in with his body and feel long-forgotten pain, one or two “new” injuries showed up every few months, or once a year. In some cases, this delayed healing continued for several years even after completely recovering from Parkinson’s. The recovery from Parkinson’s did *not* require healing of all suppressed injuries. The recovery from Parkinson’s, including the person’s ability to experience steady dopamine function as demonstrated by a return of normal large motor

function, often started up as soon as energy was able to flow correctly through the foot – so long as there was no dissociative thinking.

The presence of other, smaller injuries – injuries that didn't interrupt the Qi flow in a significant manner – did not usually appear to inhibit the recovery from Parkinson's.

Then again, many people who slide into mind-driven partial recovery insist that they aren't recovering because we haven't found "all the injuries." Watch out for this attitude! It's a ploy by the subconscious mind.

Improved circulation

Following the healing of the old foot injury, the next recovery symptom was very often an improvement of the blood circulation in the foot. The foot color often improved significantly. Blood vessels in the feet often became larger: more visible. Temperature regulation in the feet improved.

Before starting treatment, the skin on the feet of many of our patients was mottled, sometimes purplish, or even a ghastly gray, with no or few distinct blood vessels. If a large vein *was* visible, it often formed a semi-circular pattern on the top (saddle) of the foot instead of flowing all the way from the toes.

Some patients' ankles had severe staining (dark reddish brown discolorations) or angry, bright red varicosities. Following recovery from the foot injury, the skin color became healthier and healthy blood vessels stood out more. The semi-circular vein developed branches feeding into it from the toes or a completely new set of healthy veins appeared that fanned out over the toes. Sometimes, the dark "staining" lightened up a bit and angry-looking varicosities diminished in size and intensity. These changes sometimes coincided with or foreshadowed an improvement in temperature regulation in the feet, or even the hands.

Many patients who'd had cold feet for years deeply enjoyed the novel sensation of having feet that could warm up easily after having been subjected to cold.

This type of lasting cold in the extremities, also known as Raynaud's syndrome, is not unusual in people with Parkinson's disease.

One recovering patient had abject fear of getting his feet cold because they remained cold for days, following a severe chill. When circulation in his feet improved, one of the first behavioral changes that he shared with me was that now he would often sprint barefoot along the snow-blanketed walkway out to the mailbox to pick up his letters and then scamper back into the house. He didn't mind that his feet got cold; rather, he was thrilled because, after getting back into the heated house, his feet would quickly warm up again! He was as pleased as a child at the novel sensation of his feet getting warm all by themselves after having been briefly chilled.

The return of sensation

Another recovery symptom that was often set in motion by improved circulation was the cessation of numbness.

Prior to entering the recovery program, many patients insisted that their toes were not numb. As proof, they pointed out that they could feel their toes if they stubbed or touched them. However, their proprioceptive awareness of their toes, which is to say their internal sense of how the toes feel and where they are (a concept that many people with Parkinson's do not even understand) may be completely lacking. These medial toes on the more affected

side are *usually* quite numb. I have done many experiments with patients in which I have been able to prove this numbness. So has Chris Ells, one of my colleagues.

Dr. Ells did his doctoral research evaluating numbness of the feet in people with Parkinson's. As part of the research, he asked his patients whether or not they thought they had diminished sensitivity in their feet. Most patients felt that they had reasonable, even normal, levels of sensitivity in their feet.

When, in these patients, the side of the body that first developed symptoms of Parkinson's was tested with a longish acupuncture needle inserted into Spleen-3 (see Fig. 9.1, p. 136), a famously painful point near the big toe, most of the patients made rather a proud show of stating that they were able to feel the needle. When a matching needle was then inserted into their other, healthier foot, the typical response was much stronger: a sharp startle response, often followed by the slightly concerned query, "What are you *doing*?" When these people were told that the two needle insertions were exactly the same, and had been performed to determine relative numbness, the patients were usually stunned.

What they did not know is that, in a healthy person, such vigorous needle insertion at this particularly electrical location should evoke such a strong reaction that, very often, a healthy person lying down, relaxing, will jerk bolt upright in response to rude needling at this point. None of our Parkinson's patients *ever* had such a powerful, visceral, *normal*, body-wide response to abrupt, powerful needling at this point (SP-3) until they began to recover.

When I taught a class on Parkinson's at the local acupuncture college, I would often needle new PD patients at SP-3 as part of their intake, to help me determine how numb their feet were, and which foot was the more numb. Many a student, knowing the extreme, body-jarring shock of strong needling at this point, would brace himself as he saw me picking up a fairly large needle and jamming it with a lot of power and wristy follow-through into the side of the patient's foot.

I could see the concern on the students' faces as they braced themselves. The concern changed to stark amazement when the patient failed to physically react against what should have been a powerful electrical shock. The patients could overhear me telling the students that I was doing this to check for numbness in the feet. Not knowing the correct response that a healthy person would have to strong needling at this location, they were usually outspokenly proud of their keen ability to detect that I had touched their feet and inserted a tiny needle. Many said something along the lines of "I felt that. I could feel your fingers on my skin and I felt that you were putting a needle in: I'm *not* numb."

The true proof of their numbness came when feeling returned to their toes.

I think my favorite quote on this subject came from the recovering patient who asked me, in amazement, "Did you know that a person can feel his own toes even when they're inside his shoes?! Did you know that toes can tell whether or not they have socks on *without even looking*?! Of course, prior to starting the recovery program, this person had assured me that his feet were not numb in the slightest.

The sheer amazement in his face and voice as he asked me these innocent questions told the story: for as long as he could remember, he had never been able to actually know of the existence of his own toes if they were hidden by shoes. He had not been able to feel the soft texture of his socks against his skin. When he had started the program, he insisted that he

could feel his feet: if he touched his feet, he could feel the touch of his hand – therefore, he did not have numb feet. However, if he was not touching his feet, he had no awareness of how his feet *felt*.

Another sweet remark from a patient who regained proprioception and feeling in his hands – even though, prior to recovery, he'd insisted that his hands weren't numb, was, "My fingers have eyes again! I can see where my fingers are even when they're inside my sleeve!"

As foot circulation improved, foot areas that had been numb, such as the distal (toe) end of the foot and particularly the three more-medial toes (the "big" toe, second, and third toes) experienced a return of sensation.

In some cases, the sensation was mildly pleasant. In most cases, however, the return of sensation to long-numbed nerves was somewhat painful. Common descriptions of the foot sensations that occurred during recovery from numbness were "tingling," "burning," "pins-and-needles," and "like the pain of recovery from frostbite."¹

One particular area on the foot tended to experience a very powerful sensation during recovery: the medial side of the ball of the foot, in the general vicinity of SP-3 (Fig. 9.1, p. 136).

Many recovering patients have reported a particularly strong stinging sensation right at this spot. Patients have said things such as: "I was certain I had a splinter in my foot. I took my shoe off six times to try to find the splinter but there was nothing there," or "I thought a bee was stinging me; I took off my shoe several times but there was no bee. The sensation lasted for hours [or on and off for days, or some such variation]."

However, some of the tingling that occurred when the nerves come back to life was less site-specific; the sensations came and went or moved around a bit. Many people described the sensations as "ants moving around in my toes." Another description was "someone's dragging a miniature rake back and forth over the top of my foot and my toes for the last two weeks."

Interpretations of the "tingling sensation"

The emotional response to the reawakening of foot and toe nerves varies from one patient to another. Some recovering patients have found the tingling sensations to be amusing or even thrilling: proof that change was underway. Others were fearful that the pins-and-needles sensations would only keep getting worse, or even that the new sensations of pain were being caused, not by anything healthy, but by cancer, gout, imbedded nails or broken glass, or some rare and incurable foot disease. Some people enjoyed the reassuring feelings of once again having toes. Others found the awareness unfamiliar and even frightening.

As to the intensity, a few recovering patients told me that they were so shocked by or fearful of the stabbing sensations in their feet and toes that they screamed out loud during the more dramatic moments. Others said things along the lines of, "It was no big deal," "You got me worried for no reason," and "It's nothing; why did you even put it in your book?"

I cannot begin to share all of the descriptions and variations on the return of nerve function in the feet and face.

¹ Frostbitten toes are actually painless – so long as they remain frozen. In fact, they often feel perfectly normal until they warm back up. *Recovery* from frostbite, on the other hand, can be quite painful.

At the time we first started tracking recovery symptoms, we had no idea of the role dissociation was playing, or the role of negative thoughts such as “I’m not safe.” Instead, we noted that, in general, people who were emotionally closed off or mentally oriented towards cynicism, negativity or self-control tended to experience the return of nerve function as painful, “terrible,” and even, in the few cases where bones had been broken, temporarily excruciating. Those people who were more curious than frightened tended to enjoy, or at least not mind, the sensations, compared with those who seemed more negative, in general.

The sensations of recovery from Parkinson’s are merely that: sensations. Whether or not they were perceived as augurs of health or omens of suffering seemed to depend entirely on whether or not a person was in a predominantly positive or negative mindset.

Increased awareness of rigidity

Often, along with a cessation of numbness came an increased *awareness* of rigidity. This rigidity might have been there right along, but had not been felt. For example, many patients had not realized that their wrists or ankles had been moving in a cogwheel motion until their doctor pointed it out. They couldn’t feel the wrist or ankle very well (they were numb), so they didn’t realize the full extent to which the ankle or wrist was rigid.

Due to improved circulation and the concomitant return of nerve sensitivity, many patients began to notice that their bodies were far more rigid than they had realized. As one person said, “I can feel my feet better and I’m walking better and faster, but I never knew my legs were so heavy and stiff!”

Another patient said, “I think I’m getting worse. I have a limp.” In fact, she had been limping since before she started receiving treatment. When reminded of this, she admitted that, for decades, she had *heard* herself limping, but had never *felt* it before.

The red rash

(This section will take a bit more space than is possibly justified in terms of the percentage of people who get the red rash, but the fungus situation is significant to our project because it provides still more proof for our hypotheses.)

Many people with Parkinson’s have foot and/or toenail fungus. The toenail fungus causes the nails to be thick and gray, or even white. In some patients, this fungus has moved into the tissues of the feet. The fungus may blossom (present an itchy, red rash, or sores) during the summer months or anytime that the feet are hot. The fungus may become dormant when the weather is cold.

In areas where the body is numb, the fungus can thrive, unmolested. When circulation improves, the body becomes able to notice the presence of the fungus. Once the body notices the fungus, it will take steps to kill it.

Fungus is everywhere. Our bodies are constantly being exposed to fungal spores. The white tip of a healthy fingernail is white with fungus residue: fungus is digesting the underside of the nail. But a healthy person’s *awareness* of his body keeps the fungus from establishing itself in the pink, attached-to-the-nailbed section of the nail. The faint, very thin line of deeper red where the nail goes from pink (attached to the skin) to white (free standing) is the red of a biological battle line. These are the lines where a healthy body keeps the ever-present fungus at bay.

However, the immune system cannot not fight very well in those body areas in which a person has little proprioceptive self-awareness, poor circulation, poor sensitivity, or an absence of self-awareness. Fungus can therefore thrive in these areas.

Because most people with Parkinson's have very little awareness of their toes and feet, they often have fungus invading and becoming established in the nailbed (inside the toenails) and in the skin of the feet.¹

In addition to having obvious fungus in their toenails, people with Parkinson's often have thriving fungus in the skin of their toes, and the dead skin on the soles of the feet. These areas may break out into an itchy red rash when the weather is hot. If the leg is somewhat numb and there is poor circulation in the skin of the leg, the mycelium ("roots") of the fungus sometimes spreads farther up the skin of the leg, but it is usually not able to thrive and become obvious in areas where the blood circulation is sufficient to keep it at bay. Thus, its presence in the *legs* is generally limited to an asymptomatic sub-dermal invasion, if anything.

During recovery, circulation almost always improves quickly in patients' feet. As circulation improves, it seems as if the patients' immune system becomes able to detect the fungus, if there was any, and initiates battle against it. This often causes a reaction in the feet. The fungus, coming under attack, blooms aggressively, in a final attempt to produce spores before being killed. The "blossoms" of the fungus are tiny, itchy, red bumps. If there are a lot of the little bumps, they looked like a red rash. Sometimes, if they are scratched enough, the bumps open up, releasing a tiny bit of fluid.

As the fungus comes under attack from the body's newly alerted immune system, itching red sores break out wherever the fungus was located.

In some patients, the fungal infection has pervaded the skin of more than just the foot. In some cases, these sores, also referred to by us as "the red rash," have extended up the lower part of the leg(s) and, in a few cases, even up the thighs.

No treatment is necessary.

The red rash can be hot and itchy, but in all cases that we have seen, the red rash has gone away by itself. Once circulation is restored, the body is able to recognize and destroy the fungus that has snuck into numbed areas over the years.

Some patients found that an athlete's foot salve was somewhat helpful during this time, but others said that it was not. Others found that aloe vera lotion was useful in soothing the heat and itch until the battle is over. Others disagreed. One patient had good luck with rubbing garlic on the rash.

The red skin rash always ceased eventually. Even the fungus in the toenails often decreases or disappears, although this usually takes much longer. Watching the healthy new

¹ The numbness, poor circulation and poor body awareness that allows the fungus to slowly move deeper into the body may start decades before a person is diagnosed with Parkinson's.

For example, at age seven, about two years after having my foot smashed in a car door, I noticed that I couldn't tell exactly where my *fingertips* ended and the air started. In my twenties and thirties, I assumed this vagueness as to the borders of my own body was a sign of advanced spirituality – my body consciousness was contiguous with the universe. I never even realized that I had *no* idea where my *toes* ended. I developed toenail fungus in my late forties, just two years before I realized I had Parkinson's. I only had fungus on my toenails, not my fingernails. Evidently, my toes were even more numb than my fingers – so numb I didn't even know how numb they were.

nails slowly grow in, pushing the diseased toenails out, can be a cause for gentle celebration. In some cases, the toenails returned to complete health.

I found it interesting to note that toenail fungus is an illness that some doctors consider to be treatable but ultimately incurable – just like Parkinson’s.¹

The red rash battle sometimes lasts for a few short weeks. Sometimes it goes on for over a month.

One patient who had the red rash go all the way to the top of his thigh was a neurologist. It was exciting for him to observe this utterly unexpected manifestation of submerged illness. It was clear that there had been something wrong with him that was not related to “dead brain cells,” and that his body was healing from some previously unrecognized numbness. I asked him if he would tell his colleagues at one of the top medical schools in the country about our theories and his treatment. He said that he would not. “They would think I was crazy if they knew I was seeing an acupuncturist.”²

Recovery sensations in the face: feeling, taste, and smell

Tingling in the face

As with the feet, the first changes to the face are often improvements in blood circulation. This can lead to improved color and warmth in the skin. The subsequent tingling, mild stabbing pains, and the sensation of bugs crawling under and over the skin can last for many weeks, and in some cases, months.

Sensation often returns to the face more slowly and mildly than to the feet. But even if the facial sensations are milder, they are usually harder to ignore. Compared to tingling in

¹ Some patients have asked about the internal (pill form) antifungal medications. Fungus in the toes and feet is not a dangerous condition. Internal antifungal medications, however, are extremely toxic and hard on the liver. In fact, the internal antifungal medications (as opposed to the external-use ointments and salves) are far more dangerous than the fungus itself. Most of the doctors I know personally will not let their own family and loved ones use the FDA-approved *internal* antifungal medications.

When a person uses internal antifungal medication, the *dormant* portion of the fungus doesn’t die from the medication. The fungus will resume growth and thrive again within a few weeks after a person stops using the medication. In other words, the anti-fungal medications do not *eradicate* the fungus. The fungus can remain in the body, dormant, as long as a person is taking the medication. Therefore, the medication doesn’t actually “cure” the fungus; it just masks the symptoms.

² We treated him before we understood the risks of the medications. Sadly, as he recovered, this brilliant neurologist became horribly addicted to his medications. During his recovery from idiopathic Parkinson’s, during which time he found himself emotionally unable to decrease his medications, he rapidly developed drug-induced parkinsonism and suffered greatly from adverse effects of the now-excessive medication, including violent, rapid changes in blood pressure, passing out, and serious injuries from falls incurred when passing out. He was never able to decrease his medications in the slightest even though his idiopathic Parkinson’s went away. He died a few years after working with us, of drug-related health problems.

the feet, the sensations of spiders crawling through the face and even the hair are often less sharp and painful but far more startling and/or annoying for some patients.

A stickler, reading this section, might want me to say whether the facial sensations were more like ants or more like spiders. In general, people who were more defensive or more negative tended to feel as if they had spiders and spider webs whereas people who were more curious and grateful tended to feel as if they had ants and loose hairs. I suspect that, in terms of nerve function, the actual sensation being transmitted was exactly the same. Whether the transmission was interpreted to be ants or spiders was merely a matter of perception: thinking made it so.

When did the tingling occur?

The sensations tended to be intermittent. As with most of the recovery symptoms, these sensations were at their strongest when a person was awake and relaxed – in parasympathetic mode.

Some patients were worried that they might have recovery symptoms when they were “in public.” This almost never happened. It seemed as if, whenever a recovering patient was worried or frightened – and being caught doing something “not normal” in public seems to be a cause for wariness for many people with PD – a patient’s mind switched over to dissociative and/or sympathetic mode and the recovery symptoms temporarily ceased.

Bear in mind that in all people, parasympathetic (relaxed) mode is when most healing occurs. This is possibly why recovering patients noticed the strongest symptoms of tingling or crawling bugs during those times when they were relaxing. Very often, they felt their recovery symptoms most strongly while watching TV in the evening or just before falling asleep.

Numbness of sensory function in the face

In addition to poor muscle function, numbness and poor circulation in the face can contribute to diminished sense of taste and smell, and coldness and lack of sensitivity in the facial skin, including the lips.

For example, many people with PD dribble on their shirtfronts when they drink from a glass or cup because their lips are somewhat numb. They cannot accurately sense *where* to apply lip pressure to the rim or *if* they are applying pressure.

Just as with the denial of foot numbness, many of our PD patients denied that they had any impairment of taste or smell or tactile perception in the face. They assured me that their sense of taste and smell was perfectly normal. Others knew that their sense of taste, smell, or tactile awareness was declining or gone, but assumed that the loss was somewhat recent or normal aging.

For example, one patient admitted being humiliated for many years even prior to diagnosis because she was often told by fellow diners that she had a spot of food sitting on her lip or that she had a “food mustache.” Also, she had increasingly spilled drops of her beverages down the front of her shirt because her lower lip couldn’t actually feel the contours of the drinking glass. She did not realize that her facial skin was more numb than normal. Instead, she had assumed that she was a clumsy eater. Her son-in-law had even asked her once if she was able to feel the bits of food stuck on her face. Ashamed of her “sloppiness,” she had assured him that she could, even though she couldn’t. At the time, she wondered to

herself how anyone could *possibly* feel a bit of food stuck on the face. After recovering, she was able once again to feel when her facial skin was accidentally decorated with food.

When recovering patients experienced the full range of healthy sensation that returned to face, tongue, and nose, they often asked questions like, “Did you know that wet asphalt has a *smell!*?” or “Did you know that different kinds of tea actually taste different?!” These queries suggested that the person’s sense of taste or smell had been numbed for a very long time. Some patients admitted that they were experiencing common smells, such as the smell of newly cut grass, for the first time in decades. Again, when a person is numb, he cannot be a good judge of how numb he is: he may be too numb to know.

Of course, there were exceptions. For example, one of my PD patients with lifelong extremely poor eyesight had a highly developed sense of smell even though her Parkinson’s symptoms were coming on strong. And one recovering patient developed malodoria: a condition in which all smells are perceived as foul and nasty. Again, no two PD patients are exactly alike.¹

The pleasures of recovery

Whether the recovery symptoms felt like ants or spiders, nearly all patients loved the *results* of these recovery symptoms: return of sensation and function. Even in the earliest days of the project, when we could hardly dare to believe that we’d found a cure for Parkinson’s, the patients were thrilled at the improvements in their faces and feet.

Family members were especially thrilled to see the return of full facial expression.

Exceptions to every rule

Then again, a few patients grew angry when people suggested that they were moving better or looking better! These supportive compliments were interpreted as criticisms of how the person had moved or looked in the past.

I remember one recovering patient insisting that he’d never had a lack of facial expression: he claimed he had *consciously* refrained from “stupid smiles” – just like the Buddhist monks that he’d briefly studied with, back in his college days. His face had expressed emotional “reserve;” it *had* never been frozen.

His wife and I did not argue with him. He could not be argued with. Although he was a brilliant professor of sociology, he had the social skills of a three year old – including

¹ In our experience with hundreds of PD patients, only one person developed malodoria during recovery. Malodoria is a condition in which *all* smells are perceived as offensive. When, in response to Tui Na treatment on her feet, this patient became able to detect smells, she was assailed each day by whatever the first smell of the day happened to be. For hours, she could not get rid of the stench of that particular smell, and when it finally ebbed, the next thing she smelled would take its place – and would be perceived as equally noxious. This patient was extremely cynical about the *bona fides* of everyone, and sometimes even paranoid. This was in the very early days of our project: she was taking a high level of antiparkinson’s medications. When her foot began to heal and simultaneously her responses to her medications became suddenly violent, she tried for several days to decrease her medication, but found herself emotionally addicted. She dropped out of the program. Malodoria is extremely rare. It occurs when a person is deeply entrenched in sympathetic mode. The “cure” is a return to parasympathetic mode.

stubbornness and temper tantrums. He was emotionally utterly unable to deal with the idea that he had ever been imperfect – especially with regard to his facial expression.

But the fact was, over the last ten years, his wife’s friends had been increasingly afraid of him because he always looked as if he was glaring with disapproval. (He had no friends.) After muscle function returned to his face, he was clearly smiling at people once again, even as he continued to assume his lifelong look of unctuous “reserve.” Her friends were so pleased that he was finally “warming” to them, that he had become “welcoming.” His behaviors were actually just the same. So far as he could tell, he was still giving her friends the same studied look of benevolent wisdom. So when any of us expressed delight with his new smiles, he grew angry, even belligerent.

He was very intelligent and witty. I’d noticed in the early days of treating him that, when he’d told jokes, his facial expression never changed. As he was recovering, his eyebrows, cheeks, nose, and mouth all danced with expression when he told his jokes and witticisms.

After his face recovered full sensation and the ability to move, the only thing that remained unchanged was his inability to admit that he’d ever had a frozen face – or been imperfect in any way.

His stubbornness and temper tantrums were *somewhat* unusual in our experience. In general, our PD patients *tend* to be people-pleasers: careful to not show emotion, and careful to prevent anger rising up in those around them: the characteristic emotional-harm avoidance traits of the “classic” Parkinson’s personality.

The sequence of recovery symptoms

As noted previously, there was absolutely no cut and dried pattern for the recovery symptoms. Some patients even resumed full feeling without experiencing the pins and needles.

For example, one patient’s unhealed foot was treated for nearly a year. After the foot healed, over the next many months, she regained feeling in her foot and her facial expression returned. Workouts at the gym helped restore range of movement in her arms. However, she still favored her left knee and hip and she still tremored. I asked her to take a course of homeopathic pills (Arnica Montana). This particular homeopathic remedy can hasten the healing of injuries by drawing one’s attention to the injury. After taking the Arnica for about a month, at an *extremely* low dose, a mass of bruises appeared on both sides of her left knee and her left forearm. These bruises were consistent with the foot-in-the-bicycle-spokes knee-torque injury that she’d had at age seven. These bruises went away over a period of two weeks. Three weeks later, she announced, “I can feel my fingernails! They’re like wind-chimes!”

Wind chimes? She had never been prone to flights of poetic fancy. Prior to full recovery, most of our PD patients were more comfortable and experienced with analytical thinking than with metaphor or poetry. I had to ask what she was talking about. She explained, “I can feel the tiny weights of my fingernails. I’m aware of my fingertips. It’s as if I have ten little bits of weight at the tips of my hands: when I move my fingers, I feel them moving, fluttering like the little noise-makers on a wind-chime.”

I’m including this example because she never experienced any tingling in her fingers prior to the return of sensation. Also, there was no specific sequence of events that could have

led us to expect a return of sensation in her fingertips following the discovery and healing of a *knee* injury. And she'd never suspected that her fingertips were numb.

Please bear in mind – in many cases, recovering patients had no weird symptoms such as tingling or profound weakness. I'm writing about the weird things that do happen in *some* patients because they need to know that these recovery symptoms are not cause for worry.

I merely mention this, and will mention it several times, because so many of our patients insisted on determining whether or not their Parkinson's was going away based on how many recovery symptoms they had.

The reader who does not have PD may think that this is ridiculous: the way to know if Parkinson's is going away is that the symptoms of Parkinson's go away. However, many people with Parkinson's are so out of touch with or afraid of sensation in their bodies that they don't have an accurate knowledge of their symptoms and do not know when symptoms are changing.

In the same way that “a watched pot never boils,” a patient who was fixated on a particular problem might not notice that all the other symptoms *except* for the “watched” one were going away.

This seemed very bizarre to us, at the time. Also, *many* patients who resumed perfectly normal movement refused to believe that they were recovering unless an MD said that they were recovering. Of course, no MDs ever said that a patient had recovered. Any patient who recovered had been “misdiagnosed.”

One patient who attended the free clinic once a week for just over a year was thrilled when her dragging leg, tremor, bent arms, facial masking, slowness and rigidity slowly went away. However, after her victory visit to her neurologist, she was furious – with *us*.

“My MD said that, if my symptoms went away, my problems must have been caused by a pinched nerve. I spent all this time coming to Santa Cruz every week, and all I had wrong was a pinched nerve! I never had Parkinson's to begin with! You people should have noticed that from the start!”

Eventually, about five years into the project, we slowly began to realize the extent to which many patients were oblivious to how their bodies *felt* – they relied on visual analysis of their movements or the proclamations of their doctors to assess how their own bodies were doing. Over the *next* five years, we started to recognize these problems as stemming from the somatic numbness that accompanies dissociation. But in the early years, we only saw that many patients clung to the “checklist” of recovery symptoms. They did not have the capability of *feeling* the changes that were occurring in their bodies, feelings that might have confirmed that changes were afoot and that their symptoms of Parkinson's were decreasing.

The duration of recovery symptoms

How long did the increased sensitivity and “crawling ants” go on?

It seemed as if the period of *heightened*, excessive sensitivity only lasted until the brain accommodated to the new incoming sensations – a few days or a few weeks.

As with recovery from frostbite, the toe tingling comes to an end when circulation is restored and the nerves are up and running regularly again. After that, conscious awareness of the toes is possible.

After the brain becomes re-accustomed to getting incoming nerve signals from the feet, it behaves as it does in healthy people: awareness of the feet only rose to the consciousness when something significant – positive, negative, or otherwise – was occurring to the feet. For example, a healthy person might *not* notice his feet during the course of the busy day working at the computer. But when he's on vacation, he might find himself focusing on the luscious feeling of warm beach sand sifting through the toes.

Some patients, not appreciating this, worried because they'd had *constant, new* awareness of their feet for several weeks and then that constant awareness dropped away. But this is normal.

The timing and duration of the tingling sensations varies. For example, over a period of days or months, a patient might experience a few *moments* of tingling, followed by a period of calm. Or the tingling might occur a few *minutes* at a time. Or there may be a period of a day or two – or several months – during which the feet or face feel stabs of spiders, ants, or pins and needles for *hours* at a time. Anything is possible. Timing of recovery symptoms has an enormous span, ranging from moments to months.

Asymmetrical healing

Many patients noticed that most of the recovery from numbness occurred first in the *healthier* side of the body. If the PD symptoms had started on the right, the recovery symptoms might occur first on the left. It seemed as if, when the Qi started to flow correctly and the body started healing all the damaged bits, the parts that were less damaged recovered first. The recovery symptoms on the more damaged side of the body were often more severe and took longer to heal. Sometimes, the healthier side of the body would be completely returned to health and vigor before the side where symptoms first appeared even started to experience the pains, warmth, tingling, and the new movement that indicated a return to function.

Patients were sometimes alarmed that their “healthy side” was tingling or wanting to move by itself. They assumed, wrongly, that their Parkinson's disease had spread to the healthy side. Considering that the recovery symptoms were the exact opposite of Parkinson's symptoms, this fear seemed illogical to us. But we still didn't appreciate that many patients are better able to anticipate problems than anticipate health or joy.

Attitude

Many patients, prior to entering the program, have insisted on knowing exactly what their own recovery symptoms will be like. Of course, it is absolutely impossible to guess, and we never even tried. There is no way to predict who will experience what during recovery. Many patients are *very* displeased with this lack of predictability.

But the symptoms of *recovery* from Parkinson's seemed to be as variable as the symptoms of Parkinson's itself: no two patients had the exact same set of symptoms, or the exact same mindset.

In retrospect, attitude seems to be the best predictor of whether or not the recovery symptoms will be fascinating or hellish. An attitude of curiosity and gratitude allows one to

see the symptoms as wonders, miracles: harbingers of recovery from an “incurable” illness. As for the “pain,” the patients who felt safe noticed *sensations*, not *pains*. Oppositely, those who were more wary, fearful or negative – and given what we know now, probably using dissociation – had symptoms that were ominous, painful, and anxiety-provoking. The latter ones did not think that recovery symptoms were necessarily signs of *improvement* – let alone recovery.

Then again, some people have been thrilled when they’ve experienced these symptoms. They have felt immediately better, deep inside, and have been “floating on air” because they were getting better. They could feel the “lightness of movement” that is characteristic of dopamine-driven motor function.

But within hours, days, or weeks, they would experience some worrisome event that triggered their old dissociation habit.

When that occurred, *some* of their Parkinson’s symptoms – usually rigidity and tremor – would snap right back in place.

After that, they often assured us that even though *seemed* to be improving they were still certain, “I’m probably *not* going to be one of the lucky ones,” or “In *my* case, I just know that recovery is going to take a long, long time.”

“Our doubts are traitors, And make us lose the good we oft might win By fearing to attempt.”

- William Shakespeare, Measure for Measure

CHAPTER TWENTY-TWO

RECOVERY SYMPTOMS: DOUBT

This chapter shares just a few of the many case studies in which people responded to treatment in a manner that baffled us. Years later, when we understood the mechanisms behind the long-forgotten self-hypnotic instruction to stay dissociated in times of danger, together with the sympathetic mode habit of always being on the alert to danger, these weird attitudes made sense.

In previous chapters, information was presented about the ability of the subconscious to fight to the very last in order to maintain a previously received instruction to “play dead” (use dissociation mode for dealing with life’s challenges), and also how a lifetime of sympathetic-mode override leads to a pathological level of negativity and wariness.

This chapter will give examples of how this subconscious instruction plays out during recovery. Warning: this chapter will be packed with redundancies, but the very nature of the problem makes the redundancies necessary.

Denial

Many quickly forgot that they had ever experienced recovery symptoms. One patient saw me once a month after the foot injury healed and she started to recover. But after about six months, she said to me, “I don’t see why you’re wanting to work on my attitude, you’ve never gotten rid of my foot injury. I’ve never noticed any improvement in my feet.”

I flipped back through her chart to her sixth week of treatment. “Do you remember saying, on June 4, “After the last treatment, my right foot hurt right across the top of the arch?”

“No.”

“Hmm. Do you remember saying, on June 11, “I’ve had a sharp pain at the base of my third toe all week.”

“No.”

“Well, do you remember saying, on June 18, “My foot pain is gone and my feet feel warmer lately, it feels really good.”

“No, but I believe you.”

“Do you remember saying, on June 25, “This last week, I stepped on a small piece of kitty kibble with my bare foot. It *really* hurt! There’s no way I would have been able to feel something like that in the past. It really *hurt!*”

“Well, OK. I’d forgotten about that. So why did I stiffen up when I found out that my grandson was going to prison? I’ve barely been able to walk since then, and my tremor’s gotten much worse.”

“Right. So let’s get back to work on the dissociation mindset you’ve always used for coping with stress.”

“But you still haven’t fixed my foot! I never even feel it!”

This type of dialogue is very typical with people who got stuck in partial recovery.

Despite experiencing recovery symptoms, many patients were certain that they needed more foot holding – certain that the foot injury hadn’t healed yet. The more skeptical patients were often *certain* they could *never* recover even though they’d experienced *many* recovery symptoms, including better movement. And if they were certain they could not recover, they did not – except during those hours or days when, as they usually put it, they “forgot” to have Parkinson’s disease.

Some laughingly reported things like: “I forgot to have Parkinson’s on two different days this week – both times I forgot for the entire day! But don’t worry, it came right back when I remembered I have it.”

I heard, “I forgot to have Parkinson’s!” together with the incongruous, “Don’t worry! It’s back,” from *many* patients.

Some patients who had only brief, minimal recovery symptoms explained to us that they hadn’t been through enough suffering to *really* recover. They were certain that recovery should be dramatic, that it should take a very long time, and that their suffering in recovery should be apparent to all. Since they hadn’t suffered, or suffered enough, they couldn’t be recovering. Their renewed fear of “inability to recover” then triggered even higher high levels of dissociation – their favorite coping mechanism – and their symptoms of rigidity and tremor quickly became worse than ever.

One patient, during his weekly visit, told me that he’d called all his old friends in New York over the weekend and told them that he was getting worse. Minutes earlier he had told *me* that he was doing much better, and he could hardly believe how much more feeling he had in his feet, and how much his walking had improved. When I asked him why he told his friends that he was worse, he replied, “There is no way I can be recovering so quickly. If I’m actually recovering from Parkinson’s disease just because you are holding my feet, well, I’m not ready to believe that. So I told my friends I was getting worse. I don’t want anyone to have false hopes.”

An example: fear when the tingling stops

Some patients who were recovering, whose feet or face had pins and needles, panicked when the tingling and/or the *heightened* awareness of the feet and face came to an end. When the tingling stopped, they pessimistically assumed that their feet had gone dormant again, even though they could now feel them, or feel their socks, when their attention was drawn to them. Some even decided that the injury must have somehow returned! Therefore, they would never be able to recover – as they suspected from the start.

When a few patients first said things like, “The tingling in my face has stopped, so I can’t recover,” we were non-plussed.

We would point out that the person had regained full facial expression and a sense of smell and taste. Also, we would point out that the tingling only lasts during the healing process. Once the nerve healing has finished, the tingling ceases.

Our positive statement would be countered with, “Even so, I guess I can’t recover, after all.”

We were puzzled. This fairly common tendency to jump to negative conclusions seemed unwarranted and illogical.

Over the years, after running many experiments, we were able to prove that this negative mindset plays an active role in maintaining dissociation – which is what the subconscious mind has been instructed to do.

Of course, this negativity was not present in *all* patients. And in those people who had it, it was present to varying degrees.

It took more than a decade to understand that the constant use of dissociation was, in many cases, held in place by a subconscious, self-hypnosis type of instruction. And the lifetime of sympathetic mode and inability to access parasympathetic mode leads to ever-increasing levels of pessimism and alertness to potential danger.

As mentioned earlier, some patients, particularly the ones with the eye flicker that led to an uncomprehending blank face, seemed to have an alternate personality that could be used when the person was at risk of recovery. We had *no* idea what was going on until we figured out the self-induced dissociation angle, nearly ten years later.

One patient explained, with painful honesty, “Just now, when you explained what I was doing this moment, when my eyes darted sideways and you pointed it out to everyone and I was even able to realize I’d done it, at that same moment, I stopped being able to understand what you were saying. I can still see you and hear you, and I can tell that my wife and my health practitioner, sitting here beside me, are understanding what you are saying. But my mind has put up a wall, and I really don’t know what you are trying to say, but my mind is telling me that whatever you say, you are wrong, you don’t know. My brain won’t let me hear you, and it’s saying that I shouldn’t trust you.”

In the beginning, we were baffled by these strangely negative conclusions. It seemed so bizarre to hear adamant statements such as, “Since my foot isn’t tingling any more, I’m going to be one of the people that can’t recover,” coming from otherwise intelligent, analytical people who *did* know that the tingling was only a short-term event.

Some of the people who doubted their ability to recover, in spite of cessation of Parkinson’s symptoms, assured us that the Parkinson’s had merely become dormant. Their reasons were utterly illogical and tended in the direction of “I haven’t experienced as many recovery symptoms as other people,” or “I don’t *deserve* to recover,” or “It *can’t* be that easy.” (Notice I’m being redundant. There’s a reason for this – some people with PD only start to recognize themselves when they’ve read the same thing several times.)

These patients might have their symptoms go away for intervals during the day, whole days, or weeks, even months. But when some distressing life event occurred, they would manifest their old symptoms again. The resurrection of these symptoms was usually

deemed “proof” of incurable loss of brain cells. They were never going to recover. The emotional blow of this “proof” often resulted in full-time resumption of or even rapid *worsening* of symptoms.¹

Back in the early days of the project, when we thought we were just dealing with a foot injury situation, we had to wonder what was going on here.

In these cases where Parkinson’s was gone for a long time and then reappeared in response to some stress, was the short-term (weeks, months, or even years) *recovery* merely psychosomatic, or was the *return* of the Parkinson’s psychosomatic?

Something didn’t make sense. If Parkinson’s was based purely on physical problems, it shouldn’t come and go for short or long periods *or* be triggered by mood or environment. But if it was purely mental or emotional, how could we explain the similarities in the physiological recovery symptoms that patients experienced after their foot injuries healed?

And yet, it was clear that patients who doubted that they could recover did tend to get stuck in partial recovery.

Illogical responses to pain

A few patients who had been doing well in recovery suddenly fell to pieces when some unexpected places in their bodies started to hurt with a nagging or a blinding pain. As they experienced the pains from unhealed, long-ignored childhood injuries, some of them started to tremor horribly from pain and fear. They sometimes instituted a high level of body-wide dissociation, setting in motion a high degree of rigidity and extreme poverty of movement. This was somewhat understandable, but not helpful. Sometimes, in response to pain, *even though they now had normal movement*, they panicked and started taking antiparkinson’s medications even though they knew that their new ability to experience somatic pain was an indication of recovering from Parkinson’s. This seemed illogical.

Taking antiparkinson’s medications to deal with severe pain from an old injury is a completely inappropriate use of this mind-altering type of medication. I have seen people start taking these medications to treat pain and then, succumbing to the lure of these

¹ This brings to mind the turn of the century experiments in which some people with Parkinson’s had stem cells implanted in their brains in hope that the new cells would produce dopamine. Some subjects received only “sham” surgery. In the subjects with sham surgery, a cut was made in the skin, sutures were used to sew up the cuts, and the patients were falsely told that they *had* received stem cells.

The people who had the *best* results were the ones who did *not* actually receive stem cells – they had the sham surgeries.

One patient with advanced Parkinson’s did so well that all her Parkinson’s symptoms completely disappeared. She resumed all activities of daily life, including skiing. When, after a *year*, she was told that she’d had the sham surgery, she didn’t believe it, because she’s been doing so well. Shortly after learning that she hadn’t had the real surgery, her symptoms returned.

As an aside, the patients who had received actual stem cell implants had disastrous results. A few years after this experiment, I met one of the researchers who’d been on the team. He had quit practicing western medicine as a result of the disastrous inflicted on those who’d gotten the implants, and had become an herbalist.

See “Parkinson’s Research is Set Back By Failure of Fetal Cell Implants”; *The New York Times*; Gina Kolata; March 8, 2001.

extraordinarily addictive medications, cheerfully drop out of the recovery program. I've seen this many times.

The antiparkinson's medications are *not* designed to treat pain, reduce swelling, or accelerate healing. Most of them do not help with tremor, either, unless taken in doses so high that they cause the person to be stoned, out of touch with reality, and even *then* they do not always help treat the tremor. If they *do* ease the tremor, the benefit is short lived, and wears off as soon as the meds wear off. The Parkinson's meds are *mood* drugs, not anti-inflammatories.

Most patients in our program knew this. But even knowing this, patients who got slammed with unexpected pain, pain that was clearly associated with *injury*, often insisted that the pain must be coming from Parkinson's disease. This makes no sense, based on any reasonable understanding of Parkinson's, and yet the panic that accompanied the pain led many patients to conclude, illogically, that the Parkinson's had suddenly returned or suddenly gotten much, much worse.

What the patient very often could *not* do was say, "I'm in a lot of pain here. I will see some doctor who treats this type of pain (chiropractor, homeopath, acupuncturist, massage therapist, MD or naturopath). I will get an X-ray or CAT scan to learn what is causing the pain. We will figure out the best way to deal with the pain *and* the injury that is causing the pain. I might dash to the drug store for some homeopathic pills for injury or maybe I'll get some aspirin. I might also contact the doctor about something stronger to ease the pain, and maybe even something to bring down the swelling." Many patients were incapable of behaving in this logical way.

It seemed as if many patients were not even capable of *thinking* about the choices listed above. Makes sense; they often had no history of actually dealing with pain. When a recovering patient experienced intense pain from an injury he had received decades earlier, he almost never thought of how to *face* the pain and treat it. When pain appeared, some patients behaved as if death were imminent. Also, some patients were terrified of other people knowing that they were in pain, as if this would be a great risk. Sometimes they became rigid or tremored in response to the new pain, even if they had recently been becoming more fluid in their movements. They seemed incapable of understanding that *most* people freeze up, and some even shake, for a short while, in response to severe pain – they interpreted the new bout of rigidity as a sudden worsening or a reappearance of the Parkinson's.

They assumed that what was needed, after all, was antiparkinson's medications.

Again (redundancy), despite the pain, the patient was still able to move better than before. Maybe his tremor was less and he was completely aware that his Parkinson's symptoms *were* ebbing. And yet, purely in response to the *pain*, he concluded that he needed antiparkinson's medications to treat the *pain*. We saw this many times.

When it came to the ability to process pain, our patients ran the gamut from mature and sensible to immature, almost infantile. The peoples who were able to calmly feel their pain and decide how to treat it were also the ones who recovered more quickly. The ones who flew into a state of panic or who dealt with the pain by trying to mentally block it out or who fell into terror got stuck in partial recovery.

Across the board, our Parkinson's patients were extremely intelligent and highly analytical – some of them, excessively so. But with regard to their ability to feel and process their own physical or emotional pain, some of them seemed emotionally arrested. In many cases, the emotional immaturity was all the more striking because of the extremely high level of intellectual or analytical development.

Emotional immaturity

When some of the patients experienced the symptoms of a long-suppressed injury that dated back to childhood, they responded in an emotional manner that seemed more suited to a paranoid early childhood than to adulthood. Some assumed that no one could or would help them; some assumed that they would be at risk if anyone learned about the injury. It was almost as if these people dealt with pain by using their *childhood* minds. In many cases, their childhoods had not featured a lot of emotional support.

Others responded oppositely, as if the pain allowed emotional doors to be thrown wide and they were finally able to express repressed rage or hurt. Some threw tantrums; others sulked.

One recovering patient threw furniture at her husband, locked herself in the bathroom, and generally acted like a three year old – the age at which she'd been put up for adoption.

Another example

Another, according to his spouse, behaved after his birthday party “exactly like a nine-year old.” The recovering patient had used the *exact* same sentences that their child had used twenty years earlier after his fabulous 9th-birthday party was over: “Is that all I’m going to get to do for my birthday?” and “I never get to do what *I* want.” Over several more months, we all realized that this particular patient’s life-changing shock had occurred when he was nine: at age nine, he’d come home from school and discovered his grandmother, dead of a heart attack, on the living room floor. He got out his Boy Scout book and gave her all the various treatments, including mouth-to-mouth resuscitation. He was still trying to revive her when his mother finally got home. The mother heaped praise on him for not having become emotional or given in to feelings at that time. For the *rest of his life*, his mother regularly praised him for not having given in to any feelings on the day that Grandma died.

Prior to starting to recover from Parkinson’s, this patient could not recall any negative events that might have led to emotional shut-down. To his mind, his behavior with his grandmother had been heroic and a high point in his life, for which he had received regular praise. It was only when he started to recover and started acting exactly like a nine-year old that his wife recalled the dead grandmother event and we put two and two together.

Even as many patients’ *emotions* responded in ways that would have been more appropriate coming from a child, many patients’ adult *minds* were fixated on the Dreaded Parkinson’s Disease. Therefore, when they started to hurt, they 1) didn’t know how to comfort themselves and help the healing along, and 2) assumed that all problems must be coming from the Parkinson’s.

Even though most of them had already memorized the list of symptoms that defines Parkinson’s disease, they usually assumed that *any* new problem, including pain from an old

injury, must be a symptom of Parkinson's disease. but this makes no sense. In most cases, no matter how many times I told a panicked patient that that the sudden appearance of pain and a large bruise in the spot where an injury had previously occurred was *not* a symptom of Parkinson's disease, he flat out wouldn't believe me.

(Redundancy alert) Some of these people were convinced that, following a diagnosis of Parkinson's disease, any and all problems *must* be caused by Parkinson's. These were highly intelligent people, people who had read everything they could about Parkinson's disease. They knew what the symptoms of Parkinson's were, but when old injuries appeared, they panicked. These people often decided to drop out of our program and start taking the antiparkinson's medications that their doctors had offered them several months or several years earlier.

The reader may be having trouble believing this, but we saw this over and over. The onset of pain in an area that had previously been numb was just one of the many recovery symptoms that many patients chose to misinterpret. But recovering patients are not alone in this: some of their *doctors* also misdiagnosed bruised, throbbing, inflamed, injury-type pain as a symptom of Parkinson's disease – a disease that is characterized by numbness.

These MDs should know better. They should know that most of the pains that do occur in Parkinson's are due to steadily worsening stiffness and rigidity – or muscle spasms from overmedication – *not* pains from inflammation and injury.

An example of thoughtless prescribing of PD medication for treating pain

One patient who had thought she was recovering developed agonizing pain in both hips. The pain began when she first became able to imagine herself having hips. Instead of seeing a pain specialist, she went to the neurologist who had diagnosed her with Parkinson's. This patient was *not* taking any antiparkinson's medications.

Her neurologist, thinking of her only as a Parkinson's patient instead of a patient in pain, prescribed a powerful anticonvulsant (anti-epilepsy drug). This drug is often used to sedate brain activity in people with Parkinson's *whose medications are at excessively high doses*. High doses of dopamine-enhancing antiparkinson's drugs can cause enormously powerful and painful muscle dystonias. To counter the excessive level of brain activity that triggers these spasms, anti-seizure drugs are sometimes prescribed for people *who are taking high, dystonia-inducing levels of antiparkinson's medications*.

This patient was not taking any medications. She was not having dystonias (muscle spasms). She was not rigid: she was exceedingly limp, a recovery condition that you will read about in the next chapter. Therefore, the anti-spasm medications prescribed by her neurologist were completely inappropriate. For over a year, she took the anti-convulsants that her neurologist gave her. The drugs made her even more limp, extremely groggy and confused. Because these drugs inhibit brain activity, they did reduce her pain a little: a *very* little. However, she was determined to keep as active as possible: she didn't want to "give in" to the pain.

After a *year* during which the almost paralyzing pain continued, she finally went to see a pain specialist. He took CAT scans of her hips, and discovered that both her psoas muscles were badly torn in the hip area – torn right through the middle of the muscle, from side-to-side – and inflamed. He prescribed medications to reduce the swelling and instructed her to minimize activity that used those muscles. As soon as she saw the scans, she suspected

that these *extremely* unusual types of muscle tears had probably been received at age six during her father's "tickling games" in which he would have her lay down on the floor with her legs up in a fetal position. Then, he would force her knees apart to the sides. He would press her bent knees all the way to the floor and not let her get up until she cried. The "game" was to see how long she could go without crying.

This patient was a highly educated therapist. She told me that she had no emotional feelings one way or the other when she realized that her father's "games" had probably caused the hip muscle tears. I asked her if those "games" might have been a little inappropriate. She replied firmly, with no apparent warmth, "I loved my father. I looked up to him. *Everyone* admired him."

Finally, after she started getting appropriate treatment and stopped being so stoic and driven, the muscle tears started to heal. It took more than a year for the lateral tears in her psoas muscles to heal completely.

The point is, she spent a full year in agony because she and her neurologist assumed that her pain from torn muscles was being caused by Parkinson's disease. Her error is understandable: she trusted her doctor. The neurologist's error was due to the medical professionals' tendency to see every problem in terms of one's own specialty. The neurologist, assessing her in terms of overmedicated Parkinson's, assumed that her hip pain was due to either dystonia (permanent muscle cramp) or the violent spasms that Parkinson's patients often get from excessive levels of antiparkinson's medications, even though she had *no* muscle cramps and she was *not* taking medications.

I've written up the above vignette to demonstrate how patients who had been given a diagnosis of Parkinson's – *and* their doctors as well – may assume that every problem and pain in a person with Parkinson's must be due to Parkinson's. While I'm at it, I should mention that many recovering PD patients who developed flu symptoms when the flu was going around assumed that they felt worse than usual because the Parkinson's was getting worse. Sometimes, even if they ran a fever, they still insisted that the fever was a sign that the Parkinson's was getting worse. And sometimes, their doctors agreed that the flu symptoms must be symptoms of Parkinson's disease!

Inability to relate to normal aches and pains

I have *non*-PD patients who are middle-aged or older. Sometimes they come to see me because they are stiff or sore after a bout of unexpected activity such as spending all day gardening or from an habitual lack of activity or exercise. They want relief from their pain, so they get a massage or come to me for an acupuncture treatment.

But some of my recovering Parkinson's patients, becoming mildly stiff or sore after doing an unaccustomed activity or after spending several days doing nothing, fall into a panic. They've called me to announce that the Parkinson's is suddenly much, much worse.

Many patients, while recovering from PD, complain of increasing stiffness in their joints. I often ask them if they are doing regular stretching, swimming, yoga, or Tai Ji, or anything to keep the joints supple. They often ask me why they should need to be doing such activities; prior to having Parkinson's, years earlier, they didn't have such pains and stiffness, even though they hadn't done stretches. When I point out to them that, prior to recovering, they were pretty much numb, using adrenaline, and only felt stiffness if the joint was so locked up that they couldn't move it, *and* they are getting older, they struggle to understand

my point. I tell them that any person who is middle-aged or beyond, who fails to work at staying loose, is going to tighten up. This idea is usually met with disbelief, or the statement that, “I’ll start doing stretching exercises if the Parkinson’s goes away.”

People with Parkinson’s need to learn to get used to feeling their bodies.

They *also* need to learn that bodies can be stiff and sore for reasons *other* than Parkinson’s disease. Many patients have discovered, during recovery, that a large part of their neck stiffness was due to old neck and shoulder injuries. These injuries often responded very well to gentle styles of chiropractic treatment or craniosacral therapy. Parkinson’s disease might have exacerbated these injury-based problems, but Parkinson’s wasn’t *causing* them.

Many patients have said things such as, “That neck injury occurred decades ago and it never hurt, even at the time. The Parkinson’s is what’s making the neck injury become a problem. Therefore, since my neck hurts worse than ever [since the foot injury healed and I’ve become more sensitive], it’s proof that I’m *not* recovering from Parkinson’s disease.”

Eventually, we were able to figure out that the *fact* that it hadn’t hurt at the time was also the underlying problem in Parkinson’s: blocking out pain so that injuries couldn’t heal was the problem. But we spent years trying to understand why some patients could not even *consider* this possibility.

On the other hand, increased awareness of body pains can become a real problem for some recovering patients: they may develop fibromyalgia and hypochondria.

Swinging from stoicism to hypochondria

Ironically, a very few people who recovered from Parkinson’s went on to develop fibromyalgia or even extreme hypochondria during or shortly after their recovery.

These two illness patterns, fibromyalgia and hypochondria, are syndromes in which a person is over-sensitized to every ache and pain. In these two syndromes, a person may be in agony, immobilized, worried, or even fascinated, with every physiological sensation that presents itself.

I do not want to imply that either of these syndromes are purely psychosomatic. However, it is curious that, from a brain point of view, these syndromes are very much the opposite of the stoic, even numbing mindset of Parkinson’s disease. In Parkinson’s, a person goes through life with a steadily decreasing ability to feel the events occurring inside his body. In hypochondria and fibromyalgia, a person has excessive sensitivity to the events that occur anywhere in his body, and no ability to screen the important pains from the unimportant pains.

Happily, when fibromyalgia and hypochondria did appear during recovery, they were not long-lasting. Within a few months or, in one case, a few years, it seemed as if the patient’s brain centers were reset to a happy medium in terms of stimuli- and pain-recognition.

“We choose and sculpt how our ever-changing minds will work, we choose who we will be the next moment in a very real sense, and these choices are left embossed in physical form on our material selves.”

- Dr. Michael Merzenich, University of California, San Francisco, brain researcher in the field of neuroplasticity

CHAPTER TWENTY-THREE

RECOVERY SYMPTOMS: RIGIDITY AND LIMPNESS

Recovery from rigidity

Rigidity is a correct physiological response to backwards-flowing channel Qi. Following a severe injury, such as a leg-break, the backwards-flowing channel Qi helps the injured body part stay rigid, thus inhibiting movement and preventing further damage.

Areas in which Qi has been flowing backwards for *years* can develop cellular changes associated with that rigidity.

In Parkinson’s disease, the areas of rigidity occur along the portion of the Stomach channel that extends from the back of the jaw to the top of the foot and, in some cases, the portion of the Large Intestine channel that runs from the thumb side of the wrist up to the side of the neck. These areas become rigid, not numb. These rigid body parts may feel hard to the touch or as if they are slightly contracted.

In addition to causing a *rigor mortis*-like muscle rigidity, the long-term backwards running Qi in these areas also inhibits the mind-to-muscle connections for these areas: normal motor function instructions to these areas is inhibited.

Rigidity and muscle contraction along this portion of the Stomach channel pulls the head forward, hunches the torso, and inhibits lateral movement in the leg. In the secondary zone, the Large Intestine channel, rigidity may pull the arm into a “bent at the elbow” position, pull the shoulder forward, and even pull the shoulder blade laterally.

Becoming limp

Prior to recovery, many people with PD imagined their rigid, even rock-hard muscles, and the anteriolateral leg muscles in particular, to be proof of healthy, well-toned muscle. However, these muscles were *not* “toned.” They were perpetually somewhat contracted and wooden. They could *not* relax. They were *not* vigorous.

During recovery, the tissue in these muscles softened. When the backwards-flowing Qi ceased to flow through these muscles, they lost their rigidity.

They often became weak, limp or even mushy, for a while. They weren’t able to tighten and loosen in response to brain commands, for a while.

Actually, they hadn't responded to brain commands during Parkinson's, either, but because they were hard, they could be used as supports. The other, still-functional muscles in other parts of the legs and buttocks, areas that had channel Qi flowing in the right direction, could push off against the rigid muscles or compensate for them; and so many patients had thought that the rigid muscles, especially those in the thigh, were extremely healthy.

Although the muscle softening during recovery was most noticeable when it occurred in the thighs, it sometimes was noticeable in other muscle groups that had become rigid.

Then again, some patients experienced an effortless return to healthy muscle tone in all or some muscle groups, with no noticeable period of very limp muscles.

Not a question of atrophy

Some patients wondered if the sudden flaccidity was atrophy. It was not. Based on what we saw during recoveries, the flaccidity was due to the absence of parasympathetic mode mind-to-body communication in these areas.

We can conclude this because, in cases of true emergency, people were still able to use these muscles.

In our patients with Parkinson's, we had to wonder if this mind-to-injured body part disconnect had been in place for decades.

When the Qi began running correctly, the rigidity went away, but resumption of the mind-to-body part communication did not always kick in immediately.

During patients' recoveries, it seemed as if the absence of a mind-to-body-part connection, and not atrophy, was the primary cause of the limpness: as *soon* as the mind-to-body connection was restored in these areas, the muscles instantly resumed some degree of tone, or at least experienced the tingling and spasms that suggested a return of muscle function. There was never any need for patients to go to the gym to "build" the limp muscles back up. As soon as healthy awareness of the limbs resumed and the nerve connections ended their dormancy, the muscles suddenly had at least some small amount of strength again – spontaneously – without doing workouts.

"Conscious strength"

After having a few days to relax and reconnoiter, these muscles usually resumed normal tone and responsiveness. However, in a few cases, it took several months. I started referring to this resumption of normal tone and responsiveness as "return of *conscious strength*." It was a resumption of strength similar to that which a person gets when he returns to a fully awake state after having been deeply asleep or in a state of shock.

A most difficult phase

This "weakness" stage was the most emotionally difficult phase of recovery for some people. It was also physically difficult because, during this time, the muscles sometimes behaved as if they were made of limp rags.

Sometimes, a patient still had rigidity in some areas even while having limpness in others. For example, if his foot injury was healing, he might develop limp muscles in his legs.

But if he still had an unhealed neck and shoulder injury, he may have painful *rigidity* in his neck and arm while having such extraordinary *limpness* in his leg muscles that his legs could barely support him. When combinations of limp and rigid occurred, it was sometimes extremely difficult for the patients to know *exactly* what was going on.

Those who were content to enjoy or be amused by the process had few problems with these changes. Those who were still predominantly fear-based became highly distressed when they weren't able to anticipate or understand the changes happening in their bodies.

Limpness in the body, part by part

Neck limpness

Examples: a patient experienced softening in the rigid muscles in her neck. Within two days of her neck starting to go limp, she couldn't hold her head up. To hold up her head at work, she placed a stack of law books under her chin so that she could read her legal paperwork. Several days passed before she had enough conscious strength in her neck to use her muscles normally.

Another patient, a graduate student, asked me to write a note explaining she could not take an exam because she couldn't hold her head up.

Another recovering patient went through several days during which her head pulled to the right. This occurred when the rigid muscles on the left side of her neck began to melt while her right-side neck muscles were still rigid. Her Parkinson's symptoms had first occurred on her right side. Her right side symptoms were more severe, and they were also slower to heal.

Several months later, after the *sides* of her neck had resumed healthy balance, the front and back of her neck went limp and her head flopped gently forward for several days. After that, she experienced no more neck weakness.

I personally *never* noticed a time when my neck muscles became weak. I only realized that the neck muscles were no longer rigid when I tried to look to my left side while backing up the car. I was accustomed to turning my head slightly to the left by putting lots of strength into the effort and twisting from the hip. But when my neck muscles loosened unbeknownst to me and I applied the usual amount of strength, I found myself looking *behind* my when I intended to merely look to the side. With almost no effort, my neck had pivoted as far as any healthy person might be able to turn his head. I had to learn how to moderate my head-turning strength to accommodate my new neck flexibility. But the point is, my neck muscles never became problematically, or even noticeably, weak or limp.

An aside: asymmetry

Asymmetry often occurs during recovery from rigidity. Many patients have noticed muscles pulling to the left or the right as the opposing muscle group became limp. The less damaged muscle group was usually the one that became limp first.

Ankle weakness

Weakness in the area just above and below the ankles sometimes caused swelling in the ankles. This condition did not seem to be related to poor kidney function or any of the usual problems that might cause water build-up in the ankle. The root problem was *not* water

build-up, per se. It seemed more as if the muscles above and below the ankle had become so limp that they did not present enough tension to force fluids back up the legs. Consequently, fluids built up in the saggy areas of the ankles. No exercise of this area was necessary to reduce the swelling: as soon as the muscles of this area attained healthy mind-to-ankle awareness, the ankles soon resumed their slimmer, pre-recovery lines.

If ankle swelling scares you, wrap the ankle in an ace (elastic) bandage until the tone returns.

Leg weakness

The legs often became *very* limp. Many patients experienced a period during which their legs were so unresponsive and limp that they could not easily get up from a chair or from the toilet.

This inability to stand up due to mushy muscles *felt* different from the patients' previous inability to initiate movement. For one thing, the patient was able to *feel* his legs, as opposed to objectively observing the functionality of the legs.

The upper legs sometimes felt wobbly, or even like pudding. Patients who were highly cynical that they could recover nearly always decided that this new inability to stand up from a sitting position was more of a problem than their previous inability to initiate movement.

Before, when he still had Parkinson's, the cynical patient might have had difficulty in figuring out how to make his legs move. When the legs turned to mush, he still couldn't move them *and* they were limp, to boot. Many patients decided, at this point, that they had rapidly gone from bad to worse. If they decided this, they often found the rigidity rapidly returned. Which meant that they were no longer limp. Often, they then concluded that they were having Parkinson's again.

More leg limpness difficulties

Whether the condition lasted only a few days or a few months, the leg weakness was sometimes the most challenging phase of recovery from Parkinson's disease. Many patients found themselves humiliatingly inconvenienced: needing help with bathing and toilet. This phase was exhausting for some caregivers, especially elderly ones. This phase was the one in which many recovering patients began to doubt the wisdom of trying to recover.

As our understanding of Parkinson's grew, we realized that those patients who could feel and imagine movement in their legs rapidly overcame this phase: mushy legs started to firm up in a few days or a few weeks. Those who were unable to *imagine* their legs moving or who could not *feel* their legs sometimes found themselves stuck in this phase indefinitely – until they decided they could not recover, after which, they stiffened back up and could use their legs again in a PD-like manner.

The many patients with Parkinson's who proudly said, "I don't do visualization; that's not who I am," might as well have said, "I don't do parasympathetic (relaxed) movement, that's not who I am."

As for *feeling* the existence of their legs, many patients did not understand what we meant by the word "feeling." A not uncommon statement was, "I don't understand the concept of noticing how my body feels."

We had to explain that feeling is not a concept: it is a type of sensory perception, like tasting or smelling. Feeling, like tasting and smelling, cannot be *understood*; it must be experienced. Dissociation inhibits the ability to feel one's body.

We finally figured out that some patients did not *want* to be able to actually feel their legs or other body parts. Even more surprising, we discovered that some of these patients genuinely did not comprehend what was meant by the concept of somatic feeling.

The reader who does not have Parkinson's may not understand what I am talking about. How can a person hope to move his legs if he can't feel them or imagine feeling them? But many people with Parkinson's who read this will think the opposite: "How can anyone feel the "existence" of his leg? If someone touches your leg, you can feel that touch, but how can a person *feel* the leg itself if no one is touching it or it has no pain? What does the therapist mean when he says, "feel the existence of your leg"?"

- Taking the stairs two at a time: an aside

Prior to the relaxing of the leg muscles, many a person with Parkinson's had been proud of his ability to mount the stairs two at a time, using his legs like rigid rods to hoick himself up. To mount the stairs in this fashion, the person leans forwards, getting his center of gravity over the stair riser that is *two* steps up. This is easy and natural, because the PD patient's torso is already somewhat hunched forward, bringing his whole center of gravity forward. He then thrusts his leg up and forward by pushing/pulling with the leg muscles that are *not* along the Stomach channel – often using muscles of the buttocks and the backs of the legs. Then, when his foot is on the riser that is two steps up, and his forward leaning body is centered over the higher riser, he pushes down against the riser with his forward leg. The *downward*-pushing motion, which he *can* do easily (since it uses muscles that are not on the Stomach channel), serves to raise the body, including the leg that is still resting on the lower riser. As the lower leg swings up and forward, he can very often use the follow-through of this movement to swing the next leg up two risers, instead of just one.

Healthy people, those who use the balls of their feet and a forward leg swing to mount the stairs, may be a bit baffled by the above description. But I've described the above to many of my patients. They have usually chuckled, saying, "I never thought of putting it into words, but *yes*, that is what I do. I always thought I was just stronger in the legs than most people."

Part of the reason that people with Parkinson's prefer to mount the stairs two at a time is that this "extra work" causes a quick surge in sympathetic mode. The "call to action" for the extra work brings on a short burst of adrenaline. Without the adrenaline, it's harder to go up the stairs, and by making the job harder than usual, two-at-a-time, the mind responds with adrenaline that makes the job easier.

During recovery, when patients' legs began to go limp, they were no longer able to do this splinted form of leg lifting on the stairs. This special way of using the leg relies on the steel rod-like rigidity in the anteriolateral muscles of the leg. When these muscles became limp, the recovering patient could not brace against them for the pushing-down motion. For that matter, he very often was not able to lift his legs a fraction of an inch. Going up stairs was suddenly out of the question.

Some patients appreciated that they were changing. Others, insistent that their two-steps-at-a-time feat was a sign of strength, could not accept the idea that *most* people with Parkinson's, *even those with very advanced symptoms*, can usually mount stairs very well. Even those Parkinson's patients who can barely walk across the room can usually do stairs easily – even two at a time. As Parkinson's worsens, the ability to move only when challenged or stimulated makes it almost *easier* to mount the stairs two at a time than a mere one at a time. The very mild sense of challenge and concomitant adrenaline release experienced when confronted with stairs seems to *help* many patients to mount them two at a time. A few patients with very advanced PD even told me (incorrectly) that their Parkinson's must be in the very earliest stage *because* they take stairs two at a time.

(There are exceptions to everything. We have had a very small number of Parkinson's patients who'd *never* taken the stairs two at a time.)

When a patient abruptly lost his two-stairs-at-time ability, it was often deeply upsetting, leading to an immediate worsening of mood-related symptoms (slowness and tremor). On the other hand, it was sometimes – less often – appreciated as being a radical departure from his previous Parkinson's disease pattern.

Another aside: feet sticking to the floor with rigid or limp legs

The inability to lift the legs due to weakness in the anteriolateral muscles of the upper leg was different from the Parkinson's symptom of “feet sticking to the floor.” Patients' feet might stick to the floor whether the legs are rigid *or* mushy.

The foot stuck-ness of Parkinson's can be caused either by aberrant Qi flow set in motion by an injury on the foot, *or* by a particular electrical pattern in the feet that is *supposed* to kick in during dissociation – an electrical pattern that causes a terrified person to be “frozen to the spot.”

If a person is even somewhat emotionally dissociated from his body, his feet may stick to the floor whether or not the injury is gone. In this type of sticking, the foot can feel as if it's actually attached to the floor, as if drawn by a magnet. Sometimes, the foot feels as if it is being sucked *into* the floor.

Bona fide *weakness* in the legs can also make it difficult to pick up the feet. This weakness does not feel as if the foot is glued or magnetically attached to the floor. This latter situation just feels as if the leg is too limp to raise the foot.

Differentiating between these two situations proved to be difficult for those patients who could not or did not want to *feel* the sensations in their feet.

Torso weakness

Patients, often well before they were diagnosed, noticed an increased difficulty in rolling over in bed. A recovery landmark that was often disturbing was the *change* in how the patient couldn't roll over in bed.

Typically, as Parkinson's worsens, a patient lying on his back may need to turn over in bed in the following manner: he brings the knees closer to the chest and pulls the head forward, as if mimicking a fetal position. Then, in one strong movement he heaves his whole body, as a single rigid unit, over onto his side. As the Parkinson's progresses, he may need help to do the heaving bit: a strong shove by the spouse will usually shift him.

In recovering patients, the rigid muscles of the torso become limp. Patients become *unable* to pull themselves into a fetal position. Instead, they can only lie floppy or limp on the bed.

It might not have been too difficult for a healthy spouse to shove a rigid, fetal position PD patient from one side to the other. It was *much* harder for the spouse to shift a patient who had become limp, whose body felt like “deadweight.”

This limpness while trying to turn over in bed was clearly *not* characteristic of Parkinson’s – a disease that features rigidity. However, the new utter inability to turn over in bed often convinced patients that they were worse off than before.

Those with a curious attitude and an ability to feel their muscles appreciated that having the muscle tone of mayonnaise was a shift in the right direction. Some patients reported feeling genuine pleasure from the new awareness of sensation in the muscles of the torso and limbs, whether limp or strong. In the past, they had been accustomed to roll over quickly and efficiently without *noticing* any body sensations engendered by these movements. They began to appreciate a new way of moving: noticing the internal sensations that languid movement conveyed to the heart and mind.

Eventually, these patients were able to turn over in bed.

I remember how I learned to turn over in bed after I became limp. Starting at the shoulder, I very slowly moved one limp arm in the direction that I wanted to turn over in bed. Then I slowly oozed one leg over the other in the direction in which I wanted to turn. I slowly moved my head to the side. Slowly, moving one body part at a time, I was able to get enough body weight turned to the side so that my hips followed my arm, legs, and limbs, slowly pouring myself over onto my side.

Even doing this “slow motion” style of turning over, some patients needed help rolling the hips over until they regained conscious strength in those torso muscles that are used to turn the hips. But in time, these people learned how to turn over *languorously*, a movement style that many of them had *never* used since childhood.

Oppositely, as you’ve already guessed, those who feared loss of autonomy and loss of control were usually *terrified* by the worsening ability to turn over in bed. As their minds increasingly raced, day and night, through worst-case scenarios, their tremors sometimes became violent, their slowness became glacial, their rigidity became painfully tight – unless they were relaxing into sleep. That was really the problem – when they were half-asleep or almost fallen asleep, they weren’t accessing sympathetic mode – the mode that enables a person to override immobility.

Some who rapidly developed worse symptoms of parkinsonism insisted that they were not afraid, that they were calm. But when we did mental exercises to hasten the mind-to-muscle connections, we discovered that they were using the word “calm” as though it were synonymous with “emotionally numb.” And at the very root of this numbness was an enormous, paralyzing level of fear: in some cases, it was the fear of feeling the physical and emotional pain of life itself.

It was as if their bodies were going through the motions of healing from the foot injury, causing them to experience recovery symptoms, but at the same time, their minds were building up a stronger-than-ever method for clinging to the dissociation that kept them safe from pain.

Back weakness

Many recovering patients had a spate of back weakness. Two recovering patients very quickly lost *all* muscle tone in the small of the back. They were utterly unable to stand up straight. They might pull themselves to a standing position for a few moments, but within less than a minute they were once again bent over from the waist. In these two patients, this loss of muscle tone in the back was so severe that the patient's torso was parallel to the ground – if he worked at keeping his head “up.” The work of supporting this overhang of torso required them to walk with their legs severely bent at the knees. They shuffled along with their heads a few feet above the ground. If, feet on the floor, they straightened their legs, their faces were facing their knees.

We did not figure out how to effectively treat this situation, in these two cases. We were never able to figure out how to re-activate their back muscles. Both of these patients lived far away – one on the opposite coast and the other in Europe. We only saw them a few times. I wish that we'd had more opportunity to work with both of them.

We hypothesized a cause for this very rare pathology. In Chinese medicine, we recognize that the nerves that activate the adrenal gland enter the spine at the same vertebra as the nerves that activate these particular back muscles. Based on this, we guessed that, when the adrenal gland went into abrupt decline (taking a well deserved rest after decades of overuse), the energy in the entire vicinity of this vertebra, including the energy that activates those particular muscles, was also inhibited.¹

Working with the doctor when the limpness appeared

Multiple System Atrophy

Sometimes, people who were in the midst of limpness went to a doctor to ask, “What the heck is going on?”

Our patients were sometimes told, during this mid-recovery visit, that they evidently never had Parkinson's disease in the first place: what they *actually* had was Multiple System Atrophy.

Although MSA is an *extremely* rare condition, I recall a one-month period in which three of my recovering Parkinson's patients were re-diagnosed with MSA.

Or, if the doctor was less brazen and less well-informed, he incorrectly decided that, in some people, leg and/or torso *limpness*, not rigidity, were the main symptoms of Parkinson's disease. Or the doctor simply changed the diagnosis to “parkinsonism” (a catch-

¹ This posture was so impossibly bizarre that I found myself grateful for Oliver Sacks' photos and descriptions of this exact same postural problem. In Dr. Sacks' patient, the posture occurred, practically overnight, in one of his sleeping sickness patients after she was dosed with high levels of L-dopa (dopamine). I suspect that her extremely high doses of L-dopa (thousands of milligrams per day) may have caused a shift into parasympathetic and a concomitant shut down in the area of her lower back – the area that serves the adrenal glands during sympathetic mode. The same problem of proximity of adrenal gland nerve and small-of-the-back muscle nerve may have been involved. Had it not been for Dr. Sacks' documentation of this patient, I might not have believed my eyes when, in response to their return of dopamine, my two patients became bent double from small-of-the-back limpness.

all term), or even “*atypical parkinsonism*” (an *extremely* vague catch-all term), and left it at that.

Multiple system atrophy is an *extremely* rare syndrome in which a person becomes steadily more limp and weak. Multiple system atrophy (MSA) is not in any way related to Parkinson’s disease. But if the patient reminded his MD that, prior to entering a recovery program, he’d had problems of *rigidity*, not problems of limpness, the MD always ignored these statements. Other MDs explained, patronizingly, to the recovering patient that it is always hard to get a firm diagnosis in the beginning. No MDs, in our experience, changed their minds about the MSA when informed that the patient had been *rigid* prior to becoming limp.

It was hard for patients to stand firm in their knowledge of what their own symptoms had been when the MD told them that they’d never had Parkinson’s after all.

One of the first patients who received the altered diagnosis of Multiple System Atrophy was the neurologist mentioned in the previous chapter (the one who became addicted to his medications). When he started to be as loose as a blob of jelly, he asked his doctor for an assessment. His neurologist told him that he’d never had Parkinson’s: he’d had Multiple System Atrophy right along. My patient was also a neurologist. He knew darned well that his previous symptoms had not been characteristic of Multiple System Atrophy. His symptoms had been those of Parkinson’s.

Even so, when his colleague told him that he had multiple system atrophy, he decided he could not trust his own judgment any more. (This was probably accurate: his mental clarity had become heavily fogged by his antiparkinson’s medications.) He was willing to accept that his PD diagnosis *had* been incorrect even though, as a neurologist, he had originally concurred in every way with his diagnosis of PD.

The first time this happened, I was surprised. PD and MSA are very different illnesses. After this happened several times, I realized anew the difficulty that doctors have in accepting the idea that a person can have Parkinson’s disease and recover from it.

Now, we tell patients that if they *used* to have rigidity and the usual symptoms of Parkinson’s, but following foot therapy they become limp and their doctors tell them that they were misdiagnosed and that what they’ve had right along is Multiple System Atrophy, it is time to celebrate: they no longer have Parkinson’s disease. And in all likelihood, *despite* what the doctor says, they don’t have Multiple System Atrophy.

Medical reports are not detailed enough

We had to explain to our patients that it was *not* reasonable to expect an MD, who might not have seen the PD patient in six months, to quickly examine him and decide if his symptoms had changed away from their original condition: most MDs do not make thorough enough notes to be able to tell if a person’s symptoms have changed significantly, and memory of a fifteen minute visit, six months prior, is rarely precise. The doctor usually made a diagnosis of Parkinson’s based on an overall picture of what seemed to be going on after having ruled out, via MRI, brain tumor and stroke. He may *not* have even noted in his records the exact symptoms or the exact location of symptoms that the patient presented. His notes

might merely say something along the lines of “tremor, rigidity, cogwheeling, lack of facial expression.” His notes may not even mention the *exact* location or the severity of the symptoms.

Therefore, if a patient has a 75% return of facial expression, but one corner of the mouth still turns down a bit, the MD may look at that corner of the mouth and say, “Continuing lack of facial expression.” The MD will have no way of remembering that the condition used to be far worse.

We’ve had patients who’d lost their voice to PD but who subsequently regained the ability to talk, who’d been expressionless but had regained the ability to smile, and who had lost the use of their hands but had regained it again. They eagerly awaited the surprised look they expected to see on the doctor’s face, only to be told by their MDs during their next bi-annual visits that “nothing had changed.”

If they pointed these obvious changes out to the MD, the MD might say something along the lines of: “You’re having a good day today” or even, in the case of one patient who had never taken antiparkinson’s medications in the three years since his diagnosis, the doctor said, “It’s nice to see that your medications are finally starting to work.”

We also had to remind our patients that the MDs may be accustomed to seeing *medicated* patients. In these cases, he will *expect* the patient to be moving better the second time he sees the patient – thanks to the medication. Therefore, he may not be surprised to see the patient moving somewhat better than before: it’s what he’s used to. Even if he is reminded that the patient isn’t taking the prescribed antiparkinson’s medications, the significance of this might not sink in.

One recovering patient who pointed out to his MD that he was once again making his own meals after years of not being able to use his hands at all, and that he no longer used a walker, which he’d needed for several years, was told, “Your symptoms aren’t declining as quickly as before: your wife certainly is taking good care of you!”

“Do you want an increase in your medications?”

One recovering, *unmedicated* patient became almost frantic when, after showing her MD how she could once again use her hands and how she no longer dragged her foot, was asked, “Do you want an increase in your prescription at this time?” The patient *restated* that she had never taken any of the prescribed medications and that her symptoms were nearly gone. The doctor then asked her if that meant that she did *not* want an increase in her prescription at this time. The patient nearly screamed at the doctor, “Why would I want an increase in my prescription?! I’m not taking any meds. Do you see any PD symptoms in me?”

To which the doctor replied, “Fine,” and assured her that he would see her in six months, at which time she could request an increase in her prescription if she so desired.

Prior to 2010, no doctor that we know of was willing to say that a patient was recovering from Parkinson’s.¹

¹ We do have one exception, a case in which – for political reasons – a group of doctors officially stated that a person “might have recovered from Parkinson’s disease.” The case involved a French magistrate (judge). The reason behind the statement (Continued on next page)

To be fair, I must say that a few doctors have said things like, “Your case is baffling,” and, “I would have expected you to be much worse by now,” and even, “Your other symptoms are gone. If it wasn’t for that one arm still not swinging, it would seem as if you hadn’t actually had Parkinson’s disease.” But these comments, though observant of change and improvement, are not statements as to the reversibility of Parkinson’s. Rather, they suggest that the doctor was considering a change in his original diagnosis: the patient had been misdiagnosed.

A patient should not expect his neurologist to pick up on *recovery* symptoms and to notice that they are the opposite of PD symptoms. If muscles go limp, the doctor only notices that the person’s problems are worse off than before. MDs are trained to focus on what is *wrong*. If a patient became limp and weak, the MD focused on that. The doctor often said, accurately, that in terms of movement, the patient was obviously much worse than before.

Trusting only the doctor

Many patients who became stuck in partial recovery told me that they would only believe that their physical changes pointed towards recovery, and that they would only then (reluctantly) force themselves to do the visualization and the heart- and mind-retraining exercises “*if and only if an MD concurs that there has been some improvement.*” When the MDs invariably failed to do this, these people usually went into a tailspin of despair – and a rapid worsening of symptoms. Often, after these disappointing meetings with the MDs, their symptoms were “worse than they’ve ever been before” within a matter of days, or even hours.

On the other hand, some patients who did the hard mind-retraining work, even if it took months or years, and who then had a breakthrough to a healthy mindset, were suddenly able to move easily again.

Following this breakthrough, they tended to dismiss the whole subject of doctors. Their new attitude has been expressed in statements such as: “Who the hell are they [doctors] to tell me that I’ve got an incurable illness? What an idiot I was to have been so emotionally influenced by them! Why did I unquestioningly believe them?!”

These people had become able to feel the burgeoning changes within themselves, and had no reason to rely on any outsider’s opinion as to whether or not they were doing better.

was this: because her Parkinson’s symptoms were waning, she was facing a new diagnosis – a diagnosis of psychosis. From her doctors’ point of view, the only possible reason that she could have previously exhibited “false” symptoms of Parkinson’s disease for several years would be that she’d been having a psychotic episode that whole time. However, *if* her diagnosis was changed to “psychotic episode,” she obviously could not remain in her position as magistrate. Psychotics cannot be judges.

(This was in the years prior to the “discovery” of the syndrome now known as psychogenic parkinsonism. Prior to the definition of this “new” syndrome, a person who recovered from PD-like symptoms was considered to have undergone a psychotic episode.)

The patient asked me for advice. She was working with the top neurologists in Paris at the time. I suggested that she tell the doctors, in all honesty, that we had some patients in Germany who were recovering, and that the German patients would be more than happy if the first European recoveries from Parkinson’s occurred in Germany, not France. When the patient presented this information to her team of doctors, her diagnosis was changed to “possible recovery from Parkinson’s.” She was allowed to continue working.

I was actually a bit surprised at the level of disgust, even anger, that many recovered patients felt towards their doctors when they realized that doctors were fallible.

In general, it seemed as if, when the patients' *minds* and *emotions* became healthy, they knew how their bodies felt: doctors became superfluous.

Oppositely, those who were walled off from their abilities to feel and to imagine themselves moving, and who were therefore somewhat numb to the healing sensations going on within their own bodies, needed outside corroboration to confirm any changes or seeming improvements.

No more adrenaline

Another event, that sometimes occurred before, during, or after the limpness appeared, was a perceptible decrease in adrenaline-based behaviors. Pre-recovery behaviors, including physical, mental, and emotional behaviors, often suggested elevated adrenaline levels.

When the foot injury healed and/or the mindset was corrected, these behaviors often decreased or even disappeared in spite of having been dominant for much of the patient's lifetime. During this phase, some patients worried, in a mild sort of way, that they would never be as "intense" as they used to be. It appeared as if their adrenaline levels had been turned way down, or even off.

If the limp muscle phase coincided with the decrease in adrenaline, patients who were still clinging to dissociation and working at amping up their ability to stay dissociated were doubtful that, without the adrenaline, life would ever again be worth living.

When the adrenaline declined, some patients found themselves accidentally being calm, even daydreaming. This could be terrifying if the patient felt that his very nature was undergoing a change.

During this time, "Who am I?" and "Who am I becoming?" were not unusual questions. This was sometimes a period of adolescent-like self-questioning or, in some cases, despair.

Patients who used to feel that they were The One To Rely On during any situation were sometimes concerned by their new imperturbability and *laissez faire*. Some wondered what would happen should an emergency arise. They feared that their "new" personality would most likely respond to an emergency by saying, "Emergency, shmergency; let someone else take care of it."

Some admitted that nothing was ever as much of an emergency any more as they'd made things out to be, in the past. Small crises that previously would have been met with intensity and adrenaline were now met with, "It doesn't really matter; it's not as if anyone's going to die."

Decrease in adrenaline in those who *could* relax

Prior to recovery, a majority of my Parkinson's patients seemed to have been constantly relying on elevated levels of adrenaline. I know I had been.

When the dissociation ceased and they were able to use parasympathetic mode, they sometimes felt as if they could never be in *predominantly* sympathetic mode ever again. Mild

emergencies of the past, such as running late or forgetting an appointment, were no longer able to trigger even the merest drip of concern, let alone the heady response of an adrenaline surge. The sympathetic system, having been overused for years, now seemed to laugh off all petty emergencies.

And even in the few cases when genuine emergencies arose, they were able to deal with them calmly and efficiently, from the perspective of the parasympathetic mode.

Decrease in adrenaline in those who could *not* relax

Patients who remained negative, cynical, or fear-based, dissociated from their hearts and living in their minds instead of using a blend of mind and body awareness, had a very different experience when the adrenaline decreased. The decrease in adrenaline that seemed to occur when the injury healed was a very large problem for people who were not emotionally able to drop their wariness and shift into parasympathetic, dopamine-releasing, mode. These people became obsessively anxious: their minds were caught up in constant worry, but they had no impetus from adrenaline to get out and do something about their worries, no way to confront their fears.

Their anxiety made them dissociate. After a brief recovery period during which they could move easily and with lightness, they soon found themselves with much more intense symptoms of Parkinson's, particularly tremor.

Many patients, after starting to recover, have insisted, "Anyone who isn't anxious about everything is an idiot," or "It's just smart to be worried about everything." They have then resumed some, though not necessarily all, of their old symptoms.

Prior to diagnosis: using adrenaline every day

Prior to diagnosis and recovery, the patient may have used his steady flow of adrenaline to power his movement. Some patients told us that they had intentionally imagined potential emergencies to get themselves going, if they found themselves slowing down.

For most of his life, he may have pitted his ability to generate adrenaline against the immobility from the injury and from any mind-induced dissociation symptoms.

Although MDs still claim that PD becomes apparent when dopamine levels are too low, the truth is that the symptoms of Parkinson's disease become apparent when the patient can no longer summon up enough adrenaline to override his immobility. When our patient's feet healed, their adrenaline (from injury) levels took a significant drop, even if they were still locked into mentally-sustained dissociation mode. If patients were still emotionally locked into fear-based dissociation when their injury-enhanced adrenaline levels dropped, dissociation with a *decreased* level of sympathetic override became their dominant neurological mode – not parasympathetic. Dissociation causes rigidity and inhibition of the movement neurotransmitters.

When a patient's foot injury was gone, his adrenaline levels receded. If his adrenaline levels went down but the mental links to dissociation remained or continued to expand – he found himself with a *significantly* reduced ability to initiate movement – unless he nattered at himself with an almost illogical level of constant, fear-producing backchat .

Duration of limp muscles

The amount of time necessary to recover strength in limp muscles varied from one person to another and from one muscle group to another. You probably knew I was going to say that.

One of my many proofreaders was annoyed by the redundancies in these chapters about recovery symptoms. However, one of the proof-readers who was actually on the Parkinson's team said, "I'm so glad you're starting to be redundant about the most important bits. So many of our patients have been *so* resistant to the key ideas that they need to hear them over and over. So many don't even understand principles such as "each recovery is different" until they've heard it repeatedly."

But in general, recovering patients could be divided into two groups: the people who recovered very quickly and the people that got stuck in partial recovery. Because the people who recovered fast can be described very quickly, I will insert a short paragraph here about those people. The section on partial recovery will follow, and will take up a bit more time.

Fast recoverers

The people who recovered the most quickly did so without even *thinking* about it. As they recovered feeling in their bodies, they found themselves consciously enjoying the sensations of using body parts that hadn't been felt *or* used much in the past. Since it was enjoyable, they did it. They didn't have to *think* about doing it: they worked these healing muscles in the same way an infant automatically uses and enjoys his muscles by exploring and trying out movements.

These fast-recovering patients may have had limp muscles for a few hours or days, or a week or even a few months, at the most, and then suddenly recovered full function. It was not as if the muscles needed to grow strong: *it was as if the nerves that connected the imagination to the muscles needed to be hooked back up.*

This group tended to be in the five percent who only had a foot injury and had no other dissociation at work.

Then again, a few people who recognized that they had all the symptoms of long-term emotional shut-down – including me – did recover pretty quickly.

You just can't generalize accurately, and you can't know who's going to recover easily and who's going to put up a fight.

However, I must note that even those who *are* at peace with themselves, and who are enjoying the curious sensations of their unresponsive limbs, may find this stage to be particularly trying. But they get over it.

“Don’t play for safety - it’s the most dangerous thing in the world.”

- Hugh Walpole, English novelist

CHAPTER TWENTY-FOUR

RECOVERY SYMPTOMS: PARTIAL RECOVERY

Nearly everything in this chapter has been discussed elsewhere, in bits and pieces. For ease of reference, this chapter summarizes in one convenient place most of what we’ve learned about partial recovery.

After the Little Project had been up and running for five years, we had to admit that some people stayed in the limp-muscle phase, or the limp-muscle followed by sudden increase in rigidity, for a long time: even years. That’s when we decided to name this phase, if it lasted for more than a few weeks, “partial recovery.” We could see, in retrospect, that the onset of the muscle weakness was the most common time for people to slip into partial recovery – even if the muscles did not become profoundly limp.

By the time a patient began to experience muscle limpness, his body’s physiology had usually already been experiencing recovery from numbness and other blatant recovery symptoms such as distinct changes in sleep patterns and other recovery symptoms that are described in later chapters. However, when the more overt recovery symptoms eventually ceased, the mood-based symptoms of parkinsonism sometimes increased with a vengeance.

While trying to discern the difference between patients who recovered quickly and those who became mired in partial recovery, we observed that the partial recovery patients responded to the limp muscle phase with wariness and fear. It even seemed as if, in some cases, the return of awareness of long-ignored body parts triggered or amplified the fear that had allowed or caused the body to block out the knowledge of the foot injury in the first place.

Healthy fear can cause a shift towards the sympathetic system, the release of adrenaline, and an enhanced ability to move with speed and power. *Helpless* fear, or a sense that one is dying and nothing to be done to prevent it, can cause a shift towards dissociation, the inhibition of both adrenaline and dopamine, and rigidity, slowness, and *weakness*.

When patients who were starting to recover experienced an increase in fear, they tended to go towards dissociative mode instead of sympathetic mode.

A few patients never even noticed much of a limp phase: they went directly from terrifying pain, which started when the injury began to heal, straight into amplified rigidity, slowness, and weakness. In these cases, it seemed as if the *fear of pain*, together with the decrease in adrenaline, caused an abrupt increase in rigidity. It might have been fear induced by the pain of remembering the foot injury, and/or the fear induced by the tingling in the previously numbed body areas, and/or the fear induced by spontaneous movements in recovering body parts and/or the fear of not being able to recover. Whatever caused it, these people very quickly became *very* rigid, slow, and *weak*. They became almost paralyzed with

symptoms consistent with psychogenic parkinsonism and also consistent with frailty – a mentally influenced condition.

In other words, when emotionally restricted patients started to heal, they experienced a shift in the *cause* of their rigidity. Previously, their slowly developing rigidity had been caused *primarily* by injury-induced, backwards-flowing Qi, helped along by a determination to never feel pain.

During the early weeks or months of recovery, they experienced a return of sensation in their feet and face, improved circulation, tingling in the nerves that were coming back from dormancy, and spontaneous movement in toe and facial muscles – muscles that had previously been unresponsive. Clearly, these people were healing. But many of them also quickly attained a higher level of rigidity than before.

Weakness

Also, although people who got stuck in partial recovery might or might not notice a phase that they would refer to as being limp, most of them *did* notice the onset of “weakness.” Weakness is *not* necessarily a symptom of idiopathic Parkinson’s. People with classic Parkinson’s become rigid and slow. They often have problems initiating movement. But they tend to be driven and tense, rather than weak. And yet, people who got stuck in partial recovery often complained about weakness. The weakness usually started shortly after the foot injury healed up.

I sometimes wondered if the weakness experienced by people who were stuck in partial recovery was actually a variation on the limpness of muscles that was experienced by people who recovered quickly. I suspect it might also be the result of the decrease in adrenaline that occurs after the injury heals up.

They knew how to be strong via fear, but they had no way to motivate themselves in the absence of a serious injury.

Again, most people with Parkinson’s don’t complain about being weak. People in partial recovery complain almost constantly about being weak.

Duration of partial recovery

How long did the partial recovery phase last? It’s impossible to generalize. Some patients who got stuck in partial recovery steadily slogged through the mind-retraining exercises and recovered fairly quickly, in a matter of weeks or months. Some recovered slowly, over the course of years. Some have not yet fully recovered. Of the latter group, many dropped out of the program. Others have not.

But the great thing is, some patients who’d been stuck in partial recovery for more than a year did eventually make the stunning break through to feeling safe, relaxation and healthy sensory awareness of the body. The case study of Gertrude, in chapter nineteen, is an example of this: she stayed in partial recovery for nearly a decade after her foot injury healed.

When people do terminate the use of dissociation and allow parasympathetic thinking and movement again, any weakness, slowness of movement, or rigidity promptly disappears. As mentioned many times already, the sudden return of the healthy ability to move via imagining movement and anticipating the internal sensations associated with movement was as abrupt as the flip of a switch.

When this change occurred – after weeks, months, or years – the muscles had conscious strength. They were not limp. It may be that, during the months of partial recovery, the muscles re-established their mind-body relationship during those moments when the partially recovered patient was sleeping or momentarily forgetting to be afraid. So when the dissociation ended, the body was ready to go.

At any rate, we suspect that the genuine limpness of recovery actually only lasts a few weeks, maybe a month or so, at most. After that length of time, the nerves that connect the mind and the muscle seem to be restored. Any weakness that remains after that span of time is more likely due to mindset than to a lack of mind-to-muscle neural connection.

Partial recovery could take the form of perennially limp muscles, dissociation-induced rigidity, or some combination of the two. Many patients dropped out of the program when they got to this point.

Some of these partially-recovered people experienced many of the recovery symptoms mentioned in the previous and in the following chapters – symptoms that are the opposite of PD symptoms. Some of them even experienced periods of time – hours, days, or even weeks or months – during which they were moving normally. But at some point, when they relapsed into fear, disbelief of recovery, or revulsion at their new body awareness, they quickly, in some cases instantly, became horribly rigid and slow.

Some spent several years coming to terms with memories of hideous events in their past that they had blotted out. During this time, they would be uncharacteristically anxious, if not paranoid. These negative emotions, in turn, seemed to trigger the rigidity, slowness or movement, and tremor that are associated with Parkinson's disease.

In these cases, the PD-like symptoms were clearly psychogenic.

Based on our work with our two percent of patients with psychogenic parkinsonism, a condition that looks exactly like Parkinson's but which is mood- or emotion-based rather than physically induced (there is no evidence of any foot injury, and the channel Qi is able to flow normally, but usually does not, based on ongoing thoughts) we realized that psychogenic parkinsonism was exactly the same as what we were calling partial recovery from idiopathic Parkinson's disease.

Both psychogenic parkinsonism and partial recovery go away as soon as a person turns off the dissociation, for good. Oppositely, the physical condition of people with either psychogenic parkinsonism or people who become stuck in partial recovery will steadily worsen over time.

Most of our PD patients hated being told that their symptoms were the same as those of psychogenic parkinsonism. The word “psychogenic” suggests to the layman that the person is merely imagining his symptoms. This is a wrong understanding. The symptoms are very real, even though they are being triggered by a mental/emotional attitude. Most patients have preferred the terms “partial recovery,” “dissociation,” or “mental/emotional blockage.”

Western medicine has, for centuries, dismissed psychologically induced illness as “not real” or “less real.” Asian medicine recognizes that nearly all illnesses, even susceptibility to germs and “measurable” pathologies such as myopia, have a mental component.

Back to the question of how long can a person stay in partial recovery? As far as we are able to tell, a person can stay in partial recovery indefinitely. There is no *physical* treatment that benefits these people. Those who eventually recovered fully after having been stuck for a while in partial recovery had not necessarily undergone any further *physical* change that opened the door to full recovery.

The people who overcame partial recovery all did it the same way: they *decided* they were safe enough to turn off the use of dissociation, or they decided to confront their fears via strength and joy rather than freezing up inside (same thing).

As soon as they changed the mindset, their bodies behaved as if they were healthy. If they were still processing pain from long-unhealed injuries or other physiological recovery symptoms, they continued processing them. But as for the rigidity, slowness, and tremor, those symptoms were over with.

Sabotaging recovery

As noted earlier, many patients respond to their recovery symptoms with “Yahoo! I don’t know what the heck is going on, but it sure as hell isn’t Parkinson’s!” But more patients told me that recovery symptoms were only a tease, or that they couldn’t really be signs of recovery. They were certain that, even if recovery were possible for some people, *they* could not be one of the “lucky ones.”

An example of sabotaging one’s own recovery

One recovering patient left this message on my answer machine: “I went to a church dance last weekend and for the first time in my life I was moving gracefully! I wasn’t rigid: I felt like I was floating, it was glorious. I didn’t care who saw me or what anyone thought. It was the best time I’ve ever had. People were saying that they’ve never seen me look so good.

“So tell me the truth: was that the Last Hurrah? From here on out, am I only going to get worse? I can’t imagine that I will ever have such a great evening again. Was that the last time I’ll ever move easily? Should I admit that I can’t recover?”

I was stunned by his twisted thought processes.

Movement-wise, he had recently had the best evening of his life.

His conclusion, based on the fact that he didn’t *really* think he could recover, was that this was a sort of “Last Hurrah,” a spontaneous gift from God, and that, having used up these few hours of grace, he would never move easily again.

This man had been recovering wonderfully. In particular, his facial expression, the function of his hands, his loud voice and his ability to stand up straight had resumed. These were changes that he couldn’t hide, even from himself. But he was also getting better at inducing a stunning level of immobility, as needed, by the simple method of reminding himself that he couldn’t really move. As soon as he remembered that he couldn’t actually recover, he could hardly move.

He assured me that he believed that some people might be able to recover. But he was equally convinced that *he* could not. He knew that this was so because, during those times when he was *most* certain that he would never recover, his movement was the worst. The fact that he could induce immobility in himself just by dwelling on the impossibility of

recovery *further* convinced him that he could not be recovering in *any* way. Despite his tremendous number of improvements, he could not shake the idea that he was doomed.

When he admitted that he had not once tried to do *any* of the homework (an assortment of attitude-retraining techniques), he said to me, in all honesty, “Can’t you do that part for me?”

He had been off work, getting disability payments, but he admitted that he was now physically able to return to his teaching job. I told him that returning to work would be the best thing for him, but he replied he didn’t really want to go back to work. He also threw fallacious logic at me to show that he *shouldn’t* go back to work. He pointed out that, when he was in a negative mindset, he had increased problems initiating movement; since teaching *might* provoke some negative thoughts, even thinking about teaching could permanently worsen his condition.

I told him that his *mental* attitude, not his environment, determined whether or not challenges were interpreted as negative or positive, and that there was nothing inherently fear-inducing about going to work. He disagreed.

We’ve seen that patients who keep working do much better than those who take time off to “focus” on recovering. The ones who take time off usually end up dwelling on their fears and feeling bad because they aren’t “doing” anything.

Throughout our nine months of working together, my “Last Hurrah” patient had admitted that his extremities were healthier, had better color, were warmer, and had more feeling. He admitted that he had increased facial expression and better posture. He admitted that he had regained the use of his hand and voice. He admitted that, during those times when “I forget to have My Parkinson’s,” he could move easily. And he consistently denied that these changes signified “any change in My Parkinson’s,” as he always called it. There seemed to be a possessive quality in the way he always referred to his condition as “My Parkinson’s.”

Because he was increasingly able to immobilize himself with worry, when his mind took a twist in that direction, he was certain that “My Parkinson’s” was getting worse. In a spiraling fashion, the one thing that was most able to provoke a spate of immobility was thinking about how *he could never recover from Parkinson’s*. This circular bit of thinking, which made him fearful, which then made his movement ever more difficult, confirmed his worst suspicions and assured him that he could not recover, despite all his lasting physical improvements.

When I asked him why he indulged in such thinking, he said that his brain did it, not him. When I asked him who was in charge of his brain, he laughed and said that he wasn’t responsible for his own thoughts and didn’t want to do the work of changing them. He certainly didn’t want to do any work oriented towards positive thinking. He felt that positive thinking, in the face of an incurable illness, would not be “true.”

Once again, he asked me if *I* couldn’t simply get rid of his negative thoughts for him by using acupuncture or herbs, because his negative thoughts seemed to have a mind of their own. Although he laughed when he said this, he was dead serious. I had given him *many*

techniques that can get a person out of negative thought loops, but he had never even tried one of them.

He had no intention of becoming the master of his own thoughts. He knew how to mire himself in negativity. He had unknowingly trained himself in it, and he was *very* good at it.

He only saw me one more time after his “Last Hurrah” phone message. During this last session, he denied that he had moved well at the church dance! I asked him why people had told him at the time that he was moving so well. He replied that he didn’t know.

He was also fascinated with fact that people with Parkinson’s are extremely susceptible to the placebo effect. He said he wanted a doctor to give him some placebo that would convince him that he was OK so that his symptoms would go away. I asked him why he didn’t just work on generating a positive attitude in himself. He laughed and said that he wasn’t interested in doing that much work.

Another patient had recovered completely, but tripped and fell one day while playing tennis. She concluded: “The Parkinson’s has returned.” After that, she could barely move. At night, “I’m so stiff, I can’t even get into bed. Every night, I have to *pretend* I don’t have Parkinson’s while I turn down the blankets, get my pillow just right, and climb into bed. Then, once I’m settled in, I can have the Parkinson’s again.”

Are these people crazy?

A non-PD reader might think that I am making this up or that, in cases such as the above, I am dealing with a crazy person instead of a typical person with Parkinson’s. However, this man’s thought processes were fairly typical for a person stuck in partial recovery. Also, people with Parkinson’s are usually thought of as highly intelligent, responsible, and keenly self-monitoring: not crazy.

People who develop such clever ways to prove their expectation that they will get worse are not actually crazy – they are merely applying their long-practiced habits of harm avoidance – habits that include using dissociation. And these habits have, in many cases, grown entrenched over the decades.

Many patients have said to me, “I’d rather assume that I won’t recover. That way, I’ll be pleasantly surprised if I do. If I assume that I *could* recover but then I don’t, that would be painful.”

People with Parkinson’s often direct most of their thoughts towards the avoidance of pain. This kind of thinking often means anticipating a worst-case scenario. But most patients do not consider themselves negative: they consider themselves to be clever.

Many patients have cultivated for decades an elevated ability to anticipate worse-case scenarios. This attitude, in turn, keeps a person from “risking” the sensations that can occur if a person drops his fears and truly relaxes. Then again, this attitude also inhibits a person’s ability to relax – or release dopamine.

People with Parkinson’s need to make a note of this: anticipation of risk or worst-case scenarios in a person whose *uses dissociation as his response of choice* to anticipated fear or pain will inhibit his own ability to release dopamine. *A person who dissociates when he anticipates not being able to release dopamine will find that his expectation is instantly fulfilled.*

The powerful irony here is that what some patients perceive to be their greatest strengths, their ability to be analytical and to anticipate worst-case scenarios are, in fact, their greatest weakness and their physical downfall. This ability is a downfall because it has become habitually connected with biological dissociation from the heart: a condition that induces rigidity and all the symptoms of Parkinson's.

Predicting who will recover quickly

I've said this before. Please forgive the repetition.

There is no way of knowing who is going to stall during recovery. However, in our limited experience with a few hundred subjects (a small number, by research standards), five of the six professional musicians in our program breezed quickly through the phase of limp muscles. So did many others, including dancers and those who were able to enjoy the enhanced sensory experiences that occur during true relaxation.

Still other patients who *used* to know that relaxation (parasympathetic mode) could induce these shifts were not as prone to slide into partial recovery, even if they were not currently able to enjoy music or no longer knew how to relax.

However, other patients were *surprised* to learn that, in healthy people, certain sensations or events might occur during relaxation: the chest might feel a sense of expansion; a feeling of movement or expansion might occur in the chest in response to music or visuals; the mind usually calms down and pays more attention to the perceptions of sensory events; the mind ceases its harried, internal monologue. These people tended to have a hard time getting rid of their mental habit of dissociation – they were not sure that any alternative existed.

Finally, those patients who had *no* idea what was meant by the words in the above description of relaxation, who had no point of reference for the idea of palpable internal sensations such as “a feeling of expansion in the chest when experiencing something of great beauty or grace,” or who had no idea that these increased sensations were the hallmarks of true relaxation, and who instead had thought that “relaxation” referred to a welcome *cessation* of sensation – numbness – tended to slide into partial recovery and stay there.

Then again, a few of them *have* worked steadily, powerfully, at relearning how to live and feel, and have succeeded in recovering. They have also discovered an entirely new way to live in the world: and none of them would ever want to go back to being their old selves.

When they started on the path to recovery, most of them wanted, more than anything to go back to being their old self. After recovering, they *never* wanted to be that person again.

“You should only worry if your baby isn't exhibiting jerkiness or spastic movements...”

- Advice column on babies; www.thebump.com

CHAPTER TWENTY-FIVE

RECOVERY SYMPTOMS: DYSKINESIA

Dyskinesia means incorrect movement. Dyskinetic movements may be somewhat constant, like the tension caused by a long-lasting spasm such as a leg cramp or “permanently” tight muscle, or they may be intermittent, like a twitch or tic. During recovery, previously disconnected muscles regain a conscious connection to the brain. When this happens, the muscles sometimes behave dyskinetically for a short period, until correct brain-to-muscle function is restored.

Spontaneous movement

The dyskinetic moments during recovery are delightful, inasmuch as they seemed like the very opposite of the forced, difficult movements of Parkinson's. They seemed to occur when previously rigid or numb muscle begins to receive nerve signals once again. When this occurs, the muscle coordination is often poor, even spastic, at first.

When these muscles begin to connect to the brain, so that recovering patient can feel their existence, they often move imperfectly, even immaturely: these muscle movements are sometimes like those of baby. A baby grimaces asymmetrically while exploring his facial muscles; he repeatedly, helplessly, bangs a spoon on the highchair tray while learning to use his arm.

Recovering patients find themselves experiencing asymmetrical facial expressions, strangely clumsy muscles, or even muscles that spontaneously initiate repetitive movements much like those of a baby spontaneously, steadily banging a spoon on a tabletop.

We named this spontaneous, usually gentle, non-controlled movement “recovery dyskinesia.” In appearance, it sometimes resembles the dyskinesias (non-controlled, and sometimes repetitive movements) that occur in people with Parkinson's who have taken too large a dose of their antiparkinson's medication.

Recovery dyskinesia can occur anywhere that muscles have been rigid: in the large muscles of the chest and legs and the small muscles that give finger finesse or facial expression.

Some events have been one-time spasms followed by perfect conscious control. Sometimes they were gentle flexions and extensions of a single muscle, repeated a few, or a hundred times or so, every day for a few days. And they were everything in between.

Recovery dyskinesia is *not* to be confused with the uncontrolled movement of Parkinson's *tremor*. Fortunately, once you understand the causes and characteristics of each, it is not very difficult to distinguish between them. Parkinson's tremor, whether it is the

resting tremor of the fingers, shaking of the arms, legs, or chin, or the “amplified tremor” that shakes the whole body, is always at its worst when the person with Parkinson’s is stressed or thinking of something worrisome, and it ebbs when he relaxes or doses off.

Recovery dyskinesia, on the other hand, occurs when a person is relaxed and feeling safe. In fact, it occurs most often when a person was watching TV in the evening or lying down to sleep.

Another key distinction is that Parkinson’s tremor is generally somewhat vexing to the person experiencing it, while recovery dyskinesia is generally described as an enjoyable experience.

Finally, the movements themselves are different: Parkinson’s tremor is usually a predictable, rhythmic vibrating or shaking, whereas recovery dyskinesia, as you will find in the coming sections, is unpredictable: just when you think you’ve figured out what it is, it’s over or moved into another body part.

In some patients, recovery dyskinesia is only a fleeting event that happens once or a few times. Some recovering patients have no recovery dyskinesia.

Examples of recovery dyskinesia

I will describe only a few examples of recovery dyskinesia. I cannot possibly describe *all* the instances and styles of recovery dyskinesia that we saw or were described to us by astonished patients.

Toe wiggling

One place that recovery dyskinesia might appear is in the toes, shortly after the return of sensation. After the circulation in the toes improves and the tingling is over, a few people have gone through a very short phase in which their toes spontaneously wanted to move and stretch. It was as if the toes moved or “wanted” to move without conscious instruction: moving “on their own.”

The patients said that they *could* inhibit the toe movement if they wanted to. But they found it more pleasant *not* to get involved, for a change, and to allow the toes to simply express themselves. Even if the toes got into a mild cramp, they usually wiggled themselves free pretty quickly.

Movement in facial muscles

When patients’ long-dormant facial muscles began to function, the resultant facial expressions were much more obvious than the spontaneous toe movements. The fleeting facial contortions often resembled those of an infant who cannot yet control his face.

Anyone who has spent time with an infant knows that babies can make some pretty funny facial expressions. Their facial muscles don’t work in a coordinated manner for several weeks. These same immature types of irregular, spontaneous, or even spastic movements of the facial muscles might occur when patients’ facial nerves awaken from their dormancy.

Some patients are scared that they would spontaneously make a goofy face while out in public. But most recovery dyskinesia takes place at home, while relaxing in front of the TV, or while falling asleep.

No one has experienced facial spasms while giving a presentation at work.

It seems that the body only enjoys the liberty of exploring new muscle function while a person is in parasympathetic mode: whenever or wherever he is safe and relaxed.

Recovering facial muscles: an example of “safe”

After experiencing all manner of fleeting, small facial tics and spasms over a period of two months, I found myself having a major “face recovery” moment while enjoying a rare lunch at a classy restaurant with my daughter. We were seated on the rooftop patio, the warm sun was shining down, we were both laughing.

I was at peace with the world. Suddenly, the entire right side of my face went into a powerful spasm. My right eye was squeezed shut, the right cheek muscles were bulging outward, and the right side of my mouth was pulled up towards my eye. On the right side of my face, *all* the muscles that should be used during a heartfelt smile kicked in at once – at full strength. These muscles were still a bit clumsy, and hadn’t worked together as a unit in at least ten years.

As the muscles locked into a powerful spasm for over a minute, screwing up and immobilizing the right side of my face, I finished my sentence by speaking out of the left side of my mouth.

My daughter replied, and we continued chatting. After the facial spasm had been in place for what seemed like a full minute, my daughter said, “Mom, I’m not sure that ‘look’ really *works* for you,” and we both exploded into laughter.

After a few more moments, the spasm melted away. A new sensation of warmth and power pervaded the muscles in my cheeks and the skin of my face. From then on, my face was far more expressive and I was better able to feel the skin of my face.

I chose the above anecdote as an example because many patients have been terrified of having an obvious recovery symptom at a “wrong” time or place, such as when out in public, or in front of some judgmental person. The point I am making here is that, if the person feels safe, it won’t matter to him if a facial spasm appeared in public. But if the person is in a situation that renders him self-conscious, that situation will *not* be safe. Therefore, he is unlikely to experience a recovery spasm in that setting.

Patients only experienced recovery symptoms when they felt safe. Location, per se, did not make a place safe or not. What made a place “safe” was the attitude of the patient.

A sudden arm stretch

One recovering patient was practicing piano when suddenly her right arm straightened itself sideways, and extended to the keys at the high end of the keyboard. After a moment, the arm returned to its previous position. This happened several times that evening, and then never happened again. It was *not* a muscle cramp. The movement had been generated by a contraction of the muscles around the ball of the upper arm, where the upper arm sits in the shoulder socket. These muscles tend to be inaccessible to people with Parkinson’s. The movement had been powerful and graceful – and completely unexpected.

A neck pivot

Another recovering patient was standing up singing in the choir when her neck muscles painlessly but powerfully pulled her head to the left. She found herself staring at the person next to her. The person next to her stared back.

“Cramp in my neck,” lied the recovering patient. After a split second, the neck muscle relaxed and she found herself facing forward again. It had not actually been a cramp. Cramps are overly tight and painful. This neck movement wasn’t painful. It had been an involuntary, gentle contraction in a neck muscle that she hadn’t used in years. Moments later, it happened again.

“More of a nervous twitch, really,” she whispered.

After half a dozen episodes over the course of an hour, it never happened any more. Prior to this event, she had not been able to turn her head easily to the side. After this event, she could move her head easily.

Singing in the choir was one of her all-time favorite activities. She was not embarrassed by the “twitch.” She thought it was funny. *She was relaxed.*

The waving lady on a pancake house

Another recovering patient described recovery dyskinesia in her arm. “Last night while I was watching TV, my right arm lifted up and started waving back and forth, back and forth. It wasn’t fast. It was like that plywood woman on the roof of the pancake house who mechanically waves back and forth. It kept it up for about ten minutes. Never went slower or faster. It didn’t hurt. I probably could have stopped it, but I didn’t want to. It was bizarre. My adult daughter was kinda worried about it, but I thought it was kinda funny. It felt nice. It wasn’t *anything* like tremor.”

Marching in bed

Sometimes, when sitting on the sofa or lying in bed, a recovering patient’s leg(or legs) started rhythmically “marching.” Sometimes the arms join in, moving in time with the legs. This is not “restless leg syndrome.” This is recovery dyskinesia.

Fixing the foot

One patient felt an urge to bang the top of his foot against the bottom of the coffee table. Every evening, relaxing after dinner, his leg “wanted” to bang the top of his foot against the coffee table. So he let it. He would let his leg gently rise up a few inches, causing the top of the foot to get a gentle whack. The movement was steady and rhythmic. Each evening, the foot was whacked at least a hundred times or so. The whacking only stopped when his leg didn’t “want” to do it anymore.

He said it felt really good, as if his leg knew that something in his foot wasn’t quite right, and needed to be gently knocked back into place. The foot had received many Yin Tui Na treatments. The foot felt completely healed, in terms of a return to suppleness and all the other things we look for when treating an old injury. And the patient had no *conscious* understanding of something in particular that needed to be done to the foot. His leg just “wanted” to gently whack the top of the foot, that was all.

Shortly after the patient noticed that his toes seemed “happier” and more flexible, he also realized that his leg was no longer wanting to bang his foot on the bottom of the coffee table in the evening.

Technically, this might not be considered a form of recovery dyskinesia. But the movement felt almost spontaneous, it was repetitive and rhythmic, and so I’m including it in this section.

King Kong

One patient, relaxing at home in the evening, beheld her alternating fists beating on her chest as if she were doing the “proud gorilla” move in slow motion. Alternating, left, right, left right, her fists pounded her chest for nearly ten minutes. She was a very delicate, petite woman: the next morning she had bruises on her chest. She only had this experience this once, and afterwards, her arms were far more relaxed.

Hand positions

In some recovering patients, the muscles in the hand tighten for a while – never for longer than twenty minutes at a time. This sometimes creates various weird hand positions: dancer-like, stylistic hand positions. I experienced them, most often, during my morning walk. Others noticed them while sitting around watching TV.

The voice

Patients’ voices suddenly reappear after months or years of being reduced to a whisper. The return of voice is not always a straight line. The muscles that opened up in the larynx sometimes open very wide, without warning, and an embarrassingly big booming voice issues forth for several minutes – or a day or two. And then, sometimes a few days later, the voice temporarily disappears altogether. In patients that fully recover, the full, “normal” voice soon becomes consistent.

One patient called his sister when his voice returned after nearly ten years of inaudible speech. His sister accused him of being a prankster. “You’re not my brother; my brother only speaks in a whisper.” She hung up on him.

Chest muscle spasms

Several patients have grown mildly concerned while experiencing recovery dyskinesia in the chest. In Parkinson’s disease, the muscles that run down the mammary line of the torso become rigid. During recovery, these muscles sometimes experience recovery dyskinesia: either they tense up for about twenty minutes and then relax, or they tighten and relax over and over again, somewhat quickly. Either way, the event usually lasts no more than twenty minutes.

During the tightening up phase, recovering patients sometimes feel they cannot not take a deep breath. A few have wondered if they were having a heart attack. They decided to go to the hospital. By the time they arrived at the hospital, the tightness had ceased. One patient stuck around at the emergency room for a full heart work up, to reassure himself that nothing untoward had occurred.

An aside: I always tell patients to see a doctor immediately if they think they might be having a heart attack. Do not ignore symptoms that give cause for concern. If it turns out that the chest spasm was only recovery dyskinesia and not a heart attack, no harm will have been done. None of my unmedicated patients had heart attacks during their recovery from Parkinson’s disease.

During the *relaxation* phase of chest-muscle recovery dyskinesia, the opposite occurs. Patients who experience this feel as if the chest is so wide open that there is no need to breathe.

In my case, I was enjoying my shower when I suddenly realized that I hadn't inhaled in a really long time. I was a little concerned, but I just didn't feel any need to inhale. My chest felt very wide open and free. Finally, I did inhale and exhale, and again, a long time passed before I felt the need to take another breath.

Recovery dyskinesia of the head

Recovery dyskinesia often occurs in the neck, the face, and the inside of the head.

Recovery dyskinesia in the tongue

Many patients experience a bout of clumsy speech: the tongue feels as if it is moving on its own or not moving the way it used to. It may seem, for a short while, as if one needs to relearn how to use the tongue. However, the speaking skills usually come back *very* quickly. In some cases, after recovery, the tongue seems to be positioned differently. This may be caused by a change in sensory awareness of the tongue or a change in the position of the palate. In my case, it seemed to be some of both.

Many people bite their tongues and/or the inside of their cheeks during this phase.

I personally had a curious tongue situation develop during recovery: when concentrating deeply on anything, I would stick my tongue out on the right side of my mouth, ever so slightly. Just the tip of the tongue was visible. I had been doing this for several weeks when I remembered an old photograph of myself playing the violin when I was age twenty. In that photo, my eyes were closed and I wore a look of deep concentration – and the tip of my tongue was sticking out the right side of my mouth. I knew that I had not put my tongue out to the side for decades but now I was evidently reverting back to a specific time in my youth.

After a few months, after my palate lifted and my teeth spread apart, I no longer stuck my tongue out to the side. I was certain that my age twenty tongue-to-the-side had not occurred when I was healthy, prior to age seventeen. I suspect that I started doing it shortly after the weird buzzing experience on the side of my head at age seventeen, after which I always felt a little more tense inside.

In other words, the age twenty tongue asymmetry and protrusion had been a very early symptom of left-right imbalance and internal tension – a very early symptom of pre-Parkinson's disease – and not a healthy idiosyncrasy. When, after recovering, my tongue started staying inside my mouth even when I was concentrating, I it felt very good. I could then remember my tongue feeling comfortable in my own mouth when I'd been a youngster, prior to my brain shift at age seventeen, because I could compare it with the feeling of my tongue "not knowing where it should rest" that had been part of my life since my early twenties.

Recovery dyskinesia in the palate

A person's upper palate (in the mouth) is held in position by muscles. These muscles sometimes change their degree of tension during recovery. If the muscles above the upper palate gently tighten, lifting the lateral (outer) sides of the upper palate, a gap may appear between the two front teeth, as if the teeth have suddenly moved apart. This sudden, very

visible movement of the teeth is painless. The teeth have not actually moved in their sockets: the two sides of the upper palate have lifted up, and the teeth came along for the ride.

The roof of the mouth sometimes feels as if it has assumed a new position. Again, this movement in the upper mouth is not painful. Just the opposite: it feels pleasant, if it felt like anything at all. It seems to be caused by a return of vigor in previously weak cranial muscles.

Sometimes, the lift in upper palate position brought about a welcome reduction in snoring or sleep apnea.

Many patients, including me, *prior* to recovering, have experienced a sensation as if the upper palate is falling down into the mouth now and then, partially blocking the airways and the sinuses. The resumption of healthy muscle tone in the muscles of the upper palate cured or greatly improved this problem.

Recovery dyskinesia in the eyes

During recovery, changes sometimes occur in visual acuity. Many patients have noticed a sudden, extreme improvement in vision that lasts for a few minutes or a few days, which was followed by a return to normal vision or a temporary worsening of vision.

For example, one patient said, “I swear, yesterday, I could see a bird sitting in a tree half a mile away!” A few days later, the same person was hardly able to focus her eyes. Over a period of a month, this occurred several times. After that, her vision settled back down to exactly what it had been. Based on everything else we’d seen, we guessed that the muscles of the eyes had been going through tightening and relaxing exercises. The muscle tensions had caused the temporary changes in vision.

After this occurred several times in several recovering patients, I now tell patients not to rush off to the ophthalmologist or optometrist for an eye exam or a new pair of glasses if the vision suddenly alters. In our limited experience, once the recovery dyskinesia in the eye-focusing muscles is over, the vision always settles back down to something very close to what it had been prior to recovery.

Not uncontrollable

Patients nearly always want to explain to me that they probably *could* have stopped the movements in the arms or legs or hands if they’d wanted to, but they didn’t *want* to. It’s as if some muscle wanted to work out or stay in a certain position for a while, and it felt good when allowed to do so. The patient *enjoyed* feeling the sensation of the moving limb or vigorous muscle contraction *and* he enjoyed the general good feeling of expansion in the chest (heart feeling) that came from *paying attention* to how the sensation felt.

These repetitive types of recovery dyskinesia usually last somewhere between a few moments and twenty minutes. Even the most relentless recovery dyskinesia usually peters out after about twenty minutes.

In most cases, recovery dyskinesia is amusing. If it ceases to be amusing, it soon stops. It occurs when a recovering patient is relaxed or enjoying himself. If he stops being relaxed or becomes stressed, the movements soon cease.

Speeding up

A few patients have the strange experience of the body briefly moving faster than they can control. While doing an ordinary, mundane and repetitive chore, such as chopping

vegetables, it feels as if the *correct* arm muscles for the chore suddenly kick in. The muscles then move very quickly, effortlessly, in a rapid manner. The *effect* is that the knife seems to be suddenly chopping the vegetables much faster than before. The *feeling* is effortless, as if the arm is “moving by itself.”

This “speeded up” movement can happen during all sorts of activities, ranging from practicing piano scales to chopping celery. The commonality is that it only happens while a person is relaxed or enjoying himself.

Then again, this is fairly unusual. Not everyone experiences events in which limbs seem to move unnaturally fast for a few moments.

Variations in recovery dyskinesia

I’m about to be redundant: no one experienced all the types of recovery dyskinesia. Some experienced none. Some people had a few very powerful experiences, some had only a few, mild moments. Some slept through their few moments of recovery dyskinesia and were told about it by an amused spouse. Every recovery was different.

Enjoying the body

Recovery dyskinesia is wonderful. Several patients have said that they felt as if they were coming back to life when the body starting relearning, on its own initiative, how to feel and use muscles that had been rigid and somewhat numb. The feeling that one is starting afresh, growing a whole new body, is so very delightful that a few people have even said that they feel as if they have lived two lives in one lifetime: they had their first life, and they were dying from it; then they were given a second chance and they got to start again from the beginning – learning what it’s like to *enjoy* having a body, and learning how to *enjoy* using it.

Wanting to have a body versus enjoying a body

Some patients who are clinging to dissociation have protested my phrase “learn to enjoy having a body.” They have declared that they *do* enjoy having a body, or always used to. Now they just want to get their old bodies back.

I recall one patient who was adamant that he loved his body. After we’d been working together for about six months, he told me the following anecdote.

The previous weekend, he’d spent an hour floating in his daughter’s swimming pool, lying on one of those floating rafts with arm rests and a holder for a beverage. His mind was blank and the sun was shining down. He felt a wave of peace flood over him, and he realized that he was feeling good. He realized that he could feel the sensation of the sun on his skin, and the sensation of floating. It was a rare moment. He marveled at the sensations that he was experiencing.

Then, his mind kicked in. He immediately wondered to himself if this was the type of “enjoyment from the sensations of the body” that I was always “badgering” him about. His next thought was, “Heck, I can’t be expected to *feel* this much *all* the time. That’s ridiculous.” As soon as he thought this, he realized that he was no longer able to be aware of the same sensations from the sun and the floating.

The moment of pleasure from body awareness had snuck in to his consciousness as he’d felt it with his body, but he’d quickly brushed it away with his negative thoughts. As soon as he thought to himself, “Heck, I can’t do this...,” and re-immersed in negative

thinking, he realized that he was unable to feel his body in the same way. He was unable to recapture the sensation of sun, the feeling of floating, and the good feeling inside his own body. He certainly was no longer *enjoying* it in the manner that he'd done a few moments earlier.

That's when he began to understand why I frequently told him that he must learn to enjoy his body. He had incorrectly thought that his desire for a *functional* body was the same thing that I call "*enjoy the body.*" These were two different concepts, but he couldn't understand that until he actually enjoyed how he was feeling, for a few seconds, floating on a raft in the swimming pool. That's when he realized that a desire for restoration of a functional body was, in fact, very different from enjoying the sensations of one's own body.

But even when he understood what I was talking about, he refused to accept that he could allow himself to pay attention to his body's sensations just by relaxing, taking the time to notice how he felt, and most of all, shutting out any interfering negative thoughts. He told me that such a course of action would be impossible.

When I asked what was impossible, he replied, "I don't know what to do! Tell me and I'll do it!" I said that he had to practice relaxing and noticing how he felt, the way he'd done in the swimming pool. Then he yelled at me, "So what should I do? Tell me what to do, and I'll do it!" I said that he should practice enjoying the sensations of his body – maybe he could start by getting in the pool again next weekend. He threw his hands as far in the air as he was able, and said again, "I can't live in a pool! Tell me what to do so I can do it!"

I have had *many* patients who have insisted that they always enjoyed their body, who realized, during recovery, that they actually hadn't. They may have enjoyed *using* the body like a tool, they may have enjoyed having the body obey their instructions when they worked it hard during sports, but they hadn't actually noticed or enjoyed the sensory experiences produced by the body, or hadn't in a long time.

For some patients, the spontaneous, gentle movements of recovery dyskinesia and the heart-felt relaxation that occurred when the injury healed were like beginner's lessons in how to *feel the body* and *enjoy* having a body.¹

¹ More than a few patients have been certain that sensory awareness of the body and/or enjoyment of the body was self-indulgent, or even "not spiritual." They needed to learn that the sensations generated with a healthy body are, like flowers and beautiful music, something that can and should be enjoyed. The spiritual injunctions against excessive body attachments have to do with the problems that arise from wrong identification: when a person imagines himself to *be* the body instead of being the soul. Also, *excessive* fascination with the inherently restless body, which occurs when the mind is undisciplined, can be a distraction when trying to stay focused on inner stillness or on uplifting activities.

However, the sensations that arise from having a body, which include vision, hearing, taste, smell, and feeling, are not inherently bad. These sensations can be rightfully enjoyed, because they are just means of being aware of manifold expressions of God's vibratory presence, a presence that underlies and permeates the universe and all objects, even bodies. So long as a person does not *identify* himself as his ever-changing body or become overly attached to it, he risks no "sin" in enjoying the sensory experience of being able to feel his own arms and legs. Then again, many people with Parkinson's cannot even fathom what is meant by the phrase, "Feel your own arms and legs."

An infantile demonstration of repetitive, dyskinetic movement

Once, in the early days of this project, I was on the road, breakfasting in a pancake house. I was musing about the unexpected symptom of recovery dyskinesia that had recently occurred in a few of my patients. At the table next to me, a baby was sitting in a high chair. I watched as he was handed a spoon. He had little control over his movements. As he focused on keeping the haft of the spoon clutched in his fist, his bicep began to contract and relax.

The result was that his arm, and the spoon, started moving up and down, up and down. The rhythmic movement continued for several minutes. The proud parents said that he was banging the spoon on the tray. But I could see that he was not banging the spoon intentionally: he clearly did not have the coordination necessary to bang the spoon so rhythmically on his tray. What was happening was this: his non-controlled muscles were firing off on their own. The muscles in his arm were flexing and extending, flexing and extending. The infant was not doing it consciously. He looked happy and surprised at the movements occurring in his arm.

As he continued helplessly “banging the spoon on the tray,” the proud parents beamed as his movements became more vigorous. His other arm started moving up and down in time with the first. He was clearly not in control of these movements, and he was obviously enjoying himself. Within moments, his legs started moving in time with his arms. His torso started flexing and extending at the waist. All the muscles along the baby’s Stomach channel and Large Intestine channel were flexing and extending, flexing and extending. After several minutes, he stopped moving. His parents kissed him, fussed over him.¹

He had not been making these moves consciously. His brain was just starting to form awareness of muscle control. The muscles were starting to learn how to respond to signals from the brain. It would be many months before the child would be able to exhibit elegant motor control over his fingers and arm muscles. But the process had to start somewhere.

¹ The infant was learning to control the muscles of the Stomach and Large Intestine channel: the two channels that are not functional until the moment of birth. The muscles regulated by these channels are the last muscles to come “on line” in the developing child. These channels do not even start to be activated until the baby starts to breathe. These two channels drive the peristalsis of the gut. An infant in utero should have no gut movement whatsoever: any activity in the Large Intestine might eject sticky meconium (fetal fecal matter) into the amniotic fluid. If meconium gets into the fluid, and thence into the lungs of the unborn baby, it can be fatal. The baby has no need for activity in the gut: all his nutrition comes in through the umbilical cord and goes directly into his bloodstream.

All the other channels, the ten primary channels and the eight extra channels, are functional in utero. Only the Stomach and Large Intestine channels are dormant until the first breath. All of the functions that are nearly impossible for a newborn (thumb and index finger control, eye blinking control, arm control, standing, walking, holding the head up, bowel control, and so on, are regulated by these two channels. In contrast, the muscles that move the lungs, the back muscles, even the muscles under the skin that regulate the pores, and so on, are all operational at birth.

It was no coincidence that recovering patients with long-dormant Stomach and Large Intestine channels found themselves performing movements that brought to mind the spontaneous muscle activities of infancy. It is also no coincidence that a severe injury almost anywhere in the body will trigger a chain of electrical events that cause these two channels to shut down until such time as it is “safe” to heal: until conditions are safe, a person does not want to initiate healing, nor does he want to be distracted by non-essentials such as eating and digestion: activities triggered by the Stomach and Large Intestine channels.

His spontaneous, repetitive movements, set in motion, perhaps, by the curious sensation of the spoon in his hand or maybe by his desire to imitate the hand-to-mouth movements he had seen performed by his parents, looked exactly like the several instances of arm or leg recovery dyskinesia that I had witnessed.

This vignette makes two points: the repetitive, spontaneous movements that occur in specific muscle groups during recovery from Parkinson's are not pathological: they are perfectly natural; they occur as the brain is becoming familiarized with specific motor functions. Second, with the right attitude, this movement can be fun.

FEAR OF RECOVERY DYSKINESIA

Although I always make the point that recovery dyskinesia feels good, many potential patients are afraid of it. More potential patients have been far more worried about momentarily "looking like a fool" than they have been about having Parkinson's disease.

Some potential patients, having read through the earlier edition of "Recovery Symptoms" concluded that they didn't want to risk experiencing a recovery symptom while out in public. They told me, in all seriousness, that they were afraid that, in a moment of weakness, recovery symptoms might occur that would make them look "stupid," "wrong," or "sick." Several people have admitted that they would rather believe that I am wrong – that Parkinson's *is* incurable – than risk recovery incidents in which they might lose face. After all, Parkinson's is a respectable illness.

The reader who does not have PD might think that I am joking. Surely, no intelligent adult would rather be rigid and shaking than possibly have a few moments of perfectly understandable loss-of-control. But be assured, reader, that many people with Parkinson's are reading these same words and thinking, "Yeah. I'd hate to lose facial control or have my arms jerk around while someone was watching. I'm not sure that this program is for me."

I have talked with these people, argued with them, and, eventually, learned to accept the fact that some people would rather have Parkinson's than risk unknowns and potential embarrassment.

For that matter, some patients have told me that they would rather not recover if recovery requires a shift in emotional attitude. Having to change long-held fears or give up a lifetime of cynicism would be the same as admitting that they have been holding to an incorrect mindset – admitting to doing something "wrong." Many have eloquently, if illogically, explained that they would rather stay how they are than make such an admission. Some have even asked me to never use the word "admit," as in, "admit that you've been using dissociation mode." They say that the word "admit" implies that they've been doing something wrong...¹

¹ It never made a difference when I tried to explain that, with a degenerative disorder, people can't "stay how they are." I was genuinely shocked at how many people insisted that Parkinson's wasn't so bad and that they didn't mind having Parkinson's disease, because the symptoms didn't really interfere with their lives too much. They honestly did not believe that their symptoms would *ever* get worse. I had to wonder what these people didn't understand about the word "degenerative." I sometimes asked these people if they'd ever been to a Parkinson's support group. I was often told something to the effect that, "I went once, but the people in the group had a different kind of Parkinson's," or "The people in the group were a real mess: they weren't like me. My Parkinson's isn't the severe kind, like theirs is. *Mine* isn't a problem."

I repeat: people with Parkinson's are usually considered to be highly intelligent people.

Again, a few people with Parkinson's have said that they would rather believe that I am wrong, and that there is no cure for Parkinson's, than admit that they have been cultivating a "wrong" mindset. At first glance, this attitude was wondrous strange. But we now know that being "wary" can include fear of being found wanting, and fear of being wrong about something.

Some people with Parkinson's have been very resentful when we started broaching the subject of a mental/emotional component. For example, in the first years of our website, we only posted information about the foot injury aspect of Parkinson's. We were flooded with inquiries. After 2005, when we posted new information on our website that described what we'd discovered about the mental component, the number of people making inquiries about our program dropped to a trickle.

Not in the car

A person need *not* be concerned that recovery dyskinesia will occur while in a stressful situation. It has never occurred while a patient was driving or doing any job that triggered the slightest bit of extra adrenaline.

Finally, if a person is stuck in partial recovery and wondering if he is truly recovering or not *and* he has experienced one or more episodes of recovery dyskinesia (or for that matter, if he'd experienced several other recovery symptoms), he is up against the uncomfortable conclusion that his remaining bouts of rigidity, slowness, and tremor are no longer being caused by an unhealed foot injury. His *body* is healing. His *mind* is still lurching into dissociation. If the patient has recovery dyskinesia in some limbs but is increasingly susceptible to mood-induced PD-like symptoms, the logical conclusion is that he *had* a foot injury that was contributing to Parkinson's, to start with, as well as some degree of biological dissociation. But if he's had recovery dyskinesia at all and subsequently finds himself with returning, or worsening Parkinson's, he must understand that what he has now is mind-based, psychogenic parkinsonism. Further foot-holding will not help. He needs to pay attention to his thoughts and "change his mind."

“Tote that barge and lift that bale..”

“Ol’ Man River” by Oscar Hammerstein

CHAPTER TWENTY-SIX

RECOVERY SYMPTOMS: MUSCLE SORENESS

Arm swing: bicep soreness

Prior to recovering, many patients with arm-swing inhibition were able to generate a short-term, mentally forced arm swing, a swing that *doesn’t* use the bicep muscle. After resumption of normal channel Qi flow through the arms, the biceps start to function after what may have been decades of dormancy and, in most cases atrophy. When, during recovery, a patient’s arms resume true, automatic, bicep-based arm swing, the bicep muscles may become very sore, at first.

This arm swing pain is *not* recovery dyskinesia. Dyskinesia means “abnormal movement.” Recovery dyskinesia occurs when a muscle first gets back on-line and clumsily starts relearning how to respond correctly to the brain signals.

Arm soreness occurs after the arm muscles become *correctly* operational and started being used a few thousand times a day – without even thinking about it.

Prior to recovery, most of our PD patients no longer had the synchronized electrical pattern that automatically swings the arms – using the correct muscles. During recovery, the biceps, the muscles that *correctly* perform arm swing, may start to automatically contract in synchrony with the opposite-side leg stride. Once the arm-leg connection is working correctly, bicep muscle contraction automatically occurs with *every single step*. When walking, the arm muscles may soon feel sore at first, even a bit painful.

In the beginning, even if the new *automatic* arm swing is very tiny, almost invisible, that tiny movement is the result of contraction in the feeble biceps. Again, this muscle might not have been used for years. During recovery, the biceps automatically – without the patient thinking about it – makes a healthy contraction a split second prior to every opposite-side footfall, thus forming the arm swing.

If a recovering patient walks fifty steps, the convalescing biceps contract and relax fifty times. If he walks at a good clip for half an hour, the bicep contract and relax more than a thousand times.

When the biceps began to work, their usage rate might be going from zero contractions per day to many thousands. Over the next few weeks, walking often becomes difficult because of the accompanying soreness in the biceps. Whether a recovering patient *tries* to swing the arms or not, the reconnected biceps will do their healthy contraction in time with the footfalls.

Several recovering patients who previously mourned the loss of arm swing reported the irony of trying to *prevent* their arms from swinging. “My arms are *so* sore. When I go for my morning walk, I cross my arms over my chest and try to hold my biceps down so that they

can't move. Sometimes that helps, a little. But it's getting so that the arm soreness is limiting the distance that I can walk. I used to go three miles a day. I've cut back to half a mile a day because of how the soreness builds up in my arms. It's a good pain. It's like the soreness I used to get when I was in high school sports, after doing those conditioning exercises. And my arms are getting a lot stronger. But this last week, after just half an hour of steady walking, I was so sore in the arms that I just wanted to go home."

This soreness and pain eases up as soon as the muscles in the arm become accustomed to the thousands of daily repetitions that a healthy person automatically makes while walking. But for a short period, maybe a few weeks or a month, the new arm swing and the resultant workout for the budding biceps can be a bit painful.

Prior to recovery, many patients assured us that they were still swinging their arms, or *could* if they thought about it. They were surprised when the arm soreness began. Truth was, even if they'd been swinging their arms or doing biceps building reps at the gym, they had *not* been using their biceps.

We'd observed that our PD patients whose arms still *did* swing a tiny bit were usually *not* using the normal arm-swing muscles. Close observation shows that most people with Parkinson's use other arm muscles to create an arm swing.

When other muscles take over the job of an injured muscle or help stabilize an injured area, it is referred to as muscle splinting. Muscle splinting is a common, normal occurrence following an injury or loss of some muscle function.

For example, some patients generated an arm swing by *throwing* the arms forward using muscles from the torso and the back of the shoulder. Others had an arm "swing" in which the hands and forearms stayed in front of the torso, sashaying from left to right, in time with the footfall.

Although I wrote in a previous chapter that limp muscles were not atrophied, the bicep *was* atrophied: an exception to the rule. The chronic tension in the upper arms that causes the arms to stay bent at the elbow seems to be the result of rigor-mortis type rigidity – not strength.

Prior to recovery, no amount of gym work on the part of patients ever helped the biceps get strong. If he worked out in the gym, doing exercises that are supposed to develop the biceps, the only muscles that got stronger were the ones that splinted for the biceps. As long as the biceps remained out of reach of the mind, no number of weight lifts did anything for the biceps. The biceps do not work if the Large Intestine channel is not flowing over them in the correct direction.

The bent arm fetal position is normal when a person is in a state of shock or dissociation: a protective posture.

Ever since I was about twenty-five, I had not worn a sleeveless shirt. I knew that my arms didn't look right. I was very fit (or so I thought), and my arms were strong. I hadn't been able to explain exactly what was wrong with the look of my arms. After I recovered and my biceps returned, I suddenly realized what had been wrong with my arms: they'd been missing the bulge of the biceps. My biceps returned after I recovered. I started wearing

sleeveless shirts again – not because my arms looked finally normal, but because I no longer *cared* whether or not I looked “right.”

But the main point in mentioning the biceps situation is this: the biceps hurt when a patient starts unconsciously using them again. The pain eventually eases up as the biceps get accustomed to doing their correct job.

Back soreness: universal symptom of recovery

Up until now I have frequently stated that any given recovery symptom might or *might not* occur in any given patient. “Each person’s recovery is as unique as his symptoms!” has been my constant cry.

But when it comes to *back* soreness, this recovery symptom is almost universal. In our limited experience, all but two recovering patients had back soreness.

The small-of-the-back soreness was usually referred to as back “pain,” but it was not pain in the classic sense. It was soreness, like a gentle ache or pulling in the small of the back. Standing up straight was an instant “cure.”

The back soreness probably occurs because the muscles in the small of the back had been over-relaxed, over-stretched. They possibly became overstretched over the years as the muscles in the front of the torso became contracted.

During recovery, when the rigid muscles along the front of the torso begin to go limp, the paired postural muscles in the small of the back are once again able to contract. These back muscles might not have functioned correctly for years. When they begin to contract a bit, they are over-keen at first; they tighten up slightly more than necessary.

Then again, they sometimes tighten up only briefly, then relax, then tighten again and relax again: the back “pain” comes and goes as the muscles play at finding their correct tension level. The soreness is felt when the muscles are tightening – *if* the patient happens to be standing in his habitual, forward-leaning posture. When the lower back muscles tighten up (while the body is bending forward), only one maneuver will stop the mild soreness that occurs: standing up straight.

This soreness is *not* true back pain. Back pain that is due to injury or pathological spasm usually causes a person to stand crooked, in such a way as to minimize the pain. The small-of-the-back muscle tightness that occurs during recovery from Parkinson’s disease does *not* feel better if the patient stands crookedly to “favor” the pain.

Chiropractic treatment, hot or cold packs, and other back treatments do nothing to reduce the new health and vigor in the back that is causing the soreness. The only thing that makes the healthy back muscles feel good is standing up straight, allowing the back muscles to assume their correct position and strength.

This back soreness might last for weeks or even months. During this time, leaning forward aggravates the soreness. By leaning forward, I mean the type of gentle leaning forward that occurs while washing the dishes or reaching across the bed to straighten the blanket. These gentle, forward-leaning movements may cause a mildly unpleasant pulling sensation in the newly firmed up muscles. However, this problem is not severe, and could be easily remedied by throwing the shoulders back and employing good posture.

We asked complaining patients to keep in mind that, if a person has back soreness that can best be remedied by throwing the shoulders back and standing up straight, this is not

a real problem: this is your body teaching you to stand up straight once again. This is a recovery symptom.

Cases of no back soreness

As mentioned in an earlier chapter, in two patients, the back muscles did *not* pull tight. Healthy tension in the back failed to automatically kick in. These recovering patients found themselves bent far forward, with their faces nearly touching their knees.

In these two cases, we did try many acupuncture and moxa (locally applied heat) techniques to strengthen the low back. These techniques did not work, even temporarily. Because both of these cases occurred prior to our discovery of the dissociation that causes partial recovery, we did not explore the possibility of psychological inhibitions in these two patients that we saw for only a short time.

Frequent urination: oversensitivity of the bladder nerves

At about the same time that a recovering patient experiences small-of-the-back soreness, he may feel drastic changes in his sensitivity to bladder signals.

In his youth, the pre-Parkinson's patient may have had powerful bladder control. He may have been able to go *all day* without feeling a need to urinate. This was not because he had a "strong" bladder. In these patients, this lack of "need" to urinate occurred because his bladder nerves were somewhat numb. Only the very strongest signals from a *very* overstretched bladder could generate a strong enough signal to get through the relatively numb area in the low back, near where the bladder nerves enter the spine. The feeble bit of signal that got through to the spine and then traveled to the brain was all the person might have gotten, even if the bladder was actually saying "I'm really overstretched down here."

Oppositely, some people, in the decades prior to manifesting Parkinson's, have extremely "weak" bladders: they must urinate every hour or so. The problem is one and the same: the signals to and from the bladder – signals that travel through the area of the low back, and which are regulated by the parasympathetic and sympathetic nervous systems – are not running at full capacity.

When an animal is highly dissociated from a high degree of trauma, when he is behaving as if dead, the animal might not register signals from the bladder. He might find himself unable to hold his urine or, oppositely, he may find that most of a day goes by before he *feels* the need to urinate.

The combination of dissociation and/or an overstretched, numb area in the small of the back may have been the cause or at least contributed to these not uncommon symptom of Parkinson's disease.¹

¹ One patient told me how, during World War II, his buddies highly resented his ability to stay in a foxhole all day. The other soldiers had to leave the safety of the foxhole every few hours in order to use the latrine trenches, thus exposing themselves to risk.

I heard many fascinating bladder stories, and other health stories, that all helped me put together the fullest possible picture of Parkinson's disease. Our modern system of medicine, in which a neurologist sees a patient for a quick fifteen minutes, twice a year, almost guarantees that doctors will not be able to make the connections between seemingly unrelated symptoms: connections that led us to an in-depth understanding of Parkinson's.

Oppositely, a few of our patients had experienced weakness of the bladder, with a need to urinate every hour or so, for decades prior to their diagnosis. This type of problem, in Asian medicine, can be associated with chronic fearfulness.

At any rate, during recovery, as the spinal nerves of the low back began to be invigorated, at about the same time that the back soreness began, the nerves from the bladder also began to return to healthy sensitivity.

During the decades that the Parkinson's was silently worsening, the patient's brain had, in many cases, become accustomed to a very low signal from the somewhat numb bladder nerves. Because the "fullness" nerves from the bladder (the stretch receptor nerves) had barely gotten any signal through to the brain, the brain had slowly trained itself to respond to the least little signal, if any, from the bladder. The brain learned that even the smallest signal from these nerves indicated a very full bladder.

Some patients actually got few or no bladder signals during the day, unless the bladder was horribly full. The only time they felt genuine bladder fullness might be at the first urination of the morning. A few had trained themselves to urinate at regular intervals – every three or four hours – regardless of whether or not they *felt* any urgency. Sometimes, they got home from work at the end of a long day and, as they noticed how much urine was passing, said to themselves, "Huh. Looks like I forgot to use the toilet when I was at work today. Again."

In my research, I only thought to ask about this because it was one of the symptoms on my long list of "things that are unique about me." Turns out, I wasn't so unique.

In recovering patients, as the bladder signal nerves began to revive from their partial dormancy, they began sending healthier, more vigorous signals. The brain, accustomed to a *tiny* nerve signal, misinterprets these healthy, larger signals: it assumes that *extreme* bladder stretching must be occurring. When the recovering patient's brain starts receiving what seems like massive, steady surges of bladder information, the brain's response is to assume that the bladder is constantly, *painfully* full.

Eventually, the patient's brains recalibrated their responses to the healthy bladder signals.

But until then, while the brain was still recalibrating the meaning of vigorous, healthy nerve signals from the bladder, some recovering patients felt the "need to urinate" signal getting triggered every few *minutes*. This was very frustrating, because the amount of urine passed each time in response to the panic call could be measured in teaspoons, or even droplets. Nevertheless, the brain signals were adamant.

The recalibration of the bladder urgency signals occurs over a matter of a few days, a few weeks, or a few months. Just as the increased sensitivity in a previously numb foot tapers off when the brain accommodates to it, the increased sensitivity to the bladder signals tapers off over time.

Going through hell

If this bladder urgency phase occurs at the same time as the extreme limpness in the legs phase, the recovering patient might find himself in a difficult situation. Some patients have been so weak, for a short while, that they've needed help to stand up and get to the toilet. During the night, they have quickly exhausted their spouses with their constant

demands for help. Some patients – and their spouses – have referred to this phase of recovery as “hell stage.”

Some patients merely went through a mildly annoying period of increased bladder sensitivity. Others found the bladder sensitivity-limp legs combo to be the most trying part of the recovery process.

We suggested that, if the bladder urgency was severe and preventing one from getting sleep, a man might want to get an external (condom-type) catheter to wear at night. For women and men, we also suggested that there was no shame in wearing adult diapers at nighttime for a week or two.

Bladder infection

We also warn patients that a bladder infection can cause symptoms of bladder urgency. It is reasonable to ask the doctor for a urine test (urinalysis) if one develops symptoms of bladder urgency. Many people develop bladder infections during times of stress. Recovery from Parkinson’s can be stressful.

Bladder infections are a serious illness, and must be treated. Bladder infections in younger people are usually associated with frequent urination, burning pain when urinating, darker urine and sometimes fever.

However, in older people a bladder infection may be nearly symptom-free, in terms of bladder-specific problems. In older people a bladder infection can be present with no fever, no pain, or not even noticeably frequent urination. But even if no fever is present, a bladder infection is still a serious health problem. In older people, a bladder infection can cause extreme weakness and mental instability, even if there are no obvious bladder symptoms whatsoever. If there is any possibility that a recovering patient might have a bladder infection, he should seek diagnosis and treatment.

Please know, many people with Parkinson’s, after having read about recovery symptoms, have wondered whether or not they should risk entering into a program that warns of such humiliation and inconvenience. Is recovery from Parkinson’s disease worth it?

Everyone who has fully recovered has felt so grateful for the return of a healthy body that the recovery symptoms, in retrospect, were nothing to complain of.

WARNING

On the other hand, very elderly people who are no longer mentally driven enough to rebuild damaged body parts may never be able to fully recover their back and arm muscle function or bladder normalcy.

The two patients whose backs never regained strength, who were bent double with no function in the muscles of the small of the back were both older – in their late seventies.

This leads me to give this warning: not everyone is a suitable candidate for recovery. A person who is too old to summon up several months worth of mental focus directed at restoring weakened muscles may find himself recovering from Parkinson’s but living a hellish life with very weak muscles, extreme urinary frequency, and an inability to get up from a chair, roll over in bed, or stand up straight. In this case, his problems will be due to severe weakness, rather than the rigidity of Parkinson’s disease. His doctor will probably say the original diagnosis of Parkinson’s was wrong, and change his diagnosis to Multiple System Atrophy, even though this doctor will be wrong.

Even short term, the severe weakness can be a very debilitating condition, exhausting to both the patient and the caregiver. If it becomes life-long, one has to wonder whether the person might not have been better off with Parkinson's, particularly if the tremor was only mild.

It is impossible for me to state "How old is too old." It is impossible for me to guess whether or not a given person is a good candidate for full recovery. Please do not ask me.

In general, if a person is over eighty years old and only recently diagnosed, I suggest that his Parkinson's is obviously developing very, very slowly. He may be incapable of the mental changes required for recovery. He may be incapable of the mental focus needed for healing. He may be better off if he just continues with his mild symptoms. Maybe, when he's genuinely unable to move, he can use the medications at the low, safe doses, and live out his life slightly stoned from the drugs, but safe and somewhat independent.

Please do not contact me to ask if your loved one should try to recover. If you do, in a few weeks or a month I will send you a form answer that says "I can't know."

I often receive inquiries saying an elderly loved one has Parkinson's disease, is not capable of or interested in reading the material about Parkinson's, but the concerned writer wants my help in "fixing him."

I must respond, "Your loved one is not a good candidate for recovery. Recovery can require the conscious re-making of a personality. If your loved one is not keen to do this, or does not understand the need for this, it may be *impossible* for him to fully recover. *If* he recovers from his foot injury but is unable to change his mental attitude, he will find himself in partial recovery – a condition that can be worse than Parkinson's in the sense that the medications become far more dangerous. If he is in partial recovery and decides he needs the medications, the medication will be extremely stronger for him than for a person with idiopathic Parkinson's. The drugs may be far more problematic than if he still had the foot injury. Also, he may develop the intense weakness, after which he will be unable to fend for himself and will need constant physical care.

He may be better off just waiting for as long as possible before starting the medication – because they only work for a few years, regardless of the PD stage at which they are started. If he keeps his doses as low as possible, just strong enough to make him barely stoned enough to override his dissociation, but not strong enough to make him feel genuinely happy or giddy, he may be able to get good results from the medication for many, many years.

Please read *Medications of Parkinson's or Once Upon a Pill*, available for free download at www.pdrecovery.org.

Please do not ask for my help in making this decision. If your loved one cannot read the material himself or is not interested in reading the material, that is a large tip-off that he is probably not a good candidate for recovery.

Moving right along...

“You look terrible!”

Very often, patients looked haggard during the phase of frequent urination and its corollary of poor sleep.

Part of this was due to the fatigue, but part of this was due to the greatly increased expressiveness of the face. If, prior to recovery, the person had a fairly inexpressive face, and his face was now projecting “I feel exhausted and discouraged, I can’t get up out of chairs, I pee all the time, my feet hurt and I’m crying a lot,” his best friends may tell him how bad he was looking.

This new development – frank concern from friends – can be a completely new experience for some previously stoic people with Parkinson’s.

When such comments arise, recovering patients can be deeply concerned. They are going through so many changes and they can’t be certain that these changes are for the better. When someone says, “You look terrible,” the patient usually incorrectly understands this to mean, “The Parkinson’s is getting worse.” Very often, this is exactly what the well-meaning friend *does* mean.

Also, some people with PD do not have the intuitive social skills to know how much information should be shared with concerned friends; in many cases, people with Parkinson’s are not accustomed to being on the receiving end of sympathy.

Prior to recovery, most of the patients we’ve worked with didn’t mind *giving* sympathy – but they don’t like to receive it. They don’t like appearing vulnerable. The instinct of an animal that is dissociated is to lay low and be invisible – the opposite of crying out and saying, “Comfort me! Care for me!”

Many patients have not known how to deal with the very *idea* of receiving sympathy. So when concerned friends started to speak up, it was an ego-challenging time. And if the patient was sliding in and out of dissociation – indulging in partial recovery – the fear that the Parkinson’s *was* getting worse – based on comments from well-meaning and newly sympathetic friends, very often caused an increase in mood-based symptoms.

We also have to wonder if one reason for the outpouring of compassion from friends and co-workers is that the patient had finally ceased projecting supreme competence. Spouses of several patients have assured us that the patient had, for decades projected the signal “I don’t need your help.”

Many people with Parkinson’s project an air of inapproachability, especially with regard to personal matters.

And prior to recovery, the patient’s facial immobility might have conveyed internal strength or lack of compassion. After recovering tone in the facial muscles, that immobility is gone. The person no longer has a poker face or an “intentional” smile. As the face becomes more expressive, emotions such as sadness, fatigue, boredom or resentment became apparent.

Also, prior to recovery, most of our PD patients admitted that they had probably been adrenaline-dominant for a long time. Adrenaline tends to push people away. In the past, the patient’s friends might not have felt safe about offering compassion, even if they thought the person could use some.

During recovery, as the face becomes expressive, protective walls crumble, and adrenaline drops, the patient may start to come across as a person who *could* conceivably be comforted.

His wounded body and fatigue send signals to his family and friends: “I’m tired and I’m sick and I need help.” Any sensitive human can pick up on these electrical, chemical, and body language signals. But many patients have no experience at being on the receiving end of compassion.

Some family members have been grateful that the loved one was becoming more “humanized.” But sometimes, when a patient starts coming across as more vulnerable, family and friends are horrified by the patient’s changes. The patient, in many cases, is “The Rock” or “The Capable One” of the family or social group. When he becomes less heroic (less adrenaline-driven) and more “human,” family members sometimes resent the changes in family dynamic and their new need to step up to the plate.

The change in facial expression

There may be some temporary soreness in the muscles of the face as strength returns to the cheeks. This brings up a completely different subject: the change in expressiveness.

Many a person with Parkinson’s who assumed that his friendship was shown through his actions, who imagined that he was projecting sincerity and friendliness, and who prided himself on his never-changing look of stern intelligence was stunned when a “friend” or co-worker told him, during recovery, “I always assumed you didn’t like me because you always frowned at me” or “...because you never smiled at me.”

Some of our patients confided in us their outrage at these confessions. Others were thrilled by their deepening appreciation for how emotionally frozen they had become and by the “miracle” of their recovery.

If the patient is starting to recover from his foot injury *but* his emotions were still locked in dissociation, resulting in partial recovery, he may project his own fear- or cynicism-based motivations onto those who would help him or be concerned for him: he may assume that people were being condescending, scornful, or judgmental.

We suggest to patients that they should celebrate if family and friends start to express concern that the patient looks exhausted, worried, or suddenly “looks his age” (instead of looking sort of frozen). Of course, if the brain is playing the looping tape that says, “Keep up your guard! You’re never going to recover!” or the ever popular, “My friends are lying. They don’t understand that I need to prepare myself for the horrible pain I anticipate during the time *prior* to the PD going away?” then our advice was ignored, or never even heard.

Other patients, those who had made a clean break with their old habit of using dissociation to stay “safe,” did *not* need reassurance as to the *bona fides* of their family and friends. They appreciated the family and friends’ concern and the caring spirit in which it was offered.

The manner in which you respond to the loving concern of friends and family might be a tip off as to your own mental state.

Then again, many patients have found themselves under attack by loved ones because the loved ones do not believe that a person can recover, they *wrongly* think that the medication will prevent or slow the progression of the illness, or for whatever reason, they want the person with Parkinson's to "just stop being an idiot and do what your doctor tells you (take drugs and be normal again)!"

One person was able to overcome his dissociation only when he decided "to Hell with my brothers!" and stopped listening to their well-intended insistence that he take medication, and lots of it.

So this chapter ends, like so many have ended, by saying, "Each case has been unique."

“Sleep that knits up the ravelled sleeve of care...”

- Shakespeare's Macbeth

CHAPTER TWENTY-SEVEN

RECOVERY SYMPTOMS: CHANGES IN SLEEP PATTERNS

One of the more pleasant, or more aggravating, symptoms of recovery was the change in sleep patterns.

Improved sleep

During recovery, people who have been plagued by insomnia usually find that they are suddenly sleeping very well.

“Too much” sleep

Many recovering patients find themselves wanting to go to bed early, wake up late, and take naps. They often feel they are sleeping too much: “I’m sleeping my life away.”

A person recovering from a serious injury or ravaging illness needs to sleep a lot. A person who is growing new nerve cells, muscle cells, and brain cells needs sleep: lots of it.

Some accept this. Some are unable to accept it and feel chagrined, even ashamed, about how much sleep they are getting.

Concerned about sleeping too much

Many people with Parkinson’s, by the time they are diagnosed, are starting to have a hard time sleeping through the night. In the beginning of recovery, this new ability to sleep well and long seems like an answer to prayer. However, many people have to pit their glorious new ability to sleep against their lifetime conviction that people who sleep a lot are lazy and bad.

While this may not seem like a big problem to the reader who does not have PD, the extra hours of deep sleep is a true emotional challenge for many recovering patients. Many of my patients have taught themselves to feel bad about themselves if they aren’t accomplishing a lot.

Prior to their diagnosis with Parkinson’s, many patients, unable to feel their own bodies and, in some cases, their own emotions, had valued themselves because they “got a lot done.” During recovery, many of these same people avoided doing anything that wasn’t a stark necessity. One patient reported, “I plan my days around being able to get as much sleep as possible. If an activity isn’t absolutely necessary, I won’t do it.”

When the ability and *desire* to be a workaholic drops away, some patients feel ashamed and even depressed. As you can guess, depression is a condition in which the release

of movement neurotransmitters is minimized: partial recovery can be associated with these negative feelings.

A case study in “laziness”

One recovering patient, like many people with Parkinson’s, had often worked three jobs at a time. She was a math professor by day, a software designer in the evening, and a regularly performing professional musician on weekends. During the “increased need for sleep” phase of recovery, she found herself parking as close as possible to her classroom to minimize her walking distance, turning down music jobs, and unable to stay up at night to work on the software. She didn’t need the extra money; she was a successful single woman with no dependants, so the problem with working less was purely a self-worth issue.

While she was in the thick of this phase, she came into my office and exploded into tears. When she was finally able to talk, she told me about the above changes in her lifestyle. I asked why this was a problem. She replied, “I’m turning into the people I hate! *But that’s not the problem.* The problem is that I never knew I hated *anyone!*”

She was a very loving, kind and helpful human. She had always assumed that she loved everyone. But when she found herself minimizing her daily activities so that she could sleep more, her inner thoughts screamed at her, “You’re turning into the people you hate!” This realization, that she had subconsciously been judging – and finding lacking – those people who did *not* work three jobs and constantly exert themselves, made her deeply ashamed of herself.

She wasn’t sure what she was more ashamed of: her lack of interest in “doing it all” or her new realization that she had been looking down at people that were less active than herself.

The reader may think that patients like this were making a big deal out of nothing. But the increased need for sleep and the decrease in “getting things done,” or “making things happen,” was sometimes a devastating emotional experience for those people who had only valued themselves on the basis of what they were able to accomplish.

How long did the need for extra sleep last?

The need for extra sleep is not a straight line. Some people have needed a few extra hours a day, or a nap on weekend afternoons. Sometimes, this increased need lasts for months. In some cases, it has lasted for years.

Very often, the “new” amount of sleep is actually a far healthier amount of sleep. Many of our patients have chronically shorted themselves on sleep. In some cases, the patients never go back to their old patterns of getting by with less sleep than most people. As they recover, they no longer feel the adrenaline-based drumbeat that forces them to sleep as little as possible. The new, “lazy person” sleep pattern is sometimes just a “healthy” sleep pattern.

Some patients accept happily the new amount of sleep that their bodies needed. Others slide into despair because they honestly felt that they were sleeping their lives away, with no end in sight.

In general, younger people needed much less “extra” sleep during recovery than older people. For example, one patient in her thirties, who started our recovery program

immediately upon diagnosis, only needed several days of staying home and sleeping all day. A retired patient in his late sixties who had an advanced case of Parkinson's found that, during recovery, he slept long and hard at night and then needed two naps in the daytime. However, there are no hard and fast rules, and there are variations and exceptions. To say nothing of the fact that some people in their thirties had an advanced case at the time of diagnosis and some people in their eighties had a mild case when they were diagnosed.

Every person with Parkinson's is unique, etc.

Shifting sleep patterns

Some people notice that their sleep patterns go through several changes.

For several months, a recovering patient might fall asleep at nine at night and awaken at seven in the morning. A few months later, he consistently might not be able to fall asleep until three in the morning and then he would sleep until noon. And then, a few weeks or months later, the pattern changes again: he wants to go to bed at seven, and wakes at five.

Anyone who has raised a child will recall that children go through periods when they need an enormous amount of sleep, and other periods when they don't even need to nap. These periods of increased sleep and altered sleep patterns correspond to periods during which the child does an enormous amount of mental, emotional, or physical growth.

In a person recovering from Parkinson's these periods of increased sleep also corresponded to enormous amounts of healing and growth.

Two-hour intervals of deep stillness

A few recovering patients have noticed that, even if they didn't feel tired, their bodies fell into heavy, drugged-like physical immobility for about two hours. These two hours of stillness sometimes occurred at the same time every day, and went on for several days or even for months. This very weird type of sleep seemed similar to the sleep induced by strong pain medications such as Demerol, a drug that allows the patient to remain absolutely conscious, and not able to move.

The recovering patient might be perfectly conscious, deeply relaxed, and yet unable to move any part of his body – even *appearing* to be asleep.

This type of "sleep," or utter immobility while alert, usually only occurred, if it occurred at all, for about two hours at a stretch. After the two hours of feeling drugged was over, the recovering patient quickly resumed whatever his normal movement ability happened to be. But the next day, at about the same time, he might, once again, have two hours of gentle, but utter, immobility. And again the next day. And the next.

Only a few patients have had the two-hour, same time every day, limp paralysis. Of those that did, most of them only had it for a few days. One person had it for a week. One person had it for several months. The person who had it for several months also recovered from Parkinson's extremely quickly in every other respect: all of her obvious PD symptoms were gone within two months of the time she started treatment.

Channel theory review

We suspect that these two-hour periods of extreme limpness and immobility correspond to healing activity in specific electrical channels. As you will recall from chapter

eight, every primary channel has a specific two-hour period during the day when the channel is most active.

For example, the Stomach channel operates at its highest amperage level between 7 and 9 in the morning. (These times are approximate and are based on the sun and an individual's circadian rhythms. They are *not* based on Greenwich Mean Time.) If the body recognizes an area serviced by the Stomach channel that needs intensive repair, the body is most likely to do this repair work between 7 and 9 in the morning. During this channel's time, if the body is doing *enormous* amounts of healing work on any damaged places that are located on the Stomach channel, a person who is emotionally relaxed may not be able to move any part of his body. He may feel limply, gently paralyzed, or very, very sleepy, from 7 to 9 in the morning – Stomach channel time. He would snap out of it when the Qi starts flowing more heavily in the next channel in the sequence, Spleen channel, from around 9 to 11.

When this type of two-hour paralysis event does occur, the person – who might have nearly normal physical function during the rest of the day – has a bit of warning time: he can feel himself slowly relaxing, over a period of about ten minutes, into the deeply calm stillness. Once he is comfortably ensconced in it, nothing short of an emergency can pull him out of it. And at the end of the two or so hours of gentle, “soft” paralysis, he finds himself able to move perfectly normally again – until the same time the next day.

If the patient can take them in stride, these bouts of non-moving are pleasant, even amusing,. They might or might not occur on a daily basis until the area being worked on is healed. Also, after a person no longer has 7 to 9 in the morning (or whenever) soothing paralysis, he sometimes developed a new two- or so- hour stint of calm stillness at some other time of day.

For example, one person who needed a lot of repair work around his shoulder blades found himself unable to move from 1 to 3 in the afternoon for a few days while the shoulder blade area recovered more movement and feeling.

Again, It was *not* the rigid type of paralysis that a person might have following a stroke or polio. It is a time of softness, a deeply calm period during which a person might be awake or asleep, during which his ability to move is turned off. It is somewhat similar to the deep, relaxing rest that can come after a high fever has broken and a person slides into a deep, healing stillness during which he feels absolutely no interest in moving a single muscle.

This stillness will not occur if an emergency is ongoing. It happens in people who had made a decision to surrender to their bodies' inclinations to whatever extent was humanly reasonable.

An example

I was one of those who had morning “zone outs” for several months. I could get up any time in the morning, so long as it was before 7:00 a.m. Then, at 7:00 a.m., I would slowly become limp, unable to talk, barely able to blink. At 9:00 a.m., I would snap out of it. Within fifteen minutes, I would be back on my feet, functioning normally.

I rescheduled my work, changing my start time from 9 a.m. to 10 a.m. No one I worked with ever suspected that I spent two hours a day awake yet utterly unable to move.

During this phase, I desperately wanted to attend a rare, traveling exhibit of works by Leonardo DaVinci. The only place hosting this show on the west coast of North America was a museum in Victoria, BC, Canada.

I arranged to stay with a friend up in Seattle, but even so attending the exhibit was a challenge: we had to leave the house at 5:30 a.m. to take the ferry from Seattle to Victoria. I warned her about my little bouts of “limpness” between 7 and 9. Now, I always have loved being on the water. I never feel safer than when out in a boat. (I’ve since learned that many people with PD feel this way.) I went limp at around 7 a.m., just as we were boarding the ferry. My friend helped me, almost dragging me for the last few yards, to a seat in the ferry café. Maybe it was because we were on a boat and I was feeling safe, but I went into one of the deepest “immobilizations” I’d had yet. I sat, slumped, eyes half opened, body unmoving, for nearly two hours, while Sandy chatted to me about what her kids were doing at school. Then, about twenty minutes before docking in Victoria, I sat up. I started conversing with Sandy, ending her monologue. Within a few minutes, I was talking and joking effortlessly.

Sandy was mildly alarmed. “You’re normal again! You told me about these two-hour ‘quiet times,’ but I didn’t believe you. That’s the weirdest thing I’ve ever seen. I’ve been sitting here wondering how the heck I was going to drag you all over Victoria. I thought you were sick or something. I was getting ready to call for a doctor, and now you’re perfectly normal! Absolutely normal! This is the weirdest thing I’ve ever seen. And you’ve been doing this every morning for how long?”

Shortly after that, I no longer fell into this state in the mornings. During the preceding months, I’d been helping plan and execute a family wedding at my house, so you can see I was not incapacitated during these months: I just couldn’t move between 7 and 9 in the morning.

Afraid of needing sleep

I’ve heard from a few people with Parkinson’s who have decided not to enter the recovery program because they were frightened by the idea of needing lots of sleep. They explain that they cannot afford to miss any days of work, and do I know of a way they can recover without going through the recovery symptoms.

Some have also feared that, in order to explain to the boss or co-workers that they need more sleep, they might also have to confess the horrible fact of having been diagnosed with Parkinson’s disease. They fear that either the increased need for sleep *or* the admission of having a physical illness will cost them their jobs.

Being afraid to miss work, or being afraid of appearing lazy (another popular reason for not wanting to attempt recovery) during the period of increased need for sleep, is a fear-based attitude that slams right up against what many people with Parkinson’s think they need: accomplishments. As noted before, many value themselves only in terms of what they accomplish each day.

Seen in this light, it is understandable that many people are *afraid* of anything that might rock the I Get Things Done boat – including recovery.

But, as noted above, in an emergency, people with Parkinson’s are able to move. We’ve observed that, if work is an emergency for the person, he is able to attend work. However, if this was the case, he also spent his days off in sleeping around the clock. Recovering patients seem to be able to work around employment needs while still doing whatever recovery work had to be done – within reason.

Fear that recovery symptoms will expose the secret of having Parkinson's

Another reason often given for not wanting to enter a recovery program was the fear that, in order to explain any embarrassing recovery symptoms, the person might have to inform friends and co-workers that he had been diagnosed with Parkinson's: a weakness. In addition to those who merely feared momentarily looking like an idiot in public because of recovery dyskinesia, the possibility of missing some days of work due to increased sleep needs seems to strike deeply at the hearts of those people who are afraid of being "found out." Sad to say, this is *not* a rare fear.

"Cure me fast so no one will suspect I've had Parkinson's"

One patient came to visit our program in Santa Cruz, and opened his first appointment by asking, "Can you cure me really quickly so that no one will ever know I had Parkinson's disease?"

I said that I couldn't promise anything, and asked why it mattered if people knew he'd had PD.

He replied that he was a physical fitness coach. "I make a good living because my clients think that I'm healthier than they are. If they knew I had a physical problem, they would reject me."

I told him that he might be wrong, and that if he was able to show his clients how he could confront and recover from a difficult illness, they might respect him even more. He was adamant that I did not understand, and that everyone would despise him and accuse him of being a liar if he promoted fitness when, in fact, he had Parkinson's.

I said that it seemed to me that if he truly felt that he was sick, and was pretending to be well so that he could continue to mislead his clients, then he *was* lying. He replied that he had to lie, to be able to make a living. So I asked if maybe his problem wasn't so much that people might think he was a liar, but that they might find out that he actually *was* a liar. He agreed, and didn't seem to understand that the *latter* situation reflected the more poorly on him.

He then said that people would *hate* him if they knew that he was being a fitness coach while having Parkinson's disease. We went back and forth on this for some time. When I refused to guarantee that he could recovery quickly and in such a way that no one would ever know he'd been "unfit," he decided to not enter our program.

He was not the only one. Many people with Parkinson's have shared their fear that, by divulging the fact of physical imperfection, they would make themselves vulnerable to scorn or even some sort of unnamed danger. It was years before we were able to figure out that the appearance of vulnerability must be avoided during dissociation. Fear of being "unmasked" can be, in many cases, an integral part of the Parkinson's pathology.

A severely injured animal dare not show any signs of weakness to the enemy. This behavior stems from the sympathetic mode override that most people with Parkinson's employ in order to keep moving.

Many patients, neurologically behaving like injured animals, or "walking wounded," feel that they are not yet in a place that is safe enough to allow them to let their guard down. Sadly, some have cultivated such a powerful attitude of wariness for so many decades that they cannot easily change even when tempted with recovery. Worse still, some of them feel

that any *change* in this attitude would be a sign of weakness, a sign of surrender. If I had to pick one word that my patients dread more than any other, it would be the word “surrender.”

Quitting the job

Faced with the idea of possibly needing to miss a few days of work because of needing sleep, many patients decide to quit working. They tell us that they will recover faster if they had time off to “focus” on their recovery. We now discourage this type of thinking.

We’ve seen that patients who continue working during their recovery fare much better. Isolation does not encourage learning a new mindset – it allows a person to wallow in his old ways. The regular presence of others was a particular boon to patients who had never known that other people can actually be extremely helpful – even if “other” people were usually thought to be slower, stupider, and lazier than the person with Parkinson’s. Learning to *accept* help from others is a part of learning to feel safe. And feeling safe releases dopamine. Dopamine release does *not* occur when a person is hiding from challenge.

What dopamine release is not

Many a person trying to recover simply cannot understand that parasympathetic mode and its concomitant dopamine release is *not* the result of getting what he *wants* (often translated as “being happy.”) Dopamine release is *not* the result of retreating or hiding in the calm that borders on falling asleep. Dopamine release is *not* the result of suppressing or stifling the emotions in order to present a calm face to the world. Dopamine release is *not* the result of achieving “safety” by acting on fear-based impulses for self-protection. Dopamine release is *not* the result of receiving praise from others. It is *not* the result of attaining victory or success.

The one exception to this “success” rule is: dopamine release occurs when a person succeeds in vanquishing his ego and surrendering (being obedient to) the instructions given to his heart by the universe. But this success has nothing to with, is the opposite of, worldly success.

What dopamine release is

Dopamine release occurs when a person feels safe enough to be unguardedly alive – which includes being alive to risks, frustrations and failures: in other words, safe enough to be alive no matter what happens.

Dopamine release occurs when a person *expects* to experience the joy of being alive *whether or not* he gets to do what he wants – whether he wins or loses, whether he’s calm or dynamic.

Staying home from work in order to micro manage one’s time so that one can practice “being happy” *and* avoid confrontation or risks is the exact *opposite* of expecting to feel the joy of being alive no matter what the circumstances. Reveling in risks is the opposite of playing dead.

Life is fraught with risk. Commanding oneself to play dead, automatically, except during those times when one gets exactly what *he* thinks he wants, is one way to avoid risks, but at the cost of eventually developing a syndrome in which one becomes a living corpse.

Help in unexpected places

Those people who have continued working and who even shared with co-workers the fact that they had Parkinson's and that they were trying to recover found an enormous weight lifted from their shoulders when they learned – often to their shock and amazement – that their co-workers are able to take their “failure to be perfect” in stride. Some even received unexpected support and strength from co-workers.

We now recommend that a person continue working or performing his normal activities of daily living to the best of his abilities, while allowing recovery symptoms, including his increased need for sleep, to manifest during his weekends and his “down time” in the evenings. Once in a while, when he really needs to make an exception and grab a few hours, or even a day or two of nothin' but sleep, fine. He needs to learn how to feel his body and respond to its needs – even sleep needs.

“Let it all hang out!”

The Hombres, 1967 hit tune

CHAPTER TWENTY-EIGHT

RECOVERY SYMPTOMS: BRAIN SHIFTS

Some of the most delightful symptoms of recovery, symptoms that could not possibly have been expected by anyone, were the intra-cranial brain reorientation movements.

These movements, which I named “brain shifts,” were fleeting events that felt as if the left and right brain halves were shifting position relative to each other.

There were three types: front to back, top to bottom, and side to side.

Front-to-back brain shift

In what we called a “front-to-back” brain shift, a person felt as if the front and back of his brain had moved further apart.

The shift often started with a feeling that the frontal bone (forehead) was gently pulling away from the rest of the cranium, moving forward a fraction of an inch. Just after the head felt very relaxed and light due to the decrease in internal pressure in the cranium, a sensation occurred as if the front lobe of the brain was gently floating upwards and forward. The back of the brain moved slightly down and back at the same time or a moment later.

The sensations passed very quickly, in the time that it takes a muscle to relax. The sensations were non-dramatic, and were followed by a faint awareness of decreased tension in the head.

Top-to-bottom brain shift

The top to bottom shift sometimes felt as if an enormous internal pressure was compressing the brain down onto the brain stem. This brain shift was described several times as feeling “as if a too-tight hat,” or “swim cap” was compressing the head. During this brain shift, people sometimes felt a strong urge to stomp the feet, almost as if they were trying to tamp their spines down into a better position while the head pushed down on the spine, as well. There were variations that didn’t include the “too-tight swim hat,” but which seemed overall to fit the idea of a top-to-bottom brain shift.

For example, one person gave this description of the event: “I was sitting in the concert hall listening to a piano recital, and all of a sudden I turned my head and there was this deep piercing pain in the very center of my head. It went from the very top of my head down to the neck part of my spinal column. How can I describe it? I could say it’s like I pulled a muscle or something, but that wasn’t really the feeling. It was like a big train running through the center of my head down to my spine. Was it painful? Well, it didn’t really *hurt*. The big shock went away in a few minutes, but the aftershock stayed for about twenty minutes more.”

In my own case, it felt as if a massive weight was bearing down on my head, and it made me want to stomp the floor. My husband just stared at me with raised eyebrows as I

vigorously raised alternating legs and brought them down hard on the floor. It felt *so* good. It seemed as if I stomped for ten minutes, but it might have been a much shorter time than I thought. When the pressure and tightness around my head stopped, I stopped stomping. And then I felt *really* relaxed inside my head.

As an aside, as I review these notes of my own case, I wonder if this “leg stomping” is related to turning the fight-or-flight system back on – turning it on in its own right, as opposed to just using it all the time to compensate for my chronic dissociation. Dr. Peter Levine, in his book *Waking the Tiger*, points out that allowing oneself to move vigorously can sometimes restart the motor function for a person who has been locked in some form of post-traumatic stress.

Side-to-side brain shift

The side-to-side adjustment was the most strange and glorious. It usually begins on the healthier (less PD-affected) side of the brain. If one’s symptoms are worse on the *right* side, or started on the *right* side, this phenomenon will usually begin on the *left* side of the head. It usually begins behind the ear, just above the mastoid process.

It may start off as a low rumble, so slow as to be barely audible. In this stage, it is almost more of a vibratory sensation than a sound. As the vibration picks up speed and rises in frequency to an ever-higher pitch, it vibrates through the very center of the head.

At this point, the patient may find himself thinking with awe and acceptance, “Wow. I’m about to die.” The vibration continues to increase in speed and rise higher in pitch until it vibrates its way out through the opposite side of the brain, in the area near the temple. After this, a deep stillness is felt in the head.

After the vibration exits out the side of the head, the internal tremor (the drum master that sets the beat for the visible, external tremor) stops or is greatly diminished.

The sensation of internal stillness that follows the side-to-side shift is so profound, so peaceful, that some patients assume, for a moment, that they have died.

After experiencing a side-to-side brain shift, a person sometimes needs a few moments to ascertain that, *despite* the interior stillness, he is still alive. Sometimes, only after noticing that he is breathing, did the patient realize that he hadn’t died.

Years before any symptoms of Parkinson’s disease had appeared, many people with Parkinson’s have long felt the presence of a constant internal tremor, a tremor that *eventually* drove the physical tremor. Others had not suspected that an internal tremor was firing off, driving the visible tremor. Either way, it feels *unbelievably* good when it stops. Possibly a close second to “the peace that surpasseth all understanding.”¹

The side-to-side brain shift is usually a deeply significant moment in recovery. Some people must sleep right through it because they woke in the morning with no ability to activate a tremor and with a sense that something unspeakable is gone from their life.

Most of our patients who have been awake during the brain shift say that they assumed that they were dying. And when they decided that this death was going to be OK,

¹ New Testament, Philippians 4:7.

even wonderful, that's when the vibrating rose in pitch and finished its work. The word surrender comes to mind...

One patient who experienced the head shift but who continued to tremor slightly told me that, even though she was still trembling, it was only a physical tremor and not nearly so annoying.

She explained further, "There's no tremor in my head any more. I have a shake in my arm when I'm standing, and it's in my hip when I'm lying down, but it's more just a shaking, not a tremor. It's not nearly as annoying. Before, *I* was shaking; something inside of me was shaking. Now just my arm or my hip is shaking. It feels more like a muscle habit; I can laugh at it, now." (As we were to discover, she still had yet another unhealed injury that was affecting her hip.)

In my office

I was fortunate enough to observe one person experience a side-to-side brain shift while she was in my office, while I was holding her shoulder, doing Yin Tui Na.

Her eyes got huge. She brought her hands up to the sides of her head. Her mouth opened in a silent scream.¹ The whole thing lasted less than a minute.

After several minutes of trying to describe for her husband and me what had just happened, she laughed and exclaimed, "I feel *good!* I feel *good!*" She still had a few recovery symptoms to go through, but she essentially felt, at her core, that she had suddenly, unmistakably, become "all better."

After that, there was no way that she could go back to having idiopathic Parkinson's. She couldn't raise a tremor even when she tried: a few weeks later, her mother had to go to emergency room. This patient felt guilty because, "After all these years of trembling when I was stressed, I wasn't even able to get any tremor going when my own mother was in the emergency room." She was never again able to get a tremor "going" for any reason. After the brain shift, she had no internal tremor; she never again experienced a visible tremor.²

One patient's description

The following is a partial transcript of a tape recording made in my office of a patient who had experienced the side-to-side head shift a mere four hours before coming to my office. "You'll want to get this down," he said, when he arrived for his weekly session. He was the first person to experience the side-to-side head shift. Since then, several others have shared similar stories. This person was a psychotherapist, and was accustomed to writing up case studies and analyzing mental experiences. As I listened to the tape, he made a few arm gestures to demonstrate what his voice was explaining.

¹ When another patient emailed to me that he had experienced the side-to-side brain shift, he described it as being "a Silent Scream, like in the famous painting" by that name. The term fits so perfectly that I have used it often since then to describe the fleeting moment of seemingly altered consciousness that a person experiences when the brain hemispheres vibrate themselves back into their correct position.

² I write this in 2008. I saw her just a few months ago for a chest cold. She has had no Parkinson's symptoms since her brain shift occurred in 1999.

“I had an awesome experience, just awesome...the upshot of it is that some life form, or some piece of me, some part of me, died during the night. And it may have been the Parkinson’s part...I had the feeling that something was coming to an end, it was as though I were dying, but I was aware that I didn’t think I was really dying...I wasn’t getting ready for my own real death, but as though some part of me or something in me was dying. And it was a totally unique experience. I went with it, breathing was fine, and whatever it was then moved to the point of dying, letting go...(long pause). And I still am not sure what are the best words to use. (His eyes filled with tears.) Time will get some perspective on that too. But it’s as though something was lifted. And I gave it plenty of time to go, and respectfully said goodbye to it. And then when I was sure it was gone, realizing that would be the end of whatever that was, I got up on the side of the bed. (Long pause.) At that point, I was aware, more keenly than before, that I was actually alive, that it was not a death experience, that I wasn’t getting ready to have a heart attack or die, but something was dead, something was gone, something was lifted and I had a strange experience of...lightness and ...smoothness (tears)...those two words were real clear. And I knew at that point that I was not dying, that I was not dead, that I was continuing to live...

I was clear that this was an experience about me, and the interesting part was that I felt free of tremor, and it was unbelievable. But I’ve made a career out of being open to believing the unbelievable, so wait and see, time will tell, but clearly this was some kind of important experience.

“It was clear that I was tremor-free. I had a sense of balance and solidness that was new, that I didn’t really want to test, for fear that it wouldn’t really test out. So I started gently testing it. Oh. There was also a sense of symmetry that hadn’t been there before. So I kept testing it putting my arms above my head, by putting them out in front [He gestured, with hands straight up, then out to the sides, then out in front and demonstrated the wrist movements.], looking for tremor, turning ‘em, looking for cogwheel, not seeing anything, doing a bunch of touching, testing, touching the back of my head...and in the middle of this, I got up, twice, and tested my stability and balance, and ease of movement, and it was there!

“It was easy movement, it was as though I was without Parkinson’s...oh, then at one point, I said to myself, I wonder what my writing is like. So I have a pen, and a notepaper right by the bed, right by where I was sitting, to the left of where I was sitting, so I got that, held the little telephone note pad in my hand. So it’s not the steadiest thing, so I wrote something. What I wrote, interestingly enough, was ‘I am a renewing person. I am a renewing being’ and I (pause) looked at it and it was (tears again, choking a few times) luh... luh... large (choke) handwriting. (Crying.) Not micrographia! And it was a little scrawly, but then I reminded myself that my handwriting had always been scrawly, but it was just naturally as big as it used to be! [Gestures, thumb and forefinger showing an inch in height]...”

Other patients, after the side-to-side brain shift, also have a similar sense that Something Had Changed. Each person explains it differently.

Some fully recovered patients have experienced just one of the brain shift patterns. A few, including myself, have experienced all three.

Fleeting dizziness

Not everyone who recovers feels a distinct pattern of brain shift. Sometimes, the patient just has a moment of dizziness, as if the room is spinning, after which, they feel calmer inside and the internal and external tremor is gone.

One patient reported during her weekly visit that she'd been sitting on her living room couch next to her grandson watching TV, just prior to going to bed. When “the earthquake” hit, she dove to the floor and threw her arms over her head to protect herself from falling objects. When the shaking stopped, a few seconds later, she looked up at her husband and grandson who were staring at her in amazement. “Didn’t you feel the earthquake? It was huge! The whole room was spinning around.” They shook their heads. There had been no earthquake.

Another reported that he'd had a brain shift while he was relaxing, with eyes closed, during a plane flight. He felt the airplane dip one wing deeply to one side until the plane was almost sideways. Then the plane dipped deeply to the other side.

“*Violent turbulence!*” he said to himself. He grabbed onto his armrests, braced for anything, and opened his eyes. That’s when he saw that no one else around him was reacting. The flight attendant was calmly pouring a beverage. He looked at his own beverage. The liquid was not sloshing. The fleeting turbulence had been inside his head.

His tremor had been small and intermittent. After the “turbulence,” he never tremored again.

Various terms such as “room spinning,” “loop-de-loop” and “earthquake” have been offered to describe the fleeting perceptions that occurred while the brain was repositioning itself. These were painless, fascinating shifts that resulted in a decrease in internal tremor.

Again, many people did not experience these events while awake *but* they suspected that some distinct event, possibly one of the brain shifts, *had* happened to them at night, because they woke up and felt unaccountably different: taller, calmer, and in some cases, permanently free from tremor.

Fear of the brain shift

As you have no doubt already guessed, some patients have told me that they dare not enter into a recovery program because they might experience a brain shift while driving. And by now you can probably provide the same reply that I gave them: brain shifts have only occurred when the person feels deeply peaceful. These events have never occurred during times when alertness or adrenaline was called for.

Recovering patients have experienced their brain shifting events while resting, daydreaming, or while half-awake. Others concluded that a head shift must have occurred during sleep because, upon awakening, the head felt different or else the internal tremor was gone or they felt a new sensation inside: profound stillness.

No one, in our experience, underwent a head shift while driving, while bustling about, or while highly alert.

It is also possible to undergo the brain shift, have the rigidity leave the body, have the basic Parkinson’s start to go away, and still keep trembling because one isn’t *really* safe yet, all the time.

I've had two patients who had the weird brain shifts and who've experienced many symptoms of recovery who have continued to tremor and who continue to insist that it's impossible to let go of their habit of being perpetually guarded.

I point out that it's normal for intelligent people to be guarded much of the time, but normal people are guarded via sympathetic mode: they don't keep their guard up by playing dead via dissociation from their somatic awareness.

Of these two patients, one now has only tremor, the other one has reverted into slowly worsening parkinsonism that comes and goes (it only goes away now on weekends).

So it is possible to feel safe enough to have the brain shift and then, after enjoying the quiet for a while, fall back on the habit of using dissociation, rather than sympathetic (normal) mode, as one's self-defense mechanism.

Bringing on the brain shift

In order to get the brain shift going, a patient had to feel truly safe: Safe; not calm, not sleepy, not restful, but safe; no longer at risk of imminent death.

After the brain shifts occurred, patients felt profoundly peaceful: safe. Especially after the side-to-side brain shift, most patients noticed that *no* stressor was able to induce a tremor again even if they found themselves in a stressful situation.

In other words, a brain shift allowed patients to feel deeply at peace – you might say it allowed them to feel utterly safe. But in order to *initiate* the brain shift...they had to feel safe. A paradox.

The answer to the paradox appeared to be *surrender*. The word “surrender” came up often – and easily – with fully recovered patients. In their new non-Parkinson's mindset they spoke about surrendering and they meant it in the sense of surrendering from their posture of perpetual wariness, cleverness, defensiveness, or heightened alertness. The “surrender” was simply the admission that, no matter what, *even if they did nothing* in self-defense or self-maintenance, they were actually safe: safe enough to go back to living via the heart. And when they decided that they were actually safe “after all,” and let themselves *feel* safe (not think, but *feel*), their bodies had responded with relaxation and a brain shift that brought about an end to their tremors – and an even fuller feeling of safety.

And yet, so many patients have responded with *hostility* to my suggestion of trust in or surrender to some great sense of Goodness.

I recall one middle-aged man with very advanced Parkinson's. He'd already bragged to me that he's never felt emotional pain. He never felt one moment of pain when each of his three wives left him, in turn. He was proud of not being affected by emotions. He was one of many patients who said they'd read all the “important parts” in my book on recovery and had skipped over all the “unimportant stuff, the stuff about emotions.”

I suggested that, if he wanted to recover from Parkinson's, he might consider learning how to feel some emotions, surrender his stoic personality over to his heart and let his heart be in charge.

He whispered, slowly, “I make so much more money than you. I'm really successful. What do you know? You're just a doctor, paid by the hour. Just fix my foot and I'll be fine. *I'm* not going to change. It's my refusal to surrender that's made me what I am today.”

There he sat, trembling violently, hunched over, rigid, unable to get up from the couch by himself, unable to walk, unable to smell or taste, unable to use his arms, completely devoid of facial expression, barely able to get the words out, proudly whispering: “It’s my refusal to surrender that’s made me what I am today!”

His foot had already responded to treatment and was completely free from injury, by this point. His entire condition was now one of psychogenic parkinsonism.

I replied gently, “I couldn’t agree with you more.”

“Pay no more attention to the mind than you would to the ravings of an idiot”

- St. Teresa of Avila

CHAPTER TWENTY-NINE

RECOVERY SYMPTOMS: CHANGES IN ATTITUDE AND PERSONALITY

Introduction

The previous chapters focused on those recovery changes that were related to muscles, nerves, sinews, and even brain hemispheres. Those were physiological changes, changes that had a physical basis.

This chapter describes a few of the recovery symptoms that were more mental than physical: mood and personality changes. Some of these changes, in turn, led to physical changes: improved attitude and mood often caused a clear improvement in movement initiation, speed and fluidity of movement, and decrease in tremor. When the personality changes became solidified, no longer subject to intermittent use of dissociation, the Parkinson's was gone for good.

In many patients, the physical changes were harbingers of mental and emotional changes. In others, the mental and emotional changes seemed to come first, leading the way for the physical changes. It was often hard to tell which came first. And truly, it didn't matter.

What does seem significant is that the patients who became stuck in partial recovery were the ones who experienced many of the physical changes but few, if any, of the emotional changes.

For those who completely recovered, the altered personality and attitude were some of the most satisfying recovery symptoms of all. They wanted to recover, initially, in order to not have the physical symptoms of Parkinson's. After recovering, they universally appreciated their personality change more than their physical restoration.

Crying

At some point after the foot injury began to heal, recovering patients often found themselves bursting into tears at the least little thing. Various patients told me, prior to recovery, that they rarely cried, or that they *never* cried, or even that they *couldn't* cry. During recovery, for a few weeks or months, they often found themselves crying at almost anything.

Typical reports included, “I’m turning into a sap! I saw a little child walking a puppy on a leash, and it was so cute, I burst into tears,” and “I caught myself crying at *Oprah*, for God’s sake,” and “I read the headlines on the newspaper and I was so touched, I started crying!”

Usually, the onset of easy tears was a wonderful feeling, accompanied by a feeling of openness in the heart and an end of a long-time fear that tears would lead to being condemned as a sap, a weakling, or stupid.

Then again, the onset of tears could be very painful.

One patient who did not recall ever crying since she was six years old started crying one day after a session in which we’d worked on her imagining that her physical body and her “imaginary body, the body that contained her heart” bridged the several-foot gap that usually separated them and merged into one person.

She started crying in my office, saying, “Why are people so mean to one another?...gee. I’m crying.” And then she started crying harder. Soon, she was so violently wracked with sobs that I suggested she not return to work, that she go straight home and call in sick for the rest of the day.

She assured me that she wouldn’t have any problem at work: she had always been able to stay in control of her emotions.

She called me the next day, from home. Following our session, she had returned to work, started sobbing hysterically at her desk, and actually fell on the floor and was unable to stand up. A co-worker drove her home. She stayed home from work the next day and cried. She was unable to staunch the tears, but more importantly, she was unable to stop the flood of emotions that surged in her breast. She was feeling emotions for the first time since she was six years old. She felt emotionally drained by all the feelings and the crying, but she figured that it was all to the good.

Then the worst happened.

Her best friends, a couple that she had introduced to each other, died in a car crash just three days after she’d called me from home. Her friends had been on their way back from Disneyland. Their infant daughter also died. The eight-year old child was injured, but survived.

This patient, who had not cried *or felt any emotion* since she was six years old, was hit with the full force of real-time emotional loss. She told me, the next week, that when she got the news of her friends’ deaths, she cried so hard that her chest hurt, her eyes hurt, her face hurt. Her arms hurt, her skin hurt. At some point, she was in so much pain that she couldn’t tell if she was crying because she was in such physical pain or if she was in such physical pain because she was crying. She feared that she might go crazy from the emotional pain, the physical pain, and the crying.

She truly did not have the emotional skill set to deal with this tragedy. She had the emotional make-up of a six-year old.

A week later, she told me that, for several days, she questioned whether or not she had been better off back when she was unable to cry, back when she had attended family deathbeds and funerals and experienced no feelings *whatsoever*.

I asked her if she now regretted the changes that she'd been going through, if she wished we hadn't opened that door.

I will never forget her answer.

She looked me right in the eye and said, "You saved my life. I was dying and you brought me back."

She wasn't talking about the Parkinson's. She was talking about her missing heart. She had no regrets.

Nearly all patients have *enjoyed* the sensations of increased feelings and tears, even if they were terrified up until the very minute when the tears started to flow. Very often the tears ended up being tears of joy, of connectedness with others. Even in the above case, she was grateful to be able to feel and express the anguish and pain that she was feeling.

The ability to cry is very important. I cannot think of any person who has recovered from Parkinson's who retained his *inability* to cry. Curiously, some of those who recovered easily had actually worked on learning to cry, *long* before they were ever diagnosed with Parkinson's. I highly suspect that their self-taught ability to experience their own heart feelings was one of the main reasons that they recovered so easily.

Learning to cry in high school

I learned to cry when I was seventeen. It happened after one of my teachers referred me to the school psychologist for "the usual senior-year counseling session."

I only realized decades later that none of my high-school classmates had ever been sent to a "usual senior-year counseling session." I suspect that some, or at least one, of my teachers was concerned about some of the bruises I sported...

During the session, the counselor asked me a few pointed questions about my home life. He remarked on how I seemed to freeze up when asked about my mother.

I coolly replied that, "All children should love their mothers. My mother frequently reminds me that even the worst criminals love their mothers."

The counselor countered, "Not all mothers deserved to be loved. Some mothers chop up their children and flush them down the toilet."

I was shocked. Then, I was relieved. The thought that some mothers didn't merit blind devotion was new to me. The counselor then asked if I ever cried.

I replied, "No one likes a person who cries." As a very young child, I had learned that crying was one of the behaviors that made my mother insane with rage, and sometimes led to the brutal beatings with a leather strap. It wasn't until after I recovered from Parkinson's that I realized that my mother had actually panted with joy, complete with orgasmic breathing and body movements, while using the strap on me. At any rate, I had learned very quickly *never* to cry.

The counselor contradicted my statement: "No one likes a person who cries."

He said, "Everyone cries. Crying is normal. Everyone knows that tears just mean sadness. Maybe your mother doesn't understand about crying, but healthy people do. If you

walked all over school crying, not one person would be angry with you or dislike you; people would most likely just say to themselves ‘she must be sad about something’ and continue on their way.”

I was astonished at this new thought. Unable to process any more new ideas just then, I told the counselor, “I’ve got to get back to class,” and left.

I decided, right there, to do an experiment. I would cry, right there at school, and see if anyone got mad at me.

I started crying on the way back to class. I had not cried since I was five years old, so it took a while to get started. I pretended I was an actress who could cry on command, and that got a few tears rolling. Once I started, I couldn’t stop. I did not take my usual seat at the front of class that day. I sat at the back and quietly cried. To my amazement, no one, not even the teacher, got mad at me. For that matter, I was given a wide berth – the teacher never even called on me.

No one seemed to even *notice* me. Of course, this was back in the pre-hug 1960s. If I did the same experiment today, probably many people would come forth with hugs and loving support.

Certainly, no one made fun of me or scorned me. I enjoyed the novel idea that I wouldn’t be punished for crying so much that I sat at the back of the room in my next class, as well, and cried for *another* forty minutes.

Shortly after that, without even graduating from high school, barely seventeen years old, I left home.

From then on, I made a point of crying, singing out loud, dancing, and emoting whenever I felt an emotion welling up in me – if I was in private. I was still careful never to “lose my cool” in front of people I didn’t know or in situations where I might be judged.

Prior to my diagnosis with Parkinson’s disease, I had noticed it was increasingly difficult to notice my own feelings. I found myself with an increasingly flat affect and mood – but unlike many of my PD patients, I had been very aware of this decline. I had fought it vigorously by forcing my self to sing rhythmic, bouncy songs that always made me feel better, and which, in turn, temporarily improved my mood and movement. Songs that I knew would work included Tin Pan Alley hits such as “When You Wore a Tulip” and “Shine On Harvest Moon,” and the livelier gospel classics, and anything by Hank Williams.

Several of my PD patients have described similar stories of learning or teaching themselves how to cry, feel vulnerable, or focus on the feelings in their own bodies. Those people who had worked on these skills tended to recover more quickly than those who were convinced that stoicism was keeping them “safe” or “successful.”

Those patients who were *opposed* to learning to cry or *opposed* to learning to feel pain were almost certain to become stuck in partial recovery. Again, no person I know of who has recovered from Parkinson’s has retained his *inability* to cry.

Punctuality

One distinct symptom that accompanied the change *away* from adrenaline and fear was a decrease in punctuality. I’m always pleased when a patient who has been chronically punctual starts to recover – and then shows up fifteen minutes late for his next appointment...and laughs it off! It is always a sign of emotional recovery.

I am always thrilled when a previously punctual patient calls me on the phone to say something like, “Ha ha! I guess you figured out that I’m not at my appointment. I’m at the beach watching the birds and I decided not to come to your office. I’ve just realized that I’ve never really sat and watched birds before. It’s great! See you next week.”¹

Becoming “lazy”

One recovering patient said that, during this phase, her adult daughter showed up at the house, took one look at her, and asked, “What’s the matter?!” The mom replied, “Why should anything be the matter?” The daughter answered, “You’re sitting on the sofa.”

The mom, genuinely puzzled, asked, “So?”

The daughter replied, “It’s just that I’ve never seen you just sitting around before.”

A few months after recovering, I was feeling so strangely calm and content that I asked my husband and teenage son, “Do you still love me? I’m so different. How can you love me now, when I’m so mellow, if you used to love me the way I was before?”

My son answered, “Mom, we loved you; we still love you. We loved you *in spite* of how you were, not *because* of it.”

As people who used to have PD become aware that they are “getting less done,” they sometimes have to learn to love themselves in spite of their new mellowness.

Panic attacks

Many people experience a panic attack after starting to recover from the emotional aspect of Parkinson’s.

These attacks occur in situations with highly specific parameters: 1) the situation was always supremely *non-important*; 2) a decision had to be made with regard to a *new situation*; 3) because the situation was new, *no precedent* could be applied.

The panic attack was usually full-blown, complete with pounding heart and sheer terror with no way out. A common description was “my mind seemed to be going down a black hole.”

Those people who had panic attacks – and they only had one apiece – shared the following generalities.

The attacks occurred after a person started feeling very good, very comfortable with life. He could feel himself being more relaxed and less likely to use adrenaline. He may have even noticed that his heart was more calm and that he was sleeping better than he used to. His Parkinson’s symptoms might be completely gone or he might still be experiencing some of the physical recovery symptoms.

Then, along came a situation in which he had to make an innocuous decision: a decision that he had *never* had to make before.

¹ I have had *one* PD patient who was *not* compulsively on time. She was consistently, considerably late for everything. Every patient is unique. There are exceptions to every generality. She was also a musician, and one of the patients who recovered *very* rapidly.

Some examples of decisions that prompted panic attacks are: Where to put the cat dish for the new kitty's food? Where to set the knick-knacks that sit on the bookcase when the carpet man moves the bookcase to take up the old carpet? In my own case, the panic attack occurred when I tried to install a brand new computer game program. (This was back in the days when every new computer program had its own unique set of installation instructions.)

In every case of panic attack, the person was confronting a *new* situation that was not actually very important. When he *calmly* tried to think of what to do in this situation, the brain presented an utterly blank screen: no thoughts appeared. He then wondered what was the matter with his brain.

In the past, these people had been adrenaline-driven: accustomed to making lightning fast decisions. Now, their brains had gone literally blank in response to "What should I decide?"

As they tried harder to find some mental thread to grasp, in an attempt to figure out how to do the new task, they realized that there were no mental threads. The task itself became less important. The mental focus was redirected to the realization that there were NO mental threads. It felt as if all thought processes had been turned off, as if the brain itself was missing.

What was probably happening, based on detailed descriptions that we've heard, and based on my own experience, is that the person was trying – for the first time in decades or maybe for the first time in his life – to make a decision using dopamine instead of adrenaline.

A person recovering from Parkinson's may have *no* remembered experience of making a decision while relaxed, while using dopamine instead of adrenaline.

When he tried to make a decision while being parasympathetic-mode dominant, dopamine-dominant, the mental "thought screen" showed up blank. This led to the next thought, "My brain is missing!" and from there, into a black hole of terror and a full blown panic attack.

At some point, the panic forced the person to drop back into sympathetic mode – a mental condition that he knew very, very well. Once he slipped into fear mode, he was able to snap out of his panic and figure out what to do.

Only one episode per person

Happily, these attacks only happened once with each recovering patient. After that, the recovering patient seemed to know how to make decisions without going into sympathetic mode.

We have never known of anyone who couldn't figure out where to set the new knick-knacks after having had his one panic attack.

These panic attacks were very real. The woman who slid into a black hellhole of panic while trying to decide where to put the kitty dish was a NASA researcher, a brilliant scientist. She found herself standing in the center of her living room screaming, "Help me! Help me!" at full volume. She said that, even as she was doing it, a part of her brain was

thinking, “This must be a panic attack! Cool. I must be recovering!” But even so, the sense of impending doom, helplessness, panic, of needing someone to take over and take care of her, was physiologically *real*. The panic did not have to do with the kitty dish, per se. The panic began when her brain registered “Empty” when she tried to think of how to think about where to put the new dish.

One previously intrepid, world-traveling patient had his recovery panic attack when his wife proposed that they try the new restaurant in town. He went into a full-blown panic and was soon screaming for help as his wife stood by in amazement. The reason? He later explained that he didn’t know what they would do after they got into the parking lot because he didn’t know what they would need to do to find the front door of the restaurant. And when he tried to *think* about how a person might go about finding the front door on a building he hadn’t been to before, he couldn’t figure out how to think. It was the inability to think, and the feeling that his brain was literally empty, that triggered the panic.

As an aside, our patients with Parkinson’s seem to have relied on the emergency form of decision making for most of their lives. This is why, prior to recovery, they often came across as stronger, smarter, and faster than their peers. They might *not* have been stronger, smarter and faster than their playmates and peers if they had all been on the same neurological footing – using the parasympathetic mode instead of sympathetic.

I am pretty certain of this because, after recovering, patients were often amazed to find themselves becoming more average in terms of strength, quickness of mind, and speed. They did not become stupid or sloth-like. However, they became only *pleasantly* above average, not super-duper, not driven – and they were OK with it.

Because of their own chronic use of adrenaline and their amped up, emergency-induced thought and physical processes, many people with Parkinson’s had actively resented their “slow” fellow students, siblings, and coworkers: had dismissed them as “underachievers.” Ever since grade school, the mere presence of these “slower and stupider” people had often been a real irritant for many of our PD patients, who, deep down inside, had felt that life was an ongoing emergency, a state of perpetual risk.

Getting back to panic attacks: when the recovering patient needed to make an innocuous decision, one that was simply too mundane to activate his sympathetic nervous system, he found he had no way to access the decision-making part of his brain and be calm at the same time. He actually got a blank slate when he tried to make a simple decision while under the influence of dopamine. It was always the blank slate that scared him, not the implications of the decision.

As you have correctly guessed, a few people with Parkinson’s have told me that they shouldn’t enter into a recovery program because they might have a panic attack while driving the car. You know exactly what my reply was: the panic attacks occur while doing something perfectly dull in a very safe setting. No one in our experience has had a panic attack while in a risk-laden situation.

Then again, one recovering patient did have a panic attack while driving. He had taken the weekend off and had flown back east to visit his daughter at college. The visit was

purely a lark. It was the first time he'd taken off just for fun in a long time. As he was enjoying himself driving along the freeway, he missed the exit. He took the next exit instead and then realized he didn't know what to do next. He couldn't even *think* of what to do next, so he pulled over and stopped the car. Then, in this perfectly safe, non-emergency situation, in which, on some level, he was actually enjoying himself, he tried to think about what he should do next. He couldn't think! His brain was a blank!

Within seconds, he was in a complete panic because he couldn't think. His heart was pounding, he was sure he was going to die. After what seemed like several minutes but what was probably several seconds, his brain kicked in. He thought of something to do: he called his wife, long-distance. She agreed that he'd just had a panic attack. She asked him what he thought he should do. He said that he needed to pull a U-turn, get back on the freeway, and go back the way he'd come. Duh. He knew what to do.

But he had been thrown into a panic by the fear that had tackled him when his brain had failed to respond in the usual manner. He was *never in any danger*. He only panicked after he was relaxing at the side of the road, trying to calmly figure out what to do. He did get to where he was going, and he never had another panic attack.

The interesting thing about this particular style of panic attack is this: soon after the person truly begins to panic, the sympathetic nervous system *does* kick in. He is then able to think in the manner that he has always thought in the past. And so the panic attack ends.

This is very different from cases of post-traumatic stress disorder, in which the person becomes lost in an inescapable nightmare. Post-traumatic stress disorder tends to occur in people who are right-brain dominant. So far as I can tell from personality traits, my Parkinson's patients – except for the artists and musicians who recover very quickly – are classic left-brain dominant – highly analytical, highly logic-based.

In these and in other cases of panic attack, it has seemed as if the recovering patient, in the joyous throes of steady dopamine release, has been reluctant to slide back into using the old familiar sympathetic mode. But decisions can only be made in one of two ways: by using the *mind* while in predominantly sympathetic mode, or by feeling the preference of the *heart* while in predominantly parasympathetic mode. The sympathetic system is guided by mind. The parasympathetic is guided by physical heart cues.

The first time a person recovering from Parkinson's tries to make an unimportant decision using his *mind* (as per his lifetime habit) while he is in predominantly *parasympathetic* mode, he can't come up with a solution. In parasympathetic mode, the heart instructs the mind. If one tries to find a solution to a problem using only the mind pathways, while staying in predominantly parasympathetic mode, he will not get an answer: the mind may present a blank.

In recovering patients, the mind system hasn't yet been trained to work as a subordinate during parasympathetic, heart-led decision making. Hence, the panic attack.¹

¹ This reminds me of a story about Karl Jung, the famous philosopher/psychologist/ explorer. Jung asked Ochwiay Biano, chief of the Pueblo Indians, for his opinion of the white man. The chief said white men must be crazy because they think with their heads, and it is well known that only crazy people do that. Jung asked how the Indians thought. The chief replied that, naturally, they thought with their hearts. (From *The Sun*; "Sunbeams (Letters to the editor)," Laurens van der Post; Sept 2007; p. 48)

Happily, our recovered patients instinctively learned, after one panic attack, how to think and make decisions either by using the heart, in parasympathetic mode, or by using the mind, in the old familiar way, by triggering fear and a sympathetic mode response.

Guilt or boredom from lack of tremoring

Another emotional symptom of recovery was guilt. I have already written about the patient who never tremored again after a side-to-side- head shift and who felt terribly guilty when, shortly after, her mother landed in the local emergency room with a blood pressure crisis. For years, her hand had tremored during the most mild of emotions. As the emergency room clock ticked away and she failed to tremor, she thought to herself, “I must not care about my mother. I’ve tremored from all kinds of stupid, unimportant things, and now my own *mother* is in danger and I’m not even tremoring.”

She told me about her shame the next time I saw her. I had to assure her that tremoring in a crisis is not necessarily normal.

Some patients were ashamed of themselves when, upon recovering, they realized the extent to which their Parkinson’s symptoms had been the result of their own mental and emotional blockages. I recall one patient repeatedly slamming his open hand onto his forehead while saying, “I’ve been doing this to myself! What an idiot I’ve been. I’ve done all this to myself!”

Many people have assumed that a person who recovers from Parkinson’s will be proud of his victory. This is not the case. They usually feel sheepish. They have to admit that their “terrible illness” was the result of their own mindset. This can be very humbling, even embarrassing. I don’t think a person should be ashamed of having induced this illness in himself. I personally think that all illness has some emotional component. Still, patients are often a bit embarrassed.

Another type of guilt that sometimes descends on a recovering patient is the realization that, for a large part of his life, he has increasingly been an unpleasant, demanding perfectionist, know it all, or some type of personality that was based on fear and adrenaline instead of understanding and humility.

As a healthy level of humility began to take root and thrive, the temptation exists for the recovered patient to indulge in a bit of guilt for having been fear-driven, pride-driven, or whatever, in the past.

My advice is that indulging in guilt and shame is a variation on pride. Be humble enough to know that *everyone* makes errors. Forgive yourself and get on with your life. No doubt you were nearly always doing what you thought was best, at the time.

Another recovery oddity was the feeling of emptiness when the internal tremor stopped. As one person expressed it, “I miss the tremor. I know that’s weird, but I always felt some sort of internal pressure to look alert. As long as I was tremoring inside, I felt like I was always doing something. Now that it’s gone and I can sit motionless, I feel as if I’m not *doing* anything when I’m just sitting around. And I sort of miss that old intensity that wouldn’t let me sit still for very long. I’m going to have to find a new motivator.”

Loss of self-identity

As mentioned in an earlier chapter, many recovering patients have found themselves asking the question that might be more characteristic of an adolescent: “Who am I?”

This may be because, in part, the person never really experienced a period during adolescence in which he was able to dwell on that question.

Or, the person may have known exactly who he was so long as he was “on top of his game” and running on adrenaline, but he might have had no idea who he was when he found himself able to relax deeply, feel music, and not caring about the order in which someone else stacked the dishes into the dishwasher.

Who was he when he suddenly realized that most of what he’d been worrying about for years didn’t really matter? Who was he if he was starting to live in harmony with his own feelings, his own heart?

Many people with Parkinson’s value themselves in terms of what they are able to accomplish, and because they are stronger, faster, or smarter than most everyone else. What they needed to learn, following recovery, is that no one is loved *because* of his accomplishments, and no one is loved because he happens to be strong, fast, clever, or “always right.” Admired, maybe. But not loved.

People are loved because they are loveable. To the degree that they allow their hearts to resonate with the love around them, they can *feel* love.

A person with Parkinson’s *may* have a heart that can resonate with others, send love to others. It may resonate well with dogs or small children. Or not.

What people with Parkinson’s often have is an inability to feel the resonance between his own heart and his own body, or between his own heart and the love that others are directing towards him.

Because of this lack of resonance and ever-increasing reliance on adrenaline, he may have been steadily building protective walls around his own heart until he got to the point that he no longer knew who he really was.

When, during recovery from Parkinson’s, those walls begin to crumble, patients were often surprised to learn that they were not who or what they thought they were.

But nearly all the recovered patients were certain that they loved their new self far more than they’d been able to love their old, pre-recovery self. (The foot-injury patients who’d had no dissociation other than the injury did not notice any change – they’d been feeling their hearts right along.)

Losing the fear of criticism

Many recovering patients noticed a dropping away of their defensiveness.

Of course, not all patients *had* been afraid of making mistakes or being laughed at, but many had been. Some had become overly sensitive to criticism after some tragedy such as loss of a loved one. Their symptoms ranged from a protective emotional flatness to abject fear of “what others might think” to the point that they lived every moment as if an invisible critic was offering running commentary. When the inner critic died away, the relief was enormous.

Chapter summary

People really enjoy the personality changes that come about when they recover from Parkinson's.

Or you might say, when a person embraces the ability to live from his heart, instead of going through the motions of living using dissociation as his neurological mode of choice, he recovers from Parkinson's.

“If you can meet with Triumph or Disaster And treat those two imposters just the same...”

“If” by Rudyard Kipling

CHAPTER THIRTY

IS THIS PROGRAM RIGHT FOR YOU?

If you have been diagnosed with Parkinson’s and think that you might want to try to recover, good for you!

Many people have recovered from this syndrome. If you are reading this book under your own steam, you probably can too.

After reading this book, you will have noticed that there are no hard and fast rules for recovering.

Case studies in the beginning of the book gave examples of people who recovered from the mental habit of dissociation after having their unhealed foot injuries treated. Oppositely, case studies in chapters eighteen and nineteen gave examples of people who recovered first from their mental habit of dissociation who then automatically, naturally, recovered on their own, without externally applied treatment, from their unhealed foot injuries.

And most our patients have done some of both: they have found people to help them with their foot injuries *and* at the same time they have jumped right in working on overcoming their mental habit of dissociation in times of fear, anger, or other “not nice” emotions.

Can this work be done without the help of others? In one case a patient who lived in a very isolated area supported her injured foot by herself, worked on bringing feeling back to her heart by “holding” her heart area with her own hands, and recovered. One case study mentions a person who recovered by practicing Qi Gong – while using a correct attitude of somatic awareness that is *not* available to most people with Parkinson’s (Qi Gong has *not* proved helpful for *most* patients).

But most people who’ve recovered have gotten some support from others. Usually, that support came in the form of physical holding of the unhealed injuries. In most recovered patients, this work has been done by friends or family members.

In other cases, the support came from leaning on saints or sages who provided the emotional support necessary for *psychological* recovery, which then *automatically* brought about healing of any unresolved (psychologically dissociated) injury.

Professional help is not usually necessary, unless there are electrical aberrations being held in place by scar tissue. In these cases, one might benefit from having the scar tissue needled by an acupuncturist (see chapter one).

Those who have permanently sustained their recovery have decided to *no longer* suppress their emotions (dissociate from the heart in times of emotional stirrings).

Oppositely, many of those who have experienced some, or even *many* recovery symptoms but who have kept up their habit of suppressing their emotions via dissociating (playing dead) in response to any risk or negative feelings, have found themselves in a terrible bind.

Because they never know when they will be “attacked” by Parkinson’s again, they develop a *heightened* mental wariness that results eventually, after days, weeks, or months, in having *amplified* symptoms of Parkinson’s disease *all* the time. Because they are *always* worried about having the Parkinson’s erupt, they learn to *always* dissociate. In these cases, the patients’ symptoms often advance extremely rapidly as their fear of Parkinson’s – and therefore, their dissociation – spirals out of control.

Symptomatically, these people who are locked into partial recovery from inability to admit they are safe enough to live might even be better off *not* knowing what they have, not trying to recover, and just letting the mild symptoms slowly develop over the years.

But it is only fair to let people of sound mind know what they have and let them try to turn themselves around, if they so desire.

So, if you have been diagnosed with Parkinson’s and you are of sound mind and are not taking antiparkinson’s medications, be grateful for your diagnosis: you may well be able to recover.

Sound mind – an aside

Many times, people contact us because they want us to “cure” a very elderly parent who has been diagnosed with Parkinson’s. These very elderly patients, very often, are clearly no longer interested in or capable of changing their own patterns of thinking. If a person is not able to read the material we offer, and not able to understand it, we try to discourage him from entering into our program. They have very little chance of success and a very great chance of feeling confused and frustrated.

Remember, it is *not* uncommon for a very elderly person to develop symptoms of Parkinson’s. Parkinson’s used to be referred to as premature aging. In other words, normal aging can look a lot like Parkinson’s. If a person is in his late seventies or early eighties and starting to develop Parkinson’s disease, this might be considered normal – not sickness, not pathological.

If the patient is not able to read this book by himself, or if he cannot understand it after having read it, he is probably not a good candidate for recovery.

Next, not everyone wants to recover. I have met very elderly people who have said they have “earned the right” to sit in the corner and be taken care of. I have also met people who are not interested in working on recovery because they are more focused on joining their loves ones who have passed on.

These people do not always confide their heart-felt desires to family, for fear of hurting feelings or being walked over, but they sometimes confide in their doctor.

If *your loved one* has Parkinson's and *you* want him to recover, but he is not interested, please respect his desires. For more details, please read the warning on page 358, in chapter 26.

First things first: a diagnosis

If you are of sound mind and want to recover, make sure you have a correct diagnosis.

We'll assume that your neurologist has already made an educated guess as to what you've got, but thirty percent of doctors' Parkinson's diagnoses turn out to be wrong, after an autopsy is performed.

See chapter twelve. This chapter explains how the electrical channels in the legs and torso flow in a person with Parkinson's disease. Chapter six explains the physics of channels, in case you are curious.

Recruit a friend or family member to feel these channels. It is very easy to learn how to feel them.

Instruction in feeling channels and maps of the channels are available for free download at www.pdrecovery.org, in excerpts from the book *Tracking the Dragon*.

Finding someone to form the diagnosis

If you absolutely cannot connect with a friend or family member who is able and willing to learn to feel these currents, consider finding someone who specializes in light-touch therapy such as craniosacral therapy. These therapists are good candidates for mastering this material quickly.

Most acupuncturists have *no* idea whatsoever as to how to feel the flow of channels, or how to interpret their findings. However, if you already work with or know of an acupuncturist or other holistic health practitioner who *is* interested in learned to feel the flow of channels, you're in luck. It is an easy skill to master.

See chapter six for thoughts on finding a health practitioner to work with.

Interpreting your diagnosis

If the pertinent channels *always* run backwards, then there is probably an unhealed injury.

If the channels run correctly when the patient is deeply relaxed, but revert to backwards flow when someone says "Uh oh!" or any other comment that suggests a problem, this suggests psychogenic parkinsonism (Parkinson's-type dissociation without the foot injury.)

Most people with Parkinson's have both: foot injury causing an electrical flow that mimics that of dissociation, and a habit of reverting into the electrical pattern of dissociation at the least sign of danger.

If you do have Parkinson's disease, please read this entire book before launching into a recovery program. Recovery can be a challenge, and a person might be better off having

Parkinson's than getting stuck in partial recovery. Partial recovery is referred to throughout the book, and explained in detail in chapter twenty-four.

Next, if it appears that electrical flow in your legs is backwards even when you are relaxed, have someone treat your foot injury.

Instructions for performing the supportive treatments that are gentle enough even for a person with Parkinson's are available in the book *Yin Tui Na, Techniques for Treating Injuries of Parkinson's Disease*. This material is for available for free download at www.pdrecovery.org. This book also explains how to recognize exactly *where* the injuries are located.

If the electrical pattern comes and goes in response to mood or thoughts, there is probably not a foot injury. Please read chapters 15 and 16 and then do the exercises.

Good candidates for recovery

If the material in this book resonates with you, consider recovering. If it does not, that's fine, but this treatment program might not be right for you.

If you do *not* want to recover, but a spouse or well-meaning friend wants you to try anyway, you might *not* be a good candidate for recovery. Please assert yourself. There is no shame in having Parkinson's disease.

If you are not able to read this book because of lack of interest or lack of ability to focus for very long on a specific topic, you might not be a good candidate for treatment: recovery may require some ferocious mental retraining.

If you are over seventy years old or in poor health, please consider very carefully whether or not you are feel up to remaking your personality and dealing with the recovery symptoms. The recovery symptoms can be exhausting for an older person or a person in poor health.

Recovery symptoms are explained in chapters twenty-one through thirty.

If you are reading this material on behalf of an elderly person who has Parkinson's, please do not assume that the person is a good candidate just because he always *used* to be very dynamic and motivated.

His Parkinson's is *not* inhibiting his dynamism and his motivation. His natural decline in dynamism and motivation is allowing his long-hidden Parkinson's to come to the fore.

Recovery will not return him to his previous state. Then again, if he has psychogenic factors contributing to his Parkinson's, recovery might allow him to be a completely different person – a much more contented person. The patient might embrace this, or he might not. Please allow the patient to make this decision.

If a person is over seventy and is just starting to show signs of Parkinson's, it is because his sympathetic nervous system is no longer able to mask what might be a life-long

pattern of dissociation. If his dissociation is so modest that his symptoms don't appear until age seventy or later, he has *slow-developing* Parkinson's.

He might be best off by just living with the mild inconvenience of early stage, slow developing Parkinson's. Some years down the road, if and when he finds that he has difficulty dressing himself or feeding himself, he might wish to start taking the medications. The medications, if taken at the low doses recommended by the manufacturer (as opposed to the dangerous, cavalier dosing suggested by uninformed neurologists), can provide help for five to ten years.

In other words, the person might be able to get to age eighty and beyond without the Parkinson's being too severe.

Redundancy

Parkinson's was once referred to as "premature aging." In other words, the symptoms of Parkinson's can be considered normal for a person who is getting old. In a young person, these symptoms are pathological. In an older person, they are not, necessarily.

Some neurologists even say that, if we live long enough, we will all develop either Alzheimer's or Parkinson's. In other words, while this syndrome is unpleasant, it is not necessarily "unnatural" in a person who is moving into his senior years.

The danger of partial recovery

There is a genuine risk for elderly people if they only partially recover. A person who partially recovers will no longer be a good candidate for taking antiparkinson's medication. The horrible adverse effects of the medication, including medication-induced tardive tremor, may be much stronger, much sooner, in a person who no longer has an injury. Please think about this.

The medications are safe enough for a person who still has a foot injury. The foot injury sends a signal to the brain that amplifies sympathetic mode and inhibits parasympathetic mode. With this mode inhibited, the brain damage caused by dopamine-enhancing medications is moderate, and might not be problematic for five to ten years, if the medications are taken at the correct (low) dosage.

This brain situation is similar to the one that allows a person with severe pain from trauma to use opiates for pain relief without becoming addicted to pain. However, if the person *continues* to use the pain medication after the injury begins to heal, he risks becoming addicted.

If a person with Parkinson's recovers from his injury but maintains his emotional attachment to dissociation from pain (psychogenic parkinsonism), he becomes extremely susceptible to addiction (brain damage and brain changes) from dopamine-enhancing antiparkinson's medications. If this is the case, the effectiveness of the medications might be short-lived, or the patient might need rapid increases in medication to maintain effectiveness. As soon as the dosage levels become high enough, he will begin experiencing the highly traumatic, often painful side effects of the medications: side effects that many people say are worse than the original Parkinson's and which can include severe *amplification* of tremor.

However, if he gets to this painful point, he will *not* be able to stop taking the medications. He will have cause a condition known as "drug-induced parkinsonism" in his

brain. This condition will cause him to have symptoms *similar* to Parkinson's in *addition* to his original symptoms of Parkinson's: a double form of Parkinson's.

At this point, he will be addicted to the medications: he will *need* the medications. He will not have the choice of stopping even though the medications cause violent side effects.

He would have been better off *maintaining* the injury that allows his brain to tolerate these medications without causing severe, rapid addiction. Unless he is able to completely recover, he might be better off having full-blown Parkinson's than having the partial recovery that makes the medications so dangerous.

For more information about partial recovery, please read chapter twenty four.

For more information about the medications, please read *Medications of Parkinson's: Once Upon a Pill*, available for free download at www.pdrecovery.org.

Medicated patients

The member of the Santa Cruz Parkinson's Treatment Team will not work any person who has been taking dopamine-enhancing antiparkinson's medications for more than a few weeks. However, we do not pretend to know what is best for any given individual.

If you *want* to try recovering even though you have been taking these medications for some time, please read the section *Dum spiro spero* (So long as I breathe, I hope), on page 182.

Also, please read *Medications of Parkinson's: Once Upon a Pill*, available for free download at www.pdrecovery.org.

Supplements and chemical cures

We have never seen a person's recovery accelerated or initiated by the use of supplements, "magic waters," or vitamins. As for chelation therapy, we have seen that this therapy can make people extremely weak, further depleting their already exhausted adrenal glands. Chelation therapy should only be undertaken under the guidance of a medical practitioner. We have never seen anyone benefit from chelation therapy in terms of their Parkinson's symptoms, and we have seen many people greatly weakened by this type of therapy.

Those people who have recovered, and say that their recovery came about from using ionized water, various nutritional supplements, magnets, and other therapies too various to mention, have probably also gotten foot therapy and undergone a decision to change their own emotionalism. If they are trying to sell you a product that "helped them recover," please find out if they also did something for the energy in their feet and went through some sort of attitudinal epiphany.

However, some people do benefit from taking adrenal supplements. In particular, those patients who have become extremely weak and lost a lot of weight, adrenal supplements can be helpful. If a person has gotten to the point where eating is so difficult, or their tremor is so constant that their whole body is in constant motion, adrenal adaptogens can help rebuild the appetite. These supplements will *not* cure Parkinson's, but they can, in some cases, restore appetite and improve strength.

The plant-based adrenal adaptogens that have been helpful include Panax ginseng, Ashwagandha root, Rhodiola root, Eleuthero root, Holy basil (leaf). Products containing some or all of these plants are available at any health food store.

Apex Energetics, Inc., a high quality nutritionals company, makes a product containing all of the above: “Adaptocrine.” This product is only available from health practitioners. Any chiropractor, acupuncturist, or naturopath can order this for you.

Again, this product will not help you recover from Parkinson’s. However, if you become extremely weak or have lost so much weight that you are looking skeletal, this product can help you regain your appetite and retain more nutrition from your foods.

Young or “early onset” Parkinson’s

If a person is diagnosed in his twenties, or younger, he has fast-developing Parkinson’s. I would recommend that he try recovering from this syndrome, but only if the material in this book makes sense to him.

Statistics

We have encountered the many of the same difficulties that beset all researchers in the field of long-term behavioral change: patients do not necessarily stay put for long periods of time or remain “interested” in continuing a program for an extended period. Even more problematic, from a statistical point of view, most of the people we’ve heard from, via email, who’ve recovered have never physically met any of us. We have no way to verify their initial diagnosis or their recovery. Therefore, we allow ourselves to feel good, for a short while, when we get emails saying “Thank you, I recovered from Parkinson’s,” we nevertheless do *not* collect this data.

Based on the approximately three hundred patients we’ve personally worked with who appeared to have been given a correct diagnosis, 100% have exhibited backwards-running channel Qi characteristic of dissociation. A whopping 95 percent have experienced improvements in some or all of their Parkinson’s symptoms after receiving treatment for their foot injuries. These numbers are so extreme as to be suspect. However, before you write to the project with long descriptions of data collection methodology, please just check the channels on as many people with Parkinson’s as you can find. Believe me, all of us in the project would have breathed easier if we’d had more “believable” numbers such as 82% or even 54%.

Some have required a few weeks worth of treatments before seeing improvements. Some have required a few years of intermittent treatment before improvement show up. The most common improvements, at first, are the changes described in chapter twenty-one: Numbness and pain. The return of sensation is the most rapid and most common recovery symptom, in general.

Making it even more difficult to generate meaningful data, most of the patients we’ve worked with come to Santa Cruz from around the world. They work with us for a short period of time – one to three weeks. Even so, in *most* cases, we’ve seen objective symptoms of recovery – acknowledged by patients and accompanying spouses or health practitioners. And then we never see the patients again.

Of the total numbers of patients seen, about ten percent have completely, lastingly recovered. Most of these recovered people happen to be local patients who I have been able to see regularly over a period of months, even years. If others have recovered, I have not

heard. For example, I had no idea that Gertrude had recovered until a health practitioner in Germany, who knows Chris Ells who runs the Amsterdam program, mentioned her case to Chris, who happened to mention to me that she might be attending my class, just before my trip to Amsterdam. She'd been recovered for more than a year, but we have no international "reporting" procedure. And of course, to her doctor, she had been merely "misdiagnosed."

Getting back to numbers, many, maybe another ten to twenty percent consider themselves "nearly recovered."

A few patients have found themselves becoming uncomfortably emotional and have left Santa Cruz after just a few introductory treatments. Where do we place these people in the statistics?

Most patients, the majority, are, so far as we know, in a condition of partial recovery. This means that their remaining symptoms are more clearly emotion-driven. Most of these people have better motor function and less tension in their limbs than when they first started treatment, but their tremoring has become more problematic – in some cases nearly constant. Many of these people have learned to *recognize* the guarded-thought patterns that drive their tremors but have not yet been able to convince themselves that they are in fact safe enough – or worthy enough, or can forgive God enough (the reasons are *highly* individualistic) – to let their guard down.

Many of these people have told us that, because their case is unique, *they* alone are incapable of truly recovering: even though nearly all of them have experienced some recovery symptoms and have had periods during which they were somewhat or completely symptom-free. Many people in this group, people that we refer to as being partially recovered, still experience situational symptoms; come and go symptoms of Parkinson's that vary in intensity based on *anticipation* of stress or risk.

The reasons given for not wanting to change their guarded mental posture range from "it's too much work" all the way to being certain that man has a moral imperative to fear God at all times.

What does this mean for our "statistics?" These "reasons" for being unable or uninterested in making a further pursuit of recovery suggest that a simple graph or "data bank" assessment of what's really going on is pointless.

We are dealing with psychological behavioral change: a subject that may be best served, at this stage in our research, by simple reporting of many single-case studies.

Single case studies do not necessarily lend themselves to graphs and the data-driven conclusions that are so popular since the scientific community rejected uncontrolled and single-case studies in the 1950s.

However, since the late 1970s, researchers in the field of behavioral change – and behavioral change is at the root of recovering from Parkinson's – have re-established the importance of the single case study, or the grouping of single case studies. Many, if not most, of the *breakthroughs* in psychology and physiology have come about through observations of single case studies.¹

¹ Reference: *Single-case Experimental Designs: Strategies for Studying Behavior Change*; Michel Herson, PhD, David Barlow, PhD, Pergamon Press, 1976, 374 pages.

Maybe more to the point, Parkinson's used to be considered an incurable illness. We have been able to prove that it is not. What future patients with Parkinson's choose to do with this information is utterly up to them.

The Parkinson's Recovery Project exists simply to share information. We make no value judgments on people who choose not to recover, or who struggle unsuccessfully to bring about lasting changes in their outlook. Just the opposite: we do understand that this is a deeply personal choice.

Most important, I have not made this material available in order to attract patients to my medical practice: I wish to emphasize that more people have recovered from Parkinson's by reading our materials and treating themselves, or by being treated by friends and family, than have recovered by getting treatment from the Parkinson's Treatment Team of Santa Cruz, the research group that developed these findings. Recovery can be very much a do-it-yourself project. Professional help is not a requirement.

If you think you want to recover from Parkinson's, read this book.

If you think you are a good fit for this program, find people to help you. If you have no nearby friends or family who are capable of doing the therapeutic treatments, please look for someone who is experienced at light-touch therapy such as craniosacral therapy. See chapter twelve.

As for the psychological aspect, you must do that work yourself. See chapters fifteen, sixteen, and seventeen. Read up on Cognitive Behavioral Therapy, as suggested in chapter sixteen.

“If you can meet with triumph or disaster, and treat those two imposters just the same...” If you can laugh at these two, if you can keep your heart open, be ready to live, refuse to “shut down” or “play dead,” and refuse in *any* way to suppress your emotions and dissociate from your joy or your pain, then you can recover from Parkinson's disease.

I wish you all the very best. God bless us all,

Janice Walton-Hadlock

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