

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 play, curiosity, and eating.

The heart patient and the mouse are not in “flight or flight” mode; 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 awakened 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 greater detail later on. For now, briefly, the five steps are as follows:

One

Mentally focus on the injury site. Silently acknowledge that it *was*, in fact, damaged. Close the eyes and imagine you are looking at this area. It will usually appear, in your imagination, as somewhat dark and subtly vibrating or faintly tremoring. This faint internal tremor is a signal that the body is now stable: that the *internal* damage has been brought under control.

Two

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. (The technique is introduced later in this chapter.) You might need to silently invite a saint, sage, deceased loved one, or some other trusted friend to be with you, gazing at the dark, vibrating area with you.

Three

Ask your invisible friend if you are at risk of imminent death. He/she will be able to assure you that you are not. You are safe now.

Ask *yourself* if you are at risk of imminent death. You might find that, in spite of what your friend said, you aren’t ready to agree with him/her/it.

If you think you are at risk of imminent death from your old injury, ask the friend again. Maybe invoke a power that is higher than that of your friend.

When you feel ready to agree with your friend that you are not at risk of dying in the next few minutes because of the injury you received years ago, you will be able to feel safe.

“I’m safe now,” is an actual feeling. It is caused by a shift in the electrical patterns in the 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.

Focus on this safe feeling, which starts as a physical sensation of expansion in the vicinity of the heart, until you notice a bit of relaxation throughout the body: a pervasive physical *feeling* of peace and safety. You might even find yourself having the thought: “Whew. I’m safe now.”

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

If not, go through the motions: make yourself perform a deep and audible inhale and exhale.

Four

Your head needs to 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, almost as if self-massaging the back of the neck against one's collar, only more gently.

Five

The head wobble should trigger 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.

Qi Gong

The above five steps are a type of Medical Qi Gong (pronounced chee gong).

Qi Gong literally means "energy control." In Qi Gong exercises, a person consciously directs his thoughts and his energy towards parts of his body or his mind. Most schools of acupuncture require a student to take one or two semesters of Medical Qi Gong.

In most acupuncture schools, the emphasis is on directing thoughts and energy at body parts while doing physical movements, not at mental processes. This is in keeping with most patients assuming that Chinese medicine is mainly for treating injuries or physical pain.

An aside about the fifth step: shaking

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 my patients worked at 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 or injury 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 or threat (exterior) danger is no longer in the vicinity.

Effective shaking that successfully turns off pause *cannot* occur until both internal and external dangers are confirmed as no longer present.

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

Until he is safe, an animal on pause is biologically *incapable* of doing a self-convincing head wobble and shiver. 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 or re-balance 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 on 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 steps

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 tremoring.

He replied, "That's easy. It actually *is* tremoring..."

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 tremoring area, just calmly noticing it.

Next, I had him imagine that a loved one was standing nearby, gazing at the tremoring 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 or danger must be gone. The 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 feeling strangely 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, exclaiming, "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, repeating softly to himself, "That's really weird..."

Then he declared, "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 integrating the 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 banged 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 body’s electrical patterns of pause, might *not* turn off until pause is fully terminated via the five steps.

The Chinese medicine 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. It considers the biology of near-death to be a strange variant on the flight or flight mode.

If western doctors were trained 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 function of the adrenal (adrenaline-releasing) gland, located in the mid-back, is inhibited. Oppositely, in sympathetic mode, adrenaline release is increased.

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 might terminate life.

This mode is supposed to turn itself off automatically 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 if it fails to kick in automatically, the person can become stuck. Stuck on pause.

Reasons for getting stuck

People might fail to fully come out of pause for a variety of reasons. These include being rushed to “snap out of it” and being in a situation of ongoing danger, where there is no clear end point in sight.

When this happens, a person’s electrical system might continue to run, partially or fully, as if he was still on the verge of death, even though the actual damage to the body has been stabilized.

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 might 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* on 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

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.²

¹ Cotard's is a very 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.

² The actual neurotransmitter being using is most likely norepinephrine – a close cousin of adrenaline.

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.

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 fact, norepinephrine, very similar to adrenaline, also plays a key role in sympathetic mode. Based on published brain research and on my own research showing that the adrenal gland is sometimes shut down during pause, it appears that norepinephrine plays the larger role in a pause situation.

In the USA we call this pair of emergency neurotransmitters adrenaline and norepinephrine.

In the UK, we call this pair of emergency neurotransmitters epinephrine and noradrenaline.

My USA patients are very familiar with the word “adrenaline” and everything the word implies. Therefore, I just refer to the neurotransmitter override that occurs during pause as an “*adrenaline* override.” Still, if you want to do research on your own, please know that I am actually talking about a norepinephrine 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 of pause. 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.

My research suggests that Parkinson’s symptoms can be hidden (subclinical) for decades, even while the electrical system is running in the pause pattern. The more obvious symptoms of Parkinson’s 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 neural norepinephrine: what I’m calling 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.

Published online: 2007 Aug 16. Doi: 10.1073/pnas.0702753104.

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 self-induced pause plus a brain-based adrenaline 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 disease, or “PD”. When people with PD turn off self-induced pause, their Parkinson’s symptoms cease, permanently.

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. This is discussed later.

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.”) This situation can create *self-induced* pause.

Others get into *self-induced* pause when they ***commanded*** themselves to not feel physical or emotional pain, or by deciding that they would “spiritually rise above” their emotions or physical pain 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 later, in the chapters 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.¹

Looks like pause, but isn’t

A third condition that *resembles* pause can be set in motion by an unhealed injury. In this case, mental dissociation from the injury is preventing the healing. If and when the injury heals, electrical flow realigns itself correctly, and the pause-like symptoms cease.

This book will address diagnosing and treatment for all three types of pause-like symptoms:

- Pause from near-death trauma

- Self-induced pause and self-induced dissociation

- Pause-like symptoms caused by dissociation from injury

For now, basic pause, pause from near-death trauma, is the main topic.

An important point to remember with basic pause 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 reasons for this will be discussed later.

¹ Throughout this book, “Parkinson’s” refers to un-medicated, idiopathic Parkinson’s disease – not drug- or toxin-induced parkinsonism. The dopamine-enhancing antiparkinson’s drugs can cause brain damage that leads drug-induced parkinsonism.

For the most part, when not using an adrenaline override, a person on pause *might* feel heavy, extremely tired (when he doesn't need to be wary), 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* somatically living in the moment. Maybe not even living inside his body. *Not* relaxed. 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 minimized or paused.

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”: sympathetic (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 have descriptive, rather than “label” names. “Clinging to life” (pause) is one of four neurological “phases.” The Chinese character for “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.

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 to 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 the problem of turning off the downward spiral of wariness in self-induced pause. 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

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.

such as “pre-death shock” deserves a more powerful name: “zombie mode” and “mode of doom” have been suggested, to name but two.

I think that the name “pause” is more accurate because it correctly suggests that the near-death mode *can* be turned off.

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, noradrenaline, but in this book the word adrenaline will be used because, at least in the USA, most people have an immediate, gut-level understanding of the word “adrenaline.”

While on pause, an instinct or a purely mental determination that movement is called for *can* activate the adrenaline-based part of the motor area in the brain. This allows for 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.

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.

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 immobilized due to excessive perforation of the skin, which is one of the many types of injury that can induce 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 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 “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. A person who uses this override to get himself moving *might* never get around to executing the moves and thoughts that terminate pause.

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.

In my experience, I have only seen this in people who are highly analytical, word-based, (what some people call “left-brained”), highly focused, with a high level of self-control, who have decided that life itself is dangerous – that the danger of imminent damage or death is *always* present.

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. 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.

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 and norepinephrine are the main neurotransmitters (nerve-activating chemicals) for sympathetic mode, dopamine is the main neurotransmitter of parasympathetic mode. Healthy people, and the very best world-class athletes, usually use 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.

Not in sympathetic mode

Even though people on pause are using adrenaline and norepinephrine, they are *not* in sympathetic mode. 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 from his adrenal glands.

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

For 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, such as running.

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.

For another example, a healthy person shifting into a somewhat elevated level of sympathetic mode will have an electrical current at the back of the knee shunt into a medial leg current that flows directly to the adrenal gland (in the midback). A person on pause will *not*. The current that normally flows to the adrenal gland is somewhat inhibited in a person stuck on pause. It can be almost *completely* inhibited in a person who is stuck on *self-induced* pause.

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 emergency-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, one being activated by the radio control set (adrenaline-activated thoughts) that triggers norepinephrine-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. If your channel Qi patterns were still flowing in the sleep-mode pattern, you were *not* in sympathetic mode. You were in sleep mode with an adrenaline override.

Then again, a person in a *sustained*, true emergency situation *might* soon shift from sleep mode into full-blown sympathetic mode.

If you fall back to sleep quickly, you stayed mostly in sleep mode during your foray to the trash cans. If you lie awake for hours, you may have actually made the full transition into sympathetic mode when you were awakened.

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 how to activate the electrical schematics of sympathetic mode. And even then, they were often afraid to use it, at first. They had to be gently encouraged to “allow” themselves to experience sympathetic mode – a mode that is supposed to be used when dealing with fear, rage, and other “not nice” emotions.¹

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*!!!”

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.

He won’t need to invoke an adrenaline override anymore.²

¹ Many people have told me that they invoked self-induced pause in order to be more spiritual: they didn’t want to have “bad” emotions such as fear and rage. However if a person *does* have fear and rage and *suppresses* them by invoking the neurological mode of pre-death, he is essentially lying to himself. He has not “overcome.” He has “hidden.”

A truly wise soul does not feel overwhelmed by fear or rage in the first place, because he perceives the drama of the universe from a safe position, right next to the director’s chair. Negative emotions should be noted, and transmuted through wisdom into painless, compassion-building experiences. This is hard to do. But health-wise, it’s better than lying to oneself.

As Paramahansa Yogananda wrote in his *Autobiography of a Yogi*, “Truths suppressed lead disconcertingly to a host of errors.”

² Research using brain scans show that in “...Parkinson’s disease motor imagery is impaired and execution of overt movements is spared...These results underline the modality-specific nature of motor imagery...”

From “A dissociation between real and simulated movements in Parkinson’s disease”; Frak V, Cohen H, Pourcher E, *Neuroreport*; 2004 June 28;15(9):1489-92

To explain the above briefly, people with Parkinson’s disease have inhibition of their brain’s motor **imagery** area, but the actual motor function part of the brain is functional. In other words, the

brain sequence for dopamine-based motor function, which requires imagining the intended movement, isn't in place in Parkinson's, but adrenaline-based motor function is still available.

More about research on the brain's motor imagery area in Parkinson's, which in most cases is indistinguishable from self-induced pause, and in paralytic hypnosis, is in footnotes in chapter xxx,

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 idea of “Channel Qi” includes the tiny, single-charge electrical phenomena on the surface of every cell.

However, the term “Channel Qi” 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 have been illegal in China since the mid-1900s.

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, tuning 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 delighted at the end of the chapter by the biological perfection of the drastically altered the Channel Qi flow that kicks in 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.

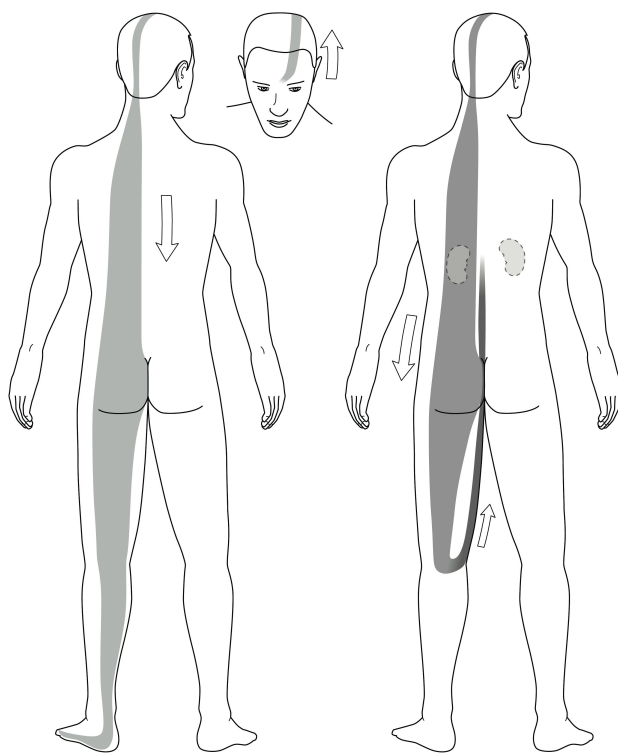
Angry and fearful thoughts activate the amygdala, small areas in the left and right sides of the brain, just under the path of the Bladder channel. An increase in activity in these brain areas increases the amperage in the Bladder channel currents running over these areas. This upped amperage flows down 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. They do *not* learn to feel the Channel Qi in acupuncture school. If they learn this art, they do it on their own.

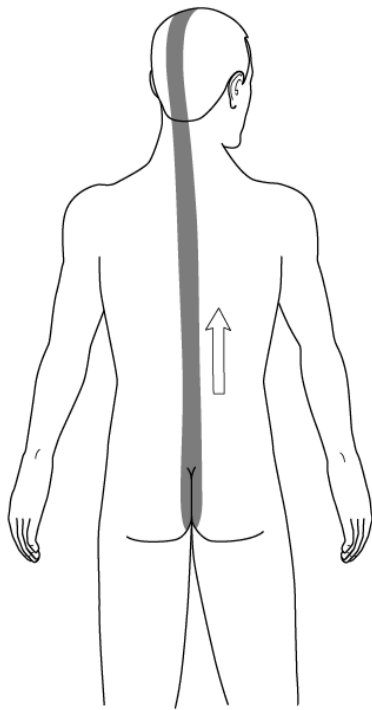
Like all channel currents, the behavior of Bladder channel currents is driven primarily by thoughts and secondarily by circadian rhythms. Thoughts also control the *amount* of a channel shift. The more powerful the thought of fear or rage, the larger will be the increase in amperage in the left- and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

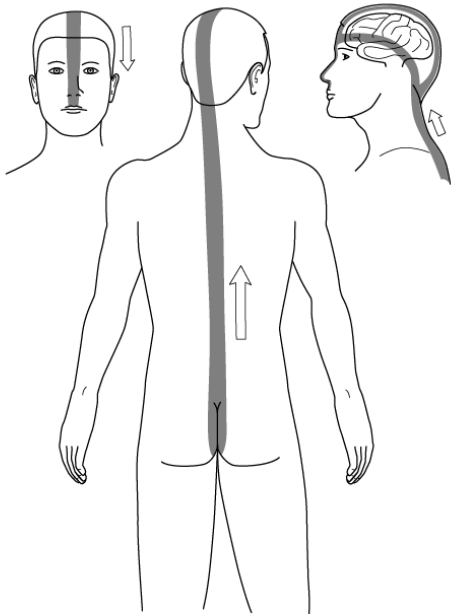
This increase in side-of-the-head amperage also sends more energy to the sides of the head. This helps the brain sort and assimilate events that happened during the day. These sorting and assimilating activities take place primarily on the *sides* of the brain during sleep, not in the frontal lobe during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

Pause mode

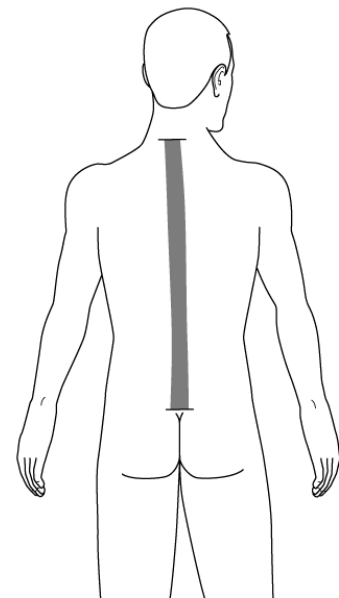
In pause mode, motor function, gastrointestinal muscle function, and digestion are all inhibited. The stomach may even move backwards, causing vomiting or nausea. The lower digestive tract may stop moving or it may lose all muscle tone, causing fecal matter to be uncontrollably released.

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.



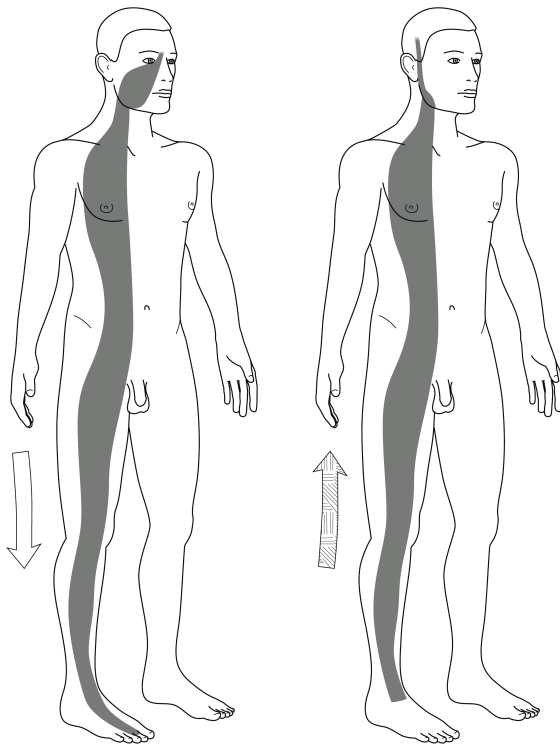
The Du channel on pause
No directional arrow: a standing wave

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 directional, foot, and facial changes when the Stomach channel is moving in pause mode *or* is reversed due to electrical resistance from a 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.

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.

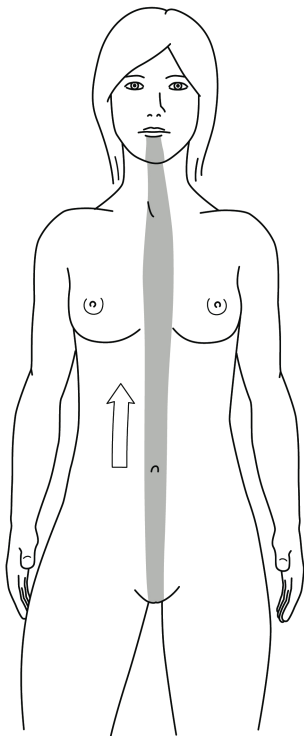
As an aside, surgical anesthesia, sometimes referred to euphemistically as “going to sleep,” is more accurately described as “going into pause”. This is the reason that vomiting is a serious risk during anesthesia, as well as other pause symptoms such as digestive stoppage, poor temperature regulation, 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

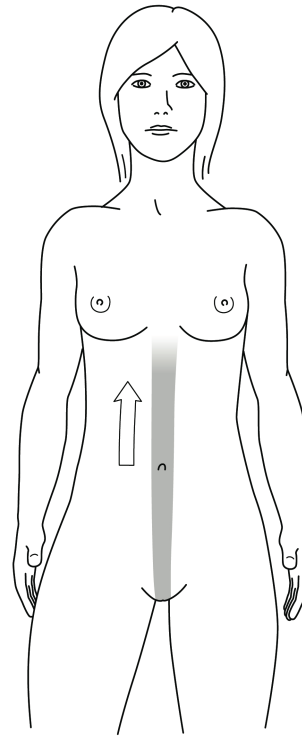
midline of the torso and neck, from pubic bone to lower lip. It is also inhibited during pause. This current is supposed to vary constantly, reflecting moment to moment changes in health or emotions.

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* and the mental *image* 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 any reason, the steps to turn it off might need to be consciously performed.

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* set in motion 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.

As soon as he does end pause, his body’s electrical schematics might instantly 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 back into self-induced 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 normal mode for a person who’s *alive*.

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.

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.

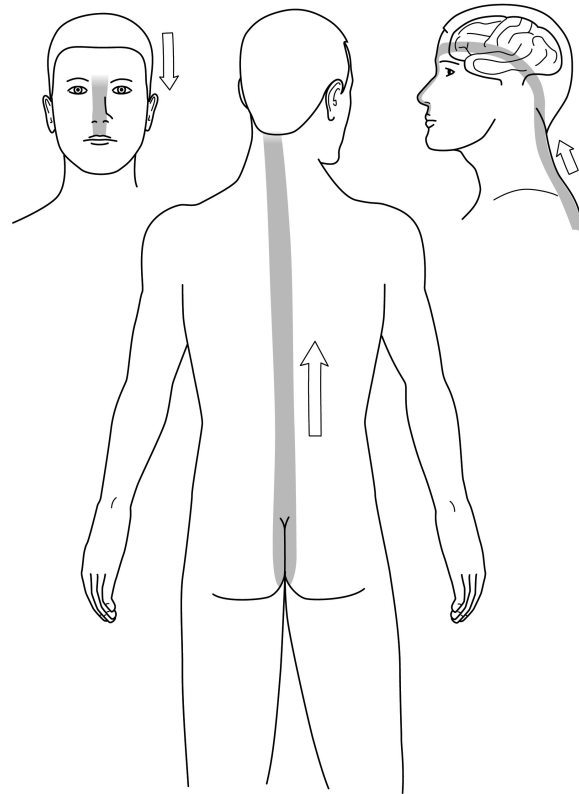
1) Not on pause:

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.



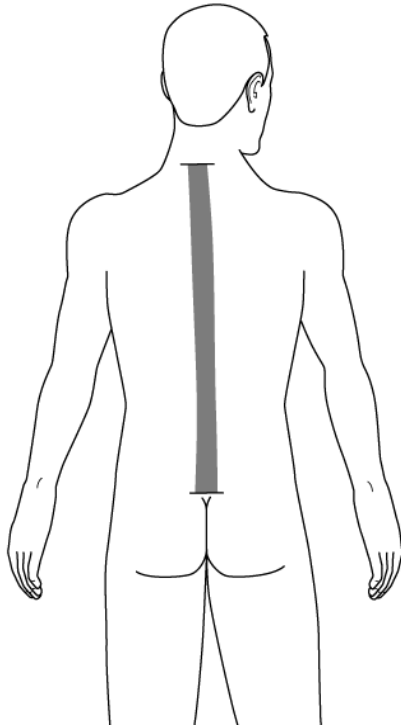
The Du channel when awake

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 not stuck on pause. (If you have some body part that never feels “right”, some smaller, isolated part of the body, such as an ankle or shoulder, you might be using a localized, pause-like channel Qi flow pattern in that area due to unhealed

injury *or* mental dissociation from a body part, but body-wide pause is probably not present. This subject will be discussed later.)

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 sooner, start noticing the changes in 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.

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” mean “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 you on pause. Going through the five 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 at the dark area as bubbling, burning, tremulous, and even “sludgy” and “sticky.”

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 teens and mid-twenties, she had been an athlete, an extreme bicyclist, and had 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, exercised when possible, and “done everything right.” She was slender and stiff. 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 hadn’t thought of 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, tremoring.

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.

After her third time going through the five steps, she exclaimed, “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.

Two weeks later she emailed me, "My energy is slowly but steadily increasing!"

Health problems with "no known cause"

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."

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 may be 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 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 jerk violently, feel an electric jolt of pain, break into a cold sweat, or even pass out in response to these wrong treatments. 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. (Continued on next page.)

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 evaporate or at least show signs that they are 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.

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.

A quick test for being inside/outside the body

I instruct the patient: "Close your eyes. Imagine you are walking down the street. It's a beautiful day. There's a gentle breeze, the sky is blue."

I give the patient about five seconds to imagine this, and then ask, "Are you looking at your body, or are you inside your body, feeling your sensations of walking?"

More cheerful information on the subject of what is and what is not currently taught in both Chinese and western 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 easily amused who are looking for a diverting book to while away the long winter evenings.

It's available at www.JaniceHadlock.com.

If the person is outside of his body, I'll ask if he can imagine himself inside his body, experiencing his stride from within.

If he's unable to imagine himself inside his body, there is a very good chance he is either on pause or is dissociated from his body.

Other easy things to look for

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

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 various the body parts as they are moved or are 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 may be 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 being released from your muscles and flowing up your spine, and your increased awareness of somatic resonance in the deep stillness of your body, you are probably *not* on pause.

Nearly all of my patients with Parkinson's who have steadily practiced the meditative arts have told me 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 steadily feel less and less joy and/or 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" or stay." (This same verb was used in signs that mean, "Keep off the grass," or you might say, "Stay off

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 somatic *sensations*. Then, when the exercise is done and the mind is still highly

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.

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 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.)

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 neural norepinephrine. 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 an adrenaline override and using, for the most part, brain-based logic and self-awareness even though he may be *talking* about heart and love.

A mental test for the doubters

If you do not believe that a person can have this much control over his own mind, you can do another test on yourself to see what it feels like to be on self-induced pause.

Earlier, in this chapter, you learned to rearrange your channel Qi so that you could observe what it feels like to be on pause. You did *not* alter your thought patterns. You *directly* activated the electrical schematics of pause. This caused you to experience some of the symptoms of pause.

In the following mental test, if you have good powers of concentration, you can activate *self-induced* pause indirectly, by commanding yourself to feel no pain.

Warning! Before starting this experiment, read this section all the way through

It is very important that you, like any professional hypnotist, give instruction *in advance* on how to turn *off* your command to feel no pain. The words “Come back” can serve as your hypnotic-command turn-off. This turn-off instruction must be delivered *before* you actually make the command to go into the altered, pain-free state.

It is easiest to put yourself into pause by staring at yourself in a mirror: this gives you a foot up in the process of being detached from your own body. Many of my patients have told me about using a mirror to induce the pain-free state of pause.

Stare at your face in the mirror. With no sense of humor or fun, as if your very life depends on it, command yourself (your “self” in the mirror) to feel no pain *until* you say the words “Come back.” Tell yourself that when you say, “Come back,” this new instruction to feel no pain shall be *permanently* removed from the brain.

After you’ve issued the above instructions, while you are still standing there, staring at yourself in the mirror, still commanding yourself to “Feel no pain,” notice what happens to the energy in your back. If you have convincingly done this exercise, the current in your back will be starting to stand still. You might feel a rush of “self-control” power from norepinephrine and experience somatic changes ranging from numbness and/or a flash of very short-term joy due to endorphins (opiate-like neurotransmitters that are released from the bases of the spinal nerves during pre-death).¹

After about five minutes, you might also notice your facial expression becoming somewhat numb. Your arm and neck muscles might feel as if they are

¹ Devotees of Scientology consider this brief flash of endorphin-induced joy to be proof of temporary “externalization” of the consciousness, a sign of spiritual advancement, of “rising above” the “lower” awareness that is dominant when being in the body.

The idea that the body is somehow “lower” is a widespread, but highly wrong understanding of the role of the body.

As St. Francis of Assisi would gently say of the body when his followers tried to show their spirituality through the suffering of long-term fasting, “Throw the old dog a bone.” The body should be loved and cared for, just as one should sweetly love and care for a pet dog or a donkey. You aren’t being “low” if you have awareness of your body and take care of it.

During the dark ages, many religions assumed that mortification and torture of the body was the only way to destroy one’s mental focus on the ego, sex drive, and other physical desires that distract a person from Universal Love.

This is wrong thinking. Abusing or “leaving” the body by pretending to be dead is not the way to grow close to the heart. Love the body, be in it, enjoy doing good while in it. (See: Jacob Marley’s uplifting exhortation in Charles Dickens’s *A Christmas Carol* just before the Ghost of Christmas Past appears.)

Do *identify* with your soul or the “life force” inside you. Do *not* think you *are* the body, because the body changes and dies. When your intuition and your body have opposite yearnings, listen to your intuition. Just as a pet must be lovingly taught how to behave, so must a body be taught good and healthful habits. Instead of indulging body desires for immediate gratification, the body can be trained in self-control and behaviors that allow for increased soul awareness.

Having a body or being in the body does not “lower” you. Thinking that you *are* the body and forgetting that you are the soul, that incorrect *thought* lowers you. The *ego* loves to tell you, wrongly, that you *are* the body. So discipline the *ego*. Treat the *body* with respect.

tightening, pulling in just a wee bit. Your ability to feel your heart and/or relax will be noticeably diminished.

Be *sure* to permanently countermand this order by saying “Come back” as soon as you have seen and felt enough.

Don’t do the previous test

If you are at all concerned that you will be playing with fire if you start giving yourself mental commands that are an exercise in self-deceit, such as “feel no pain,” then by all means, do *not* do this exercise. I completely respect a person’s healthy concern with regard to this mind-altering exercise.

I won’t do it, myself. I lived in that feel-no-pain state unwittingly for nearly forty years, from childhood up until the late 1990s, so I have an utter disinterest in revisiting that weird, self-induced state of mind.

I only included this exercise because some people do not believe that a person can induce a lasting neurological shift in himself simply by telling himself to feel no pain. To those doubters, I offer this proof. For everyone else, please leave well enough alone. Though, of course, if you do get temporarily stuck, you can always reaffirm “Come back” a few more times and then jump ahead to the chapters on turning off self-induced pause.

However, please do *not* be concerned about practicing the exercise at the beginning of this chapter, in which you directly, temporarily alter the flow of channel Qi in order to experience what it is like to be on pause. Have no fear: merely *experimenting* with controlling channel Qi will *not* get you *stuck* on pause. So long as you haven’t commanded your *mind* to change the way it interfaces with your body, you’ll be fine.

For that matter, if experiencing the sensations of pause via the exercise at the beginning of this chapter is new to you, you will probably be repelled by it and thus all the more prepared to *resist* this state should an occasion arise in the future that tempts you to make yourself numb.

Finally, wrapping up this chapter on diagnosing pause, you can have a friend feel how your channels are behaving. If they are flowing in pause patterns and don’t budge even when you are laughing, you are probably stuck on pause.¹

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.

¹ See footnote in chapter four regarding my book, *Tracking the Dragon*, a text for learning how to feel the flow of channels.

Diagnosing dissociation

These next few chapters will divert away from the subject of pause and consider how to diagnose conditions that look a lot like pause but which are actually held in place by a different mechanisms: dissociation, self-induced pause and self-induced dissociation. Each of these distinct problems requires a distinct treatment technique.

The subject of pause will be picked up again in chapter 10.xxx

Both pause and dissociation are natural coping mechanisms that a person might use for a short time in order to survive a trauma. However, just as a person can become stuck on pause, a person can become stuck in dissociation.

The treatments are different. *Diagnosis* is key.

Injuries that are unable to heal because of mental *dissociation* from an injured body part can lead to electrical disarray. Sometimes, the body reduces energy flow to the area. Sometimes, it shunts energy under or around the dissociated area.

In some cases, under highly specific conditions, dissociation from some body part can produce long-term electrical changes that *resemble* those that occur during pause. In these cases, the person might have some symptoms that look like pause, but he is *not* actually stuck in pause or in self-induced pause.

Around five percent of my Parkinson's disease patients were merely dissociated from an injured foot or ankle. Their symptoms appeared very similar to those of people with self-induced pause. But the dissociated patients recovered quickly: as soon as the long-ignored injury was gently brought back to the brain's awareness.

By treating a patient with a light-touch, non-intentioned holding technique such as Yin Tui Na (mentioned in chapter one), the patient can learn to feel safe enough at the injury site to mentally re-connect with a dissociated body part. Once the brain is able to recognize that an injury has occurred, it can then set in motion the necessary healing processes.

As forewarned, the word "dissociation" has multiple meanings.

One meaning is "perceiving yourself as if outside of your own body."

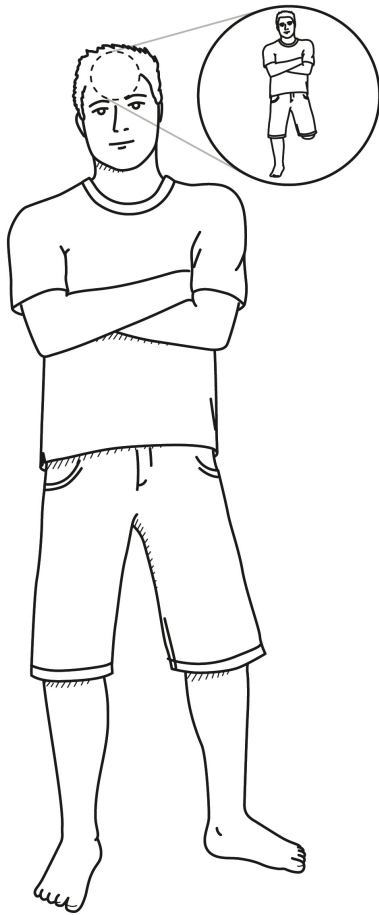
Another meaning, and possibly the most common, is psychological dissociation: as it says in the psychology texts, "compartmentalizing awareness of certain events *away* from normal consciousness." Or you might just say, "mentally blocking out unwanted information."

In *this* chapter, the word "dissociation" refers to this second type of dissociation.¹

¹ Historically, dissociation first meant distancing oneself from one's previous church. Later, the word was used to simply mean "being apart," as in this sentence from Dorothy Sayers in *Gaudy*

When someone psychologically dissociates from a negative event, he instructs his brain to behave as if the event never happened. In some cases, in the event of an injury to some body part, the brain may also interpret the instruction to read, "Pretend I don't have that body part."

For example, a person who hurts his knee badly but instructs his mind to "ignore that knee pain" might block out somatic awareness of his knee, as well as memory of the knee injury.



Or he might remember the specifics of the injury but might not be able to imagine himself or visualize himself even *having* a knee. In such a case, he may not realize that he's going through life without awareness of his knee. After all, he's dissociated from the knee, so how would he know?

It's impossible to know how the brain will respond to a vague instruction such as "I don't want to feel that pain!" Very often, the brain responds as if the instruction was "I don't want to *know* about the pain" or "I don't want to have had the pain."

Unfortunately, but logically, the body *cannot* fully heal some body part that it no longer knows about.

In the case of this hypothetical knee injury, aside from rudimentary healing of the skin and broken blood vessels, the damage to the knee may never *fully* heal. After all, the brain has essentially been told, "that knee injury never happened," or even, "I do not have a knee!"

Over time, the knee may become weak, or a source of chronic problems.

The injured area *exists*. The *brain* has dissociated from (is denying knowledge of) the injured area.

Night, written in the 1930s: "...she strongly disapproved of uncle and nephew alike, and was anxious to dissociate herself as far as possible from their affairs." (I love Dorothy Sayers' novels!)

I mention this because many people have mentioned eastern spiritual writing that encourages a person to "dissociate from his pain." In these cases, the teacher is not using that word to mean *suppress* or *hide* from pain (lie to yourself), which is the modern psychological meaning. Instead, he is asking you to not *identify* with or *belong* to your pain. The pain is only affecting the *body*. The real you, the soul is untouched by it. Lovingly care for the injured body, as you would for any injured friend or animal. Use innate wisdom and healing energy to *heal* from your pain. Don't take pain *personally*.

The brain is not clever

Why doesn't dissociation from pain stop when the pain stops?

In general, the brain is not very bright. It does *not* necessarily work in your best interests. The brain is *extremely* obedient. It learns through habit. For better or for worse, it does what you tell it to do, it thinks what you tell it to think. The brain forms neural connections in response to your instructions and habits.

The more *often* you tell it to do or think something, the stronger, deeper and faster those particular brain connections become.

The brain is not the fixed switchboard that we were taught about in the 1900s.

The brain changes constantly. It changes in response to changing instructions from *you* and the responses you choose to make to external events: your own thoughts and decisions.

The brain's ability to change is called neuroplasticity.

If you think the same things over and over, the brain effectively becomes more rigid, more locked in to doing the same thing over and over. Still, no matter how locked in a person is, he *can* change his thoughts. It requires self-aware observation of one's thoughts and the replacement of outmoded or unwanted thoughts with the new, preferred thoughts.

If one of your instructions to the brain is "pretend the problem never happened," you will have to live with the consequences of that suppression until such time as you rescind your instructions.

Electrical disarray that resembles the flow patterns of pause

How can dissociation end up looking like pause? An unhealed injury *may* eventually build up an electrical disarray: one that resembles the flow patterns that occur during that mode.

In *most* cases of unhealed injury, this does *not* occur. In most cases, a person's channel Qi is able to reroute *around* the dissociated area in a manner that leaves minimal numbness and minimal electrical alterations. The new pattern might cause only minimal (though chronic) changes in the body's *overall* flow pattern of channel Qi.

Sometimes, however, an unhealed injury is in a location that allows electrical aberrations to accumulate or even grow larger.

The foot problem

For example, a significant injury at or near the ankle or the top center of the foot can cause the channel Qi to flow backwards up the leg until the injury heals enough that current can once again flow normally through the foot. (See: diagram page 33 xxx)

A *dissociated* injury at this location might not fully heal. This can lead to *long-term* electrical disarray that just happens to match some of the electrical patterns of pause, including the Stomach channel changes seen in pause.

The narrow terminus for the long and wide Stomach channel, which runs from the face down to the foot, is located at the top center of the foot.

At the top center of the healthy foot, the Stomach channel funnels its power into a narrow switching point before bifurcating off in two very different directions: it flows to the toes for parasympathetic mode, it flows to the medial ball of the foot for sympathetic mode. Most often, some of the energy goes in one path and some goes in the other: a blend of the two modes.

A channel Qi disruption at or near this switching point can prevent normal dispersal of channel Qi through the foot. Worse, an injury near this point can cause the electrical current of the Stomach channel to stand still, or even run backwards.

Over time, the backwards flow of this current can become so established that it is indistinguishable from the backward flowing Stomach currents that occur during pause.

In pause mode, as you recall, the Stomach channel runs backwards. Backwards flow in the Stomach channels can cause other currents to also run in pause-like patterns.

When, due to a long-standing, unhealed injury in the foot, several currents run in pause-like patterns, the whole body can start to behave as if it is on pause.¹

The result of the long-term unhealed foot injury (unhealed due to dissociation) can be sections of channel behavior throughout the body that mimic those of pause. And if the *channels* are behaving as if the body is on pause, the organs, (including the brain, if the Du channel has become involved) can start behaving as if they are on pause. Rigidity in the legs, inhibition of peristalsis (digestive movement), and/or even pause-like, wary thoughts might arise. The person may even start to feel as if he is outside of his body.

In other words, even though the person has *not* experienced any sort of life-threatening damage, nor has he created a self-induced pause command, he can nevertheless start to *behave* as if he is stuck on pause.

In my experience, the underlying problem in cases of pause-like symptoms from electrical aberrations due to unhealed injury is almost always that the person has dissociated from an injury. An injury cannot heal if the person's brain has been instructed to pretend that the injury never happened or the body part no longer exists, or somatic awareness of the body part is blocked. .

Temporary dissociation is normal

Many people temporarily dissociate in a healthy way from an injury or traumatic situation at the time of injury rather than dropping everything to it nurse it back to health right there on the spot. Even very young children are able to do short-term dissociation.

For example, a very young child who hurts himself while playing in his room might *not* react right away. Instead, he will wander through the house looking for

¹ For an explanation of the simple physics of electricity and magnetism that directs these domino-effect type changes, please read *Tracking the Dragon*, available at www.JaniceHadlock.com

his mother or father. When he finds a parent, he will burst into loud sobs and the injured area will begin to throb with pain.

The ability to *temporarily* dissociate from pain is a normal ability. Most mammals have this ability. The ability to dissociate from the pain of an injury until one gets himself to a safe place can be very helpful for survival.

For example, if my dog gets a thorn in her foot while we are out walking, she will not limp or allow me to remove the thorn if another dog is in the area. As soon we are alone or as we near home, she will start to limp again and allow me to remove the thorn.

This short-term dissociation behavior, which might be appropriate at the actual time of the injury, *should* be followed up by getting to a safe place. Once there, one can focus on, soothe, and care for the injury.

Again, if a person fails to do this, if he *stays* dissociated, he can end up with an injury that never fully heals – and the electrical disarray that is caused by that failure.

A person with electrical disarray causing pause-like symptoms, one who is merely dissociated, will probably *not* have inhibition of the Du channel or stopping of the Du channel at the base of the neck: characteristics of true pause.

This is another way to differentiate between pause and dissociation.

Then again, if the injury from which he dissociated is a neck or head injury, he *might* have inhibition of the Du channel.

The more focused and intelligent a person is, the more likely he is to be able to dissociate from distractions.

A person who is deep in a book might not hear the phone ring. A person playing music might not notice the passage of time. These are all aspects of dissociation.

Failure to heal

The body is designed to heal. If a body part fails to heal completely from an injury, illness or assault, it is usually because something is preventing the flow of channel Qi through the injury area. Electrical blockage can have many causes. It can be set in place by the presence of scar tissue (which is electrically non-conductive), structurally displaced bones and/or soft-tissue, or a mental instruction to avoid the painful area (dissociation), to name just a few.

When a part of the body fails to fully heal, that body part might, for *no apparent reason*, be somewhat clumsy, frequently banged up, painful, and/or hot or cold. Symptoms of clumsiness or banging into the sides of doorways, or even “things hurting” or body functions “not working” or being “sick for no reason” (such as autoimmune diseases) are *usually* are at their worst in one or a few specific body parts.

But if an electrical current has a problem at one end, the *other* end of the current will likely be symmetrically affected, as you learned in high school physics. So it's always possible that the problems stemming from the electrical aberrations

in one location *might* end up somewhere else in the body, not just in the immediate vicinity of the injured area.

Some people develop both *body*-wide and localized problems from an unhealed injury.

There aren't hard and fast laws as to what the body might do once it's mentally dissociated from an injury *or* stuck on pause. All healthy people are healthy in the *same* way. All unhealthy people are unhealthy in their *own* way.¹

If pause-like symptoms are manifesting because of dissociation, the solution is fairly simple: re-associate with the injured area. Change the instruction to the brain. Allow the brain to notice the injured area. As soon as this instruction takes hold, electrical flow will at least *try* to flow correctly through the injury area once again. As the injury heals, the electrical flow will increasingly revert back to the normal pattern for health: predominantly parasympathetic mode.

After which, the body part that previously was "clumsy" or "often getting banged" or "frequently painful, hot, or cold, even though there's nothing wrong" can resume normal, self-healing, healthy behavior. The word "painful," in the above usage, includes *any* pathology, including *painless* situations such as lesions or tumors or numbness)

Diagnosing dissociation

If I suspect a patient might be dissociated from some body part, I want to know what he sees when he visualizes – or fails to visualize – bright, cheerful light in parts of his body, especially parts that might be having problems.

I ask the patient "Can you close your eyes and imagine a bright light in the tip of your nose? Can you imagine the inside of your nose being dark? Which is easier, light or dark?"

Most people, even if they have dissociated from some limb or torso area, are still able to imagine light in their *nose*. Of course, if they have had a broken nose or a nose surgery, they might not be able to do this. In these rare cases, I choose another presumably neutral starting point such as the chin or an ear: some small area close to the head with presumably no history of injury, scarring, or pain.

If the person says, "Yes, I can imagine bright light in my nose" (or whatever neutral starting point he's using), I then ask him to imagine light in some digit.

If the suspected dissociation is on the right, I ask the patient to imagine light in his *left* index finger. If the problem is on the left, I ask him to imagine light in the *right*. In these beginning, testing enquiries, the patient is working at increasing his confidence in being able to visualize.

Then, after he has successfully imagined light in a few places that are *not* problematic, I ask him to keep his eyes closed and imagine light or dark, whichever is easiest, in the vicinity of the problem area.

¹ Credit Tolstoi for his opening lines from *Anna Karenina*, "All happy families are happy in the same way....")

If the person has dissociated from the problem area, this area will be very hard to imagine as being full of light but it may be very easy to imagine it being dark, shadowy, or cloudy. Sometimes, it is dark to the point of non-existence. That's fine.

Very often, the person interprets the darkness as proof that the body part is badly damaged. This is wrong.

The darkness is not coming from the body part. The darkness is a purely mental construct. It's the *brain* that not being able to imagine anything in this area.

I repeat: if unable to imagine light in the area, the person is NOT actually *seeing* the damage in the area. His brain is failing to *imagine* anything in the area.

When a person imagines light in some part of the body, he is merely playing a visualization game – the person isn't actually seeing the inside of that body part. What he's seeing, in his mind's eye, is how he *feels* about that part of his body – whether or not he's even able to *think* about that part of his body.

When he sees darkness, he's not actually seeing the area. He's seeing that, in his mind, access to that area has been fully or partially blocked off.

If the area is dark, it is likely that the brain has been instructed to dissociate from the area. If that's the case, the brain will continue to do so until instructed otherwise.

Once in a while, a person has so many injuries and/or health problems that he has no idea where in his body to begin imagining light and dark. In such a case, he might choose to be methodical. He can start at one extremity (the toes or the fingers) on one side of the body and try to mentally imagine light or dark in one area after another, spreading out from the starting point. Or he can start at the head.

Another way to search for a dark spot is: "Look for the body part that you don't want to look at."

Or "Look at the area that tightens up or feels yucky when you're nervous or emotional."

Also, if a chronic problem appears as if filled with light, but you suspect dissociation, look at the very *center* of the problem area. The very core center, the size of a pea, or smaller, might be dark even though it is haloed with light on the perimeter.

Remember, not every one with a chronic health problem has dissociated from the area or is on pause. In my own practice, I've seen that *most* people's chronic problems are due to something more physical and not so much mental. Only when the usual factors are ruled out and the channel Qi keeps running incorrectly for no apparent reason and does not respond to traditional treatment do I start to consider that the patient might be using his mind to hold his problem in place.

In general, in my very limited experience, if a person has a dissociation situation or a self-induced suppression of injury or fear, the more likely he is to be highly intelligent and word-based: to some degree, "living in his head."

After a person finds some spot that's easier to imagine as dark, less bright, cloudy, or finds himself not wanting to look at a particular area, he *might* find his mind saying things like "I don't want to do this," "I can't do this," or even "I've *never* been able to visualize." If the patient finds an area that evokes these types of responses, I ask him to imagine the area is even darker, maybe even invisible. This may help him focus more easily on the area.

The area may be not merely dark, it might be a bit bizarre. I've had patients say the dissociated part of the body looked decayed or "confused." One patient said one side of the body was a rotten, stinking wharf, even though the other side of the body was filled with "normal" bright light.

If there is any darkness in a certain area, even splotchy or spotty darkness, cloudiness, or simply "something bizarre," then the person is very likely dissociated from this area of his body.

If any area inside the body is easier to imagine as being dark instead of light, and if that dark area is "heavy," "not moving," "weird" or "rotten," if it seems oppressively *motionless*, as if tied down or dead, that body part is probably dissociated away from normal consciousness.

You will recall from the first chapter, people who are stuck on pause due to a near-death trauma see a dark area that seems to be vibrating, trembling, or somehow agitated.

With dissociation, there is an *absence* of movement, sometimes an absence of the feeling of life itself.

Focusing on the negative.

Like many people, you might be saying to yourself, "Focus on the dark? Focus on the *bad* stuff? That can't be good, that can't be *right*..."

Some people are shocked that I ask people to focus on dark or tremoring places, what you might call "negative" images of their own body.

The need for some people to *focus on* and *pay attention to* the problem was one of the final breakthroughs in my Parkinson's research, and has helped with countless patients who were never able to get lasting benefits from repeated attempts at "fill yourself with sweetness and light," or "positive thinking."

For nearly fifteen years, we tried to get our patients whose injuries had healed but who were still stuck on pause to focus on positive images or thoughts. It never helped for more than twenty-four hours.

We thought our patients were stuck in sympathetic mode and needed to get back to parasympathetic.

We were barking up the wrong tree. We were treating people as if they were merely in the wrong place on the sympathetic/parasympathetic continuum. They weren't even *on* that continuum. They were on a completely different continuum, which will be described later.

Denial

Patients often resist the idea that they have dissociated from some part of their body.

Case study of dissociation from the gut

I sent an email to a long-distance patient with severe bowel disease asking him to assess if he might be dissociated from his intestines. I wrote to him about visualizing light inside, and also sent him some material on pause.

He wrote back to me (I paraphrase), “I can dissociate at will, but I usually re-experience the trauma later, when it’s safe. For example, I was attacked on the street one night, and I didn’t cry until later. But I don’t think I *store* trauma.

I *might* have some degree of injury-based dissociation due to the extreme pain I have experienced in my gut, but my experience of life is not dissociated.

He continued, “It is easier for me to imagine my gut being dark, but I *can* send light through it if I really concentrate. When I imagine my gut, I imagine it *not* in the first person (it’s not *me* seeing it). It’s as if the gut is sitting like a “tiny me” inside of my colon, or seeing my colon as though looking at a diagram. Imagining I’m looking at it directly, as if it’s me on the inside of my body, looking out, is hard when I come to that specific part of my body.

“But I can do it eventually, I can send light there from me. Just not easily. Also, it looks like patchwork in there. Some light goes through, but there are some patches that are dark. Maybe those areas are injured or scarred. My problems with my gut started a couple of weeks after a very painful breakup with my long-time partner. But I don’t think I’m dissociated from it. I can definitely feel pain in my gut. When I visualize the gut and see darkness, it’s dark because it’s *injured*, not because I’m dissociated.”

This person – like many people – is assuming that the dark areas in his gut look dark because he’s actually looking at injured areas. He is not.

He is fairly confident that he is not dissociated because he *can* see the area, temporarily, if he works hard at it. Or if some minion works at it on his behalf. Also, since he can *justify* the darkness as being due to pain, injury or scarring, then he’s pretty sure he’s not dissociated: he thinks he is just the opposite. He’s highly aware of what a mess his gut truly is, and therefore he is *not* dissociated.

He is wrong.

The imagination does *not* see what is actually, physically going on deep inside the body. The relative darkness or light in an *imagined*, given body part has *nothing* to do with what is physically happening in that area. The *mind*, not the health status or injured status of an area, determines whether or not a given body part is going to be easy to imagine and filled with light, or is dark, or a mishmash, or speckled with dark and light areas or, for that matter, illuminated as if by creepy stained glass windows, which one of my patients “saw” when he tried to imagine light in his leg.

You can’t *actually* see what’s going on in your body with your mind’s eye. Trying to visualize light or dark is merely an exercise in seeing what your mind is willing to consider. This exercise with light is a way to diagnose the *mind*. It doesn’t actually help diagnose the body.

Some patients have found it helpful to think of dissociation as causing a moat or barrier to be built around the brain cells associated with the trauma. When you

tell yourself that you don't want to feel the pain or remember the trauma to your *foot*, for example, it's as if the brain builds a neural detour around the foot-awareness part of your brain. Then, when you try to imagine light in your foot, you won't be able to. *Not* because the foot is injured, but because your mind is telling you, "There is no foot." Just as you instructed it.

The mind is obedient. If you tell it to lie or be in denial, it will lie or be in denial.

Also, if *you* aren't the one doing the looking around inside, if you are employing some mentally produced minion or alter-ego to do the looking for you, you have probably dissociated. If a body part is easier to imagine as "not bright and perfect" or easier to imagine being in some location other than the location where the physical part actually is, then dissociation is very likely going on.

Many of my patients have *not* wanted to think that they have dissociated from some body part. Some would have preferred to have an incurable illness for "no reason at all" rather than consider the possibility that their own mind is playing a role in their sickness.

For historical reasons that I'm not going to go into here (look up René Descartes vs. the Pope on the question of physical versus "spiritual" illness), western culture has long considered mentally-triggered health problems to be less "real" and even somewhat shameful, as if mind-activated problems indicate a lack of high morals.

The fact is, nearly all illnesses have a mental component. Even the *rate* of healing from an injury or illness can be influenced by mental behaviors. The degree to which a person is physically sickened by physical and/or emotional damage or stress depends to a large extent on mental behaviors.

Please don't think less of yourself if it turns out that you have dissociated from some problem or body part. It is a perfectly human thing to do. Dissociating is *not* an indication of a poor moral compass. It *may* be an indication of a relatively high intelligence and/or a high degree of mental self-control. It may be a *misguided* intelligence, driven by fear-based commands rather than wisdom, but a strong intelligence, nevertheless.

Then again, if you find yourself wanting to *justify* the darkness that you have created inside yourself, it may be helpful to note that *some* people – people who are *not* using dissociation - can imagine bright light even in terribly injured or smashed-up parts of their bodies, even if they are in a significant deal of pain. Some might even automatically imagine angels getting in there and healing the injury. In fact, imagining light or miniature loved ones in a painful area is one of the most effective ways to reduce the pain and accelerate healing.

How one responds to pain or damage depends on one's personal style in dealing with difficulties. You *can* say that dissociation is not rare. You cannot say that *everyone* does it, or that it's automatic. It's a decision.¹

¹ I highly recommend *Where There is Light*, an extraordinary memoir by Jacques Lusseyran. He was part of the French resistance during World War II. He was captured. When he was dying in a

If there is no light in an injured or sick area, it means the brain is trying to avoid acknowledging the existence of that area...because you told it to do so. In such a case, there's no way that efficient, complete healing is going to occur until you re-associate with the area in question.

Nazi concentration camp, he decided to once again fill himself with light, a practice he started when he lost his eyesight as a young lad, but which he abandoned when he was captured. He survived and wrote his autobiographical book. The book makes a profound argument against the negative practice of dissociation and the positive practice of literally keeping oneself filled with light regardless of circumstances.

In 2015, a movie based on his experience was released. The movie title is different from the book. In a cursory search, I could not find the movie title .

Distinguishing dissociation from pause

Both dissociation and pause can cause the brain to perceive “damaged” areas or “off limit” areas as dark. To determine if the problem is dissociation or pause is fairly simple.

Dissociated

If the area just seems like a dead lump, or heavy and motionless, or even oppressively immobilized, that area is most likely dissociated. Re-association, or you can say “re-connection,” is called for.

On pause

If the area is dark and *trembling*, or vibrating, sludgy, or even “bubbling,” as one patient described it, that area is most likely associated with a pause-inducing trauma. Turning off pause is called for.

As described in previous case studies, people on pause have been able to easily “see” (imagine) that some dark place inside was moving in an agitated manner.

Using self-induced pause

If the dark area comes and goes, moves around or is otherwise evasive, self-induced pause or self-induced dissociation is probably at work.

If the dark area, whether dark and immobile *or* dark and agitated, lightens up in response to treatment, but becomes dark again in ten minutes or over the next week, it’s probably from *self-induced* pause or *self-induced* dissociation.

The term “self-induced” means that the person made a conscious decision to be in control of his sensory perceptions, memories, or behaviors. He commanded himself to behave in a somewhat artificial manner.

In these cases, the problem is that the person never got around to turning off that instruction. The mental instruction, still working away as instructed, is what keeps restoring the darkness, keeps the problem from healing.

What if It’s *all* dark?

It is not unusual for a person to say, “I can’t see anything. Everything is dark. There’s no light in my nose, or anywhere.”

In such a case, look around in the darkness for the area that is the darkest or densest of all, or the area that most “doesn’t want to be seen.” Don’t spend more than a minute on this.

Gaze into the area that *most* doesn’t even want to be looked at to see if it’s heavy and/or still, or moving and/or agitated. This should only take a few seconds.

If no area in particular comes to mind, do check out the base of the spine or the areas that tense up when you’re under stress, such as stomach, throat, or solar plexus.

If the mental image of one's insides is uniformly dark, and no one area seems darker or more stand-offish than another, then you can assume the problem is probably one of self-induced pause or self-induced dissociation.

Test it out

If you have some body part that is chronically weak or susceptible, imagine light inside the body, starting with the nose, as noted earlier. If/when you get to the vicinity of the problem area, play with visualizing in the area: notice if it's easier to imagine as dark than as light. If it's easier to imagine the area as dark, then focus on that dark place. This whole seeking event should take less than a minute. This is not something to spend hours on. A quick internal glance will tell you if it's easier to imagine an area as dark or light.

Next, let yourself gaze into the dark area. Let yourself imagine it as *really* dark.

Next, notice whether the very center of the dark area is better described as heavy and/or motionless *or* vibrating and/or agitated. This should only take about five seconds. Please don't worry about the exact nature of the movement, if any. Everyone's imagination can present in a unique way.

The "non-movement" seen in a dissociated body part is acting that way because, according to the brain, the area doesn't exist.

Oppositely, the vibrating, trembling, or even "burning" in an area that is on pause can be thought of as the traumatized area "waving its hands" at the brain, trying to get the brain's attention so that the process of coming out of pause can be triggered.

Which comes first, pause or dissociation?

Both pause and dissociation might be present at an injury site.

In this case, the person *might* first see a dark, heavy, non-moving area when he gazes at the area. However, after turning off the dissociation by mentally reconnecting with that area, he may discover that the area is now dark and trembling. The underlying pause situation has been exposed, and can be addressed.

Or oppositely, his inner gaze *might* first reveal that some body part is dark and agitated. After turning off pause, the area is dark and heavy: dissociated, and able to respond to techniques that reconnect.

Because both dissociation and being stuck on pause are caused by the person failing to address the original trauma in a timely manner, they can both be thought of as mind-based, rather than biological, creations.

This means that there is *not* a one-size-fits-all scenario to describe what the person might mentally have done while quickly sequencing his original trauma response.

If a person put his trauma on hold, all bets are off when trying to figure out whether pause or dissociation came first. He might have one, the other, or both.

Don't *worry* about whether dissociation or pause came first. Just treat whatever presents as dominant. If, following treatment, something else shows up or becomes dominant, treat that.

For pause, use the five-steps treatment described in chapter one. For dissociation, use the treatment described in chapter xxx.

However, if both the dissociation and the pause are treated and the body becomes full of light *but* five minutes later or the next day or week those body parts are dark again, then *self-induced* pause or dissociation is most likely the culprit.

That requires a completely different treatment because the person needs to destroy a brain pattern that started with a powerful mental command to “feel no pain” or something similar. This subject will be covered later.

Other combinations

It is also possible for a person to have an assortment of issues, including being both dissociated and using *self-induced* pause. Or to be mildly dissociated from his whole body and *extremely* dissociated from his limbs. Anything is possible.

This next section may seem confusing. Just skim through it. The point is merely that logic and neat labels do not necessary exist when a person has decided to suppress his emotions and/or his past.

For example, I had one patient whose entire body was perceived as from the outside. He was on self-induced pause.

He perceived himself as being outside of his body. Inside his body, everything was dark. *But*, and here’s my point, his neck and arms were darker and *more* dissociated than the rest of his body.

When, with eyes closed, he imagined he was looking at his *arms*, they were withered and nearly dead, and sticking straight up in the air, unable to be lowered. His own mental image of his neck was that it was snapped, as if he’d died from a hanging.

This person had both self-induced pause and dissociation from his arms and neck. His whole body was on pause *and* his arms and neck didn’t even “belong” to him.

From his out-of-body perspective, looking at himself, his actual physical body – with normal looking arms – was a mere object, which he could observe from his paused vantage point of floating in space, observing his physical body from a distance.

When he temporarily slid into the personality that *didn’t* have pause, by recalling how he’d felt being in a famous dance company in his youth, he could move his arms perfectly normally. In fact, after about half an hour out in his yard, with me encouraging him to pretend he was still a dancer (I held his shoulders and moved him in small circles while singing), while he protested he couldn’t remember how, he suddenly began to trot in big circles, flapping his wings like a bird. Next, he held his arms out sideways and played at being an airplane, dipping and banking. He was radiant and laughing. As soon as he stopped, his body became rigid again. He had to be helped into the house, and his arms were once again pressed hard against his torso, nearly impossible for him or me to move.

Making the case even stranger, he was pretty sure his neck dissociation started when he saw a movie in which a person was hanged by the neck. He had no recall of any neck incident that happened to him – it was from a movie.

This example might seem over the top, but I can assure you, I've had patients, especially patients with Parkinson's, who've presented with even stranger ideas about where their "real" bodies actually are (miles away, in many cases) and what their various body parts are doing, and can nevertheless switch into normalcy for a short time if doing something that they've decided is safe. And no two people have the same definition of "safe."

In terms of deciding which to treat, if some body areas are on pause and some are dissociated, treat whatever you think is the main thing presenting at the moment. What you treat first doesn't really matter, in the big picture.

The nature of the more dominant problem (pause, dissociation, or even self-induced mindsets) can change in response to treatment: a different problem may come to the surface and grab your attention. Again, an area that is dissociated may turn out to be hiding an old injury that has triggered pause. And vice versa.

Don't worry about what, exactly a person is in terms of labeling. A person on pause *or* dissociated *or* using self-induced behaviors might be dissociated from his whole body, some parts of his body, or even somewhat dissociated from the whole body but *extra*-dissociated from certain body parts or events related to those body parts. And he might have local areas on pause or be on body-wide pause.

In general, treat the self-induced behaviors first. After turning off the commands that are maintaining self-induced pause or dissociation, it will be easier to re-associate with the other body parts that "don't belong" or turn off any residual local areas that are still on pause.

Behaviors and emotions

A dissociated person may not have some of the same mental and emotional thoughts and behaviors as a person who is stuck on pause or using self-induced pause.

A person who is merely dissociated *might* have more access to his emotions (might know what it means to "feel the heart expand") compared to a person who is stuck on pause or self-induced pause: he might be able to cry easily, he might be able to imagine visual images with ease, he might have no resistance to the idea of "surrender." He may be able to somatically feel the parts of his body that are not dissociated. Then again, he might not. But in *general*, a person who is only dissociated will have these inhibitions to a lesser degree than a person who is stuck on basic pause *or* self-induced pause.

In many other subtle ways, a person who has merely dissociated behaves physically and mentally somewhat more "normally" from a person who is stuck on pause or self-induced pause, even though *some* of his electrical patterns might be flowing in a manner and causing symptoms that seem similar to those of pause.

Basically, the brain can do anything it darn well pleases. There are no limitations to the mischief a person can get into with his own brain. When, with the best of motives, a person starts down the path of suppressing pain or lying to himself about his trauma or injury, instead of observing it and dealing with it in a timely manner, anything can happen.

There are no hard and fast rules for what an individual might do to himself in the privacy of his own mind. Don't worry too much about categorizing your brain's misperceptions.

Just jump in and start correcting them.

In my own work with patients, I really don't worry too much about which came *first* if the patient is dealing with basic pause *and* dissociation.

If the patient imagines he's dark and *vibrating* or *agitated* somewhere inside, I help him turn off pause.

If he's dark and *heavy* or *immobilized* inside, I have him do techniques to re-connect.

If he's not sure, or he's seeing bits of both, I have him do both, one at a time, addressing whatever situation comes up first on his visualization radar.

If the area becomes light and the agitation or immobility resolves but returns again, I have him destroy the commands he gave to his brain, commands that keep these suppressions in place.

It's not as if there's a specific brain flaw that needs to be laboriously altered. It's more a question of getting the person to start being aware of his own thoughts and working on the ones that are stuck in a pattern that is causing health problems.

The techniques for fixing both basic pause and dissociation only take a few minutes to perform. It's OK to play around with them and have a bit of fun while quickly learning how to re-take charge of your own mind.

A memorable work moment for me was with a patient who had been steadily re-connecting with each of the places in his body from which he'd dissociated. He had slogged through the two-minute technique at more than a dozen dark, dissociated locations. He suddenly stopped in the middle of re-connecting yet another dark and immobile spot. He yelled to his own brain, "Screw it! Just re-connect with everything!"

Suddenly, all the dark and heavy places were gone and he was back in his body. He was so pleased. He was back in charge.

In summary, even if you have *symptoms* of pause, you will want to determine whether you are actually using pause or using dissociation. Then treat accordingly.

Diagnosing self-induced pause & self-induced dissociation

Chinese terminology

In Chinese medicine, a condition that has stabbing pain and is *fixed* (stays in one location) is called “Blood Stagnation.” This can be translated as: physical, tangible blockage or obstruction, including blockage of fluids and electrical energy. Blood stagnation is usually the result of injury or internal damage from illness such as a ruptured appendix or hernia.

A condition that comes and goes is considered a manifestation of “Qi Stagnation.” Some health issues come and go in response to foods, weather, circadian rhythms, movement against pinched nerves and other chemical or environmental influences.

A condition that comes and goes in response to stress and/or emotions is also considered to be Qi stagnation. (In English, “Qi Stagnation might best be translated as “a blockage or aberration in the flow of channel Qi, as opposed to a physical blockage from a broken bone or other injury.”)

Qi Stagnation situation that comes and goes in response to stress or emotions can be considered to be, at least in part, mentally driven.

In western medicine, some syndromes with come-and-go symptoms are also assumed to have a psychological component, with this major difference: in western medicine, it is sometimes assumed that the patient’s problem is therefore not “real.”¹

Mental behaviors that lead to Channel Qi disorders are real. The channel Qi alterations can cause physical damage and emotional stress. People can experience pain, suffering, and death from illnesses and channel Qi disorders that have a psychological component.

Self-induced pause behaves like “Qi stagnation”: its symptoms can come and go or move around. Symptoms might vary in severity depending on mood or external circumstances. It doesn’t matter if the patient imagines himself dark and

¹ For years, people with chronic fatigue syndrome were dismissed by MDs as “head cases.” After the virus that causes it was discovered, many MDs were still reluctant, for decades, to take seriously those people who had this syndrome, previously considered “purely psychological.”

People with fibromyalgia have likewise been marginalized and even mocked by their doctors. Only after research showed chemical changes in specific body areas were some doctors willing to consider that the come-and-go, move-around pain of fibromyalgia was an actual, physical problem for the people that suffered from it.

One of the hardest problems in advancing the discovery that Parkinson’s disease is, in most cases, the result of self-induced electrical disarray due to the long-term pain and fear suppression that triggers pause-like symptoms, is that people with Parkinson’s are seen as hard-working, upright people – good people: people who shouldn’t be *accused* of having a psychological problem. Even today, doctors and the population in general often think that psychological problems automatically make a person less deserving of help and compassion.

vibrating (pause) or dark and oppressively motionless (dissociation). The real problem is neither pause nor dissociation. The real problem is a self-directed instruction to *not* deal with pain or fear – an instruction that has never been rescinded.

If a person can turn off pause while relaxing in my office and his Channels are moving in parasympathetic mode *but* the channels revert back to the pause pattern in a few minutes or a few weeks, then he isn't "stuck on pause" due to life-threatening damage - he is using self-induced pause.

Somewhere in his brain is an instruction that says, "At the first sign of danger, pretend you are numb!" or "Live in your head!" or whatever phrasing the person used at the time he decided to be in conscious control of his somatic functions.

A major breakthrough in my research

A person stuck on pause *cannot* slide in and out of the parasympathetic mode continuum.

A person who is using self-induced pause *can*. (This is why so many people with Parkinson's respond so well to placebos.)

The ability of my Parkinson's patients to slide in and out of parasympathetic mode baffled me for nearly two decades.

For example, I had one patient with advanced Parkinson's who could move normally if she was doing the laundry, even when her symptoms were increasingly severe at all other times. She explained, "Doing laundry is always good."

Another patient never had Parkinson's symptoms after 6:00 in the evening, when he got home from work. He was stunned to learn that some people have Parkinson's even when they are at home. He even asked me why anyone would *need* to have Parkinson's at home. He'd never mentioned to his neurologist that it only happened away from home.

One patient *never* had Parkinson's symptoms during sex.

Many patients had *worse* Parkinson's symptoms during sex.

Some never had it while playing music or painting.

Other never had it while playing with the grandchildren. Others were worse when the grandchildren were around.

What made an activity "safe" or not was all over the place, and very often made no sense at all.

Many, maybe most people with Parkinson's have lots of safe times when they are first diagnosed. Over time, the number of "safe" activities dwindles. Eventually, many people with Parkinson's have no safe times at all. Even so, the *severity* of their symptoms might vary depending on mood and external circumstances.

Although this baffled me at first, I now use this come-and-go behavior as a helpful diagnostic. For example, if a person with Parkinson's can move perfectly normally during a "safe" time, but reverts to Parkinson's inhibitions when the safe

time is over, he is *not* stuck on pause, nor is he dissociated: his Parkinson's is due to a self-created mental *instruction* to use pause *or* to use dissociation. Or even both.

(For the rest of this chapter, for brevity, I will mostly use the phrase self-induced *pause*. Please know that self-induced *dissociation* is included in the discussion.)

A person with a self-induced condition can slide in and out of pause because he is *not* actually on pause. Although he doesn't realize it, he is only pretending to be on pause. The same goes for the self-induced dissociation.

Years earlier, he commanded himself to *behave* in a certain manner, which the body answered by setting in motion pause mode. But he is *not* actually on pause; he is only physically and electrically *behaving* as if he is because he told himself to be impervious to pain or fear or whatever.

If he has not carefully created a similar instruction to turn off this behavior at a later time, he will not be able to easily stop it. This "acting," if you will, will slowly snowball into a major personality. Because of the way pause neurology works in the brain's risk-assessment area, he will be unable to turn off the act until such time as he feels safe. But the instruction telling him to behave as if he's on the verge of death seems to create a brain pattern that, over decades, genuinely makes him feel increasingly *unsafe*.

Getting back to the diagnosis aspect, a patient with self-induced pause may also have a dissociated injury or two or more. A person using the pause personality *tends* to dissociate from injuries.

Very often, a person's dissociated areas behave as if they are mentally linked with use of the pause pattern. If pause turns off, so does the dissociation. If it does, the old dissociated injury might suddenly be painful, seeming to appear "out of nowhere."

Then again, if the dissociated injury is *not* linked in his brain with his pause personality, then when he temporarily stops using the pause personality, he *might* stay dissociated from his injury.

Examples from the office

Before I figured out how to turn off self-induced pause, I worked on many Parkinson's patients' injuries using the extremely supportive technique of Yin Tui Na called Forceless, Spontaneous Release, or FSR. You can think of FSR as being a human elastic-support bandage.

FSR treats dissociated injuries. Yin Tui Na just means any kind of non-forceful, hands-on treatment. FSR, a type of Yin Tui Na, is *extremely* passive and non-intentioned. The "therapist" (it could be a family member, even a child), just holds the injured area firmly.¹

¹ Many westerners are at a loss when told "Just hold the injured place." So I've written a book on Yin Tui Na. It has turned out to be popular with massage therapists as well as acupuncturists and other professionals in the healing arts. But it was written for the layperson, a non-professional who wants to learn how to provide hands-on support to accelerate healing and, sometimes, help a person re-associate with an injured area.

I had seen patients recover from long-term illnesses, and even a few recover from “incurable” Parkinson’s disease, in response to Yin Tui Na treatments. I assumed, in the early days of my research, that *all* people with Parkinson’s had the same underlying cause. (They don’t, it turns out.)

After seeing some people recover after re-connecting with a dissociated injury, I wrongly assumed that dissociated injuries were the *only* cause of the Parkinson’s symptoms: symptoms that turned out to be are a dead ringer for pause...but I didn’t yet know about pause mode.

About five percent of my Parkinson’s patients recovered quickly and completely after re-connecting with a dissociated foot injury.

But *most* of my Parkinson’s patients recovered for only a few hours, days, or a week or two at most, and then their symptoms returned – usually with a vengeance. I incorrectly assumed, for years, that these people were more deeply dissociated, and just needed more FSR treatments than the people who recovered quickly.

It turned out, these people with returning symptoms *weren’t* stuck on pause or merely dissociated. They were still using self-directed commands, usually issued in childhood, to avoid fear or pain. No matter how many times these people felt safe in my office and experienced a cessation of symptoms, these childhood commands restored their pause-like behaviors *and* any dissociations linked to pause at the first sign of risk. “Risk” gets steadily redefined after the mental instruction is installed.

Many people with Parkinson’s wake up in the morning and feel perfectly normal until they come to full consciousness. When they realize that they are alive and awake, they can feel the Parkinson’s symptoms kick in. At this point in their “degenerative” illness, “Being alive” has become a risk.

If you totally understand the above, just skip the rest of this chapter. If you are wondering what I’m talking about, I’ll give some examples of how this plays out.

Case study behaviors

Before I understood the risk of treating the dissociated injury before turning off self-induced pause (the risk is that it often strengthens the blocker personality, not yet discussed), I treated the injured/stiff/ dead-feeling area, usually on the foot or ankle, in my Parkinson’s patients.

The displaced bits of bone and/or soft tissue settled back into their correct position. Swelling might show up in the previously numb area, or soreness, or the patient might suddenly remember the injury event, if it had been long forgotten. Blood circulation or nerve function might return. The injury moved forward with healing.

The person might feel more relaxed, “lighter,” maybe even less tremor-y, as if something deep inside was cleared up.

In five percent of cases, the patient maintained the improvement and quickly recovered from Parkinson’s.

The book, titled *Yin Tui Na: Techniques for treating injuries...* is available for free download at pdrecovery.org.

But if the patient was using self-induced pause, his body would soon behave as if the actual *injury* had returned! As soon as he felt anxious or wary, his Parkinson's symptoms returned...as would the *symptoms* of his dissociated injury, even though the injury was utterly gone.

Brain linkages

I now suspect these injuries were mentally linked with the patients' pause instructions. The thing the brain does best is make links.

When you hear a song from your teen years, your brain triggers a cascade of links. You might feel the emotions you had when you first heard the song. You might have sudden recall of old friends long forgotten, you might even remember the smells that had wafted through the air as you listened to the song the first time.

The brain makes links.

If an injury was ignored (dissociation) because a person was currently using self-induced pause (feeling no pain), it's very likely that the brain's associations with the injury will be linked to being on pause. As soon as the pause personality returns, the injury symptoms return – even if the injury has completely healed.

I saw this over and over.

So many patients, hundreds, were symptom-free after a treatment session, but their symptoms returned the moment they walked out the door of my office or as soon as they got in their car to go home. The previously rigid patients might have waltzed around my office but when they stepped outside the door, the old foot spasm kicked in, the painful limp returned, or whatever.

At this point, I was often told, "You didn't fix me enough."

So many times, a patient left my office with a bounce in his step, declaring that his injury was healed or healing. He could feel increased blood supply in the injured area, and the injured area might be feeling unaccustomed tenderness, soreness, and/or flexibility.

A week later, when he came for his next visit, the patient had dissociated from the site of the old injury again (it was dark and immobilized) *even* though the injury had obviously healed in the meantime. Even though I might be able to move the previously rigid joint in every correct direction, and the previously displaced bones were still in the right place, the patient was, once again, mentally experiencing the injury area as dark and trembling or dark and heavy, whichever his mind thought was the best way to go. And the hammertoes or torqued ankle or whatever appeared to be the same as before or *worse*.

The patient was usually determined that his foot or ankle *injury* had spontaneously returned. It hadn't.

The mental habit of *behaving* as if the injury was still there had returned.

The patient's body part was just as tensed up, or purple, or circulation just as inhibited as *if* the injury had returned. The channel Qi would be running backwards, or standing still, or whatever the previous situation had been. All the pause

symptoms would be up and running again *and* the symptoms and the dissociations from injury would have returned, as well.

If I held the injured area in Yin Tui Na, again, briefly, it will often start behaving as if it was healed, again. The area would quickly relax.

Blood flow would return to the area. Channel Qi would quickly flow correctly. But again, at the first suggestion of anxiety or danger, the flow shifted back to paused-and-injured.

At first, I was baffled by this phenomenon. Now I know that this is an indication that the patient is using a self-induced behavior that mimics pause and/or dissociation. Until the self-induced mental format is destroyed, the habit of injury *symptoms* might return every time that pause kicks back in.

The joke test

Very often, if the injury or the electrical pause pattern has “returned” after having been healed, I will tell the patient a quick joke. Within seconds, the channel Qi will almost always flow correctly. The pain and rigidity, if any, may begin to melt away. (The tremor, if any, may or may not remain in place. Turning off the tremor can take several minutes. The joke test only takes a few seconds.)

I then pretend to feel something troublesome in the channel Qi of the leg. I say out loud, “Uh oh...”

The patient hears me say “Uh oh...” and almost immediately, the Stomach channel Qi flowing under my hand reverts to the pause pattern. The other channels, upon examination, are also running in the pause pattern.

Very often, the rigidity or tension in a specific location, such as toes painfully curled under (the opposite of hammertoes) or flattened foot arch, problems that were directly related to the *injury*, returns.

This “joke test” proves that there is no longer an actual injury. An actual injury would prevent the flow of channel Qi regardless of the patient’s state of mind. A *physical* blockage of channel Qi does *not* come and go depending upon mindset.

In the joke test, the patient’s channels flowed correctly so long as he was relaxed, in the safety of my office.

This joke test proves that the person is using a mental directive to jerk back into pause mode at the first sign of trouble: self-induced pause or self-induced dissociation.

What it also shows is that the injury-induced muscle *behavior*, such as hammertoes or flattened arch, which developed after the patient dissociated from a foot injury, has a brain link to the person’s pause pattern. When the paused personality kicks in, the muscle response to the injury resumes, even though the injury has healed.

But shutting down is just normal, isn’t it?

Patients often protest that it’s *normal* to shut down and assume the physical behaviors of someone on the verge of death in response to someone saying “Uh oh.”

I have to explain that it's normal, if a person responds at *all*, to respond with a slightly elevated *fight or flight* response.

It's *not* "normal" or healthy for a person to respond to the slightest suggestion of risk by invoking near-death behavior and perceiving himself from outside of his own body (pause).

It is also not healthy to respond to the slightest suggestion of risk by pretending that you don't have a body part (dissociation).

The following case study demonstrates the come-and-go nature of self-induced dissociation. It also introduces a very common scenario: a *combination* of self-induced dissociation and self-induced pause.

By the way, in order to do the techniques for a self-induced condition, you do *not* need to know what the original instructions were.

You just need to tell your brain how to deal with "the brain cells that are sustaining the habit of...(fill in your own symptoms) and/or "any brain linkages created to indefinitely suppress fear and/or pain."

There's a bit more to it than that. The techniques are in the chapters on treatment for self-induced pause and dissociation. For now, I just want to assure you that you don't need to remember whatever it was you actually said to yourself at the time.

Case study: broken leg on the golf course

A patient, female, age 72, a healthy, very busy professional had burning pain in her legs. The pain was much worse in the evenings, or whenever she was pressed for time or under stress.

A year earlier, a golf cart had rolled over and landed on her right foot, ankle, and lower leg, breaking several bones in her foot. The event had also thrown her onto her head.

She had worn a heavy stabilizing boot for a few weeks, but decided it was an inconvenience and stopped wearing it. Instead, she told herself, "I don't need this. I'm not going to let this slow me down!" (She didn't remember having given herself these instructions until *after* she did the techniques for turning off self-induced dissociation.)

From that moment, she had no pain in her foot and was able to move normally. She had the usual follow-up visit with her doctor after six weeks. The doctor was concerned about how the foot moved. She x-rayed the foot and found that the bones were still broken.

Even so, my patient assumed that the bones would heal, given time, considering that she no longer had any pain.

About six months later, the burning pain in the legs showed up. At the time, she associated it with an allergic rash that she got while using a soy-based probiotic (gut bacteria supplement). When she stopped using the probiotic, the rash on her chest cleared up, but the heat in her legs remained. By the time she came to see me,

the heat in her legs was becoming extreme, and in the evenings or during stress, it was nearly unbearable.

When I started working with her, it was clear that the bones were still slightly displaced and very possibly still broken.

I did Yin Tui Na on the lower leg, ankle, and foot, but *first*, I had her address various areas in her body that were either stuck on pause or dissociated.

The back of her skull was dark and heavy, not moving, as were her right shoulder, the medial (inner) side of her right knee, and her right ankle.

When she imagined looking at her third cervical vertebra (neck bone), about an inch down from the base of the skull, she saw an area that was dark and vibrating. She saw another area that was dark and “burning” (which qualifies as vibrating or agitated) just below her right knee on the lateral (outer) side, and on her right ankle on the medial side.

Basically, she was a collection of dissociated and pause locations. The areas that were dark and agitated were locations where her injuries had been dangerous enough that she felt she was at genuine risk of death: neck and knee.

The areas that were dark and not moving had obviously been injured, but she was able to merely dissociate from them (“I don’t need this.”) Maybe her subconscious didn’t see those injuries as “possibly lethal.”

In my office, she re-connected with the dissociated areas and turned off pause in the body parts that were dark and vibrating.

I treated her foot with Yin Tui Na. Bones slid back into place, the muscles in her leg relaxed.

She had no heat symptoms for the next twenty-four hours. But the symptoms returned the next evening, in response to thinking about an upcoming golf event.

At our next session, when she told me her symptoms returned after being gone for a while, I said I suspected she was dealing with a self-induced situation. She did not agree.

So once again, I had her go through the steps that turn off pause while focused on her right ankle.

Even though the friend she invoked for turning off pause (steps two and three, described in chapter one) assured her she was not at risk of imminent death from the gold cart injury, she had a hard time agreeing with him.

She had a bit of a struggle, going back and forth between what her friend was saying: “You’re not going to die” and what *she* wanted to say: “But I am at risk of imminent death!” She battled this out for about two minutes – which seems like a long time if you’re in the middle of it.

She finally said to me, out loud, that she was *not* at risk of imminent death from the gold cart injury. It was hard for her to get those words out.

She immediately took a deep breath and was able to do the neck bobble and shiver that occurs when pause is turned off.

Her legs had no heat for nearly a week.

However, after six days with no burning heat in her legs, she set up a golf date for the next day. The burning pain in her legs returned that night, full bore. It

was gone in the morning, but resumed for the whole time she was on the golf course.

Since her symptoms had been gone for six days, her problem was obviously no longer the broken bones or being stuck on pause. She was obviously in a self-induced condition. When I saw her next, she was once again using a combination of pause behaviors (visualizing body parts as dark and agitated and dissociation behaviors (dark and immobilized) in areas that had previously been “cleaned up.”

At this point, she laughingly admitted that her subconscious was playing tricks on her.

I led her through the treatment for self-induced dissociation.

This time, the darkest area was at the base of the spine – an area that is often dark and vibrating when a person is in a near-death condition. In her case, it was dark and immobile, not dark and vibrating – but that doesn’t matter.

The whole problem, at this point, was a brain construct. When it’s purely a matter of consciously-installed brain instruction to suppress facts, it doesn’t really matter if the brain has thrown up a wall of pause-like symptoms or dissociation-like symptoms.

After quickly getting rid of her misguided brain instructions, she had no more episodes of burning pain in her legs. She told me later, she hadn’t even realized it consciously, but for six months she had been subconsciously avoiding the golf course and even finding ways to get out of golf dates. After getting rid of her self-induced suppressions, she found herself keenly looking forward to getting out on the links.

The above case study shows how the patient was diagnosed with both pause *and* dissociation. After her symptoms and her imagined dark areas kept returning she was then able to admit that she mind seemed to be contributing to her problem.¹

¹ In the first chapter, I suggested that being stuck on pause (or being dissociated) could lead to a wide-ranging collection of symptoms. The “golf cart injury” patient contacted me a month after the pain was gone from her legs. Could I help her with the severe hair loss on her forehead that had started about six months earlier? Her MD had told her there was no cure.

When I worked on her golf cart injury, I had never even checked her Bladder channels down by the ankle. The Bladder channel, running behind the lateral ankle bone, is not involved in foot injuries as often as the Stomach and Gall Bladder channels. But when she came in for the hair loss issue, I found that the *head* portion of her Bladder channel that bordered the hair loss zone wasn’t running and neither was the *foot* portion of the same channel. This type of electrical symmetry in channel blockages is common, and is a basic characteristic of electrical currents. This isn’t mystic Asian medicine. This is high school physics.

Long story short, she was still dissociated from the Bladder channel portion of her injury. She worked on re-connecting, I did Yin Tui Na on her ankle, and within fifteen minutes she said softly, “Oh my! I’ve got feeling in my forehead! I didn’t even know it had been numb!” A week later, she emailed to say she had increasing feeling in her forehead. Her hair had been falling out and a line of inflammation had been growing across her hairline in the area that had been numb due to lack of channel Qi in the vicinity.

This is just another example of how health problems can be due to pause and/or dissociation.

Summing up

For diagnostic purposes, if a person's symptoms spontaneously return after a hiatus of any length, if symptoms vary depending on mood or external circumstances, the person is probably using a self-induced suppression mindset.

Whether the symptoms appear as pause or dissociation doesn't matter. The actual problem is the mental instruction to *not* process pain or fear: a mental instruction to suppress it or hide from it.

Healthy use of self-induced pause: a case study

While proof-reading this nearly-finished book, I learned that a patient of mine was accustomed to inducing pause as a tool for focusing on his work. His explanation was illuminating. I inserted this case study into the book right here, even though I had to change all the following chapter numbers.

I had seen him a few times over the last ten years. He always came in to speed up the healing of some injury. This time it was low back pain from playing with his increasingly heavy three-year old. He was thirty-two years old.

The last time I'd seen him, for elbow pain, I'd had written in his notes, "(Goes into pause, briefly, when acupuncture needles go in.)" This was based on noticing how his channel Qi behaved when I inserted acupuncture needles.

Since I'd last seen him, I had learned a lot more about pause. I just *had* to ask him a little bit about his habit of sliding into pause in response to needle insertion and going back into parasympathetic after the needles were in. I was thinking he might be using *self-induced* pause: come-and-go pause.

I had to bring it up in a way that didn't worry him or suggest there was anything wrong with him.

So when he came in, I said, "Before we get started, I just want to check something. If you imagine yourself walking down the street on a beautiful day, what do you perceive? Could you try it right now for a few seconds? Then I'll ask some questions."

After giving him five seconds to imagine this, I asked, "Are you *looking* at yourself walking down the street, or are you inside your body, *feeling* yourself moving?"

His shocking reply was, "I'm getting myself inside my body, so that I can feel it."

I had never heard this response before. I blurted out, "What?" I'm confused." I asked gently, "Are you *in* your body or *out* of it?"

"Well, I started out being out of my body, but for something like this, I'd rather be inside, feeling it, instead of using the outside perspective. It can take a moment to switch over."

"So, you can *choose* whether or not you're going to be inside or outside?"

"Well, yeah, so when you asked me, I was in the middle of getting back inside."

I was stunned. Then I hit him with a barrage of questions. "When did you start being able to do this? What are your triggers for being outside? What do you perceive as the benefits of the two ways of being?"

He replied, "I use it a lot when I'm working. I do electrical engineering problem solving. Sometimes it's easier to focus on a problem when I step outside. Then I'm looking at the situation while being sort of shut down in my body, and my mental focus is sharper. I get real still. I don't get distracted. I don't even feel my

body. I can get *really* clear focus, a new perspective on the problem. It can be really helpful.”

He continued, “I call it ‘the coach.’ It’s like I’m playing a sport, and if I need to, I can switch over and be the coach watching myself from the sidelines. From there, I can see more clearly what I need to be doing. So *then* I go back inside. It’s better being inside, because I can *feel* myself, I’m more alive. But sometimes, for work, when I just need to see a problem from a different perspective and have a more powerful focus, I go outside.

He went on, “It’s funny you want to know about it. No one has ever understood me when I talk about it. No one. They have no idea what I’m talking about!”

I laughed an ambiguous Yeah.

I added, “I’m curious: why *would* you tell your friends about it?”

I marveled that he mentioned it to his friends. Most of my patients on pause don’t even know they’re doing it. If they *are* aware that they are “playing dead” or pretending to be numb, or “keeping up barriers,” they feel the need to keep it a secret. If they *do* remember the day they commanded themselves to feel no pain, it was a dark secret. They would *never* talk to their friends about it.

He replied, “Well, if someone gets hurt or they’re real scared, I suggest they just go outside of their body for a minute and calm down, observe the situation objectively. But no one ever knows what I’m talking about.”

“Do *you* ever do this when you’ve been injured?” I asked.

He answered, “Oh yeah, but I’m always real careful to come back in. And after I get back in, I have someone hold the place that got hurt. You know, just put their hands on it. It’s not the same if you put your own hands on the place that’s hurt. It’s got to be someone else. When you do it yourself, you know where your hands are going and you’re thinking about it, worrying about doing it right. When someone else gives you some support, holds the hurt place, or gives it a mild massage, you don’t know what they’re going to do. You just have to relax and experience whatever they do. Wherever they put their hands, you just have to let go and enjoy it. And that helps you relax, by *trusting* someone else and *feeling* what they’re doing.”

I was stunned. He had just described, way better than I had ever done, the reason behind the second of the five steps of turning off pause: let someone *else* provide comfort. Surrender to the support of someone else, even though you don’t know what they’re going to do or say. After all, the hands-on support is *not* really about what they do, it’s about the fact that someone is caring and you are *accepting* that care because you’re safe.

My patients who are using self-induced pause or dissociation usually can’t even comprehend this concept. They are so worried that the person helping them come out of pause or re-associate with an injury won’t be able to do it exactly “*right*.”

They only want to “invoke the *best, most correct* person” to work with or a Yin Tui Na *professional* to help them with their healing – as if the healing is done by the helper.

They don't understand that the one who needs to actually do the work is the patient. And the "work" consists of surrendering to the fact of being cared for.

The health care provider or the "invoked presence of a friend" is just there, primarily, to give the patient heart support and maybe a focal point while the patient works on changing his own mental postures.

This guy was doing something I'd never come across, despite my having worked with hundreds of people using self-induced pause.

I interrupted him, "Please, I can't charge you for this session. I'm writing a book about this, and you're really teaching me a lot. Do you mind?"

He laughed, "Oh no, it's cool. No one has ever even known what I'm talking about. It's funny you're writing a book about it!"

"So. How did you figure out how to do this? You talk about doing it for work or some injury. But most people learn how to do this when they are under terrific danger or pain.

He just stared at me and his face became mildly blank.

A rueful smile passed over *my* face, in reply.

I said quietly, "Yeah. I know."

Actually, I did *not* know his *specifics*. It could have been anything. But I've heard enough stories about "why I decided to feel no pain" that I knew he'd been up against something heinous or excruciating. There was no need to go into details.

He stared deep into my eyes and smiled back.

I shook my head and said, "Don't even tell me about it. I don't need to know. How old were you?"

When he didn't answer right away, I volunteered, "Myself, I was five, the first time I turned off. I was tempted to step outside my body for good when I was seventeen. For the next thirty years, I only came back inside (used parasympathetic mode) now and then, mostly for singing or playing music."

I didn't want to discuss the horrible foot injury I'd had, because I didn't want any compare/contrast thoughts running through his head. By leaving it wide open, he could imagine that my own horror was the same as his own, or not.

Also, and maybe more importantly, I've seen that people who have successfully turned off self-induced pause when the trauma is over are not particularly fascinated with their old insults and injuries. They can *recall* them if needed, but *emotionally*, they have left the old problem behind. The trauma is over; The event has been successfully processed. No need to bring it up again.

Oppositely, people *stuck* in self-induced pause often can talk *ad infinitum* about the injustice(s) worked upon them, thus increasing the amount of brain area devoted to their past problems and keeping themselves more deeply entrenched in the memory of the pain and their secret emotional response to the trauma, even though they are hiding from the pain and the emotion by using self-induced pause and/or dissociation. They cannot let go of their painful memories and resentments from long-ago.

I find it interesting that norepinephrine, the power behind the adrenaline override, is associated with long-term memory.

He nodded with understanding. "Eight years old. I remember exactly."

I asked, "But you came back into your body when it was over?"

He nodded and said, "Yeah, but another time, the worst time, I was a teenager then. I left my body, you know how it is. But this time it was so bad, I remember telling myself, "BE SURE to come back inside when it's over. Maybe I was feeling mixed about whether I would or not. I think I knew that there was some kind of risk if I didn't come back, that I'd never really be alive again. So I told myself BE SURE you come back when it's over."

I just nodded. We were both silent for a while.

Then I said, "You were so wise to say that to yourself. In my medical experience, most people don't want to come back in the moment *and* they aren't thinking about the long term. Or they make the other choice: they decide that they don't want to *ever* come back. They might not come back for decades, or never. If they do try to come back, it can be really, really hard because the brain has trained itself to be afraid of ever coming back.

I continued, "Being out of your body makes you think differently. As you know. That's why you do it. But that way of thinking, if you do it for decades, it can develop the wariness habit in the brain and the longer you stay out, the more you fear going back. After a while, you forget about the sweetness of being inside the body. It can make you sick, staying outside. Your body can't be as healthy if you aren't in it."

He looked shocked that someone would stay outside indefinitely.

"Whoa. That would be really bad, to *stay* outside. The whole point of life is being *inside* the body, being alive."

We were both silent again for a moment. We both nodded.

I said, "Yeah."

By this point in our conversation, I was feeling giddy inside, but trying to preserve a doctor-esque calm. "Thank you so much for talking about this. I'm so grateful. You know, you're the first person I've ever met who goes in and out at will, in a *healthy* way."

"Well you're the first person I've ever talked to who even knows what I'm talking about. No one has any idea. My friends act like I must be crazy or something when I try to describe it. I don't know why other people don't do it. It's really helpful, it's a helpful skill."

I explained, "You're not crazy. It's a real thing. *Some* people do it. But not everyone *can* do it. From what I've been able to figure out, to even do it, a person has to be pretty darned intelligent, in a word-based, analytical way, with terrific mental focus and will power."

"Yeah, I wouldn't say that I'm like that to someone else, but you're the doctor, so I can admit, that describes me pretty well. But I know it's important to also just listen to my heart and feel joy. Doing the go-outside thing, that's important too, but it's just a tool. It's gotta be a temporary thing."

I was so fascinated. I had a hundred questions and so little time. I knew his last name was Portuguese, though he'd been born in this country, so I asked him, "Do you still speak some Portuguese?"

He replied, “*Oh yeah!*”

I asked, “Do you know what the words ‘*espírito santo*’ mean?” (‘Holy Ghost,’ in English.)

Now, I don’t actually have any idea what the Portuguese pronunciation is, so I sort of slurred the words. I do know the phrase in Latin, Spanish, and French, and they’re all pretty similar, so I figured his ear would adjust for any error I was inserting.

He knew exactly what I was trying for.

“Oh yeah, oh yeah.”

“Could you define it for me, in English?”

And then he did the same thing that I’ve seen and heard from so many people who speak romance languages, people who are *not* on pause, *not* dissociated from their hearts, people who are very much living according to heart resonance.

He started off, “Well, it’s kind of hard to explain...It’s more of a way of, it’s a, I mean, well, it’s more like, well, it’s sort of...”

Usually, he was extremely articulate. I let him go on for a while like this, stumbling around, trying to think of the corresponding phrase in English. And then, like all the other romance-language speakers I’ve known who’ve tried to translate these two words into English for me – again, these are people who are *not* on pause – he started making The Gesture.

He placed his fingers lightly on his sternum, along the midline of the chest, and then repeatedly moved his hands gracefully forward and towards the sides, outward, upward, symmetrically, as if a fountain was pouring forth out of his chest into the air.

People who are stuck on pause do *not* make the gesture. They don’t even know what it represents if I demonstrate it for them.

As soon as he started doing the gesture, which demonstrates this feeling of heart expansion, for which no words exist in English, I laughed and told him he could stop.

I continued, “I just wanted to be sure that you really do go back inside your body. If you’re doing that hand gesture, then we are both using the same understanding of ‘back in the body,’ and ‘feeling the heart.’ ”

He was a little surprised. He didn’t even realize he’d been doing a hand gesture until I did it back at him. He started to try to explain again, as if he thought he hadn’t done a good job because he hadn’t put it into English words.

I stopped him and said, “Don’t even try. There aren’t actually any words in English for *Espírito Santo*. In English, we say “Holy Ghost” or maybe “Holy Spirit.” Many English speakers think of Holy Ghost as some diaphanous personage that flies throughout the air, like the cartoon character in Caspar the Friendly Ghost. Most English speakers, in my experience, don’t know that those words refer to a vibratory sensation that you can tune into with your heart or all of your body: a sensation you can resonate with, which expands and pours out of the heart.

“Don’t feel bad if you can’t define it. There *is* no word or short phrase in English. You *have* to fall back on the hand gesture.

I went on, “In my experience, the hand gesture is what Romance-language Catholics always fall back on when I ask this question, even if they are highly educated in English, even if their English is excellent. But *native* English speakers, if you ask *them* to define Holy Ghost, they *don’t* do the gesture. They just give some lengthy, word-based definition.”

I kept going, “People who have been outside for a long time and never go back inside, they usually have no idea what “heart feeling” means.

He looked relieved. He had been looking a little surprised at his own inability to explain this most basic, simple, concept, the most basic concept of life and love. He hypothesized that he always used his “Portuguese mind” when he thought of this feeling, and so had never realized until that moment that the phrase doesn’t have an English equivalent.

After that, I started working with him on his back pain, but we kept talking. We only had an hour, but I could have listened all day. For the first time, I was talking with someone who consciously used his capability of moving outside his body and activating pause. He consciously benefited from the extreme focus ability that a person can have while on pause, while the sensations of the body become distant and unobtrusive, even “frozen”. Not only that, he knew it was important to always go back inside afterwards: “the whole point of life is being inside your body.”

He even knew that it was important to have another person touch him, and physically comfort him, if he’d “stepped out” due to a painful injury or something startling.

I asked him about the head shake and the shiver that travels down the spine when a person turns off pause: the final steps in turning it off.

He replied, “What? No...I don’t think...oh. You mean that sort of electrical feeling down the back? Yeah. I get that. Sometimes I notice it, but sometimes it’s real mild. It’s just a little shiver, kind of electrical.”

I was almost clapping my hands with glee.

On his own, with no background in medicine or even biology, he was completely aware – if I brought his attention to it – of all the steps that a healthy person uses to turn off pause automatically, but he was using them *consciously*. He would activate pause to help him through rough spots or to help him focus more intensely about his work and then he would *consciously* turn it off and go back to the “important” way of being.

He would acknowledge that he had been in an altered state, then access supportive touch, if needed, or at least surrender to the idea that he was OK, he was loved. Then, he would automatically take a deep breath and a little shake and shiver would shoot down his spine.

He could use self-induced pause in a conscious, healthy way.

The pause track

And now, back to the subject of pause, basic pause. Finally!

This chapter sets aside, for now, the subjects of dissociation and self-induced pause/dissociation. The subject of basic pause, and its treatment, resumes.

Healthy people, when awake, are nearly always using a blend of sympathetic mode and parasympathetic mode.

Sympathetic mode is on one end of the “normal” neurological continuum, and parasympathetic is on the other. If sympathetic mode thoughts such as fear or anger *increase*, parasympathetic mode electrical patterns and their amperage automatically *decrease*.

Oppositely, as sympathetic mode thoughts *decrease*, parasympathetic mode electrical patterns and their amperage automatically *increase*.

Most of us are usually somewhere along the middle of this continuum, using a bit of both sympathetic and parasympathetic patterns, with moderate amperage in both.

We can easily influence our location on this continuum by changing our thoughts or behaviors. Fear, rage, and other negative emotions bring us closer to sympathetic. Deep breathing, meditation and/or positive affirmations move us closer to the parasympathetic end of the continuum. So does exercise, cognitive behavioral therapy, and helping others. The list of methods, ancient and modern, for increasing parasympathetic mode is nearly endless.

Parasympathetic, not sympathetic, is actually the default mode for healthy humans. If a human has “nothing going on” in terms of mental, physical, or emotional stress, his body should be closer to the parasympathetic end of the continuum.

By using calming techniques to influence our thoughts and mindset, we can teach ourselves how to stay closer to the parasympathetic end of the usual or “normal” continuum.

Pause is not even on that continuum

Moving closer to or further from parasympathetic mode is not possible while a person is stuck on pause. Being on pause means that you are out of reach of parasympathetic mode and sympathetic mode. You have no way to get to these two *normal* modes unless you *first* go through the steps that turn off pause.

None of the *usual* methods that allow a highly stressed or intense person to calm down will work, or will work only fleetingly, on a person who is stuck on pause. That person is not even *on* the parasympathetic/ sympathetic continuum. He is on the *pause/* adrenaline-override continuum.

For a person on the pause continuum, anything that *reduces* the adrenaline override will cause an *increase* in pause symptoms – which might include slowed

motor function, increased rigidity, a blank staring affect, poor temperature regulation, lack of joy, and maybe nausea and loose or blocked stools.

Symptoms of shakiness or tremor, or sliding into sleep at the drop of a hat might also be present. These are all symptoms that might occur if a person is closer to the pause end of the pause/ adrenaline override continuum.

At one end of this continuum is full-blown pause – immobility and minimized metabolism. At the opposite end of this continuum is powerful movement activated by the adrenaline override.

A person in pause mode can use highly stimulating, wary, or negative thoughts to activate an adrenaline override. This will allow for emergency-type, adrenaline-based motor function and keep the muscles moving even though stuck on pause.

During pause, the healthier, more common, *dopamine*-based motor function used in parasympathetic mode is *not* available.

To a casual observer, the movement of adrenaline-driven muscles will look similar to the movements that occur with dopamine, the neurotransmitter of parasympathetic mode. But if you look very closely, you will see that the dopamine-driven movements of parasympathetic mode are more graceful, easier, more attuned with heart feelings and imagination. The truly great dancers and athletes are using parasympathetic mode and dopamine, not fear-based adrenaline or norepinephrine.

In 2016, Usain Bolt, the world's fastest sprinter, won another gold medal at the Olympic games in Rio de Janeiro. What thrilled the crowd, in addition to his incomprehensible speed, was his radiant, beaming smile as he flew down the track. This is a man who manifests *joy* when he runs. He uses dopamine. He flies. He does not pound down the track with emergency neurotransmitters.

I had a patient who was an Olympic swimmer. I asked her if she powered up with adrenaline.

She replied, "Oh, no, you could never swim [at that level] if you had tension. When I swim, I always have 'the sun on my back'. When I feel that joy, I don't have to *work* to swim. There is no water to fight against. I just fly."

People who are immobilized by pause can move by calling for the release of adrenaline. But they don't fly. They pound.

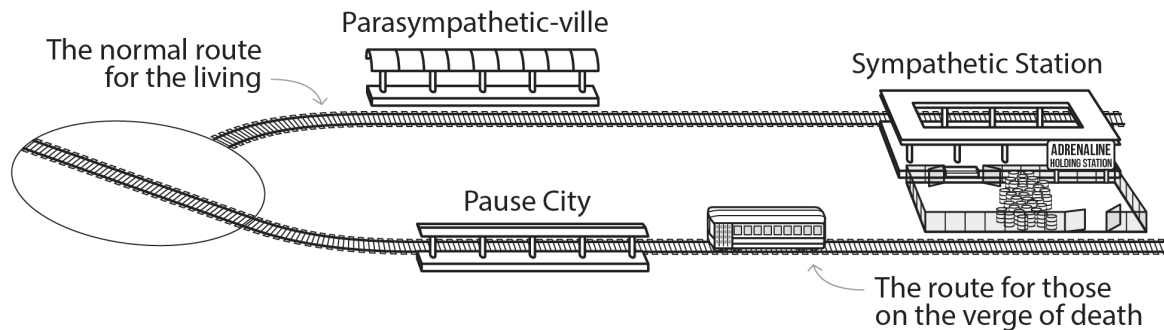
The train track analogy

Many patients have found a train track analogy to be helpful, so here you go.

Consider two parallel track lines. One is the parasympathetic / sympathetic continuum. This is the normal system.

The other system is the pause/ adrenaline override continuum. The latter system is only supposed to be activated when a person is on the verge of death. It can only be turned off if very specific steps are taken to ensure that the risk of impending death is over. Just like the parasympathetic/ sympathetic continuum, one

end of the pause line goes to a holding yard where emergency neurotransmitters, adrenaline and norepinephrine are stored.¹



In this drawing, the trolley is on the pause tracks, traveling between Pause City and the stockyard where the adrenaline and norepinephrine is stored. The sign in the stockyard is hard to read. It says “adrenaline holding station.” It would be even harder to read if it said “norepinephrine.”

Think of these two continuum systems as parallel train tracks. Again, *both* tracks go to the adrenaline / norepinephrine end of the line, which is located somewhere in the State of Emergency.

One of the tracks is coming from Pause City and the other track is coming from Parasympathetic-ville.

You simply *cannot* get a trolley to jump from the Pause City track to the Parasympathetic-ville track.

If the trolley is using the Pause City track, it has to get to a roundhouse or a turntable at the track’s *origin*, at the Pause City end of the line, and there be mechanically *switched* over to the line that runs through Parasympathetic-ville.

Only then can the trolley once again travel the “normal” route: the awake and healthy route, the parasympathetic/ sympathetic continuum.

How did the trolley get onto the pause track in the first place? A cataclysmic event that damaged the body, almost fatally, might be compared to an earthquake or tornado that tossed the trolley into the air. When it landed, damaged but still somewhat functional, it was on the pause track.

In this metaphor, the engine is *you*: your energy, will to live, the life force that drives your bodily existence. *You have only one engine.*

The turntable represents the self-assessment process: “Am I safe now?” The deep breath, wobble, and shiver are the push that sends your life-trolley off of the turntable and back onto the normal parasympathetic mode track.

¹ This is a bit of an overstatement. We use adrenaline and norepinephrine for everyday activities, as well as for emergencies. But in an emergency, levels of these will spike.

There are many biological, life-saving reasons that are built-in to animals, including humans, to prevent us from accidentally lurching our trolley, our “life engine,” across the bumpy grass that separates the two tracks. Biologically speaking, we should *not* go into parasympathetic mode if the coast is not yet cleared of danger.

If a person is using the pause track, he will find that his chronic, pause-induced wariness and/or his tremor do not derive a lasting benefit from “calming exercises” or attempts to “rest” himself out of his troubles. These techniques merely move him *away* from the supply of emergency neurotransmitters and closer to Pause City. At the Pause City end of the line, he is in a deep state of pause and possibly immobile or dozing off. (Remember, this is basic pause. Self-induced pause has different behaviors.) People who are stuck on pause often develop a lifestyle that lets them keep the adrenaline-override as active as possible.

A person who is stuck on pause who wants to “do good” for himself by practicing meditation, yoga, Tai Ji, Qi Gong, or other “uplifting” practices may find that, for him, they don’t work, work only briefly, or even make him feel worse. They certainly don’t bring lasting joy, or sometimes any joy at all. These behaviors might allow him to pull away from the adrenaline stockyard, but they don’t get him off the pause track.

For the same reason, a person who is stuck on pause cannot pop out of it by doing exercise or the various types of movement or shaking therapies that can help a person on the parasympathetic / sympathetic continuum. So long as he’s on pause, he can’t “snap out of” his stress or his overly wary or anxious mindset.

Using the train analogy, the person must climb onto the turntable, where he can assess the *internal* damage and confirm that the *external* danger is gone: it’s safe. Then he powers himself back into parasympathetic via the deep breath, the wobble, and the shiver.

The background music

I like to think the trolley on the normal, healthy track is playing Brahms waltzes when it draws close to Parasympathetic-ville. When the trolley draws near to Sympathetic Station the sound system might be pounding out “Run for your life if you can...”

When the trolley is on the pause track, the message in the background is subconscious, but it’s constantly screaming, with no discernable melody, “You’re about to die!”

The turnaround music is the sweet gospel number, “Rock My Soul in the Bosom of Abraham.”

Being joyless is special

Leaving the trolley analogy behind, consider some other aspects of pause.

I’ve met many people who are stuck on pause who have decided that their abnormal or joyless responses to meditation or other calming techniques are proof that they are special, different, or spiritually more refined than the rest of humanity.

In fact, these people are biologically normal. They are simply conforming, mentally and physically, to the little known laws of being on pause.

The joy that is reputed to accompany meditation, positive affirmations, yoga, Qi Gong and various spiritual practices is a characteristic of parasympathetic mode.

This joy cannot show up, or can last only fleetingly, if a person's channels are stuck in the schematics of pause.

As for joy, joy is only available in parasympathetic mode.

Don't confuse peaceful joy with "excitement"

Peaceful joy is not to be confused with the short-term, adrenaline or norepinephrine-based giddiness that comes with "winning," with "thrills," or striving for or succeeding at some glorious challenge. Many of my patients have insisted that they feel joy. But when asked what condition produces that joy, they usually say something like "downhill skiing," or some other activity that calls for increased *adrenaline* or *norepinephrine*, not dopamine.

Those on pause who say that they feel joy when serving others, if questioned closely, often say they *don't* feel expansion or resonance in the heart (joy). What they are actually feeling is a fleeting sense of *mental* relief because they know they are technically *doing* good.

You cannot arrive at actual joy if you are desperately busy not dying. You must *turn off* the "almost dead" system before you can transition over to the "possibility of joy" system.

Summary,

A person who is on the pause/ adrenaline override continuum is not able to access the normal modes of living until he *actively* takes physical and mental steps that remove him from pause and put him back onto the normal, parasympathetic/ sympathetic continuum.

This is the opposite of trying to "relax" one's way back to normal. While traveling on the pause track, reducing the use of the adrenaline override, which some people equate with "relaxing", merely moves one closer to the overt symptoms of near-death.

A person who is stuck on pause typically doesn't feel *lasting* joy, if any, or *lasting* relaxation, if any, from the calming methods that *will* work for a person on the parasympathetic/ sympathetic continuum. The parasympathetic/ sympathetic continuum is the normal continuum, the healthy continuum. It is used by people who *aren't* at risk of dying in the next few moments due to life-threatening damage to the body or mind.

If a person is on the pause/ adrenaline override continuum, the only way to get off is to *actively* take steps that turn off pause.

Turning off pause

Humans can get stuck on pause because they were rushed or commanded to “snap out of it” at the time of the trauma and didn’t have time to process the damage. Or they might not have turned off pause due to incomprehensible grief, terror and/or a sense of being abandoned.

Happily, no matter what the reason for becoming stuck, a person can *mechanically* go through the steps that he was unable to *automatically* take, so many years earlier.

The first three steps in turning off pause quickly address the “not safe” *idea*, the *feeling* of abandonment, or not being allowed enough time to assess and process the shock when it first happened.

The next two steps mechanically initiate the *physical* behaviors that a person was unable to automatically perform, so many years earlier.

A very quick review of the five steps

1) Close your eyes. Notice that you can imagine some area inside you that is dark and is also agitated or trembling. Gaze at that area.

2) Silently invite a trusted friend to come gaze at the trembling with you. Ask your friend if you are at risk of imminent death. When he says, “No,” ask yourself if you are at risk of imminent death. When you feel ready to agree with your friend, you’re ready to feel safe.

3) A feeling of safety registers in the heart. Mentally acknowledge it and confirm, “I’m safe now. I can stop shaking inside at that dark place.” Take a deep breath.

4) Tilt your head back slightly as if relaxed and let the head “bobble”: rock the left ear to left shoulder, then right ear to right shoulder.

5) Perform a little jerk at the base of the neck, and let a shiver or *frisson* travel down the spine.

The five steps in depth

It is usually easiest to do these steps if you are lying down on a bed or couch, as relaxed as possible. You might want to have a friend nearby who can observe or help you with some of the steps.

One: notice that you are shaking.

That’s pretty straightforward for animals and many people. But a person who has been in denial, or suppressing the pain or even the memory of an injury might

need to spend a few seconds, even a minute or two, “scanning” his insides with his imagination’s eye.

Begin by mentally imagining light and/or dark, whichever is easier, inside your body. This is identical to the process used when looking for an area that might be dissociated, in chapter xxx, page xxx.

Start with a place that’s easy, such as your nose. Once you’ve gotten warmed up at looking around inside for light and dark, look in the vicinity of the place where you were injured. If you can’t recall, look all around, including at the base of the spine and the back of the neck.

You are looking for an area that’s *easier* to imagine being dark instead of light *and* which is vibrating, moving in some way.

You might know just where to look: an old injury site. You might not have any idea where to look. In that case, you can scan your whole body slowly, including the head and the toes, looking for the place that seems dark and vibrating.

The “vibration” might be sludgy or it might be agitated. It might seem like the capillaries in the area are vibrating, or the cells or even the atoms. One person described what she saw in her imagination as “burning.” Others have seen “tremulous,” “quivery,” and even “sticky.”

Any type of unsettled movement qualifies.

This movement is the opposite of what people see if they have dissociated from some body part. When a person has dissociated from an area, the area seems heavy, oppressed, not moving, or even “strapped down.”

Take your time. You might want to spend two or five leisurely minutes, but no more than that, looking for any place inside that is dark and agitated or showing “troubled” movement.

If the trauma was not at a specific location, but more of a body-wide event such as the bee sting attack in a previous case study, be sure to check the base of the spine, a common place for internal vibration following a near-death event.

And don’t forget to look all around at the head and neck, locations for long forgotten concussive blows.

If you absolutely can’t see any specific place that’s darker than the surrounding areas and trembling, but you *sense* that you are trembling or agitated inside, you can just imagine that you’re looking at the insides of your whole body.

Or wherever the trembling is *greatest*, gaze at that area.

As an aside, a person who has developed an obvious tremor in some limb might not be aware, or might be suppressing the awareness that, in fact, his body has an internal tremor in some *other* area that has been present for years, which he has been stifling for years. If this is the case, the first step in turning off pause is to *stop ignoring* that *internal* agitation and take a good look at it. Forget the obvious, external tremor, for now.

Two: confirm that you are now safe

For an animal, this is the time to determine that the predator is no longer present. For a human, this might be the time to acknowledge that he is still alive

even though his leg is broken, or that the enemy has moved on, or whatever was causing the damage has stopped, at least for now.

When no immediate danger is lurking on the horizon, he is safe.

For the human heart, being safe also means knowing “I am not alone” in the sense that he is connected or resonant with other humans, his community or even a loving universe that he *trusts*.

When he feels the connection to this love, he *feels* safe. It’s an actual physical feeling.

Many people who have been stuck on pause for a long time become numb to the physical heart-feeling of connection. Being on pause turns *off* one’s sense of being connected. One perceives himself as *outside* of his body and *disconnected* from the tangible types of electrical resonance (“*espírito santo*”) that healthy people feel, often most strongly in the heart area.

This is why, in simpler times, in small communities, a wounded person would be coddled and cared for, physically attended to and reassured that he is, in fact, safe. Today, in big cities, when so many people either live alone or have even been taught that wanting physical comfort from others is a sign of weakness, getting stuck on pause might be more common.

In step two, you can fulfill the requirement of being safe and re-connected by inviting someone or something unseen to come and be by your side. Invite your “friend” to gaze at your dark area with you.

The friend can be a beloved teacher, a saint or sage, a deceased grandparent or friend, a totem animal, or anyone who deeply loves and wants to protect you.

For some reason, it’s easier to invite and work with someone who is not currently in the flesh.

I’ve had patients who have invited the presence of a late cat or dog. Oddly enough, in several cases where a person invoked the presence of a beloved pet, he also unexpectedly saw, in his mind’s eye, a loving humanesque form standing just *behind* the animal.

It doesn’t really matter who or what you are using. The important thing is that you are *willing* to invite someone or something to share your problem. This isn’t about inviting some friend with “magical” or “spiritual” powers. This has nothing to do with who you choose. This is all about changing the way you use your own mind.

I can’t say who’s the right “friend” for any given person. It just needs to be someone or something you trust, a friend who makes you *smile* or *laugh*, with whom you are at ease, who has your best interests at heart. Don’t spend too long thinking about who you want. Don’t spend more than thirty seconds figuring out who to work with. Have fun with this.

Silently invite your friend to be near you and gaze at the dark, vibrating place with you.

For about twenty seconds, you and your friend can gaze at the area inside that you imagine to be dark and quivering.

After twenty seconds have elapsed, silently ask your friend, “Am I at risk of *imminent* death?”

You aren’t asking if you might die *someday*. You are asking if you are going to die in the next few seconds or minutes *because* of some specific trauma in your past.

The friend will say no.

If you don’t believe him, ask him again.

Many people say that their friend has laughed at them, or even said, “Don’t be ridiculous!”

Then again, if your friend says, “Yes, you’re about to die!” ask him again:

“Really? Right now? I’m going to die in the next few seconds because of an trauma that happened years ago?”

Your friend will soon enough laugh and say, “No, of course not.”

Once your friend has confirmed that you are not at risk of imminent death from your old trauma, silently ask *yourself* the same question.

“Am I at risk of imminent death?”

This is the interesting point in the process.

Doing this in my office, many people have told me that the friend says, “No, you aren’t at risk of imminent death.” *But* when I then ask the patient what *he* thinks, “Are *you* at risk of imminent death?” it can get complicated.

Obviously, the answer should be no. If you were going to die as a *direct* result of the trauma, you would be dead. You aren’t.

Patients *know* this. But many struggle with it. A patient might end up saying saying, “I have to admit, I *am* still at risk.” Or even, “I’ll *always* be at risk of imminent death,” Or, trying to change the subject, “I want to discuss what, exactly, do you mean by imminent,” and even the sulky, “I don’t want to say.”

You might recall the patient in the golf cart case study, who really struggled with this, even while laughing at herself. She realized she was being, in her words, “ridiculous!” but at the same time, her brain habit of being on the verge of death was playing a tug-of-war with her conscious knowledge that she *wasn’t* going to die in the next few seconds from her golf cart injury.

When a patient tells me that he *is* still at risk of imminent death, I ask him to ask his friend again.

Usually, by the third time a person has asked his invisible friend if he’s at risk of imminent death, the patient tells me, “My friend is laughing at me! He says of course I’m not about to die in the next few seconds from that thirty year-old trauma.

Then I ask, “Do you believe your friend?”

If the patient says yes, then we just repeat the questions over and over until the patient can say, with conviction, “I’m not at risk of imminent death.”

If the patient says he isn’t sure if he believes the friend, I ask him to “Find a better friend: someone more spiritually powerful. Someone who will always tell you the truth. Someone you can trust.”

I never inquire as to *who* the patient has decided to invoke. I figure it's none of my business. But in my limited experience, if the first friend isn't convincing enough, the second, "more trustable" friend has always been able to convince the patient that he is indeed safe: not at risk of imminent death.

Three: feeling safe

Once the patient tells me that he knows he is not at risk of imminent death, he will very often take a deep breath, an audible sign of relaxation.

During the inhalation, the abdomen visibly distends as the lungs fill deeply with air. This is not a shallow, invisible breath that hopes to pass unnoticed. The exhalation may be an audible "Aaaah."

Some people, despite admitting they are safe, are not able to take a deep relaxed breath. Some people feel resistant to taking a *noisy* breath.

After all, an animal that is on pause takes muffled, inaudible breaths in order to not draw attention to himself.

If you are going through these steps with someone nearby, coaching you, your coach can observe whether or not your belly moves. When a barely moving belly suddenly relaxes and moves visibly with a deep inhalation and exhalation, that's what you're looking for.

If the loud sigh and/or the belly movement does *not* happen spontaneously after you decide you're not at risk of imminent death, you must do it mechanically:

Force yourself to take a big noisy breath. Try to let your stomach relax and move with the breath.

It might feel extremely awkward, even dangerous, to do this, at first.

Don't worry, you'll get better at it.

Take a deep breath one or two more times, and move on to the next step.

Technically, this step, together with the silent confirmation, "I am safe" (I'm *not* at risk of imminent death from my old trauma) is what turns off pause.

However, if the body isn't able to get parasympathetic and sympathetic modes up and running, the person will have to *revert* back to pause and its adrenaline override in order to resume motor function. To activate these two modes, do the next two steps:

Four: wobble your head

Most westerners really struggle with the head wobble. If you are familiar with the "Indian head bobble," that's the move you are aiming for. You can find delightful Youtube videos online demonstrating the wobble.

You *do not* want to pivot your head from left to right, while keeping the top of the head upright and aligned with the spine, as if signaling "No"

You *do* want to tip your head slightly back, *almost* as if you are planning to self-massage the back and sides of your neck against your shoulders. But don't actually let head and shoulders meet. It's a very gentle tip backwards. Very mild.

The left ear comes a bit closer to the left shoulder and then the right ear comes a bit closer to the right shoulder. The top of the head goes left when the left ear dips toward the left shoulder, and then to the right, following the right ear.

The movement is loose, as if you are relaxed and dancing to a song with a sensuous beat.

The head only needs to bobble left-and-right three or four times. Then again if it feels good, do it as much as you like.

It is very common for a person long stuck on pause to be mentally and/or physically incapable of doing the head bobble. If you can't bobble, the friend who is serving as your coach can place a hand on either side of your head and very, very, very gently move the head back and forth in the manner described above.

Resistance to the head bobble

This head motion feels very strange for most westerners. This is because much of our western conditioning about posture is about keeping the head somewhat rigid: *not* bobbling. Bobbling is a motion in animals and humans that says, "I'm feeling good. I'm relaxed and content."

In this west, this sort of postural looseness has been, for centuries, associated with loose morals, low caste, or lack of a strong work ethic. This is ridiculous, of course. But many of the postural problems we have in the west, including the almost pervasive back pain in adults, is due to an unspoken social rule that says "use an unnaturally rigid posture!"

In the west, we admire a person who distorts his natural, easy posture. "Stand up straight!" (Don't be relaxed.) "Tuck the hips under!" (Don't project sexuality.) "Shoulders back!" (Make yourself appear cold and rigid!)¹

Some of my research on turning off pause was done in India. I had learned that, up until the last few decades, Indian Hindus had one of the lowest rates of Parkinson's disease in the world. The *British* people living in India during the British Raj had a very high rate of PD, as high as the British back home. This suggests that environmental causes in the air and water are *not*, as has sometimes been suggested, a trigger for idiopathic Parkinson's.

In India, while going about my activities, I observed as much as I could of the movement, posture, and behaviors of the Hindu people going about their daily business. In the evenings, back in my room, I replicated as carefully as I could the movements and postures I had seen during the day.

I was surprised to see the changes in mood, tension, and spinal position that kicked in when I performed the head bobble. My abdominal muscles immediately relaxed, my stomach protruded, my buttocks stuck out in back, and my posture felt much more stable, as if my legs were situated more correctly in the hip sockets. I felt stronger and yet more relaxed. My breathing slowed, and I could feel a wave of "easy feeling" (parasympathetic mode) pass through my body and mind.

¹ Call to mind some British period drama. The upper classes are distinguished by their voice and their posture. The lower classes move more easily, have a more relaxed posture (unless they are trying to be "above their station") and bob their heads.

I took careful notice of *when* people performed the head wobble. In part, it appeared to be mere habit. But I also noticed that the head bobble appeared quickly in response to even a very mild stress.

For example, if I ran up to an officer at the train station and said, “Have I missed my train?” he would bobble his head while saying, “I’m so sorry...”

As I practiced in my room reviewing these types of situations, I realized that giving someone bad news (“Yes, you missed your train.”) causes a mild bit of stress to the giver, and a concomitant decrease in dopamine. By bobbling the head, the stress feeling immediately backs down. The body is flooded with a positive feeling in spite of the social discomfort.

If you ask people in India about the head bobble, they offer dozens of delightful reasons for it. But in practice, I saw it used both from sheer habit and as a stress inhibitor.

Five: the shiver

A physical shimmy or shiver, or a little “electrical feeling” should travel down the spine. It starts with a tiny jerk at the base of the neck, where the neck joins the back. Then it travels down the spine.

If the body does not automatically do this, you may need to ask your coach to hold your shoulders and gently rock them back and forth, trying to send a wave of movement from the shoulders down to the mid spine.

One shoulder can be moved slightly towards the front while the other moves towards the back. Then reverse. Or one shoulder moves “down,” towards the feet, while the other moves towards the head. It really doesn’t matter. The coach is just trying to “shake things up.”

If you *can* contribute to the process, think of it as moving like a wet dog shaking off water.

This doesn’t need to be a subtle or gentle movement like the head bobble. This can be a much larger, more glorious and uninhibited expression of being alive. Or it might just be an electrical shiver that shakes your spine slightly.

After the five

You may need to repeat the five steps over and over, until you start being able to bobble your head and shiver/ shake by yourself, without assistance.

Don’t worry if you aren’t able to wobble and shake after your first attempt.

I have had patients who went through the five steps more than twenty times in one session with no indication that shaking was on the horizon. And then, suddenly, something kicked in. A patient might then shake over and over, not wanting to stop, shaking the body, the arms, the legs: a celebration of shaking.

More examples about the five steps in nature

A wild sea otter giving birth

When I returned to the USA from India, I couldn’t sleep from the jetlag. I was up late, surfing nature videos on the Internet when I came across footage that showed the head bobble.

In the clip, a wild sea otter was giving birth in the Great Tide Pool, down in Monterey, just south of my home in Santa Cruz.

A videographer from the Monterey Bay Aquarium had taped the event from a balcony overlooking the outdoor tide pools.

By chance, an OB-GYN nurse happened to be watching. She stepped to his side, offering her insights into what the mother sea otter was doing. The videotaping microphone picked up her words.

"Look! She's having a contraction right now. See how still she is? Her whole body is tight."

Sure enough, even with the somewhat shaky, hand held video camera, it was clear that the sea otter had stopped grooming herself and was being fairly motionless and contracted.

"Now the contraction has stopped," said the nurse.

I could see that the sea otter was no longer quite so rigid.

And then...

The sea otter wobbled her head gently from left to right, and then shook herself briskly, once. Her whole body immediately relaxed and she resumed grooming herself, for all the world as if nothing intense had just happened.

I could hardly believe my eyes. If I hadn't just returned from India and a month of observing and experimenting with head wobbles and postures, I would not have noticed that she wobbled her head and then gave herself a shake before resuming her very relaxed behavior. After about five minutes, the nurse announced, "There, she's having another contraction!"

The sea otter was motionless, scrunched up a bit, tight.

About approximately five to ten seconds, "The contraction is over now."

Followed by the head wobble, shimmy, and contented relaxation, again.

I was mesmerized. I watched the video over and over. I had the feeling that I had been seeing animals do this kind of head shaking my whole life and I'd never realized what I was seeing.

After I started practicing the head wobble, and observing the immediate shift in neurological mode that occurred every time I did it, I was suddenly able to recognize this move in dogs at the beach and goats at the petting zoo. I had always been aware of my own dog doing a shaking movement (step five) after a startle or after getting wet, but now I was able to see that her shaking was always preceded by a more subtle, very quick, head bobble.

Animals do this head move if they have been under some sort of stress: stress automatically puts an animal closer to the sympathetic end of the spectrum. When the stress is over, they do this head move and maybe a shake, and their body responds by shifting back into a higher level of parasympathetic mode and re-balancing the spinal nerves that regulate sympathetic mode.

The sea otter had *not* been on pause. She had been working hard, tensed up with a uterine contraction. When the tension ended, her head wobble increased the amount of parasympathetic behavior and decreased her temporarily elevated degree of sympathetic mode behavior. She relaxed.

You see this move all the time in sports: coaches tell an athlete who has just been fouled, “Shake it off.” The player will do a little head shake and maybe even a body shake and get back into a higher degree of parasympathetic mode, the mode in which athleticism is easiest, most graceful, and most fun.

For that matter, a recent pop tune came out with the title “Shake it off!”...an admonition to get over one’s emotional wallowing and get back to living by giving yourself a good shake.

You might recall – if you are not on pause – a little head bobble and/or a shiver running down your spine after emerging from a scary or intense movie. The head shake and shimmy is an automatic, natural way to shift the body back into a higher level of parasympathetic mode after some sort of distress, tension, or shock.

But what about pause mode, a condition that is almost the opposite of sympathetic mode?

Pause is turned off by realizing one is safe, and by taking a deep breath.

Once pause has been turned *off*, the head bobble stimulates the vagus nerve and thus turns parasympathetic mode back *on*.

The frisson or shiver that then travels down the spine stimulates the spinal nerves and thus turns sympathetic mode back on (if you were on pause) *or* balances the nerves back out (if you *were* in sympathetic), by re-setting the spinal nerves back to their optimal (minimal) settings.

Wildlife rescue work

In wildlife rescue programs, rescuers are increasingly aware that a traumatized, severely injured animal *must* go through these steps before being released back into the wild.

Dr. Peter Levine, a pioneer in trauma recovery work, quotes Andrew Bwanali, park biologist of the Mzuzu Environmental Center in Malawi, Central Africa:

[Dr. Levine was telling the park biologist about the] “...spontaneous shaking, trembling, and breathing” that thousands of his patients have exhibited as they recover from trauma.

“He (the park biologist) nodded excitedly, then burst out, “Yes ... yes ... yes! This is true. Before we release captured animals back into the wild, we try to be sure that they have done just what you have described” He looked down at the ground and then added softly, “If they have not trembled and breathed that way [deep relaxed breaths] before they are released, they will likely not survive in the wild. They will die.’ ”¹

¹ *In an Unspoken Voice: How the Body Releases Trauma and Restores Goodness*; Dr. Peter Levine; North Atlantic Books; Berkeley, California; 2010; p. 15. In Dr. Levine’s earlier, seminal book, *Waking the Tiger*, he address health problems that arise when a person becomes stuck in the process of activating sympathetic mode: stuck in pre-sympathetic mode. This can happen when a trauma is so abrupt and/or confusing that the body gets stuck in a “deer in the headlights” pattern, shifted out

Baby burp

Shortly after figuring out the sequence that turns off pause, I noticed my four-month old grandchild do this sequence after a large burp. A burp requires a very fleeting reversal in the direction of the Stomach channel flow. The Stomach channel momentarily runs *backwards* during a burp, just like runs backwards on pause. This temporarily reverses the stomach's peristalsis and allows the air trapped in the stomach to flow out through the mouth.

After his burp, his chin trembled for a fraction of a second. Next, his head bobbed one time. Immediately, a large shudder traveled down his spine, visibly shaking his body.

Then he gave a big grin: he was back in parasympathetic mode again.

I'd seen the "baby chin tremble" behavior hundreds of times, but never understood the significance. The subsequent "head wobble and shiver" never registered on my conscious mind until this time.

Swimming in the lake

Have you ever gone swimming in a really cold mountain lake, or in the cold ocean? When you get out, you will very soon start shivering, even if you are sitting in the sun. At some point, as you warm up, it suddenly hits you, "Hey, I'm shivering."

This thought is soon, maybe immediately, followed by something along the lines of, "But I'm OK; I'm sitting in the sun." Or "But I'm OK, I'm warming up now." Followed by your silent statement of the obvious, "I don't *need* to be shivering any more."

As soon as you register that affirmation, which is a variation on the theme of "Now I am safe," you automatically take a deep, relaxing breath. Then you experience a subtle side-to-side head wobble at the base of the skull followed by a shimmy or *frisson* that goes down your spine, starting at the top of the neck. After which, your shaking immediately stops.

When I recount the cold-lake scenario to my Parkinson's patients, they usually say that they have *no* idea what I'm talking about. They usually have *no* memory of ever having "shaken off" a bout of trembling. At the same time, the Parkinson's patient's *friend* or *spouse* who is sitting next to the patient on the couch in my office smiles and gives a yes nod, and says something like "Oh yeah, I know just what you mean."

In my experience, most healthy people *do* recognize this confirmation-bobble-shake sequence. It isn't just a cold lake that can trigger it. The tremoring, the realization of safety, the sigh and the shiver can also happen after being startled, after an unexpected fender-bender, or a physical assault. As the first, obvious shock starts to wear off and the trembling begins, you then realize you are OK, after all. After that the head bobble and shiver are over in an instant.

of parasympathetic mode but not yet in sympathetic: unable to even activate even a basic fight or flight response.

Getting back to the cold lake experience, the swim itself gives an example of a body being on pause with an adrenaline override. A person doesn't "get used" to frigid water. He becomes numb. His body turns off his sensory awareness by going into pause mode. Blood moves interiorly, away from the skin. Endorphins are released to numb the "pain" of the cold water. At the same time, the swimmer, who is hopefully having this swim for pleasure, immediately uses an adrenaline override so that he can move vigorously – but not sensuously – through the dangerously cold water.

The swimmer experiences shock and numbness plus norepinephrine and powerful action: pause mode plus the adrenaline override. When he comes out of the frigid water, he quickly begins to tremor. As soon as he starts to warm up enough, he confirms he's OK, takes a deep breath, wobbles and shimmies, and he's back where he wants to be: fully alive.

Turning off pause after an exam: an example of delayed response

A friend of mine told me about experiencing the sequence that turns off pause after finishing his oral exams for his Master's degree. He was calm during the exam. He didn't think he'd been nervous: he'd felt *numb* to any fear during the exam. He didn't start shaking until he got home later that evening. He was amazed to see that his knees felt weak, and then when he collapsed into her chair, his whole body started gently shaking. He realized he was finally "letting" down from the stress of the exam. He was "shaking it off."

He recognized he was shaking, realized he didn't *need* to be shaking anymore, instinctively did the deep inhalation and exhalation, and felt a shudder go down his back from neck to tailbone. The shaking turned off. He was able to laugh about it. He'd told me he must have been more frightened during that oral exam than he'd realized.

He recalled afterwards, he *had* intentionally made himself numb so that he wouldn't feel fear. He added that, after the exam, he'd been walking around "like a zombie."

He had induced pause in himself, but only temporarily. His shaking didn't show up for hours, but it did show up as soon as he was in a "safe" place.

Cat and mouse

I've used the mouse example before. It's helpful because so many people have seen this play out. Here are some additional insights.

As soon as the cat's claws perforate the skin of the mouse, the mouse becomes rigid. *If* the cat was hunting for sport, not hunger, the cat will take a few tentative swats at what now seems to be a dead rodent. He will soon become bored with the unresponsive, rigid lump. The cat will saunter off, looking elsewhere for stimulation.

While the mouse lies there, apparently lifeless, for the next several minutes, the risk-assessment area of the mouse's brain obsessively asks, "Do I see the cat? Smell the cat? Hear the cat? Feel the cat? See the cat? Smell the cat? Hear the cat? Feel the cat? See the cat?..."

This process is called risk assessment. It uses dopamine, and takes place in the right anterior cingulate (risk assessment) area of the brain.¹

The risk assessment process is the normal way to come automatically out of pause. In the mouse, as soon as the risk assessment area confirms that the cat is gone, the process for turning off pause kicks in.

In a human who is stuck on pause, as soon as he finishes the risk assessment *or* feels reconnected with love, or fellowship, or humanity in general, his heart feels safe. He takes a deep breath and pause turns off.

The mouse doesn't need to "invite a fellow mouse" to gaze at his vibrations of post-shock and provide comfort. The mouse won't be "rushed" by a coach or nervous parent into moving before he's good and ready. He doesn't imagine for a *minute* that he will *never* be safe enough to come out of pause. He never considers the existential possibility that he is alone in the universe.

Only humans do that.

That's why, if a *person* has gotten stuck on pause, *he* may need to take the leisurely time that he never took before to observe his own condition and assess it. He may need to consciously destroy his fantasy that he is still at risk of death. He may benefit from the comfort given by someone or something that can succor him, reminding him that he is *never* truly alone. He may have to *consciously* admit that he is safe.

A classroom exercise

Before sharing the next example, I want to share an experiment my students do when I teach channel theory at the local acupuncture college.

The students pair up. One of the pair keeps silently saying to himself, "I do not feel pain, I do not feel emotion." This affirmation causes the spinal current to stop flowing up into the neck. It becomes a standing wave, just like it does during pause. This Channel Qi shift is *very* easy to feel by hand.

The other member of the pair is allowed to do any physical Chinese medicine technique he wants to try to shift the spinal channel Qi and get it moving. He can use needles, massage, any technique he wants. Of course, he cannot get the current to flow normally so long as his "patient" is powerfully affirming, "I feel no pain."

Even if he uses powerful electrical stimulation to literally force the spinal current up the neck and into the head, the moving current will revert to a standing wave as soon as the stimulation is turned off.

¹It was hypothesized in the 1960s that people with Parkinson's do not have enough dopamine in their brain, based on the finding that massive overloads of dopamine were able to get them moving again. *But* it turns out that people with Parkinson's actually have more than enough dopamine in the brain. They actually have *higher* dopamine levels than normal in their brain's risk assessment area.

What they do *not* have, just like any person on pause, is the ability to use dopamine in their *motor* area. [See: "Personality traits and dopaminergic function in Parkinson's disease"; *Proceeding of the Natinoal Academy of Sciences USA* 98;13272-7; Valtteri Kaasinen, MD, PhD et al; 2001.] Today, in medical schools, doctors are still being taught that Parkinson's is due to a dopamine insufficiency. Note the date of this research, which was published in a top, highly respected journal: 2001!

I do this exercise to drive home the point that *no* external treatment is stronger than a patient's own mental convictions and affirmations – even his determination *not* to heal.

My name for this exercise is “Ain’t no needle big enough.”¹

I am always careful to remind the students to powerfully reverse the affirmation when the exercise is done.

Sometimes, the dark-and-vibrating isn’t where you expect it

A patient of mine came in for a chronic shoulder weakness. He’d strained his right shoulder a bit twenty years earlier and it had never fully healed: his range of movement in the shoulder had remained limited for twenty years

He was generally healthy and vigorous, except for his long-term inability to heal in his right shoulder. This made me wonder if the patient’s shoulder was dissociated or locally (not body-wide) stuck on pause. If it was, I needed to treat that problem first before doing any other healing techniques on the shoulder.

After all, doing physical therapy and/or acupuncture on a given body part is pointless if the patient’s brain is busy pretending that body part doesn’t exist or if he is in a state of severe shock.

I asked him to close his eyes and imagine that there was bright light in his nose, then his hand, and then his shoulder. He *was* able to imagine bright light in his shoulder. So in his right shoulder he was *not* dissociated from or stuck on pause. I had to keep looking for whatever was preventing his shoulder from healing. The body is designed to heal. If it’s not doing so, there’s a reason.

If he had been doing this work on his own, he could have mentally scanned his right-side collarbone, neck, arm, wrist, and hand. Since he was in my office, I helped him in his search. It’s faster for me to just check how the channels are moving.

I felt for the electrical currents that run from the thumb, to the wrist, up the side of his arm, and through the front of the shoulder. There was no current running there at all!

The current I was *expecting* to feel going up his arm to the front of the shoulder was shunting out of its proper path. It was flowing from his thumb over to his little finger! From there, it was flowing up the *back* of the arm to the *back* of the shoulder.

This absence of current in the front shoulder could certainly explain the failure of the shoulder to fully heal.

I considered the possibility that the shoulder current was merely stuck in a wrong pattern and just needed an electrical jostle to go back to its correct path.

I inserted a quick acupuncture needle into the front of his shoulder to act as a lightening rod and inserted another needle just above the wrist, in line with the thumb, to draw the current away from the little finger and back into the channel where it should have been flowing.

No change. I inserted a few more needles. Nothing.

¹ Sung to the tune of the Motown classic, “Ain’t no mountain high enough”.

So I asked him to imagine bright light in his wrist, like he had just done with his shoulder.

His reply made no sense.

"I can't do visualization."

I pointed out that he'd just done it with his shoulder.

"Oh. But I can't." He mused silently for a moment.

"Maybe I can. But I *can't* visualize my wrist, anyway. It's dark, there's a shadow. I can't imagine light in it. I don't know how I'd even go about it."

I asked him to imagine it dark inside. This, he could do.

I asked if the center of the dark area was immobilized or moving in any way, shape, or form.

The dark place in wrist was vibrating fast.

Diagnosis: pause.

I had him do the five steps for turning off pause.

He mentally gazed at the darkness in his wrist. He imagined that someone he trusted deeply was gazing at that dark, tremoring area *with* him. Since this was just localized pause and his other currents weren't running in a pause pattern, I didn't even bother to ask him if he was at risk of death.

I merely asked him to tell me when he started to feel safer, comforted by sharing his situation with his invisible friend. Within moments, his breathing shifted slightly and he said softly, "I'm feeling safer now."

He automatically took a deep, audible breath.

He bobbed his head.

He *didn't* shiver.

Some people don't *spontaneously* shiver, even though they might be physically capable of doing a shiver.

If a person has been stuck on pause for a while, he might need to prime the pump by mechanically performing a shivering motion even though it doesn't feel natural. I explained this and added, "Do a *visible* shiver. I want to be able to *see* it."

He forced himself to wiggle his spine.

Within moments, I could detect that the waylaid current for the front of his arm was running normally again. He noticed that his shoulder was already feeling stronger. By the time he left my office, with me having done nothing further, he had greater range of movement in his shoulder than he had had for twenty years.

More than one place is vibrating

Finally, a person can have more than one area in his body that his brain perceives as dark and vibrating.

Don't worry about how many dark and vibrating areas there are.

Just pick one and get to work.

Very often, in cases where several areas appear to be stuck on pause, the process of turning off the first few (or the first dozen) sends a general message to the brain: we are *not* at risk. Turn off *all* the remaining places that were keeping me on pause and do it *now*.

In closing, the five steps are simple. They might need some of repetition if the person has been stuck for a long time. Once you have turned pause off, and turned parasympathetic and sympathetic back on, you won't go back into pause again. At least, not until your next life-threatening damage from trauma.

Then again, if you're using self-induced pause, you can get rid of the darkness and agitation over and over, but it may re-appear with your very next negative thought.

Turning off dissociation

If, while doing the diagnostics tests in chapter six, Diagnosing dissociation, some area in the body was dark and *motionless* instead of dark and vibrating, the problem is dissociation. Not pause.

(Again, if the entire body is dark, you're probably on pause. You need to find the *darkest* area and gazing at it, turn off pause.)

Think of dissociation as an instruction in your mind that forbids you having access to some particular bit of brain information, information that's stored in your brain's "Events Memory" area and/or your "Somatic Awareness of Body Parts" area.

The goal in turning off dissociation is to destroy the neural connections that your brain built to block off these areas. The information is still in there. It's just walled up.

The light and energy technique

Lie down and relax.

Start by doing the exercise in chapter xxx on diagnosing dissociation: see if you can imagine light in your nose, and then moving on to other areas until you are ready to home in on the problem area. The problem area will be dark and heavy, or dark and immobilized: not moving.

Gaze at this area inside your body at the area that is dark, cloudy, gray or even "non-existent."

Focus on the center of this area: the area that is darkest, least visible or that you least want to look at.

When you've found the spot you want to work on, imagine a small sphere of bright white laser light right in the center of the area that your brain doesn't want you to access. Hold this light for a count of ten, and then relax.

The light should be small: smaller than a lentil, bigger than the head of a pin, if possible. If all you can get is a fleeting spark, fine. Start with that.

If possible, in addition to the bright light, you may also send a tiny bit of muscle tone to the area. This will make the re-connection go a little faster.

Do *not* send light or muscle tension to the *entire* area. Just send it to the very *center* of the dissociated area. Isolating the *core* of the problem area will force your brain to allow access to the exact spot it is trying to avoid.

Next, you will do this "bright light, hold for a count of ten, maybe add real or imagined muscle tone" another nine times. Ten times altogether.

After your first count to ten, but before jumping in and doing the rest of the set, first take a moment to talk to your brain.

You might want to silently say thank you to your brain for having protected you from awareness, as requested at some time in the past.

Then tell your mind, “Now it’s time to end that. I’m going to re-connect with the areas that were dissociated.”

Be firm but loving. Your brain might not trust that you are sincere, at first, or it might be slow to abandon old habits.

Having established that you are, in fact, going to re-connect with the dissociated area, repeat the “white light, hold for a count of ten, maybe use slight muscle tone,” nine more times.

That’s it. That’s the technique.

When you are done with ten sets, mentally look around inside and see if the dark area is starting to lighten up.

If it is still dark and immobile, do this technique again, maybe two or three more times.

If it is still dark but is now *trembling* or moving in *any* way, switch over to the technique for turning off pause.

If it’s getting lighter, congratulate yourself and maybe blow the previously dark area a mental kiss.

Watch out for the detour

Very often, the brain will not want to comply with this technique. After all, you once told it to forbid access.

While you are trying to do ten sets of this exercise, your thoughts might suddenly wander. You may find yourself silently saying something like, “What’s for dinner tonight?” or “What should I wear tomorrow?”

This ploy of distraction is extremely common. As soon as you notice it, just power yourself back into what you were doing: a small area of bright light, hold it for a count of ten.

After all, who’s in charge here? Your conscious mind or your stodgy brain habits? With increased determination, finish your ten sets.

The attempt at detour usually occurs around the 5th, 6th, or 7th set, right around the time that you are about to successfully modify your brain’s neural behavior. However, it can occur at any point in the process.

I can’t do this

If you can’t imagine even this small amount of light, just do the best you can.

If you can only imagine colored light, fine. Keep at it, and you will soon enough be able to imagine white light.

If the light flickers or comes and goes, fine. Stick with it.

Do not worry about making it perfect in the beginning. You are changing a long-term habit. It may take several repeats of the technique or even several attempts spread out over a few hours or several days. *Don’t* be obsessive about it. The brain will change fairly soon in response to this technique.

The very nature of the brain is to be obedient to your instructions. If you stick to your new intention, your brain will rally round and make the changes you are working on.

If it doesn't, you are probably using a self-induced mental state, which requires a different treatment technique.

If the problem doesn't resolve or keeps returning

If the dark area(s) change locations, or are restored to "light" and "alive," *but* resume darkness and immobility, or has some new weird and unhealthy presentation in a few minutes or in an hour or so, or in a few days, you may have a different problem: self-induced dissociation. You may have *consciously* commanded yourself to not ever feel or be aware of that body part or event, ever again.

This problem requires a different technique. You will need to destroy the brain instruction instead of just re-connecting with the inaccessible area.

If this is the case, you will want to use the technique discussed in the next chapter. xxx.

My introduction to focusing on pain

Back when I was in college, I banged my head on an open kitchen cabinet door and yelped. I caught my breath and told my concerned housemate, "Don't worry, I'll distract myself by thinking of something else."

She drawled, "You know, In *China*, they *focus* on the area when it gets hurt. They don't try to *avoid* it." (This was before president Nixon's famous visit to China in 1972. China had been a locked box for decades. Anything having to do with China was cloaked in mystery to most Americans. One could say *anything* about China and have some believers.)

I snapped back, "Well that's just stupid! Why would anyone want to make the pain *worse*?"

I didn't know then that pain from injury is usually just a message to the brain saying, "Hey, we might have a problem here. Will you take a look at it?"

If the mind responds by calmly *observing* the painful area, the pain level drops enormously. And if the observation is followed up by sending energy and love into the injured area, the area can heal *much* faster than if ignored or denied.

Filling an injured area with light and/or power is an ancient, eastern way of quickly activating healing and reducing pain in an injury. The light and energy technique is also an ideal way for *immediately* dealing with injuries. It is the opposite of dissociating from them and waiting for a more convenient time to do your healing.

An example: great scenery and a knee injury

I've used this light-and-tension technique a lot on myself, but never with more surprise and success than the summer day I blew out my knee. We had been hiking the extremely steep Four-Mile Trail from the Yosemite valley floor to Glacier Point and back down again.

The trail seemed to be slathered with very small, *very* slippery, tiny granite "beads". It was like walking on ball bearings. On one side of the switch-backing trail hacked from the mountain's side was a granite face. On the other side, a steep, drop-off, high above the valley floor. On my way down, I used my knees at every step to brake, to come to a full stop, amongst the slithering beads.

I finally hit level ground and was within a hundred feet of the trailhead and the parked car. I relaxed my guard. My knee exploded in pain. I fell to the ground.

My friends offered to help me hobble to the waiting Toyota.

I said no, but thanks, and made myself comfortable on the dirt. I just sat there and filled the most painful point inside my knee with light and extremely minimal tension, more *imagined* tension than actual muscle tone. I held it for a count of ten. I repeated this ten times. When I was done, I could scarcely believe it – my knee had no pain and, though slightly shaky, seemed to be almost completely healed. I repeated the exercise a few more times, and then walked to the car, slowly, testing it out, under my own steam. Over the course of the next hour, it healed completely.

Decades earlier, when I was in high school, I experienced a nasty anterior cruciate ligament tear in my *other* knee. It didn't heal, which is considered normal.

A year later, I had the usual knee surgery to remove the torn section which had not healed at all.

The Yosemite injury felt exactly the same, in the opposite knee. But it completely healed within the hour. The injured spot never swelled up, it never caused any pain other than the first searing rip inside my knee. The Yosemite event was nearly twenty-five years ago. The knee is still just fine.

At the time, this technique was somewhat new to me. I was stunned at how well it worked. The technique simply consists of paying loving, focused attention (light and power) to an injury rather than trying to block it out.

Since then, as soon as possible after I stub a toe or get injured in some way, I stop what I am doing and spend a moment paying attention to the injury. My mind takes this to mean that I want my brain to be focused on *healing* the injury. After the initial "set up," my mind and body automatically takes care of whatever healing needs to be done without my conscious interference.

Yet another method: using a beloved

An ancient and beautiful technique for dealing with an injury is imagining someone – any inspirational figure who is trusted and loved – being miniaturized and allowed into the injury site. Once there, he/she/it stays there, filling the area with warmth and light. You can talk to the figure or just gaze at it. The more you engage with the beloved figure that is sitting there sweetly in the middle of the injury area, the faster the injury will heal.

The beloved does not serve as protection *against* the problem area. Just the opposite. He/she serves as your guide *into* the problem area. You give permission for your loved one to fill the area with warmth and love and you *pay attention* to him/her.

Because you love being with and communicating with your friend, you are happy to watch/feel energy, light, and love flowing into the area that you've injured or from which you've previously dissociated. Your loved one is there to hold your hand as you focus on the area.

You can do this until the darkness brightens or the sharp pain starts to climb down. Or you can keep your friend there until the area is completely healed.

For that matter, some people keep an image of a loved one in their heart at all times.

Busy miners with helmet lights

If you need to have helpers that are more dynamic than just a statuesque figure ensconced in your injury, you can try this one:

This method was used by a highly respected Buddhist teacher whose name, sadly, I do not recall. I learned of this method decades ago, from one of his students.

The teacher's hand had been badly smashed in an accident. The doctors wanted to amputate before gangrene set in. He asked for three days to work on it before they cut it off.

He spent the next three days in solitude, imagining work crews of tiny miners marching into and out of his hand. They were pleasant, well-experienced miners. They knew what to do. He didn't have to teach them anything...but he constantly watched them.

He imagined the miners wearing little hats with lights on them. They had wheelbarrows and picks and shovels. In the beginning, the miners were marching from his healthy arm down into his smashed hand. They broke up the debris with their picks. They shoveled the debris into the wheelbarrows and carted it away, up into the arm, up to around the level of the elbow.

At some point, the tiny miners used hammers and new lumber, building new scaffolding and supports. They continued to come from his arm down into his hand and then back up his arm.

He observed them for three days, allowing no distractions.

By the end of three days, the smashed bits of bone in his hand had started moving back towards their original layout. The blood flow in the hand was healthy, and there was no sign of gangrene. There was only severe weakness, soreness and achiness – the body's warning signs to be very careful.

After the first three days were over, he continued to do his visualizations now and then with the miners, but he also allowed himself to resume some of his other activities. Over time, the hand healed perfectly.

Twenty years after learning about this technique, I shared the "miners" method with a friend whose hand and four fingers were smashed by a falling boulder during a hiking accident. He was airlifted out.

The doctors wanted to amputate the fingers immediately.

My friend said no.

The doctors found what little skin they could from the fingers and wrapped it around the hash that had been his fingers. They told him to come back in two days to have the fingers removed.

Instead, he called me. I started him on the visualization with the little miners.

My patient saved his fingers, although it took him more than three days.

In addition to the visualizations he used, I immediately started doing Yin Tui Na on his bandaged palm and his pericardium area. As soon as the skin had regrown

enough around his fingers, I also did Yin Tui Na and acupuncture on them once a week over the next few months.

After several months, he had regained enough manual dexterity in his hand and fingers that he was able to go back to his job as an acupuncturist.

Today, a casual observer would be hard put to notice the residual stiffness in two of his fingers.

You don't have to use miners. You can use anything that amuses you or fills you with love. The main thing to keep in mind is that something good is going into the injured or traumatized area and the debris is being moved out.

Over and over, lovingly going in and coming out. This will keep your mind focused on the injured area. This will also help realign the electrical currents in the traumatized area, if they have been disrupted. These currents, when running correctly, carry instructions to the cells.

Most of the strongest rivers of current run in fairly smooth lines, to and from the fingers and toes, running parallel to the "straight-line" bones in the body.

This technique will not only restore the correct linearity to currents that, from injury or illness have gotten swirly or are mistakenly running sideways or in whorls, it will make the point to your brain that you do *not* want to be dissociated from this area.

The brain is not particularly clever. It doesn't know what is best for you. However, it is very, very obedient. If you repeatedly command your mind to do a particular thing over and over, your mind will quickly get good at doing it.

Practicing a new mental habit that you want to encourage will stop a previous, unhealthy mental habit, in favor of the new pattern. You don't need to get rid of the old dissociation habit or the negative thought pattern (unless, of course, you've given yourself a mental instruction to stay a certain way). You just need to actively work on the new, healthy pattern. This will change the way your brain works.

This is another example of neuroplasticity.

"Neuroplasticity" is just a fancy way of saying "Whether healthy or unhealthy, your mind gets good at what it practices."

You alone are, or should be, the boss of what your brain is practicing.

And yet another: Yin Tui Na

Yin Tui Na is a Chinese medicine technique that consists of extremely gentle, supportive holding of an injured, dislocated, or dissociated body part until the body pays attention to the problem and starts fixing it.

A book on how to do Yin Tui Na is available for free download at www.pdrecovery.org. This book was mentioned in an earlier footnote.

The book, titled *Yin Tui Na for Dissociated Injuries*, uses lots and lots of photographs to "teach" how to do something normal and natural: hold and support someone who's been hurt. The technique is extremely simple. A child can quickly master it. After all, it consists of firmly holding an injured body part. Nothing tricky about that.

The only reason I had to write a textbook on the subject for American students of Chinese medicine is that, in American culture, we tend to not touch each other. Many of us here in “cowboy culture” also tend to ignore injured areas.

I remember, when I was very young, if I got hurt, my mother would command me to “not think about it; think of something else.” This way of dealing with injury was common when I was a child.

In a culture that automatically gives succor and comfort to someone who is injured, no book on Yin Tui Na would ever need to be written: giving hands-on support to someone who is injured should just be an immediate response.

But in modern western culture we don’t touch much.

If someone has dissociated from some body part, and especially if bones have gotten displaced – a lot or a little – during the injury, Yin Tui Na can be a very helpful technique to accelerate re-association with the injury.

This technique is particularly helpful when bones have broken and have failed to knit. In ancient times, Yin Tui Na was referred to as “bone medicine.” It can be especially useful in helping bones reset themselves into their correct alignment following a nasty break that has a twist in it, or a situation in which the bones “refuse” to knit.

I know people who have done Yin Tui Na on themselves because there was no one around to provide hands-on support. It works. But it is nicer and more “connecting” to allow someone else to provide the support.

This chapter shared several methods for learning to re-associate with an injury or dissociated area. The one I usually teach my patients is the first one: light and energy – hold for a count of ten, ten times.

In this method, your attention is focused very narrowly, like a laser. This is because you aren’t actually trying to fix or heal the injured area: you are trying to pinpoint and alter the part of your *brain* that is saying, “We don’t *have* that body part.”

Once the brain has been changed so that it says, “Huh. Look at that spot. Hey! It’s injured.” the mind can give permission for the body to heal. Healing will kick in automatically. The body is designed to heal. The main thing for dissociated areas is to change the way your brain is behaving: Destroy your neural blockades by the mentally focusing on the areas that had been walled off. Resume active awareness of these areas.¹

¹ I learned this yogic technique, which is also a form of medical Qi Gong if you prefer to think in terms of Chinese rather than yogic protocols, in the late 1980s, possibly from a book with a collection of lectures by Paramahansa Yogananda (1893-1952) or else from the magazine he founded, *Self-Realization Magazine*. I do not remember the title of the talk or which book or magazine.

Turning off self-induced dissociation

Self-induced dissociation is not extremely common, but it does arise.

Simple dissociation is a somewhat automatic process. A person has a bad experience or a nasty injury that he doesn't have time to deal with, and his subconscious mind will just put it aside, to be dealt with later.

Pathologies can arise when "later" never comes. The event or body part remains "stuck" in dissociation.

But sometimes, a person will *consciously* command himself, maybe several times, to not remember a specific event, or not have pain in a specific body part.

This can lead to a situation in which the darkness-and-immobility in a given body part is well nigh impossible to get rid of without conscious work to first destroy the command. In response to the *regular* dissociation treatment described in the previous chapter, the dark area might re-appear following what seemed like, at first, a successful treatment, or it might even to a slightly different location.

Case study

A patient with intractable knee pain remembered telling himself in college, "I don't want to have this knee pain. I *refuse* to notice it." He did this several times over two days, and it worked: his knee suddenly stopped hurting. He never had knee problems again.

When he came to see me for something else, twenty years later, while looking for a dark area in his left-side foot, he happened to notice the dark area in his right leg, from the knee down.

He did the exercise of putting light and energy in his knee and holding it for ten sets of counting to ten. By the time he finished, the lower leg was filled with light.

About ten minutes later, mentally scanning his body again, he noticed that the darkness had returned.

He attempted to put light in the center of the darkness again, but this time, the dark area kept moving around, sidestepping his attempts to focus on it.

That's when he laughingly told me what he'd mentally done to himself in college.

With some self-induced situations, treatment may take a bit more time than the previously discussed forms of mental Qi Gong. You have to actually destroy the unhealthy mental command. If you don't, the problem might keep coming back, in compliance with your instruction. .

As it turns out, it's nearly impossible to destroy the instruction if you are in the same state of mind – you might say same degree of sympathetic mode – that you were in when you first created the instruction.

To override a conscious, fear-based instruction, you can first re-position your mind into what is sometimes called the “superconscious mind,” a highly parasympathetic state. Some people call this part of the mind the intuitive mind or the heart-connected mind. It is a very circumspect, patient, loving, non-judgmental state of mind.

As an aside, the superconscious mind is also considered to be the state of awareness that is attained by single-point meditation.

When one part of the every-day mind is arguing with another part of the every-day mind, for example, over whether or not to quit smoking, or change some other noxious habit, the battle can rage for years, with one side winning temporarily, and then the other side, depending on one’s mood or thoughts at the moment.

In eastern spiritual teachings, it is said that the *superconscious* mind has the ability and the *authority* to immediately override and lastingly change the merely *conscious* mind.

An example of this override is when a smoker, after decades of trying to quit smoking, suddenly has a moment of deep internal clarity and realizes, “I’m not a smoker anymore.” And he never smokes again.

A burst of awareness from the superconscious mind enabled him to see himself as a *non-slave* to the smoking habit. He was then able to *immediately* alter the smoker’s-habit brain pathways, permanently destroying the brain cells of desire for and habit of smoking. Ask an ex-smoker for details.

Technique for destroying self-induced dissociation

It’s best to be lying down, relaxing in a quiet spot.

1. First, *define* the brain habit that you are going to get rid of.

For example, my patient in the above case study defined his habit as “ignoring my knee.” He said this out loud a few times: “I have a habit of ignoring my knee.” Then he said it mentally a few times.

By defining it, you will be able to simply use the phrase “this habit” while doing this technique, instead of going into a long verbal description, a long song and dance, during every repetition about what it is you are destroying.

2. Next, choose a short affirmation that resonates with you and confirms that you are part of something larger than yourself.

Examples of this affirmation are, “(Universal) Love and I are one.” Or you might say, “I am part of the loving universe,” “My heavenly Mother and I are one,” “I am one with the Force,” “I am one with Divine Spirit,” or “My spiritual teacher/guru/prophet and I are one.”

3. Start silently saying your short, positive affirmation, one that confirms that your self, or your “soul” if you wish, is connected to some aspect of Universal Love.

Say it over and over. Focus on the words. Be so focused that your normal, always nattering mind stops its chatter and listens to what you are saying.

As you say this affirmation for at least thirty seconds, or even several minutes, notice that, at some point, you start feeling calm.

That's good, but it's not good enough. Be pleased that you're feeling calm, but continue saying the affirmation.

At some point, minutes later, you will start feeling peace. Peace is a more dynamic feeling than mere calm. Peace allows the heart to expand, or maybe shares itself with the world. It's good that you are feeling peaceful, but that not's good enough. Be pleased that you are feeling peaceful, but continue saying the affirmation.

At some point, twenty seconds to several minutes later, never wavering in your mental intensity, you will start feeling joy. Joy is expansive, radiant and, well, joyful. You will know when you start feeling joy.

4. Once you get to joy, focus on the *feeling* of joy in the heart. Affirm, "This joy is my *real* self. This joy is what I *really* am.

Then, *use* this joyful personality. While being your loving, joyful self, proceed to sweetly, compassionately, command your brain: "Destroy the brain cells of that wrong habit."

Or "Destroy the neural network of that wrong habit."

I read about this technique in a journal of Eastern meditative science, "*Self-realization Magazine*. The author, Paramahansa Yogananda, suggests that the joyful self use the phrase: "Cauterize the brain cells of this wrong habit."¹

"Cauterization" is medical burning, with great precision, of cells that must be killed.

Kill my own cells?!

Some people are taken aback at the idea of destroying their own neurons (brain cells). Don't be. You have billions of neurons.

Think of it this way: if a few of them were cancerous would you hesitate to destroy them? No, you would cheerfully cauterize any cancerous brain cells.

Like cancer cells, these brain cells that you created to pretend you weren't hurt are *not* working in your best interest. You created them in a moment of emergency or in error. You get to destroy them.

If neurons are creating mischief in your brain based on your own instruction, an instruction that created them, it is reasonable to destroy them. Think of it as mopping up after spilling milk.

This is a very powerful technique.

¹ I am sorry to say I do not recall the edition number of this journal, but I think it was in the 1990s.

The first time I used it, I was disgusted at my years-long habit of falling asleep within a few minutes of sitting down for a long meditation.

After catching myself falling asleep, yet again, I performed this technique. I spent about five minutes getting calm, five minutes getting peaceful, and needed nearly ten minutes to build up a head of joy.

At some point, I realized I was overflowing with joy, so I stopped the affirmation and joyfully commanded my brain to destroy “the habit.”

I lovingly, joyfully commanded, over and over, that the brain cells of that habit be cauterized: burned up.

After a few minutes, I actually felt an area of highly focused heat in one side of my head. At first, I considered being alarmed by this heat, but my heart, still joyful, assured me that I was OK.

Never again have I fallen asleep in meditation except for the times when I was over-tired. These few times were not sleeping from *habit*. They were due to my fatigue.

This Qi Gong exercise is much more powerful than the exercises described earlier, those for merely turning off pause and turning off dissociation. In those cases, the problem is that the brain got stuck and wasn’t able to resume the normal processing of a trauma. Your treatment, in these cases, merely returned your attention to the place so it could resume the normal healing process that had been interrupted.

In the case of a self-induced mental change, the treatment has to be more powerful. You created a wrong habit. Now, it’s causing trouble. You need to destroy the wrong habit that you created.

No one can do it for you.

You get to do it by yourself.

The next chapter is long and possibly a bit unsettling. Get yourself a snack and something to drink, and settle in.

“Oh what a tangled web we weave when first we practice to self-deceive.”¹

Chapter fifteen

More about self-induced pause

A word of warning: this chapter introduces ideas that might be a bit controversial. Please know, I could never present these bold, some might say crazy, or even “unfair” hypotheses about altered mental states if I had not seen what happens when people come out of them.

Prior to recovering, some patients have been insistent, even angry, that they were *not* using some oppressive, self-created self-protection mentality. Then, they went on to experience a nearly instantaneous, heart-opening physical, mental, and emotional change when they took steps to rid themselves of their oppressive, self-created self-protection mentality.

After which, they *knew* they had changed their mental state. They could see in retrospect that they had, in fact, been using an altered state and, best of all, their pause symptoms were gone.

So please suspend judgment until you’ve had a chance to ponder some of my observations and conclusions and weigh them against observations of your own.

Before describing the *techniques* for turning off self-induced pause, more details about self-induced pause might be helpful. This chapter is going to skim lightly over many examples that led to my conclusions about self-induced pause *and* the discovery of methods that can end it.

Probably the most important point to cling to is this: the person is *not* actually stuck on pause. He has commanded himself to *behave* as if he is.

I worked for over twenty years trying to figure out why people with self-induced pause could not lastingly benefit from the usual self-help techniques, meditation, or Qi Gong techniques. They might do these techniques and feel more relaxed for a bit, but they would bounce right back into their previous (pause) mindset with a few minutes or a few days.

Only when I started treating these people as if they had created a second personality was I able to get fast, consistent results.

Returning to the earlier train track analogy in chapter xxx, a trolley on the pause track is not able to get onto the parasympathetic/ sympathetic continuum until he gets on the turntable and goes through the steps that turn off pause. But if he has *two* completely separate systems, he can use either one.

A person who creates an alternate personality that uses pause as needed can still access parasympathetic mode any time he wants – so long as he is able to feel safe. Then again, chronic use of pause makes a person less and less *able* to feel safe.

¹ A riff on Sir Walter Scott’s famous line from “Marmion”, Canto vi, stanza 17.

As an aside, I hypothesize that this steady decrease in the ability to feel safe is related to chronic inhibition of the Du channel when a person is on long-term pause.

You will recall, when on pause, the energy in the Du channel stops at the base of the neck. The *back* portion of the Du feels like a standing wave. The energy in the *head* part of the Du channel, the part that should normally flow through the midbrain, thalamus, and striatum is therefore greatly reduced when a person is on pause.

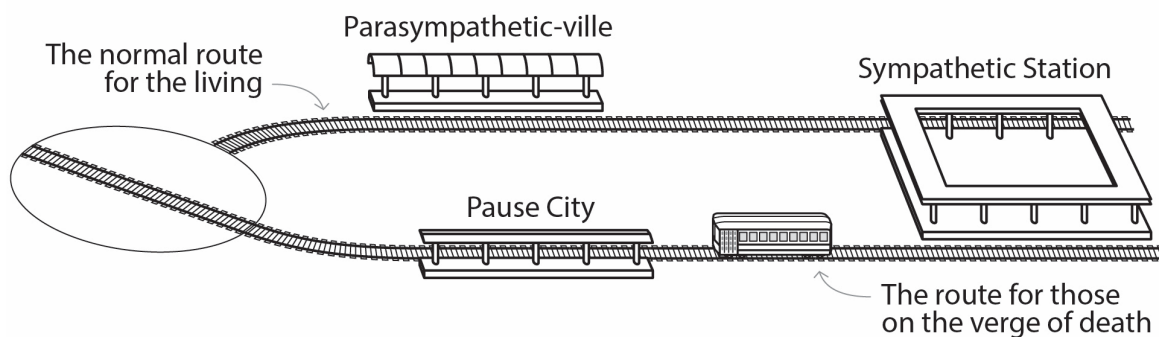
The brain's striatum can be thought of as the dopamine tank (among other functions). The brain's thalamus is the heart-feeling center (among other functions). The thalamus is also the tremor center, when a person is on pause.

Flow of energy through the striatum is what makes a person feel safe. Research support for this idea is provided in the next chapter.

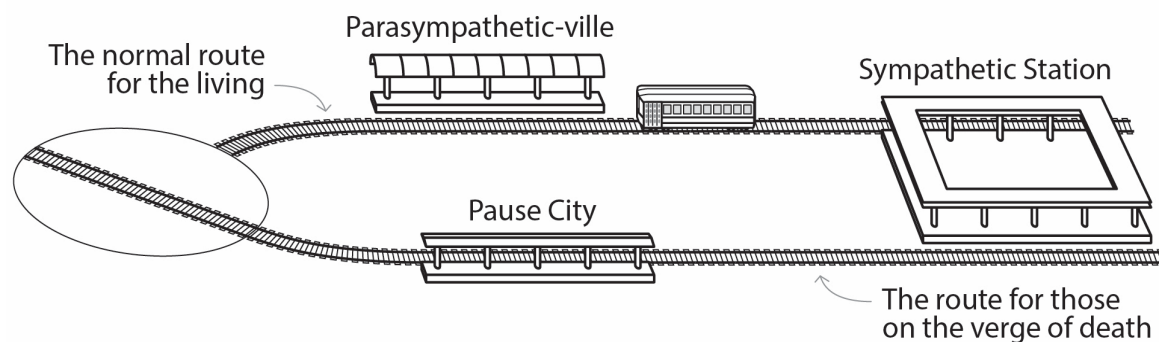
Frequent inhibition of energy flow through the striatum may contribute to the declining ability to feel safe when a person uses pause for a long time.

A two-trolley model

#1 Self-induced pause personality (dominant)



#2 Real personality (subordinate)



The second personality hypothesis

I cannot say with certainty that people on self-induced pause have in fact created second and third personalities. I will leave that decision to the psychologists.

If you don't like the idea of "two personalities," the observed behaviors in people with self-induced pause could also be said to resemble that of a person who has "hypnotized" himself into activating pause when he needs to be wary (almost always), and letting himself slip into parasympathetic when things are safe.¹

I do not use lightly the terms "multiple personality" or "self-hypnosis". These are emotionally loaded phrases. Some people have shown tremendous resistance to these terms.

However, many, maybe most, of my patients have often told me that my descriptions of what self-induced pause *feels* like are uncanny in their accuracy: "I never thought anyone knew what I feel like inside. Your book, it's as if you are writing about *me*."

However, by treating these people *as if* this is what they are doing, I have been able to develop techniques that turn off self-induced pause. The most common examples of self-induced pause that I have seen have been in my patients with Parkinson's disease. Those patients with Parkinson's who did not recover in

¹ There are many types of hypnosis. I am *not* referring to the type of hypnosis in which a person "steps back" into his past to recall dissociated events. Nor am I referring to the type that is used to destroy or create a new self-operating system, such as "I am not a smoker" or "I am a non-smoker."

In this chapter, I am referring to the type of hypnosis in which a person is instructed (or self-instructed) to behave in a particular manner, often in response to a specific cue.

For example, a person can be hypnotized to think his arm is too heavy to move ("hypnotic paralysis").

Curiously, brain scans show that this type of hypnosis works by inhibiting the motor function **imagery** area of the brain – the same part of the brain that is inhibited in Parkinson's. The footnotes below show the connection. (Continued on next page.)

*For hypnosis, See: "The Brain under Self-Control: Modulation of Inhibitory and Monitoring Cortical Networks during Hypnotic Paralysis"; Cojan, Y, Waber, L, Schwartz S, Rossier L, et alia; *Neuron*, Volume 62, Issue 6, 862-875, 25 June, 2009. Doi:10.1016/j.neuron.2009.05.021

[In the hypnotized subjects, but not the controls or those with feigned paralysis] ..."Preparatory activation arose in right motor cortex despite left hypnotic paralysis, indicating preserved motor intentions, but with concomitant increases in precuneus regions that normally mediate [intercede with] **imagery** and self-awareness. [Bold-type emphasis mine.]

*For Parkinson's, See: "Motor Imagery in normal subjects and in asymmetrical Parkinson's disease: A PET study"; [PET = positron emission topography xxx (brain scans)], Thobois S, Dominey PF, Decety PJ, et alia, *Neurology*, 2000, Oct 10;55(7):996-1002. Briefly, the abstract states that "Previous work in PD has shown that bradykinesia [slowed motor function] is associated with slowness of motor **imagery**...In patients with PD...brain activation during motor imagery is abnormal...characterized by lack of activation..." [Bold-type emphasis mine.]

In both studies, one on hypnosis and one on Parkinson's, actual motor *intention* and *function* behaviors in the brain were normal, but the *imagery* area, an area that must be activated prior to *dopamine*-based motor function, was inhibited.

Whether the inhibition of motor function **imagery** area causes the perception that one is outside of his body, or the re-location of one's consciousness outside of his body is what inhibits the motor function imagery area, I have no idea. *If* these two events are in fact related, I would favor the latter possibility. This may be a fruitful avenue for further research.

response to re-connecting and healing of a childhood foot injury were able to recover by destroying the pause personality – if they were willing to do so.¹

Dominance of the personalities

In people with self-induced pause, from what I have seen, the pause personality is the most often used: the default position. The real personality only shows up when a situation is confirmed as safe.

Otherwise, the assumption is that the person is *not* safe, and must be using his self-protecting personality.

Although the pause personality might be subordinate in the beginning, it will, quickly or over decades, become the dominant personality. I know that, in my own case, once it was activated, it was immediately the dominant personality for me.

One of my Parkinson's patients was extremely resistant to the idea that he might be using something along the lines of self-hypnosis. He was a prominent psychotherapist, and he refused to consider the idea of *any* mental component. He wrote to me, "I'd rather have Parkinson's than think I was mentally ill."

A few others have said that they would be willing to consider Parkinson's being caused by a foot injury and the need to suppress emotions, but they've rejected the idea that anything "mental" might be involved.

In fact, by dissociating from a foot injury or suppressing emotions, one is taking "mental" actions. Even if Parkinson's is set in motion by a foot injury, it's not really the injury that's at the root of the problem: it's the *mental* attitude, the *dissociation* from the foot injury, that's the trouble...not the foot injury.

For the record, I've never said anything about being "mentally ill." I just say that people with Parkinson's or with self-induced pause behave in some ways similar to people with multiple personalities and/or those who are hypnotized to perform a certain behavior on cue.

If you really can't stand the idea of multiple personality or self-hypnosis, you can think of being stuck in self-induced pause as being like an actor who has become mentally stuck in his role. This does happen.

One famous example is the original actor in "The Lone Ranger" TV series, who notoriously was never able to abandon the "white-hatted hero" personality that he created for his role.

If it's easier for you to think of self-induced pause as a "role" in which you have gotten stuck, fine.

Lets leave the semantics to the psychologists, who consider multiple personality situations to be incurable.

Luckily, self-induced pause is *not* incurable.

¹ I do not work with people who have ever taken dopamine-enhancing antiparkinson's medications for more than three weeks. To understand the problems that arise while working with medicated patients, please see my book, *Medications of Parkinson's or Once Upon a Pill*, available for free download at pdrecovery.org.

Getting back to the multiple personality model

In the trolley model, the *active* trolley represents the personality that a person is using at a given moment. No matter how many personalities a person creates, he can only *use* one trolley at a time. If there is more than one personality in place, the trolley(s) that are dormant, that are not in use, will still be chugging away on “idle.” The trolley, you will recall, represents a person’s life force: the energy and consciousness that keeps him alive.

A vacant trolley’s motor won’t turn *off* just because the trolley is standing still. The trolley is always on “idle,” fired up and ready to move at any moment in response to brain instructions. If there are two trolleys some of the person’s energy is divided between the two trolleys. Neither trolley has fully as much energy as you would find in a person who is using just one trolley.

Invoking self-induced pause so as to avoid physical or emotional pain allows one personality to use pause, while the other personality is available to use normal (parasympathetic) neurology once in a great while, during very specific, safe conditions. But even when a person is briefly using his parasympathetic mode personality, the pause-using personality is *always* running in the background.

Although only one personality can be *active* at a given time, a person using the trick of self-induced pause can *appear* to do the impossible: flip back and forth between pause and genuine parasympathetic.

Of course, *most* of the mood-related variations one experiences in pause symptoms are from merely moving towards one end or the other on the pause/adrenaline-override continuum. But sometimes, a person on pause makes a genuine shift into a true state of joy, temporarily turning off the electrical circuitry of pause.

I have seen patients do just this in response to the joke test described in chapter nine xxx. As mentioned, their channels shift into parasympathetic mode flow in response to the joke, and back into pause flow when I say “Uh oh.”

A trip into parasympathetic mode

I remember the first time I lurched into full-blown parasympathetic mode after years on pause. I left home at age seventeen (Finally safe). I had a job (safety!) and was living on my own (safe).

One weekend, I stayed with a friend who lived near an isolated stretch of southern California beach. (There used to be such a thing). My friend was at work and I was alone on a pristine beach, swimming and sun-bathing on a beautiful day.

Suddenly, I was stunned by an unexpected transformation. My body was light, weightless. The colors of the sand, sea, and sky were intense, pure, sparkling. I felt joy surging through my body. I didn’t know what was happening.

No, I was not on drugs.

After about an hour of amazed wonder, I realized I needed to be getting back to the house. I immediately was back to my normal self: happy, pleasant, but with my usual inhibited sensory functions.

After that, for years, I used the memory of that hour of bliss to give myself strength and encouragement during challenging times.

I *was* always able to feel some relief from negativity while playing music, but it was never at the same level as the day on the beach – I was always judging my musicianship, always self-critical.

Until I ended my use of self-induced pause, decades later, I never felt that level of joy again. Since recovering, I can feel it as often as I let myself. Turns out, it's perfectly normal to be *able* to feel joy.

This ability to *seemingly* turn off pause now and then is only possible with *self-induced* pause. People who are actually stuck on real pause after life-threatening damage, or using pause-like electrical patterns caused by dissociation from an unhealed injury (with no self-induced pause), are *not* able to turn pause fully off during a moment when they feel safe.

However, even though a person with self-induced pause might *sometimes* be able to use his “safe personality” and behave as if pause is turned off, he may still feel a weird drag on his mental state, as if he is on guard and ready to slip back into pause at a moment's notice.

His emotions, even when in parasympathetic mode, may be somewhat weighted down or muted so long as the pause personality *exists*, even if it is just idling in the background. He might think that he has times of feeling really good. But when he finally terminates what I'm calling the pause personality, he feels exultant, and distinctly different than he has felt in a long, long time.

The astonishing buoyancy of the body and carefree joy that rushes in when the pause personality is permanently ended is very different from the short-term ability to feel somewhat restful, curious, or playful while the “real” personality is in use and the pause personality is “on idle,” is waiting in the wings. So long as pause is an active *possibility*, so long as that secondary personality is there and silently watching to make sure no risk arises, a person is not actually fully free just to be himself

Hidden personalities

“Multiple personality disorder” is commonly associated with the idea that at least one of the various personalities is unknown to the other(s).

In the case of people with Parkinson's disease, the paused personality knows about the safe personality. A person can say, “My symptoms are always less when I'm on vacation,” or “when painting,” or in whatever situation is “safe.” This person is *aware* that he has two or more ways of being.

However, it is not uncommon for a person with Parkinson's from self-induced pause to develop a highly specific third personality, one that the other two personalities do *not* seem to be aware of.

The blocker personality

I refer to this third personality as “The Blocker.” The blocker shows up when someone (often the spouse) suggests to the person with Parkinson's (also known as PD) that his symptoms seem to have a mental or emotional component.

In response to this suggestion, the eyes of the person with a blocker personality may quickly dart from side to side once, twice, or even three times. He

may experience a break in conversational continuity: “What were we talking about?” He may have a distinctive glaze over his eyes. Later on, he will have no memory of whatever was discussed during his “glazed eyes” phase. This memory lapse is highly uncharacteristic for most people with Parkinson’s, who tend to have very high degree of recall. So when it does occur, it is remarkable.



The blocker personality

In this sense, the blocker *does* conform to the classic idea of one personality’s actions being hidden from the other personalities or from the “master” personality.

Making the blocker personality even stronger

For years, before figuring out that my patients were using self-induced pause, I had often observed that *if* a patient seemed to have a breakthrough during treatment, such as admitting that he might finally be safe enough to turn off his perpetual wariness, then, in our next session, the blocker personality (which protects the pause personality from being exposed), had a *greatly* heightened presence and would be called up more quickly and more often than before.

These sessions were sometimes chilling. Spending time with a blocker can be a bit creepy. The person can become abruptly illogical, with selective memory, and an almost blank stare in the eyes.

One patient said to me at the beginning of the session, “I know I need to listen to my heart, I need to learn to trust the universe.”

At the end of the session, after an hour of positive affirmations (back when I was still using those to get a brief benefit), as he was going out my office door, he turned to me and said, “So, my homework is remind myself over and over: “I need to close my heart, and I have to be careful to not trust anyone. Right?”

I replied, “Um, no. Just the opposite...”

I told him what he’d been talking about, told him that he’d just now stated the *opposite* of his previous thought, and asked him if he was clear on what we were working on.

This highly intelligent person, said, “No. I didn’t get it wrong. I got it right. *You* told me to keep my heart closed and *you* said I can’t trust anyone. I’ll see you next week!” His eyes were glazed. He smiled at me with his teeth and walked away.

I went cold inside.

One of my patients told me, several times, that he didn't know what I meant by the word "feel," and that it would be impossible for him to ever know.

During a subsequent session, while doing Yin Tui Na therapy on his injured foot, I was very chatty. I intentionally used the words "feel" or "feeling" in every sentence. For example, "I *feel* like your right foot needs more work," and "Do you *feel* like it might rain tomorrow?" Some of the sentences were a bit of a semantic stretch, but I tried to insert some variant of the word "feel" or "feeling" into every sentence.

His highly intelligent and compassionate wife, aware of what I was doing, was trying hard not to laugh out loud during the hour-long treatment.

At the end of our session, he had a hard time figuring out where he was (he was in my office). As his wife walked him to the car, he asked her, "Aren't I going to have a treatment today?"

She told me later that he was deeply confused for about half an hour and was never able to believe that he had been inside my office that day, let alone received a one-hour treatment.

Sometimes, when a patient suddenly shifted into a blocker state, his eyes not connecting to anything, I have asked, "Is there a voice in your head telling you not to listen to *me*? Is it talking to you *right now*?"

Many times, the patient stared at me with glazed eyes and a grin frozen on his lips, saying nothing. Just stare and grin. But a few times, the patient has silently nodded, "Yes."

If asked about it later, the patient might have no recall whatsoever of me having asked the question.

The blocker isn't logical.

One patient told me she could no longer get herself into bed because her Parkinson's symptoms were so severe. She had to stop having Parkinson's, get into bed, get her blankets and pillows just right, and when she was ready to fall asleep, she went back to having Parkinson's.

When I asked her why she didn't just turn off the Parkinson's all the time, she looked at me as if I were an idiot.

She looked offended. "But I *do* have it. I *have* to have it. If I pretend *not* to have it at all, that would be a lie. I'm not a liar!"

This was an extremely intelligent woman, a highly respected psychotherapist. She could *never* see that this statement was medically illogical.

This type of illogic, appearing in a person who was *usually* highly logical and analytical, showed up *so* many times, with *so* many patients, that it could not be discounted as a fluke. It often seemed that, the more a person worked towards *changing* or overcoming his inhibition of parasympathetic mode, the more often, more quickly and strongly the protective "blocking" behavior kicked in.

Activation of this personality led to some truly bizarre, highly illogical, and even unsettling conversations. This could be the subject of an entire book.¹

¹ The strengthening of the blocker personality in response to partial healing was one reason that the Parkinson's Treatment Team of Santa Cruz disbanded in 2013.

We had been able to figure out how to successfully treat people who had merely dissociated from a foot injury. The treatment was simple Yin Tui Na. The treatment could be done by anyone, a family member. There was no need for these people to come to Santa Cruz to be treated. For these people, we had attained our goal of finding a cure, and it was a do-it-yourself situation. We were no longer needed. We posted this information on our website.

But the majority of people with Parkinson's who got their foot injury treated got rapidly worse. They slid into "partial recovery," in which the pause symptoms were more likely to come and go, but when they came, they were far more powerful. This too was posted on the website.

Some people, after years in partial recovery, fully recovered following a seemingly spontaneous epiphany, after which the Parkinson's simply disappeared. But many were still stuck, and we didn't know why. As for the epiphanies, the commonality in all of them eluded me for nearly two decades until, in 2014, I stumbled on new brain research that enabled me to make the connection between what else they'd been doing at the time of the epiphany. It turns out, it wasn't the epiphany. The epiphany came afterwards, in the seconds following the event that actually turned off pause.

But we had seen, for years, that *some* people in partial recovery, the *more* they were treated with Yin Tui Na and positive attitude therapies, the stronger and more frequent became the blocker behaviors. Some people became weirdly withdrawn from family members or wouldn't even talk to friends or family who might *possibly* want to help them. The blocker, if steadily strengthened, seemed to "want" to take control over the person's mind. The blocker phenomenon was so improbably and beyond our comprehension that it was *not* posted on the website.

We had no idea what was going on. Although we'd seen some people with blockers who had not yet received any treatment, it did seem that the sudden appearance of a blocker was sometimes related to healing of the foot injury healed and the onset of partial recovery symptoms. We didn't understand that these people had self-induced pause. We agreed to disband the Treatment Team.

After that, I continued working with a few people with Parkinson's, on my own.

I never sought them out. If people contacted me and pleaded for treatments, I warned them that there were no guarantees and there were risks. I was careful to make very clear to them that some people end up with a bizarre mental state if they got the foot injury treated *before* they turned off the negative, wary mindset. I no longer did Yin Tui Na on anyone. After all, I had seen that in cases with what I now call a "pause-component," getting rid of self-induced pause usually allowed the foot injury to heal by itself.

It was during this much more cautious period, by bringing together new findings in various science and medical fields, that I was able to figure out some underlying problems such as pause, self-induced pause, and dissociation from a foot injury, all of which might lead to symptoms of Parkinson's disease. It turns out, the original channel theory that helped me explain Parkinson's disease from an electrical point of view was correct. What I didn't know was that these electrical patterns could be mentally induced, and that they were a match for those of near-death trauma, a neurological mode that plays by its own set of rules.

It was only after figuring this out that I understood in retrospect why the Yin Tui Na had helped some people: it was a technique that, at its core, turns off dissociation.

As for the blocker, while it was alarming to me, it also forced me, eventually, to consider the possibility that Parkinson's was, in fact, most often a mentally-induced condition: a possibility that was sort of obvious from the start, but which I stubbornly didn't want to consider. (As far back as the 1930s, doctors were writing about the "Parkinson's personality." Research on the "Parkinson's personality" continues in our century.)

We'd seen the mild and intermediate forms of self-protection (dissociation and self-induced pause, respectively). But it was the blocker, a far fiercer layer of self-protection, and other quirks, that me to discover what was actually going on in my patients.

Many patients do not have a fully formed blocker *personality*, but still have blocker behaviors going on. They are able to recognize that *something* in their own brains is operating counter to their own instructions. These people don't shift into a fully altered state. Instead, they are able to be circumspect about what happens in their heads when they try to modify their thinking. But that doesn't mean they are able to override the commands of the blocker voice. They usually cannot.

Patients have told me things like, "There's a voice in my head these days. It's audible. It tells me *not* to feel safe, especially when I'm trying to do some positive-thinking exercise."

Often, this controlling voice first shows up in response to turning off some injury dissociations via Yin Tui Na. When the pause patterns that were held in place by an injury cease, the person's brain becomes the only thing that's keeping the pause pattern going. Due to brain changes that occur while using chronic pause, the brain has learned to think that it *is always* at risk. When the injury heals, the brain will need work harder to maintain pause, which it now thinks is the correct way to be. One of the tricks the brain uses, evidently, is creating blocker behaviors. The blocker behaviors might or might not develop into an independent personality.

I've also heard, "There's someone in my head that forbids me to even think about changing myself." Or "...distracts me when I try to do positive thinking."

I've also heard, "There are signs in my head [or "on my heart"] warning me not to put myself at risk. The words "No!" [or "Stop!"] are written on them."

"When I try to do the techniques you describe, to make myself feel safe, I hear a voice like a robot. I call it the "computer voice." It says, "You cannot access these functions at this time."

And, *very* often, a patient has said to me, "There's a devil in my head who won't let me do this exercise!"

The people who mentioned "devils" or "demons" were not necessarily religious. Often, just the opposite. And yet, words denoting "evil" often arose when patients tried to describe the battle going on in their own minds. This "battle" occurred when the patients were trying to do some technique that increases use of parasympathetic mode.

The mental battles or written warning signs were often alarming for the patient. This might be an understatement.

But at least these people were *aware* that there was a struggle going on.

On the other hand, people with a blocker personality didn't have these battles. If they tried to do parasympathetic stimulating exercises, the blocker just stopped them. Their eyes darted, the eyes glazed over, and they had no idea what they were supposed to be doing – or they became convinced that they were supposed to be doing the opposite of the exercise.

I was alarmed the first time a patient did this, even though his wife said, "There he goes again. I hate it when he does this..."

Another time, I was trying to discuss the subject of learning to feel safe with a patient. His wife was sitting beside of him. His friend was sitting across from him. The patient eye's flickered and the blocker showed up.

She said “There! You see what he’s doing? That’s what he does *whenever* I say something that he doesn’t want to hear!” (This person had not yet been treated by me, so his blocker was *not* the result of partial recovery.)

His life-long friend, facing him, said, “Whoa. That’s really weird. Hey man, what did you do with your eyes?... [a long silent pause] Can you even hear me? ...Hello?”

I have seen this behavior many times.

Now, I am used to it, but it’s still unpleasant to spend time with.¹

Again, the blocker personality seems to exist in order to protect the paused personality and fend off any behavior or thought that threatens it or “accuses” the person of having symptoms that are linked to emotions.

Some patients who cannot recognize their blocker personality when they are told about it out loud *can* recognize the behavior when they *read* about it.

Others can recognize the concept and agree that *other* people might have a blocker, but are not able to see their own.

For example, a patient wrote to me after the first version of this book was posted online. Although he had read the chapter about the blocker, he wrote: “I tried doing the five steps but I keep dozing off into crazy dreams. It’s a struggle to even get through one step before I mentally wander or doze. Same as when I do Qi Gong. I think most of my problem is mental and I don’t know how to handle that...I’m sure I’ve already reconnected with any physical trauma I might have experienced in life.”

He made *no* reference to himself having a blocker – about which he had just read earlier that day. He was clearly baffled by his inability to keep focus when doing mental work to turn off pause, but was unable to make the leap from his own, obvious mental blockages and my writing about blockers.

I’d be willing to bet he has a blocker in use when he tries to do the steps or do Qi Gong. And I’ll suspect therefore he has *not* re-connected with his *significant* past traumas. If he had, he wouldn’t *need* the blocker.

Many patients with severe inability to access heart-based feeling or who have blockers have assured me they’ve read every page of my books. But, as we talk, they obviously have *not* read the material about heart feeling or blockers or, if they did, they could not recall it.

Sometimes when I ask, “Did you read the *whole* book?” I am told something like: “I read all the *important* parts: the parts about the foot injury. I skipped the other stuff, the emotional and mental stuff. That stuff isn’t important.”

¹ This is not a problem of “the dementia of Parkinson’s.” That type of dementia is caused by brain damage from the powerful antiparkinson’s medications, drugs that elevate dopamine levels far above normal, in ways similar to the actions of cocaine and methamphetamine.

I will not work with a person who has *ever* taken dopamine-enhancing medications for more than three weeks. To understand why, please read my book, *Medications of Parkinson’s: Once Upon a Pill*, available for free download at pdrecovery.org.

These are *highly* intelligent people, with keen memories, for the most part. But if the blocker is doing his job, they may not be able to read, understand, or remember words that threaten the “safety system” that they’ve created.

In my experience, the blocker cannot be destroyed until the patient destroys the personality that it is protecting. The personality and its protector seem to be linked. When the command that created the pause personality is destroyed, the blocker disappears.

Post-hypnotic lightness

Another reason I dare to suggest the word “hypnosis” when describing behaviors seen in self-induced pause is from observing what appears to be a post-hypnotic lightness of spirit and body, together with the other “Where am I?” changes that occur immediately when the pause-inducing command is destroyed. The behaviors seem identical to post-hypnotic release.

I’ve seen, in the blink of an eye, a glorious personality change. The person goes from highly self-conscious, even guarded, and needing to be perceived as “always correct” over to unself-conscious, carefree laughing, and blurting out cheery exclamations such as “Ha ha! I was just doing this to myself! Ha Ha!”¹

¹ I recall a high school-sponsored camping trip. One of the parent chaperones was an amateur hypnotist. Sitting around the campfire, we begged him to hypnotize someone. The student that volunteered to be hypnotized was instructed, under hypnosis, to stand up and yell “Peaches!” anytime a person said the word “camping.”

For over half an hour, while he was in his hypnotic state, he did just this. He seemed like his own self, except for regularly jumping up and yelling “Peaches” when we managed to sneak the word “camping” into the fireside conversation. Most of the students laughed hysterically every time.

But his girlfriend was sobbing, and kept saying, “Stop this! He’s not himself! There’s something wrong with him!”

For myself, I remember thinking, “Um...um...I’m on the verge of seeing something here, but I don’t know what...” I was *deeply* intrigued and also very concerned. In retrospect, I think I must have recognized something in that hypnotized young man that struck very close to home. After all, I had unknowingly put myself into a condition of self-induced pause when I was young and was still in it.

When the hypnotist instructed the young man to no longer be under the influence of the hypnotic instruction, the young man was momentarily dazed, and then seemed deeply relieved, as if a huge weight had just come off his heart. In other words, while hypnotized, he had *not* actually been normal, with a mere *addition* of the peaches instruction. It seemed more as if he had been forcing himself to operate a second job or a second personality that was on the lookout for the word “camping.”

Keeping an eye out for this condition (use of the word camping) seemed to have ever-so-slightly weighed him down. This “extra personality” was able to dominate his main personality. While hypnotized, he projected a faint, *vague* sense of overall suppression despite all his behaviors and cheerful attitude seeming to be almost the same as before. (Continued on next page.)

I don’t think most of the kids noticed any significant shift in him. Only his girlfriend could tell that there was something seriously altered in him. Or maybe she was just embarrassed on his behalf.

It only became apparent to me after the instruction was terminated, and he resumed using his eyes in his former, deeper, manner again, plus moving more lightly and smiling with more depth again. That’s when I realized that he had, in fact, been different, somehow oppressed, while under the hypnotic influence.

Diagnosed with dissociative identity disorder

Some of my Parkinson's patients were diagnosed with dissociative identity disorder (DID), the newest name for multiple personality disorder, prior to being diagnosed with Parkinson's.

I have also seen a few patients with a full collection of Parkinson's *symptoms* who were not yet "officially" diagnosed with Parkinson's but who *had* been diagnosed with DID.¹

Usually, when they recovered from Parkinson's, only one personality remained: the other personalities were permanently gone.

One patient who had been diagnosed with DID only had Parkinson's symptoms rarely, in one rarely used personality.

Oppositely, one patient had many multiples, most of whom did *not* know about the others, all of whom had Parkinson's. In his case, he had started using the self-secret multiples when he was eleven years old, after his father died and his mother insisted he perform with her *all* the roles of her late husband.

He suspects that his ability to have Parkinson's started years earlier, when he dissociated from a childhood foot trauma. We hypothesized that, because he had pre-Parkinson's before he divided himself into many multiples, all of his personalities had Parkinson's.

After starting treatment for his Parkinson's, the patient was able to unite all his selves with a "master" personality that *was* aware of all the others.²

In the first moments after turning off self-induced pause, a very similar shift occurs. Patients have mentioned feeling "lighter" and freer, the eyes look deeper, less wary, the smile more effortless. The body language seems somehow "relieved."

¹As an aside, in an autobiographical book by a person with severe multiple personality disorder, she describes one personality that has symptoms somewhat similar to those of Parkinson's disease. She describes this personality as the one that "moves like I'm in cement." Her descriptions of this personality seem like a likely match for Parkinson's disease.

He book is *When Rabbit Howls*, written by The Troops for Truddi Chase, Introduction and epilogue by Dr. Robert A. Phillips, Jr. PhD, psychotherapist, Berkley Books, New York, 1987. You might not want to read this. It's extremely graphic in describing the physical and sexual abuse she suffered at the hands of her stepfather.

² I teach psychology and counseling at the local acupuncture college. I read as much as possible, every year, on psychological pathologies and the current treatments, if any. I need to keep students up to date in the rapidly changing vocabulary, definitions, and treatments for psychological pathologies. Despite my long-time and ongoing studies in this field, I will be the first to declare that I am *not* a psychologist.

If the reader is curious to learn more about the mechanisms of hypnosis and of multiple personalities, I would suggest that he avoid the lurid and sensationalist literature of the 1960s through 2010. The professional attitudes of that period considered these mental states to be freakish and incurable. The *non*-professional understanding of these mental states, in some cases, even leaned towards demonic possession. In recent years, we have thankfully begun to have a healthier attitude towards these various mental states – states that might be far more common than was once thought.

In a quick canvass of some of my acupuncturist colleagues, most of them have seen patients with behaviors characteristic of at least one "extra" personality. For example, binge eating and other not-in-control-of-myself behaviors that erupt in response to stress, or behaviors that make a person

Lack of sympathetic mode

On a less controversial note, some people who are stuck on pause also are unable to activate sympathetic mode even after they get rid of the pause personality.

I have also seen this, very rarely, in patients who are *not* stuck on pause or do *not* have Parkinson's. And yet it shows up *so* often in people with self-induced pause that it needs to be included here.

I cannot say what percentage of people with Parkinson's has this symptom, as I only discovered this problem in 2016. In my recent PD patients, since I've started looking for it, I've seen this behavior in at least half.

feel "I'm not myself" may have their origin in a brain response similar to that of an additional personality.

Today, if a person behaves one way in front of his grandmother and another way in front of his friends, we might even recognize that as a very mild and *healthy* form of multiple personalities.

The *severe* forms of multiple personality disorder, now known as dissociative identity disorder, can manifest with personalities so separate from each other that they are each unaware of actions performed by the other(s).

In these cases, one personality might have certain illnesses: *measurable*, visible problems such as allergic reactions, diabetes, or high blood pressure. Other personalities in the same person might *not* have these problems. The health problems can vanish almost instantly when the sick personality switches over to a personality who does not have the condition.

For example, a personality with very high blood sugar might almost instantly have normal blood sugar levels if he switches to a personality with normal blood sugar levels. A personality that has an allergy might break out in his three-day allergic-reaction rash, but if he changes personality, the rash may almost immediately disappear.

In fact, the study of people with dissociative identity disorder, as well as placebo studies, is pushing western medicine in a direction that it *really* does not want to go: the fact that nearly all medical problems have a major psychological component. It begins to look as if our DNA and our environment are not the major determinants for whether or not we will develop and behave in a certain way. Instead, it may turn out to be that our thought processes and attitudes determine how our DNA will or will not express, and how much we interpret our environment to our benefit or our detriment.

In the ever-changing field of psychology, deciding whether or not a brain behavior is pathological (an *unhealthy* problem) has been greatly simplified over the last twenty years. Today, if a mental behavior prevents a person from being able to work and support himself, maintain social relationships, and/or is a risk to self or to others, it's a pathology.

Otherwise, even if a person's mind functions very differently from the "normal" (whatever *that* is) but he can still work and support himself, maintain social relationships, and is not a risk to self or others, his situation is *not* pathological: it's not necessarily a *problem*.

One direction of modern thinking with regard to multiple personalities is that a healthy person has an "ecology of relatively discrete minds." Traumatic life experiences can twist these aspects of mind into detached (hidden) mentalities with negative behaviors. A person can, with therapy, get the various minds to work together and modify any problematic behaviors. Internal Family Systems is a model created by Dr. Richard Schwartz, PhD, for addressing what he calls "systems thinking and the multiplicity of the mind." In this model, a person does not need to *destroy* any of his personalities to be healthy.

However, from what I have seen in people with Parkinson's, the personality that activates pause *must* be destroyed in order for the person to recover. Although some patients have been resistant to the idea of destroying a self-created personality, I have *never* had a recovered patient say that he wanted to go back to having his oppressive Parkinson's personality, once it was gone.

In these cases, in addition to commanding one's self to "feel no pain" or "feel no emotion," the person had *also* commanded himself to be more "mature" or "spiritual" via *suppressing* (hiding) "bad" emotions such as hate or rage.

When people with this self-induced sympathetic mode shut-off learn to re-activate the electrical channels that drive sympathetic mode, they experience a surge of adrenal gland adrenaline, as well as other sensations on the legs and back. People have been thrilled and/or alarmed, and then concerned, when they first feel the unaccustomed surge of vitalizing animal power that comes with using a normal degree of sympathetic mode.

They also often protest their new sensations.

Patients have said things like, "This *can't* be good," or "This *can't* be spiritual," or even "I feel *powerful*. That's *bad*."¹

The brain command that led to disabling sympathetic mode can sometimes be destroyed using the same technique that was used for turning off self-induced dissociation, in the previous chapter.

In other cases, the blocker and self-induced pause might need to be destroyed first, and *then* the anti-sympathetic mode stance can be destroyed.

The various sequences of techniques that a person might need in order to turn off self-induced pause and its concomitant creations are discussed later.

Bumbling research

As an aside, I spent more than ten years trying to help my patients turn *off* sympathetic mode. I labored under the western medical delusion that only two neurological modes exist: sympathetic and parasympathetic.

Clearly, my Parkinson's patients were *not* able to access a significant degree of parasympathetic mode. Their wariness resembled a high degree of fight or flight.

If humans only have two neurological modes, and my patients clearly couldn't access parasympathetic, I *had* to assume that people with Parkinson's were in an elevated state of sympathetic.

I was wrong.

Many of them had forbidden themselves to *use* sympathetic mode ("Never feel *anger*, never fight back.")

Many didn't even know *how* to use sympathetic mode.

¹The point of regular meditation and learning to "center" the life force is, in part, training the channel Qi to stay more steadily in the midline of the brain, instead of being injudiciously squandered on the left and right sides of the brain. The left and right sides are, among other things, locations for ego, fear, and rage behaviors.

As one learns to consciously spend more time in the alert-curious-peaceful midline of the brain, via good actions, prayer, single-focus correct meditation and a thousand other techniques, the fear and rage habits are diminished and eventually conquered. This is referred to as transmutation of energy (changing of an energy flow pattern), and is not the same as suppression (denial or inhibition).

In order to recover, they had to be taught Qi Gong exercises to activate the channel shunt that redirects Bladder channel energy to the adrenal gland during an emergency. Some needed psychological support to be convinced that it wasn't *evil* to do so.

People with Parkinson's were *not* in sympathetic mode, after all. All those years of encouraging them to do techniques for increasing parasympathetic had been a waste of time.

Rising above the pain

As mentioned earlier, many people who use self-induced pause and/or turn off their ability to access sympathetic mode have told me that it is a good and noble thing to "rise above the pain." Instead of feeling that they had done something evil, they were certain they had done something spiritually superior.

For the record, "rising above pain" actually means allowing your pain to be observed calmly, lovingly. Observe it with your heart or your soul (metaphorically "above"), not your mind or your ego. Share it with God or whatever serves as your representative of Universal Love. *Don't* take it personally. *Don't fear* it. Do not *suppress* it. There may be pain. There needn't be fear.¹

Denial

The idea of something like a secondary personality or a self-hypnotic condition is not always well-received. However, once a person turns off pause, he is happy to admit that in fact he had been in a mentally altered state.

Until a person destroys the secondary "personality," or the "hypnosis" or even the "set of instructions" if you prefer, he *might* have a very hard time accepting the idea that he has been using a paused personality as a self-protection mechanism.

If he has a blocker, he might not be able to even understand what he is *hearing* if you speak to him about second personalities.

Then again, even some people with blockers *have* been able to understand these ideas from the *printed page* even when they could not understand the words when spoken aloud.

Making things even more challenging for me, and making me very cautious with my hypotheses, was that some of my patients felt that *any* suggestion of a mental component, let alone a multiple personality, was an accusation that they were evil, that their behaviors were morally reprehensible.

Many of my patients struggled under a severe oppression that constantly told them that they must always do the "right thing." They must never be caught doing a "wrong" thing. They *must* behave with superior moral standards. These people were

¹ Fear can make pain much, much more painful. Brain scan research in the late 1990s even found that some types of pain, such as the pain of arthritis, don't cause activity in the "pain" area of the brain, but activate the "fear" area of the brain. Some people with terribly arthritic joints feel no pain. Others with just a tiny bit of arthritic bone growth suffer terribly. And they suffer in the fear region of the brain, not the pain region.

not always easily able to accept the idea they might be using evasive mental devices, even while admitting that my descriptions fitted them with uncanny precision.

“No one’s gonna die”

Possibly the most common remark from recovered people was, “I don’t know why I was so worried about everything; it’s not like anyone’s gonna *die*, after all!”

When I heard the exact same phrase, “not like anyone’s gonna die!”, from *three* recently recovered people over a span of few weeks, I made a note of this oddity. This was in 1999. The significance didn’t hit me until almost twenty years later, when I realized that they had all been stuck in near-death shock.

Then I understood: They’d been *biologically* on the “verge of death” for most of a lifetime. No wonder they were delighted to realize that no one – including themselves – was going to die, after all.

Making a choice: to judge or not to judge

For those who are *not* dealing with a self-induced condition, it might be easy to look askance at a person who is. It’s easy to be critical of a person who has created a secondary personality and then created a bunch of seemingly random rules as to what is safe and what isn’t. It might be easy to dismiss his subsequent health problems by saying, “Well, he brought it on himself,” or “It’s all in his head.”

Please don’t.

One of my Parkinson’s patients was never able to focus on the death of her brother, her only sibling. They had been very close. They were teenagers, driving at night. The accident killed him, she got off with almost no pain. For the rest of her life, she was not able to really think about this event. She was aware of the event, and could speak of it in a supremely detached way, but she had *never* felt any physical or emotional pain in response to his death.

This type of trauma can be so excruciating that a person might be justified in creating, and staying in, a somewhat numb state, for self-protection.

This patient had a variant on the blocker personality. She named him the Ice Man. The Ice Man was a monster who froze her muscles into rigidity, even torqued the muscles until she screamed in pain, and various other physical tortures. He didn’t help her hide when she tried to turn off pause: he *attacked her*.

She had an unhealed foot injury, which healed after treatment with Yin Tui Na. After that she was stuck in partial recovery. She developed dementia and had to stop working with me.¹

Some people have known such horrible trauma that they might be better off staying on pause. The health problem side-effects that arise might be the lesser pain.

¹ This patient was one of the ones who had used antiparkinson’s medications for years before working with me. The Ice Man showed up when she had slowly, carefully gotten off her medication. Her hellish experiences and subsequent complete mental breakdown and dementia were non uncommon among people who had used dopamine-enhancing drugs for years before going into full or partial recovery. Please read *Medications of Parkinson’s: Once Upon a Pill* to learn more. This book is available for free download at pdrecovery.org.

I had one patient who wished he had *never* recovered memories of the day that all his fellow soldiers were killed in an attack during WWII. He had received his foot injury that day. Prior to having his foot injury treated, he literally had *no* memory of that day's events. After the memory came flooding back, he went into shock, and then body-wrenching agony. He dealt with it by rapidly increasing his dosages of antiparkinson's medications, which led to excruciating dyskinesia.

He later told me, "I wish I had never been treated by you. I was happier when I just had Parkinson's."

Many of the stories I have heard from my brilliant, beloved patients with Parkinson's have been heartbreaking. A person who has created a nearly dead secondary personality and simultaneously cut himself off from the possibility of real joy usually did it because, at the time, he didn't think he had a choice. It was a survival technique.

A person might feel so desperate or abandoned that he *needs* to take desperate steps in order to maintain his precarious hold on life and safety. A person must make these decisions for himself.

It is not for anyone to judge another person's survival method, especially when it seems, at the time, that no one is being hurt but oneself.

It's been a long chapter. Thanks for sticking with it. Now you've got a sense of what a person might be up against when he decides to stop using pause as a coping mechanism.

In this chapter I've not even described the tip of the "weirdness iceberg" of self-induced pause. Still, the very powerful methods required for turning off self-induced pause will make more sense, in light of what I've touched on here, be it ever so lightly.

Turning off self-induced pause

None of the techniques described thus far will get rid of self-induced pause.

The five steps introduced in the first chapter only serve to turn off *true* pause. These steps do *not* turn off self-induced pause.

Filling dark areas with light and energy reconnects the mind with areas from which it somewhat spontaneously dissociated during sudden trauma. This technique does *not* get rid of self-induced dissociation. This technique does *not* get rid of self-induced pause.

Commanding the brain to destroy brain cells of self-induced dissociation can destroy mental patterns that were created to *intentionally* dissociate from a specific situation. This technique does *not* get rid of self-induced pause.

Self-induced pause is a very special situation. The person has commanded himself to behave as someone he is not: a person who doesn't feel pain, or fear, or maybe emotion, or maybe his body, or goodness know what. He may have created an entire persona – or more than one.

That personality will continue to exist until such time as the command has been negated.

In order to destroy the old brain instructions and/or persona, several biological rules must be observed.

First, a person has to feel safe. This means not just using positive *words*, but actually using the part of the brain that is activated when one *feels* safe. It's a feeling, not a thought.

This is a large part of the difficulty: after decades of using the brain in the manner of a wary person, it can be nearly impossible to conjure up the actual mental behaviors, the electrical flow behaviors in the brain, of a safe person.

Essentially, if a person installs in himself the self-induced pause mindset, he cannot turn it off until he develops a safe-feel mindset. A safe-feel mindset is *not* available so long as he has installed pause.

There *is* a way to do an end run around the brain habit of not feeling safe. However, it can require a fair amount of brain retraining. This retraining has taken some patients a few weeks. Others have had to work at it for up to two years before realizing that, in spite of their negative thoughts, they are starting to experience a deep internal *feeling* of being safe.

Because of the significant time commitment to this retraining and also to answer patients' inquiries as to why all this work is necessary, this chapter will go into details about the biological nature of the problem *and* the brain scan research that led to the techniques in this chapter: techniques that bypass the looping

negative-thought system of a person using self-induced pause, techniques that *directly* stimulate the brain's striatum.

The problem

I worked with hundreds of people in partial recovery who ran up against their inability to turn off self-induced pause.

Some patients even remembered the exact phrases they had used to help themselves “play dead,” as some of them called it. But even if they recalled their original instruction, they were not able to turn it off.

By using self-induced pause, they had created a situation in which the brain is biologically *required* to be wary: not safe. This prevented them from changing their own brain behaviors.

Similar to hypnosis

A powerful, mind-altering command given to the self by a person of strong mental focus and determination can trigger brain changes and thought changes. These changes can be similar to self-hypnosis suggestions or commands.

For now, consider that the self-induced change into a person who “feels no pain” qualifies as a hypnotic suggestion. Our current understanding of hypnosis holds that the “authority” to turn *off* a hypnotic suggestion rests with the person who installed the command or someone else who was given authority at the time of the original command.

However, hundreds of my patients have unsuccessfully experimented with commanding themselves to turn off the pause personality. It never worked, or worse, it worked for a day or two and the pause personality returned, stronger than ever. Usually, if there hadn't been a blocker before, there was one after the pause personality resumed after having been temporarily banished.

There are exceptions to the hypnosis authority “rule”. A “*higher*” authority can negate the hypnotic commands of a lower authority.

As mentioned before, you can ask a few people who successfully quit smoking what I'm talking about. At the moment they decided they were no longer a smoker, something noble within themselves had the authority to instantly terminate the person's addiction behaviors, or you might say destroy the “addiction personality.”

BUT, one cannot *access* (feel oneness with) the “higher” (wiser, more loving) authority within himself so long as he's being wary. Being on pause can make a person numb to most somatic feelings. People who are using self-induced pause can often feel almost nothing of the somatic feelings associated with positive emotions. The question I struggled with for years was, how can a person learn to feel safe if he's stuck on pause – a condition that inhibits the ability to feel?

In the chapter on destroying self-induced dissociation, one gets access to one's own “higher authority” by repeating some phrase that moves a person's heart from calm, to peaceful, to joyful.

The joyful person is always a higher aspect of a person's "self" than his fearful aspect. In the technique for turning off self-induced dissociation, the joyful aspect, as a higher authority, is able to successfully destroy a wrong habit or wrong instruction.

Unfortunately, in the case of self-induced pause, the joyful aspect is biologically inhibited.

A person cannot access the genuinely joyful part of himself in his heart or in his brain's striatum so long as he has issued instructions to be numb. So long as he is in self-induced pause, or always prepared to be, he will be inhibiting the feelings of deep calm and joy, and his ability feel his own somatic sensations in general.

A person with self-induced pause can attempt feeling calm or joy. However, these attempts will probably have only short-term success and will very likely be answered with a subsequent creation of or a strengthening of the blocker.

A bit of research history

I spent thousands of hours working closely with people in partial recovery from Parkinson's, trying every sort of self-instruction for turning off the wariness/pause, but nothing ever worked. The closer a person got to feeling joyful, the more strenuously did the blocker become within a few hours or a few days.

And yet, I knew some people *had* recovered completely from self-induced pause and from the version of self-induced pause that we call Parkinson's disease. Some had been in the living hell of partial recovery for years when suddenly, accidentally, they found themselves completely, fully recovered.

Why?

Similar behavior of those who recovered

An uncanny similarity existed in all these cases. Just before the moment of recovering, they had all been all talking to the heavens, or to a late mother, or someone invisible to the naked eye who, to that individual, represented loving support. This had been true in my own case as well.

I had studied the words we'd said just prior to and after recovering. I noted as many parameters as I could about the moment of recovery: the time of day, the meals leading up to the conversation with God, every possible thing. But no one in partial recovery was able to recover by imitating the overt behaviors or the word spoken just before the moment of recovery by someone who *did* suddenly recover.

The one thing everyone who "spontaneously" recovered had in common was they had all been saying something heartfelt to God or some other beloved supporter. I refused to address this commonality. It smacked of religion, not science.

Breakthrough: 2014

For more than fifteen years I tried to figure out what was going on during the pre-recovery conversations with God or an invisible representative of Love.

I got nowhere. In retrospect, the problem was my intentional blindness to the facts: I was not willing to allow “God,” “universal love” or *anything* with spiritual overtones to play a role in recovery. I was convinced that anything spiritual was necessarily unscientific. I wanted everyone to be able to recover, not just people who had a working relationship with God or any aspect of “spirituality”.

In 2014, in the documentary movie *Awake*, I was spellbound as a brain researcher, Dr. Andrew Newberg, MD, spoke of his work in the very new field of neurotheology.

As soon as I got home I bought his latest book, *How God Changes Your Brain*.¹

His research, for years, has been focused on how the human brain responds to the idea of God, talking to God, feeling in the presence of God, and so on. Some of his other book titles include *Born to Believe: God, Science, and the Origin of Ordinary and Extraordinary Beliefs*, and *Why God Won't Go Away*.

The introduction to *How God Changes Your Brain* makes the point that the author himself is not religious. And although he uses the word “God” rather than an assortment of synonyms that serve as an alternative to the word God, he is, in fact, writing about *whatever* it is that a person understands to be universal Love or the source of all creation.

This book was primarily about measurable brain changes that can be self-induced by meditation, prayer, and so on. But another set of his research discoveries caught my heart in a noose.

His research, using brain scans, showed that the human brain is automatically wired to respond in a particular *part* of the brain in response to the instruction “Think about God.”

For example, when children with no religious training are asked to think about God, or whatever it is that creates everything, they show increased neural activity in their cerebellums (at the back of the brain).

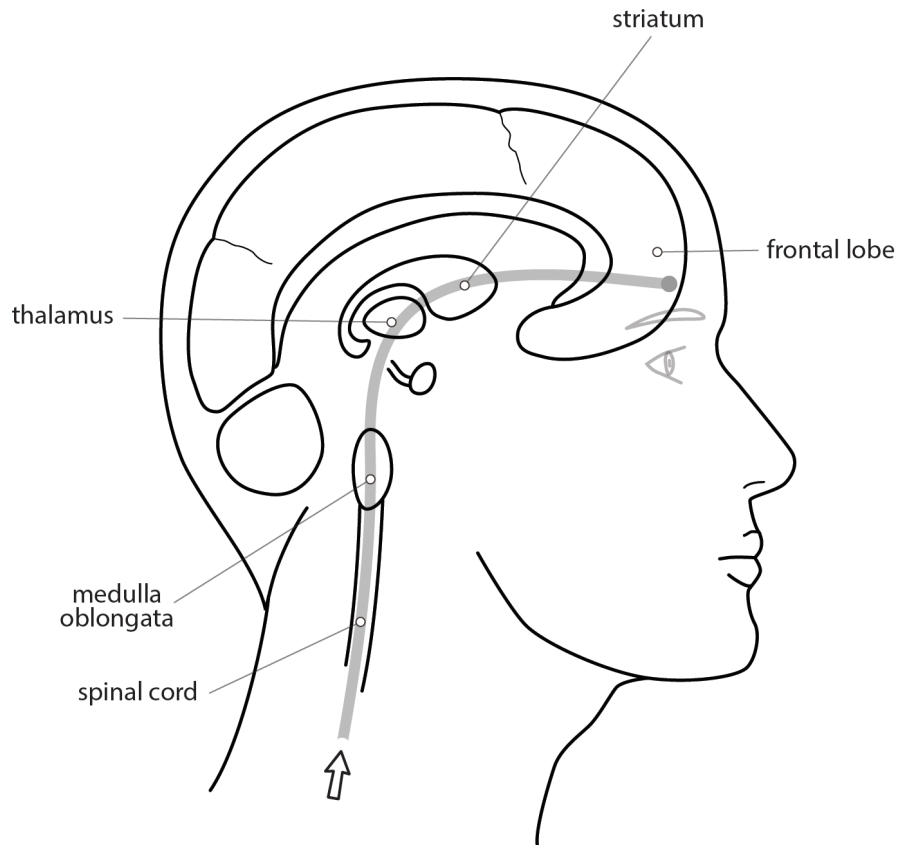
In adults who were asked to think about God, he saw specific brain-area variations.

What he found was riveting: an adult's *style* of understanding God determines what part of the brain is activated when thinking about God.

The *part* of the brain that is activated when told to think about God depends on what *type* of God a person has, or on the *relationship* a person has with God.

Please keep in mind here, I'd been looking for years for a way to wake up a seemingly dormant striatum in people with Parkinson's. When a person is on pause – or pretending to be – the healthy flow of energy up the spine and into the head is halted at the base of the neck. The normal flow of energy is inhibited through the “midline” of the brain, a line that passes through the striatum and thalamus.

¹ *How God Changes Your Brain*; Andrew Newberg M.D.; Ballantine Books; New York; 2009.

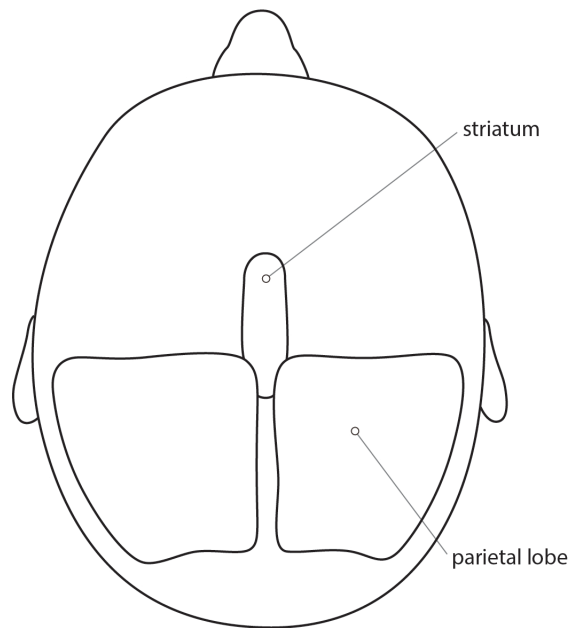


Side view of the brain and its midline. The light gray line shows the path of the midline current. The midline is not a biological structure. It is merely a term used in biology to differentiate between the brain parts that sit along the center of the brain as opposed to those that are on the left and right *sides* of the brain.

When a person is awake, the head portion of his Du channel, mentioned in chapter four, follows the light gray line shown in this diagram. When a person is calm or joyful, the Du channel tends to stay on the midline. When a person is stressed, fearful, or angry, the current diverges into two pathways, making left- and right-side currents.

When seen from the top, the midline current runs through the center of the brain, from the back of the head to the front, swerving neither to the left nor the right.

In practicing what is called “single focus meditation,” in which one focuses on one’s breathing, on the “third eye,” on a repeated “mantra” (uplifting word or words), or some other deeply focused behavior, the electrical energy traveling through the brain becomes more aligned with the midline of the brain: it flows *less* in the left and right sides of the brain.



Top-of-the-brain view.

The “midline” is an imaginary line that runs from the back of the brain to the front. Many parts of the brain have two sections: a left- and a right-side section. Other brain parts do not have left- and right-side parts: they are just one section, located on the “midline.”

In the picture above, the parietal lobes have left- and right-side parts. The striatum is on the midline. The thalamus is directly below the striatum, also on the midline.

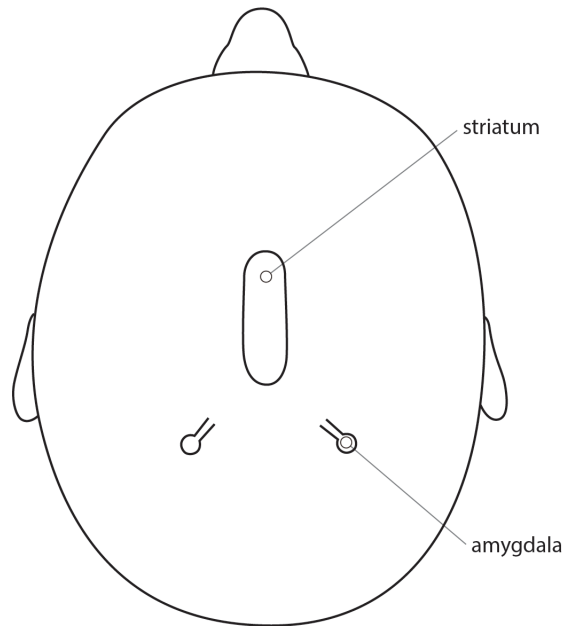
Feeling safe

When a person *feels* safe, the electrical flow through the brain travels closer to the midline, and is diverted less to the left and right sides of the brain. This feeling of safety has *nothing* to do with *thinking* about safety. Using word-based thoughts is a parietal lobe (left brain) function. *Feeling* safe is a feeling, a sensation, a wordless somatic state of being. If you have no idea what is meant by “feeling of safety” rather than “thinking about being safe”, you are probably not having much current moving through your brain’s midline.

Oppositely, when a person is increasingly fearful, wary or angry, the electrical currents through the brain are increasingly diverted towards the left and right sides of the brain, away from the midline.

A vengeful God

Some people fear God. Brain scans show that a person who thinks of God as someone or something that is vengeful or angry will show increased activity in his amygdala when asked to “think about God.” The amygdala are the fear-and-rage centers in the brain.



Top-of-the-brain view

The amygdala (plural for amygdalum) are on the left- and right-sides of the brain. The amygdala can also be seen in the previous diagram showing the *side* view of the brain.

A word-based God

Some people think of God in terms of words, definitions, and rules. A person who considers God to be something knowable via the study of words *about* God, will, when thinking about God, show increased activity in his parietal lobes. The parietal lobes are the left and right sides of the brain, the areas where the brain stores words and does analytical thinking and risk assessment, among other things.

A God that can be felt

Some people consider God to be a “feeling.” It might be an expansion of the heart, or the feeling one gets in response to something beautiful or poignant. Thinking of a feel-able God increases activity in the brain’s thalamus. The thalamus is snugly positioned under the little umbrella of the striatum.

A God to talk to

Some people think of God as something/someone with whom one can communicate. God can speak to us, and we can mentally or out-loud communicate with Him. If your understanding of God is that he is a communicant, and that you can

have a communicating relationship with him, then thinking about God activates the brain's striatum.

I will now repeat this because this is a crucial point in figuring out how to bypass the "biological rules" of pause: when a person thinks about a God – or anything that serves as a loving supporter – who can be talked to and from whom a response might come, the person's striatum is activated.

The part of the striatum closer to the back of the head is the part that controls the release of dopamine for motor function – a job that is inhibited in people with Parkinson's, and most probably the location of dopamine inhibition in all people who are stuck on pause.

A short aside: using the word "God"

I will take a short break here to go over my decision to use the word "God" in this book.

I know that many people have resistance to this word. If you do not like the word God, please substitute whatever word you like that fulfills the idea of unconditional or universal love, loving support, wisdom, fairness, forgiveness and any other infinite and eternal principles you respect and admire. Keep it simple. The word "Love" is an excellent choice.

If you have no word, or even no *concept* of anything that fits this description, this chapter might help you understand why your lack might be a biological problem, a *physical* problem, and not just a metaphysical problem. If this is the case, you might want to start actively looking for some word or concept that you *can* use. It turns out, our brain works best when we use this concept of an omniscient, loving supporter *all the time*.

I had one person who was so violently opposed to the idea of using any word that could be associated with religion or love that she decided to focus on communicating with air. For her, even this level of communication was a painful stretch. Still, it was a starting point.

Others have used totem animals, deceased pets, and various saints or sages. The main thing is to turn off the internal monologue, which stimulates the parietal lobes and keeps your brain in a negative spiral, and start talking to something "outside yourself." This phrase, "Talk to someone outside yourself," will be discussed in great detail in following chapters.

If thinking about a God who communicates with words...

When I first learned that the striatum is activated when a person thinks of a God who is a communicant, I was deeply concerned. Most of my patients were dead set against talking to God.

As you can read in *Recovery from Parkinson's*, from the very start of my research, a disproportionately high percentage of my Parkinson's patients have been religious professionals or semi-professionals. I thought this was a bit strange.

This fact became even stranger when I found, through questioning, that many of my Parkinson's patients (nearly all of them) felt that they should *not* talk to God or any saint or sage regarding their problems. Even if they were a religious

professional and regularly exhorted parishioners to talk to God, they felt strongly that they personally should *not* talk to God outside of the usual proscribed prayers. They certainly should not talk to God about their problems.

“God wants me to figure this out on my own.”

“I don’t want to bother the Holy Mother with my problems, she’s got enough to worry about.”

“God deals with His concerns, and he wants me to deal with mine.”

Right from the beginning of my research, with my first group of twelve volunteer patients with Parkinson’s, I had been surprised that, even though most of them were retired religious professionals, none of them felt they should talk to God about the things they were really worried about, such as their health problems. Many were protective of God, and didn’t want Him to be worried about their health issues: they were in a better position than God to deal with their problems.

All of them said they encouraged others to pray to God as often as possible. And yet they didn’t feel it was proper or good for them to talk to God about their own situations.

Something wasn’t right with this.

I often asked them, “Why not? Do you think He doesn’t already know? Why are you so coy?” They never had an answer. They just knew they shouldn’t talk to God about their own issues.

After poring over the new brain research, it finally dawned on me. The few people in partial recovery who had managed to have “an epiphany” and suddenly found themselves without Parkinson’s – I had to admit it, scientific or not – had all been talking passionately to God, or some saint, or some beloved deceased grandmother just moments before the Parkinson’s ceased forever. For some, it was the first time they’d had a talk like this in decades. For a very few others, it was a part of a fairly regular conversation, but the conversation had unexpectedly taken a turn into more heart-felt matters and uncharacteristic openness.

What sense could I make of this? How could I use this to help others who were still in partial recovery?

Of course I had known right along that these people had been talking to God in their breakthrough moment of turning off pause. They had never hid this from me. For that matter, I had been talking to God in the moments just before I recovered.

But I had assumed – I should say, I *wanted* to assume – that it was the specific words, thoughts or attitudes we’d expressed that had been significant. And as noted previously, I *really* didn’t want spiritual behaviors or vocabulary to be a necessary part of recovery.

As for the *act* of talking to God, I hadn’t understood its *biological* significance until I read *How God Changes the Brain*. The new brain research suddenly made the fact of talking to God – or just having a God with whom one *could* converse – highly significant in light of finding a way to stimulate the striatum.

I suspected that the people who suddenly came out of self-induced pause had, without realizing it, engaged in behavior that directly stimulated the sleeping striatum. They had tickled the striatum back into action by talking to God.

This striatal activity, as you will learn, makes a person *feel* safe. When the dopamine-rich striatum has increased activity, and the energy along the midline flows vigorously towards the frontal lobe instead of being sidetracked into the left and right lobes, a person feels safe.

A person feels safe enough to trust something other than his own, wary mind to be in charge. He can also realize, instantly, in this flood of feeling safe, that he doesn't need to be using self-induced pause anymore. And he can stop using it.

I shouldn't because I can't

I suddenly understood the *biological* significance of my *very* weird bit of data about people with Parkinson's thinking they shouldn't talk to God about their own troubles, hopes, and fears:

They thought they shouldn't be in an intimate, confiding, verbal relationship with God because they biologically *couldn't* be in an intimate, confiding, verbal relationship with God.

When they induced pause in themselves, they had hugely inhibited the amount of energy flow to their own striatum.

– In earlier chapters you saw that pause creates a standing wave in the spinal current, stopping the current at the back of the neck. This decrease in spinal energy causes the inhibition of the *normal*, human sense that there is something in the universe that we can talk to and which talks to us.

This type of communication isn't merely intuition. It is a deeply personal sense that someone is listening to us, loving us, and very often, talking back to us. Young children often give a name and even a location to this "Something" that they communicate with. Until they are ordered by parents or teachers to stop having this relationship with something invisible, this communicant is often their closest and most necessary friend.

My patients, so many of them religious professionals or deeply spiritual even outside the context of traditional religion, had, in childhood, inadvertently or knowingly turned off their ability to converse with God and to hear God's voice talking to them. How abandoned they must have felt!

I had to wonder, how many of them answered this frozen silence with a determination to study about God, maybe become a religious professional, maybe even "find" God, *because* they could no longer hear him or talk to him?

So here I was, reading about this new research. I suddenly understood that it wasn't the words, thoughts, or attitudes of my patients that had "miraculously" turned off pause: it was having a God with whom they could *communicate*. A communication that most people with Parkinson's feel they *shouldn't* perform. Because they can't, biologically, perform it.

This research revolutionized my approach to people who were stuck in partial recovery.

Looking ahead, it also revolutionized my approach to people with the unhealed, dissociated injuries that can also lead to Parkinson's.

As it turns out, even people with unhealed foot and/or ankle injuries who *first* took care of their *striatum* problem by talking to God, very often didn't *need* to work on their dissociated injuries.

As soon as they re-established a sense of communication with God, their own minds re-connected with their unhealed injuries, for the most part. Maybe a little hands-on support was needed, but not very much. And the Yin Tui Na went much faster than before – a few sessions might be needed instead of weeks or months.

The key to the whole thing seemed to be getting people to activate their striatum even though the currents that run through the striatum were being blocked due to being on pause. How can you *do* this?

You do this by talking to God or whoever can serve in the role of God: something outside of yourself. Turn off your constant, *internal* monologue, an inner voice that's being driven by the risk assessment area in your brain.

Whether or not *you* believe in God, whether or not you believe in Universal Love, whether or not you believe that something is supporting you and always has been, whether or not you *used* to believe and rejected your beliefs when you were "betrayed," it doesn't matter.

You want to turn off self-induced pause? Start talking to someone outside yourself.

The mere talking might not spontaneously turn off self-induced pause. In my experience, a person who does not spontaneously recover in response to a heart-to-heart talk with God will need to turn off pause mechanically, biologically, one step at a time.

The first step is talking to God or someone outside of himself.

This can get a person to the point where he suddenly notices an odd sensation: he feels safe.

After that, he can mentally create a tube of light in his spine and brain. As you will recall, a person who is on pause is usually not able to visualize anything in the upper reaches of his spine and brain. However, once he feels safe, his brain will be easily able to visualize, once again.

Then he can imagine electrical currents running up the back of this tube of light, and down the front. Details on this will come later. (If a person imagines the current going the opposite directions, he will feel extremely agitated.)

The imagined current almost always seems to be running "too fast."

By using the imagination and, in many cases asking God for help, one can adjust the speed of the imagined current until it *feels* "right."

Once the current is running the right speed, the *feeling* of calmness increases.

At this point, feeling both safe and calm, a person can, if he wants, use the technique for destroying brain cells of wrong habits, a technique in the chapter on

turning off self-induced dissociation. Now, because he feels safe, this technique can provide a lasting benefit: destroying brain cells that were created to sustain pause.

When one can steadily imagine the current moving along the “tube” of light in the spine, one can perceive that the sacrum (the bone near the bottom of the spine, in between the hip bones) feels agitated, as if something is moving back and forth inside the sacrum.

A person has to decide, often needing the confirmation from God or his friend, that he’s safe enough to allow energy in the sacrum to flow down into legs and, from the legs, throughout the rest of the body.

When current flows downward, out of the sacrum, the electrical agitation in the sacrum can decrease or cease. When this happens, the person’s *internal* tremor stops.¹

Over time, the energy that *drives* the *external* tremor will start calming down.

When the atrophied muscles in the arms, legs, and face recover enough strength, the external tremoring will be able to stop.

These are a lot of steps, but they are very straightforward and do-able. Patients do not *struggle* to do these steps. They are simple, and the person can tell that he is shifting inside, that his body and mind are gently moving back to a state that might not have been experienced since childhood.

And the starting point? Stimulation of the striatum, most easily obtained by talking to God.

I’ve seen, in those people with the sudden epiphany and the miraculous recovery, that the resumption of a long-forgotten *emotional* relationship with God might allow a person to recover almost instantaneously.

Oppositely, going through the above steps, what I refer to as “mechanically” turning off pause, a person recovers over many weeks or months, with small but distinct changes in mindset and physical function as each step is solidified.

Add to this the several weeks or years that might be needed to establish enough sense of communication with God that a person needs to *feel* safe and begin the other mechanical steps, and you can see that a mechanical recovery might take quite a bit longer than an emotional, instantaneous one.

Still, both paths lead to recovery. And the both start with getting the conversational ball rolling.

¹ People who have studied deeper, more arcane spiritual practices might be saying, “The goal is to get the spinal energy to move up, not down!” Right.

But first you need to come back to life. Getting that spinal energy to move up can only be done when you feel safe enough to be alive. So long as the energy coiled in the sacrum is banging back and forth with no way to move either up or down, you aren’t going to make any progress in controlling this energy or getting it to flow towards the head. You are controlling this energy, but in a way that lets you pretend you are always on the verge of death...and fighting death, not allowing it.

Huh? Who should I talk to? How do I get started?

Nearly all of my patients have been completely baffled by the idea of talking to God or “someone who isn’t there.” The next few chapters explain how to go about learning how to do this very, very human activity.

Someone to talk to

Many patients are completely baffled by the idea of developing or restoring a conversational relationship with something outside of themselves. They have no idea how to start.

As an aside, young children have a part of the brain that is pre-wired to be able to think of God.¹ Young children know, automatically, how to talk to God – or whatever it is that “creates or is in charge of everything.” An *inability* to know how to start a conversation with the universe is something that people using self-induced pause have taught themselves.

They must unlearn it.

This is a situation in which an animal has the advantage over an over-intellectualized human. An animal doesn’t need to know that he can trust nature. He just does. Now, a nit-picker might say that some animals *shouldn’t* trust nature: their role is to get devoured, sick, or die of old age. But animals don’t worry about the metaphysical big picture. They only need to feel safe enough in any given moment to be alive in that moment.

“Feeling safe” does *not* mean that everything in future will be perfect. Just the opposite: problems and pain might arise, death will occur – as they are supposed to do. But knowing that you are a part of a loving whole *even when fearful, angry, or stressed* does mean that you can experience these challenging circumstances as being appropriate, correct and maybe even in your ultimate best interest most of the time; you can feel safe *even as you experience them*. Until you are actually dead, you can and should be *alive* even if you dislike or despise what is happening.

An overly-intellectual person can carry on for lifetimes worrying about how he isn’t going to be safe forever. But “forever” doesn’t exist in any given moment. The only moment that actually matters, when it comes to whether or not you are going to behave as if you are dead or alive, is the question “Am I safe enough to be alive right *now*.”

So maybe you will want to rephrase the “Am I safe” question to the universe, and ask “Who can I trust to share my fear and pain with in *this* moment?”

That answer might be easier to hear.

And actually, if you even ask the question, you have already started healing: you are talking to something outside yourself.

“There are no atheists in foxholes,” is a famous quote from World War I. When a human is truly at risk of impending death, he *will* cry out to the universe, “Help me!” He doesn’t worry about *who* he is talking to.

¹ *How God Changes the Brain*; Andrew Newburg, MD; Ballantine Books, New York, 2009.

When most people are distraught, they cry out to others, or to the cosmos. People who are stuck on pause don't want to do this. They might have an infinitude of reasons for staying secretly stoic and aloof, as I personally did, but those reasons aren't helping them move forward.

Calvin and Hobbes

In a *Calvin and Hobbes* cartoon strip, Calvin has been distraught for days because a dog ran away with his stuffed tiger doll, Hobbes. You see Calvin sobbing in his bed, alone. The crescent moon is visible through the window. Calvin laments the fate of his best friend in a variety of phrases. In the last panel, Calvin has shoved the window open and is leaning out, screaming at the moon, "Whatever I did, I'm **sorry** already!"

Calvin is automatically doing something that most humans can relate to: he is taking his problem to the universe, to a higher power.

In another strip, Calvin has found a wounded baby raccoon. He runs for *help*, (a healthy human response) and his mother comes. She instructs Calvin to bring a clean dishtowel and a shoebox. While Calvin is away, the baby raccoon dies. The mother starts expressing her sadness to the stuffed tiger sitting next to her, and ends up with "...I hate it when these things happen...I can tell I must be upset if I'm talking to *you*."

Calvin and his mother, when feeling lost or unsafe, talk out loud to the ever-listening universe, whether it's in the form of the night sky or a stuffed tiger.

When that strip was running, millions of people around the world *loved* their daily dose of the *Calvin and Hobbes* comic strip. It resonated. Fans of the strip could relate to a person crying out for help or talking through problems with someone or something outside of self.

Oppositely, most of my patients with Parkinson's or self-induced pause or body-wide dissociation have *no* idea what I'm even talking about when I suggest they do the same.

Bill Watterson was the author of the strip. His father had Parkinson's disease. Many of the strips address the way that Calvin's *dad* seems impervious to sleet, hail, and the vicissitudes of life. In one strip, Calvin raises the question of self-control-freaks and asks his father, "Are you their God?"

The father answers, "If anything in this world works, it's because one of us took charge."

You never see the father character, a good, thoughtful and well-meaning man, talking to God. He *often* talks to himself.

A person who has taught himself to become numb in response to painful experiences instead of crying out to the heavens for help might never get around to healing from that experience. He shuts out the possibility of heart resonance with the universe.

The erroneous idea that one is apart from the rest of the universe, or that one thinks in a unique way from the rest of humanity – an idea made strong by chronic

use of pause, and which is characteristic of the Parkinson's personality – must be terminated if one wants to have optimal health.¹

This pathological type of thinking might be described as feeling *apart* from others, apart from God. This type of aberrant thinking does *not* occur in parasympathetic mode.

If you understand the principles here and are ready to start talking to God, skip ahead to the next chapter. If you are still struggling with the idea of talking to something outside yourself instead of directing your thoughts towards your own mind, the next few sections of this chapter might help.

One with nature

“Feeling one with nature” is a term sometimes used to describe the feeling that can occur while out in the wild, when the distinction between one's own self and the wildlife and maybe even the earth and sky drops away.

In these situations, a person knows that he is an individual but also *feels*, in a somatic, physical way, that he is highly connected with everything else. Like a fish in a school of fish that all change direction at the same time, a person who is feeling one with nature can recognize that he is an individual, but also that he is “moving” in time with everything else in his “school” or “flock,” or in his ocean or universe.

Feeling “one with God” is another common phrase that means the same thing. This *feeling* triggers increased activity in the thalamus part of the brain, which can then lead to increased activity in the striatum. Increased activity in the striatum causes an increase in the feeling that one is *communicating* with greater presence.

Choosing the right “friend”

Even being familiar with all of the above concepts, many people still struggle mightily with figuring out *who* is the *best* person to have a conversation with.

My suggestion: don't worry about it.

¹ Since the 1930s, doctors have pondered and published theories about what they call “The Parkinson's Personality.” The Parkinson's Personality has been described as compulsive, industrious, introverted, morally rigid, punctual, serious, stoic, wary, and more. From “Personality Traits and (Continued from previous page.) brain dopaminergic function in Parkinson's disease”; *Proceedings of the National Academy of Sciences USA*; 98:13272-7; Valtteri Kaasinen, MD, PhD et al; 2001.

But these are traits that are seen in people whose Parkinson's symptoms have already become apparent. In the decades *before* the symptoms appear, it might be better to describe these people as “intelligent, focused, with a strong moral compass and intensity of purpose.” They may be bold, daring, heroic, and charming and witty. Due to the chronic use of adrenaline, they might appear stronger, smarter, and faster than most. They might be friendly, even outgoing and loving. And yet, many of them will admit, while they behave lovingly towards others, they often have a hard time *feeling* love in their heart. Their love tends to be a more cerebral and idealistic love than it is a resonant vibration from the heart. And many have told me that, although they deeply care about others, they have a hard time loving *themselves*. It is nearly impossible to have loving resonance in the heart while being on pause. A person might feel no physical and emotional pain if he makes himself numb, but his numbing will also prevent him from *feeling* heart expansion or resonance, or what we call “love.”

As for their personalities after they start taking mind-altering antiparkinson's medications, which work by making a person “stoned” or “high,” all bets are off.

Most of my patients have changed, several times, the person they are talking to.

For example, one patient, a practicing Buddhist who spent a year in India, at the Buddhist shrine at Bodh Gaya, decided he would mentally talk with Ganesha, the many-armed Indian “god” with the head of an elephant.

Two weeks later, he told me, “Ganesha isn’t working; I can’t really have a conversation with him. I’ve started talking to my late grandmother.”

Several weeks later, he announced, “I’m not talking to Nanny any more. She disapproves of so many things. I can’t be honest with her. My Nanny was catholic; she loved Mother Mary. So I’m going to talk to Mother Mary.”

He ended up feeling a beautiful relationship with Mother Mary. This surprised him, because he continued to think of himself as a Buddhist.

Another person said to my, “I’m a Catholic. I know I should be talking to Jesus. But this beautiful image of an Indian God with lots of arms keeps showing up in my mind’s eye. He’s so beautiful. I love him. Is it OK to love an Indian God even though I’m Catholic? Will He be willing to talk with me?”

I assured her he would. And it worked for her.

Another spent more than two years getting to the point where she felt that she was not only talking constantly with her friend, Jesus, but she sometimes felt He was talking to her. She felt strangely safe, but not safe enough to move on to the next steps. Curious as to why she seemed stuck at this stage, I asked her if she felt that Jesus was her friend: “Can you two laugh together about stuff?”

“Oh no. He never laughs.”

“What? Jesus never laughs?”

“No. Jesus is like Mr. Spock, on Star Trek.”

“Your friend Jesus is like Mr. Spock? Not Captain Kirk?”

“No! Captain Kirk is bad. He kisses girls.”

After my patient said this, she started laughing out loud. We both marveled at how her childhood Catholic education had somehow led to her eight-year-old conclusion that Captain Kirk was bad because he kissed girls.

She realized that she would never be able to have a laughing, friendly relationship with Jesus. In her mind, Jesus would always be a stern, non-emotional, rigid and frigid example of a teacher.

I asked if there was anyone in the universe who she could laugh with and express emotions with.

She replied, “Mary. His mother.”

She switched over to talking to Mary and within two weeks she was making progress on the next set of steps.

My point here is, you don’t need to know to whom you should be talking. Start talking to anyone reasonable. Soon enough, you will know whether or not you’d rather be talking to someone else. You can change as often as you want until

you find yourself talking to someone whom you trust and love, someone who is your friend as well as your supreme protector.

It might not be anyone you know by name.

I recall one person who had a mental image come to mind. She named it “Grampa” although she knew he was not an actual relation.

Please don’t waste time making a search through spiritual books so that you can be sure you are getting the “right” person to talk to.

It is characteristic of a person with an overactive risk-assessment area in his brain to think he needs to find the exact right person to talk to. But this is merely the wary mind over-thinking the issue.

Trust me here. It doesn’t matter with whom you start. Just get started.

If a patient tells me that a month has gone by and he still hasn’t thought of anyone he can mentally talk to, I suggest that he talk to St. Francis of Assisi.

The simple moral precepts of St. Francis are usually acceptable to people of almost any faith, and people of little or no faith, so he’s a reasonable starting point. Also, St. Francis is known for his constant talking to Jesus, so he can be a good example, as well.

Even so, don’t be surprised if, after talking to St. Francis for a few weeks, an idea pops into your head of someone else that will suit you even better. Or not.

Talking outside yourself

In addition to talking to your friend, learn to talk, silently or out loud, to passing birds, flowers, the sky. Anything. The thing you *don’t* want to do is talk to yourself.

For example, when a bird flies past *don’t* silently say to yourself, “That’s a pretty bird.” This is an ego-based evaluation of the bird, and is all about you.

Instead, say, “*You’re* a pretty bird.” Or “Thank you for flying past me,” or just “Thank you.”

Don’t say, “*It’s* a beautiful day!”

Instead, say, “*You’re* a beautiful day!”

If you enjoy the warmth of the sun on your skin, say to the sun, “I love you.” Or better yet, “I love you, too,” thus acknowledging that the vibrations from the sun are a form of love that is being directed at you. You might feel like a nut, at first, but that self-conscious feeling, coming from your own norepinephrine-driven, highly judgmental and prejudiced mind, *not* coming from your wise heart, will go away within a few months.

These few examples of talking *to* the sky or the sun, instead of passing judgment on it, are just to help you get started. Every person who is trying to change his internal monologue habit needs to find his *own* way to converse with that which is outside of himself.

As you get better at addressing your thoughts to someone/something outside of yourself as much as possible, you can then progress to developing a *continual*

conversation with someone/something. There is no such thing as too much time directing the thoughts outwards. By the way, directing your thoughts towards the sensations of the heart or towards the soul (non-thought and non-logic based intuitions) is the same thing as directing the thoughts outward.

The word “outward” means “away from the judgmental mind.”

The word “continual” means just that. This is not something to practice for two minutes at bedtime. Every thought you have, no matter what, throughout the day, can be directed towards God.

Yet another aside

Some patients have pointed out to me that lots of people are self-centered and not oriented outwardly, and appear to be perfectly healthy.

This is true. But most people are in sympathetic mode, not on pause. These presumably healthy people aren’t pretending that they are partly dead, and unable to heal because of it.

If a person is in sympathetic mode, being self-centered might make him a miserable codger, a successful businessperson, or just plain “normal.” But it won’t paralyze him, make one side of his body numb, or prevent healing in his skin, organs, or heart.

A person on pause or a person with Parkinson’s is not using sympathetic mode. He is so disconnected from everything that he might not even perceive himself as being inside his own body. The person on pause or with PD is dealing with a much more severe problem than the person who is merely self-centered. A person stuck on pause is going to have to make a drastic change in order to feel safe and come back to life.

Of course, after the on-pause person recovers, if he wants to be self-centered again, he can be self-centered all he wants. He won’t get sick again or have Parkinson’s again, so long as he stays on the normal, parasympathetic/sympathetic continuum, instead of using pause as a lifestyle.

But until that time, if he wants to get himself out of the hole that he has dug himself into, he should start talking to things outside of himself, and turn off the internal monologue.

For the reader who is not stuck on self-induced pause or who does not have Parkinson’s, you might be saying to yourself, “My friend with Parkinson’s frequently talks to other people. He never talks to *himself*.”

You are so wrong.

While your friend with Parkinson’s is talking out loud to another person, he is also listening carefully to his constant internal monologue.

That internal voice is saying something like, “Am I getting across? Is this person appreciating what I’m saying? I’ve been talking for about half a minute. He spoke to me for about half a minute. It must be time to ask him a question and turn the ball back over to him. Does he think I am making sense? Is he impressed? I don’t want to him to get angry about my thoughts on this subject. He seems to be frowning. Have I said a wrong thing? Did I wait too long to turn the conversational

ball back over to him? I'm being more logical than him. Can he really be this dull-witted compared to me?"

That's the voice that has to be stopped. The person appears to be engaged in a conversation with another, but his primary voice is talking to himself. He's barely listening to the other person. He's certainly not relaxing and enjoying the feelings he experiences as he digests the other person's words: as he "puts himself in the other person's shoes."

As an example, a recovering Parkinson's patient told me: "It was so weird! I was walking with several of my co-workers, as we always do during our lunch break, and I found myself just talking! In the past, I've always paid attention to what sequence people were talking in, so as to only talk during my turn, and carefully selected my words to be pertinent to the subject at hand, and it was always so much *work*. But this last week, I just said whatever came to mind, and it was easy! No work at all! And I suddenly realized that's what everyone else had been doing right along. Just talking to each other. *Not* planning when and what to say!"

The best way to stop the nattering, self-damaging internal monologue is to direct your full attention and silent conversation at something or someone who is outside yourself, that doesn't use *you* as the measure against which all others are judged.

Informality

Talking to God is a great way to practice talking to something outside of yourself. However, many people assume that "talking to God" should be done as repetitive prayers, or should be formal.

Nope. Talking to God can be as ease-filled as talking to a best friend. Here's an example from a scene in the play *You Can't Take It With You*.¹

Grandpa sits down to the family dinner and starts the prayer before food: "Well, God, here we are again..."

Just picture that.

Grampa is demonstrating the intimate, easy-going, comfortable conversation you can have with God, or your Divine Friend, your totem animal, or with the The Force.

In the next few chapters, though I usually just refer to "God" or "The Divine," you can apply your own personal version of these concepts.

Most importantly, as you talk to him, *don't* be simultaneously saying to *yourself*, "How am I doing? Am I getting it right? How long will I have to be doing this?" If you need to have your behavior assessed, ask God how you're doing. Maybe even pause and wait for an answer.

Don't secretly be making self-directed statements and questions while you are also talking to someone or something outside of yourself. It's rude. Give your friend or give God your full attention.

¹ *You Can't Take It With You*; a play by Kaufman and Hart, 1936.

A case study

One of the Parkinson's patients to whom I made these suggestions was a lapsed Catholic. She had also studied eastern religion and was very determined to live by spiritual, rather than prosaic, religious, ideals. Even so, the idea of mentally talking directly to God, or to some saint or sage, was drastically new to her.

I gave her the above suggestions for talking to something other than herself.

About a month later, she told me, "I'm still trying to direct my inner conversation to someone outside myself. I must be getting used to it because now when I do it, I don't feel as stupid as I did when I started."

Feeling like an idiot when first starting to talk to "no one" is a very common initial response.

A few months later she said, "Something's changing. For thirty years, I would *try* to think kindly of the idiots that work for me, but it was nearly impossible.

In the past, at work, when somebody did something stupid, I used to silently think, 'What a jerk!' or 'What a moron!' But lately, I just think it's funny. It's just a part of being human."

This was a huge change in outlook for her. For decades, she'd been consciously trying to change her habit of being judgmental, along with working hard at various stress-reduction techniques, none of which had worked for more than a few minutes.

After her report about feeling more kindly to "the idiots at work," I waited a few months before asking her again if she was still working on directing her thoughts outwards, to someone else, rather than mentally talking to herself. I try not to get too pushy when a person's working on developing a relationship with the Divine. I never ask who or what a person is using to communicate with, although people often volunteer the information.

She replied, "Yeah, I'm still working on that *all* the time. And I still have my PD symptoms. But something's changing. Sometimes, this will sound crazy, I know, but I feel as if He's *listening*. He doesn't talk back to me yet, but He's listening to me...He's there..."

She added, bashfully, "I chose Jesus. You know, go straight to the top."

I share this example not only I found it heartwarming, but because it also shows that the process can be somewhat slow.

Another case study

A patient who was stuck on self-induced pause, who had debilitating pains that came and went in response to upcoming, potentially negative situations, who did *not* have Parkinson's, decided that she was going to talk to Raven, a totem animal. She had a strong connection with the Inuit people of Alaska. Raven was her immediate choice. As she said, it was just *obvious* that it should be Raven.

A week later she reported, “Raven is becoming my reflection and my reasoning. He’s taking on a greater spirituality. As a child, I thought of this as talking to God: He was separate from me, but he was also an extension of myself.

“When I was a kid, I was always talking to something outside myself. I loved doing this. I was raised in a traditional Christian church, so I just assumed that the person I was talking with was “God.” I talked to Him all the time. He was my *best* friend.

“This week, I remembered when I stopped talking to God.

“My father was an alcoholic. A scary alcoholic. When I was eight years old, I realized I had to do something to deal with my fears. To be safe, I had to abandon normal feelings and allow the heat and darkness to take over.

“After that, my whole life, I only talked to myself, until I started talking to Raven this week.”

In the first case study, above, the patient needed a bit more than two years of steady, constant talking to God before she felt the comfort of a constant friend.

In the second case study, the person felt a return to her long-forgotten relationship with God in less than a week.

Learning to habitually talk with and trust the universe after shutting it out for decades can take months, or years. Usually not minutes. Then again, anything is possible.

For example, C.S. Lewis, the famous author whose best-known work is probably *The Lion, the Witch, and the Wardrobe*, had long been a determined atheist despite the spiritual exhortations of his dear friend, JRR Tolkien.

One day, the atheist C.S. Lewis got into a cab, intending to visit the London Zoo. When he got out of that cab a short while later, at the zoo, he was a devout lover of the Divine, and ever after maintained a deeply personal, abiding relationship with God. So when it comes to timing, you just never know.

One thing is certain: you can hugely speed things up by getting the conversation going, and keeping it going no matter what.

A name for the feeling of connection

Re-connection with God after having been apart for a while is a normal thing for people to do. This experience is so common that it’s been given names.

For example, the Jesuits, a highly respected male Catholic “congregation” that emphasizes education and intellectual research, refer to this moment of spiritual re-connection as a “conversion experience.” I only point this out to show that the idea of reconnecting with God is not something I’ve made up.

Maybe a person forgets to stay in touch with, resonate with, the universe, or intentionally turns his back on it. He starts to feel alone, abandoned, yucky. And with a few prods in the right direction, he can resume the relationship, and then he feels normal again.

The increase in joy, contentment, and resonance one feels when connected to God is very likely related to activity in the brain’s striatum – which is not to say that God is a product of one’s imagination. It might be more accurate to say that man’s

brain works more correctly when he is resonant with the universe, Love, and God instead of being focused primarily on himself.

Many people experience a feeling as if the brain has shifted somehow into a more harmonious, heart-resonant state when they first join a new religion, or when they fall in love. This surge of dopamine-based joy is *not* something extremely rare. It is relatively common. Then again, if there are habits of negative thinking, it can be hard to sustain.

If biological activation of the striatum has become electrically *inhibited* by being on pause, you can get it going again by striking up a conversation with the world outside of yourself, or with God, and keeping it going.

Another example of relationship

A swami I've met, who is *not* stuck on pause in any respect, shared an experience he'd had while on a retreat. He woke around dawn and went to gaze out the window. He saw a little bunny. It was so sweet that his immediate response was to mentally say, "Guru, I wish you could be here with me to see this." And no sooner had he mentally shared this thought than he was overwhelmed with a sudden sensation of being surrounded by intense, palpable love.

He was accustomed to silently talking outwardly, to his Guru, not inwardly towards himself. His automatic "wish you could see this" thought was deeply intimate. He *felt* an immediate *reply* to his thought: a stronger connection with the Divine, and an overwhelming sense of joy.

Falling in love

When a person is deeply in love, he is always thinking of the loved one. He will experience all his daily activities with a thought in the background, "I wish you were here" or "I'm going to tell you all about this when we meet again."

This doesn't require practice. It doesn't "waste" a person's time. It takes no time at all. It's purely automatic – a redirecting of one's thoughts towards the loved one.

This is the kind of relationship that a person stuck on pause is going to have to develop. He can develop it by constantly talking to the divine. It might be harder, at first, than directing one's thoughts to a flesh and blood loved one. But in the end, it is even more rewarding because, unlike the flesh and blood loved one, Universal Love, the Beloved, the Teacher, the Prophet, or the Archangel is *always* right there. Unlike the human beloved who might *change* or go away, the Universal Beloved is unchanging and ever-present.

Still, it can take a while to develop this relationship. Get started now.

By the way, the thoughts you share with God do *not* need to be spiritual or uplifting. They can express anger, fear, bitterness, and cynicism. You can say to God, "I hate you!" and God won't mind a bit. He'll just be glad that you're finally talking to him again. All the thoughts you normally hoard to yourself, share them with God. You don't need to change your thinking or develop special thoughts. Just share them.

A do-it-yourself project

Talking to someone *outside* yourself instead of talking to yourself is something a person must do on his own. There is no therapy or counseling that can change the intended recipient of a person's innermost thoughts.

The habit of pointlessly talking to oneself in downward spiraling circles of negativity is, well, a habit. Don't worry too much about destroying wrong habits. It is easier and faster to simply replace them with good habits.

A person must make his own good habits by doing them.

Also, many people have attested that they have been helped in the destruction of wrong habits by...get this...asking for help from a higher power of one sort or another. If the new desired habit is talking to God or Love, it's OK to ask God or Love for help in establishing this new habit.

By the way – using the technique of destroying the brain cells of bad mental habits will *not* work if you are dealing with a self-induced pause situation. If you've commanded yourself to feel no pain and you use a technique to destroy the brain cells of the old habit of feeling no pain, you still won't feel safe. So you will resume talking to yourself and using the risk assessment part of your brain – not your striatum. Therefore, from habit, you will build new pause-type brain habits, and possibly create or strengthen the blocker personality, as well.

I have seen this over and over. You can't get rid of self-induced pause until you *feel* safe. Until your striatum, and it's partner, the thalamus, are active, you can't feel safe. If you don't feel safe, you can't get rid of self-induced pause.

Again, until you actually *feel safe*, a concept that you can't even understand so long as you are on pause, you don't know *how* to behave correctly in your mind. You will simply recreate your wrong habits as fast as you destroy them.

Happily, talking with God will *physiologically* bypass the spinal energy blockage you've created, stimulate the crucial areas in the midbrain, and cause you to feel safe. Then you can get rid of the old brain habits and they will *stay* gone.

Brother Lawrence

Possibly some of the most straightforward, early western writing on this subject is *Spiritual Maxims: Practicing the Presence of God*, by a French monk, Brother Lawrence (1614 – 1691).

The main point that Brother Lawrence makes is that one should *always* be talking to God. Always. Even when fearful or angry. As he points out, God already knows that you are fearful or angry, or hungry or sinning, or whatever. So why not talk with Him about it? He called this constant communication "practicing the presence of God."

Brother Lawrence wrote that he could always tell when he forgot to keep talking to God because he would stop feeling *safe*. As soon as he resumed his communication with the Divine, he felt normal again.¹

¹ His book is still in print, in French. The English-language publications purporting to be his work are usually published by Catholic groups who shy away from many of Br. Lawrence's actual words and substitute their own. Br. Lawrence has some ideas that are at odds with official Catholic doctrine.

The Catholic church-based versions of his book that I have seen often feature essays written by Br. Lawrence's archbishop, writing *about* Brother Lawrence and paraphrasing his actual words, bringing the words closer to official Catholic doctrine. A typical title for these interpretive writings is usually something like *Conversations with Brother Lawrence* although sometimes they are misleadingly titled "*Practicing the Presence of God*", thus implying that the words are those of Br. Lawrence. Here's how you can know what you are getting: if the first chapter of the "*Spiritual Maxims*" says anything about baptism in the church being the most important action you can take, you are reading catholic doctrine, and not Br. Lawrence.

For English readers who would like to read the unmodified words from his *Spiritual Maxims: Practicing the Presence of God*, I have translated his very short book into English and included it as an appendix at the back of this book.

The experiences of Brother Lawrence, three hundreds years ago, match up with the modern MRI studies of the brain that show the striatum lighting up when a person thinks about God – a God that he can *talk* to.

As you read the words of Br. Lawrence, you will see how extremely simple it can be to talk to God. All you need to do is do it.

Another great resource for learning how to talk to God is a DVD recording of a lecture given by Brother (Swami) Bhaktananda. In this talk, the swami talks about his own experiences resulting from practicing the presence of God. This DVD, "*The Personal Approach to God*", is available at bookstore.yogananda-srf.org. Click on audio/visual, then click on "other speakers." I highly recommend watching this video if you have questions about the practicality or effectiveness of practicing the presence of God.

The first half of the DVD talk by Br. Bhaktananda is about general yoga principles, and is addressed to people who are trying to get from sympathetic mode to parasympathetic mode: from stress and tension to peace, joy, and love. After 20 minutes, he starts talking about practicing the presence of God. At around 40 minutes, he shares specific, delightful details on his own experiences in practicing the presence.

Vocabulary tips: in the DVD lecture, he refers to Paramahansa Yogananda as "Master." This is a traditional title of respect for one who is master of his own soul. It does not in the least suggest a "master/slave" relationship. If you, like many American English speakers, choke on the word "Master", remember that this word is the English language equivalent of Maestro, or Maître.

When Br. Bhaktananda speaks about "the lessons," this is in reference to free or very low cost (to cover the cost of mailing) lessons in yoga meditation written by Yogananda and made available through Self-Realization Fellowship, at www.yogananda-srf.org. The "lessons" are the most complete and thorough course on yoga that I have ever read.

Br. Bhaktananda often refers to "the guru." Sometimes he is referring to his own guru, Paramahansa Yogananda. Other times, he is referring to "the guru" in the sense of any great spiritual teacher, one who has attained utter oneness with God and whose mission on earth is to teach others how to know God. "Guru" literally means "dispeller of darkness."

I actually attended this talk, and it added fuel to my determination to be constantly talking with God. Admittedly, I talked with resentment and flippancy, and sometimes bitterness, until I was diagnosed with Parkinson's. Then, my habit of talking to him paid off. I knew to whom I should address my thoughts about what to do next. The enormity of my diagnosis forced my conversation to be more focused, honest and open than it had ever been.

After hours of talking about my diagnosis with my spiritual teacher, who had passed away the year I was born, I was finally able to admit that he knew best, that he'd always loved me, and that

A translation of Br. Lawrence's book is provided as an appendix at that back of this book.

More about talking to God

When directing your constant thoughts towards someone other than yourself, make sure that your communicant is someone who is:

- 1) Always present and able to hear you.
- 2) Capable of loving you.
- 3) Capable of being loved by you.
- 4) Always directing his/her/its actions, and directing your whole life, towards your highest good.

Again, it's best to be talking to someone who is no longer in the body, someone who makes you laugh, someone you trust.

Reality check: Important Point

Just mechanically talking to things outside of oneself, or any of the other exercises in this book, will *not* quickly bring about the critical change. It *will* start modifying brain behavior so that the desired change will come about more easily...when you are ready to make the change. Eventually, to really make your brain change over to *safe*, you need to feel *love* for whomever you are talking to.

Before you can love and trust someone, you have to get to know that someone. Changing your focus outwards, away from self, can be a first step in getting to know what is out there, outside of yourself.

Just talking to the sky and the bird and the sun doesn't make you *necessarily* have a constant loving relationship with them, which is the eventual goal.

However, the opposite, which is talking to *yourself* and *not* talking to things outside yourself, *does* make you steadily go further down the mental rabbit hole into negativity and feeling apart.

Talking to God will not make you feel safe if you are determined not never feel safe. However, doing the steps in this book might bring you to the *precipice* of feeling safe.

Ultimately, whether or not a person wants to jump off into the safety net of Divine Love or the love of a deceased grandparent is up to the individual. A person can stand at the edge of the precipice without jumping for as many lifetimes as he wants.

the "unfairness" of events in my life had in fact been fair, though I didn't know how or why. *He* knew what was going on. *I* didn't. I didn't know anything. I needed his help.

When, in my distress, I stopped fighting him and just thanked him for everything, the good and the bad, that's when the Parkinson's unexpectedly turned off.

In retrospect, I had been blessed by the decades of yogic training that included practicing the presence of God, even though, at the time I only did it because I'd been told to and so that I could pride myself on doing a "spiritually superior practice."

There is NO technique or exercise that will mechanically shift a person's consciousness into *admitting* that God knows best, after all. That he knew best right along.

A person who has decided to stay on pause may have spent years or lifetimes sulking and resisting God because some terrible event occurred. At the time, the event(s) seemed to be unfair. Due to the human inability to understand the big picture, the person got his back up. Maybe he's still resentful. I know I was. I loved God, but boy, was I bitter towards him.

Very often, my patients stuck on pause have a strong moral compass, a strong leaning towards spiritual paths or "doing what's right." They also feel, strongly, that God didn't do the right thing at some point in the past, even though they were "so innocent" or "so good" and "didn't deserve what happened." They are not ready to forgive Him. No way, not gonna happen.

They love other people, they are good (as they understand goodness), and it's God or the Universe who has made all the trouble.

That's understandable. It's understandable to see where a person might also have a hard time admitting that, in fact, the original trauma, whether just simple fear or injury, or brutal torture, was inherently fair inasmuch as it was the outcome of laws of cause and effect. But even though the original cause behind your suffering may be unknown to *you*, you can rest assured, humans are *not* exempt from the laws of physics.

And making it even trickier, you can't know how fair life is and the extent to which the laws of cause and effect are inviolable *until* you are safe in the bosom of Divine Love. You cannot know, especially if your main point of reference is your own circular, negative thinking.

That brings me to the next subject.

The kindest possible explanation

Many patients have told me that they can't possibly trust a God who causes so much pain in the world. Getting more specific, they want to know why they should communicate with a God who has caused them, as an innocent child or as a well-meaning person, to suffer from sickness or emotional pain.

I will often ask a person with this question to come up with the kindest possible explanation for why he is sick or suffering and get back to me in a week. I tell him that he can use any possible fantasy or imagined reason. No holds barred.

A week later, the person is back, still bitter towards the "unfairness of it all," and certain that my assignment was pointless.

I offer the following:

"Is it possible, is it remotely possible, that you, being a good and kind person, did once, in a previous life, have a loved one who was suffering from some sickness, pain, or torture? Maybe, compared to your loved on, you felt you were the stronger, more confident, or perhaps you were older and more ready to move on or die. And

so you prayed that the person's problem might be granted to you, so that your loved one, who was weaker or less capable, might live and recover.

What if that prayer was granted? Your friend recovered. But you didn't get the illness or the pain, at least not at that time.

"Now, a lifetime or two later, you are experiencing the other half of your successful prayer: you have the illness that you were willing to bear.

"Is this *possible*?"

The patient is usually dumbfounded. A typical response is something like, "Um, yeah, but that would make me *heroic*..."

"Yeah," is my deadpan response. "Maybe that's closer to the truth."

This understanding of the situation would also make the universe a much less cruel and random place.

If a person is determined to be angry at the universe, it's usually because he's taking a very narrow, very short-term view of the universal laws of cause and effect. It can be helpful to consider that forces might be at play of which one is not aware. Forces that were set in motion by the person himself, for reasons that made sense at the time, but which have been obscured by the passage of time or the passage of lifetimes.

But even if a person *is* angry at the universal law of cause and effect, or at how the laws of action and reaction are playing themselves out, wouldn't it make more sense to argue it out with the universe rather than sulk in silence?

Sulking in silence

Which teenager would you rather have? The one who comes home from school and immediately yells about how unfair the teachers are and how she's angry at her best friend and as for you, the parent, "It's all your fault!"

Or would you prefer the one who comes quietly home and doesn't say a word, goes upstairs and locks herself in her room and doesn't say a word to you or anyone, and doesn't talk to you, doesn't talk to any friends, for days, weeks, months at a time?

Most of us would prefer the one who is angry but still in the game, instead of the one who is dead to the world, silently killing herself in slow motion.

It is far healthier to get a relationship going, even an angry one, with the "higher power" than it is to hold one's breath until one passes out, which is essentially what a person is doing when he decides to be numb and pretend he's not alive.¹

¹ And while I'm on the subject of taking a broader, wiser outlook on *seemingly* negative situations, I've noticed an interesting phenomenon: some patients have said they would rather dwell on past wrongs that were done to them than move forward and recover.

Shortly after my first edition of *Recovery from Parkinson's* came out, someone set up a website devoted to people with Parkinson's who had "bad mothers." I was invited to join, but refrained. A patient told me how the members tried to outdo each other with stories of maternal

Another helpful tip

Br. Bhaktananda, the swami mentioned in an earlier footnote, suggested in one of his talks that a person can just put a short phrase in motion in his head, and keep it there, repeating, all the time.

A person might mentally intone, over and over, a short phrase such as “Om, Krishna” or “My Lord, my Lord.” He might say, “You are Great!” or “Mother Mary, come to me.

The idea is to get this so deeply planted in the brain that it runs constantly.

Many of us have experienced getting a musical snippet in the brain that plays over and over (an “ear worm”). If it’s a song you don’t like, it can drive you crazy, You have to replace it with something else.

Getting a short phrase established doesn’t take a lot of mental focus, it just takes doing. The brain, which abhors a vacuum, is actually hard-wired to repeat a snappy phrase. The idea is to choose a phrase and play it constantly in the background, even when you are working or doing other things with the main part of your mind.

This, too, is called “practicing the presence of God.”

cruelty. None of them wasted words on how their own mental attitudes might be contributing to staying stuck in Parkinson’s.

One of my patients told me, “I have to recover as fast as possible because my mother’s getting old. She might die soon. I need to be able to shove it in her face that the reason I have Parkinson’s is because of her. She was so cruel and unfair to me. I want her to suffer in the way she made me suffer!”

This person dropped out of the program after our first session, when I told him recovery might take a while and his mother might well die before then. I asked if he wanted to recover if he wasn’t going to be able to shove his mother’s face in it. He didn’t think so.

I do get regular missives from people with Parkinson’s, people I’ve never met, that start out, “You’ll be fascinated to learn that in my past...and then comes pages and pages of justifications for having emotionally shut down forever, reasons that the person now has Parkinson’s: the drunken parent; pervert uncle; overly rigid religious expectations, abuse, criminal abuse, genuine horror stories.

The writer is mistaken: I am not fascinated. Please don’t send me these tomes.

I have heard these stories from hundreds of my patients and countless correspondents. They usually *love* to dwell on this subject. Very often, these stories are sent to me to show why they will not be able to recover or why recover, in their own special case, will take a very, very long time. These people are not helping themselves, which always makes me sad. They are certainly not helping or impressing me. I am far more interested in the changes that will lead to their recoveries.

Until they are able to be grateful for their pasts or at least ready to leave them behind, as deactivated memories, they might have a hard time feeling safe. I would rather hear that they have recovered than hear their reasons that they won’t be able to.

Please do *not* send me essays long or short justifying why you have Parkinson’s. If you can recover and then write to me about the ugly past from a place of wisdom, I would love to hear it.

Of course, we don’t need to obliterate our pasts. Writers like the late Elie Wiesel, who wrote about his experiences in the Nazi death camps, and who exhorts people to speak up against evil, serve as important historical reminders and moral crusaders. These writers are moving forward: living in the present, advising for the future.

In one of Br. Bhaktananda's talks, he says, [My Guru said] "God does not have to respond to words, but He has to respond to love. That is His law. ...the heart is the center of feeling and love."

[And so I imagined] my heart had a mouth, and the words [Om, Divine Mother] were coming out of the mouth of the heart. When I began to chant "Om Divine Mother in this way, I felt more love within. "¹

To sum up, you can practice talking to things outside yourself, thus turning off the internal monologue.

You can teach yourself that every thought you have is being shared with the divine.

You can talk to God in the language of your heart, sharing all thoughts, including the angry and bitter thoughts, accusations and fears.

You can choose a short, rhythmic phrase (You, you, you!") and play it over and over, constantly, in the background of your mind.

You can imagine that your thoughts do not emanate from your head, but from your heart – maybe even from a little mouth that's located on your heart.

In Chinese medicine, all of these techniques are considered forms of Qi Gong: energy control. These are all ways to change the way you direct the energy flow in your body and brain.

In the world of psychology, these techniques are referred to as cognitive behavioral therapy. People can best do cognitive behavioral therapy on their own, without a therapist.

In spiritual communities, these techniques can be considered helpful steps in learning to feel increased joy or inner peace, *or* to grow closer to God – which some religions consider to be one and the same.

Whichever way you choose to regard these techniques, as physically or emotionally healthy or as spiritual, they are healthy practices that *increase* the amount of energy that flows through the midbrain and into the frontal lobe, and *decrease* the amount of energy that flows through the fear and risk assessment areas on the left and right sides of the brain.

These practices bypass the electrical habits that make you feel unsafe and *directly* stimulate the part of the brain that makes you feel safe.

¹"Practicing the Divine Presence"; *Self-Realization Magazine*; Self-Realization Fellowship, Los Angeles, CA, Summer 2016, Vol. 87, #3; p.26

Chapters eighteen through twenty five are not yet finished enough to post.

The next fifteen pages are from an appendix titled

Appendix I

Spiritual Maxims

From the writings of Brother Lawrence

This edition of the Spiritual Maxims of Brother Lawrence was translated from *Frère Laurent de la Resurrection: Ecrits et entretiens sur la pratique de la présence de Dieu*, an edition with an introduction by Conrad De Meester, Carmelite, Les Éditions du CERF, 2007.

The following introduction is also translated and greatly shortened from the above:

Brother Lawrence was known for his utter simplicity, deep humility, and unfailing peace.

He was a source of spiritual inspiration to lay people and to his fellow priests and nuns.

He was born Nicolas Herman, in 1614, in Hériménil, a tiny village near Lunéville, in the French province of Lorraine. Little is known of his family. At age eighteen, he experienced a “sudden intuition, cosmic, of the grandeur and the presence of God,” to quote the bishop who wrote up details of his interviews with Brother Lawrence.

He served as a soldier during the thirty-years war, was wounded, and returned home. In his spiritual searching, he first tried life in solitude, in a hermitage. At age twenty-six, he joined the Shoe-less Carmelite order in Paris (they only wore sandals), on the *rue de Vaugirard* (Vaugirard Street).

He took the religious name Laurent. Possibly, this was in the tradition of many Carmelites in taking the name of the patron saint of their home town.

His first fifteen years in the monastery were spent working in the kitchen. However, his worsening spinal injury (war wound?) made work in the kitchen, such as scrubbing the floor, too difficult. He was moved to the sandal making and repair quarters, where he kept up the sandals for the two hundred “shoe-less” monks.

He also performed other duties for the monastery, such as acquiring food supplies. In fulfilling his various duties, he had contact with many outsiders: workers at the convent, beggars at the gate, visitors to the church, and businessmen.

Little by little, word of the humble sandal maker/repairer spread throughout the region. As did many of his order, he assisted and gave advice to many who came asking. He was visited regularly by people of great learning, both religious and ecclesiastic. However, Conrad de Meester notes in his introduction (I translate), “The abbot Goujet, of Paris, might have been exaggerating when he claimed that Brother Lawrence was venerated throughout *all* of Paris. But it is nevertheless true that people from all walks of life, from the high to the low, greatly appreciated conversations with the humble priest who was so anchored in God.”

Note: This translation begins with a “chapter one” which, in the more traditional presentations, is considered chapter two. The traditional chapter one is widely considered to have been added by the church, after the Brother’s passing, to

counter some of the rather unorthodox positions taken by Brother Lawrence, positions that conflict with the 17th century stance of the Catholic church. I have included the traditional chapter one at the end of this translation, and renumbered the chapters accordingly.

Chapter One

Necessary Practices for Acquiring the Spiritual Life

1. The practice that is most holy, most common, and most necessary in the spiritual life is acknowledging the presence of God. This consists of being pleased with and becoming accustomed to His divine company, speaking humbly to Him and holding on to Him lovingly at all times, at every moment, without rules or measure, above all during times of temptation, pain, spiritual dryness, disgust, and even during infidelities and sins.

2. We must perceive, continually and equally, all actions as forms of small conversations with God, without study or planning, but as they come from the purity and simplicity of the heart.

3. We must perform our actions with dignity and orderliness, without the impetuosity or precipitation that marks the lost soul. We must perform our work gently, tranquilly, and lovingly with God, praying that our work is pleasing to Him, and by this continual attention to God we batter the head of the devil and cast down the devil's weapons from his hands.

4. We must do this during our work and other actions, even while reading and while writing, however spiritual. And I say further: during our external devotional exercises and vocal prayer, pause for a brief moment, as often as we can, in order to love God from the bottom of our hearts, like a quick taste taken in passing, and in secret.

After all, you cannot forget that God is present, right in front of you, during your actions; that he is at the core and center of your soul. So why not at least, from time to time, stop your external occupations, and even your spoken prayers, in order to adore him interiorly, to praise him, to give him your questions, to offer him your heart, and thank him?

What could be more agreeable to God than to stop thus, thousands of times every day; what could be more agreeable than that all beings withdraw into their interior and love Him?

As an aside, it is a fact that this destroys one's self-love, which only exists among humans. These moments of turning inwards towards God imperceptibly get rid of this self-love!

Finally, we cannot give greater testimony to God of our fidelity, than by renouncing and being contemptuous of our animal nature, thousands of times a day, in order to playfully be glad for a moment with our Creator.

I do not say that, to use this method, you must leave forever your exterior existence: one cannot do that. But that prudence which is the mother of virtue will help you to self-regulate.

I add, nevertheless, that that it is a common error among spiritual seekers that they fail to leave, from time to time, the exterior world in order to love God within themselves and to enjoy peace, for brief moments, in His divine presence.

This digression has been long; I believe that this material requires this much explanation. Let us get back to our practices.

5. All these adorations must be made with faith, believing that, truly, God is in our hearts, that he must be worshipped, loved and served, in spirit and in truth, that he sees all that happens and that will happen, in us and in all his creatures, that he is free and independent, that all creatures are dependent upon Him who is infinite in every aspect of perfection.

It is He who deserves all credit for his infinite excellence and His sovereign domain over all that we are and all that exists in the heavens and the earth, over which He may rule as he wishes, now and forever. We must give him, in all fairness, our thoughts, our words, and our actions. Let us observe ourselves to see if we are doing this.

6. We must consider carefully which are the virtues that are most necessary to us, those which are the most difficult to acquire, which are the sins where we often fall, and which are the most frequent and inevitable occasions where we slip up.

We must run back to God with complete confidence during the height of battle, remaining firm in the presence of his divine Majesty, worshipping him humbly, sharing with Him our troubles and our weaknesses, asking him lovingly for the help of His grace.

And we will find there, in Him, all virtues and qualities, while we ourselves have none.

Chapter two

How one should love God as Spirit and as Truth

7. There are three points to this question that must be answered.

I have said, "Worship God in spirit and in truth." This means love God as we must worship him: God *is* spirit, therefore we must worship him in spirit and in truth. This is to say, by a humble and true worship by spirit, from the core and the center of our soul.

We do this, not so much because God will notice this often repeated worship, but rather that, in the end, this worship will become natural and we will feel that God is one with our soul and that our soul is one with God. The practice makes this apparent.

8. To worship God in truth; this means to remember who He is and to remember who we are. To worship God in truth; this means to remember truly, actually, and in the inner spirit, that God is infinitely perfect, infinitely loveable, infinitely removed from evil, and has all the divine attributes.

Who would want to be a person who, with his small intelligence, doesn't use all his strength to give all his respect and love to this almighty God?

9. Love God in truth, this also means that we are utterly contrary to Him but that He deeply wants us to be as a fellow man to Him, if we so wish it. Who will be so imprudent as to turn away, even for a moment, from the respect, the love, service and the continual worship that we must give to him?

Chapter three

The Union of the Soul with God

10. There are three types of unions: the first is common, the second is virtual (seemingly real), the third is actual.

11. The common sense of union occurs when one feels united with God during a moment of God's grace.

12. The virtual union occurs when, beginning some action during which one feels united with God, one feels united with Him due to the virtue of this action, for so long as the action lasts.

13. The actual union with God is the most perfect. And, being purely spiritual, it creates an awareness of sensation of His movement, because the soul is not "sleeping" as it is during the other forms of union, but the soul itself, conscious of itself, feels strong excitation. And this strong stimulation is more lively than that of fire, and more luminous than the naked sun, and cannot be obscured.

One can, nevertheless, be fooled by this feeling, which is not a simple feeling of the heart such as that which occurs when saying "My God, I love you with all my heart" or other similar words. But it is an indescribable sensation of the gentle soul: peaceful, spiritual, respectful, humble, loving and very simple, which carries and hurries one to love God, adore Him, even hold Him with tender affection that cannot be described and cannot even be imagined.

14. All those who claim to have Divine union must know that all that gladdens the will is to Him agreeable and delicious, and that the will clings to Him. All the world must avow that God is incomprehensible and that, in order to unite with Him, we must deprive the will of all forms of desires and pleasures, both corporeal and spiritual, so that, thus apart from all desires, the will can love God above all things.

For, if the will can in anyway understand God, it cannot help but love Him.

There is a wide difference between the desires and emotions of the will and between the spiritual functions of this same will, since the desires and emotions of the will are in the soul on their own terms, but the spiritual function of the soul is the love that terminates in God, at the end.

Chapter four

On the Presence of God

15. The presence of God is giving our mind's attention to God or recalling to mind that God is present. One can do this using either one's imagination or one's understanding.

16. I know one person who, for forty years, has practiced the presence of God with his mind, who has given to God many names [terms of endearment].¹ Now, he considers this to be a simple action, yet it has brought him a clear and distinct knowing of God. Sometimes, feeling confusion about how to behold and love God, he simply *remembers* God. Other times, he focuses his attention on the name of God, or silently converses with God, confides in God about his life and the peace of his soul. In the end, this person has told me that all descriptions of how to be present with God are synonyms that mean only one thing: and that is to behave naturally with Him. This is how:

17. This person says that by strength of his actions and frequently recalling his mind to the presence of God, the habit was formed in such a manner that as soon as he is freed from external busyness and, even often when he is engaged in external busyness, the focus of his consciousness, the highest aspect of his soul, will lift itself up without any work on his part and stay as if suspended and fixed, motionless, on God, above all things, as if God is his center and his resting place.

Feeling, almost always, his mind in this suspended state, accompanied by faith, this is utterly fulfilling to him.

And this is what he calls the "actual" presence of God, which includes all the other sorts of His presence and even beyond, so that he lives, now, as if there is nothing more in the whole world besides God and himself. This person is always talking to God, asking God for whatever his needs might be and rejoicing with Him, without ceasing, in thousands and thousands of ways.

18. One should know that this conversation with God comes from the core, the center of the soul. This is where the soul talks heart-to-heart with God, and always from a vast and profound peace which the soul enjoys in God: everything

¹ In the 1996 edition of Frere Laurent de la Resurrection; *ecrits et entretiens sur la Pratique de la presence de Dieu*, presented by Conrad de Meester, a Carmelite, a footnote states (translated into English), "from the context of all of his writings, it is clear that Brother Lawrence is speaking of himself in these passages." [in this portion of chapter five].

that occurs outside is not the soul, but only a flickering flame from a burning straw which sparkles and sheds a bit of light, but which never disturbs the interior peace.

19. Returning to our being in the presence of God, I say that this gentle and loving way of regarding God brings a light other than a sensory light, a divine fire in the soul, which embraces one so ardently with the love from God that one must stay busy with outside activities in order to moderate this embrace.

20. One might even be surprised by what the heart is saying to God, sometimes, for the joy is so strong in these conversations that all subjects are allowed, provided that the soul desires always to dwell with God, in his core. And if one fears that his soul will never return to his physical body, God takes care to give him everything that he desires, and does this so well that the soul often finds within himself a nourishment, a food, so savory and so deliciously to one's liking that the soul might never desire or procure anything else, of any sort, without even having contributed in any way other than having consented.

21. The presence of God is, therefore, the life and the food of the soul, which can be acquired with the grace of God. And this is the way.

Chapter five

The Means of Acquiring the Presence of God

22. The first requirement is great purity of lifestyle.
23. The second, a great loyalty in practicing his presence and, with inner awareness of God in one's self, one must always keep himself gentle, humble, and loving, without allowing himself to be bothered or anxious about anything.
24. One must take particular care that this interiorized awareness, whether it sometimes precedes, however briefly, his external actions or, at other times, is simultaneous with the external actions, must always be present when the actions are finished: when one is finished with all external actions one must end, always, with the internal awareness.
- Because it takes time and much work to acquire this practice, one should not be discouraged if one forgets to do it, because habits are only formed by steady care; but when the practice does become habit, it will have been done with willful pleasure.
- Isn't it only right that the heart, which is the most important part of the body and which dominates the other members of the body, should be the first and the last to love and worship God, to be the beginning and the end of our actions, both spiritual and physical, and in all our expressions of life? And it is in this location that we must take care to create our small interior awareness which, as I've already said, must be done without pain and without study, but rather with gentle ease.
25. It will not be unusual, for those who begin this practice, to come up with little words or phrases such as, "My God, I belong only to you," "God of love, I love you with all my heart," "My Lord, shape me according to Thy will," or other phrases that the heart creates spontaneously. But they must be careful that their minds do not lead them astray, that their thoughts do not return to the body. They must keep the mind turned to God alone until they see their own will is thus trained, even pressed, and forced, to remain with God.
26. This practice of presence of God, a painful practice in the beginning, when practiced with loyalty, secretly works its marvelous effects on the soul, and abundantly drapes the soul with the blessings of the Lord and brings it, without knowing how, to this simple awareness, to this loving view of everywhere-present God. This practice is the holiest, the strongest, the easiest, and the most efficacious form of prayer.
27. Notice, if you will, that in order to arrive at this state, one must destroy the desires of the flesh, since it is impossible that a soul who is still obliging

the body can find complete enjoyment in the Divine presence, for in order to be with God one absolutely must leave the physical desires behind.

Chapter six

The Benefits of the Presence of God

28. The first benefit that the soul receives from the presence of God is a faith in God that is more alive and stronger in all aspects of our life, especially with regard to our needs. We see that they come to us easily, by grace, during our temptations and in the inevitable businesses that we have with other people.

For the soul becomes accustomed, by this exercise in the practice of faith, by the simple remembrance of the ever-present God, both seen and felt, which the soul can invoke easily, efficaciously, to obtaining that which is needed.

One can say that the soul has, by this method, several ways for approaching a state of deep happiness; and the more one advances in this practice, the more one's faith comes alive, until finally the soul becomes so penetrated with awareness of the presence of God that one can almost say: "I do not *believe* in God; I *see* and I *experience* God."

29. The practice of the presence of God strengthens our hope. Our hope exists in proportion to our knowing.

The degree to which our faith is penetrated by this holy exercise in the secrets of the divinity is the degree to which the soul discovers, in God, an infinite surpassing beauty. A beauty not only in the bodies that we see on the earth, but in those souls that are most perfected, and in the angels. To the degree that we discover this beauty, to that same degree our hope grows and is fortified.

And the more the soul feels the greatness of this goodness, by which the soul lays claim to joy, the more the soul can savor it in a manner that strengthens and reassures the soul.

30. The soul inspires in the will a contempt for material creation. Because the soul is always with God, the soul embraces instead the sacred flame. Because God is a consuming fire, He reduces to dust that which is opposite of Him.

And the soul thus embraced cannot live without the presence of his God, a presence that produces in his heart a holy passion, a sacred eagerness and a powerful desire to behold the God who is beloved, known, served by and worshipped by all creation.

31. By the presence of God, and by this interior awareness of this presence, the soul becomes familiar with God in such a way that it spends nearly all its time in continual acts of love, worship, contrition, confiding, thanking, offering, asking, and actions of all the most excellent virtues.

And sometimes, even, the soul becomes only a single action of stillness, because the soul has become continually engaged in the constant practice of the divine presence.

32. I know that one finds few people who attain this degree of the divine presence: the stillness. This degree comes through the grace of God, who favors only certain, chosen souls. Then again, this practice in simple awareness is itself a gift from His generous hand. But I shall say, in order to give hope those who wish to embrace this holy practice that, ordinarily, He only gives this practice to those who are already disposed to practice it.

And if He does not give this degree of stillness, one can at least, with the help of His usual blessings, acquire by the practice of the presence of God a way of being and a state of prayerfulness that comes very close to this form of pure awareness.

In catholic literature, the following is usually presented as chapter one. However, many scholars feels that this chapter contains phrases that are not typical of the wordings used by Brother Lawrence, and this chapter might be a creation pulled together from the published "In Praise of Brother Lawrence" (Eloge du Frère Laurent), a compilation based on the writings of Joseph de Beaufort, a Parisian priest who served as the grand-vicar to the bishop of Châlons-sur-Marne.

This chapter does use language that is more consistent with the positions of the church, and is less like the writing that brother Lawrence used in his other chapters of Maxims and in his correspondence.

However, because this chapter is traditionally presented as "chapter one," I have included it in this translation – but have placed it at the end.

The original chapter one in the church-approved version

Principles

1. All things are possible for those who believe, even more so for those who hope, even more for those who love, and yet even more for those who practice and persevere in these three virtues. All those who are baptized, believing – as they must – have made the first step on the road to perfection. They will become perfect themselves, eventually, if they persevere in the practice of the following maxims.

2. Always see God and His glory in that which we do, say, and undertake. The goal that we hope for is to be the most perfect lovers of God, in this life, just as we hope to be perfect lovers of God for all of eternity.

Make a firm resolution to overcome – by God's grace – all the difficulties that come to you in your spiritual life.

3. When we undertake the spiritual life, we must consider what, at our very core, we are. We find ourselves beneath contempt, unworthy of the name of "Christian", subject to all sorts of miseries and an infinity of accidents that disturb us. We may find that we are unequal to others in our health, our moods, our inward and outward dispositions. We may be one who God, it seems, wants to humiliate by an infinity of pains or laboring, both within and without.

4. We must believe, without a doubt, that it is to our advantage, that it is pleasing to God that we work and sacrifice; that it is common and ordinary that the laws of Divine Providence will cast us into all sorts of conditions, will allow us to suffer all sorts of pains, miseries and temptations. We will experience these

conditions willingly, for the love of God, for however long He sees fit, because, without this submission of heart and spirit to the will of God, devotion and perfection cannot exist.

5. A soul that aspires to the highest perfection is, above all, dependent on God's grace. The help of God is, to the soul, utterly necessary at every moment, for without Him, the soul can do nothing. The world, animal instinct, and the devil all wage against the soul a concerted war so strong and so continuous that, without the specific aid of God, and humility, and reliance on God, one is allured and carried away in spite of oneself.

These forces seem harsh, but God's grace manifests as He pleases, and at the time of His choosing.