

Almost dead

The cardiac patient watches the open-heart surgery on his anesthetized body while floating around the ceiling of the operating room. The patient is not “relaxed,” nor is he “sleeping.” He’s in a highly specific neurological state of near-death. Most western doctors are familiar with the “Watching from the ceiling” phenomenon. But most western doctors are not trained in the subject of near-death neurology. This condition doesn’t even have a name in western medicine.

The mouse, grabbed by the cat, becomes cold and rigid, with no detectable signs of heartbeat or breathing. The cat biffs the inert mouse around a few times. Then, if the cat is not hungry, he leaves in pursuit of something more interesting. The mouse is *not* playing dead. The mouse couldn’t make himself cold by “pretending.” The mouse is in the same near-death neurological state as the above cardiac patient.

Most of the mouse’s biological systems are on pause, except for his eyes, ears, sense of smell, and the super-active risk assessment centers in his brain. If his *body* successfully staunches the internal bleeding caused by cat’s claws *and* if his sensory functions decide that the cat has left the area, the mouse will take a deep breath, shake his head from side to side, and a shudder will run down his spine. He will no longer be on pause. He will spring back to life, scampering off to live another day.

The heart patient watching from the ceiling and the seemingly dead mouse are not highly “relaxed.” Relaxed is what doctors call “parasympathetic” mode, the ideal conditions for relaxing, playing, and eating.

The heart patient and the mouse are not in “flight or flight,” what doctors call “sympathetic” mode.

They certainly are not sleeping, the third neurological mode, in which breathing is loud and relaxed, internal cleaning and healing work is in motion, and most aspects of consciousness are turned *off*.

The heart patient and the mouse are in the neurological mode of near-death. The heart patient has gotten there chemically, through anesthesia. The mouse has gotten there honestly, by being damaged to the point of near-death. They are both using the fourth biological mode: pause.

A case study: the youthful soccer player

A male, 33 years old, came to my office for knee pain. Six months earlier, I had treated his knee pain with acupuncture. The pain had quickly disappeared. Now, “out of the blue,” the pain had resumed. It was steadily worsening instead of healing.

By running my hand a quarter inch above the skin of his knee, it was easy to tell that the electrical currents that should run just under the skin of the knee were, once again, not moving at all.

These currents, the underlying basis of Chinese medical theory, are called “channels.” Sometimes, these currents are referred to as “meridians,” a term that means “*imaginary* lines drawn up to provide a template.” These currents are not imaginary. I personally do not use the word “meridian” to describe the electrical currents that flow just under the skin.

These channel flow patterns can easily be felt by hand after a very short bit of training.

Because the patient hadn’t had a new injury and the pain had resumed for “no reason,” I decided to check the electrical currents that lead *into* the knee current. Those currents were also running only feebly.

I was a bit puzzled, and asked if he’d had *any* injuries in *any* part of his body in the last six months. He insisted that, although he’d been very active with hiking, climbing, and bicycling, he had not been injured.

I directed him in a quick imagination technique of visualizing light inside his right knee to determine if he was mentally dissociated from that joint. I was a bit surprised to learn that, based on his inability to imagine light in his entire right side, he was somewhat dissociated from not *just* his knee, but from the entire right side of his body.

I led him through one of the simple re-association techniques in this book, with a focus on the knee. He was then able to imagine light in his knee, but he could only imagine it as if he were outside his body, looking at his knee from the outside.

This was puzzling to me, because this technique, being focused on the knee, should have made him able to mentally imagine seeing, and even *feeling* bright light, from a perspective *inside* his knee. This “outside the body” perspective suggested to me that there was a far bigger problem than just his knee. I asked him if he had any other health issues going on.

He replied that he’d been suffering from a painful itchy rash for nearly a year, but he’d seen six doctors, including specialists, and they had no idea what the problem was. He hadn’t mentioned it to me earlier because he assumed that acupuncturists only treat pain from injuries: a common misconception.

In Chinese medicine, itching skin for “no known reason” *can* be, but is not *necessarily*, a manifestation of the “life force trying to leave the body.”

I asked him about that, and it didn’t ring any bells for him. He replied, “I’m very athletic, I love my body. I don’t want to leave it...”

I asked him if he could imagine a narrow stream of light, energy, wind, or anything it all traveling up his back, just under the skin, directly over his spine, starting down at the sacrum and going up his neck and into his head. He could imagine a tiny bit of current at the low end of his spine, and a tiny bit near the neck, but he couldn’t even begin to imagine any light or movement in his head.

His imagined current in his spine could not go up his neck even when he tried to imagine forcing it. *Inside* his head, he couldn’t imagine light or any other form of energy. It was as if, with his eyes closed, he didn’t actually have a head, let alone anything moving through it.

At that point, I changed my entire approach. I now suspected that he was in near-death shock: on pause. I asked, "Have you ever had a traumatic injury? Or a spine or head injury? In the last few months? The last year? Ever?"

He said no.

People often don't remember injuries if the query is too general, especially if they have dissociated from them. To get his mind more focused, I started on a more specific string of questions. I opened with "Have you ever had a concussion?" We were lucky. This very first question wakened a memory.

"Yes, I think maybe I did. I was eleven years old. Playing soccer. The strongest player on the team kicked the ball and it hit me on the right side of my head. I was about ten feet away from him. I don't know what happened exactly, but I remember being stunned, lying on the grass. The coach told me to get up and keep playing.

"I remember trying to dribble the ball along the grass and it was really weird. I felt like I was in a dream. Everything seemed different, looked a little different, felt different. I felt as if I was outside of my body. It was surreal. I was definitely in what I would now call an altered state.

"Actually, I still kind of see myself that way, like I'm looking *at* myself instead of *being* myself. I'm outside of my body. Looking at myself from outside."

He showed me the location on the right side of his head where he'd received the blow. I placed one of my hands on that location, and my other hand on the opposite, left side of his head where the force from the blow might have traveled through the head and caused a bit of internal brain damage, a slight cranial bone displacement, or sustained muscle tension.

Under firm support from my hands, using the very simple holding technique called Forceless, Spontaneous Release or FSR, a type of Yin Tui Na (Chinese light-touch therapy), his head and scalp muscles relaxed from their positions of what I presumed was habitual tension.

Next, I led him through the five simple steps that animals, including humans, usually go through quickly and automatically to terminate pause mode and bring a person's self-awareness back *inside* his body after the body has stabilized from the damage and any imminent danger has passed.

Five steps for turning off pause

The five steps will be discussed in great detail later on. For now, briefly, the five steps are as follows:

First

The person needs to first mentally focus on the injury site and silently acknowledge that it *was*, in fact, damaged. He can close his eyes and imagine he is looking at this area. It will usually appear, in his imagination, as somewhat dark and subtly vibrating or faintly trembling. This faint internal tremor is a signal that the body is now stable: that the *internal* damage has been brought under control.

Second

The person on pause needs to observe this tremoring while feeling *connected* to or *succored* by something or someone loving or caring.

For animals and many humans, this is automatic. If the immediate danger is no longer audible, visible, smell-able or palpable, one reconnects automatically with a feeling, an actual sensation, of being part of the universe, or you might say a feeling of being “connected” to everything. Note: a person who has long been stuck on pause may have no idea what the previous sentence even means.

The absence of immediate threat and the resumption of a feeling of reconnection with life allows the animal or person to recognize that he is now safe. The immediate danger from *external* causes has passed.

For some people, especially those who have been stuck on pause for a long time, the feeling of being connected needs to be consciously induced. Either way, the conclusion, “It’s safe now,” needs to be felt via a shift in the sensations perceived by the physical heart.

Actually, the electrical shift occurs in the pericardium, the connective tissue that *surrounds* the heart. Saying that a palpable shift occurs in the “area of the heart” is close enough. When poets and saints refer to the feelings of the heart, they are actually referring to the electrical waves given off by the pericardium. These waves change moment by moment, and reflect one’s resonance, or lack of, with things and events.

Third

The person needs to focus on this safe feeling, which starts as a physical sensation of expansion in the vicinity of the heart, until he experiences a relaxation throughout his body: a pervasive physical *feeling* of peace and safety. If human, he may even find himself consciously expressing to himself the thought: “Whew. I’m safe now.”

As soon as this thought registers, he will almost always spontaneously perform a deep, relaxed, even noisy inhalation and exhalation: a “sigh of relief.”

Fourth

His head will wobble once or twice, high on the neck, from left to right, activating the vagus nerve where it emerges from the base of the skull. The movement is not a left to right nod. Rather, the head is tipped slightly backwards while the left ear moves closer to the back of the left shoulder, and then the right ear moves closer to the back of the right shoulder.

Fifth

The head wobble should trigger the sensation of an electrical shiver running down the spine. The shiver starts with a jerk at the bottom of the neck and shimmies towards the low back. The shiver might be small, just a slight jerk followed by a spinal shudder. Or the shiver might be large, like the movement of a dog shaking off water.

As an aside

In anticipation of the reader who might say, “Oh, Shaking Therapy. I know all about that,” please note that a person stuck on pause is usually not *able* to shake meaningfully or convincingly until he confirms that he is now safe.

Shaking therapy is, for westerners, a fairly modern stress relief treatment. Shaking allows a person to go from a higher degree of sympathetic mode to a lower one. It can also help a person come out of a stuck “startle” behavior. We say, “shake it off,” or “snap out of it.”

Mere shaking will *not* help a person who is stuck on pause.

Shaking therapy is one of the many therapies I used during my years of research with people who were stuck on pause. It didn’t work. Ever. They physically couldn’t do it. If they could do it, they felt uneasy, as if it were somehow “wrong.” Which it is.

Even if a person stuck on pause *is* able to do a bit of shaking, the benefits will be fleeting.

Animals who are in severe shock following a near-lethal attack are biologically inhibited from shaking until they have taken specific steps that confirm that the physical (internal) danger to the body has been stabilized *and*, maybe more importantly, that the predator (exterior) danger is no longer in the vicinity. *Effective* shaking that successfully turns off pause *cannot* occur until both internal and external danger are mentally confirmed as no longer present.

In the wild, premature shaking could potentially re-attract the attention of the predator.

An animal on pause is biologically *incapable* of doing a self-convincing head wobble and shiver until he is safe. He is hard-wired to *not* perform these steps until he has *confirmed* that he is safe and taken a sigh of relief.

Any soldier who has found himself lying on the battlefield amidst his dead comrades while his victorious enemies stroll through the corpses knows exactly what I’m talking about. So long as the enemy is present, he *cannot* move: his biology will not allow it.

Again, mere shaking, if the previous steps have *not* yet been performed, does *not* turn off pause.

Many of my patients who have been stuck on pause for a long time don’t even comprehend when I describe the “head wobble,” and the “shiver or shake.” Even when I demonstrate these moves, they often insist, usually without even trying, that they cannot and will not do these moves.

Somewhere deep inside, these moves are being prohibited by a core biological law. That law states that a person who is on pause shall not move the head and spine in that specific manner until he has confirmed that the danger has passed.

Pause turns off

As soon as the fifth step is convincingly performed – performed well enough to re-activate the spinal (sympathetic) nerves – the person instantly shifts out of pause and into a high level of parasympathetic (relaxed joy) mode

My soccer patient at the fourth step

Getting back to my soccer-playing patient, when he got to the last two steps, in which he needed to wobble his head and allow a shiver to run down his spine, he absolutely couldn't do it.

As already mentioned, *inhibition* of this reflex is the norm in people who are pause. If a person has been stuck on pause for an extended period, he may no longer be able to even *understand* the idea of wobbling or shivering. I had to hold his head and shoulders and very gently move them for him.

We repeated all the five steps over and over. I needed to assist him, the first several times, by gently rocking his head left and right, and then gently shaking his shoulders to replicate the “shimmy” or “electrical shiver” travelling down his spine.

Expanding on my patient's step one

The first step in coming out of pause is acknowledging that damage has occurred. My patient did this by imagining he was looking inside his head at the place where he'd been injured, at the impact point. He then confirmed that his body was now physically stabilized by mentally noticing this part of his head was minutely trembling inside.

This was easy for him to do. I asked him to imagine that he was looking inside that dark part of his head, and tell me if the dark area inside was heavy and motionless or slightly trembling.

He replied, “That's easy. It actually *is* trembling...”

This subtle internal tremor from an injured body part is a message to the brain from the injured part of the body saying that the physical damage, the *internal* damage, is no longer *life threatening*. The *body* is now stable enough to come back to life – so long as the brain confirms that the *external* danger is also gone.

I had the patient imagine that he was gazing at the trembling area, just calmly noticing it.

Next, I had him imagine that a loved one was standing nearby, gazing at the trembling area *with* him. The feeling of safety generated by being comforted by something *outside* of oneself can serve as the signal to the brain that the person has now arrived at a “safe place.” Finding oneself in a “safe place” biologically satisfies the rule that the predator must be gone and/or any other form of immediate, life-threatening risk must be over before the person can move his head and shiver his spine.

He had *not* consciously felt *unsafe* prior to starting this exercise. However, just after he noticed, and mentioned to me, that he was starting to feel safer, the patient spontaneously took the next step: a deep inhalation and exhalation.

He then needed me to assist him in his first attempts at rocking his head and “shivering” the spine. He needed to repeat the five steps many times.

This need to repeat the steps is normal. The steps often need to be repeated many, many times if pause has been in place for years.

The fourth time he went through the cycle of the five steps, his shoulders started twitching. The fifth time, his shoulders and back starting doing little jerks back and forth as if the frisson that *should* automatically travel down the spine was trying to manifest. It didn't look to me like a fully recovered shiver, but his one-hour appointment was nearly over. I asked him to continue doing the five steps at home if he still felt he was observing himself from outside his body.

But when he stood up and got ready to leave, it was clear that his work had already shifted something. His eyes filled with tears. He said, "I'm so different..."

I asked him to walk back and forth across my office to make sure he wasn't going to experience delayed concussion symptoms, a not uncommon response.

He stopped in mid-walk and turned to me, saying, "I want to run and play! I want to play!" He then looked puzzled, and said softly, "I don't know why I said that. The words just came out of my mouth..."

He resumed pacing, saying softly, mostly to himself, "That's really weird..."

Then he said, "I'm so short!" He was six foot, six inches tall. But he suddenly had *feeling* awareness of being the height of an eleven-year old.

When processing an old, long-ignored injury, one often feels the simultaneous sensations of being the "old self" (the self at the time of injury) *and* being the current self.

A person's brain may need some time to reconcile its somatic (sensations inside the body) sense of self from the time when he went into pause and reconnect that sense with his *current* body. The time required for processing the integration of previous, paused somatic awareness and new, current somatic awareness isn't too long, usually just a few hours, never longer than a few days, in my experience.

I'd seen people act like four year olds and even younger after recovering from long-term pause, so I wasn't too concerned about an eleven-year old. Eleven year olds usually have the ability to be circumspect to some degree.

In general, the older the person is at the time of the original shock, or the more recent the shock, the less time it takes to integrate the somatic awareness of the old self at time of injury and that of the current self.

I wanted to make sure that he was actually experiencing a shift out of pause mode and into parasympathetic mode. I asked him to look out the window at the flowers, the trees fifty feet away and the blue sky.

"How does it look?" I queried.

He stared, transfixed. Then he said, softly, "It's beautiful. It's sparkly, it's so bright!"

Bingo. He was in parasympathetic mode. By definition, this meant that he was no longer on pause. Parasympathetic mode is the neurological system used when a person is contented, playful, or happy. A person *cannot* be on pause and use parasympathetic mode at the same time. They are mutually exclusive modes, using mutually exclusive electrical currents.

As an aside, an exquisite enhancement of perception is normal when a person first comes out of pause and is temporarily in a high degree of parasympathetic mode. During pause, sense perceptions are somewhat muted. When a person turns off pause and jolts back into parasympathetic mode, the senses – vision, hearing, taste, smell, and tactile senses – all feel ultra-enhanced in a beautiful, joyful way, for a brief while, before settling back to normal.

“Normal” for most people is somewhere in the *middle* of the parasympathetic/sympathetic continuum. Sympathetic mode (“fight or flight”) also alters perceptions, but in a different way than pause mode. Most healthy people, when *awake*, are nearly always using a blend of parasympathetic and sympathetic mode: using sensory perception that blends a bit of glory with slightly narrowed perception and a bit of risk assessment.

In the brief moment when a person first comes out of pause and is, for a short while, in a very high degree of parasympathetic mode, his perceptions and sense of being inherently connected to or resonant with things outside of himself are briefly enhanced and emotionally uplifting.

Health providers in emergency rooms are familiar with this short spurt of radiant bliss that often manifests when a patient is pulled back from the brink of death.

Getting back to the subject of my now bright-eyed patient, I quickly checked the electrical currents in his knee and spine. They were all running normally. His knee pain was receding. A few days later, his red, bumpy, painfully itching skin, a problem that no MDs could make sense of, began healing.

When I saw him again two months later, the skin condition that had been “driving me crazy” was nearly gone.

Another case study: the patient with a perm

My patient, age 26, female, had frequent, violent, migraine-type headaches. She was in the emergency room several times a month from dehydration from vomiting and inability to eat due to the blinding, crippling pain of her headaches. “Headache” is far too mild a word for the tortures she experienced, but that’s the word we’re stuck with. Repeated radiological tests showed “nothing wrong” in her head.

Her headaches began shortly after she slammed her head into the parallel bars on the schoolyard playground, when she was ten years old. She’d been swinging around the bar as fast as she could when she lost her grip and flew off. Her head bashed into the opposite bar as she crashed to the ground.

She was still lying on the ground, dazed, probably concussed, when the impatient schoolyard monitor commanded her to get up off the ground and go back to class, as the bell had already rung.

She went back to class. The headaches started a few days later. Since then, she’d missed a lot of school. She was still a student, taking some college classes part-time, but living at home, as she often needed nursing-type care for days at a time.

When she came to see me, I used extremely supportive, firm but nearly motionless FSR techniques to induce relaxation in the terrifically tight muscles all over her head. During my third session with her, her head muscles finally relaxed, she took a deep breath and her body gave a little shiver. A moment later, a weird, very distinctive, caustic smell assaulted my nostrils. I was surprised, because her long hair was only slightly wavy.

“Did you just get a perm? I inquired.

“Oh no, I never get my hair permed. Why do you ask?”

“Because your scalp is giving off the smell of a day-old perm that hasn’t been washed out yet.”

“What? Ew, yeah! I can smell it too! But I didn’t get a perm.”

“Did you *ever* get a perm?”

“Oh, years and years ago. I haven’t gotten one since I was a child.”

The perm stink was nasty. I got up and opened a window. I went back to silently, supportively holding her head.

After a few minutes, she volunteered, “I just remembered when I got my last perm. School-picture day was coming up. It was the day before my head injury. I was ten. I hadn’t washed my hair yet because you have to wait a day before washing it out.”

I replied, “The day you hurt yourself, your scalp was full of those chemicals. They haven’t been washed out yet. I suspect your scalp tightened down when you got hurt and hasn’t relaxed enough since then to release those chemicals. Your body, or at least your scalp muscles, have been on “hold” ever since your accident. Your head smells as if you just had the perm yesterday.”

She agreed. The smell went away over the next two days, as it should, after she shampooed her hair in her usual manner.

This quick case study provides another example of the weird, unexpected ways in which a body, parts of a body, or a mind can go into pause, be put “on hold,” or can “lock down,” in response to a life-threatening injury...and get stuck there.

The parts of the body or mind that are locked down might not go back into genuinely normal behavior until the life-threatening damage has been attended to and the immobilizing pause response has been turned off.

The passage of time has nothing to do with whether or not healing takes place. If a person is stuck on pause, the behaviors that kicked in at the time of the damage, which might include protective holding patterns of muscles, wary thoughts and altered perceptions, and/or some or all of the electrical patterns of pause, might *not* turn off until pause is fully terminated via the five steps.

The western understanding of pause

Pause mode is poorly understood from a western perspective. In Chinese medical theory, the unique electrical behaviors that kick in during near-death are recognized as the fourth “phase” (mode). The Chinese name for this neurological mode translates as “Clinging to Life.”

Western medicine, incorrectly, assumes that there are only two neurological modes. Therefore, it considers the biology of near-death to be a strange variant on the flight or flight mode.

If western doctors bothered to note the changes that occur in sub-dermal electrical circuits when a person slides into pre-death, they would see that, in near-death, several of those circuits run in the *opposite* direction of how they run in sympathetic. Also, the neurotransmitter behaviors are nearly opposite: in pause, the adrenal (adrenaline-releasing) gland in the mid-back is inhibited. In sympathetic mode, adrenaline release is hyperactive.

For lack of any useful western terminology, I use the word “pause” to refer to the neurology of pre-death shock.

Pause mode kicks in instantly in response to excessive loss of blood, excessive perforation of the skin, excessive damage to the brain, near death from fever illness, or near-death from almost any physical or emotional damage that threatens to terminate life.

This mode is supposed to self-terminate when the danger assessment process says “I’m OK now.” This thought is followed by a deep breath, a head wobble, and a spinal shimmy or shudder. This should happen very quickly, as soon as the immediate threat of death is over. But...

Some people slip into this state but, for a variety of reasons, don’t fully come out of it. Their electrical system continues to run, a lot or a little, as if they are still on the verge of death. If this happens, the more subtle types of healing such as swelling in response to injury, repositioning of displaced soft tissue or bones, and deep emotional repairs might not occur. So long as a person is even somewhat stuck in this mode, in the state of near-death, only stop-gap healing measures such as forming scar tissue and stopping bleeding might be available in the immediate danger area, or bodywide. For example, in those cases where broken bones “refuse” to knit, it can be because the patient is stuck on pause.

A person who has *not* been able to turn off pause mode might feel constantly alert, even wary, not able to *truly* relax. He might even become increasingly numb to his own somatic (inside the body) sensations, or his own emotions. While he may be aware of and sensitive to the emotions of *others*, he might come to feel as if he is emotionally numb to his own heart.

Very often, a person in this state considers his absence of emotionalism and his numbness to personal pain either as a sign that he is deeply relaxed or “in control” of himself. If he thinks this, he is very, very wrong.

Being almost dead is *not* the same thing as being relaxed or in control.

Being relaxed is healthy. The chest expands. Breathing is deep and full. One has increased awareness of sensory experiences from a perspective of bemused benevolence, curiosity, or joy.

While deeply relaxed and awake, a person might become aware of injuries or traumas that happened earlier in the day - injuries that were put on hold until the

person has time to calmly focus on the them. Once the person mentally “processes” the injury or pain, moving it from what you might call the “holding pattern” or “in-box” in his brain over to the “historical interest” part of his brain, the body is able start healing the injury in earnest.

Oppositely, being even *somewhat* in pause – a situation where just one or a few body parts are on pause, as opposed to being bodywide stuck on pause – can prevent full healing from a large array of injuries and trauma. Being stuck on pause can have long-term physical and mental consequences ranging from chronic and mild to degenerative and devastating.

As for relaxing, relaxing *cannot* bring a person *out* of the neurological state of almost-dead. Specific, pro-active behaviors starting with the determination that the risk is now gone, leading to a few highly specific physical movements, are required to terminate the pre-death state.

Most people who go into pause perform these pause-ending actions automatically, as soon as their body and mind agree on two points: the body’s damage has been stabilized enough for now *and* any *imminent* danger has passed.

So long as *any* part of the body or mind is behaving as if it is still at risk of impending death from physical or emotional damage – fully or partly on pause – the body might not heal efficiently and fully from illness or injury, including subsequent injuries.

The possible health problems that can arise from failure to *completely* terminate pre-death shock have a wide range: from digestive impairment and metabolic problems to problems with the autonomic nervous system. The autonomic system regulates temperature, breathing, heart rate, and other “automatic” functions. Problems might be local (in one specific location) or body-wide.

Examples of “local” problems are chronic pain, numbness, clumsiness, weakness or tumors in the vicinity of an injury that hasn’t fully healed. The injury that failed to heal might have mentally been placed on hold. The mind may have been told to dissociate from the injury or the body part: pretend that the injury never happened or that the body part in question doesn’t exist.

Body-wide health problems stemming from either pause or dissociation from one’s body can include syndromes ranging from the relatively common, such as idiopathic Parkinson’s disease, to the rare and even obscure, such as dissociative identity disorder (previously known as multiple personality disorder) and Cotard’s syndrome.¹

¹ Cotard’s is a rare syndrome characterized by denial of the existence of the body or some body part, inability to feel one’s body or some body part, a feeling of being dead or, oppositely, in rare cases, the assumption that one has become immortal (alive despite having no physical body). Cotard’s syndrome, defined in 1880, was and is considered to be a purely psychological problem, even though cases usually follow a life-threatening injury or emotional trauma and the symptoms can be consistent with failure to completely come out of near-death shock.

Being stuck in pre-death shock can also cause a wide range of mental and emotional problems such as a feeling of being separate from and/or unable to resonate with other humans, and/or an inability to feel calmness, joy, or the sense of expansion in the chest that normally occurs in response to something beautiful or poignant.

These problems may develop slowly, over decades. But everyone's different: some people's pathologies might kick in much sooner – within weeks or even days. It's impossible to guess how any given individual will respond to being stuck, even partially, in the neurology of near-death.

Pause can sometimes be *masked* by a mentally-induced adrenaline override. While using high levels of adrenaline, a person who has gotten stuck in some aspect of severe shock, a condition usually characterized by immobility, might nevertheless come across as stronger, faster, and more focused than most of his colleagues.¹

¹ The actual neurotransmitter being used is most likely norepinephrine – a close cousin of adrenaline.

Most people in the USA are familiar with the word “adrenaline” and understand it to be the neurotransmitter of “fight or flight,” or “emergency.” In the UK, this neurotransmitter is called “epinephrine.”

Based on brain research, the actual neurotransmitter used to temporarily override near-death shock is probably norepinephrine.

Most people, in my experience, aren't familiar with the word “norepinephrine.” Therefore, to make it easier on the reader, I just refer to this neurological override as an “adrenaline override.”

Much of my research on pause comes from working with people with Parkinson's. People with Parkinson's disease are able to override the fact that their body is constantly using pause mode by activating neural norepinephrine. (“Neural” means it comes from cells in the brain, *not* from the adrenal gland).

A research study in 2007 proved that norepinephrine is the crucial element in the immobility override. Using lab mice, researchers at Emory University proved that merely destroying dopamine neurons in the brain does *not* create Parkinson's-like motor behaviors (Parkinson's motor function inhibition is a perfect match for the motor inhibitions of pause).

Mice, like people, are able to use norepinephrine, a fight-or-flight emergency neurotransmitter, to stay physically mobile even while their dopamine-movement neurons are inhibited. Only when the norepinephrine-releasing neurons in the brain's locus coeruleus area are *also* inhibited do the mice manifest behaviors characteristic of Parkinson's. (Research suggests that Parkinson's symptoms can be hidden (subclinical) for decades and do not begin to *appear* until the person is no longer able to summon up a constant mental sense of emergency, one sufficient to trigger adequate release of norepinephrine: the “adrenaline override”.)

See: “Norepinephrine loss produces more profound motor deficits than MPTP Treatment in Mice”; K.S. Rommelfanger, G.L. Edwards, K.G. Freeman, et al; *Proceedings of the National Academy of Sciences of the United States of America*; 2007 Aug 21; 104(34):13804-13809.

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As you will learn in later footnotes, researchers have known since 2001 that people with Parkinson's have more than enough dopamine. Dopamine levels are *not* the problem. The problem is that, during near-death shock, a person is biologically *inhibited* from using dopamine in the motor area of the brain until the person acknowledges that he is safe.

In my research, I have learned that many people with Parkinson's disease decided, as children, that they could *never* be safe. They have been using pause plus a brain-based adrenaline override (technically, a “neural norepinephrine” override) for motor function ever since childhood. When the ability to sustain this override begins to decline, the underlying immobility of pause becomes increasingly apparent, and the person exhibits the symptoms that we call Parkinson's

For decades, due to his elevated adrenaline levels, this person might exhibit a heightened intensity of focus and purpose, with piercing eyes and a powerful smile even while insidious health problems are developing and true relaxation is elusive. Friends might lovingly say to him or her, “You think too much!” or “You should relax now and then.” He or she might reply, laughingly, “I’ll relax when I’m dead!”

So true.

As an aside, a person on pause might think he *is* capable of feeling heart joy based on the exhilaration he sometimes feels. But in these cases, the stimulation he feels usually turns out to be the adrenaline-based stimulation of exciting, compelling, or even dangerous thoughts and activities. He might *not* be able to feel actual joy, a heart-based feeling that is not dependent on outer circumstances.

There are exceptions to this rule in people with *self-induced* pause. They will be addressed in the chapters on *self-induced* pause.

In summary

This book teaches how to turn off pause mode so that healing from trauma can begin. An unprocessed trauma might be the original cause behind an “incurable” chronic pain or illness.

Living while neurologically staying on the verge of death might inhibit healing. At its worst, it can lead to localized or even body-wide syndromes of “incurable” illness.

If the *body* is nearly ready to come back to life but has not yet gotten a *mental* confirmation that the danger has indeed passed, an internal tremor, external tremor, or shivering might also be subtly or overtly present.

Other ways to get stuck on pause

Taking a sneak look ahead, many of my patients have gotten themselves stuck on pause after a terrible injury or fright via ***deciding*** that they can *never* again be safe: danger will *always* be imminent. (Sometimes expressed as “Only an idiot could think he’s ever really safe in this world.”)

Others have self-induced pause. They inadvertently initiated the use of pause mode by ***commanding*** themselves to not feel physical or emotional pain, or by deciding that they would “spiritually rise above” their suffering by being numb to it.

For people who have self-induced pause, the five steps will *not* turn off pause. Instead, these people must first destroy the long-forgotten instruction. This subject is discussed in the second part of this book, in the section on self-induced pause.

In my experience with hundreds of people with Parkinson’s disease, just over ninety percent of them have *self-induced* pause.

disease. When people with PD turn off self-induced pause, their Parkinson’s symptoms cease, permanently.

For now, the main point is that a person *cannot* relax or “affirm” himself out of pause. Relaxation is an expansive, loving, calm, and/or joyful state, one that *cannot* be attained while desperately clinging to life.

A person on pause might be able to make himself *appear* calm in the sense of not visibly moving, but he is not actually relaxed: he cannot access parasympathetic mode.

As for positive affirmations, I have seen that they do *not* turn off pause. It took me years to figure out why. The several reasons for this will be discussed later.

For the most part, when not using an adrenaline (norepinephrine) override, a person on pause *might* feel heavy, painful, or even rigid in some *parts* of his body *or* bodywide.

He might be physically or emotionally numb.

He might perceive himself as being outside his body, *observing* himself rather than *being* inside his body and somatically experiencing himself.

He might be constantly wary about the future and/or dwelling on the past. *Not* relaxed. *Not* somatically living in the moment. Maybe not even living inside his body.

Stuck on pause.

What's in a name?

The word “shock” can be used to describe a person whose body is on pause following life-threatening damage. But “shock” is not actually a specific medical term. “Shock” is a vague word, one that describes situations ranging from the mildly disturbing to pre-death.

A person might say, “I am shocked, shocked, to learn that illegal gambling is going on in this café!”¹

Or he might say, “I was so shocked when he said that to my grandmother that I punched him in the mouth!”

In the first example above, the word means “surprised”. In the second example, the word “shock” means “outraged.” The response to this outrage might be the adrenaline-drenched, heart-pounding energy of a high degree of sympathetic mode – the mode that is nearly the opposite of the stillness and withdrawal from the body that occurs during pre-death.²

Neither of the above examples of the word “shock” describes a highly specific medical condition in which certain muscles might be somewhat tightened up and other muscles relaxed, thus pulling the arms, legs and torso closer to a fetal position. The person’s heartbeat might be slow and/or barely detectable, his breathing slow and faint, blood pressure low, digestion stopped or evacuating (vomiting or diarrhea), the skin cold or clammy, facial expression blank and/or eyes somewhat glazed. Most biological functions are *paused*, or minimized.

All of these are symptoms that might appear when a body is on pause from a potentially mortal trauma, including excessive loss of blood, excessive perforation of the skin, concussion, and/or violent, deadly emotional shock. Either the body is going to navigate its way back to life...or die.

Tremor, either subtle and almost microscopic, or else overt and easily visible, *should* occur when one is beginning to come out of pause. Tremors that arise while coming out of pause are usually a sign that the body is doing a bit better, becoming more stabilized: starting to come *out* of danger. Tremor is a way of the body saying

¹ Captain Renault, in the 1942 movie “*Casablanca*”.

² Many people reasonably assume that the word “sympathetic” must refer to a state of sympathy, or compassion. Nope. The sympathetic system got its name in the 1800s. Marconi, in his experiments on frogs, noticed that the legs of dead frogs would jerk in response to electric stimulation of the frog’s spinal nerves. Because these spinal nerves reacted “in response” to something (an electric jolt), the response was named “sympathetic,” meaning, “responsive.” Decades later, it was discovered that the spinal nerves are the nerves activated in times of fear or rage. As it turns out, all the nerves in the body, not just the spinal nerves, are activated via electricity They are *all* responsive. But we still use the now inappropriate word “sympathetic” to refer to a system that is activated in response to fear or rage – not sympathy.

to the mind, “We *were* hurt but now we’re *physically* stable again: is the immediate, *external* danger gone? Now is it safe to turn off pause and come back to life?”

In western medicine, the neurological mode of pause has no name. A doctor might refer to a patient as being in “severe” or “traumatic” shock, suggesting that the symptoms are just a more extreme version of “shock from surprise” or “shock from rage or fear.” The word shock, by itself, is biologically ambiguous.

MDs might need to use modifiers such as “tonic immobility” (muscle rigidity) and other specific metrics to convey just what condition a given patient is in, after they have first applied the vague, blanket term “shock.”

Because so many systems in the body are put on pause while in a state of profound shock from life-threatening physical or emotional damage, I refer to this neurological mode as pause.

Conflicting ideas about neurology and shock

In the nineteenth century, western medical theory taught the fact that there was only one neurological mode or “set of responsive behaviors”: emergency mode. Everything else was just “passively normal.” In the twentieth century, western medicine changed that “fact” to the existence of two modes. In the twenty-first century, western medical theory still *incorrectly* assumes that a person has only two modes. The first is excited and/or stressed mode (sympathetic mode, over-dramatically nicknamed “fight or flight”), and the second is its opposite: calm and/or joyful mode (parasympathetic mode).

In much of the twentieth century, it was assumed that a person was using only one mode or the other at any given time. More recently, in the last thirty years, some medical professionals have realized that most people are using some of *both* modes at any given time: they are somewhere on a continuum between “pure” sympathetic mode and “pure” parasympathetic mode. However, many doctors still use language that suggest a person is in one mode or the other, not both.

Also, western medical theory has long presumed, incorrectly, that the immobilizing symptoms that occur in response to life-threatening physical damage are simply an extreme expression of “stress” or “emergency.”

Chinese medicine has recognized, for thousands of years, that the neurological behaviors that kick in during a potentially deadly injury are the results of a completely different, rarely activated, neurological mode.¹

¹ In Chinese medicine, the four modes are described, but not have snappy names. “Clinging to life” is one of four neurological phases. “Phases” is *often* (poorly) translated as “seasons.”

The other three phases correspond to parasympathetic (“Close to the Divine”), sympathetic (“Running from danger”), and sleep. Sleep mode, like pause mode, is not recognized in western medicine as a distinct mode with its own electrical schematics and shifts in organ behaviors, neurotransmitter release, and consciousness. For that matter, in western medicine, sleep behaviors such as *lack* of conscious awareness are wrongly – and illogically – assumed to be an extreme expression of parasympathetic mode, the fullest expression of which is heightened, *expanded* awareness.

In pause mode, in order to “cling to life,” as it says in the Chinese classic book of medicine, the *Nei Jing*, unique electrical currents are triggered, unique organ behaviors kick in, even a unique set of thought patterns are activated.¹

These pause-specific electrical patterns, organ behaviors, and thoughts cannot be turned off until highly specific movements and, in humans, specific thoughts, are executed. These movements and thoughts were described as “five steps” in the preceding chapter’s case study of the soccer player.

Some patients, as soon as they are able to truly relax, as with the patient with a perm, automatically experience the deep breath, head wobble, and spinal shiver.

Still other patients, those who have intentionally put themselves into pause by various methods, such as commanding themselves to not feel pain or emotion (often done while staring into a mirror), or by creating an alternate personality that can’t be hurt, are not able to come out of pause until they first turn off the mental instruction that they used to self-induce pause in the first place.

The underlying problem for people with self-induced pause is that they did not include instructions to their own mind as to when to turn *off* their instruction to be impervious to physical and/or emotional pain. The pause behavior that stepped up to fulfill the mental request has never turned off.

Their pause-like condition will not turn off until the person turns off the instruction. Due to a biological feedback loop, inducing pause makes a person feel, over decades, increasingly *not* safe. An effective instruction to turn off pause *cannot* be issued by the mind until the person feels safe. The person is stuck in a downward spiral into severe pause, a spiral of his own, inadvertent making.

In 2014, I stumbled across new information derived from brain scan research that led me to the solution to this problem. By reverse-engineering some thought patterns, a person can train his striatum to behave as if he is safe. Once this new pattern is established, the person can turn off his pause-inducing instructions. When he does this, the self-induced pause will cease. He might not even have to go through the five steps that turn off pause, since the person was never truly stuck on pause, but was merely commanding himself to *behave* as if he was.

The biological changes that can occur in self-induced pause resemble those of true pause, but there are also some distinct differences, in addition to the steps required to turn it off.

In closing, what’s in a name? Plenty. Some of my colleagues disagree with my choice of the word “pause” because it’s “too innocuous.” They feel a drastic mode such as “pre-death shock” deserves a more powerful name: “zombie mode” and “doom mode” have been suggested, to name but two.

¹The *Nei Jing* is a collection of medical and philosophical writings by various authors. Scholarly analysis has determined that it was compiled circa 400 AD. Most modern practitioners of Chinese medicine consider that their medical theory is based, for the most part, on this philosophical tome.

In line with historical tradition of the day, the compilers, showing the expected modesty, ironically attributed the entire philosophical/medical collection to a short-lived emperor, circa 221 BC, a military despot who despised philosophers and had them buried alive.

I think that the name “pause” offers more hope.

After all, even if some biological mechanism gets “stuck on pause,” the phrase suggests that all you really need to do to “unstuck the pause button” is to get the “play” button activated again. As it turns out, this is apt.

You now have two new medical terms. They are short and snappy. They aren't in Latin. Their meaning is easy to understand: pause mode and self-induced pause.

Using adrenaline while on pause

One of the more fascinating behaviors that can occur when a person or animal is on pause is the ability to activate skeletal muscles if movement becomes utterly necessary. Immobility, a complete lack of movement, is the standard behavior while on pause. However, in cases where movement is immediately required, an animal on pause can create an adrenaline-based override of the pause system. As noted in the first chapter, the actual neurotransmitter is an adrenaline cousin, norepinephrine, but in this book the word adrenaline will be used because more people have an intuitive understanding of “adrenaline” and the “adrenal gland.”

Despite the use of an adrenaline override, many of the behaviors of pause can still be in place, including the pause-type electrical currents, the inhibition of digestion, the shunting of blood interiorly, inability to feel physical or emotional pain, and self-awareness being located outside of the body. However, despite being on pause, a purely mental determination that movement is called for *can* activate the adrenaline-based part of the motor area in the brain, thus allowing physical movement even in an animal that is on the verge of death. A dying animal’s body will behave *electrically* as if he is rigid and immobile, while using a neural (coming from the brain, not the adrenal gland) adrenaline override to provide movement.

A common example

A mouse is caught and clawed by a cat!

The mouse will usually collapse into an inert state immediately after the cat’s claws perforate the skin. The mouse will lie motionless: on pause. The claws and limbs will be pulling in towards the fetal position. The skin and extremities will be cold. The breathing rate and heart rate will be extremely low.

The mouse is *not* “pretending to be dead.” She is immobilized due to excessive perforation of the skin, which is one of the many types of injury that induces pause. In many cases, the cat will lose interest in the cold and rigid mouse. If the cat then ambles off, looking for livelier sport, the mouse will soon, within minutes, execute the five steps that turn off pause, and scamper back to life.

However, if the motionless, paused, mouse sees through its unblinking eyes that the cat is now moving towards her *nest* where her babies await, this mouse will be able to trigger the release of an adrenaline override. A surge of adrenaline will enable her to move powerfully, in a manner that might distract the cat from its interest in her babies.

The mouse’s body is still on pause, in terms of its electrical system, blood being shunted away from the skin, digestive inhibition, and other pause characteristics. However, so long as she is capable of it, she might use an adrenaline override to distract the cat by running in the opposite direction of her nest, or she might even attack the cat with her last dying breaths. Neurologically, electrically,

this mouse is on pause. But the adrenaline override might allow her to behave dynamically – even more dynamically than usual.

When her purely instinctive goal of diverting the cat has been attained and if the mouse gets herself to a safe enough location, she will revert back into the rigidity of pause. Only when the mouse has recovered sufficiently from her physical damage will she then execute the five steps. Only then will she be able to truly “come back to life.” Only then will the mouse be able to use the normal blend of parasympathetic behaviors and sympathetic behaviors.

Humans also can activate an adrenaline override while the body is on pause. However, a person who uses this override to get himself moving *might* never get around to executing the moves and thoughts that terminate pause.

This is most often the case if the person is highly analytical, word-based, (what some people call “left-brained”), highly focused, with a high level of self-control, and has decided that life itself is dangerous – that the danger of imminent damage or death is *always* present.

If a person has decided that the danger of imminent death is always present, this decision can prevent a person from turning off pause. In this case, the person might never terminate pause until he *consciously* decides to do so and *consciously* decides that he is, in fact, safe enough to be alive again.

Remember, one of the five steps in turning off pause is confirming that one has become, once again, safe enough to live. If life can never be safe enough to live, then pause will *not* turn off.

In such a case, when pause cannot be turned off, some of the person’s electrical systems, organ behaviors, and thoughts characteristic of pause may continue running, to some extent, as if the person was still in a near-death state. His use of adrenaline to override the rigidity and immobility of pause might become semi-permanent. If so, pause-type thought patterns, movement style, and heightened risk awareness might become chronic. An inability to access some of the “finer feelings” such as poignancy, joy, or the sensations of resonance with others might also become chronic, or at least predominate in the person’s personality.

After enough of the actual near-death damage has stabilized, a person who has decided that danger is always present might be able to *appear* almost normal via constantly summoning up a mentally driven adrenaline override. Even if he *doesn’t* execute the movements and thoughts that turn off pause, he can appear to move normally, while often coming across as a bit “intense,” by using adrenaline instead of dopamine to go through the motions of daily life.

In the case of the concussed soccer player in chapter one, he had grown into a person who felt a constant need to burn off his high levels of adrenaline. He worked in a physically demanding job and spent his spare time bicycling, hiking, and rock climbing. He did not know how to relax. He couldn’t access parasympathetic mode. He was stuck on pause, with an adrenaline override.

A person who is stuck on pause might *appear* highly functional, even hyper functional. In the years following his pause-inducing trauma, if his adrenaline levels happen to drop below the level needed to provide mobility, he may find himself using negative or highly stimulating thoughts to resume “excited and stressed” brain behaviors, thus bringing his adrenaline levels back up. By learning to use thoughts that increase adrenaline levels, a person who is stuck on pause can be able to move nearly normally, using adrenaline-based motor function, for decades.

Healthy people use mostly dopamine-based motor function. Just as adrenaline is the main neurotransmitter (nerve-activating chemical) for sympathetic mode, dopamine is the main neurotransmitter of parasympathetic mode. Healthy people, and the very best world-class athletes, usually rely on dopamine-based motor function. Athletes who rely on fear, tension and adrenaline to maximize their performance never fly quite so high or swim quite so effortlessly as those who perform out of joy, using dopamine. Healthy people usually turn to adrenaline-based motor function only during times of fear, rage, or emergency.

I do *not* refer to people on pause as being in sympathetic mode when they are using adrenaline. I say they are “on pause while using an adrenaline override.”

A *healthy* person, in response to rage or fear, *decreases* his use of parasympathetic mode and makes a corresponding *increase* in sympathetic mode. This leads to specific electrical and biological changes, *including* an increase in adrenaline levels.

A person who is on *pause* while increasing his levels of adrenaline undergoes a somewhat different set of electrical and biological changes.

For example, a healthy person shifting into a higher degree of sympathetic mode will usually experience a short-term increase in blood pressure. A person on pause who summons up an increase in adrenaline might *not*. His blood pressure might stay low and his *adrenal* gland might not be discharging adrenaline even though his brain’s awash in *neural* adrenaline.

For another example, a healthy person sliding into a higher level of sympathetic mode will have a surge in amperage in the soles of his feet, the better to provide for a foot-based response to danger. When a person on pause activates an increased adrenaline response, the electrical circuitry to the soles of his feet remains inhibited, as it is during pause. If any increased foot movement is called for, it will be driven by mental commands to mechanically move the fairly numb feet.

Again, a healthy person who is upping his use of sympathetic mode has different biology than a person who is on pause while using an adrenaline override.

Really?

If you consider this ability to use an adrenaline override while staying on pause to be unlikely, or even impossible, consider your own sensations when you’ve been awakened in the middle of the night by a hideous crash and a tiny, shrill shriek coming from the alley behind your house. Your heart is pounding as you stagger into a bathrobe, grab a flashlight, and try to focus your eyes as you stumble out into the night. Arriving at the scene, you see the trashcan is overturned and raccoon

footprints are everywhere. You sigh, realize you forgot to put the bungee cord on the trash can lid, and head back to bed. Once you get into bed you realize that your arms and legs feel strangely rubbery, your stomach feels dreadful, your breathing doesn't feel right and your heart is still pounding even though there is *nothing* wrong.

This is a classic episode of *sleep* mode with an adrenaline override. Your arms and legs were moving, thanks to adrenaline-based commands in your brain. But your arms and legs didn't actually have a normal supply of electrical energy. During sleep, electrical amperage in the skeletal muscle of the legs is greatly reduced. So your legs were moving as per brain-based instructions, but they didn't actually have any electrical support for the movement, only brain instructions. You were essentially moving like a lifeless robot that is being activated by the radio control set (adrenaline-activated thoughts) and adrenaline-based motor function in your brain.

Meanwhile, your lungs were still using a minimal, sleep-type amount of oxygen. The electrical supply to the lungs was minimized because you were still in sleep mode. Your heart was *pounding* because your physical movements were using up way more oxygen than your sleeping lungs were able to accommodate.

This is how it feels to have your body's channel Qi moving in sleep mode while experiencing an adrenaline override. Just because you were using adrenaline, you weren't actually in sympathetic mode. In sympathetic mode, electrical energy in the currents of your legs, feet, arms and lungs is *increased*.

When you were going outside to check on the noise, most of your body was *electrically* in sleep mode even though you were using a blast of brain-based adrenaline in order to be awake and physically functional. Based on the channel Qi patterns in your body, you were *not* in sympathetic mode. You were in sleep mode with an adrenaline override.

To review, a person who is stuck on pause can temporarily override, with adrenaline (norepinephrine), many of the more obvious physical symptoms of pause, symptoms such as physical immobility from lack of normal, *dopamine*-based motor function. By using the override, he will be able to physically move, and maybe move powerfully, although his *electrical* system is using pause-type schematics.

Using adrenaline, he will be able to give the appearance of being perfectly OK, or even stronger or more focused than "weak," "dull," or "normal" people.

But – and here's the nub – he will *not* be able to access "relaxed" or "joyful" mode, parasympathetic mode, the mode in which most healing occurs. That access can only be obtained when pause mode is turned *off*.

And here's something that took me nearly twenty years to figure out: a person who is stuck on pause might not be able to access sympathetic mode, either. After years of pause, he might need to be retrained to use it.

Many of my patients in partial recovery from Parkinson's disease, who had been using self-induced pause since childhood, had to be taught to use the electrical schematics of sympathetic mode. And even then, they were often afraid to use it. They had to be gently retrained to "allow" themselves to experience sympathetic mode.

They were unnerved when they felt the somatic feelings and energy from a surge of normal adrenal *gland* function.

Many said something like, "Are you sure it's *OK* to feel like this?" or "Yuck. I feel like an animal!" and even, "I don't think feeling this way is very *spiritual!!!*"

No rest for the paused

A person who is stuck in some degree of pause mode while stimulating himself with a *neural* (brain) adrenaline override might *not* be able to truly relax unless he's sleeping, let alone feel calmness or joy. If he stops using the adrenaline override while awake, he risks experiencing the unprocessed pain that triggered pause in the first place. Turning off the mental adrenaline *might* reveal the underlying trauma from which he has failed to completely recover: he might feel stunned, or weak, but *not* peacefully relaxed. Ceasing to use adrenaline might temporarily diminish some symptoms, because it lets the person go into a deeply, quieter state of pause. But turning off the adrenaline will *not* turn pause *off*.

You cannot relax your way out of pause. You have to face the trauma, decide you are now safe, and then do physical moves to restart the system.

Life after pause

A person can turn off pause mode, however belatedly. After turning it off, he can resume a life that doesn't require invoking an adrenaline override just to brush his teeth or get up off a chair.

He no longer needs to stimulate adrenaline release via a sustained illusion of constant emergency or at least the cultivation of constant alertness, even wariness.

Once pause has been turned off, the person can resume a life in which he's able to *hear* or *receive* the sounds around him, rather than *listen* warily for them. He can *behold* his surroundings rather than *look for* danger and/or intellectually *assess* what's going on visually. He can *feel* once again the expansion of his heart in response to calm, beauty, love, and joy. He can relax and be intensely, fully alive again.

Neurological modes

“Neurological mode” is a term that refers to the *combination* of nerve behaviors, neurotransmitters (chemicals that activate specific nerves), brain and organ behaviors and motor (physical) behaviors that are unleashed in response to certain types of thoughts and/or external and internal stimuli.

Historically, in Chinese medicine, the idea of “neurological mode” includes all of the above. It *also* includes the highly specific flow patterns of “channel Qi” that are unique to each mode.¹

The term channel Qi includes the tiny, single-charge phenomena on the surface of every cell.

However, the term “Channel” most *often* refers to the large, easy-to-detect “rivers” of electrical current that flow in the sub-dermal (just under the skin) fascia.²

¹ For the benefit of my readers who are keen on Chinese medicine, you may recall the section from the *Nei Jing, Su Wen*, passage 13-9, that says, “Change of colors allow for the pulses of the four seasons that allow a person to be close to the Divine, run from danger, or cling to life.”

This nonsense would be helpful if the translators had used “four neurological modes,” or simply “four modes” instead of “four seasons.”

Also, it would have been more helpful if they had used the words “biological changes arising from” instead of the generic word “pulses.” To an English reader, “Pulses” implies “heart rate.”

Plus, Channel Qi, or “*Qi Se*” (literally “light-wave energy”), is the Chinese medicine term for the electrical currents that run all through the body. Due to lack of comprehension, *Qi Se* is sometimes translated as “colors Qi,” or even more off the mark, “complexion.” If the translators used “energy from lightwaves (electricity), which in English is called channel Qi, not “colors Qi,” this passage could have been useful instead of obfuscating.

If the translators understood what they were translating, you might have ended up with, “Shifts in channel Qi cause the various biological changes that occur in the four neurologic modes: parasympathetic, sympathetic, pause, [and sleep, which seems to have been dropped from the list of four].”

But I would bet that the modern translators had no idea what they were even writing about, especially considering that Channels and Channel Qi are now illegal in China.

So often, the Chinese classics, translated into English, are packed with quasi-literal ramblings that make the old teachings endearingly cryptic, meaning anything and nothing. It can be pleasing for those English-speaking students who enjoy that sort of thing. But it’s not medicine.

² Fascia, usually referred to as a membrane, is a highly conductive, body-wide complex tissue that constitutes 60% of the body’s volume, and connects all the body parts. Its anatomical name is “connective tissue.” Fascia is a 3-D, visco-elastic, temperature sensitive, highly organized liquid crystal system. It has semi-conductor, piezoelectric, and photoelectric properties. For more information about fascia, please read the first appendix in my book *Hacking Chinese Medicine*, available at www.JaniceHadlock.com. The appendix was written and contributed by Raymond Lord, CMT.

The study of channel Qi, the electrical currents that flow in the fascia, is no longer taught in most schools of Chinese medicine. Even basic channel theory, which explains the subdermal electrical schema of each of the different modes, is rarely taught in schools of Chinese medicine, in China or in the west. In modern times, most students of Chinese medicine merely learn the “ideal” flow patterns of the main channels: the flow pathways that occur in a person who is in perfect health, who is joyful, and motionless: pure parasympathetic mode.

These currents can easily be felt by hand. Nearly anyone can learn to feel these currents. It is far easier to learn than, say, learning to tune one's violin or guitar, feats mastered by millions.

Acupuncture students who are lucky enough to have this subject offered at their school can usually become competent at feeling the movements of a patient's channels within sixteen to twenty hours of practice. This is the amount of time in a one-hour per week class, over the course of one semester.

The sensations given off by the patient's channel Qi is objective, not subjective: two people trained in feeling channel Qi will both feel the same channel behaviors on a given patient.¹

This chapter will give a simple introduction to some of the flow patterns that occur in each of four modes. Don't memorize any of it, but just skim lightly, noticing the distinct and useful variations in electrical schematics that occur in each mode. Pause mode will be described last, so that the reader can appreciate just how bizarre the flow patterns of pause actually are. Compared to the other modes, whose Qi flow patterns vary from each other by just a bit, pause has currents that shunt deep inside the body, away from the skin, one current that stops flowing altogether and becomes a standing wave of energy, and one current that runs *backwards*.

Channel Qi flows over every cell of the body. In response to changes in thoughts, movements, injuries, and even the time of day, flow patterns change constantly, immediately, elegantly. Changes occur in the largest channels, just under the skin, and also in the smaller bifurcations that spread through the entire body and eventually over each cell. But this chapter will only consider the flow patterns that occur in the main channels, the "primary channels," which flow just under the skin. This chapter describes a sampling of the changes that occur in the primary channels when a person is each of the four modes.

Again, this casual introduction to how channel-Qi flow varies in the four neurological modes is provided so the reader might appreciate how truly different the *pause* patterns are when compared to the other three. *Don't* try to learn all this material. Just flit through it, enjoy the pictures, and then be stunned at the end of the chapter by how drastically altered the channel Qi flow becomes when a person is on the verge of death.

¹ *Tracking the Dragon* is a textbook for learning to feel the flow of the channels and differentiate, by feel, the different types of channels. This book's basics of learning to feel the channels plus its maps of the channels, are available online for free download at www.pdrecovery.org, the website of the Parkinson's Recovery Project, a non-profit that makes freely available information on treating Parkinson's disease using techniques and theory of Chinese medicine. This textbook, in chapters that are *not* included in the free materials on the pdrecovery website, also describes class assignments to help assure the marveling students that they are, in fact, feeling something objective. The *whole* book is available for purchase at www.JaniceHadlock.com.

Sympathetic mode

In sympathetic mode, the “fight-or-flight” mode, the *spinal* nerves are activated, the neurotransmitter *adrenaline* activates motor function and thoughts, the brain conveys motor instructions in a commanding “just do it!” manner, the digestion is shut down, and all sensory perceptions are interpreted in terms of risk.

The *drivers* for these changes include changes in the electrical currents in the fascia that flow down the back, directly over the spinal nerves. When a person is relaxed, in parasympathetic mode, the electric currents running down the sides of the spine, currents known as the Bladder channels, flow from head to foot at low amperage. In response to fearful or angry *thoughts*, these Bladder channel currents have a surge in amperage.

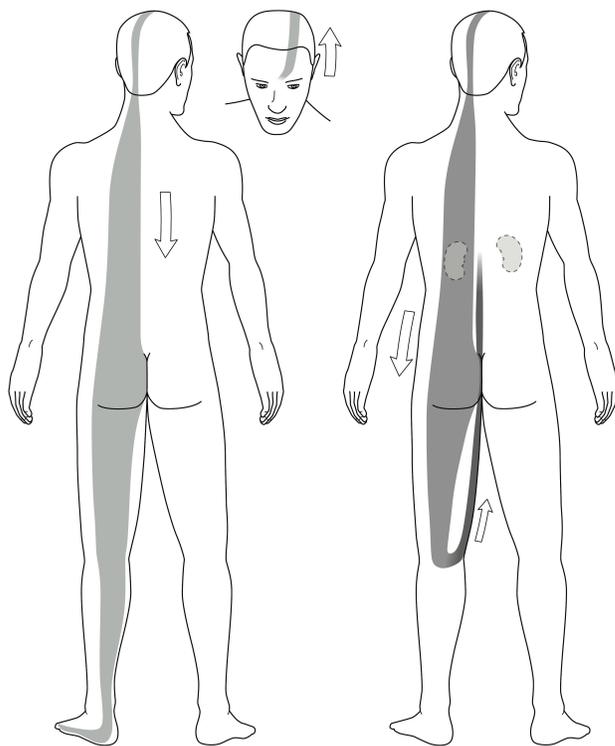
Angry and fearful thoughts activate the amygdala, small areas in the left and right sides of the brain, just under the path of the Bladder channel. An increase in activity in these brain areas increases the amperage in the Bladder channel currents running over these areas. This upped amperage flows down the length of the Bladder channel, causing changes in the physiology along this pathway.

For example, as amperage in these currents increases, the spinal nerves over

which these currents flow receive an increase in stimulation. Increased amperage over the spinal nerves causes increased sympathetic mode behavior in the organs.

The Bladder channels also change *shape* when they receive a large enough fear- or anger-based surge. When significantly amped up Bladder channel currents arrive at the back of the knees, the currents are shunted into nearby currents named “Kidney channels” that flow *up* the leg and deep into the torso, and then directly over the adrenal glands.

This surge of amperage at the adrenals releases a burst of adrenaline.



parasympathetic mode

sympathetic mode

Note: for the sake of clarity, the drawing shows only the left-side Bladder channels. A person actually has symmetrical left and right side Bladder channels. In sympathetic mode, both left and right Bladder channels change their flow patterns at the knee in response to an increase in amperage.

This type of shunt, or change in direction of a current, is a change in the current's electrical "schematics."

Practitioners of Chinese medicine refer to the schematic variations away from parasympathetic mode as "divergences." The schematics of each mode are different. The various electrical patterns drive the *physiological* changes that are observed in each of the different modes.

A doctor who can assess the flow patterns of the currents can discern exactly what mode a patient is using at the moment the doctor is making an examination.

Western medicine recognizes that increased stimulation of the spinal nerves and the adrenal gland occurs during sympathetic mode. Chinese medical theory shows *the mechanism* behind these changes in spinal nerve and adrenal stimulation. The chemical changes and releases can be understood by knowing the *locations* and *changes* in the electrical currents in response to thoughts: the changes that *cause* the increased stimulation.

By knowing the mechanisms behind these chemical and nerve shifts, a person who has studied Chinese channel theory can make an educated guess as to what's going wrong when these mode changes get stuck or fail to kick in correctly. Most acupuncturists *never* study channel theory in depth. It is *not* required in schools.

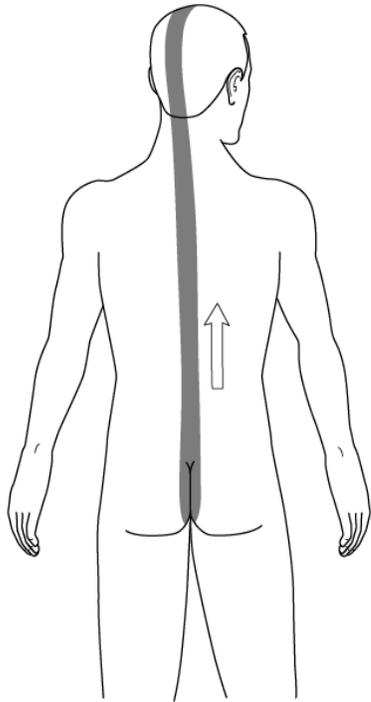
Like all channel currents, the behavior of Bladder channel currents is driven primarily by thoughts and secondarily by circadian rhythms. Thoughts also control the *amount* of a channel shift. The more powerful the thought of fear or rage, the larger will be the increase in amperage in the left- and right-side Bladder channels.

Other electrical shifts also occur during sympathetic mode, but I'm going to ignore them for now. This is still just an introduction to what is meant by "neurological mode." It's also an introduction to the role played by changes in channel Qi flow in each mode. The changes in the channel flow are the electrical drivers that trigger the recognized, physiological changes, including chemical and nerve activation changes, of the various modes. Thought waves instruct the electrical currents. Current changes influence cellular and chemical behaviors. This is similar to how wireless signals instruct your computer's electrical circuitry, which in turn makes variations in what you see on your computer's screen.

Parasympathetic mode

In parasympathetic mode, the mode for digesting food and feeling playful curiosity, the *vagus* nerve is activated, the neurotransmitter *dopamine* activates motor function and thoughts, the brain conveys motor instruction via *imagining* physical movement, the digestive system is activated, and sensory perceptions are interpreted in terms of pleasure, fascination, and fond memory. In this mode, the subdermal electrical currents run in the patterns that appear in beginners' textbooks of Chinese medicine.

The charts of acupuncture channels that are posted on the walls in many acupuncturists' offices show the channel-flow patterns for parasympathetic mode.



The Du channel
Note the directional arrow.

Most humans, when awake, are always using a blend of parasympathetic and sympathetic modes.

Most humans are *never* in *full* parasympathetic mode. If they are, their heart is barely beating, if at all, and breathing is barely occurring, if at all. The person is profoundly alert. He perceives himself as utterly free from ego consciousness and self-centeredness.

In this state, he beholds himself as a wave of conscious energy, a pure soul, stripped of all ego-related identifications. He is a droplet of energy in the universe's ocean of energy.

This is the state that some saints and sages attain in deep meditation. Usually, in this state, the body is motionless and the channel Qi is barely flowing...but what little channel Qi *is* moving is flowing in the schematics of parasympathetic mode. This directional movement is especially critical in the channel that runs *up* the spine and into the head: the Du channel.

All or nothing

In full-blown parasympathetic mode, when a person is awake with absolutely no sympathetic mode thought stimulation going on, one is in a state of attunement with the vast consciousness of the universe. The body is using *no* adrenaline. Spinal nerves are not being stimulated. *No* sympathetic mode electrical currents are running. Dopamine is the dominant neurotransmitter as one approaches this state, although even dopamine use may fall away as a person becomes *utterly* at peace, in the so-called "mystic," or "breathless" state.

Most animals and humans are almost *never* in this condition of purely parasympathetic mode. Also, they are almost never in full-on sympathetic mode. Exceptions exist: overwhelming levels of fear or rage coming from psychosis, or rabies, to name two possibilities, can lead to an almost pure state of sympathetic mode, with parasympathetic mode turned off almost entirely.

During *extreme* emergencies, if a person is in a high degree of sympathetic mode, he may become capable of fantastic feats of strength or endurance. When an utterly enraged person performs violent acts of superhuman strength, or suddenly has tunnel vision or is not able to hear anything but the roaring in his head, that

person is in a very high degree of sympathetic mode, and he *may* be using *only* adrenaline for motor function.

But usually, even during fear and anger, a blend of adrenaline and dopamine is being used. Even an enraged momma bear, protecting her cubs, is still using a *blend* of adrenaline and dopamine – she is still able to pay watchful attention to her little ones while attacking an enemy.

For the most part, we tend to *not* be at one extreme or the other. We are usually using a blend of adrenaline and dopamine, a blend of sympathetic mode and parasympathetic mode chemistries, electrical circuits, and organ behaviors.

Sleep mode

In sleep mode, blood flow to the liver, gallbladder, and intestinal *membranes* (not *muscles*) is increased, blood flow to the *muscles* of the gastrointestinal tract and to the motor muscles is greatly diminished. *Both* adrenaline and dopamine levels are greatly diminished, in the body as well as in the brain.

Thoughts cease, except for dreams, during which small amounts of neural dopamine or adrenaline are released in response to sweet dreams or nightmares, respectively.



Du channel, side view

When awake, the Du flows through the head. To fall asleep, the Du is shunted over the top of the head.

The most important electrical shift for sleep alters the path of the main current flowing through the brain: during sleep, most of the midbrain current is redirected over the *top* of the head.

During wakefulness, the strongest current in the body, known in Chinese medicine as the *Du* channel (often translated as “Governor channel”), runs *up* the subdermal tissue that lies directly over the spine, up *through* the head, through the midbrain and into the frontal lobe. During sleep, most of the current that runs *through* the head to the frontal lobe, which sustains consciousness, must be redirected over the *top* of the head so that consciousness can be temporarily turned off and restful sleep be attained.

The main, through-the-head pathway can be activated, bringing a return to consciousness, by *either* a surge of adrenaline or by the amperage changes in other channels that traverse the face, changes that are regulated primarily by circadian rhythms.

Don't sweat the details, but in case you are curious, the Gallbladder channel runs on the *sides* of the head from front of the head to the back – in the *opposite* direction of the *Du* channel, which runs from back to front. Amperage temporarily increases in the Gallbladder channel every night, a few hours after sundown (if a person is living in accordance with the sun. The classic texts say that this channel gets a surge from 11:00 p.m. to 1:00 a.m.). This night-time power surge on the *side* of the head, running in the *opposite* direction of the *Du* channel, helps *reduce* the power in the part of the *Du* channel that runs *through* the head. This *decrease* in power, in turn, allows the *Du* channel to be switched over to the top-of-the-head route that allows sleep to commence.

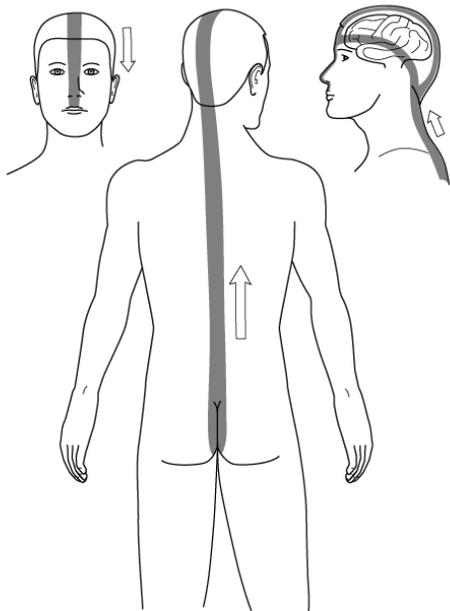
This increase in side-of-the-head amperage also sends more energy to the sides of the head. This helps the brain sort and assimilate events that happened during the day. These sorting and assimilating activities take place primarily on the *sides* of the brain during sleep, not in the frontal lobe during wakefulness.

Pause mode

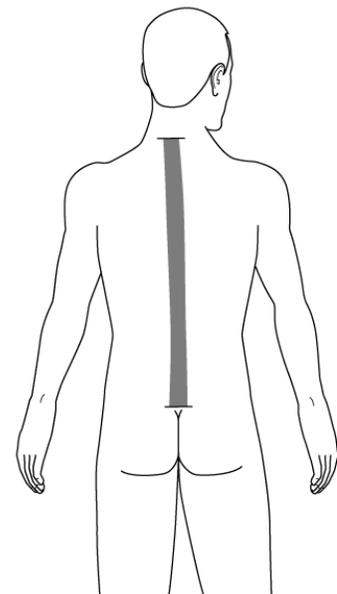
In pause mode, motor function, gastrointestinal muscle function, and digestion are all inhibited. The stomach may even move backwards, causing vomiting or nausea. The lower digestive tract may stop moving or it may lose all muscle tone, causing fecal matter to be uncontrollably released.

Heart rate may become very slow. Blood pressure may drop. Breathing rate may slow. Temperature regulation may be poor. The skin may be cold. Cold sweat might escape through the opened pores. Endorphins may be released, inhibiting transmission of pain signals to the brain. The release of both dopamine and adrenaline is inhibited. Thoughts may become deeply focused, less susceptible to distractions.

Sensory experiences may cease except for vision and hearing. Thoughts may be emotionally neutral, or, while on the verge of coming out of pause, fixated on risk assessment. Even while dopamine levels available for *motor* function might be near zero, dopamine levels may be *elevated* in the part of the brain that assesses risk (the right anterior cingulate).



The Du channel in parasympathetic, sympathetic, and/or (over the top of the head) sleep mode: Always running upward into or over the head.

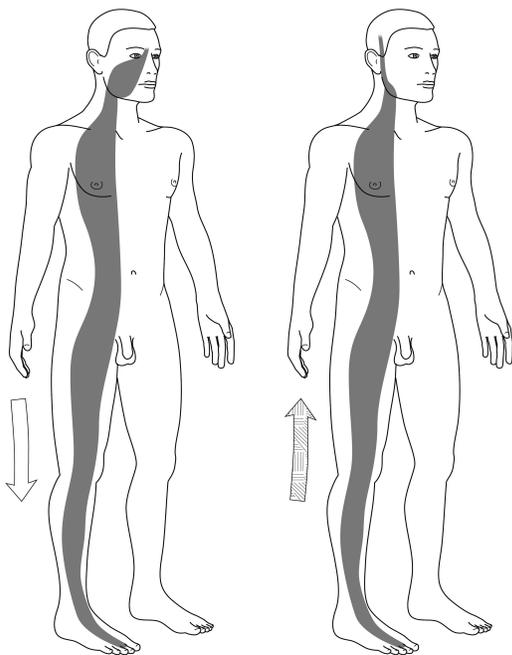


The Du channel on pause No directional arrow: a standing wave

Visual perceptions may be experienced as if originating from *outside* the body. This phenomenon is known as dissociation from the body, and is related to what appears to be a shift in the *location* of a person's consciousness.

(Unfortunately, the word "dissociation," also pronounced "disassociation," has been appropriated to describe a potpourri of unrelated conditions. In conversions, you have to use context to decide which meaning is intended. Hopefully, in this book, I'll be able to make clear which meaning I am using in any given sentence.)

During pause, changes in the subdermal electrical flows are extensive. The current that ordinarily flows up the spine and through the head becomes inhibited: it *cannot* flow past the top of the neck and up into the head: the channel is blocked. This blockage inhibits sensations of pain that would normally travel up the spine. This electrical configuration also triggers the release of endorphins from the nerve junctions in the spine. Endorphins reduce pain awareness. Normal, dopamine-based activation of motor function (physical movement) is inhibited.



Instead of the main *spinal* current carrying electrical energy to the head, auxiliary currents from the sides of the neck bring energy to the head. These side-of-the-neck currents energize the sides of the brain, particularly those brain areas in which negative, fearful, and ego-based thoughts are activated. Oppositely, the currents that run through the center of the head are diminished. This center-of-head current is associated with feelings of connectedness with others, with nature, and with the universe, as well as heightened intuitive understanding - functions that may be inhibited during pause.

parasympathetic mode pause mode *or* severe foot injury

The drawing on the *far* left shows the path of the Stomach channel when a person is predominantly in parasympathetic mode. The drawing to its right shows the direction and facial changes when the Stomach channel is moving in pause mode *or* is reversed due to resistance from an injury somewhere on the foot part of the channel.

In these drawings only the right-side channel is shown, for clarity. A person has two Stomach channels, one on the left side of the body, one on the right. Except when affected by an asymmetrical injury (injury on only one side of the body), the channels in a person at rest are usually symmetrical.

The Stomach channel currents normally run from the eyes down to the anterior-lateral sides of the legs and all the way to the toes. On pause, Stomach

channels cease to flow “downward,” towards the toes. They might seem to be standing still or they might even run backwards up to the back corner of the chin and *then* shunt up to the *side* of the head and into the Gallbladder channel.

Notice the absence of energy flowing over the face when a person is on pause. This absence can cause a reduction or absence of facial expression and even an unblinking, fixed stare.

As noted in the previous chapter, even if dopamine-based motor function is shut down, a person on pause might be able to *move*. The mind can order up *adrenaline*-based movement even when a person is electrically on pause. This allows a person (or animal) to perform some emergency maneuvers even while on the verge of death. However, *dopamine*-based movement is *not* possible when a person is on pause.

When on pause, or anytime the Stomach channel is running backwards, it does *not* travel up to the center of the forehead, meeting up with the Du channel at the point between the eyebrows. Instead, it is shunted to the side of the face and flows into the path of the Gallbladder channel.

This shunt increases the amount of amperage in the Gallbladder channel. As mentioned in the previous “sleep mode” section, an increase in the amperage of the Gallbladder channel on the head will cause a *decrease* in the oppositely moving flow of energy in the portion of the Du channel that runs through the center of the head.

This decrease in Du channel amperage triggers activation of a Du channel shunt that redirects the inner brain current to instead flow over the top of the head: into the sleep pattern. When the Du flows over the top of the head, consciousness is diminished. This shunt into the Du channel sleep pattern, activated originally by the backwards flow of the Stomach channel that shunted into the Gallbladder channel, together with the standing wave of the Du channel, can cause a person on pause to very possibly lose consciousness or at least fall asleep very easily – unless he mentally activates an adrenaline override which might allow him to stay unnaturally alert despite being on pause.

Of course, when the Stomach channel stops or runs backwards, peristalsis (movement of the digestive muscles) stops or reverses. Nausea or vomiting may occur.

Too much information

Again, don’t worry about learning all these pathways. You don’t need to know the details about them. You just need to appreciate that pathways change, depending on thoughts or internal or external influences.

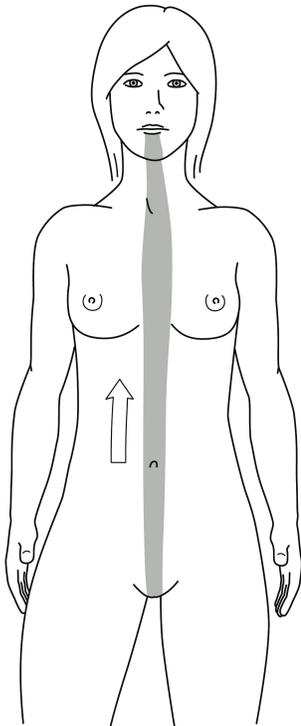
As an aside, surgical anesthesia, sometimes referred to euphemistically as “going to sleep” is more accurately described as “going into pause”. This is the reason that vomiting is a serious risk during anesthesia, as well as other pause symptoms such as digestive stoppage, poor temperature regulation, pathological slowing of heart-rate and breathing, and so on. What nurses call post-operative “shivering” while coming out from anesthesia is related to the tremor behavior that

automatically occurs as a person takes the first of the five steps for turning off pause.

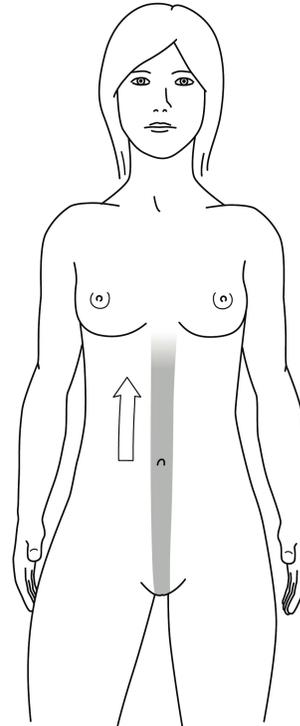
Another example of changes that occur during pause take place in the *Ren*, or “Divine Mother” or “Mankind” channel (the modern, more “scientific” English translation is “Conception” channel.) The Ren channel runs up the front of the midline of the torso and neck, from pubic bone to lower lip. It is also inhibited during pause. This current is supposed to vary constantly, reflecting moment to moment changes in health or emotions.

For example, when a person is fearful or anxious, this subdermal current may *seem* to abruptly stop flowing just under the skin... when actually it has dived internally just below the sternum, providing extra electrical support for the heart.

When a person is stuck on pause, this current may be very feeble, or may appear to stop at one or several locations along its path to the mouth.



Healthy Ren channel



One of many possibilities
for a Ren channel on
pause

Again, this chapter holds just a sampling of the largest schematic changes. These samples serve to introduce the idea that electrical schematics, thoughts, motor function, digestive function, and neurotransmitter levels can vary from moment to moment, depending on what neurological mode a person is in.

Switching modes

The electrical schematics that drive the neurological modes can switch back and forth between the four modes at the speed of thought.

Also, the number of possible variations on the basic patterns are nearly infinite. The number of electrical pattern variations that are possible in a human is far greater than the number of possible electrical pathways in a supercomputer.

In addition, individual body parts can call for *more* or *less* energy (amperage) at any given moment, depending on activity levels in that body part.

For example, while bicycling, the quadriceps muscles of the upper legs need more energy. Increased amounts of channel Qi are directed to the quadriceps by brain waves associated with the *idea* of those upper leg muscles moving up and down. Energy from the Stomach channel that would normally flow down the leg to the second and third toes is diverted into the quadriceps. This causes an increase in amperage of the channel Qi in the quads themselves, an area that has minimal channel Qi flowing through when a person is at rest. This increase in the amount of channel Qi in the quads, in turn, causes an increase in blood flow and metabolism in this area.

This diversion of most of the Stomach channel Qi into the quadriceps is why, when getting *off* a bicycle after a steady ride, the lower legs might feel a bit wobbly for a moment, until the full measure of Stomach channel Qi resumes running all the way down the sides of the legs to the toes.

In addition to being able to redirect different *amounts* of electrical energy to any given body part, as needed, at the speed of thought, different parts of the body can also be using the schematics of different *modes*, using different *patterns* of current flow, all at the same time: one part of the body can be using parasympathetic mode currents at the same time another part of the body is using a sympathetic-type current diversion, and yet another part of the body is using a snatch of current flow that resembles that of pause.

For example, if a person is eating while driving, his *digestion* is using a modest level of parasympathetic mode while his eyes and ears are hopefully using somewhat heightened wariness (sympathetic mode). However, since he is not in a *large* degree of sympathetic mode, the particular channel Qi diversion that can shunt energy away from the stomach and into the vicinity of the heart during a significant fear or rage event (one of the many sympathetic mode diversions that are *not* discussed in this book) will *not* have been activated.

At the same time, if this eating-while-driving person has, sometime in the past, dissociated from the pain of an old ankle injury and never gotten around to consciously re-associating with it and processing the results of the injury, including feeling the original pain of the injury and allowing the natural resetting of any somewhat displaced bones or soft tissue in the area, the channel Qi in the vicinity of the ankle may still be running *backwards* due to high electrical resistance in the vicinity of the injury – and backwards happens to be how some of the leg channels are supposed to run while on pause. Also, mental dissociation from some body parts can activate localized schematics that resemble pause patterns in the immediate

area. In short, this snacking driver with an injury in his past might have channels flowing in three different mode patterns in various parts of his body, all at the same time.

As an aside, this person's failure to have re-associated with his ankle after the injury, and the resultant inability of the body to naturally reset and restore displaced or broken bones and soft tissue might contribute to a pause-like, backwards flow of electricity in and around the foot, leading to a chronically weak ankle, foot spasms, hammer toes, bunions, Morton's neuroma and/or other chronic ankle and foot problems that an MD might say, "occurs for no reason."

The crucial difference: pause will not stop until it has been turned off

Unlike the other modes and channel Qi variations that can slide from a lot to a little and back again, or redirect energy temporarily on an as-needed basis, pause mode, once activated, will *not* terminate until the paused person goes through the specific steps that turn it off.

Symptoms of pause can be *masked* by an adrenaline override, but the schematics of pause, once activated, will continue running until pause has been turned off. Symptoms of pause will never go away just by temporarily switching into a different mode, such as sleep. Pause will not be turned off in response to attempts at "resting" (parasympathetic mode) or deciding to ignore the past and "just move on" (psychological suppression).

I repeat, pause will *not* turn itself off until specific steps have been *actively* taken. Those turn-off steps might be performed automatically, which is to say, without even thinking about them – the way a dog automatically shakes after he's been startled, gotten wet, or experienced a potentially damaging injury.

If turning off pause has been delayed for some reason, the steps to turn it off might need to be consciously performed. But until they are performed, pause, once activated, will continue running.

Channels running amok

In my work as an acupuncturist, I often see seemingly relaxed people who have some *part* of the body stuck in an electrical pattern that should only be occurring during a high level of emergency, or during sleep, or even during pause.

The way that acupuncture works, much of the time, is by jostling an electrical pattern that has gotten *stuck* in some incorrect flow, an aberrant flow *originally* activated by an illness, injury, or emotional stress. The illness, injury, or stress is now, supposedly, resolved. But the electrical disarray is stuck and is staying in the sick or injured position.

Very often, after being startled by the tiny electrical jolt from the metal acupuncture needle, or even by acupressure, the electrical currents jerk out of their stuck patterns and resume working as they should: in immediate resonance with brain signals. Needless to say, this electrical jiggle back to "normal" does *not* work when a person is stuck on pause.

The health problems of a person stuck on pause might not begin to fully heal until he terminates pause. As soon as he does end pause his body's electrical schematics might be able to revert back to the healthy, normal blend of mostly

parasympathetic mode together with a little bit of sympathetic mode: brain waves tuned in mostly to inner joy and playful curiosity together with a little bit of self-serving ego.

Then again, people with *self-induced* pause might need to be *taught* how to activate sympathetic mode. If a person has forbidden himself use of emotions, he might find that even though he *has* learned to turn off pause temporarily, he has no way to deal with fear or rage. Therefore, he will keep reverting into pause at the least sign of danger or risk. After learning to use sympathetic mode, he won't need to keep putting himself into pause – a drastic mode – when he merely needs to be in sympathetic – a mode of the living.

In summary, just notice that pause is significantly different from the other modes, and stick like glue to the fact that terminating pause requires specific actions be taken before it is turned off: five easy steps. A person on pause will probably not be able to easily move back and forth into greater or lesser degrees of the other modes, in the way that healthy people can.

As for *self-induced* pause, a person with this condition might be able to go abruptly from pause mode into a high degree of parasympathetic while doing some specific activity that he has deemed “safe.”

However, at the merest thought of stress, danger, or unwanted emotions, he might be immediately plunged back into pause. In some cases, close friends or spouses might notice that it's almost as if the person has two distinct personalities: one personality can use parasympathetic mode in highly specific settings and the default personality uses self-induced pause.

Diagnosing pause

Try it yourself!

To diagnose pause in yourself start by comparing what it feels like to *be* on pause and to *not* be on pause. If you are *not* already stuck on pause, you can temporarily experience and compare these two states by doing the following exercises. If you suspect you *are* stuck on pause these exercises might help you confirm or deny your diagnosis.

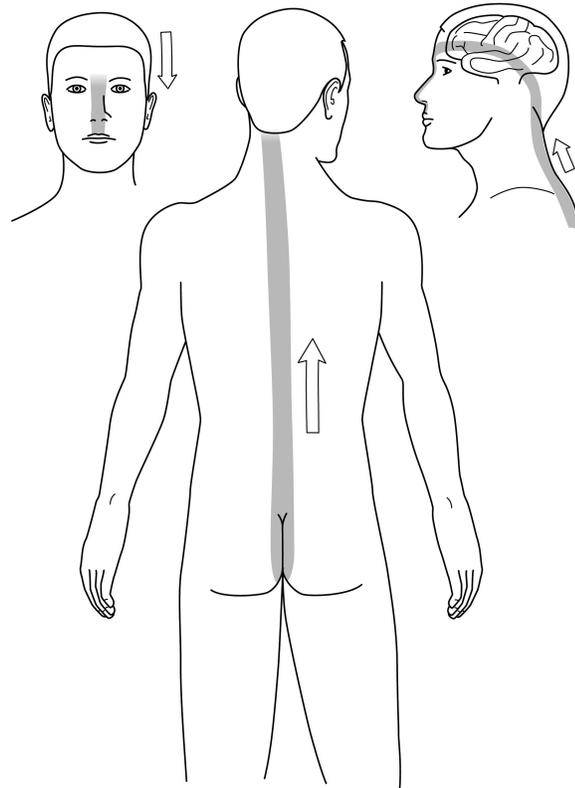
1) Not on pause:

Close your eyes. Imagine a current moving up your back, from the lowest part of the back, either your coccyx or sacrum, up into the neck and head. The current is about an eighth of an inch under the skin and about a quarter of an inch wide.

The imaginary current can be made out of anything moveable: light, electricity, wind, water, warmth, or a tingly feeling – anything at all that you can imagine as moving.

Pretend you can feel this energy as it flows just under the skin that lies over the spine, from the base of the spine, up the neck and *into* the head, then through the midbrain over to the forehead, where it emerges from the head and flows down to the upper lip and into the mouth.

If your immediate response to these instructions was “I can’t do visualization,” you may well be on pause.



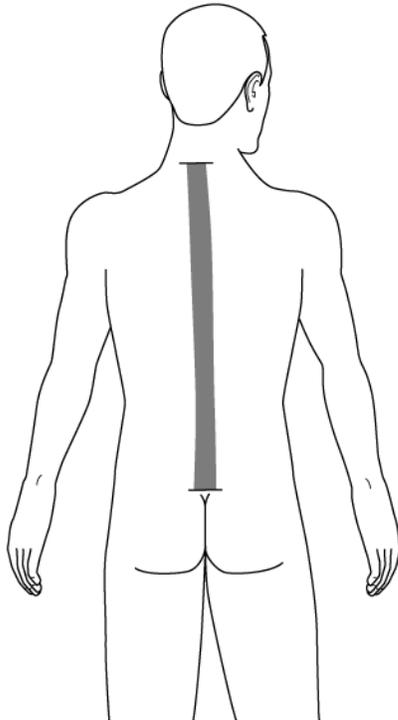
The Du channel when awake

If you can easily imagine a current moving up into the neck and head and if it feels good, normal, and even automatic, requiring no mental labor, then you are probably is not stuck on pause. Some smaller, isolated part of the body, such as an ankle or shoulder, might be using a localized, pause-like channel Qi flow pattern due

to unhealed injury or mental dissociation from a body part, but body-wide pause is probably not present.

2) On pause:

After doing the previous exercise with the spinal current, now *stop* the flow of the spinal current at the base of the neck. Do *not* allow any current to flow up into the head. Feel that you have created a holding pattern, a standing wave, in the current that runs over your spine. There might be energy there, but it's *not* moving into the neck or head.



The Du channel on pause

In the ancient Chinese description, the Du channel has ceased to be a river, and has become a reservoir.

Note: the drawing of the Du channel on pause has *no* arrows showing directional movement.

Maintain this holding pattern for up to five minutes, if you can stand to do it for that long.

After about five minutes or maybe even much sooner, start noticing what is happening to your muscles, your facial expression, your thoughts, and your ability to feel joy in your heart.

Your muscles may feel as if they are tensing up a bit. Your arms might even be bending at the elbow, pulling in, tightening up. Your facial muscles might feel heavy.

Your facial expression might be getting stony. Your thoughts may be wary, and might include notions such as “I really don’t like this” or even “This is horrible; I feel like I’m dying.” Your sense of having a resonant area in your heart that expands or contracts with joy or fear, respectively, will feel deeply deadened.

You might perceive yourself as being slightly “outside” of your own body. A common “outside” location is a quarter inch or so behind the back of the neck. This phenomenon, in which a person perceives himself as being outside of his body, is known as “dissociation.”

These are all symptoms of being on pause.

Done? Let the current resume moving through your head again.

Don’t worry. As soon as you resume the flow of energy through your head, all those weird pause symptoms will go away...assuming you were *not* already stuck on

pause before you started this exercise. If you were already on pause, you won't feel much difference, if any, while doing the healthy and the pause parts of the exercise.

Assessment

If you feel more "normal" or more "natural" or it's "easier" when you are *preventing* current from going into your head or you feel more familiar with *allowing* the current to stop at the base of the skull, you are probably stuck on pause.

If current moving through up your neck and into your head in the first part of this exercise made you feel a little giddy at first (an unaccustomed surge of dopamine release that won't last), *or even more wary* than usual or more vulnerable, or maybe experiencing the thought, "I shouldn't be doing this" or, if you feel a tightening or discomfort, or even the fear of *potential* discomfort, in your heart, stomach, throat or other area, if you simply feel "not normal," or if you simply could not do it, couldn't feel anything, or didn't understand the assignment, you are very likely stuck on pause.

For that matter, if you do not know what is *meant* by the words "the resonant area in your heart that expands or contracts with joy or fear, respectively," you are probably stuck on body-wide pause, and may have been for a long, long time. Ditto if all the other references to "heart feeling" (an actual, physical sensation) or "heart resonance" (an actual, intuitional sensation) in this book don't make sense. If you are accustomed to thinking that phrases such as "open your heart" means "think good thoughts" as opposed to what they actually mean, which is an exhortation to redirect more of your awareness towards the actual *sensations* of resonance-driven expansion in the chest and thus expand the number of frequencies the heart can "tune in with," you are probably stuck on pause.

Lack of spinal current is not *always* pause

If you have a very hard time imagining any part of the correct spinal energy movement, or if the energy in the Du channel seems to move in fits and starts or is difficult to even imagine, you *might* have electrical currents stuck on pause *or* there may be an unhealed back, neck, skull, or brain injury, and even mental dissociation from the injury – which is why the injury hasn't fully healed.

A lump or a quiver?

How can you tell if dark, unmoving energy is caused by pause or a dissociated injury blocking the spine? A quick, easy way is to imagine you are seeing darkness in the area of the spine that can't experience moving energy. Look into the center of the dark area, or the darkest part of the area that seems blocked or unmoving.

If it is easier to imagine this area is dark instead of light *and* if it's easier to imagine it's dark and *heavy*, like an inanimate, *unmoving* lump, you've probably dissociated from an injury in that area, thus preventing healing of the injury. A later chapter on re-association will explain what to do in this situation.

If it's easier to imagine that the area is dark instead of light *but* subtle movement is occurring, you are probably stuck on pause.

If the dark area is microscopically trembling or vibrating, the area might be the *site* of a near-death shock/injury that has put the person on pause. Going through the steps while focused on this specific area might well turn off pause. In addition to “faintly trembling” or “as if the atoms are vibrating,” some people have various described their imagined movement as “bubbling, burning, tremulous, and sludgy.”

It doesn't matter *how* it's moving. Just decide if the darkest part of the dark area seems to be motionless or moving.

(Then again, if the area seems to moving in a pleasant, back and forth manner, in time with your breathing, that's just normal. But if the area is easier to imagine as dark than light, it's unlikely that there will be “pleasant” movement going on.)

The phrase “Spinal energy”

By the way, I am going to use the words “spinal energy” or “spinal current” now and then while referring to the Du channel. Technically, for some practitioners of the esoteric and spiritual arts of controlling life force energy, the words “spinal energy” refer to energy *inside* the spinal column or on the inner and/or outer surfaces of the vertebrae. But in this book I use the words “spinal energy” in the way that it is often used in Chinese medicine, to refer to the energy that runs in the Du channel, just under the *skin*, moving *parallel* to the spine, neck, and up into the head.

Case Study: Bee attack

A patient, female, age forty-six, had extremely low energy. In her mid-twenties, she had been an athlete, an extreme bicyclist, and with many enthusiasms. For no apparent reason, she suddenly lost all her energy. Since then, for twenty years, she had eaten an excellent, careful diet, worked on positive attitude, and “done everything right.” But she *never* had enough energy. She had to go to bed early, be careful never to exert herself, and pace herself very carefully. She dragged herself through every day, and worked on staying positive. Her doctors found “nothing wrong.”

As I worked with her, she recalled that, several months before the fatigue set in, she had been attacked by a swarm of bees and stung all over her body. She didn't think she had gone into anaphylactic shock, but she had been profoundly stunned by the episode. She had assumed she had gotten over it, and hadn't even remembered it in years.

She could not imagine energy flowing up her spine.

I asked her to imagine light in her spine, and she could. I asked her to imagine dark in her spine, and that was even easier. I asked her to imagine her spine being dark and then look for the place in the spine that was the darkest, and notice if it was heavy and motionless or vibrating, trembling.

She replied, “Down at the very bottom of my spine. My coccyx. It's vibrating.”

In Chinese medicine, the energy at the base of the spine is a fairly common place for energy to get stuck in a near-death situation such as being resuscitated after almost drowning or, as in this case, extreme allergic reaction.

She focused on the vibrating in this area, and did the five steps for turning off pause.

Almost as soon as she had finished going through the steps three times, she said, "I'm so loose!" She got up from the treatment table and started walking around the room, swaying at the hips and swinging her arms. "Wow! I'm so loose!"

She was smiling excitedly and taking little dance steps, something she hadn't done in twenty years. XXX follow up?

Other things to watch for

Lumps under the skin, lipomas, moles that are increasing in size, and fungus intruding under the toenails or fingernails are examples of "not healing properly" situations in which the somewhat bizarre electrical patterns of pause may be preventing some location in the body from doing its normal job of healing from physical injuries, illnesses, or everyday wear and tear.

Side effects of being on pause are often what bring a person to my office: he has some numbness, weakness, pain, nausea, an annoying chronic condition, or even a serious health problem that doesn't go away – one that "the regular doctors" aren't able to help with. Very often, there is "no known cause" or the problem has even been diagnosed as "purely psychological."

Chronic symptoms that happen to match those that might be expected following an episode of near-death shock or concussion might be indicators that a person is stuck on pause. For example, nausea can be a symptom of post-shock or concussion. Frequent or chronic nausea from "no known cause" can also be an indication that a person is stuck on pause.

Poor temperature regulation such as "incurable" Reynaud's syndrome, a condition of pathologically cold hands and feet has "no known cause" and may be an indication that a person is stuck on pause.

Not just physical symptoms, but emotional symptoms common during shock or post-concussion can also be due to being stuck on pause. For example, an emotional numbness or joylessness that doesn't respond to cognitive behavioral therapy or medication might be dismissed as "purely psychological" but might actually be a case of being stuck on pause.

Pretty much any symptoms that occur for "no known reason" that also happen to match symptoms that can occur during or immediately after shock are very likely occurring because the person had a near-death trauma and never got around to turning off the electrical circuitry that characterizes near-death.

I sometimes discover that a patient who comes in for acupuncture to help with his chronic problem is, in fact, stuck on pause. No amount of acupuncture is going to help him. For that matter, acupuncture will probably make him worse.¹

¹ First semester training at any good acupuncture school includes the principle that one should "never tonify an excess condition." Translated into English, that means, among other things, never *increase* or stimulate the flow of energy in a system where the energy is stuck (generating increased resistance), overflowing into other channels, or flowing backwards. These situations are all examples of "excess" channel Qi flow. Encouraging the flow of energy under these conditions will

If I find that the person is stuck on pause, I can lead the patient through the five steps necessary to turn it off. The health problem(s) that brought the patient to my office often evaporates or at least shows signs that it is starting to heal.

Although new patients usually come to my office expecting acupuncture, there is no way that an acupuncture treatment, Yin Tui Na, cupping, dietary change, and/or herbs are going to fix a problem if the patient is stuck on pause. Whether he is stuck on pause due to being too abruptly rushed out of a shock or concussion *or* due to a psychological decision made at some point in his past that he is better off being able to feel no pain, doesn't matter. Before I can treat a person who is stuck on pause, I first have to help him turn off pause. After that, the patient may very well not *need* any further treatments. His problem area(s) may very likely heal on their own.

More tests for being stuck on pause

Another test for whether or not you are on pause is determining if you are going through your moments of self-awareness by *feeling* your body from the inside *or* by imagining you are *looking* at yourself from some location outside of your actual body.

probably *increase* the amount of current running in the wrong (not parasympathetic) directions, contributing to *increased* resistance, *increased* symptoms, or *increased* static in the system.

As noted in the previous chapter, when a person is stuck on pause, some of the channels may be stuck (getting shunted in some odd directions or at least experiencing electrical resistance), some may be forming a standing wave, as does the Du channel, and at least one (the Stomach channel) may be flowing backwards. Although some students imagine that techniques reputed to "drain" the energy can be used in these situations, these techniques do *not* decrease the amount of channel Qi nor do they correct the direction of wrong-flowing channel Qi.

As for the ludicrous teachings from the dark ages that say "pointing the needle one direction will *increase* the energy and directing the needle the other way will *decrease* the energy," they are simply wrong. I invite any acupuncturist to feel what is actually going on in the channels and then test those medieval theories and prove for themselves that "needling backwards" does not "drain" a channel, and also confirm that acupuncture should *never* be done on channels that are diverging due to blockage, stuck (standing wave), or flowing backwards. If you do, your patient might even jerk violently, feel an electric shock or pain, break into a cold sweat, or even pass out in response to these wrong treatments. Certainly, if you use needles inappropriately, the patient's aberrant channel flow will be made worse, not better: exactly as you should have learned in your first semester.

This first semester instruction is widely ignored. Many idealistic acupuncturists want to believe that *everything* can be fixed with acupuncture needles. Others unquestioningly believe every statement in the compendiums of ancient knowledge, even though many of them contradict each other.

More cheerful information on the subject of what is and what is not taught in both Chinese and western modern schools of Chinese medicine, and a look at some of the error accumulations of centuries in the literature of Chinese medicine can be found in *Hacking Chinese Medicine*, an introductory book I wrote for beginning students, for fans of Chinese medicine, and for the mildly curious who are looking for an amusing way to spend the long winter evenings.

It's available at www.JaniceHadlock.com.

If you tend to observe or think of your body as if you are outside of it, looking at yourself instead of *feeling* your existence by using the resonance of your heart as your primary point of reference, you are very likely stuck on pause.

If, when you speak, you imagine the words appearing in front of you on the “video screen” of your imagination, you may be stuck on pause.

If you mentally use *words* to self-assess how you are feeling instead of checking in with your wordless heart *sensations*, you may be stuck on pause.

If you have no idea what I mean by “*feeling* your body from the inside,” you are probably stuck on pause.

If you *command* your body to move rather than enjoying the languorous sensations of motor actions that occur in response to imagining your body moving, and especially if you don’t know what this sentence means, you may well be stuck on pause.

The yoga and Qi Gong tests

If years of yoga, meditation, Qi Gong, Tai Ji (aka Tai Chi) have not brought you the expected heart feelings of peaceful, expansive joy, you may be on pause.

If you have done years of the above practices and have done it without feeling increasing joy and energy flooding the body parts that are being moved or focused on, you may be on pause.

If you do the above types of movement while trying to make your movements symmetrical, or uniform, or “correct,” you may well be on pause.

If you like doing the yogic “corpse pose” because it lets you “turn off” and/or pretend you are dead, you are probably on pause.

If you enjoy doing these types of self-improvement exercises because you turn off your internal monologue and savor, wordlessly, the heightened awareness of somatic energy in your various body parts, you are probably *not* on pause.

If you like doing the yogic “corpse pose” because you love the heightened awareness of energy flowing up your spine and your increased awareness of energetic harmony in the deep stillness of your body, you are probably *not* on pause.

Nearly all of my patients with Parkinson’s who have steadily tried practicing the meditative arts have remarked that their decades of silent meditation or “spiritual movement exercises” have *not* led to increased awareness of inner joy or heart resonance. Just the opposite: they feel less and less joy, less heart awareness, despite decades of doing these so-called “uplifting” exercises.¹

¹Vocabulary note: for those who do certain types of Buddhist meditation, remember that going into the so-called “emptiness” refers to turning off ego-driven thoughts and constant mental chatter. It does *not* mean becoming numb to the joy that vibrates silently behind every atom. The use of the word “emptiness” is a poor translation. “Love-filled absence of ego” might have been a better choice.

I have had many Buddhist patients, including Buddhist monks, who were stuck on pause, who had Parkinson’s disease. In every case, they had assumed that the word “emptiness” means numbness, even joylessness!

To illustrate the translation challenges, let me share a story about signage in India. I noticed, in ashrams in India, dual language signs in Hindi and English at the entrance to some of the meditation halls. The Hindi message had two words. The first word was a verb that can mean “keep”

Also, many of them have said that “corpse” is their favorite yoga pose.

The purpose of all these types of physical training is to practice focusing your attention on the sensations of, and exercising mental control over, the energy in your body.

For example, the tree pose lets you pretend that you are a tree: feeling what it’s like when the energy in your body is imagined as tall and balanced.

If you are doing “wild crane” Qi Gong, you can imagine yourself flying as you flap your wings (arms), and *feel* the sensations of energy moving inside your body as you go through these bird-like moves.

If you make swirling waves with your arms while imagining you are the ocean, the cosmos, or whatever, if you are doing any of the joyful and energy-aware movements that make up your routine, the purpose is two-fold:

First, the mental play helps turn off the constant analyzing and assessing of your mind and lets you focus on being in the moment, like a little child. I watch my grandchildren pretend that the living room rug is the heaving ocean. They must leap from floe to floe (pillow to pillow) to cross from one boat (sofa) to the other. They are completely focused on their game. They can do this for hours.

I wonder when I lost the ability to effortlessly use my heart and mind in this manner. Still, doing my morning yoga-based exercises, I can be in this joy for fifteen minutes.

Pretending to be a tree or a wild crane, or even simply tuning in to how you can mentally control the energy in your muscles, helps your mind focus.

And as the focus moves away from the nattering mind, it moves into a focus on your heart (the heart *joy* of pretending to be something other than your ego-controlled body) *and* on the sensations of energy you experience inside your body. While doing any pre-meditation body exercises, you get to turn off the incessant mental back-chat of criticism, anxiety, and fear, or the dwelling on past and future.

Second, the real goal of these types of movement disciplines is that one learns to focus the attention like a *laser* on one’s motor instructions and subsequent

or stay.” (This same verb was used in signs that mean, “Keep off the grass,” or you might say, “Stay off the grass.”) The second word in the phrase was “shanti,” which is usually translated into English as “peace.” These two words together *might* be translated into English as “keep peaceful: full of quiet, radiant, joy.”

But the sign’s translation into English said, “Maintain silence.” The words shanti (peace) and silence have utterly different underlying meanings. Joy is implied in the first. Self-control and rigidity is implied in the second.

This is just to point out how hard it can be to put into English the words and phrases from other languages that have to do with heart-joy and peace. Many English speakers who are stuck on pause even think that the word “peace” means “motionless,” and point for an example to the phrase, “a peaceful evening.” I doubt the word “motionless” could be applied to the greatly dynamic Jesus, who is sometimes described as a “Prince of Peace.” Peace is a dynamic heart-feeling. Many people stuck on pause are not able to access this feeling, or even understand what is meant by these words.

somatic *sensations*. Then, when the exercise is done and the mind is still highly focused, one finds it easier, during the meditation that should immediately follow, to bring that highly focused attention into the heart, or spine and midbrain, instead of letting it flop back into the parietal (left and right sides) areas of the brain.

The parietal areas are the brain locations where ego-based thoughts, fear, and risk assessment take place. In other words, once you've got your attention focused by placing it on your body during your exercises, which directs your thought energy to the brain's motor area and *away* from the nattering, ego-based, word-based areas of the brain, you then have more control over where your attention goes next. You can then more easily place your attention on your heart, your spine, your "third eye", or whatever location you associate with your spiritual discipline instead of going back to squandering your mental energy on pointless mental backchat and circular thinking.

All the famed movement disciplines of the east were originally methods for getting the scattered thoughts focused on the body instead of a thousand worries. After thus focusing on one's life energy, the life energy can then be more easily directed by the mind. The life energy can be sent inward, towards the ever-patient soul abiding within, the energy of which is housed primarily in the spine, midbrain, and forehead.

It may seem that I am rambling from the question of how to diagnose pause. However, I'm introducing these ideas here because *consciously* altering the way specific brain areas are activated plays a large role in turning off self-induced pause.

Ask a friend!

It can be difficult for some people to accept that they might be on pause. In some cases, not all, spouses can be helpful in confirming a diagnosis.

For example, I was chatting with a patient and his wife about their recent trip to Florence, Italy. I asked if they had seen Michelangelo's statue of David. Myself, when I first beheld that statue at the far end of the long corridor, my heart expanded as if it would burst. A wave of indescribable energy pouring out of the statue stopped me dead in my tracks.

The patient said, "Oh yeah. I saw it."

The wife said, "No, he didn't. He looked at it, but he never *saw* it."

The patient countered, "I *did* see it. The fingers were very realistic. The whole statue was very realistic, very well done."

"See what I mean?" said the wife, "He didn't *see* it. He doesn't really see *anything*."

Then again, a spouse can't know if a person is perceiving himself from outside of his physical body.

Finally, a diagnostic reminder: a person who is stuck on pause doesn't necessarily *look* as if he is in shock. He needn't appear stunned or blank-faced. He may be highly mobile, by commanding himself to use "emergency" thoughts, thus releasing adrenaline. He might be able to instruct himself to be "socially correct,"

smiling and sincerely conforming to the rules of polite conduct. However, unlike people for whom these behaviors flow somewhat naturally, from the heart, the person who is running pause in the background will always be performing these behaviors somewhat self-consciously, using adrenaline and using, for the most part, brain-based logic and self-awareness even though he may be *talking* about heart and love.

In closing

If by doing the diagnostic exercises in this chapter you realize that a pause situation is ongoing, be of good cheer: the techniques in this book can help you get back to being fully alive.