Stuck on Pause

Dr. Janice Hadlock, DAOM, LAc

Illustrations and Cover Design by Ben Bateson

Stuck on Pause
Dr. Janice Hadlock, DAOM, LAc
Illustrations and Cover Design by Ben Bateson

Other books by Janice Hadlock are available at www.JaniceHadlock.com:

Hacking Chinese Medicine
Tracking the Dragon *
Yin Tui Na: Hands-on Therapy for Traumatic Injury *
Recovery from Parkinson's *
Medications of Parkinson's: Once Upon a Pill – Patient experiences with dopamine-enhancing medications and supplements * **

*Also available for free download at www.pdRecovery.org
** Not available in hard copy

Published by Raja Books, Santa Cruz, CA
www.JaniceHadlock.com
Second edition, 2022

Table of Contents

Dear reader,

This pre-publication edition of *Stuck on Pause* is being posted on the www.pdRecovery.org website even though it is not completed.

The posting of the previous, also incomplete, edition of *Stuck on Pause* led to several-years worth of extremely helpful feedback. The questions and suggestions from readers contributed in large measure to the changes in this edition. The most significant change from the previous book to this one is the greatly increased emphasis on self-induced pause being a mental habit, and not an actual biological necessity.

Many readers have been baffled by the way that they keep slipping back into self-induced pause mode, and wonder why it returns after they have first turned it off. This edition, thanks to input from patients and ongoing research, shares new information about what causes this situation. Using self-induced pause is a mental habit. So long as this habit is retained in the brain cells, self-induced pause – and all the old motor malfunctions that the body has developed to accompany it, such as rigidity, tremor, soft voice, etc, – might resume any time a person employs the mental habit of inducing pause mode. No matter how many times self-induced pause is temporarily turned off, it might be re-employed as soon as a person stops feeling safe. This edition discusses in greater depth techniques that can help change a mental habit.

For readers who have found the previous edition helpful, please know that this edition is going to include nearly everything that was in the previous edition. Again, the main thing that has changed is an increased emphasis on the difference between a well-developed mental habit such as using *self-induced* pause, which kicks back in over and over after temporarily being turned off, until such time as the re-training is successful, and *biological* pause, which is a neurological shift due to life-threatening danger which stays turned on until the body stabilizes and then goes through steps that turn it off, lastingly. Or until the next potentially-fatal trauma.

A "flowchart" chapter has been included to help with self-diagnosis, for distinguishing between self-induced pause and biological pause. The readers who tested this flowchart format felt that it was extremely helpful, and even "It's what I'd been looking for."

Also, this edition has much more information about mentally focusing on someone or something outside of oneself, as opposed to keeping the mental focus attuned to one's own fears and pains.

I hope that these changes will make this book more helpful, especially for the reader who has decided to discard the habit of purposely using pause mode as a lifestyle, and who is working to learn new, mentally helpful and positive habits that allow the brain to *release* dopamine instead of using old habits that cause the brain to *inhibit* its release.

I hope to finish this book by the end of 2022.

Thank you for your patience.

JJW Hadlock

Chapter one

Almost Dead

From the ceiling of the operating room, the cardiac patient watches doctors performing open-heart surgery on his anesthetized body. The patient is not in the neurological mode (chemical and electrical behaviors) of eating and relaxed curiosity (parasympathetic mode). He is not in the mode of "fight or flight" (sympathetic mode). He is not in sleep mode. He's in the neurological mode of near-death. In this mode, a person often observes his physical body as if from outside of it. Most surgeons are familiar with the phenomenon of post-op patients reporting that they'd "watched the surgery from the ceiling." Surgeons can usually offer no explanation. They are not trained in the subject of near-death neurology. This condition doesn't even have a name in western medicine. In Chinese medicine, it is anciently referred to as "Cling to Life," one of the four "phases" or four neurological modes. I named this collection of chemical and electrical behaviors "pause mode."

As the cat's claws sink into the flesh of the mouse, the mouse becomes cold and rigid, with no *detectable* signs of heartbeat or breathing. The cat biffs the inert mouse a few times. If the cat is not hungry, he then departs in search of more stimulating prey. The mouse is not *pretending* to be dead. The mouse can't make himself cold at will. The mouse is in the same near-death neurological state as the cardiac patient who observes his own surgery from a vantage point outside his body.

Most of the mouse's physiological systems are halted or greatly reduced in activity except for his vision, hearing, sense of smell, and the now hyper-active risk assessment area in his brain. If his body successfully staunches the internal bleeding caused by cat's claws *and* if his sensory functions then determine that the cat has left the area, the mouse-brain's risk assessment area will call the "all clear." The mouse will take a deep breath, wobble his head from left to right and back again, and then a shudder will run down his spine.

The head wobble awakens the vagus nerve and its *parasympathetic* mode (contentment-regulating) behaviors. The shudder down the back occurs as the spinal nerves kick back in, allowing the resumption of a healthy degree of *sympathetic* mode (fight or flight) physiology. These actions completed, the mouse is no longer in pause mode. As the mouse resumes his usual blend of parasympathetic and sympathetic mode behaviors, he springs back to life, scampering off to live another day.

In the above cases of the surgery patient and the mouse, pause mode will probably turn off automatically, as it is supposed to do when it is no longer needed. However, in some cases, for various reasons, a person or animal might get "stuck" in pause mode or in a partial degree of pause mode. Being stuck in pause mode to any degree might cause all sorts of baffling, seemingly "incurable" health problems, either right away or down the road.

This book explains how to become unstuck.

What is a "mode"?

A neurological mode is a specific combination of certain motor (muscle movement) behaviors, stomach, intestinal, and digestive behaviors, neurotransmitter releases or release-inhibitions in the body and/or the brain, and highly specific mental behaviors. The physiological conditions of a living system have ever-changing physical and/or emotional needs that can vary from one second to the next. They are reflected in the ever-changing *ratio* of one neurological mode's usage *amount* relative to another's.

Western medicine only recognizes two modes: parasympathetic and sympathetic. Parasympathetic mode activates the physical and mental behaviors of playful curiosity and healthy digestion. (This is a gross oversimplification, but gives us a starting point.) This mode activates the release of dopamine in specific areas of the *mid-brain*. Dopamine is a neuron (brain cell) stimulator (neurotransmitter), used in various parts of the brain for various purposes. In parasympathetic mode, dopamine is released from the brain's substantia nigra, in response to instructions from the nearby striatum. The substantia nigra and striatum are both located along the midline of the brain, in very nearly the exact center of the brain. The striatum can signal for release of *midbrain* dopamine for motor function in anticipation of playful, joyful, unself-conscious mood and movement.

Dopamine has *many* functions in the brain. In the *mid-brain*, dopamine is the "feel good" and "effortless movement" neurotransmitter. However, on the *sides* of the brain, dopamine is the neurotransmitter for anxiety, wariness, and risk assessment. Healthy people, when awake, are always using a blend of parasympathetic mode and sympathetic mode. When use of parasympathetic mode *decreases*, dopamine release for midbrain-directed motor function decreases. If one is awake and moving more into sympathetic mode or lurching into pause mode – moving *away* from parasympathetic mode – one might have an increase in dopamine release in areas on the *sides* of the brain. Again, dopamine in *these* areas can activate negative-mood responses, such as anxiety, wariness, or risk assessment. In people on pause, midbrain dopamine release for movement and feeling good is severely *inhibited*. In people on pause, dopamine release on the *sides* of the brain for risk assessment is greatly increased. [1]

---

[1] "Personality traits and brain dopaminergic function in Parkinson's disease"; *Proceedings of the National Academy of Sciences USA* 98:13272-7*;* Valtteri Kaasinen, MD, PhD et al; 2001.

This 2001 study describes the utterly unexpected discovery that people with idiopathic Parkinson's disease (PD), which is a manifestation of pause mode, have *elevated* levels of dopamine activity in the brain's anterior cingulate area, an area that is involved in risk assessment.

Since the 1970s, Parkinson's disease researchers assumed that dopamine levels in the brains of people with Parkinson's should be pathologically low across the brain's board. This wrong conclusion grew out of the observations that people with PD had increased motor function when they were given brain-swamping levels of dopamine-elevating drugs. It turns out, people with PD have more than enough dopamine – but their brain's release of dopamine for *motor* function is inhibited because they are stuck on pause mode. Even though dopamine release for *motor function* is inhibited while on pause, dopamine release in some *other* brain areas is increased. For example, in people with Parkinson's, their dopamine levels in the risk assessment area of their brains are at *higher* levels than is seen in healthy people, while dopamine levels in their midbrain for *motor* function are *lower* than normal or very nearly turned off.

Note the date on the citation in this footnote: 2001. This information has been available for over twenty years, but because most doctors have no understanding of pause mode, this

Muscles can be activated using either parasympathetic mode's mid-brain, striatal dopamine system *or* via the brain chemistry of sympathetic mode. Sympathetic mode powers the "fight or flight" response. To the degree that use of sympathetic mode is increased, adrenaline release is *increased* and the striatum's midbrain instruction for dopamine release for carefree muscle movement is correspondingly *decreased*. Other brain molecules also play a part in sympathetic mode, but I'm keeping it simple, for now.

Almost all people, when they are *awake*, are using a blend of these two modes: parasympathetic and sympathetic. The more content a person is, the more he is using parasympathetic mode for movement, thoughts, and sensory awareness. The more stressed he is, the more he is using the sympathetic mode chemistries for movement, thought, and sensory assessment. Again, nearly all people, when awake, are always using a blend of the two modes: a blend of drivers for motor function, a blend of thoughts, and a blend of types of sensory awareness and assessments. For example, a person driving a car while eating is using the alert intensity of a mild degree of sympathetic mode *and* the digestive behaviors of a mild degree of parasympathetic mode.

Chinese medicine, for more than a thousand years, has recognized that there are *four* neurological modes.[2] The third mode, sleep, allows us to lose consciousness and become fairly motionless. In this mode, dopamine release in the brain *and* adrenaline release from the adrenal glands are *both* highly inhibited.

The fourth mode, pause mode, allows us to be *somewhat* physically and emotionally numb in response to a life-threatening injury or trauma. In this mode, the release of both dopamine (in the brain area for *motor* function and positive mood) and adrenaline from the adrenal gland is inhibited. Dopamine release for risk assessment is *increased*. If motor function is necessary in spite of the body being dangerously damaged, the brain can release norepinephrine, another neurotransmitter (known as noradrenaline, in the UK). Norepinephrine makes possible emergency use of hyper-powerful motor function. This type of motor function is not spontaneous and flowing from the imagination, like that driven by dopamine. Instead, norepinephrine drives super-powerful motor function in response to mind- or instinct-based *commands*.

Biological shifts

Pause mode also causes a shift in the physical location of the electromagnetic waves that are an inseparable part of consciousness. In a healthy person, most of the electromagnetic phenomena associated with consciousness are located 1) at the front midline of the brain's frontal lobe and 2) at the pericardium. The pericardium is the highly conductive fascia (connective tissue) around the heart, the home of the so-called "heart's brain."

The *frontal lobe* of the brain is the housing for the aspect of consciousness that turns on when we are awake and turns off when we are sleeping. The *pericardial* aspect of

---

information has not been incorporated into the current Parkinson's lore – much of which is pure fiction, unsupported by data and perpetuated as medical theory by the pharmaceutical industry.

[2] *Su Wen*, chapter 13-7, from *A Complete Translation of Nei-Jing and Nan-Jing translated by Henry C. Lu, PhD*; International College of Traditional Chinese Medicine of Vancouver, 2004; p. 114.

consciousness is always active, whether a person is awake or sleeping. It should only depart the body at death *or* during near-death.

When in pause mode, the waves of pericardial consciousness are still active, but they might prepare for a potentially permanent exit from the body (death) by moving away from the pericardium to a location just outside of the physical body. This removal to just outside the body might allow a person to observe himself from outside of his body, as if he is floating nearby his body, but is not inside of it. The body might be perceived as a somewhat numb, maybe even mechanical, construct. Oppositely, when a person is in a high level of parasympathetic mode, he has heightened somatic (inside his body) awareness and might even experience his body as a tangible manifestation of his heart feelings and his intangible soul.

The heart patient watching from the ceiling and the seemingly dead mouse are in pause mode. They are *not* in an ultra relaxed version of parasympathetic mode. They are *not* in sympathetic, "fight or flight" mode. They are certainly *not* sleeping, the third neurological mode, in which breathing is loud and relaxed, internal cleaning and daily healing work is in motion, and most aspects of consciousness are turned *off*. In sleep, the warm, relaxed, muscles have only faint, but balanced, tone, for the most part. Muscle movement, if any, is usually slight and languorous.

Oppositely, the heart patient and the mouse that start this chapter might both be somatically numb, with motor function *highly* inhibited. The heart patient is highly conscious: observing and listening to all the events in the room. The mouse is probably highly conscious. Since we can't ask the mouse about it, we can't know if its attack-victim consciousness is outside of its body. But if it were a human instead of a mouse in that situation, we could assume that it was.

The anesthetized heart patient is in a *severe* degree of pause mode. The amperage coursing through his body-wide non-neural network of highly conductive connective tissue is extremely low. His muscles are *profoundly* limp and cold. The almost-dead mouse is in a milder version of pause mode: its electrical circuitry is running in the same pause-mode patterns as the surgery patient but there is greater amperage, a greater *amount* of electricity, running through his body's connective tissue. Because the mouse has more energy, its muscles are not as utterly limp as the anesthetized patient's. Instead, the muscles along the backside of the mouse's body are limp and the muscles along the ventral (stomach) side are pulled tight and rigid. This combination causes his torso to be curled forward and inward. The legs might be rigid, or pulled into a fetal position.

The comatose heart patient and the left-for-dead mouse are in the fourth neurological mode: pause mode; the mode of near-death. The heart patient has gotten there chemically, through anesthesia. The mouse has gotten there biologically, by being physically or emotionally damaged or destabilized to the point of near-death. Recognized biological triggers for pause mode include excessive loss of blood, excessive perforation of the skin, near-drowning, anaphylactic shock, and concussion.

We can assume that the heart patient and the mouse are both going to easily come out of pause mode as soon as their crises are over. When the anesthesia wears off in the heart patient or the damage from injury has stabilized enough that the mouse's body can once again support life, pause mode will automatically turn off. The body is *designed* to turn off pause as soon as possible following an episode of near death.

Turning off pause: Five Steps

The process for turning off pause can be broken down into Five Steps:

Step 1) Confirmation of the resumption of *internal* stability: The first step in turning off pause is acknowledging that one has been traumatized *and* that the traumatic event might be over or very nearly over: the interior of the body is now stable.

This confirmation of a return to stability leads to the activation of tremoring or shaking. When the bleeding, if any, stops and/or the blood pressure stabilizes, or the anesthesia wears off, the tremor or shaking can begin. The tremor might be so faint that it is not visible to an observer, although the person coming out of pause can usually feel that "some body part is shaking" or "I'm vibrating inside." The vibration might be mild, and/or localized in the injured area, or in the low spine or inside the head. Or it might be large, even body-wide, and easily visible. In the post-anesthesia state, the tremor is often extremely obvious, body-wide, and is referred to as "post-anesthesia shaking."

Again: *Step one is the assessment and confirmation that the "interior," the physical body, is now biologically stable enough to stay alive. This confirmation triggers the onset of tremor.*

Step 2) Confirmation that the *exterior* is now safe: The tremoring and/or shaking triggers an increased level of dopamine-driven activity in the brain's risk-assessment area, the right anterior cingulate area. As activity in the risk assessment area increases, that area makes use of the brain's sensory functions. Eyes, ears, and senses of smell and touch are used in order to determine whether or not the *exterior*, outside-of-the-body danger is gone: to decide if the surrounding area, the "perimeter," is now safe: to make sure the cat is gone. If the perimeter is safe enough, the body can take the next step in turning off pause.

In humans, the hearing sense also listens for thoughts or words from the self *or* from others such as "I'm safe now," or "I'm OK," or "I don't need to be shaking anymore" *or* "*You're* safe now." or "You're going to be OK."

As soon as the risk-assessment area in the brain determines that the *external* danger is gone – the predator or enemy is gone, "I'm safe now," or "I'm going to be OK" – then the body should automatically perform the next three steps: three specific moves that turn off pause mode. Again, *Step two is the assessment and eventual confirmation* that the area *exterior* to the body is now safe enough that the body can come back to life.

Step 3) Deep breath: The body automatically makes a deep, audible breath, like a loud sigh of relief.

Step 4) Head wobble: The body automatically makes an ear-towards-shoulder move: left ear to left shoulder and right ear to right shoulder, alternating sides, high on the neck. This move is commonly referred to as the "Indian head bobble." It can be viewed online. Do a search for: India head bobble.

Step 5) Shiver: A shimmy or shiver travels along the spine. It might occur once or several times. It most often starts at the shoulders and travels down the back, but in some cases it starts at the low back and travels up to the shoulders.

If the trauma was severe or if there is still a significant level of anesthesia in the body, a person might spontaneously do the above sequence of Five Steps several times before pause is lastingly turned off – turned off until the next time that some near-death event occurs.

To review, the Five Steps that turn off pause mode are:

1) Acknowledgement of trauma or injury and confirmation of *internal* physiological stability. This leads to the onset of tremor.
2) Tremor triggers assessment of the safety *outside* the body. A confirmation of the *surroundings* being safe leads to step 3.
3) Deep breath
4) Head wobble high on the neck
5) Shimmy or *frisson* travels down or up the spine

The body is *designed* to turn off pause as soon as possible following an episode of near death. But sometimes, a person gets stuck and the electrical circuitry that drives pause behaviors doesn't revert back to the circuitry that drives parasympathetic and sympathetic modes. Very often, getting stuck occurs because the person was rushed to get up and moving too soon, following the trauma. In this situation, a person might not be able to complete either Step 1 or Step 2, and so will remain stuck on pause. Sometimes, the person remains stuck on pause because he is *psychologically* never able to feel safe enough to complete the second step: his brain has become stuck in a wariness pattern.

Two types of pause

The type of pause discussed thus far is "biological pause." Biological pause is usually the result of dire injury, dire emotional trauma, anaphylactic shock, concussion, general anesthesia, or some other near-death situation. The other type of pause mode is self-induced pause.

Self-induced pause occurs in response to a highly specific type of self-instruction. Self-induced pause presents with the same electrical circuits as biological pause but has a few variations that make it distinct from biological pause.

For example, *biological* pause will *almost* always turn itself off as soon as the body's physiology is stable – unless it gets stuck, which is fairly rare. It operates as if it's using an on – off switch.

Self-induced pause is held in place by a *habit* of initiating pause mode in order to deal with stress, trauma, or some negative emotion. Biologically, it behaves more like an entrenched habit than a switch. It will only *rarely* turn off *permanently* by itself. The brain might *temporarily* switch over to using a high level of parasympathetic mode, if the person is feeling extraordinarily calm or at peace. A few people, not many, whose inadvertent use of self-induced pause is creating their symptoms of Parkinson's disease, demonstrate this ability to *temporarily* decrease their symptoms. This ability is unique to *self-induced* pause. Some people with Parkinson's can even temporarily turn off their symptoms in a *predictable* manner. Oppositely, people stuck in biological pause cannot turn their symptoms off even if they temporarily feel safe.

For example, one of my Parkinson's patients using self-induced pause never had symptoms after 6:00 in the evening. Another, whose symptoms of Parkinson's disease were quite severe, nevertheless *never* had symptoms while doing the laundry. Another,

who was nearly immobile at all times, could always move perfectly normally as soon as he was positioned in front of his painting easel. A few of my Parkinson's patients who were using self-induced pause only had symptoms on weekdays (workdays), and never on the weekends.

These people with situation-dependent Parkinson's disease were all using *self-induced* pause – a *habit* of forcing the brain to imitate the neurology of pause mode and using it *most* of the time. When these people felt unusually safe, such as while doing a favorite activity such as painting, or an emotionally "virtuous" activity such as doing the laundry, they might slide into parasympathetic mode and move perfectly easily, with no pause symptoms – meaning no symptoms characteristic of Parkinson's. They were *not* actually in need of the neurological state of pre-death: *biological* pause mode. Biological pause is a potentially life-saving neurological condition that, if *stuck*, does *not* temporarily ease up when feeling safer than usual.

If a person using *self-induced* pause feels unusually, but temporarily, safe or relaxed, his symptoms might *temporarily* let up or stop. This shift into a high degree of parasympathetic mode might occur in response to calming activities such as going on vacation or listening to favorite music, or by using psychoactive drugs such as methamphetamine, cocaine, alcohol, nicotine, opiates, or dopamine-enhancing drugs such as some anti-parkinson's medications, In these situations, the symptoms of rigidity, slow movement, tremor, or postural instability might *temporarily* cease, or at least diminish. When this happens, the body and brain electrical circuitry of a relatively high degree of *parasympathetic* mode might temporarily kick in. But due to habit, the activation of pause-mode symptoms and pause electrical circuitry will immediately resume when "normal" conditions return. No matter how peaceful and safe a person might feel during a lull in between the usual stresses of life, the electrical and physical *habits* of using of self-induced pause is always ready to resume at the first sign of life's imperfections.

Once self-induced pause has been initiated, it might *remain* the default neurological mode. This is similar to the way that some people become physically addicted to nicotine after their *very first* cigarette. Whether the habit of using pause becomes the dominant brain pattern after its first use or after dozens of uses depends on the individual. But once it has become the dominant brain habit, it can remain the default, automatic brain habit regardless of circumstances. It might remain the default mode until such time as it is *intentionally* turned off using certain very specific *self*-activated psychological steps that destroy the habit.

Biological pause turns off via the Five Steps. The habit of using *self-induced* pause will *not* disappear in response to the Five Steps. A completely different type of self-administered, psychological re-training is needed to get rid of the entrenched habit of using self-induced pause. Again: the Five Steps will *not* work to turn off self-induced pause.

Biological pause from trauma sometimes fails to turn off *automatically* after the body stabilizes. In these cases, the Five Steps can be used as a prod to turn off pause. Sometimes, biological pause fails to turn off because the injury remains unhealed due to the severity of the injury *or* mental dissociation from the injury: the body cannot heal that which it doesn't know exists. In these cases, treatment of the injury and/or re-association with the injury will often lead to spontaneous completion of the Five Steps.

But the habit of using *self-induced* pause is very unlikely to spontaneously remove itself from the brain repertoire. Once it has been used the first time, the possibility of inducing pause mode in oneself *will* remain highly available for future use. In some people, this habit quickly becomes the preferred mode: pause mode might *never* be turned off. In others, after repeated use, it can *eventually* become the default mode. In most cases, unless very specific *mental* steps are taken that can get rid of the pause habit, it will not go away. Again: the Five Steps will NOT turn off self-induced pause. I repeat this statement a lot. Experience has shown me that many readers with self-induced pause do not notice or understand, or easily remember this statement.

In my years of medical experience, most of my patients who have induced pause in themselves did so in order to escape from a tortuous, almost lethal level of physical or emotional pain: at the time of the trauma, the world offered no safe haven from that pain. The pain compelled them to issue a self-instruction to feel no pain – an instruction that might never have been rescinded. Very often, this instruction was regularly reinforced by *habitual* self-reminders to be stoic or to feel no pain.

Technically speaking

To turn off self-induced pause, one must first do a bypass of the intellectual / sensory assessment of external safety. Safety, in this case, is a physical *feeling*, a sensation in the chest; it is not an intellectual assessment exercise. Step 2 in the "turn off pause" process requires that a person is *capable* of experiencing the somatic feelings of being safe. The instructions for self-induced pause, "I don't want to *feel*," block that capability. So in order to turn off self-induced pause, the electrical brain circuits that create a feeling of safety must be re-created mechanically.

Again, while on *self-induced* pause, self-assessment of somatic feeling has been forbidden ("Feel no pain!"). Feeling safe, *feeling* the sensation of relaxation in the chest, is biologically not accessible. A person on self-induced pause cannot *feel* safe. To work around this and turn off self-induced pause, one can do an end-run around the assessment process and directly re-create the brain currents that generate the somatic *feeling* of being existentially safe. This feeling is generated in the striatum, in the center of the brain.

In otherwise healthy people who are in *biological* pause, the *feeling* of being safe and the electrical currents that support it should occur automatically just *after* the assessment process confirms that the exterior is safe. In *self-induced pause*, even though Step 2, the *assessment* process, has been self-blocked, a person can do techniques that re-create the currents that cause a person to *feel* safe. This feeling, in turn, allows the process to move forward through the next three steps for turning off pause. BUT, this turn off is only *temporary* in people habitually using self-induced pause as the default system. By repeatedly practicing turning pause off, a person can start building up a new habit of *temporarily* using healthy neurology (parasympathetic mode) in the midbrain. When the new, healthy habit becomes sturdy enough, one can use techniques that destroy the dominant brain habit of using pause mode. In its place, one can install the newly developed, healthy brain pathways of parasympathetic mode as the *preferred* mode: the new default system.

A highway metaphor

The entrenched habit of using pause mode is like a wide highway in the brain. To get rid of this habit, one must destroy the on-ramp. The un-used on-ramp to the *healthy*

pathway through the brain needs to be re-opened by practicing techniques that restore a *feeling* of being safe. Then, the re-opened *healthy* pathway through the brain, narrow and rutted through lack of use, has to be widened and paved. This requires *practicing* the new, healthy, mental behaviors. This can take time: anywhere from a few hours to a few years.

Review of self-induced pause

In most cases of self-induced pause, the habit of using pause mode as the default system will cause the behaviors and symptoms of pause mode to quickly return even after it has been turned off. Pause will *remain* the default system in spite of temporary shifts into parasympathetic mode. Until the habit of using pause is *intentionally* destroyed *and* a new, "I'm safe enough to be alive" brain habit is installed and *practiced*, the habit of using pause mode might become increasingly dominant.

To get rid of the *habit* of using self-induced pause, a person must first train himself to have "I'm safe enough" behaviors in the brain, employable on command. Then, he can do a specific technique that destroys the mental habit of using pause mode. He must then do another specific technique to permanently install the "I'm safe" brain behaviors that he's learned to create. This can restore *lasting* usage of the healthy, normal feeling of being safe enough to be alive. This combination of destroying one mental habit and replacing it with a healthier one can make "safe enough to be fully alive" become the default system – as it is in healthy people.

In summary, people stuck on *biological* pause can use the Five Steps to turn it off. People on self-induced pause can learn techniques that replace the pause-using habit with a healthy habit of using a normal level of parasympathetic mode. Either way, turning off biological pause mode or replacing the habit of using self-induced pause can lead to turning off the pathological physiology and symptoms that can occur when a person is stuck on pause. This book explains how to determine if a person is stuck on biological pause or is using self-induced pause. It also explains how a person can turn off biological pause or destroy the habit of using self-induced pause and replace it with a healthier habit.

A list of some possible symptoms from being stuck on pause

This short, incomplete alphabetical list shares just a few of the more common symptoms of being stuck in pause mode or in pseudo pause. Some of these symptoms might show up soon after starting to be on pause. Others might not manifest for decades. A person with many of these symptoms might *not* be stuck on pause or pseudo pause: the symptoms might have some other origin. To determine if symptoms are being caused by pause mode, do the exercises in Chapter 8: Diagnosing Pause Mode.

For further details about how a given symptom might manifest and the physiology behind it, please see Chapter 14 in *Recovery from Parkinson's*. The *Recovery* book is available for free download at www.pdRecovery.org. In that book, the symptoms are listed in the order of which channel qi pathology is at the root of the symptom. Here, symptoms are listed alphabetically.

Anxiety, circular thinking, "thoughts get caught in a loop"
Arm swing: inhibited, slowed, or swinging with elbows sticking out to the sides.
Blood pressure too low: "orthostatic hypotension"
Choking on "nothing," choking on saliva, painful choking while eating

Cold: Reynaud's syndrome in the extremities, cold skin on the cheeks
Crying: inability or difficulty in crying or sharing negative or deeply personal emotions.
Constipation that doesn't benefit from laxatives
Drooling, excess saliva
Eyelids: minimal or slow blinking or sagging of the lower lid
Facial expression decrease or loss
Finger numbness or weakness, especially in the index finger and thumb
Foot: cramps, grayish or bluish discoloration, foot drop, limpness in the foot
Forehead lines: overuse of the eyebrow and forehead muscles
Handwriting is small, cramped
Immobility: movement initiation is hard or requires powerful mental focus
Inner ankle tingling, itching, or burning
Insomnia
Itching skin for no apparent reason
Nausea tendency for "no reason"
Needle shock: extreme needle phobia, passing out from being needled
"Out of body" feeling
Pain: between the shoulder blades and spine while trying to sit up straight
biceps pain from rigidity
in the groin for "no reason"
in the legs from "woodenness," "buzzing," "emptiness," or "strange irritation"
in the lower back molars
anywhere in the body for "no reason" or that cannot be explained
Paranoia
Parkinson's disease
Postural hunching, head pulled forward
Proprioception problems – inability to know where a body part is if one is not looking at it
Restless leg syndrome
Roof of the mouth feels dropped into the mouth cavity
Seborrheal skin on the sides of the nose and/or cheeks
Sinusitis
Sleep apnea
Smell: loss of sense of smell *or* malodoria (everything smells bad)
Snoring: might be severe, maybe even with sleep apnea
Startle reflex is too strong: "hair trigger" reactions to sudden noises or being startled
Taste: loss of sense of taste
Throat spasms that seem to close off the airways
Teeth: lower back molars are easily cracked, have an absence or degeneration of roots
Toes: numbness, curling, fungus
Tremor in the fingers, hands, legs, or face
Turning over in bed is difficult due to muscle rigidity along the torso
Turning to the side while walking is difficult
Visualization inhibition
Voice inhibition, soft voice

Chapter two

Channel Theory and Case Studies

This chapter starts with an introduction to the "channels" of Chinese medical theory and then goes on to share three case studies of people whose channels showed that they were stuck in biological pause.

Channels

"Channels" is the name for the pathways of electrical currents that flow in all the connective tissue of the body. Channels are wide rivers of electrons. The rivers range in width from a fraction of an inch on the fingers and toes, to several inches wide on the torso and sides of the legs. The *exact* routing of individual electrons flowing in these rivers at any given moment are a reflection of the person's thoughts, mood, activities, diet, time of day, history of injuries, and a nearly infinite number of other factors. The non-neural (not related to nerves) electrical currents that flow in the connective tissue just under the skin are the underlying basis of Chinese medical theory. The moving electrons are called "channel qi" or "channel energy." The word Qi is pronounced chee.

The currents that flow in the *sub-dermal* (just under the skin) connective tissue (fascia), make up the main, or "Primary" and "Extraordinary" channels that are accessed and manipulated by various modalities of Chinese medicine such as acupuncture, moxa (smoldering mugwort), suction cups, and so on. These channels have names. The named currents are discussed in most acupuncture schools as if they always flow in specific, unchanging pathways. This is incorrect. The paths of the electrons making up the "channel energy" *constantly* vary. Their routes shift in immediate response to internal and external influences. The ever-fluctuating, shape-shifting electrical currents flowing in the connective tissue, and over all the organ and cell surfaces in the body, *direct* all the biological processes in the body, in very much the same way that the ever-changing flow of electron pathways through a computer chip determines what processes the computer will perform and what images the computer screen will manifest.

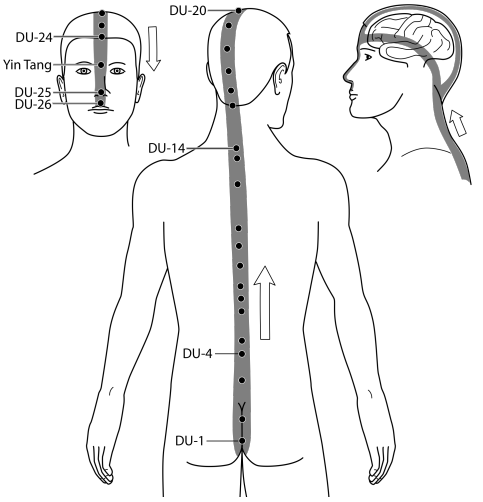
Channel variations in the four modes

Most of my students can easily feel the Channel qi flow in the sub-dermal fascia by the end of a one-semester, 2-hour a week course. Using hands to track the channels, it's obvious that the channel qi flow patterns are mode dependent. The flow patterns are distinctly different in each of the four modes: parasympathetic, sympathetic, sleep, and pause. The *amount* of current (amperage) flowing at any given location in the system varies according to thoughts and biological need at any given moment.

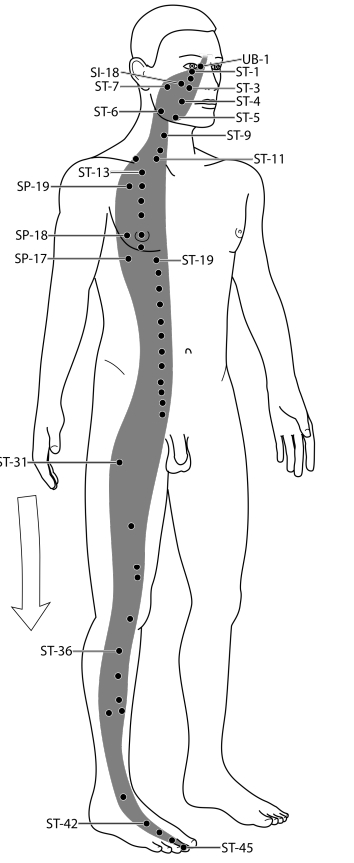
In *parasympathetic* mode, the channel qi flows *approximately* in the patterns shown in acupuncture textbooks. The more a person's channels run in the parasympathetic mode pathways, the healthier a person is, and the more likely the person is to heal easily from any physical or emotional traumas that might arise.

In *sympathetic*, "fight or flight" mode, a significant amount of channel qi is shunted away from the stomach and directed towards the heart and lungs. In this mode, in the Urinary Bladder channels, the *amount* of channel qi that flows down the back, stimulating the spinal nerves (nerves that activate fight or flight responses) *increases*.

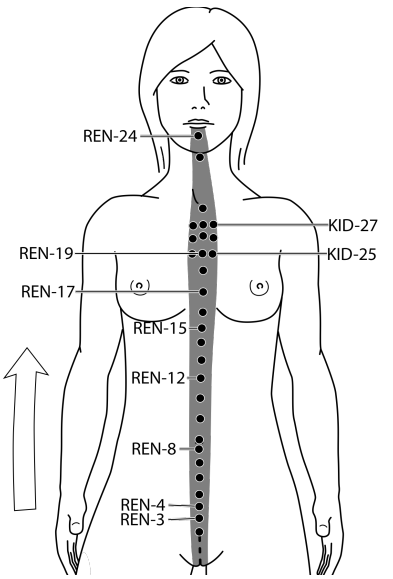
Other changes occur, as well, including shunts away from the tips of the fingers and toes. How *much* of a given current is shunted, increased, or decreased depends on the degree of sympathetic mode being called for.



The Du channel



The Stomach channel



The Ren Channel

Fig. 2.1 The drawings above show the *parasympathetic* flow patterns of three channels *and* the over-the-head sleep pattern of the Du channel. Larger, more detailed drawings are in Appendix III.

During *sleep* mode, the Du current, the current that runs through the midbrain during waking hours, is shunted away from the midbrain. Instead, it flows from the back of the neck to up-and-over the back and top of the skull, so that it cannot stimulate the frontal lobe. With the frontal lobe essentially turned off, a person's conscious mind drops away and sleep ensues. Other channel flow changes also occur during sleep mode.

Channels on pause

In *pause* mode, the currents make drastic changes away from parasympathetic mode flow patterns. In pause mode, the Du channel does *not* flow up into the neck and head, but moves in a back-and-forth manner from the sacrum (very low back) to the neck. In pause mode, the Stomach channel qi flows *backwards*. In pause mode, the Ren channel dives deep into the torso. In pause mode, the Urinary Bladder channel qi (See p. 47, Fig. 4.3) converts to electromagnetic wave form at the base of the neck and flows out of the body. In pause mode, other channel flow patterns are altered, as well. These changes can be felt by hand.

An aside about "meridians"

Some people have been taught to refer to the currents of channel energy as "meridians." The word meridians means "*imaginary* lines used to provide a template or grid for organizing information." The detectable-by-hand electrical currents running through the body's sub-dermal fascia are *not* imaginary. I personally do not use the word "meridian" to describe the very real, *not* imaginary electrical currents that flow just under the skin. [3]

The atheist Chinese government decided, more than half a century ago, that the concept of electrical energy moving under the skin *is* imaginary. The idea of "invisible energy" (electromagnetic forces and their associated electric currents) in the body was long associated with the religious teachings of Taoism – now forbidden. Since the government's anti-religion medical stance was taken, teaching medical channel theory in China is illegal. Most western schools of acupuncture and Chinese medicine have followed the Chinese government's atheist lead. They do *not* teach channel theory even though it is the underlying basis of all aspects of Chinese medicine. The electrical energy that flows in the channels was historically known as "channel Qi," "channel energy" or, in Chinese, *Qi Se*: literally, the energy of light waves and electromagnetic waves. For more information on this historical subject, please read my book, *Tracking the Dragon*.

Most western students of Chinese medicine, if their school offers a course in feeling the energy in the channels can, after a few weeks of training, start to feel, by hand, the channel flow patterns in a patient. Fixing aberrations in the flow of the channel energy is the ultimate goal of all Chinese medical modalities, from acupuncture and moxa to herbal formulas, Tui Na (hands-on bodywork) and Qi Gong (mentally-driven channel qi control).

However, because of the far-reaching effects of the Chinese government's atheist decree that channels are "an historical superstition," most acupuncture schools, even in the west, do not offer a course in applied channel theory. Instead, they teach a short course on the names and purported historical locations of the channels. The channel locations taught in schools of Chinese medicine are almost always incorrect in terms of where the channels

[3] Dan Bensky, a preeminent scholar of Chinese medicine, in his "Editor's Introduction to Chinese Medicine" writes, "The channels are regarded as three dimensional passageways through which the Qi [referring to the electrical currents called "channel qi"] and Blood [in this case, the molecular structures over which the currents flow: the connective tissue] flow…Therefore it is inappropriate to refer to the channels by using the two-dimensional term "meridian," as is common in English translations." From: *Acupuncture, a Comprehensive Text: Shanghai College of Traditional Medicine*; Eastland Press; 1981; p. 16.

actually are located in the body, but since the students learn no applications, the incorrect locations don't matter. Working with channels, detecting their flow patterns and using them to determine diagnoses and treatments are *not* required skills for licensing or for passing the board exams for acupuncturists. Hopefully, this will change someday.

For decades, some beginning acupuncturists have used small, hand-held devices to detect areas of high and low electrical resistance along the channels, to assist beginners in locating acupuncture points (locations of lowered electrical resistance just below the skin). As I write this, a new device that can actually track the flow of the sub-dermal, non-neural currents (the channels) is in the process of being patented. If/when this device becomes available to the public, I plan to put a notice about it on the website of the Parkinson's Recovery Project (www.pdRecovery.org) and on my own website (www.JaniceHadlock.com).

For an in-depth discussion of the channels, including how to feel them by hand and how to make a medical diagnosis based on aberrations in flow patterns of a body's electrical currents, please read *Tracking the Dragon*. The chapters of *Tracking the Dragon* that teach how to feel a patient's channel qi by hand are available for free download at www.pdRecovery.org, on the Publications page, along with maps of the channels. The hardcopy of the book can be purchased at JaniceHadlock.com.

For an introduction to the exciting new research in the field of bioelectricity that proves the existence of channels, please read the 2020 edition of *Recovery from Parkinson's*, p. 6, including the footnotes, available for free download at pdRecovery.org.

Case studies

These three case studies feature people who were stuck on *biological* pause.

Case study #1: The young soccer player

A male, 33 years old, came to my office because of 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* flow in the connective tissue just under the skin of the knee were, once again, not moving at all, except for one, which was flowing backwards. Because he hadn't had a new injury, the pain had resumed for "no reason," and most of the currents weren't flowing well in the vicinity of his knee, I decided to check the electrical currents that lead *into* the knee currents. Except for the one that was flowing backwards, all the leg currents were 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 verbally guided him through 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 seemed to be 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 taught in my book *Yin Tui Na*, chapters 5 and 6, 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 "outside" point of view increased my concern. The techniques he'd done, when 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 recent knee pain. I asked him if he had any other health issues going on.

He replied that he'd been suffering from an extremely painful, itchy rash over much of his body for nearly a year. 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 if he was trying to leave his body, 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. This is how the Du channel flows when a person is using even a moderate amount of parasympathetic mode. 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 *movement* of energy or any light in the area over his spine.

His imagined current in the skin just over 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 neck and head, let alone any energy moving through it. At that point, I changed my entire approach. I now suspected that he was stuck in pause mode. I asked, "Have you ever had a traumatic injury? Or a significant spine or head injury? In the last few months? The last year? Ever?"

He said no.

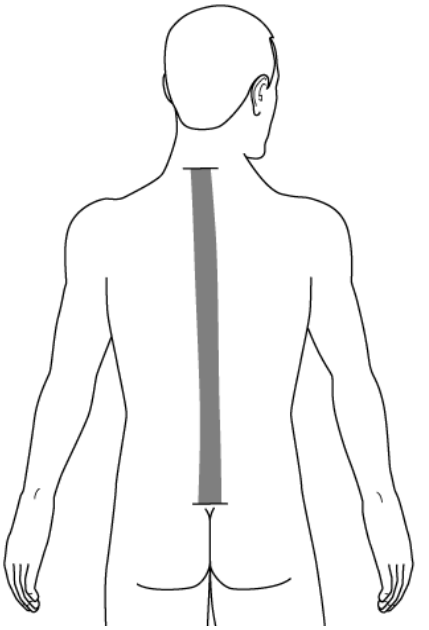


Fig. 2.2 The Du channel during pause mode. Note, there is no directional arrow. If there is any energy moving in the Du channel during pause, it is most often a standing wave, a back-and-forth oscillation. Compare this drawing with the map of the Du channel in *parasympathetic* mode on p. 12, Fig. 2.1.

People often don't remember injuries if the query is too general. 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 was still on pause from his childhood head injury!

I had him lie down. 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.[4]

Next, I led him through the five simple steps that most mammals, 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 life-threatening damage and after any imminent danger has passed.

My soccer patient at the fourth step

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 them.

Inhibition of these two reflexes is the norm in people who are on pause. If a person has been stuck on pause for an extended period (decades), his brain might 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 in steps 4 and 5, the head wobble and spinal shimmy, 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

As noted previously, the first step in coming out of pause is *acknowledging* that damage has been stabilized. This in turn starts a tremor to vibrate somewhere in the body. Often, the vibration is at the location of the trauma. Then again, with body-wide trauma, such as near-drowning or anaphylactic shock from an event such as being stung by a swarm of bees, the perception of post-trauma vibration might be located at the base of the spine, the neck, or brain.

[4] *Yin Tui Na: Hands-on Therapy for Traumatic Injury*, a book that teaches how to do Yin Tui Na, is available for free download at pdRecovery.org. It is also available for hard copy purchase at JaniceHadlock.com.

To acknowledge his soccer injury, I asked my patient to imagine he was looking inside his head at the place where he'd received the blow: at the impact point on the right side of his head. When he imagined he was looking at that area, it appeared dark. It was impossible for him to imagine filling it with light. Visualizing *light* in his head was *hard* for him. Visualizing *dark* inside his head at the area that had been injured was *easy*.

In order to determine if he was dissociated from the injury *or* if he was on pause – two very different biological processes – I asked him to imagine that he was looking inside that darkest part of his head and then tell me if the dark area was heavy, motionless, or hard to focus on *or* agitated and/or slightly tremoring.

If a person is *dissociated* from a body part and imagines that he is looking inside of himself at that part, the dissociated area is dark and motionless or seems to be missing altogether. Or it might be evasive: as soon as you stare at the dark area, the entire dark area might seem to shift a few inches up, down, left, or right, as if trying to avoid your gaze.

If a person is in *pause* mode and imagines he is looking inside himself at the dark and/or injured part, the dark/injured area appears to be agitated, tremoring, or restless in some way. Details on the appearance of "agitation" will be described in depth, later.

When I asked him what it looked like to his imagination, whether the head injury area was motionless, evasive, or missing altogether, or if it was tremoring or agitated, he replied, "That's easy. It actually *is* tremoring. I can see it."

This subtle internal agitation perceived in a visualized body part is actually a message from the *brain* (not the body part!) that the damage to the body part in question has stabilized: the physical damage, the *internal* damage, is no longer *life threatening*. The body is now stable enough to turn off pause mode and come back to life – as soon as the brain takes the next step and confirms that the *external* danger is also gone. The perceived agitation is a cue to scope out the perimeter to see if the *external* situation is now safe.

I had the patient imagine that he was gazing at the tremoring area, just calmly noticing it. This is still part of Step one: acknowledging the injury or trauma.

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 imagining that one is being comforted by someone or something such as a pet, a trusted character from fiction, a spiritual teacher, or a loving friend, standing-by just *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" satisfies the biological rule that the predator or external danger must be gone before turning off pause. Any imminent, life-threatening risk on the perimeter *must* be gone before the person is physically able to wobble his head and convincingly shiver his spine.

The patient had *not* consciously felt *un*safe prior to starting this exercise. However, just after he imagined that a beloved friend was standing next to him and observing the agitated area with him, he noticed, and mentioned to me, that he was feeling strangely comforted (safe). Then, 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. One of my patients who thirty years

earlier had a head-injury concussion that left her unconscious for three days needed to repeat the Five Steps twenty-two times before she suddenly snapped out of pause mode.

The fourth time my soccer-injury patient 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 had suddenly resumed somatic *feeling* awareness of being his height at age eleven.

Somatic sensations out of sync

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 might need some time to reconcile its somatic (sensations inside the body) sense of self from the time when it went into pause and became more or less numb, to the newly awakened, post-pause bodily sensations of the here and now. The mind will usually "fast forward" very quickly, reconnecting the somatic awareness with the *current* body. The time required for integrating the somatic awareness that existed just prior to going into pause mode with the new, current somatic awareness isn't too long, usually just a few hours, never longer than a few days, in my experience. In general, the more recent the trauma, 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'd seen people briefly behave like four year olds and even younger after recovering from long-term pause, so I wasn't too concerned about a person feeling like an eleven-year old. (The patient had been eleven at the time of injury.) Eleven year olds usually have the ability to be circumspect to some degree. So I decided he was safe to go home.I first 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!"

Yes! His new, "sparkly" perceptions indicated he was now in a significant degree of parasympathetic mode. By definition, this meant that he was no longer in biological pause mode. Parasympathetic mode is the neurological system used when a person is contented, playful, or curious. A person *cannot* be on biological pause and use a significant degree of parasympathetic mode at the same time. If my patient was suddenly seeing things as being "sparkly," that told me that his channels, especially the currents in

the brain, were now running predominantly in the circuitry patterns characteristic of parasympathetic mode.

As an aside, an exquisite enhancement of perception is normal when a person first comes out of pause and is temporarily in a very high degree of parasympathetic mode. During pause, sense perceptions are somewhat muted. When a person turns off pause and glides 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, with *none* of the channels moving in a manner characteristic of pause. Sympathetic mode ("fight or flight"), like pause mode, alters visual and auditory perceptions, but in a different way than pause mode. Most healthy people, when *awake*, are nearly always using a blend of parasympathetic and sympathetic modes: using sensory perception that blends uninhibited glory with somewhat narrowed perception and wariness.

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 and is still using a very *low* degree of sympathetic mode, his perceptions and his sense of being inherently connected to or resonant with things outside of himself, things such as nature and other people, are briefly enhanced and emotionally uplifting.

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

Returning 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: in the healthy blend of parasympathetic and sympathetic patterns. His knee pain was receding. A few days later, his red, bumpy, painfully itching skin, a problem that none of his six MDs could make sense of, began healing.

When I saw him again two months later, his channels were running correctly, the knee pain had not returned, and the long-term skin condition that had been "driving me crazy" was gone.

Case study #2: The patient with a perm

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

Her headaches began shortly after she slammed her head into the parallel bars on the schoolyard playground, when she was ten years old. She'd been swinging around the bar as fast as she could when she lost her grip and flew off. Her head bashed into the opposite bar before 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 still 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 down the spine. A moment later, a weird, very distinctive, caustic smell assaulted my nostrils. I was surprised, because her thick, 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. Then I went back to silently, supportively holding her head.

After a few minutes, she volunteered, "I just remembered when I got my last perm. It was the day before my head injury. School-picture day was coming up. 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.

Case study #3: Death of a spouse

A woman, age 87, was brought to my office by her daughter. The woman's husband had died a week earlier, after a long battle with renal cancer. The woman had been married to him since her early 20s. She was very meek and had always been utterly dependent on her husband for making even the smallest decisions. She was perfectly OK until, the day after his memorial, she suddenly became barely able to walk or move her body. When she did take small, shuffling steps, she was rigid and hunched forward. She needed help from her adult children to get up from a chair. Her facial expression was frozen in an uncharacteristic scowl. Her voice was faint. She was profoundly cold. Her arms and fingers tremored faintly, now and then. All these symptoms were new, and had started full-force the day after her husband's funeral/memorial.

She had gone into the state of near-immobility that MDs call "psychogenic parkinsonism." This diagnosis means, "There's nothing *really* wrong: the patient is just being overly emotional." The problem is condescendingly deemed psychogenic (purely

mental) because the onset can be fairly quick: within a few hours or within ten weeks of the actual traumatic event. Also, it usually goes away by itself, within a few days or a few years. Because Parkinson's disease (PD) is (wrongly) considered to be *incurable*, MDs assume that any patient whose PD-like symptoms clear up over time must not have had actual Parkinson's disease. Instead, they must have had something that *looks* similar to Parkinson's but was purely a mental imagining: they had "psychogenic parkinsonism."

In fact, people with psychogenic parkinsonism do have something physically wrong: their body is temporarily – and appropriately – using pause mode. The trauma might have been either emotional or physical. The patient felt, at the time of the trauma, as if life was impossible; death was imminent.

I checked her channels. They were flowing in the patterns typical of pause mode.

This patient had *not* told herself to feel no pain. She was *not* the strong, analytical, dynamic type of personality that can command himself or herself to feel no pain and thus end up using self-induced pause. Instead, her sense of loss and emptiness had been so profound that her pericardial signals had nearly shut down. This is a pre-death behavior. Accordingly, her body went into self-preservation mode: pause. It would stay there until she died *or* her pericardium started having enough amperage and sense of connectedness to others that pause could turn off.

I explained to my patient's daughter that she would come out of this immobilizing condition over time. Until then, the best thing to do would be to keep the patient warm and feed the patient rich foods: salmon, eggs, chocolate mousse, anything high in fats with lots of digestive staying power. Also, music can be a powerful aid for keeping the pericardium and striatum functional. I recommended uplifting music but nothing too stimulating: Strauss waltzes, Brahms, upbeat and simple folk music, or music from the patient's favorite light operas or musicals: music that might induce a person to sing along. Most of all, the daughter should regularly reassure her mother: "You're going to be OK. This is a temporary condition. You're going to be OK."

The patient snapped out of her rigidity and tremoring in just under two weeks.

Psychogenic parkinsonism

Doctors who give their patients a diagnosis of psychogenic parkinsonism are wrong about so many things. In the above case, her symptoms were *not* "all in her mind." Her symptoms were *real*. The electrical and biological processes of pause mode were driving her symptoms. The electrical, non-neural currents in her body were running as if she was on the verge of death. Her body was working to stay alive and stable while she was undergoing a genuine, near-death trauma.

If a person gets stuck on pause, isn't able to turn pause mode *off*, and eventually his norepinephrine (override neurotransmitter) levels begin to drop, exposing his underlying use of pause, the pause symptoms that begin to appear are called "idiopathic Parkinson's disease." Most cases of idiopathic Parkinson's disease, around 95%, are caused by self-induced pause: caused by thoughts. Doctors could therefore legitimately refer to this type of idiopathic PD as "psychogenic" Parkinson's.

If a person gets temporarily stuck on pause but is able to turn off pause within a few days or months, the doctor on the case will call it "psychogenic parkinsonism" and will probably think to himself, "It went away by itself. That means it was all in the patient's head: it wasn't *real*." The doctor is *wrong*, even though this smug attitude is

what he was taught in school. The short-term, temporary use of pause mode was real. The body's use of pause mode was healthy. It was keeping the person alive during a period of life-threatening trauma or stress.

I repeat: most people with idiopathic Parkinson's disease, around 95%, are using self-induced pause. This problem is at the root of their Parkinson's symptoms and it *is* thought-based. The only difference between people with idiopathic PD from self-induced pause (Type I Parkinson's disease) and people with "psychogenic parkinsonism" is that the people with the latter are mentally healthy enough to turn pause off when it is no longer needed. Most people with idiopathic PD are mentally unhealthy in the sense that they usually cannot resume a healthy "safe" mindset, the mindset that turns off pause when the trauma is over. In many cases, they do not *want* to turn off the pause mindset. They might imagine that their long-term wariness and carefully cultivated emotional numbness is keeping them smarter or safer. Or they might be *unaware* that they are subconsciously still confronting terrors or bitterness from their pasts. The brain *loves* to hang on to old thoughts. If a person is steadily solidifying the habit of using pause mode, even if he has no idea he is doing so, he might be developing pathological syndromes such as rigidity, tremor, severe constipation that doesn't respond to laxatives, frequent choking on saliva, and/or weak voice, without ever knowing why.

Maybe we should reverse the terms: people with idiopathic Parkinson's disease from self-induced pause mode should be referred to as having, in most cases, a psychogenic problem. People who have temporary symptoms of parkinsonism in response to a life-threatening physical or emotional trauma should be referred to as having a healthy response to trauma – a temporary, possibly life-saving shift into pause mode. If the patient has even a moderately healthy emotional relationship with his pericardium, his healthy use of *biological* pause mode in response to near-death trauma will cease when the pericardium and core physiological behaviors such as blood pressure and temperature regulation become stabilized.

Being stuck on pause is not rare

Many, many people with injuries that "fail to heal" or pathological syndromes of "no known cause" are stuck on pause. This "stuck" situation is *not* rare. What is rare is finding a doctor who knows what the problem is, how to diagnose it, and what to do about it. Happily, the do-it-yourself or do-it-with-a-friend therapies described in this book are, in almost all cases, all that is needed to turn off biological pause *or* to learn how to end the habit of using self-induced pause. Oppositely, treatments from medical professionals, including acupuncturists or counseling therapists will be, in nearly all cases, completely useless – or worse.

The type of pause in this chapter's three case studies is called "biological pause," to differentiate it from self-induced pause. Biological pause is usually set in motion by a physical or emotional trauma. It can be turned off, once the trauma or injury is addressed and the body is stabilized, by going through the Five Steps.

The next chapter will delve into the subject of *self-induced* pause. Self-induced pause has the exact same channel behaviors and presenting symptoms as biological pause, but it is initially triggered by a mental command such as "Feel no pain!" or "I refuse to be a part of this world!" Its use becomes habitual. It cannot be turned off by using the Five Steps.

"I always remember this truth when I mentally try to find a way to escape from some thing that seems too hard for me. I think then: "I am escaping, not overcoming."

– Sri Gyanamata (1869-1951)

Chapter three

Self-Induced Pause

Sometimes, pause mode is triggered in response to a powerful, highly focused mental instruction, not a biological situation. The mental instruction is usually something along the lines of "I refuse to feel any more pain," "I don't want to feel physical or emotional pain," or "I don't want to be a part of this world" or "…be a part of this life." The brain interprets these instructions as "Do not *feel*." This type of pause mode is called self-induced pause.

In pause mode, some types of pain, including certain types of emotional pain, are inhibited, either mildly or strongly. Again: in pause mode, *some* types of pain do not register. If a person of strong mental focus and will power gives the above types of instruction to himself, his brain might comply by invoking a set of brain behaviors and channel qi behaviors that are *very* similar to those of pause mode. If a person gives himself a powerful instruction to not feel either physical or emotional pain, or not be a part of the world, or anything that fits in with the body's and mind's behaviors during pause mode, the brain might shift into behaviors highly similar to pause mode – and might even stay there. Or if the self-induced pause *does* turn off by itself in a moment of feeling safe, the person might induce pause mode again, at the next hint of upcoming pain. A habit of using self-induced pause might gradually become the dominant behavior.

Redundancy

In *self-induced* pause, energy flow in the channels is altered just as it is during the use of *biological* pause mode. In self-induced pause, neurological shifts such as dopamine inhibition for motor function and/or feeling as if one is *outside* of his own body, and other symptoms of being on pause can manifest in exactly the same way as symptoms of *biological* pause mode. But self-induced pause mode does *not* turn off the same way as biological pause. Many of my in-person patients could not absorb this fact. Many *readers* also seem to miss this important distinction. I get frequent emails from people with Parkinson's: "I'm doing the Five Steps to turn off pause and it's just not working."

Most people with Parkinson's, around ninety-five percent, are stuck on self-induced pause. About one percent of people with PD are stuck on biological pause. The small percent remaining are *psychologically* dissociated from an injury and have pseudo pause. The inability to heal from an injury due to *dissociation* can sometimes cause the body's channels to flow in aberrant patterns, even flowing in patterns similar to those of pause mode. When this occurs, the condition can be referred to as "pseudo pause." Pseudo pause is the trigger behind Type II PD and Type III PD. (See *Recovery from Parkinson's*, Chapter one.)

Nearly all of the Parkinson's patients I've worked or corresponded with are dealing with Type I PD from self-induced pause. My books that touch on the subject of Parkinson's repeatedly explain that the Five Steps will *not* work to turn off self-induced

pause. Nevertheless, I receive frequent emails steeped in frustration from people who keep going through the Five Steps and none of their symptoms change. Perhaps they prefer to think that they have the extremely uncommon Type IV PD. I've had patients tell me flat out that they are willing to believe in my theories but only so long as they themselves do not have self-induced pause. They often said something to the effect that they would be ashamed of themselves if they have used their minds to find shelter from what was, at the time, an un-livable situation. [5]

There is no shame in having retreated from pain by using mental instructions.

Early on in my research, I had a correspondent with Parkinson's disease who was a highly respected psychotherapist. He refused to believe that he, of all people, might have a self-induced mental behavior of which he'd been unaware. He wrote to me using the strongest possible language that my theories made perfect sense from a psychological and electrical basis but that there was no way in the world he could support my work if I was suggesting that *he* had what he called "a psychological aberration." He would rather live with "no-fault Parkinson's," *incurable* Parkinson's with no known cause, than *recover* from a psychological condition that he had unknowingly triggered in himself. I came to learn, over the years, that this attitude is not uncommon.

Ending the habit of self-induced pause

In the book *Recovery from Parkinson's*, I often use the term "turning off pause," as if the processes for ending biological pause and self-induced pause are the same. That book was mainly about the generalities of Parkinson's. *This* book is about the fine lines between the two kinds of pause. In *this* book, I refer to "turning off" biological pause and "ending the habit of using" self-induced pause: two very different processes.

As noted earlier, the body is *designed* to turn off biological pause as soon as possible following an episode of near-death. Not so, the *habit* of using self-induced pause. In cases of self-induced pause, the pause-like channel behaviors usually do not turn off unless a person creates a shift back to the "safe" electrical position of the currents flowing in the midbrain. In using the Five Steps while trying to end the habit of using *self-induced* pause, the person's brain is not able to complete step 2: confirm that you are safe.

It seems as if, because the person has commanded himself not to *feel*, he cannot *feel* safe. That's why a very specific process, different from the Five Steps, is required for turning off self-induced pause. The process includes doing mental techniques that alter the electrical behavior in the midbrain. When the striatum, a part of the midbrain, is sufficiently activated, the person will *feel* inherently safe in spite of his previous

[5] Throughout this book, "a person with Parkinson's disease" refers to a person who has idiopathic Parkinson's disease who is ***not*** taking antiparkinson's medications. I am *not* referring to medicated patients or people with drug- or toxin-induced parkinsonism. The dopamine-enhancing antiparkinson's drugs can cause brain damage that leads to drug-induced parkinsonism. Some symptoms of this syndrome superficially resemble some of the symptoms of Parkinson's disease, but brain damage that causes drug-induced parkinsonism has nothing in common with the underlying causes of idiopathic Parkinson's disease. Many recreational drugs, and especially the synthetic opioids, can cause brain damage that leads to drug-induced parkinsonism. One famous example is Michael J. Fox, who does *not* have idiopathic Parkinson's disease. He explains in his autobiographical book that his Parkinson's-like symptoms began within days after he "partied" using brain-damaging synthetic opioids.

instruction to be numb to pain. By forcing the brain to behave neurologically as it does when one *feels* safe, one can turn off the long-forgotten mental instruction to *feel* nothing.

After the first few moments of creating "I'm safe" currents in the brain, a person might feel a lightening of the body, as if he weighs less, is "lighter." His limbs might move more easily, and he might have a wide smile on his face. However, this won't necessarily last very long.

The "I'm safe" mental behavior must be continually *practiced* in order to form a new brain habit, one that can eventually be used to replace the habit of using self-induced pause. When specific brain techniques are used to destroy the pause habit and replace it with a healthy habit, the use of self-induced pause can come to an end.

The "I'm safe" mental state activates the brain's channel qi patterns of parasympathetic mode – a mode in which a person primarily *feels* his life experiences rather than *analyzing* them. When a person shifts into this state of somatically feeling, rather than mentally *assessing* himself, and realizes that he *feels* safe, then the second of the Five Steps can be successfully completed: the person *feels* safe; he is not at risk of imminent death; his world, in general, is a safe enough place to live in, once again. This feeling of safety has nothing to do with physical, actual "safety," per se. It is purely a somatic feeling. After a person *feels* safe, then the last three Steps, which turn parasympathetic and sympathetic mode back on, usually follow automatically, with no further assistance. In people with a habit of using self-induced pause who manage to turn it off by feeling uncharacteristically safe, this un-paused condition might last several minutes or a couple of days.

But as soon as the person has one of his habitually negative or safety-analyzing thoughts, his brain will go back to using the previous, *habitual* brain currents: the ones that activate self-induced pause. The electrical currents in the brain will always follow the path of least resistance: the most familiar paths. This tendency to use the more established brain pathways doesn't mean a person is lazy or "bad." Currents flowing in the path of least electrical resistance is just a basic law of physics. This is why the pause habit has to be *destroyed* and a new habit installed, if a person wants to stop habitually using pause.

Feeling safe: an electrical configuration

Most of my patients who had Parkinson's really struggled to understand that *feeling* safe is not based on analytical assessment of one's situation. When a person is stuck on pause, he tends to think in terms of risk assessment. When he's been stuck for years or decades, he might not even remember a time when he understood that feeling safe is a *sensation*. Feeling safe leads to a sensation of being physically lighter, as if experiencing a decrease in physical density, and also, a sense of expansion in the chest. This sensation occurs as the amperage in the pericardium increases. This sensation is accompanied by the awareness of feeling calm and joyful.

Many of my Parkinson's patients have been so unaccustomed to somatic awareness that, when I casually asked, "How are you feeling?" they have often replied, "How should I know?" or something along those lines.

An experiment in feeling

One PD patient in his mid-fifties who was using self-induced pause, when trying to imagine his heart filled with light could only see it covered in little signs saying, "Keep out." This type of visualization is not uncommon in people with Parkinson's. Some also

see little signs inside their brain saying things like "Keep out," if they try to do visualizations that introduce light or positive feelings into the brain area. This patient with "Keep out!" signs on his visualized heart told me that negative emotional feelings were bad, and that the whole point of being an adult was not feeling negative emotions.

As an experiment, with his and his attending wife's permission, I did a Yin Tui Na session on his foot injury and kept up a mild stream of banter the entire time. I inserted the word "feeling" into every sentence. For example, "The air feels humid today; I'm feeling like we might get rain." And "Driving up my driveway feels so bumpy. It feels to me as if my driveway might need repairing." *Every* sentence in my rambling monologue had the word "feeling" in it.

At the end of the one-hour session, during which he'd been awake with a puzzled look on his face and I'd been working on his foot injury, he had no idea that he'd had a treatment. When I told him, "Session's over, time to sit up and get your shoes on," he just stared at me. Then he stared at his wife, who had been laughing out loud for most of the session. "Aren't you going to work on my old foot injury?" he asked, deeply puzzled. They told me later that he was profoundly confused for several hours after the treatment. Ordinarily, his memory was extremely sharp. But he had no memory of the treatment session, from the time I first sat down and started using sentences with the word "feeling" in them.

Because of the profound inability of so many of my patients to understand how healthy people are aware of how they feel, or even what the word "feeling" means when it comes to somatic feeling or "*feeling* safe," I'm offering the following.

Daniel in the lions den

A scriptural example of *feeling* safe is Daniel in the lion's den. According to the Jewish scriptures (Christian Old Testament, Daniel 6:22,), Daniel was *not* physically safe: he'd been thrown into the lion's den. *Logically* thinking, death was imminent. However, because he was keeping his focus on the Divine ("blameless", as it says in scripture), his brain circuitry allowed him to *feel* somatically safe. The Chinese medical scriptures refer to parasympathetic mode as "Close to the Divine." As Daniel's body emanated frequencies characteristic of an extreme degree of parasympathetic mode, the lion was unable to recognize Daniel as potential prey.[6]

[6] In a side note that's more applicable than it might seem at first glance, researchers at Yellowstone National Park discovered that wolf pack attacks on members of elk herds were not random or based on obvious weakness in the victim elk (small stature, youth, or old age). Rather, the wolves singled out their intended victim based on the circling of a flock of scavenger birds. First, the birds select a target animal. The wolves follow the lead of the birds and bring down the selected elk. Subsequent analysis of the dead elk by research biologists showed that the elk taken down in a bird-led wolf attack always had some significant infection, tumors, or other internal weakness, to a much higher degree than was normal compared to the other herd members. These weaknesses were not necessarily obvious to the eye. To start the process, the birds would follow the elk herd. They were evidently able to sense if an animal was in poor health – *not* in parasympathetic mode – despite its *appearance* of normalcy.

According to Chinese medical theory, this assessment would use electromagnetic wave information (channel qi information) being projected by the sick animal. In Chinese medicine, this assessment of wave signals is not considered some mystical or bizarre power on the part of the

I haven't personally been confronted by lions. I did have an experience altering the behavior of a dangerous dog. I was out on my morning amble, enjoying the stillness of the dawn. As I passed within a few inches of a parked camper-truck, a deep-throated, terrifying snarl and barking broke the quiet. I jumped several feet and screamed. The dog kept barking. For several minutes, the camper kept shaking violently.

My heart was pounding for the next two blocks. On my way back, I had to go past the truck again. I was about to cross to the other side of the street to avoid startling the

---

birds. The birds, just like so many other animals and some humans, including the more proficient doctors of Chinese medicine, are able to detect the irregular, "wobbly" frequencies of an animal that is in poor health. Myself, after having practiced the stillness of deep meditation for decades, when I first meet a patient, I can't help but notice from across the room if there are strongly aberrant frequencies coming from the patient. These aberrant signals are associated with possibly invisible but nevertheless significant physical or mental health problems...or pre-problems.

After the birds have selected a weak elk, most likely based on the irregular, *non-parasympathetic* mode signals being broadcast by the sickest animal in the herd, they fly to the nearest wolf pack and give the "come hither" signal. The wolves follow the birds and bring down the elk that the birds have selected. This shared hunting behavior is advantageous to all three groups: the wolves, the birds, and the elk. The wolves have easier hunting, the birds scavenge the elk after the wolves have feasted, and the elk herd is culled, conserving scarce food for the healthier members of the herd.

This is just to point out that a healthy body that is in a high degree of parasympathetic mode generates different electromagnetic signals compared to those of a body that is fearful, sick, or stuck in pause mode. In humans, a part of the healthy, parasympathetic electromagnetic pattern is a specific brain current that's part of the Du channel. When active, this current allows a person to feel existentially safe. This feeling has nothing to do with actual physical safety, per se. Until actual danger impends, most healthy animals are in a moderate degree of parasympathetic mode much of the time. Daniel was in an exalted, very high degree of parasympathetic mode. His electromagnetic fields were projecting that he was *not* prey.

The philosopher Thomas Hobbes had it wrong when he wrote: "[In nature there are] no arts, no letters, no society, and worst of all continual fear and danger of violent death." Thomas Hobbes was basing his assumptions on man, not animals in nature, when he inked those words. Only man can make the choice to *keep* his mind focused on fear and constantly embrace the theoretical *possibility* of imminent death: death in the next few minutes. An animal in the wild that becomes *stuck* on pause following a trauma will usually refuse food and soon die. In wildlife rescue programs, rescuers are increasingly aware that an injured animal *must* go through the steps that turn off pause mode before being released back into the wild.

Dr. Peter Levine, a pioneer in trauma recovery work, was talking with a Andrew Bwanali, park biologist of the Mzuzu Environmental Center in Malawi, Central Africa, explaining the behaviors that turn off pause: the "…spontaneous shaking, trembling, and deep breathing" that his human patients exhibit 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.' (From *In an Unspoken Voice*; Dr. Peter Levine; North Atlantic Books; 2021; pp 15, 16.) Wild animals will die if they become stuck on pause and cannot fully embrace life. Man alone might willfully induce changes in his psyche that cause him to spend his whole life as if stuck on pause, going through the motions of life while stuck between this world and the next: in a perpetual state of pre-death.

dog. I changed my mind. I imagined an image of Divine Mother centered in my heart. I imagined her, and felt her, projecting waves of beautiful light towards the dog. I started silently singing an inspirational song. I felt profoundly safe and loved. I projected those feelings of safety, imagining that they were radio waves being sent from my heart to the dog's. I got within twenty feet of the camper when I heard the dog. He was whimpering softly, as if asking me to pet him! I continued my visualizations and came as close to the camper as I could, without slowing my stride. It seemed as if his muzzle must be pressing up against the side of the camper closest to me. The dog's loving whimpering increased in volume as I walked past. I felt, yes, I *felt*, in my heart, waves of love washing over me from the dog.

Most of my patients with Parkinson's would not be able to relate to much of the above vignette, because it is based on the dog and me first *feeling* unsafe, and then mutually *feeling* safe. In our first encounter, I illogically felt unsafe even though the dog could not get out of the camper. Obviously, the dog had also felt threatened. In the second encounter, both the dog and I felt safe even though *nothing* had physically changed. The only change was that I was projecting outwardly the *feeling* of being safe. Of course, I wasn't in a lion's den. Even so, this brief interchange with a dog helps me better understand how Daniel, by staying focused on his love for God, might have made himself safe from the lion.

Stories abound of saints who are unharmed by, who even play with, animals that are usually considered highly dangerous. This is because those saints *feel safe*. Their *feeling* of safety has *nothing* to do with any *logical* assessment of the odds for physical safety in a given situation.

Feeling safe enough to stop using pause, for a short time

After a person on self-induced pause makes his brain currents run powerfully enough in the parasympathetic patterns that confirm safety, using a technique involving an invisible friend standing nearby, the last three steps for turning off pause mode might kick in automatically. Depending on how long ago pause mode was self-induced and with how much intensity the person commanded himself to *not* feel, he might be able to learn to feel safe and override/replace the habit of using self-induced pause in a matter of minutes or, more likely, over a few years.

If the self-induced pause habit was used for decades, it might have become deeply entrenched. If so, then even after turning off self-induced pause for the first time, the person might find himself reverting into self-induced pause mode again in response to even a *mild* emotional or physical upset: if the phone rings, or if someone knocks on the door. If this is the case, the person might need to turn off self-induced pause repeatedly over a few months or years, until he starts solidifying the new habit of feeling safe. When that habit can be invoked on command, he can destroy the pause habit and replace it with the new healthy habit.

Sympathetic mode: fight or flight

In addition to addressing the pause habit, a person might *also* need to retrain himself to automatically, *correctly*, use *sympathetic* mode in unnerving situations instead of lurching into the mode of pre-death at the slightest uneasiness.

The healthy way to deal with fear, rage, anxiety and/or many types of stress or unhappiness is to activate an increase in the amount of sympathetic mode. *Not* pause

mode. Sympathetic mode. Pause mode should *not* be used to deal with the unpleasant trials of daily life. Pause is a last-ditch, desperate, pre-death mode that makes the body somewhat numb and causes the consciousness to exit the body. Pause mode should only be triggered if on the verge of imminent death from physical trauma or when the pain of life is so severe as to potentially cause death. Chapter 14 teaches how to re-learn how to trigger sympathetic mode, for those who have forgotten how.

The three case studies in this chapter share examples of people recovering after having been stuck in self-induced pause. To understand what happened in these case studies, it is first necessary to introduce the concept of a duologue, a two-way conversation, with an "invisible friend."

The invisible friend

In the previous chapter, in the first case study, you will recall that I asked the patient to imagine that a loved one was standing by, to provide a feeling of being in a "safe place." The loved one was what I call an invisible friend. People can make use of an invisible friend to help themselves feel safe enough to turn off pause or even to help themselves diagnose the source of a health problem. In people who are stuck on pause, an invisible friend can help them determine whether or not they are stuck on biological or self-induced pause. This subject is so important for recovering from Type I Parkinson's that three chapters of this book, chapters five, six, and seven, are dedicated to this subject, and include the recent scientific research regarding the therapeutic use of an invisible friend, referred to in the field of psychology as a parasocial relationship. Here, the next few paragraphs provide an introduction to the subject.

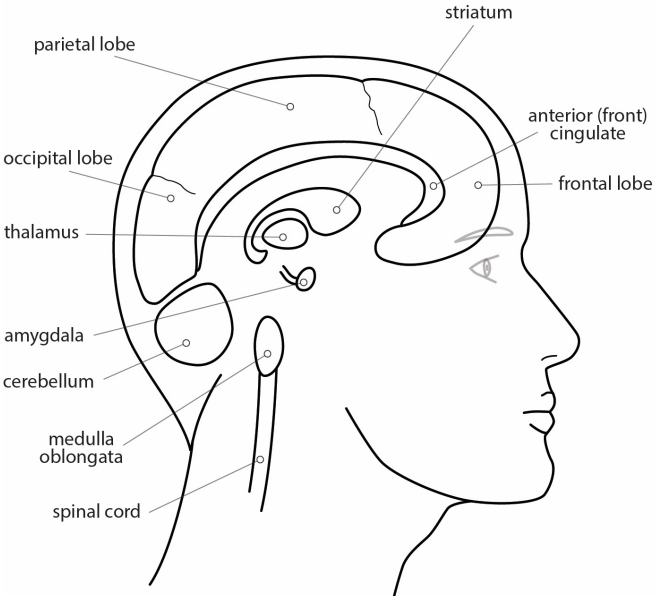


Fig. 3.1 A few brain areas

The best way to turn off the wariness-based, internal-monologue habit that occurs in people using self-induced pause is simple: stop talking to oneself in a monologue and instead, replace that habit with a constant, biologically healthy, silent duologue with an invisible friend.

Brain research shows that having a silent conversation with someone loving and trusted, or even *thinking* about communicating with someone or something who is loving and trusted, stimulates activity in the striatum – a brain area that is electrically inhibited in people on either type of pause.

This might sound preposterously simple – *too* simple. But it can actually be quite difficult to do, for a person who is entrenched in the monologue habit. Developing the duologue habit might be a real challenge: the on-pause brain might resist change to the pernicious monologue habit and put up a powerful fight.

The unhealthy monologue typical of pause mode can create and sustain attitudes ranging from heightened alertness to overwhelming paranoia. In a spiraling worsening, these attitudes can sustain and strengthen the habit of using self-induced pause.

Again, this monologue habit can most quickly be conquered by consciously replacing the silent monologue with a silent *duologue*: an almost-constant mental conversation with a loved, trusted, and invisible someone.

The mental shift towards a silent *duo*logue with what I call an invisible friend *and* the electrical flow changes that accompany this shift stimulate the very middle part of the brain: the striatum and thalamus, also known as the "feel good" areas of the brain. The stimulation of the striatum created by talking to a beloved invisible friend and always having the invisible friend close to hand can lead, quickly or eventually, to the release of dopamine for motor function.

This dopamine release then creates the *feeling* of being inherently safe. The feeling of being inherently safe, even if invoked via conscious stimulation of the striatum via an invisible friend, satisfies the second of the Five Steps for turning off the pause mode circuitry – even in cases of self-induced pause mode.

In self-induced pause, there might not be any injury that needs to be assessed and pronounced safe. Instead, the center of the brain must start behaving as if the situation *is* already safe. Again, talking almost constantly with an invisible friend can eventually cause the brain to activate the striatum enough that it releases dopamine for mood and motor function. This makes a person *feel* safe. This leads to further dopamine release, which leads to an even greater feeling of safety. This feel-safe, dopamine-releasing spiral might take minutes or months to build up enough so that pause mode circuitry turns off, or it might take a few years. How long it takes to build up enough stimulation in the striatum can depend on how attached and habituated a person has become to using the anxious, bitter, and/or emotionally detached risk-assessing internal monologue. The assessment monologue is *supposed* to happen when a person shifts into biological pause mode for the *short* term. As *soon* as the brain determines that the coast is clear, the monologue should stop. The "I am safe" refrain again becomes dominant in the brain. But in people using *self-induced* pause as their *default* behavior, the assessment monologue doesn't stop. It becomes a life-style.

When a person is *not* on pause mode, a constant, intimate, loving mental duologue with some trusted confidant is normal and healthy. This type of mental behavior is quite common, especially in people who tend to feel inherently safe, at peace and who tend to live in a relatively high degree of parasympathetic mode. Also, as all major world faiths attest, in order to feel the soul-joy that is our birthright, we can and should be *always* communicating with the Divine or some representative of Unconditional Love.

Oppositely, many people with Parkinson's disease, including religious professionals, have assured me that "Only a crazy person imagines talking to someone who's not there!" Many people, especially if they are stuck on *self-induced* pause, choke on the idea of talking to what they invariably refer to as an "imaginary" friend. If *you* are struggling to take seriously the idea of an invisible friend, jump ahead to chapters five and

six, where the hard science, the modern physiological and psychological brain scan research on this subject, is discussed in depth.

If you're curious, and many people have been, self-induced is the type of pause mode I was using in the decades that my body was silently developing subtle signs of Parkinson's disease. Although the symptoms were not obvious enough to merit a diagnosis of Parkinson's until I was in my late forties, all the pause-based mental habits were present since my childhood years and growing stronger daily. I was talked to my deceased guru when I suddenly recovered.

Case study #4: Talking to Grandma

A patient with all the symptoms of early Parkinson's disease and with channels clearly running in the patterns of pause mode was in my office for our first meeting. He was having increasing rigidity in his legs, scuffing his feet when he walked, increasingly carrying his arms crooked at the elbow and his head bent forward, losing his facial expression, and recently having a faint, off-and-on tremor in his left-side fingers. He was in his late twenties and was still able to override all these symptoms when he focused on them: typical of early stage PD. I started to explain why it was biologically important to turn off the inner monologue, a monologue characteristic of self-induced pause, and replace it with a duologue with an invisible someone or something.

Up until this moment, in my decades of working with Parkinson's patients, my patients *always* wanted to use their office-visit time with me to argue with me about their need to change anything in their mental behavior or their capability for doing so. Either that or they would ask a seemingly infinite number of questions about *how* one can go about talking to something invisible and benevolent, or *who* they should talk to, as if these were crucial questions for making "the right choice" for an invisible friend. Instead, shocking me to my core, this patient asked, "Can I talk to my late grandmother? She passed away recently."

I replied yes. He shut his eyes and completely ignored me. I could tell he was deep in silent conversation with someone. I was amazed. I had told patients to do this very thing so, *so* many times, but not *one* of them had ever been willing to do so in my office.

After just a few minutes, with his eyes still closed, he gasped. His head wobbled slightly, and a visible shiver ran down his spine several times. Still he sat there, eyes closed, ignoring me.

I was so excited. For the first time in my decades of research, a patient in my office had actually done what I suggested instead of arguing with me that he shouldn't have to turn his negative internal monologue into a duologue, or that he didn't know how to and so wasn't going to. We both sat there in silence for what seemed like a long time: maybe five or ten minutes. He opened his eyes. "I feel so different." He looked different. He was smiling gently.

He had not yet read the chapters on recovery symptoms in *Recovery from Parkinson's*. So, before he talked to his late grandmother, I had given him a quick verbal run-down of some of the recovery symptoms that might occur in the months following turning off the habit of using pause. After his conversation with his grandmother, as we sat there, talking about how he felt about the conversation, his facial muscles started to spasm. The facial muscles were suddenly receiving a normal load of energy after years of

being highly inhibited. “Powerful facial spasms in a previously expressionless face” was one of the recovery symptoms I had warned him about.

He stopped in mid-sentence. “Did you see that?!” he blurted.

“Yes. That’s a recovery symptom: it’s the facial spasms I mentioned earlier.”

“No way! I heard what you said but I didn’t believe *I* would actually have those things! Are *all* those things are going to happen to *me*?”

I just laughed. Then I reminded him that he was going to feel exhausted for the next few days or weeks, and asked him to read, as soon as possible, the chapters on recovery symptoms in the book *Recovery from Parkinson’s*. And I told him to talk to his grandmother as often as possible – which he said he would be very happy to do.

This session took place many years ago. He’s had no more sessions with me. I still check in with him once a year. He’s doing great and is completely symptom free.

At the end of our first and only session, during which time I performed no physical treatment, but only warned him about recovery symptoms and asked him to talk with an invisible friend, he suddenly remembered when he had told himself to “not be a part of this horrible world.” He had been six years old at the time and the butt of schoolyard harassment after his best friend blabbed to all their classmates about his (my patient’s) single mother’s poverty: they were living in her car, parked in the best friend’s driveway. His shame and feeling of betrayal by his best friend had been excruciating.

As an aside, this patient had assumed, when he first learned of my theories, that he had put himself into pause at age five when his father abandoned both him and his mother. He was not able to remember the *real* cause, the shame of being ridiculed in school and the agony of betrayal by his best friend, until after he recovered. Most people, in my experience, mentally *dissociate* from whatever it was that caused them to first self-induce pause and *cannot* access the information until pause is *lastingly* terminated. If you are stuck on self-induced pause, please don’t waste time trying to figure out what caused you to activate this form of self-defense. You might not be able to access information that’s hidden in your brain until *after* you are safe and the pause habit has been permanently conquered.

As an aside, one of the more common reasons that people think they have Parkinson’s is their appendicitis surgery. Intestinal troubles, including appendicitis, are very common in people with Parkinson’s. This is because the peristalsis of the gut does not work very well when the digestion is nearly shut down, as it can be when on pause and/or when the Stomach channel is chronically running backwards. Many people who end up with Parkinson’s disease have had their appendices removed due to blockages in the appendix due to being on pause. However, this is a *side effect* of being on pause for years. It is *not* the cause of being on pause mode.

I do recommend that the scars from an appendectory be acupunctured according to the instructions for scar needling in my book *Tracking the Dragon*. The chapters on this subject are available for free download at www.pdRecovery.org. Even if the surgery was laparoscopic so that the scarring is very small, it can be extremely helpful to needle these scars. Needling these scars can stimulate the deeper, invisible damage from the surgery to begin healing.

Case study #5: Yelling at God

This patient had advanced Parkinson's disease. She was in her early 60s. She was mostly bed-ridden. She'd been working on trying to recover for several years, but her symptoms continued to worsen. One morning, while the rest of the household was out for the day, she started having a very painful headache. Headache had *never* been one of her symptoms. It struck her that this new symptom, coming on top of her immobility, rigidity, slowness, and tremor, was the last indignity. As the headache worsened, she started to think that the end was nigh: she was going to die. She began to panic.

She doesn't know how it happened, but she found herself standing up, yelling at God at the top of her lungs, and repeating, among other statements of great bluntness and honesty, "I DO want to live; I DO want to live!"

In her earlier years, she'd had decades of experience "relating" to God. She had made spiritual pilgrimages and stayed in ashrams in India. She had followed spiritual paths in which she had dutifully, respectfully, perfunctorily "talked to God" and "practiced the presence of God." But she'd never talked to him like this. This time, she was yelling at Him, truly talking to Him from her heart, holding back nothing about her honest feelings about the whole damned Parkinson's thing. She was upset with Him and let Him know it. She yelled at Him as if He were right there in the room. She kept this up for a long time. Unlike her decades of experience in methodically talking to God, this time, suddenly, due to her new level of desperation, causing increased intimacy and honesty with God, she could tell that He was right there in the room and He was *listening*.

Immediately after she started to calm down she realized, to her horror, that her symptoms of Parkinson's were changing: waning. This feeling of alarm is not uncommon. The person feels deeply altered, and isn't sure what the future holds. But although apprehensive, she nevertheless felt strangely safe. Loved. Certain that God was *still* there, listening. She suddenly had a realization that God had always been right there with her, protecting her, loving her, listening to her. A *deep* peace came over her. She knew immediately that whatever had sustained the Parkinson's symptoms had turned off, even though her body still had a vast amount of recovery work to do. Over the next few hours, the rigidity in particular started to ease up. Her tremor seemed to be less intense.

Some days later, when she realized that her tremor was steadily diminishing, she immediately implored God, who was still palpably there and still listening, to let her have tremor again in one finger any time she ever again forgot that she was safe. After all, God was taking care of her and always had been: she *was* inherently, existentially safe. Years later, after not having any of the other symptoms of Parkinson's for many years, *if* she starts to worry about something over which she has no control, such as the choices and behaviors of her adult children, her left little finger will gently tremor. She will notice it and smile, and change the direction of her thoughts. Her friend, the finger tremor, will immediately stop.

I met her several years after she'd "had it out with God." She shared her story with me. I had already heard it from her Yin Tui Na therapist who had done work on her foot injury, but it was good to hear it from the source. I didn't write down her words at the time, but she told me something along the lines of, "I never knew that I had told Him that I didn't want to live. I had no such thoughts in my head. So I don't know why I found myself yelling to Him that I *did* want to live. Maybe I had that thought a long time before

and didn't remember it." And then she laughed with *unself-conscious* joy – something she could not have done during her decades of using self-induced pause.

"Epiphany" recoveries

The two preceding case studies are examples of what I call the "epiphany" route to recovery. An epiphany is an "aha moment," an "eye-opening" experience. This route features an abrupt, *lasting* change in a person's ability to feel connected to love, and the concomitant feelings of safety. In my experience, *most* people working to overcome the habit of using self-induced pause mode did not have an abrupt epiphany. Instead, most of my patients have taken the slow route. They would have *liked* to have an abrupt epiphany but it never happened. Instead, they *gradually* overcome their habit of using self-induced pause mode. In the slow route to recovery, the progress is usually uneven. It can feel like two steps forward, one step back. It might take years to fully recover from the habit of using self-induced pause.

Many of my patients have told me that they spent the first year or two of trying to recover telling themselves that they were *never* going to be able to talk with "an imaginary nothing." They were certain they could *never* even try to pretend to have a conversation with an invisible friend. They didn't work at cultivating this relationship until their worsening symptoms made them desperate. Those who immediately or eventually learned to silently converse with a friend found their minds, their moods, and their movement slowly but definitely improving, even though they continued to relapse into the *previous, full-blown severity* of their old pause symptoms when reverting to negative thoughts. It often took my patients several years to conquer the habit of using pause.

An example of epiphany recovery from nicotine addiction

Most of us have known people who have tried to quit smoking. Some try reducing by one cigarette per day, or per week. Others might use a nicotine patch. Still others chew gum, finger "worry beads," or try all sorts of tricks. The tricks might or might not work. A person might quit dozens of times. My nephew, an MD, encourages his patients by pointing out that every time they quit, they get better at quitting. He's right. The brain's strongest influence is *habit*. Any time you do something, you get better at doing it.

Some smokers, either the first time they quit or after countless attempts at quitting, suddenly have an epiphany: "Damn it! I'm not a smoker any more." And they aren't. They simply throw away their cigarettes and never look back.

They have not necessarily had a religious conversion experience or a realization that they are safe. They just shifted their brain's electrical pathways so as to perceive themselves as *not* being a smoker, and not being regulated by the entrenched patterns in their brains that linked them to their smoking habits.

For example, an acquaintance of mine had been fortunate enough to get into a research program on heart health for seniors. He got free extra heart exams and free extra appointments with a team of cardiologists. At one appointment, the doctor noticed the pack of cigarettes in his shirt pocket. "You never told us you are a smoker! Why are you wasting our time!" The doctor abruptly ended the appointment and shooed the research patient out of the room. On his way out to the parking lot, he threw his pack of cigarettes into the trash. He never smoked again. He had tried to quit smoking many, many times, over the years. Somehow, being chastised by the MD and accused of having wasted the researchers' time drastically shifted something in his mind. This was an "epiphany"

experience in that it shifted him *immediately* into being a non-smoker. He did *not* feel that it was a spiritual experience. But he recognized that his mind had been immediately, permanently altered in response to what the doctor said to him.

Epiphany while talking to an invisible friend

The sudden epiphany phenomenon does sometime occur in people who have been using self-induced pause. Very often, in my limited experience, the person who has done this also experienced a sense of spiritual re-awakening at the time of the epiphany. This might be because, while turning off pause, the person has usually been speaking, more honestly and powerfully than usual, with his invisible friend. When the realization suddenly comes that the friend has *always* been there, always loving, always protecting, the person who was on pause can be emotionally altered by the experience. Suddenly, the long years of feeling somehow apart from others, either alone in the universe or trapped in a world with what he imagined to be a silent, judgmental God, are ended. In many, many cases, the person perceived his previous mental attitude as sulking and petulant, even infantile. During the epiphany, he decided to stop sulking and – usually sheepishly – accept the love and membership in the human race that he has been spurning.

Thus, the "epiphany" of no longer needing to use pause mode. The door to the habitual use of the pause pathway in the brain is instantly slammed shut and the healthy "I'm safe enough to be alive" door opens up – permanently. This change might be far more profound than the change that occurs when one stops smoking. It often feels to the person as if he has had a spiritual experience of *feeling* and *knowing* that he's part of a loving universe. He didn't just have a merely physical change.

Feeling safe can terminate a habit – if healthy replacement behaviors are available

The case studies in this chapter so far are examples of people making themselves feel safe via talking – having a deeply honest, intimate conversation – with someone loving, someone *other* than the self. This open hearted conversation alters the behaviors of the currents that flow through the midbrain. The duologue increases current flow through the striatum, through the exact middle of the brain. This causes the person's brain currents to move in a pattern that creates a feeling of safety and releases dopamine for motor function. This release makes a person feel even safer. This makes the currents run straighter and with increased amperage. Even more dopamine is released. An upward spiral of increasing levels of parasympathetic mode behaviors can kick in. The brain scan research supporting this is presented in the book *Recovery from Parkinson's*, and some will also be shared later on in this book.

In the two previous epiphany case studies, the switch back to parasympathetic mode was lasting and permanent. However, for most people stuck on self-induced pause, the switch into parasympathetic mode is only temporary.

When a person feels safe enough, he fulfills the needs of Step #2 for turning off pause: confirmation that his body has stabilized and that the vicinity is safe enough for coming back to life. *After* this confirmation, the person might notice that he expels a deep sigh, his head bobbles slightly, and a shiver runs down his spine. He might need a physical assist from a friend to get the bobble and shiver going, at first. But once his brain is able to execute these moves easily and automatically, he will no longer be on pause mode *unless* he reverts back into pause mode from sheer habit. Some people have become so habituated to using the self-induced pause mindset at any potential distress, pain, or even

mild uneasiness that they re-launch themselves into it over and over, in response to *any* negative or cynical thought. Even after they experience a few minutes, hours, or even days of using mostly parasympathetic mode, instead of pause, they might quickly revert back to full-blown self-induced pause mode at the first hint of a negative thought.

Techniques in upcoming chapters teach how to get out of this relentless return to pause mode. After a person has learned to mentally create the safe feeling on command, he can use very specific techniques to mentally *destroy* the pause habit and install the "safe" habit, using techniques described later in this book.

Of course, recovery from Parkinson's disease or from being stuck on pause does *not* require a person to never again have a negative thought. In response to stress, pain, or a negative thought, a mentally *healthy* person uses *sympathetic* mode, not pause. People who have used pause mode for much of a lifetime might not even remember how to activate sympathetic mode. In addition to replacing the pause habit, a person *might* need to learn how to activate sympathetic mode. This is highly uncommon, but instructions are included. A technique for doing this is in chapter 14.

Case study #6: Not wanting to talk to Allah – a non-epiphany case

A patient, male, aged 55, had been raised Moslem. He never had a relationship with Allah, although he was well versed in Islam. For two years after he was introduced to the Parkinson's Recovery Project, he refused to consider talking to Allah as if He were listening. He *also* refused to talk to anyone *lesser* than Allah. After two years of steadily worsening symptoms, in desperation, he decided to try talking to Allah. After two years of talking to a silent Allah, he began to feel that Allah was listening. After this the relationship quickly deepened. His love for Allah and his understanding of the scriptures he'd grown up with suddenly blossomed. He was supremely grateful for the changes in his heart than came from talking to Allah and eventually even feeling His presence.

He finally felt close enough to Allah that he was able to ask Him if he was at risk of imminent death – and get an answer. This specific question is a way of asking if one is using *biological* pause due to not yet recovering enough from some physical or emotional trauma. He received an answer: yes. He sensed that the unhealed injury was in his neck. He sought out a craniosacral therapist who found a severely displaced bone in his neck. Over two sessions, she supported his neck using Yin Tui Na until it repositioned itself. After this, he asked Allah if he was still at risk of imminent death. Allah replied no, he was not. His use of biological pause had turned off. But although he could now turn his head easily from side to side for the first time in decades, he still had most of his symptoms of Parkinson's disease. He asked Allah if he was still on pause due to also using self-induced pause. Allah replied yes. The patient understood that the best treatment for overcoming the self-induced pause habit was going to be continuing to talk to Allah until he had incontrovertible feelings that he was safe. And then he could mentally destroy or turn off permanently the old habit of using pause. He is still working on recovering. As of this writing, his moments of ease of movement and relaxation in his body are lasting longer. His smile is more often apparent, and he is constantly being surprised by movements that he can make that has hasn't made in years.

The main significance of this case study is that the person refused to even *consider* talking to Allah, or *anyone*, for two years while his condition steadily worsened. He just didn't think he could or should. He told me, "That would be the behavior of a

crazy person." Then when he finally, from desperation, decided to start talking to Allah, it didn't feel real to him for another two years. I've seen this long, slow approach to turning off pause in a majority of my patients with Type I Parkinson's from self-induced pause.

So when people ask me how long it takes to turn off self-induced pause and/or recover from Parkinson's, I have no answer. It's completely up to the person who is going to have to change himself. There is nothing I or anyone else can do to change another person's mental habits. I can present the information. That's all. The rest is up to the person who's inadvertently created the pause habit in himself.

The difference between the epiphany recovery and the slow recovery

The difference between the sudden, lasting epiphany recoveries and the slow, "two steps forwards one step back" recoveries seems to be that the former have a shift in understanding. The epiphany people have sudden realizations such as "I have always been safe! I was just imagining that I was alone and at risk. It's not like I'm going to die, after all." The slow-recovery people do *not* have these life-changing thoughts. Instead, when they first manage to turn off pause, they might say, "I feel so much lighter!" "I can move more easily!" Or "I feel so happy, like I just had an exorcism of my negative thoughts!"

You can see the extreme difference. The epiphany people realized that they had been supporting a wrong mental attitude of imagining themselves to be alone and unsafe. They felt a truth had been revealed to them, that they were, always had been, and always would be safe, in the ultimate sense of being unconditionally loved by something greater than themselves. They stopped sulking and embraced the fact that they were loved. As for their diminishing symptoms, that was just a secondary benefit.

The slow recovery people did *not* have attitude-shifting insights for a long time – sometimes several years. When they temporarily turned off pause, they merely observed changes in their *symptoms*, but not in their relationship to safety and being connected to Love. When they felt safe from talking with a friend or from some fleeting insight or a determination that they were temporarily safe, they noticed that they could move better and felt an unaccustomed level of joy. They appreciated the change in how they felt and moved, but they did not truly comprehend the deeper reasons behind their change: that they had temporarily stopped using their self-created negative thought process. Because they had no realization that they actually were and always had been safe, after all, they reverted back into their self-induced pause habits at the next negative thought. Their underlying *mindset* had not actually changed *at all*. They had only experienced a few moments or hours of having their brain circuitry running in a healthy manner. Their assumptions that they needed to use pause mode, and their habits of using pause mode, had not been altered despite their fleeting experiences of having temporarily turned pause off.

Most of my patients with Parkinson's experienced the initial joy of turning off pause mode fairly quickly after starting to talk to their invisible friend. They also relapsed quickly, usually within an hour or two. Due to their long-term habit of using pause in the presence of negative thoughts, they soon, seemingly automatically re-instituted pause mode even though they had enjoyed the physical sensations of *not* using it.

Returning to the subject of sympathetic mode inhibition

In some cases, a person with long-term use of pause is no longer *able* to access sympathetic mode. These people might revert into pause after temporarily turning it off

because they have no other option for being physically active. Very often, these are people who learned at an early age that the best way to avoid danger was to be as motionless and quiet as possible in the presence of an unpredictable and dangerous family member. A person who has commanded himself to be as still as possible during danger, or never *express* anger or pain, might need to learn how to re-activate the electrical currents that drive sympathetic mode in *addition* to replacing his pause habit, or maybe not. Chapter fourteen will discuss how to test for this problem and how to overcome it.

A person who has to learn *how* to use sympathetic mode and has to retrain himself to *choose* sympathetic mode in response to negative thoughts, in addition to replacing the pause habit, will usually need a bit more time, maybe two or three weeks, to recover from Parkinson's than a person whose body remembers how to use sympathetic mode and who can feel safe enough to be alive even while experiencing the long forgotten, powerful sensations caused by sympathetic mode's rush of adrenaline.

In summary, some people using self-induced pause will have the nearly instantaneous type of epiphany recovery described in this chapter's first two case studies. Most people who use self-induced pause might need a long time to overcome the habit of using pause mode, as described in the third case study in this chapter. Those who must also re-learn how to activate sympathetic mode might need even a few weeks longer to lastingly recover. [7]

---

[7]My favorite critic and editor told me that I should insert, by this point, some background on my education and research. I am the founder and director of the Parkinson's Recovery Project, a non-profit corporation dedicated to making available, for free, research on and information about Parkinson's disease from the perspective of traditional Chinese medicine. The Parkinson's Recovery Project was founded in 1998. The website is www.pdRecovery.org.

After seeing several patients with Type II Parkinson's unexpectedly recover, I ran a free clinic for people with Parkinson's from 1998 to 2003, staffed with my students from Five Branches, a college in Santa Cruz that offers Master's and Doctoral degrees in traditional Chinese medicine. From 1997 to 2019 I worked with hundreds of people with Parkinson's disease. While examining their channels, treating them for various injuries, and being baffled by the strange psychological barriers I found in most of my PD patients, I extensively interviewed these patients during every clinic session, digging into subjects ranging from their childhoods to their philosophies and motivations in life. I found an astonishing similarity in personality, intelligence, and intensity of purpose among nearly all of my PD patients, which matched the research findings about the "Parkinson's personality" that date back to the 1930s. I also found a stunning similarity in their behaviors and thoughts that occurred immediately before and after "epiphany recoveries," as described in the book *Recovery from Parkinson's*.

I have a BA in biology from University of California at Santa Cruz, and master and doctoral degrees in Chinese medicine from Five Branches. I've been a professor at Five Branches since 1998, teaching Yin Tui Na, Psychology/Counseling, Advanced Channel Theory, and clinic.

I've had articles published in the top-ranked, peer-reviewed *Journal of Chinese Medicine*, *American Journal of Acupuncture*, the *California Journal of Chinese Medicine*, and other English-language journals of Chinese medicine, and a commentary published in the *New England Journal of Medicine* pertaining to L-dopa and brain damage, based on my four-year research project on patient responses to their subtle or over-rapid alterations in the dosages of their anti-parkinson's drugs. My educational videos for acupuncturists about various aspects of channel theory are available through EasternCurrents.ca. That's "dot CA", *not* "dot com."

Maybe more to the point, I have seen many people recover from "incurable" Parkinson's disease. I noticed uncanny similarities in their life histories, and in the events and personality changes that accompanied their recoveries. The utterly unexpected recoveries and the many unexpected common denominators, and not just the obvious physical symptoms of my Parkinson's patients, were the starting points for my research.

Even while I was making discoveries about people with Parkinson's, I was able to use my findings with other, non-PD patients. I have helped countless people who were stuck on pause, *usually* biological pause, and often localized pause rather than body-wide pause, who had problems ranging from intrinsic asthma to broken bones that have failed to knit. At the beginning of this book, I purposely used case studies from *non*-PD patients to make the point that being stuck on pause can lead to all sorts of "incurable" problems, not just Parkinson's disease.

The Biology of Pause Mode

Introduction: This chapter was lifted, with a few modifications, from chapter fourteen in *Tracking the Dragon*, a book that describes channel qi flow in each of the four neurological modes, and explains how to detect the flow of channel qi by hand. Much of this chapter is directed towards acupuncturists or people who are familiar with channel theory. However, the reader with no medical background will be able to follow the material.

Some of the details about the flow of channel qi on pause were already presented in chapter 2, but I'm leaving them in on the possibility that the review will be helpful. You might find the material in this lengthy, detailed chapter to be dull or fascinating. Either way, you don't *need* to learn the material in this chapter in order to turn off pause mode. Please, just take what you want from it. Don't be concerned if you don't follow or remember some or any of it.

In western medicine, there is no *dedicated* term for the collection of physical and neurological shifts that occur during coma and/or near-death trauma. The word "shock" is too general: it covers situations ranging from surprise and alarm all the way to loss of consciousness.

In Chinese medicine, the name for the fourth neurological mode is translated from the *Nei Jing*, the "gospel" of Chinese medicine, as "Stay close to life" or "Cling to life." Aiming for something snappier and more descriptive, I've given this mode the English name of "pause." [8]

Pause mode is the correct, healthy neurological response to severe blood loss, concussion or other potentially mortal injuries and traumas. Pause might also be triggered by excessive perforation of the skin, which can include self-cutting and excessive acupuncture needling. Excessive in this case means the use of too many needles during a

[8] The *Nei Jing*, the most comprehensive and authoritative book about Chinese medicine, was mostly likely compiled around 400 AD, according to scholarly researchers. The current, official Chinese government position on the *Nei Jing* is that the book was written in 221 BC, to coincide with the brutal destruction of the Chinese city-states and the bloody "unification" of China by its first emperor. Because the book was *titled* in honor of the first emperor, error crept into the understanding of this book's anonymous authorship. Centuries ago, it was decided that the first emperor, a ruthless military leader with no medical background whatsoever, who ordered that the scholars and philosophers be buried alive, who died fairly young, *had written* the quintessential book of Chinese medical theory…because the title bears his name. The current government, in its ongoing attempts to portray the first emperor as an heroic, almost god-like figure, perpetuates this myth of authorship despite the solid research on the book's writing style and syntax indicating that the book is a compilation of many theories by many authors, assembled approximately six hundreds years after the despotic emperor's passing.

treatment. If a patient feels out of his body during a treatment, the acupuncturist used too many needles, or needled into a current that was running backwards.

Pause is not an all-or-nothing mode. Like the other three modes, it can manifest on a continuum from mild to severe, and it *might* manifest in combination with any of the other modes, now and then. At the mild end of the pause continuum, symptoms can include out-of-body consciousness and the release of pain-reducing endorphins. At the severe end, immobility and/or coma can manifest.

An impala on pause

For a stunning video of an impala going into life-saving pause mode during a hyena attack and then escaping when the hyena leaves the kill site in order to chase off a leopard, please visit www.pdRecovery.org and click on the red bar that says Impala on Pause, located half way down the home page.

Physiological changes during pause

During pause, one might experience, to varying degrees, a *decrease* in heart rate, shallower or slowed breathing, and a *drop* in blood pressure. Blood might leave the skin and muscles and shunt deeply interior – to the spine and brain – *not* to the heart and lungs. The skin might be clammy. Temperature regulation might be poor, especially in the extremities. Endorphins, which are pain-inhibitors, are released from areas alongside the spine.

These alterations in physiology might be life saving: for example, the inhibition of heart-force *greatly* slows the rate and strength at which blood is pumped. If a dangerous number of blood vessels have been broken, this pause mode inhibition of heart rate and strength might help reduce further blood loss.

The release of pain-inhibiting endorphins and a concomitant reduction in somatic awareness might occur. The voice, if any, might be faint. The senses of taste and smell might diminish greatly. The body might curl into a fetal position. This fetal positioning occurs because, in the parts of the body where channel qi flows *backwards*, the underlying muscles become rigid. Where channel qi is *cut off*, the underlying muscles become weak. The combination of backwards and turned-off channel qi flow over paired, *opposing* muscle sets can cause muscle rigidity and relaxation in the opposing muscles. This can cause pulling up of the legs and arms, and maybe curling in of the torso and pulling forward of the neck: the fetal-esque position observed in some people who are on pause.

The senses of hearing and vision might be *heightened* while on pause, although the *type* of hearing and vision is altered and behaves more as it does in sympathetic mode. For example, in sympathetic or pause mode, a person is *less* able to imagine fanciful images in the clouds or in tree bark. The ability to visualize positive images or playfully imagine shapes and faces while gazing at something is a feature of *parasympathetic* mode. The ability to do this type of playful imagining diminishes as a person slides into a higher degree of sympathetic mode or lurches into pause. Oppositely, a person on pause might easily be able to imagine or visualize dire or distressing situations. The inability to visualize is sometimes referred to as aphantasia. Many people on pause do not have full-blown aphantasia because they *can* easily visualize dire or frightening situations. They just can't imagine pleasing or emotion-neutral situations.

Hearing also shifts during sympathetic mode and pause. It becomes more attuned to sounds of possible danger. Background noise can become a source of agitation instead

of pleasure. For example, if a person gets lost while driving and becomes concerned, one of the *first* things he might do is turn off the music in the car. As the driver transitions from parasympathetic-dominant to sympathetic-dominant, the music transitions from pleasant to distracting, even irritating.

On pause, various aspects of digestion, including peristalsis (movement in the gut) might cease or be greatly reduced. Long-term, this might cause severe constipation that does not respond to laxatives. The stomach might be prone to nausea due to the reversal of the currents that regulate stomach function.

When a person is parasympathetic-dominant, an unexpected burst of bird song might evoke laughter or at least a smile. In a high degree of sympathetic or pause mode, the same sudden song might elicit a startle response.

Other pause-specific behaviors also occur, but this is enough to get us started – to give us a mental picture of a person who is on pause, and let us recognize that this is *not* a variant of sympathetic mode. It also is *not* the pre-sympathetic hesitation that we refer to as "deer in the headlights." A deer in the headlights has not yet activated his body for making a dash for safety – but he certainly isn't almost dead or preparing to die. A person or animal on pause, in preparation for possible death, is switching over into suspended animation, feeling no pain (of a certain type), and most likely perceiving himself from outside his body. Observing oneself as if outside the body is referred to as dissociation.

Dissociation

The term "dissociation" has been adopted by several fields of scientific inquiry, each with a very different meaning of the word. In the field of medical *biology*, the word dissociation refers to perceiving oneself from outside the physical body, a change in perception that often occurs during pause.

In the field of *psychology*, the term refers to a separation or compartmentalization of some mental data away from normal consciousness. You might describe this type of dissociation as mentally blocking awareness of some event or body part to the point where the person has no memory or a distorted memory of the event or body part. This is the most common meaning of the word dissociation for today's general public. [9]

While on pause, a person might experience *biological* dissociation. He might *observe* his own body from outside of it, while having a diminished level, or even none, of the usual physical sensations of being inside his own body. He might lose both somatic awareness (*how* the body feels inside) and loss of proprioception (awareness of *where* one's body parts are if one can't see them). [10]

---

[9] Going off on a tangent here, in the field of *chemistry*, the word dissociation refers to molecules breaking apart in a specific manner. In quantum physics, it has to do with certain quark behaviors. And while I'm on a semantics jag, the word dissociation *first* appeared in print as a *social science* word. It meant separation from one's previous religious organization. Shortly after that, it came to mean "no longer associating with a given person, or idea."

If you are a budding word geek, you will want to know that the Oxford English Dictionary lists, if possible, the first time a given English word appeared in print. It's great fun!

[10] In my earliest writing on pause mode, I decided to refer to this as yet un-named (in English) near-death neurological mode as "dissociation mode." This led to lots of confusion: readers often assumed the *psychological* meaning of this word despite my repeated clarification

While the idea of a person perceiving himself as if outside his body might stretch credulity for some readers, *many* people who have had a concussion or severe, life-threatening injury have described the strange experience of this shift in self-awareness, so that they are somewhat numbly *looking* at themselves from outside of their body instead of *feeling* as if they are inside their body. The *skin* isn't necessarily numb. The *skin* might even be *overly* sensitive, *hyper*-ticklish, or prone to inflammation. The *internal*, somatic self-awareness feelings might be missing.

Anesthesia

Full medical anesthesia puts a person into a high degree of pause mode. It does *not* put a person to *sleep*, despite the popular euphemism. The phenomenon of "watching my surgery from the ceiling" is *not* unusual during lengthy surgeries, and is even somewhat common in heart-related surgeries. [11]

---

that I was using the *biological* meaning. I have since changed the name of this mode to pause, which is crisper and less ambiguous, but excerpts from some of those early editions are still out there on the internet, posted on personal websites and blogs without permission, keeping the confusion alive.

[11]While *western* medicine has no explanation for the normal outside-the-body dissociation that is a common feature of being on pause, it is simply the re-centering to a location outside the body of one's "Yuan Qi", often translated as "source energy". Yuan Qi refers to the energetic, as opposed to physical (chemical), *manifestations* of the immortal soul. It is made up, in part, of electromagnetic, light, and gravitational wave energy.

Normally, this wave-type "source" energy does its receiving and broadcasting while centered in the pericardium, so long as a person is alive, but it can actually be centered anywhere. These consciousness-carrying waves of energy leave the body after death. During pause, the pericardial electromagnetic "center" for receiving and transmitting these waves may relocate to outside the body, but usually stays in the vicinity.

The idea that "waves of energy carry consciousness" was hard to comprehend in the days before satellite TV, cell phones, and internet WiFi. These are all examples of systems that interpret electromagnetic waves that carry information. The information becomes "tangible" (viewable and/or audible) when converted into electrical *currents* that flow through the "chips" in the systems' receiving devices. The waves carrying soul consciousness, which include EM, light and gravitational waves, carry information in much the same way. While embodied, some of one's soul information is converted to electrical currents that flow through the highly conductive, positionally-ever-varying micro struts that make up connective tissue, tissue that overlays every other tissue and organ in the body. In Chinese medicine, the connective tissue is called, among other things, the Triple Burner, or Three Energies. The connective tissue carries wave information from the three realms of existence: physical, astral (light- and sound-wave based), and causal (the pure *idea* of a thing). The information carried by the soul's manifested energy waves is much more complex and profound than that carried by the electromagnetic waves serving cell phones and WiFi. The gravitational wave system of the soul can even broadcast and receive to and from other consciousness systems, those nearby and those across the universe. (Continued on next page.)

Pathologies that arise from chronic use of pause mode

Body-wide health problems stemming from long-term use of either pause mode or *psychological* dissociation (compartmentalization of information *away* from normal consciousness) can include syndromes ranging from the relatively common, such as asthma and itching skin, to the moderately common such as idiopathic Parkinson's disease (affecting approximately two percent of people over age seventy), to the rare and even obscure, such as dissociative identity disorder (previously known as multiple personality disorder) and Cotard's syndrome.[12]

Being stuck on pause mode 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 might 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.

Shifts in channel qi during pause mode

During pause, highly specific shifts in channel qi flow kick in, in various channels. The following are brief, channel-by-channel descriptions of these shifts.

Changes in the Du channel

When on pause, the torso portion of the Du channel becomes a standing wave. It stays between the sacrum and the base of the neck (near the spinal bones named T-1, C-7, and C-6). It does *not* flow up the neck and into the head. (Fig. 4.1, p. 46).

(Continued from previous page.) I am reminded of Nikola Tesla's remark, nearly a century ago, regarding the debate on direct current versus alternating current to carry power along wires, thus providing domestic electrical supply. Recognizing the interchangeability between airborne electromagnetic waves and wirebound electric currents, Tesla asked, "Why not just get rid of the wires?" At the time, his words were utterly incomprehensible to most scientists. He was asking about using electromagnetic waves to transmit power and information, a concept that has only become accepted as possible in the last forty years. In his day, most of Tesla's ideas were mocked as impossible, even ludicrous. In the same way, the Asian medicine recognition of the role played by soul-created heart and thought waves in directing, augmenting or suppressing the human electrical circuits that carry instructions for building and sustaining a physical body, and even the very existence of these circuits (channel electrons, sometimes called ion flux, or in Chinese medicine, channel qi, *Qi Se*), is mocked and despised by many western doctors – even those who use cell phones and WiFi.

[12] 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, neurologically, come out of a near-death episode (being stuck on pause mode).

In translations of the classic Chinese texts, we see a reference to how the Du channel qi behaves in pause mode: “The Du channel can act like a reservoir for channel qi [during pause].” Ordinarily, the channel qi of all the channels should flow freely, “Like a river.” During pause, the Du channel qi behaves like a standing wave in the spine and doesn’t flow up into the neck. It is dammed up: “Like a reservoir”.

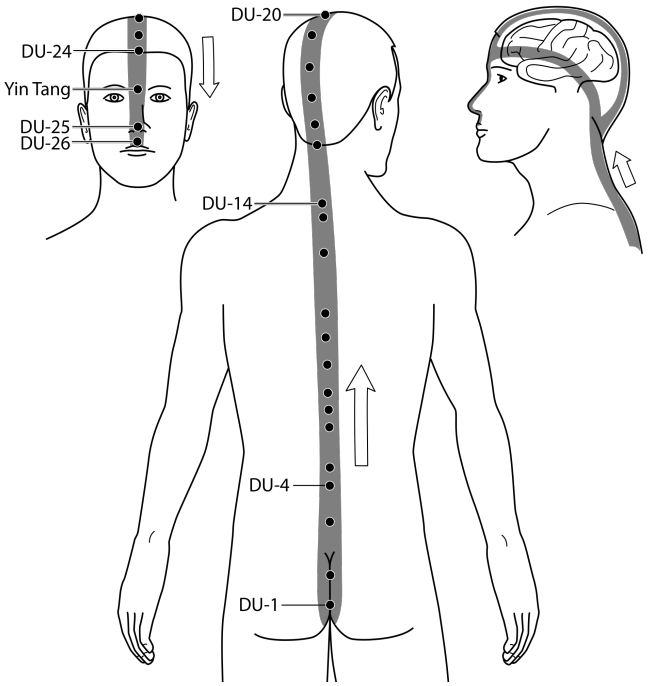
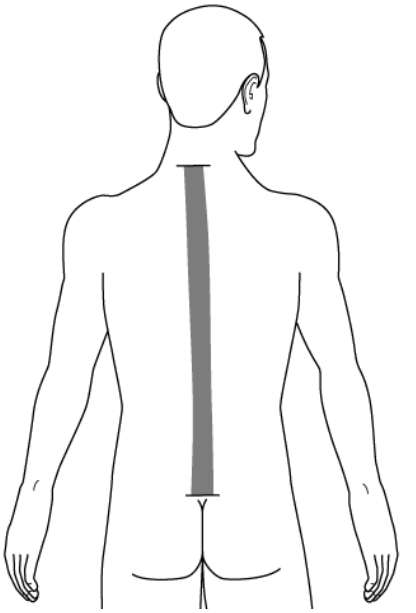


Fig. 4.1 Du channel in parasympathetic and in sleep (over the top of the head) modes



Du channel in pause mode

Changes in the Ren channel

On pause, downstream from Ren-2, the Ren’s channel qi leaves the skin level and dives *deep* within, becoming undetectable. The location from which it dives deep is variable, but the skin-level Ren channel qi rarely gets as far along the channel as Ren-17, on the sternum. (See p. 12, Fig. 2.1.)

Changes in the Stomach channel

In pause mode, on the foot, Stomach channel qi does *not* flow from ST-42 to the toes (the parasympathetic and sleep mode patterns) *nor* does it flow from St-42 over to Sp-3 on the side of the foot (the sympathetic mode pattern). In pause mode, the channel qi in the Stomach channels runs backwards from St-42 on the foot to, depending on severity, the leg, torso, or even the head.

When you feel the paused person’s Stomach channel qi with your hand, you might detect a sensation of it flowing *up* the leg (upstream), or making a “standing wave” (rapidly vibrating back and forth), or even seeming to disappear (dropping deep under the skin or shunting sideways into a different channel).

If backwards-flowing Stomach channel qi makes it all the way up to the jaw, it is shunted from St-6, on the back of the jaw, to St-8, on the forehead. From St-8, it can flow into the Gallbladder channel at GB-7, on the forehead (See Fig. 4.5, p. 50.)

On pause, in addition to flowing backwards from St-42 towards the ankle and on up the leg or higher, some Stomach channel qi on the foot might seem to vibrate back and forth between the top of the foot, at St-42, and the center of the bottom of the foot, at Ki-1.

In clinic, I have seen backwards Stomach channel flows set in motion by C-section scars, appendectomy scars, and by foot or leg injuries, old or recent, from which the bones were still displaced, to name just a few *non*-pause examples of backwards-flowing channel qi.

The possibility of backwards channel qi flow is not limited to the Stomach channel. *Any* channel might flow backwards, when doing so is the path of least electrical resistance.

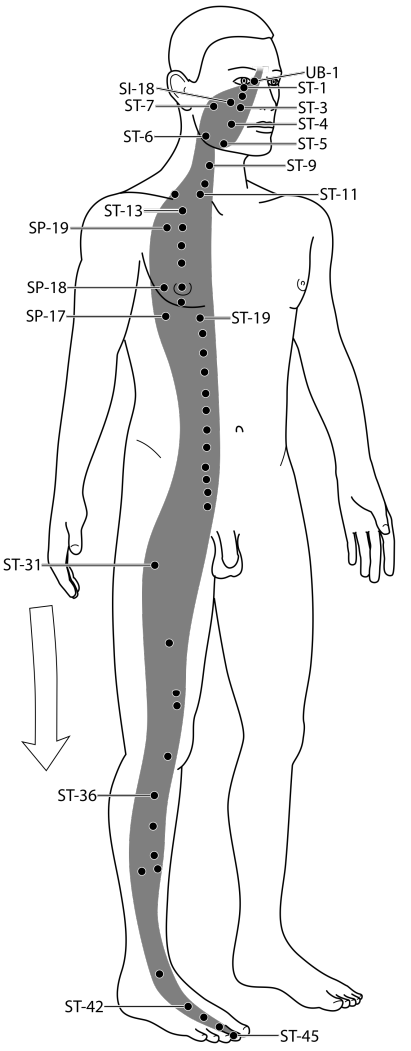


Fig 4.2 Stomach channel qi in parasympathetic mode flowing *from* head *to* toe. The Stomach channel, like all Primary channels (channels named in honor of an organ), has two parallel paths, on the left and right sides of the body. This drawing shows only the right-side Stomach channel, for a less cluttered look.

Changes in the Urinary Bladder (UB) channel

On pause, at the back of the neck, in the vicinity of UB-10, the UB channel electrical currents might convert to electromagnetic wave form and depart the body. When this happens, the energy can easily be felt, by hand, as it flows out from the neck into the air.

This might be the mechanism that causes a person on pause to feel that his consciousness has moved outside of his body. This shift in location of consciousness can make a person see himself as if outside his body, looking at it, rather than *feeling* as if he is inside his body.

Anhedonia

When biologically dissociated, the electrical chest-expansion sensations of joy are no longer somatically feel-able because the consciousness has moved to outside of the body. This externalization of the electro-magnetic waves of consciousness means that a person might not be able to *feel* joy – an actual *physical* feeling – or *feel* other positive emotions.

Again, this externalization causes an inability to perceive expansion and contraction in the heart area (increase or decrease in pericardial amperage) in response to positive and negative emotions, respectively.

This inability to somatically *feel* the body's sensations of joy is called anhedonia. Anhedonia is common in advancing Parkinson's disease. The patient usually describes the problem as "depression." His MD might attribute it to insufficient dopamine.

One of my patients with Parkinson's, an English professor, said to me: "Joy? I literally don't even know what that word means anymore."

In a healthy person, release of mid-brain dopamine in anticipation of pleasure is paired with the somatic sensation of pericardial expansion *IF* the pleasure is in tune with uplifting, soul-attuned, "heart opening," values.

But during biological dissociation, a person might have true anhedonia – the body's inability to *experience* the increased amperage in the pericardium that creates a physical sensation that we call "joy," or an "open" or "expanded" heart.

The English language does not have a *dedicated* word for this perception of heart-area expansion. Many other languages do. In Chinese, *Kai Xin* (unfurling heart) suggests the heart area is expanding like a flower. In the romance languages, *spiritus sanctus* (breath of God, or sacred breath) and its cognates means the same thing – the sensation of expansion or overflowing energy or love in the chest, feelings associated with joy, and maybe even the thrill of tingling or electrical sensations elsewhere in the body that might accompany it.

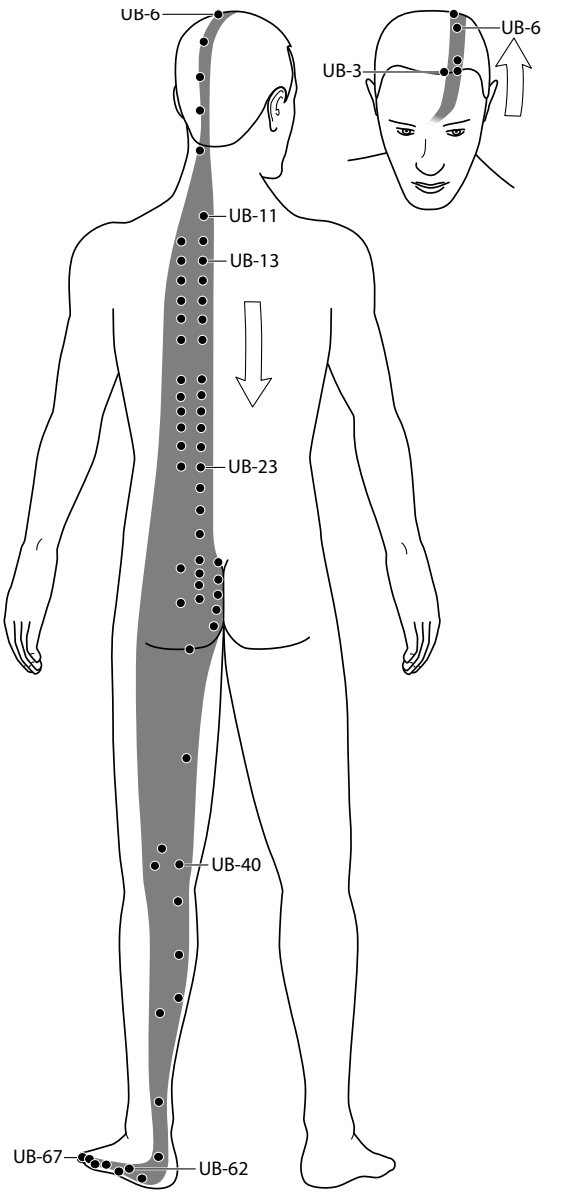


Fig. 4.3 The left-side Urinary Bladder channel in parasympathetic mode. In pause mode, the electrical current of channel qi might convert to electromagnetic wave-form. As a wave, it might exit the body at the base of the neck, in the vicinity of UB-10 or -11. The force of this exiting wave can be felt by hand.

As an aside, a person stuck on biological pause might *think* he *is* capable of feeling heart joy, a subject that will be addressed later. He imagines he feels joy because he sometimes feels exhilaration. But this intensity of emotion is often the result of intensely stimulating fear, competition, or other powerful emotions – not actual joy. There are exceptions to this rule in people with *self-induced* pause. Because some people using self-induced pause can temporarily shift into parasympathetic mode when they manage to feel very safe for a short while, they *might* feel fleeting positive emotions such as joy.

Changes in the Large Intestine channel

On pause, if the Stomach channel qi flows backwards all the way to the head, the Large Intestine channel, traveling up from the hand to the shoulder, neck, and head, might also begin flowing backwards from its point of intersection with the Stomach channel, on the side/front of the neck, near the shoulder.

The other channels

The alterations in the Du, Ren, Stomach, UB and LI channels *might* lead to further changes in channel qi flow. The possibilities include changes in the flow of channel qi in the Heart, Pericardium, Gallbladder, Liver and Triple Burner channels.

More details about changes in the Stomach channel's path during pause

Perhaps the most important Stomach channel shift during pause is the shunt to St-8, on the forehead. (See Fig. 4.5, next page.)

Although most acupuncture schools teach the Chinese government-approved theory that St-8 is on the "Primary" (parasympathetic) route of the Stomach channel, it is *not*. Stomach channel qi is *only* routed to St-8 when the Stomach channel is running *backwards*: from the foot up to the head. If the backwards flow is mild, channel qi might merely accumulate at St-6 or St-8. Tooth or jaw pain at St-6 or a pressure-type headache at St-8 might then develop, brought on by the build-up of localized channel qi.

St-8 behaves somewhat like an electrical capacitor: a place where charge can accumulate. As channel qi builds up at St-8, it might cause headache. If *enough* channel qi builds up at St-8, the channel qi might surge out of St-8 and short circuit into the nearby Gallbladder (GB) channel, causing an increase in the amount of Gallbladder channel qi.

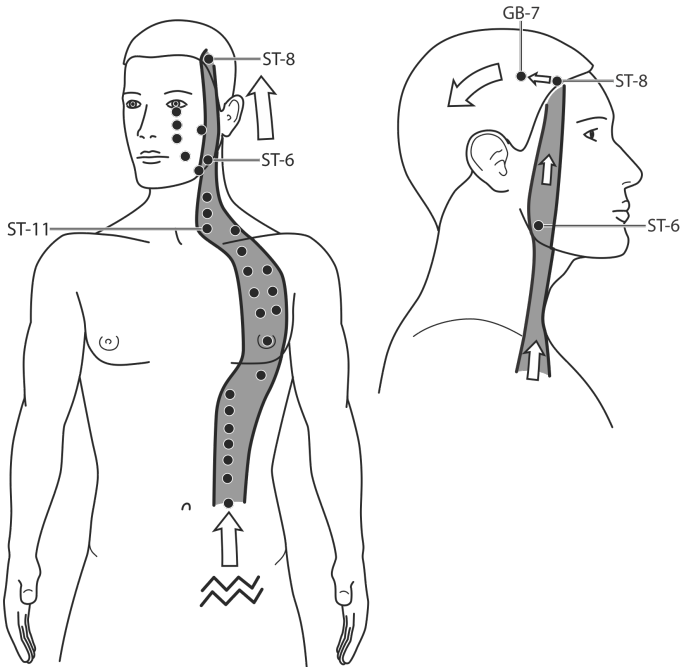
Again, when Stomach channel qi is flowing *backwards*, when it gets to St-6, at the back of the jaw, it is shunted up to St-8, on the forehead. There, charge either accumulates, causing a headache, or it short circuits into the nearby Gallbladder channel.

It is easy for the backwards-moving Stomach channel qi to flow into the Gallbladder channel: the GB channel is very wide across the forehead, and offers little resistance. If the backwards flow becomes chronic, a new, constantly open path from St-8 into the GB channel might develop.

In chapter 13 of *Tracking the Dragon*, the chapter on sleep mode, you can read about what happens in the brain when a nightly circadian surge of increased amperage runs through the *head* part of the Gallbladder channel: a corresponding decrease occurs in the amount of channel qi in the *head* part of the nearby Du channel. This head part of the Du channel regulates awake-time consciousness.

The head portions of these two channels, the Du and the GB, run in *opposite* directions. When the amperage (the *quantity* of moving electrons) in the head-part of the GB channel *increases*, the amperage in the head-part of the adjacent Du channel

decreases. If/when the Du decreases in power *enough*, sleep or even coma might ensue. Again, during pause, backwards Stomach channel qi shunting up to St-8 might flow into the Gallbladder channel…thus increasing the amperage in the GB channel.



The location of a Stomach channel blockage in Fig. 4.5 is represented by zigzag lines on the lower torso. This location was selected at random. The blockage might just as easily have been drawn on the neck or the foot part of the Stomach channel.

Although the Gallbladder channel is not shown, a large arrow on the side of the head shows the location and direction of flow in the head portion of the Gallbladder channel.

The addition of Stomach channel qi (the small arrow) to the channel qi already flowing in the Gallbladder channel *increases* the overall amount of channel qi in the Gallbladder channel path – which *decreases* the amount of channel qi in the head portion of the adjacent Du channel. (See Fig. 4.2)

Fig. 4.5 St-6 to St-8, the safety shunt for *backwards* flowing Stomach channel qi.

In this diagram, backwards-flowing channel qi is due to a blockage on the torso. The blockage causing backwards flow might actually be *anywhere* along the Stomach channel below the neck *or* the backwards flow might be due to the use of pause mode.

Notice the absence of channel qi from the eyes to the chin. When the Stomach channel runs backwards and shunts to St-8, on the forehead, the absence of channel qi on this part of the face can cause the underlying muscles to droop or look lifeless.

If traumatic, life-threatening damage occurs somewhere in the body and pause mode kicks in, the activation of the St-6 shunt in response to the sudden surge of backwards-flowing Stomach channel qi might send a huge surge of channel qi up to St-8 and thence into the Gallbladder channel. This can cause the flow of *Du* channel qi to *decrease* so much that the person or animal might pass out and stay passed out until the body stabilizes and pause turns off.

Then again, sometimes the amount of backwards Stomach channel qi flowing over into the GB channel is small enough that the traumatized person might merely find it very easy to drop off to sleep at a moment's notice. Or he might feel woozy, or go in and out of alertness. The Du channel qi supplies the electrical currents along the midline of the brain: it determines how much activity the brain will have in the striatum and along the

midline of the frontal lobe. When in a high degree of parasympathetic mode, this part of the frontal lobe is the seat of calm, highly focused thought.

When the amperage in the head portion of the Du channel qi is *reduced*, as it is during sleep mode and during pause, release of midbrain dopamine for motor function is greatly diminished or even inhibited. *Conscious* awareness of the *peaceful*, soul-centered aspect of sense of self is then reduced or turned off, as it is during sleep, coma, and on pause. In sleep, the wakeful consciousness is turned off. In a high degree of pause mode, if the wakeful consciousness *is* alert, it might be out of the body, wary and feeling as if at risk of imminent death: not aware, or at least not fully aware, of one's inherent peaceful and even blissful soul nature: on pause, the consciousness and motor function are activated by norepinephrine, not dopamine, if a sense of emergency is active.

Backwards qi flow in the head: an aside

In terms of life-saving physiology, the design for shunting Rebellious or Counterflow (backwards) channel qi up to the corner of the forehead at St-8 is simple and elegant.[13] If Rebellious Stomach channel qi were allowed to flow backwards all the way to Stomach-1, at the eyes, and continue backwards into acupoint Yin Tang, located at the point between the eyebrows, it could then flow backwards into the brain portion of the Du channel. Backwards flowing channel qi in the head portion of the Du channel can quickly cause loss of consciousness and even death. The St-6 to St-8 shunt prevents that.

Thanks to the St-6 shunt, the Du channel does not take a *direct* hit from backwards flowing Stomach channel qi: the Du channel itself does not flow *backwards*. Instead, the power of the Du channel is merely *diminished*. The anteriorly-flowing Du channel qi is *influenced* by the posteriorly-flowing Gallbladder channel qi. That influence is a *much* weaker force than a direct hit backwards into the Du from backwards-flowing Stomach channel qi would be.

When Du channel qi sedation occurs in response to Rebellious Stomach channel qi surging into the *GB* channel, the resultant wooziness, sleep, or even coma can last for as long as the Stomach channel qi is flowing backwards.

The Du channel sedation can be helpful to a person on pause. The physical stillness might allow the injured person to rest while the body navigates its way back to stability. In some cases, profound stillness can also serve to induce the dead mouse effect, which can sometimes save the life of an animal being attacked by a non-hungry predator.

The elegance of this Du channel protection mechanism never ceases to amaze me. If you ever get the chance to work on someone with Rebellious Stomach channel qi running all the way to the head, take a moment to check out the palpable channel qi flow running from St-6 up to St-8, and then into the GB channel.

---

[13] In some British publications, *Rebellious* channel qi is referred to as Counterflow or Retrograde channel qi. I prefer the term Rebellious, a more literal translation from the Chinese. For thousands of years, the Chinese political system has considered rebellion to be *the* single greatest threat to civic peace and harmony.

Using the word Rebellious to refer to channel qi running backwards suggests how *very* dire this condition can be. Rebellious channel qi is not just preventing correct physiology in the vicinity of the backwards flow: like rebellion, it can be a deadly threat to the entire system.

As soon as pause mode turns off and/or the Stomach channel blockage is broken up, the Stomach channel qi will *usually* resume flowing in the correct direction automatically: any previous build-up of charge at St-8 will disperse by flowing back down to St-6. As with any channel qi variation away from parasyampathetic mode that arises anywhere in the body, it's possible for the channel qi variation to get *stuck*. Channel qi might get stuck in any or all aspects of the pause mode circuitry.

Variations in channel circuitry away from parasympathetic mode are referred to in Chinese medicine as "divergences." The shunt at St-6 is one of a nearly infinite number of possible divergences located throughout the body. Most are *not* related to pause mode.

Confused qi

In classic Chinese medicine, shifts in channel qi flow during pause mode are referred to as "Confused [channel] Qi," but "confused" is a poor translation. There is *nothing* confused about it. The axiom we are taught, "Terror Confuses the [channel] Qi," is a reference to the logical and even life-saving channel qi changes that occur during pause. Pause does *not* trigger an *incorrect* flow of channel qi, as the word Confused implies. The changes of pause are *healthy* and *correct* responses to severe, life-threatening damage. Pause can be a life-saving mechanism. However, getting channel qi *stuck* in some pause-related pattern after the near-death crisis has ended might sooner or later lead to serious health problems down the road.

The joy of inner stillness is not the same as pause

Many people have asked me if pause mode is the same as the deep stillness and joy of meditation. No.

The stillness and joy attained by long practice of single-focus meditation and devotion during which all breathing and heart rate/strength functions might become slower and lower or even almost stilled is *not* pause. Just the opposite: this type of joy is a manifestation of almost pure parasympathetic mode. The Chinese refer to parasympathetic mode as "In tune with the Divine"; resonant with Love.

Holding the body motionless while practicing single-focus types of meditation trains a person to bring all the life force energy deep within the spine, head, or heart and from there to other specific locations, so that *physiological* functions might *cease*, *but* joyful consciousness and awareness of sensations of "heart expansion" (increased pericardial amperage) are maintained and even increased. In single-focus meditation, a person can *narrow* the flow of his Du channel: keeping the Du channel energy in a thin line through the center of the spine and brain.

In people with poor powers of focus and mental efficiency, the Du channel qi spreads wide, and even meanders to the left and right, especially in the sacrum and head.

With training, one can discipline the Du channel qi to stay in a narrow "antenna" of current that flows in a straight and narrow path up the spine and curves neatly through the midline of the brain, so that the current is somewhat in the shape of a shepherd's crook. When the Du channel veers neither left nor right, but stays in the "narrow" path, one can literally tune in with the Divine. Consciously connecting with the electromagnetic, light, and gravitational waves, or "vibrations" of Universal love, via this spinal antenna is then possible. One can then *know* that one is a soul. The delusion of being *defined* by the constantly changing body, a delusion sustained by activities in the right and left sides of the brain, is thus destroyed.

While on pause, it can be *extremely* difficult to perceive any sense of the expansion in the chest that is associated with joy, love, and universal wisdom. Awareness of heart-feeling sensations are *greatly* inhibited: the opposite of joy.

On pause, the flow of the Du channel through the head is diminished in strength. What little flow there is is pulled towards the left and right sides of the brain.

On pause, a person or animal is struggling to stay alive so that he can get his consciousness back inside his precious, unique body. If he is conscious, the areas on the left and right *sides* of his brain, especially the risk-assessment area, might be *extremely* active. The activity level for the risk assessment area of the brain is elevated until the danger level comes down, physiological (autonomic) stability resumes, and pause is turned off – or until the person or animal dies.

On pause, the ego-identified sense of self – a sides-of-the-brain creation – can cause a person to perceive himself as being *apart* from everything else in the universe. This sense of being "a thing apart" or separate from others and from the universe might be extremely strong when in pause mode. During pause, a person might feel as if his consciousness has been expelled from his physical body and falsely imagine that he is teetering on the verge of dreaded, permanent annihilation of the soul.

These on-pause conditions are the opposite of joy. This is the opposite of the sense of being resonant with and literally *connected* to others and to the universe.

If stuck on pause long-term, the *sustained increase* in energy on the sides of the brain, combined with the energy *decrease* along the midline of the brain, can cause the development of anxiety, even paranoia. Anxiety and paranoia are very common side-effects of being stuck on pause for the long term. The anxiety can be focused on a single subject or it might be free-floating. For an example of focused anxiety, one of the more common paranoias seen in advancing Parkinson's disease is fear of "wrong diet": a morbid fear of eating "unhealthy" foods. This fear can become so illogical and severe that it can lead to starvation.

Oppositely, in a high degree of parasympathetic mode, a person realizes that his real nature is waves of loving vibration...not a physical, ever-changing body. In this state, while the head portion of the Du channel is running in a straight, narrow line through the center of the head, ego-based neural activity on the *sides* of the brain is deeply stilled. One can then feel the actual connection between one's individualized soul and Universal Love. Instead of starving to death from paranoia, a person in a high degree of parasympathetic mode might not *need* to eat. Instead, he can be nourished by the life-force energy flowing into his body at the medulla oblongata, on the back of the neck, near the brain stem. This inflow location is referred to in ancient scripture as "the mouth of God." [As in, "Man does not live by bread alone, but by every word (vibratory energy, the Amen, the Om] that enters from the mouth of God." (Matt 4:4).

Research using brain scans of highly experienced meditators, including some Hindu and Buddhist monks, shows them having this type of narrowed, highly focused electrical brain behavior. A person in this nearly pure parasympathetic condition can know his physical body as a temporary residence in which and from which he might lovingly experience various sensory events without having ego-based attachment to his experiences and observations. His pericardium wave energy becomes resonant with the midbrain's

electrical currents. This generates a profound body-mind harmony, and an increase in soul awareness and attunement with the Divine. [14]

During pause mode, when the Du channel is blocked at the base of the neck and unable to flow through the head in significant amounts, the other currents that flow over and through the head (Bladder and Gallbladder) can still provide support and direction to the currents inside the brain.

As noted earlier, when on pause, the amount of Du channel qi flowing through the *midline* of the brain is greatly reduced. When on pause, some of the structures that straddle the midline such as the thalamus and striatum (grossly generalized in some writing as the "feel-good" areas of the brain) are inhibited, even when awake. At the same time, the brain experiences *increased* activity in the *sides* of the brain: in the brain locations for fear-based risk assessment, hyper-analysis (anxiety), and the fear and rage centers (the two amygdala). These negative emotion areas are located directly under the Urinary Bladder and Gallbladder channels: channels that run on the *sides* of the brain.

In pause mode, the channels that flow front-to-back over the *sides* of the brain, the UB and the GB, seem to become more influential on thought behaviors *because* the back-to-front, midline-stimulating Du channel is blocked. This configuration of increased channel qi in the UB and GB channels, happening at the same time as a decreased channel qi in the Du channel, stimulates the various anxiety and rage-and-fear centers to a higher degree than normal. And meanwhile, the dopamine-regulated "feel-good" and motor areas are simultaneously inhibited. [15]

---

[14] For citations for this and some of the research and related physics on heart-wave/ brain-wave resonance, please see *The HeartMath Solution*, Childre and Martin, HarperSanFrancisco. ISBN 006251606-x.

[15] As an aside, one that might only matter to an acupuncturist, we are taught in school that all the Arm Yang channels have a branch that flows to Du-14. From what I have observed, these divergent branches are only active, only flow into the Du at the back of the neck, *if* the neck portions of the regular pathways for these channels are blocked. That's the only circumstance under which I've ever felt any of these workaround shunts that deliver Arm Yang channel qi to the head in spite of blockage. These shunts, officially called "branches," are technically divergences. These alternate routes are *only* used when the main neck pathways are blocked. These detours for neck channel qi blockages are incorrectly taught as being *always* active parts of the related Primary channels.

I've included this footnote to drive home that channel qi behaviors in and around the brain are *highly* variable if the body is not in good health and the mind is not under conscious control. In school, we are taught that the channels flow the same way all the time. Nothing could be further from the truth. The body has many ways to ensure maximum amounts of Du channel qi through the midbrain when awake. And the arm Yang channels only detour to Du-14 when a neck injury or neck illness prevents the normal route of arm Yang channel qi from traveling to Yin Tang. When blockages are present, these divergent routes provide alternative ways for getting this channel qi to Yin Tang: using the Du channel's pathway through the brain.

We read in ancient Vedic scripture that there are "ten thousand nadis." The nadis are the non-neural, connective tissue electrical pathways in the body. The phrase "ten thousand" was used in both ancient Vedic and ancient Chinese writing to mean "infinite."

Self-induced pause

The channel circuitries of pause mode can also be set in motion in response to a person's forceful command to himself to "Feel no pain" or some similar avoidance instruction. This command might refer to emotional pain and/or physical pain. The body does have a mode in which certain types of pain are minimized: pause mode. Use of this mode can quickly become habitual.

The usual five steps for turning off pause will not turn off this type of pause. Instead, the person must learn how rewire his brain so as to create a somatic feeling of being safe. Next, he must destroy the habit of using pause and *replace* it with the new habit of feeling safe. Only then can his brain override the seemingly addictive neurological behaviors that he unwittingly set in motion with his self-instruction, and thus stop his habitual use of pause.

Pseudo pause

In response to an unhealed injury, electrical circuits that *resemble* those of pause mode might develop quickly or develop slowly, over years. The injury might, at first, fully *or* only *partially* block a channel. In my limited experience, blockages from injury that lead to pseudo pause have almost always been along the Stomach channel or Du channel. This is not true pause: the patient hasn't lapsed into a state of near-death. Again, pseudo pause is a condition in which some or all channel qi behaviors might come to *resemble* those of pause.

The channel qi behaviors of pseudo pause can become chronic if the person *psychologically* dissociates from the trauma or injury. So long as *psychological* dissociation from the trauma or injury remains in place, the trauma or injury might never fully heal. The channel qi flow might remain aberrant in the vicinity of the trauma or injury. Immediately or over time, the channel qi flow might become completely blocked at the injury site or at a location that's become twisted or displaced while performing a *compensating* role for the injured tissues.

In the early years of a dissociated and therefore often painless unhealed foot injury, the Stomach channel qi might be only partially blocked on the foot. In my experience, the foot is the most common location for pseudo pause triggering injuries. Due to increased electrical resistance in the channel qi of the foot due to the injury, *some* amount of the channel qi might diverge on the side of the leg, upstream from the blockage, maybe going sideways from St-40 into GB-35, on the lower leg. This not unusual divergence might cause tension or a weird, unsettled feeling in the leg but there will be no backwards-flowing Stomach channel qi getting up to the forehead and no significant symptoms of pause. Yet.

Whether the electrical confusion at the site of the unhealed trauma or injury *initially* forms a partial or complete electrical blockage of a channel, this blockage might increase in size over time. If the electrical disarray grows larger, backwards Stomach channel qi might back up a little higher on the leg or even back up into the torso, where it might then flow sideways into another channel. If it flows backwards as high up as the neck, it might intersect with the Large Intestine (LI) channel qi on the neck and cause the LI channel to start flowing backwards, going *down* the arm.

After a few days or a few decades, as the chaotic channel qi in the vicinity of the injury continues to spread out, at some point, it's possible that almost *no* Stomach channel

qi can get past the original trauma or injury site. The affected channel qi might begin to spread sideways, dive deep inside, or flow backwards. In pseudo pause, symptoms might begin to appear that resemble those of pause, in areas where channel qi is now flowing in directions that resemble those of pause mode. For example, with almost no channel qi flowing into the vicinity of the 2nd and 3rd toes, at the terminus of the *parasympathetic* Stomach channel pattern, the toes in pseudo pause might become numb, just as they eventually do in actual pause mode, whether biological or self-induced. Fungus might eventually start to grow on the second and third toenails, just as it might do in pause.

Meanwhile, the force of the backwards-flowing channel qi might gradually become severe enough that Stomach channel qi flows backward all the way to St-6, and thence to St-8. In pseudo pause, when the build-up at St-8 is large enough, the channel qi will shunt into and augment the Gallbladder channel, just as it does during pause mode. From there, a decrease in the amount of Du channel qi can lead to inhibition of certain midbrain behaviors such as dopamine release for motor function, just as it does during pause mode.

To turn off pseudo pause, the trauma or injury must be treated. More exactly, the psychological dissociation that is inhibiting healing of the injury or trauma must be treated. Yin Tui Na is the most effective way that I have found for turning off the dissociation and thus allowing the trauma or injury to finally fully heal.

– (This book only goes into details for the treatment of pause and self-induced pause. Treatment for pseudo pause from dissociation is discussed in the book *Yin Tui Na*, available for free download at www.pdRecovery.org. It is also available in hard copy at www.JaniceHadlock.com.)

As a general rule, when aberrations in the flow of channel qi of *any* channel remain uncorrected for years, all bets are off with regard to how the channel qi flow might change, over what time frame, and what health problems might arise.

In pseudo pause, long-term, chronic, pause-type channel qi behavior can eventually affect more than just the muscles and nerves. If pause-type alterations occur in the channels that regulate the digestion and the mind – the Stomach, Du, Ren, UB, GB, Pericardium, and Liver channels – the digestion and brain might start behaving as if the person is on pause.

Blockages that prevent channel qi from flowing in the healthiest, parasympathetic mode patterns might come from a near infinitude of causes. Some of the most common reasons for channel qi to stop flowing in the healthiest, parasympathetic mode patterns are scar tissue, broken or displaced bones, damaged soft tissue and negative thoughts – including dissociative ones.

If the post-injury paths of least resistance are also paths that resemble those used during pause, then pause-like symptoms might appear. Whether from pseudo-pause, chronic (stuck) biological pause, or self-induced pause, the only certainty in terms of channel qi flow is that the channel qi will always flow in the path of least resistance. [16]

[16] Here's a plumbing analogy about resistance: blocked plumbing in a house causes the wastewater to flow *seemingly* unpredictably as it follows the path of least resistance through the pipes that are hidden in the walls. Sometimes a mild blockage will cause bubbling noises in the toilet and water moving transversely into other lines until it slowly drains, but a severe blockage

The pause override: the illusion of normal movement

Pause mode can sometimes be *masked* by an emergency-driven pause override.

The body is capable of producing *emergency* motor function even during pause. The "pause override" uses brain (neural) norepinephrine to provide emergency motor function. During pause, release of adrenaline from the adrenal glands is inhibited, as is the release of dopamine for the brain's motor area. But a mammal, and possibly other vertebrates, can still use brain-based norepinephrine to activate the motor neurons in the brain – not using the dopamine-driven, *parasympathetic* mode motor system but using the brain's motor instructions that are normally used when a person is sympathetic mode-dominant or when on pause.

If the animal or human is still conscious while being in pause mode, the risk assessment area of the brain is hyperactive. As noted earlier, visual and auditory sensations might become danger-oriented. If visual and auditory cues cause the risk assessment area to call for emergency physical movement, brain norepinephrine will be released for an override of pause mode's motor inhibition.

Pause mode is a condition usually characterized by immobility. In a life-threatening emergency, even while using pause mode, an animal or person using the override might be able to move seemingly normally. He might even come across as stronger, faster, and more focused than usual, while using the override. In this case, motor function is being activated via norepinephrine instead of dopamine. Dopamine activates motor function when a person is playful, peaceful, and un-self-conscious. Norepinephrine activates motor function during times of fear and emergency.

If he has elevated norepinephrine levels, a person who is stuck on pause might exhibit a heightened intensity of mobility, strength, and focus. He might have especially piercing eyes and/or a powerful smile. He might seem hyper-healthy even though pause mode is active. Invisible, insidious health problems such as Parkinson's disease or certain cancers might be developing, due the continuous use of pause mode…but the norepinephrine override will allow him to *appear* as if hyper-healthy.

As an aside, many of my Parkinson's patients were cancer survivors. I have to wonder if some part of the increase in Parkinson's disease diagnoses seen in the last fifty years is related to the fact that many people with cancer now survive. In Chinese medical theory, the growth of cancers is likely when there is a long-term disruption in the channel qi in the affected part of the body. It might be that, historically, many of the people who had backwards-flowing channels or channels that were standing still from the use of pause

---

beneath the house might result in raw sewage from upstairs spewing up at the downstairs shower drains.

If you can't *see* what's happening behind the walls when sewage is blocked, the movements of the sewage can seem unpredictable as to direction. But in fact, there is a logic and predictability in the system. The sewage will *always* flow in the path of least resistance. Water flow is guided by gravity. The flow of electrical systems, including the flow of channel qi, is guided by voltage differentials. In humans, the voltage differentials that drive channel qi flow, sometimes called ion flux, occur in response to many forces, including thought waves, body chemistry, food, the electrical fields of DNA molecules, and especially mental habits, to name just a few.

If the movement of either water or channel qi is blocked, the result might be "standing" water or build-up of channel qi, or sideways spillage, and/or backwards flow.

mode died of cancer or other pause-related pathologies long before any symptoms of Parkinson's got a chance to appear. Now that people are able to survive these previously deathly pathologies, they live long enough for their lives to ease up. This causes their emergency-driven norepinephrine levels to drop. This, in turn, reveals the pause behaviors, the symptoms that we call Parkinson's disease, that had been masked by norepinephrine. [17]

[17] 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.

According to the above research done at Emory University, when dopamine is not available for motor function due to MPTP application, the brain neurotransmitter used for motor function in place of dopamine is norepinephrine – a close cousin of adrenaline.

In this study, mice brains' *dopamine* receptors were chemically inhibited using MPTP, a synthetic opioid. Instead of exhibiting the expected Parkinson's-like behaviors, the mice still had what appeared to be normal motor function. Only after the *norepinephrine* receptors were then chemically inhibited did the mice show the "poverty of movement" and rigidity characteristic of Parkinson's.

Mice, like humans, are able to use norepinephrine, a fight-or-flight emergency neurotransmitter, to stay physically mobile even while their dopamine-movement neurons are inhibited. This research shows that only when the norepinephrine-releasing neurons in the brain are *also* inhibited do the mice manifest movement behaviors characteristic of Parkinson's.

My research suggests that Parkinson's symptoms can be hidden for decades via the norepinephrine override, even while the body's non-neural electrical system is running in the pause patterns. The more obvious motor 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.

As discussed in the book *Recovery from Parkinson's*, researchers have known since 2001 that people with Parkinson's have more than enough dopamine. An insufficient level of dopamine is *not* what causes the immobility of Parkinson's. My research suggests that the motor and peristalsis inhibition inhibition of Parkinson's occurs because a person on pause is biologically *inhibited* from using dopamine in the *motor* area of the brain. This inhibition stays in place until the use of pause mode is turned off.

In a high percentage of my hundreds of patients with idiopathic Parkinson's disease, a syndrome in which the channel Qi runs in the patterns of pause, the symptoms of PD began to appear when the various emotional "spurs" used by people on pause were no longer realistic enough to activate the norepinephrine override of pause. When a person can no longer use his favorite imaginary emergency scenario to keep the norepinephrine levels high, his underlying use of pause mode is exposed. In my patients, this loss of effectiveness of their emergency storylines often occurred when some life challenge was finally laid to rest: the youngest child finished college, the mortgage was paid off, tenure was attained, or the predatory uncle died.

For example, one patient told me that he was deeply concerned about losing his high level management job when his company merged with another, larger firm. His new manager called him in and said, "I can tell you're worried about your job security. You have no reason to worry: we don't get rid of good people." At that moment, my patient suddenly felt more relieved, and then more relaxed, than he remembered ever feeling in his life. Unexpected, profound waves of relaxation flowed over his body and mind. A few days later, his first, subtle symptoms of Parkinson's were visible. He was no longer worried enough about job security – his most

In the decades before the appearance of Parkinson's, because of their high levels of norepinephrine, true relaxation is often elusive for people who are stuck on pause. Friends might lovingly say, "You think too much!" or "You should relax now and then." The person who is stuck on pause and powered by norepinephrine might reply, laughingly, "I'll relax when I'm dead!" So true.

---

developed mental source for imaginary, emergency-grade fear – to sustain an adequate level of norepinephrine release. For most people with idiopathic Parkinson's, the reason their Parkinson's symptoms appear is *not* that dopamine levels have dropped. It's because their norepinephrine levels have dropped. The norepinephrine was *masking* the pause-driven inhibition of dopamine release. These people haven't used dopamine for *motor function* for decades – sometimes since childhood – and when they recover they are shocked by how utterly foreign it feels to use dopamine-based movement.

Dopamine release for motor function is inhibited by both the use of pause mode and pseudo pause, if pseudo pause mimics fully the circuitry of pause. In either pause or pseudo pause, people with idiopathic Parkinson's may have *long* used norepinephrine to override their inhibition of dopamine-based motor function.

Use of neural norepinephrine enables a person to keep moving, even moving with heightened power and speed. (Think of the mouse attacking the cat.) But eventually, when the ability to rouse or sustain a mental sense of constant emergency diminishes (this often happens when life finally becomes less stressful and/or a major stressor is ended), the ability to mentally activate the emergency norepinephrine override also declines. That's when the pause-like symptoms of idiopathic Parkinson's, including rigidity, slowness, and tremor, begin to manifest.

Tremoring is a *normal* transition behavior while coming out of pause or out of medically induced anesthesia. In people with idiopathic Parkinson's, their sense of diminished emergency makes their bodies behave as if the emergency or high degree of risk is ended or diminishing: the body is designed to tremor when the biological crisis/ emergency is over or is diminishing.

The tremor behavior is *not* a pathology. Tremor is *supposed* to kick in when the body has stabilized enough and it's time to assess whether or not the enemy is gone or the perimeter is safe: whether the danger is over. But in most of my PD patients, the appearance of tremor did not lead to a calm assessment of the situation resulting in turning off pause. Instead, the appearance of tremor *increased* the person's fear and sense of impending doom. Their fear-oriented minds quickly learned to fear the tremor itself. This new fear might even strengthen a person's conviction that pause mode is needed, and thus increase the strength and frequency of the pause-using habit.

Many people still cling to the "dead dopamine cells" theory of Parkinson's, but researchers have known since 2001 that people with Parkinson's have more than enough dopamine, and that the cells are dormant, not dead. Dopamine levels are *not* the problem. My research suggests that the problem in Parkinson's, as it is when stuck on pause mode, is that a person is biologically *inhibited* from using dopamine in the motor area of the brain during pause mode.

During in-depth interviews with hundreds of people with Parkinson's, I learned that many people with Parkinson's disease decided, often as children, that they could *never* be safe from physical and/or emotional pain. They were able to invoke, often while staring into a mirror, a state of relative numbness (pause mode). Ever since commanding themselves to feel no pain or be apart from feelings, they have been using self-induced pause. To sustain motor function, they have used the norepinephrine pause-override. When the ability to sustain a sense-of-emergency wanes, the movement-activating override begins to decline. Then, the underlying immobility of pause mode becomes increasingly apparent. The person begins to exhibits the early symptoms of the syndrome that we call Parkinson's disease.

Moving powerfully while on pause

The mouse going into pause after being caught by a cat was discussed in chapter one. The mouse returns in this chapter so that we can consider his pause-mode responses in more detail. Many of us have seen the cat-catches-mouse scenario. As the claws of the cat sink into the mouse (excessive perforation of the skin), the mouse immediately goes into pause. His body curls up into a fetal position and becomes rigid. He might appear to be dead. When the cat loses interest and leaves the scene, the mouse "comes back to life."

The mouse was not "playing dead." A mouse does not have the intellectual capacity or self-control to play dead. The mouse entered into an involuntary condition of pause brought about by perforation of his skin by the cat's claws. This collapse into the inert immobility of a high degree of pause renders the mouse cold, rigid, numb, and even corpse-like, and may well save the life of the mouse.

Many, many people have seen this "dead mouse" behavior. Sometimes, people imagine the mouse is just "playing possum": pretending to be dead.[18]

The pause *override* might occur *if*, after the cat abandons the seemingly lifeless mother mouse…the cat starts moving towards the mouse's nest and her babies!

If the motionless, open-eyed and listening, on-pause mother mouse perceives danger to its young from the cat, the mother mouse can immediately activate the neural norepinephrine *override* for pause mode. In this condition, the mother mouse might blatantly dart off in the opposite direction from her nest, to lure the cat away. Even though the mouse's channel qi is still running in the pause pattern, the mouse can move *super* powerfully and rapidly, by using the norepinephrine override. The mouse might even attack the cat.

We know that a person can run for miles, feeling no pain, on a badly broken leg *if* he is in mortal fear of his pursuer. If there has been significant loss of blood or other body-destabilizing traumas, his body's channels might be running in full-out pause circuitry. But he can still run for his life by using the norepinephrine override. Only when he gets to a safe place will his norepinephrine levels drop. At this point, he might pass out or exhibit other symptoms of pause.

Again, when he is finally in a *safe place*, norepinephrine levels will drop. (The significance of "getting to a safe place" will be discussed in the chapters on turning off pause mode.) Then he can succumb to the brain-altering effects of Rebellious Stomach channel qi shunting into the GB channel. He can rest deeply, barely moving, maybe on and off, maybe for days, curled up in an almost fetal position, while his body stabilizes and heals.

Of course, this type of *full-blown* pause mode, a condition in which a person or animal is motionless, is not usually seen in an acupuncture clinic. However, patients with

---

[18] The North American possum's "go-to-sleep" response to being startled is not a conscious trick. The possum has a hair-trigger, *involuntary*, full-body pause response when startled. The possum isn't making a decision: he is hard-wired to go into pause in response to just about any startle event.

The various species of Australian possums are *not* related to the North American possum. The Australian possums do *not* have hair-trigger pause responses. Some species are even cuddly. Thank you, Dr. Kevin Ryan, of Australia, for this natural history note.

a modified degree of pause or a situation in which some *portion* of channel qi has become stuck in the circuitry of pause might very well come to your office. Long-term use of a pause-type channel qi pattern can cause significant health problems, often causing syndromes of "no known cause," or various "incurable" syndromes and health problems.

A note to acupuncturists: just because a person is able to move perfectly normally, do *not* assume he cannot possibly be stuck on pause, either body-wide or in some portion of his body. He might be on pause *and* using a pause override. If a person or animal is still conscious following the onset of pause and is activating a strong pause override, he will *not* manifest a deathlike immobility. If a person can maintain a powerful mental prod of emergency – even a fictitious one – he can activate the norpepinephrine override and appear to move normally. The ongoing, constant mental script of emergency might have lines such as: "Gotta make lots of money for the kids' college or they'll be failures!" "Gotta pay off the mortgage or we'll be homeless!" "Gotta live up to my late parents' ideals or God will hate me!"

When a person no longer feels the need to sustain these fear-based, self-invigorating thoughts, when the long-practiced mental emergencies of risk or fear are no longer necessary or convincing enough to spur an imminent need for action, that's when the fear-driven, elevated level of noreprinephrine will *drop*. Then, with the norepinephrine override turned off, the underlying symptoms of of pause mode will begin to reveal themselves.

The pause pause override does ***not*** *work in drug- or toxin-induced parkinsonism*

It should be mentioned that a person who is nearly immobilized with advanced PD can usually move normally, even quickly and powerfully, in the face of a *true* emergency. Confronted with a fire, flood, or other emergency where death to self or others might be imminent, a person with *immobilizing* Parkinson's disease might move perfectly normally by using the healthy norepinephrine override until the emergency is ended or a safe place has been attained.

The phenomenon of people with PD moving normally during a *true* emergency was mentioned centuries ago in some of the earliest western-medicine writing about Parkinson's and has been a comfort to countless people with Parkinson's. [19]

It is important to note that these observations were made long before the use of the 20th century antiparkinson's drugs. In modern times, if the person has the almost inevitable brain damage from years of taking anti-parkinson's medications, the norepinephrine override might not work even in a true emergency. During the 1989 "San Francisco" earthquake that registered 7.1 and which was centered just outside Santa Cruz, my hometown, many long-time medicated people with advanced Parkinson's were alarmed when they found themselves not able to move at all in spite of the roaring noise, violent shaking, and collapsing house foundations. As plaster rained down from the walls, those people with Parkinson's who had been taking antiparkinson's medications for years expected to have full mobility during an emergency, based on the PD literature. But possibly due to brain damage from their antiparkinson's drugs and their consequent drug-

[19] *An Essay on The Shaking Palsy*; James Parkinson, Sherwood, Neely, and Jones; London; 1817.

induced parkinsonism – a syndrome that they now had *in addition* to their original idiopathic Parkinson's disease – those who had been on the medications for several years and were in an "off" period of their medications were completely immobile, as usual during an "off."

In summary

During pause, channel qi shifts into stoppage in the Du channel at the neck, disappearance of the Ren channel, backwards flow in the Stomach channel, and exteriorization of the UB at the neck. Other channel flow changes might also occur.

Pause mode is supposed to turn off *automatically* when a trauma comes to an end and the body navigates its way back to autonomic stability. Sometimes it doesn't turn off.

If a person's channel qi gets stuck in pause patterns following a nearly fatal injury or trauma, that person is stuck on *biological* pause.

If a person's mindset has been self-altered so that pause *cannot* turn off until the pause habit has been destroyed and a parasympathetic habit has been installed, that person is stuck on *self-induced* pause.

Either way, we can say that the person is "stuck on pause." Fortunately, even if a person has been stuck on pause for years, he can still turn off the process(es) that are keeping pause in place.

Chapter five

The Friend

Logically, chapter four, The Biology of Pause, would be followed by the chapter on How to Diagnose Pause. But before I can write about making an accurate diagnosis (Am I stuck on pause or not? If so, what type?), the subject of the invisible friend in the room needs to addressed.

In the second chapter, in the case study of the soccer player with itching skin, I asked him to imagine that a friend was in the room with us. The presence of his friend enabled him to relax, feel safe, and quickly help him determine that he was no longer at risk of imminent death. The next chapter, Chapter 3, had a few paragraphs introducing the concept of an invisible friend and a case study in which the patient *permanently* turned off self-induced pause mode within minutes, while silently talking with his deceased grandmother.

When trying to restart a dormant striatum, heal an emotional disconnect, or other aspects of turning off pause, cultivating a relationship with an invisible, beloved friend can be the fastest and most lasting way to do it. The parasocial relationship can help access parts of the mind that have been separated away from normal consciousness (psychologically dissociated). This access can be extremely valuable in forming a diagnosis or figuring out what type of pause a person is using (biological or self-induced).

In the field of psychology, silent or spoken communication with an *intangible*, *not* physically present, loving and trusted friend, real or imaginary, is referred to as a parasocial relationship. The parasocial relationship, what I call "the invisible friend," can be one of the most helpful tools for making an accurate diagnosis and for turning off pause. Going forward, for the sake of brevity, I will often refer to the invisible friend simply as "Friend" with an upper-case F.

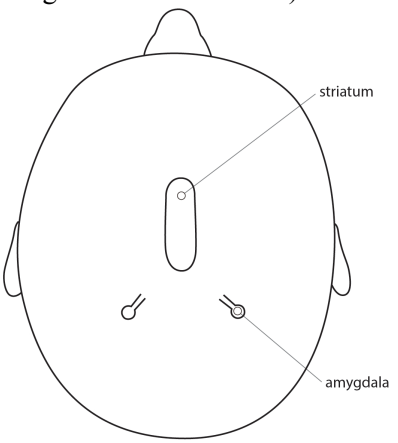
When a person is on pause, he is often neurologically disinclined to have this very normal, healthy type of relationship. Though it can be challenging, even seemingly impossible, for those using self-induced pause, cultivating this type of relationship can help speed or complete the process of turning off both types of pause. Cultivating this type of relationship is therefore my recommendation for the *first* step in turning off pause. The most common questions I get from people with Parkinson's disease who have been directed to my research are, "Where do I begin? How do I get started?" The answer, unlikely as it might seem, is: Start talking to a Friend, someone you love and trust.

What happens in the brain when conversing with a Friend?

In the early years of the 21st century, medical researchers in the field of neurotheology saw unexpected brain responses in people who were told to think about god during their brain scans. *Different* areas of the brain showed increased activity in different

people. What *type* of god a person had determined *which* brain area(s) showed increased activity.[20]

For example, if a person's god is a critical or vengeful god, then thinking about god brings about increased activity in the amygdala (the fear and rage centers on the left and right sides of the brain).



If a person's god is presumed to be knowable through word-based study such as memorizing or quoting scriptures, then thinking about god increases activity in certain word-driven brain zones, such as the Broca'a area on the left side of the brain.

If a person's god is feel-able and/or something one can physically resonate with, including causing the sensation of expansion in the heart/ pericardium, then thinking about god increases activity in the brain's *thalamus*, tucked inside the striatum. The thalamus processes somatic feelings (awareness of sensations inside the body) and regulates how and where we sense that we physically exist.

Fig. 17.3 Top-of-the-brain view
The amygdala (plural for amygdalum) are on the left- and right-sides of the brain. To review a side-view drawing of the brain, please see p. 29, Fig. 3.1: "A Few Brain Areas."

If a person's god is someone or something with whom the person can enjoy loving, mutual, thought- and/or word-based *communication*, then thinking of god increases activity in the brain's *striatum*.[21]

The neurotheology research project described in *How God Changes Your Brain*, cited below, started out as a search for *where* the idea of god was located in the brain. The discovery that god wasn't located in *one* place in the brain, but that different types of god activated different locations was actually *more* intriguing than just finding a brain location for god. My own research, building on that neurotheology research, suggests that it isn't

[20] *How God Changes Your Brain*, Andrew Newberg, M.D., Ballantine Books, 2010, Chapter 3. Some of his other books are *Why We Believe What We Believe*, *Words Can Change Your Brain*, *Why God Won't Go Away*, and *The Metaphysical Mind: Probing the Biology of Philosophical Thought*.

[21] For an example of further confirmation of the relationship between loving, word-based communication and the striatum, research done in 2019 used brain scans to show which brain areas are activated in children when they are being read to, as opposed to when children use computers or other "screen" devices for self-amusement. While books are read out loud to children – a type of loving, word-based *communication*, the children's brains' striatums become highly activated. This finding is from a study done by the Reading and Literacy Discovery Center of Cincinnati's Children's Hospital. "This is your child's brain on books: Scans show benefit of reading vs. screen time"; CNN Health, Sandee LaMotte; Jan 16, 2020; www.cnn.com;2020/01016/health/child-brain-readubg-book-wellness/index.html .

just communication with *god* that can stimulate the striatum. It appears that word-based communication with an unseen *anyone*, remembered or fictional, who is unconditionally loving, will have the same benefit to the striatum. This brings us to the subject of the new, twenty-first century understanding of the benefits of a parasocial relationship.

A quick history of our understanding of parasocial relationships

In the 1950s, the term parasocial relationship was coined to describe the strong relationship that an audience member might let himself feel with a performer that he does not personally know. Sometimes, an audience member member let themselves imagine that the performer has become a constant, personal friend. After the performance, when at home, the person might talk to and ask questions of the performer, silently or aloud, as if the performer was there. For example, "Oh Cher, what should I wear to work today? Help me decide." And the person would be able to hear or understand the responses that Cher made.

In the 1950s, when these relationships were first being described in psychology journals as a previously undiscovered form of psychosis, the researchers thought that any sort of conversational relationship with an invisible someone was a very rare and pathological event. These relationships with an invisible friend were assumed to be limited to fan/celebrity situations, because this is the first context in which psychologists came across this phenomenon. Now we know that parasocial relationships are extremely common and their nature is often determined by cultural settings.

For example, an older patient of mine with cultural links to native Alaskan traditions told me that, as a child, she was in almost constant communication with Raven. It was a two-way, loving and nurturing relationship. When she was a bit older and learned about the idea of God, she made a seamless transition: she understood that "God" was one of Raven's given names.

The Spirit Guides of many indigenous cultures can be thought of as parasocial relationships: they are healthy, helpful relationships in which a person gets love, support, and instruction from an invisible someone or something.

In ancient Hinduism, Bhakti yoga (the practice of constant devotion) can take the form of constant communication with any aspect of the Heavenly Beloved, including a guru.

In ancient Greece, visible *or* invisible loved ones that inspired and advised artists were called muses.

Brother Lawrence of the Resurrection (1614-1691), a French Carmelite monk, named the practice of maintaining a constant conversation with an invisible representative of divine love "practicing the presence of God."

The mystic (personal relationship with the Divine) branch of every major world religion holds that these loving, invisible relationships are crucial to knowing one's true nature and/or knowing God.

As every major world religion advises, "Pray without ceasing." (From Paul, in 1 Thes. 5:17–19, in the Christian New Testament.) Constantly communicating with a loved one, including listening to the loved ones' replies, activates the same parts of the brain and heart as constant, heart-felt, *not* rote, prayer, whether or not the loved one is physically present. The sense of connection and Love that we feel during word-based communication

with God, a messenger of God, or a beloved friend, is real. It is mutual. It is not imaginary, nor is it necessarily one-way, as will be discussed later.

By the way, if for you, there is no such thing as god, that's fine. Please mentally substitute the word "love" or "Universal Love" for the word "god" throughout this book. The message will be unchanged.

In the 1950s, in the USA, when psychologists (possibly atheists with little training in cultural and/or spiritual practices?) started enquiring into parasocial relationships, the relationships were presumed to be one-way conversations, highly unusual and unhealthy: a mental problem. Since the turn of the millennium into the twenty-first century, research suggests that parasocial relationships are not only normal, they are common, usually two-way, and extremely healthy. The conversations might be silent or, in a private setting, might even be one-sidedly out loud.

Recent research shows that people with vibrant, frequent mental communications with a *beloved* and *supportive* Friend, whether an actual historical person, a deceased relative, or a fictional character, are better able to make healthy decisions and better deal with emotional stress. People with parasocial relationships are more self-confident and less prone to depression and anxiety. They are *emotionally* healthier than average.

The ongoing research suggests that a healthy parasocial relationship is very much a nurturing, *two*-way relationship. It stimulates the same part of the brain as talking to God. These relationships can be enormously comforting, advisory, mutual, and *casual*: one might ask God or an invisible friend if they are having a good day, and then wait for the reply. The reply might come as words, or as a feeling of peace, or a sudden thought of something poignant and beautiful.

Some people still, incorrectly, consider parasocial relationships to be one-way, purely imaginary situations. You can find comments to this effect on the Web. This is the old, 1950s way of thinking about these relationships.

Significantly, and as noted in *Recovery from Parkinson's* since the earliest editions, most of my PD patients who were using self-induced pause didn't think it was *right* for them to talk silently, intimately with anyone: God, saints, sages, saviors, or even loved ones who had passed on. Most were certain that it was good for *others* to talk to God, saints, or deceased loved ones but for themselves, including the *many* religious professionals I worked with, this type of communication wasn't "morally right" for *them*.

Many of my paused patients have been *highly* reluctant and/or concerned about starting a conversational relationship with a Friend, when I asked them to do so. Many have told me – incorrectly – that only crazy people carry on silent conversations with departed loved ones, totem animals, or spiritual guides.

The ultimate goal for lifestyle hacks

Many modern day teachers of meditation, breathing techniques, affirmations, and other methods of retraining the mind and body state that, eventually, with enough practice, these types of techniques help a person feel a connection to something greater than the self – a connection to and even an ability to communicate with someone or something loving and wise. So why not go directly to the goal? Learn to talk constantly with a representative of love, whether a spiritual figure, a deceased relative, or a beloved pet. The goal is knowing one's true nature: love and wisdom and a feeling of connection with something universal. Meditation and mantras and service and watching the breath can all

help move one towards the sense that one can communicate with some representative of Love. But if that is the eventual goal of all these self-help techniques, one can also aim for it directly: talk to a Friend.

A person who is on self-induced pause will usually not get much benefit towards overcoming the pause habit from using indirect techniques that supposedly lead to calm, or to wisdom – techniques such as meditation and spiritual study. Likewise, the brain behaviors that occur while on self-induced pause inhibit the effectiveness of "lifestyle improving techniques" such as yoga, qi gong, and service. The purported highest goal of nearly all these techniques and methods is the attainment of a sense of peace and well-being that leads to feeling profoundly loved and connected to others: joy.

In my research, I have seen the *non*-results of these methods with hundreds of patients. But I *have* seen that just going directly to the goal, the goal of joy that comes with feeling loved and connected to others, *can* be attained, even by people using pause mode. Communication with a Friend, in my experience, is the most likely method for getting to that goal: feeling loved and connected to another: joyful. That joy causes a person to feel existentially safe. When a person feels safe, he stops using pause mode.

A Friend can help a person who's stuck on pause

For examples of how the Friend can be helpful in the context of turning off pause mode, it can be used in Step 2 of coming out of pause, when a person needs assurance that he is no longer at risk of imminent death or that the "exterior" is now safe. The Friend can give that assurance with authority. Focusing on the Friend can help divert a paused person away from his chronic internal monologue and his hyper-focus on the overactive risk assessment processes in the brain. After the brain's attention has been wrested away from its focus on risk, it can then focus on other information that has been "put on hold," such as what a lovely day it is, or how delightful the breakfast orange is, *or* what Type of Parkinson's disease a person has.

The Friend, whose very existence helps "open the heart" (increase the amperage in the pericardial tissue), can help a person access his superconscious mind. Access to the superconscious mind is related to the amount of energy traveling through the brain's striatum. The "open heart" works in tandem with the striatum. Both of these areas, the pericardium and the striatum, have diminished amperage when a person is on pause. Communicating with, or even *thinking* about a loving, ever-present Friend increases activity in the pericardium *and* the brain's striatum and can shift the consciousness closer to a positive attitude and even towards superconscious awareness. A person's higher level of consciousness, the superconsciousness, has fuller access to the information in the brain than the regular consciousness, and already knows if a person is using biological pause, self-induced pause, or both.

Most of my patients who have been stuck on self-induced pause, a mental state in which a constant, highly judgmental *mono*logue is usually active, have struggled with the idea of having, let alone talking with, a Friend. In that sense, the Friend – or lack of – can be diagnostic: if a person doesn't want such a relationship, can't fathom how to go about having such a relationship, or is repelled by the very idea of such a relationship, this strongly suggests that the person is using self-induced pause – a condition in which the person – or his subconscious mind – has become accustomed to, and comfortable with, and might even prefer, some level of emotional numbness and or a deep need for privacy.

He might even be nursing the conviction that "no one can understand me." An all-knowing and all-loving Friend will challenge that conviction.

Then again, a person using self-induced pause might very well *already* have some sort of communicative relationship with a Friend. If that's the case, and if the person wants to turn off self-induced pause, he might just need to *increase* the openness and honesty of his existing parasocial relationship: *greatly* increase degree of trust he has for his Friend. Instead of resenting or always wanting to argue with the Friend, he might need to start trusting and laughing with his wise and non-judgmental Friend. He might need to trust the Friend *more than he trusts his own clever mind.* He can decide to trust his Friend with his very life, instead of being certain that his own mind has all the right answers. And his conscious mind obviously *doesn't* have all the right answers, if it's gotten *stuck* in the habit of using self-induced pause mode and can't overcome it.

Most importantly, spending time with an always-present Friend helps sustain a healthy balance in the heart-brain relationship. People who are stuck on pause are stuck in a situation in which the brain has become electromagnetically dominant over the heart. This situation can also be phrased as "fear becomes dominant over joy." (Please note, in this chapter, when I say "heart," I am referring to the pericardium, what the poets call the "breast" or "inner breast") As will be discussed later in this chapter, in an emotionally *healthy* person, the *heart's* electromagnetic waves are dominant over those of the brain. In an emotionally healthy person, the *brain* waves are electromagnetically resonant with and *subordinate* to the waves generated by the heart. [22]

Cultural examples of the importance of the heart-brain relationship

Karl Jung, the famous philosopher/ psychologist/ explorer recalled a conversation with Ochwiay Biano, an elder of the Taos Pueblo Native Americans. Ochwiay Biano said,

---

[22] *The HeartMath Solution*; Childre, Martin; HarperSanFrancisco;1999; starting at p. 28. "The heart communicates with the brain through electromagnetic field interactions."

If you are curious about the physics and electromagnetic waves material in this chapter of *Stuck on Pause*, please read *The Heartmath Solution*. The groundbreaking research in *The Heartmath Solution* discusses the science behind the heart's emotional intelligence and wave behaviors, and provides the hard research data behind many of the statements in this chapter on heartwave behaviors. Other material supporting these same statements comes from Vedic (ancient India) scripture.

Western medicine continues to view human bodies and life itself from the archaic viewpoint of Newtonian mechanics, with physiology reduced to a sort of "clockwork" system of tangibles being subjected to entropy. However, cutting edge research shows that the dynamics of physiology are better understood using more ancient concepts of electromagnetic and gravitational (attraction/repulsion) forces and thought waves, as well as our hearts being connected to a universal intelligence that regulates the tiny atomic particles and the vast cosmos. These deeper principles were expounded in ancient Asian medicine, but due to the incomprehension of these principles during the last few thousand years of dark ages, the *science* of ancient Asian medicine was lost, and only the superficial processes of Asian medicine were continued. In the perpetual, thousands of years' cycling of decline and increase in human capacity for understanding, the hard science of biophysics that was the original basis of Asian medicine more than two thousand years ago is only recently, once again, comprehensible to eastern and western scientists, as well as the general public.

"White men…We do not know what the want, we do not understand them, we think that they are mad…They say they think with their heads."

Surprised, Jung replied, "Why, of course. What do you think with?"

"We think here" he said, indicating his heart. [23]

In other words, they paid attention to and obeyed the signals coming from the heart, including sensations of expansion and contraction, which occur when one is thinking and behaving in a manner harmonious or in conflict, respectively, with others and with the cosmos.

In some Native American cultures, a rite of passage to adulthood might include going alone into the wildness until the seeker feels a connection with someone or something, a "spirit guide," who will serve as the person's lifetime Friend. The relationship with a traditional spirit guide, who is a constant companion and loving confidant, is a type of parasocial relationship. In some cultures, people are encouraged to constantly rely on and talk to the ever-present, benevolent, even though invisible, ancestors. In most major world religions, people are encouraged to be always talking silently to whatever aspect of the Divine they hold most dear. There's a good reason that so many cultures and religions encourage cultivating the practice of constant conversation with a benevolent, invisible, *constant* companion. It keeps your brain working in the most healthy, honest, and efficient manner, and keeps the heart as "open" as possible. This heart /brain stimulation helps a person be parasympathetic dominant, with actions guided by joy and wisdom instead of focused on doom and gloom.

In Chinese medicine, the heart/pericardium is referred to as the King of the body. The Du channel, which can be translated to the "Governor channel," plays a large role in regulating the brain. The "Governor," by his very nature, is always trying to overthrow the King. The job of the King is to rule wisely, and not let the Governor get out of hand and throw the Kingdom into chaos. The true state of the Kingdom (the body, mind, and soul) is self-harmony and peaceful attunement with the Divine. The biological design of the brain will cause the mind to sow disharmony and conflict *if* it is not carefully, lovingly regulated by the heart and a well-disciplined Du channel.

In Chinese medicine, poor regulation of the heart–mind relationship is referred to as "Heart and Kidneys not communicating." The brain is considered to be an adjunct of the overall "Kidney aspect" or, more technically, the adrenal gland, which sits atop the kidney. The adrenal gland, energy storehouse for the fight or flight response, is closely associated with the brain's propensity for negative thinking. One of the most important jobs for humans is good regulation of the heart–mind relationship: making sure that the open heart is always dominant over the mind and that the fight or flight response is used as little as possible, and only when necessary.

Electromagnetic heart waves

The pericardium is a powerful source of electromagnetic waves. Even the primitive wave detection machines of the 1990s were able to detect waves from the heart from ten feet away. This includes the waves generated by the electricity that drives the beat of the heart as well as other electromagnetic signals that come from the pericardium.

[23] CG Jung; *Memories, Dreams, Reflections*; Pantheon Books; New York; 1961

Heart waves are much more powerful than brain waves. (See: The HeartMath Solution, cited on page 68.)

Once again, this crucial point: in a mentally and emotionally healthy person, the brain waves are resonant with and *subordinate* to the heart waves. In a *healthy* person, an increase in calm or joyful feelings causes the heart-area of the chest to be perceived as expanded, "lighter." The sensations of the heart area being "more open," "lighter," are related to an increase in the range of frequencies that are available to pericardial awareness. Oppositely, while stating or listening to universal untruths or an intentional lie, the number of frequencies available to pericardium awareness is decreased: the accompanying perception is one of tightening and shrinking in the chest area, and a feeling of heaviness, of increased density, in the body.

The consciousness of a person who is stuck on pause is usually outside of the body. When the consciousness is outside the body, the pericardium feels "tighter," more clenched, and has fewer frequencies available to it. This renders the pericardium unable to have full-strength responses to feelings or thoughts that reflect *either* truth *or* untruth. In this situation, brain waves lose coherence with heart waves. The brain signals can then become dominant over, "louder than," the signals from the heart.

Great saints and sages, through their attunement with wisdom and its concomitant fearlessness, have almost no restrictions on their heart's receiving and transmitting frequencies. This means their "heart radio" is able to tune in with the frequencies of others' hearts and minds, as well as other frequencies found in nature and throughout the universe. This is why people with "greatness of heart" are often able to tune in with Cosmic Intelligence and make huge breakthroughs in science, the arts, and social change. Oppositely, one whose heart is "shut down" (diminished pericardium function) can become dominated by ego-based, sides-of-the-brain behaviors. When the pericardium, the heart-radio, is significantly inhibited, as it is in pause mode, the striatum's release of dopamine is also inhibited. Life can become a downward-spiraling slog of negative thoughts, or a relentless obsession with risk assessment and the accompanying anxiety, fear, or even paranoia.

Attuning the heart

Tuning one's heart in with the electromagnetic signals generated by nature or even the thoughts of others is *not* some rare and magical phenomenon. Nearly all of us have unexpectedly thought about a friend who hasn't been on our radar for a long time and then, within the next day or two, that friend calls, sends a letter, or makes contact in some way. We might remark, "That's uncanny! I was just thinking of you!" The friend was thinking of *you* when they dropped that letter in the mailbox, and *your* heart-radio receiver picked up their thought. That's why you suddenly thought of your friend.

Anyone who has ever had an uncanny hunch that came true was using the heart as a radio receiver. Anyone who has ever uttered a "heart-felt" prayer has been using the heart-radio as a transmitter. The so-called "sixth sense" is merely an enhanced ability to be aware of, to mentally tune in with, the signals that the heart-radio is constantly receiving and transmitting. Humans can learn to use the heart radio as a life guide.

For beginners just learning how to use the heart as a guide, the heart can be used as a truth detector for simple, yes-or-no statements or questions.

The heart as a truth-or-lie detector: an exercise

The heart radio can be used as a truth-or-lie detector. We can use this feature in countless ways, including for medical self-diagnostics. To test this premise, you can try the following:

1. Notice how your chest feels inside.
2. Say out loud that your birthday is on some day that is *not* your birthday. For example, if your birthday is January 1st, say out loud, "My birthday is August 12th ." or any other un-true date.
3. Notice how your chest feels inside.
4. Say out loud the real date of your birthday: "My birthday is January 1st."
5. Notice how your chest feels.

If you have a healthy relationship with your heart – actually your pericardium – you will have noticed that the general area of your heart felt smaller, withdrawn, or tense when you did the false birthdate part of the experiment. When you said your true birthdate, your heart area felt expanded, larger, and lighter.

Your heart is constantly responding to your thoughts, activities, and your surroundings with expansions or contractions. Paying attention to these responses is what's meant by the phrase "listening to your heart."

If you are stuck on self-induced pause, your pericardium *might* feel chronically small, tight, and tense, so you *might* not be able to *feel* in the chest the difference between the truth and a lie. If this is the case, and you do not believe that the heart behaves differently during a lie than during the truth, have a friend who is *not* using self-induced pause do the above birthdate experiment. Your friend – if not also on pause – will notice these chest sensations. This might help you feel confident that the heart truly can be used as a truth or lie detector – so long as pause is not currently the dominant mode. This confirmation might help strengthen your resolve to develop a healthy relationship with a Friend…because constantly communicating with a Friend can open the heart.

Conversing with the Friend can help expand the number of reception frequencies of the heart-radio that one is *aware* of. This allows the heart to serve even better as true-or-false detector. Cultivating a relationship with a Friend can increase the amperage and bandwidth of the heart-radio. And here's the snapperoo, or payoff: a healthy heart-radio works in sync with the striatum. Remember, the striatum is a part of the brain that is inhibited to some degree when a person is on pause. An *inhibited* striatum leads to *inhibition* of joy, of dopamine release, and of flowing, unself-conscious movement. And thinking of or communicating with a Friend directly *stimulates* the striatum. So if you want to stop using pause, talk to your Friend.

The heart: a powerful diagnostic tool

The body is designed to heal from trauma or injury. Very often, health problems fail to heal because some aspect of the health problem – or some related problem – has been *dissociated* from normal consciousness. The body cannot heal those things of which it is not aware. The mental blockages that prevent healing might be buried in the sub-conscious mind, *deliberately* made inaccessible to the conscious mind. But the heart-intelligence and the superconscious mind have access to *all* the information in the brain – the hidden as well as the obvious. By learning to pay attention to the Friend *or* the shifts in

the heart's electromagnetic fields, one can ask questions of the Friend or the heart – and get answers. Then, using the responses of the Friend or the expansion or contraction responses of the heart as diagnostic tools, a person can discover those issues lurking in the brain that are causing healing to be stalled – and resolve them.

For example, we can mentally state. "I am going to be OK in spite of a pain in my wrist." If the Friend says yes, or if the heart expands in response to that statement, that means the statement is correct – you don't need to worry or do anything: the body is aware of the wrist situation and is working on fixing it.

Oppositely, if the Friend says, "No" or "you're wrong," and/or the heart feelings in the chest grow tight in response to the statement, your wrist problem might need help or might be indicative of a larger problem, one that might benefit from your paying some conscious attention to re-associating with the area and fixing it, or might include working with a medical specialist. You might need to ascertain, again asking your Friend or listing to your heart, *what* the underlying problem is, and how to fix it.

More to the point of this book, if you are trying to determine if you are stuck on pause, and whether or not it's biological pause or self-induced pause, you can ask your Friend or heart that question. Asking the Friend is electromagnetically the same thing as asking your heart. Many people have a very hard time having conversations with their heart or with the formless Infinite Omniscience. They often find it far easier to have a conversation with a beloved, ever-supportive and even brutually honest Friend. In most cases, I recommend communicating with the Friend, *not* the heart. For most people, it's much, much easier, and the answers are clearer, at least in the beginning.

For many people who've grown up in western culture, learning to stay in tune with subtle changes in heart feeling is a challenge, at first. For many people who are using pause, it is nearly impossible. Therefore, I do not ask patients on pause to listen to their hearts. Instead, I ask them to talk to a Friend. Talking to and learning to love and trust the Friend who is always there, always listening, and always answering with truth is much, much easier. The result is the same: talking to the Friend helps make the heart more accessible and feel-able, and vice versa: learning to keep the heart as open as possible allows the most intimate sense of connection with a Friend. And they both stimulate the striatum and thus restore the Du channel flow through the center of the brain, which allows for the release of midbrain dopamine, which makes a person feel safe, and which is the immediate goal in working to turn off pause mode.

So talk to your Friend.

Chapter 6

How a Friend Helps Turn off Pause

This chapter will give a few short examples of how a Friend can help a person turn off pause, and then explain some eastern medicine principles regarding the Du channel and how the Friend assists in keeping that channel healthy.

The heart and the mind at odds: an example

This example shows in detail how the Friend can be used therapeutically. There is no need to memorize the treatment sequence: a later chapter goes into more specifics. Very often, the heart and the mind of a person stuck on pause will not agree. They will give opposite answers to the same question. For an example of the heart and mind not being in agreement, I often ask this pair of questions when working with a patient who seems to be stuck on *biological* pause:

First, the patient asks his Friend, "Am I at risk of imminent death (death in the next two or three minutes) from that decades-old injury/ trauma?" Second, I ask the patient, "Do *you* think you are at risk of imminent death from that old injury/trauma?

Remember, being at risk of imminent death is the underlying reason for being on *biological* pause mode. The paused patient silently addresses this question to the Friend. In response to the question, the patient will either have a feeling that the Friend is saying: "No, you are not at risk of imminent death from that decades old injury" *or* the Friend will say "Yes, you are still at risk of imminent death." Let's assume the *most* common response that patients in my office receive from the Friend: the Friend says no, you are *not* at risk.

Then I address the question to the *patient*. I ask the *patient*, not the Friend, "What do *you* think? Ignore your Friend for a moment. Forget what your Friend says. Do *you* think you might be at risk of imminent death?" The reply to this question must be spoken out loud.

Almost always, a patient who is stuck on pause will say to me something like, "Yes! I *am* still at risk of imminent death."

This is what I mean when I say that the heart and the mind do not agree. The patient's Friend (and therefore his heart) is saying, "You are no longer at risk of imminent death." But the patient's mind is saying, "Oh yes I am!"

If the Friend says the patient is no longer at risk and the patient says the opposite, this means that the *body* is stable enough to turn off pause but the patient's *mind* is still stuck with the idea that he can't yet turn off pause.

Turning off biological pause

For turning off *biological* pause, and especially if the patient has found an area in his body that seems to be dark and *agitated*, I might use the above pair of questions – one addressed to the Friend, the other addressed to the patient, quite a few times – until the patient's Friend and the patient's mind come into agreement.

I repeat the above questions: again, the patient asks his Friend if he, the patient, is at risk of imminent death. The Friend says no, you aren't about to die in the next few

minutes from that old injury. Next, I ask the patient *again* if he is about to die from the old injury. He will say yes. I will repeat this pair of questions as many times as necessary, until the patient's mind can finally agree with his heart. The Friend will not change his position – he's speaking the truth. At some point, after several or twenty rounds of the same two questions, the patient suddenly realizes that his Friend is right. Often, this occurs when the Friend is perceived as starting to laugh or roll his eyes at the patient. But even so, the patient often can't *say out loud* that he is no longer at risk of imminent death for at least a few more go-arounds. His words might catch in his mouth as he tries to say out loud, "No, I'm not at risk."

But eventually, in every case I have worked with, the patient is finally able to form the words, spoken out loud. "No, I'm not going to die in the next few minutes from the old injury." And when he does this, he experiences a wave of relief.

This failure to agree between the conscious mind and the superconscious mind, this "difference of opinion" can be called a heart/mind conflict. As mentioned previously, this is referred to in Chinese medicine as "Heart and Kidney (brain) not Communicating." I have seen this type of heart/mind conflict countless times in patients who were stuck in some situation where the body was failing to heal or failing to turn off pause.

After the first half dozen repeats of both questions, the Friend might be at the point of laughter. The Friend might say something like, "I already told you. You're being ridiculous. How many more times do I have to tell you? You aren't about to die in the next two minutes because of that neck injury fifty years ago!"

After several – or dozens of – repetitions of these questions, the patient will reply to my question with less confidence: "Well, yes. *Maybe*. I mean, sure, yes, it's *possible* that I'm gonna die right now." His conviction that he's at risk of dying in the next two or three minutes from the old injury is beginning to waver.

Eventually, after four or five, or fifty rounds, alternating between asking the Friend and asking the patient, as the Friend remains firm in his conviction that the patient is not going to die in the next few minutes from the decades-old trauma, and is very often highly amused by the patient's sullen determination, the patient starts to grow increasingly uncertain that he is, in fact, at risk of death in the next few minutes from the injury.

After a few more, or a few dozen more, back and forth questions addressed alternatingly, from the patient to the unwavering Friend and then from *me* to the sheepish or conflicted patient, the patient starts to laugh. Finally, the patient is able to state, in all honesty, "No. I'm not going to die in the next few minutes from that old neck thing" (or whatever the trauma was).

However, even at this stage in the questioning, the patient's voice might not carry conviction. His voice might sound as if he is harboring doubts. I continue asking the questions until the patient says with firm authority, "No! I'm not going to die in the next few minutes from that old injury/trauma!" The patient might even laugh, or feel a wave of relief rush over his body. He might automatically take a deep, audible breath – a sigh of relief.

This completes Step 2 for coming out of biological pause: I am no longer at risk of imminent death: I am safe.

After that, the body's long-postponed, natural inclination to let go of being on pause from the old injury or trauma kicks in. The patient might then *automatically* go through the rest of the Five Steps that turn off pause. Or the patient might need to get

coached through the three remaining steps. Either way, the patient finally is *capable* of healing – he's stopped enforcing a wrong thought in his mind: "I'm about to die!" The stuck, wrong thought was the thing that was preventing him from turning off *biological* pause mode, then shifting into parasympathetic-dominant mode, and then healing.

The Friend's many roles

The above was just one example of how helpful it can be to have a Friend. Getting back to the main point, a supportive, invisible Friend can help a person figure out a diagnosis, determine what needs to be done, or in the dueling questions described above, can challenge and even help remove the mental blockage that was preventing healing or keeping pause in place.

The Friend can be helpful in overcoming a wrong habit, as well. In working with health disorders where someone is dissociated from an injury or trauma, hasn't been able to move on from it, or is stuck on biological pause, working with the Friend can be the fastest, most effective way to end the stymie and start the healing.

The injury-based, stuck on imminent-death situation described in the above example mainly arises in people with injuries that failed to *fully* heal, such as the non-Parkinson's patients described in the first chapter of this book, or in people with Type IV PD – Parkinson's from being stuck on *biological* pause. This dialogue will *not* help treat *self-induced* pause. In these cases of being stuck in biological pause, the injury *was* initially life threatening, at first, and so the person switched into pause mode. Over time, the injury stabilized and was no longer life-threatening, but pause never turned off. That's the problem: pause never turned off. The body does its deepest healing work in parasympathetic mode. When a person is in pause mode, some superficial healing can occur, but the more thorough healing is put on hold until the risk of imminent death has passed. "Superficial healing" includes stopping the bleeding, restoring normal blood pressure, and other issues that must be dealt with immediately in order to prevent death. The deeper healing, such as repositioning displaced bones and soft tissue to their correct settings, fully healing damaged tissues, nerves or organs, and/or correcting the disrupted flow of channel qi, might not occur until after pause has been turned off and the body is able to spend time in a "safe place."

"Yes, you are at risk"

In the preceding, dueling-questions scenario above, the Friend said, "*No*, you are *not* at risk. Sometimes, *much* less often, the Friend says, "Yes, you are still at risk of imminent death." This means that the degree of displacement of bone or soft tissue, or other aspects of the trauma are still severe enough that you might seriously injury yourself further or even die if you turn off the rigid back, neck, or head muscles lock-down that usually accompanies pause mode. In this case, the physiology of pause might be keeping your spine somewhat rigid, and/or keeping various micro-muscle lock-downs in place along the spine, neck and head, preventing further damage in these critical areas.

If the patient gets a "Yes" response from the Friend, the next question the patient asks the Friend is "Where in the body is the danger located?" After the Friend suggests the location of the on-going problem, that's the area that should be held with Yin Tui Na until the mind re-associates with the area and starts doing healing work in that area. During the treatment, the patient can ask the Friend now and then, "Am I still at risk of imminent death from *this particular* trauma?" After the area being supported finally fully relaxes –

which might take more than one treatment session – the Friend might say, "No, you are no longer at risk of imminent death from *this particular* trauma."

If, at that point, the patient does not automatically take a deep breath, bobble the head, and shiver the spine, he can be encouraged to mechanically do so. If he needs help getting his neck or shoulders to move, a family member or friend can move these areas for him. If the patient feels that those areas *should not* move, that it's still unsafe to move those areas, he can ask the Friend if he is still at risk of imminent death. The Friend might say yes: if so, there might be *another* injured area(s) that still needs to be addressed.

These two vignettes, the "No, you are not at risk" and "Yes, you are at risk" were provided to give examples of ways in which the Friend can be of help. Later chapters will go into other specific ways in which the Friend can be used therapeutically, depending on what type of pause a person is stuck in. When an illness cannot heal because of an electrical glitch, the source of which is primarily in the *mind*, the fastest treatment method will be one that engages the mind's *overseers*: the heart and the superconscious mind, which can be accessed via the Friend.

Using the Friend in other situations

In people with Type I Parkinson's disease, the problem is usually not a specific injury that still is or is still presumed to be imminently lethal, as was the case in the above examples. Instead, with Type I PD, the most common type of Parkinson's disease, the problem is usually a *generalized* conviction that one is unsafe. The person does not have a specific injury or trauma which, at the time, might have been potentially fatal. He has a *habit* of using pause. The Friend can play a crucial role in helping people get rid of the habit of using self-induced pause.

People with any type of Parkinson's disease, or almost any other condition that involves being mentally or emotionally stuck in a trauma mindset, might find themselves benefiting – as most humans do – from having a loving, fun, conversational relationship with a constant Friend. A loving relationship with a Friend can activate the striatum and thereby make the person feel safe. Again, being able to feel safe is a crucial part of turning off pause, whether biological or self-induced. For a person stuck on *biological* pause, the Friend can be the voice of wisdom that helps a person admit that he is not going to die in the next few minutes from a previous, maybe decades-old, traumatic event. For a person stuck on *self-induced* pause, cultivation of an utterly safe, loving, and *constant* friendship can, over time, slowly increase activity in the person's striatum, thus making his body *feel* safe now and then, and thus start to develop a new habit of feeling safe that, once strong enough, can be used to replace the old habit of using pause.

A spot of theory

The rest of this chapter has information on physiology, Chinese medical theory, and ancient spiritual teachings that help support the idea of using a Friend to address medical issues that have a mental or emotion component.

The animal mind, the animal brain

The undisciplined mind, non-coherent with the electromagnetic waves of the heart, is usually scattered: tuned in with one's own ego and its attendant resentments, fears, prides, desires, wrong habits, wrong ideas, and a thousand personal attachments.

Oppositely, a disciplined, highly focused mind using wavelengths that are coherent with and subordinate to the heart can help the pericardium tune in with any or all of the electromagnetic frequencies being released by the brain *and* all wave signals that are floating around in space – an almost infinite number of electromagnetic signals.

In order to attune the conscious awareness with truth, with the signals from the pericardium that reflect truth, so as to *feel* joyful inside or get a correct answer to a question, one needs to train the mind to hold the mental focus on love and joy – *or* on a Friend who inspires feelings of love and joy. The simplest and fastest way that I've found to both re-activate the striatum and increase heart attunement, based on my decades of following the modern research, my study of world scripture, and my patients' experimenting with nearly every theory, ancient and modern, for attaining the inner peace that leads to feeling inherently safe, is to have the patient communicate with a loved and trusted Friend.

Again, many people have a hard time "hearing" and/or feeling signals from the heart. Whether it's easier to listen to the brain or the heart depends on one's personality, upbringing, and spiritual training. For many people, especially in western cultures, listening to thought-type signals from the brain – most of which are negative, by design – can be much easier than listening to the heart. But talking with a Friend can override one's focus on the brain's negative nattering and shift it to a positive focus.

Our human brains are derived from an animal model. Many of a mammal's learned behaviors serve to increase the animal's wariness and self-protection. The mammal brain, in most cases, is designed in large part to learn what to fear. As humans, we can use our brains for much more than this, but still, many underlying animal features of our brains are oriented towards learning about danger: learning wariness around *realistic* dangers; what to *reasonably* fear. The animal brain is not designed to learn what to love. That comes automatically, from the heart. Most mammals are born curious and loving. Fear of realistic, practical danger is what most animals must acquire, and quickly, in order to be safe. The brain is designed to help them learn this. But humans who are not taught to focus on their hearts are at risk of developing an exaggerated, unhealthy level of focus on fear and/or negativity.

Of course, a few species are known for not being easily susceptible to fear. For example, members of the cat family do not have many natural enemies, and have only a few, innate fears. Maybe this is why cats were so respected in ancient Egypt.

Our human *hearts* are also derived from an animal model. They provide electromagnetic attunement with the world around us. For an example of this heart attunement in animals, go to your local civic aquarium and watch an entire school of fish change direction while moving as if one. Or watch a dog circling before sleep, attuning his spine along the earth's magnetic north-to-south axis before settling down.

As humans, we can *consciously* choose to listen to our hearts instead of our minds. Many of the spiritual practices of major world religions and of indigenous communities are methods that help us develop our awareness of our heart radio and increase our attunement with the signals of choice: the signals that give us compassion, understanding, wisdom, and even contact with the Divine: signals that make our hearts feel open and in harmony with our brains. As heart awareness grows stronger, the mind necessarily becomes more subordinate to the heart. The strength of ego diminishes as a person trains himself to listen to and obey the heart rather than the mind.

We have many ways to increase heart receptivity and learn how to pay attention to it. For example, as we calm the restless mind in meditation or practice various "mindfulness" exercises, and/or as we recite rhythmic prayers or mentally send positive wishes to others (another form of prayer) then we are better able to shut out nattering, circular, fear- and ego-based brain behaviors. We become more aware of the signals and information being constantly received and transmitted by the pericardium. But while on pause, access to the heart might be limited. So instead of trying to *force* the heart to feel open, talk to your Friend. Being in a nearly constant duologue with a beloved Friend is one of the fastest ways get better access to heart intelligence and diminish the negative habits associated with ego/fear dominance.

Reluctance

Many of my patients who were stuck on self-induced pause had a profound fear of engaging with a Friend, or strong doubt that they could ever develop such a relationship. After all, being on pause makes it very hard to communicate with some loving intangible. Over the years, people stuck on pause might come to fear the very idea of communicating with someone or something intangible. They often justify this fear by deciding that it isn't a perfect or morally right thing to do. I've often had patients justify their fear or reluctance to have a Friend by saying it will distract them from what they feel is their job of assessing everything and/or worrying about everything: "Worrying about everything is *smart*. Always anticipating what might go wrong is what keeps me safe."

Still, no matter how much a person on pause doesn't *want* to cultivate such a relationship or is certain that he cannot, he still should learn to do it, if he wants to turn off pause. This idea, the conviction that one cannot, absolutely cannot, have or talk to an invisible Friend, is a pause-related brain habit. If talking to a Friend proves to be an utter impossibility, Chapter twelve has an exercise that destroys this particular idea. You created this idea and you can destroy it. The habit of thinking that you cannot silently talk to anyone who is loving and non-judgmental is *not* smart, nor is it keeping you safe. It *can* be a part of the stuck-on-pause pathology.

As an aside, this chapter's brief introduction to the "heart radio" could serve as a doorway to endless and possibly pointless philosophical and/or spiritual discussions about the role of the heart and consciousness in man's attempt to know both his own soul and the nature of the Divine. But I'm not going down that path. The heart information presented here is only meant to help the reader understand the role of the Friend.

My concern, in this book, is not philosophy or trying to cram spiritualism or any particular religion down anyone's throat. My purpose is to help people stop being stuck on pause mode. Conversing with a Friend serves to augment communication with the heart and diminish the decibel level of the ever-nagging, negative, fear-driven aspects of the mind. It also increases activity in the striatum.

Talking silently to a loved one is not unnatural or "crazy," nor is it "dangerously spiritual," as many people on pause assume. Talking silently to a loved one is one of the healthiest and most natural mental activities you can do.

For example, let's forget about God, for a moment. Instead, consider that this conversational stimulation of the striatum is also related to the glorious feeling of being in love. When a person deeply loves and trusts another, then even when they are apart, the person might be constantly thinking about the loved one and even silently conversing.

And as a friend said to me recently, "When you're in love, you're always thinking of your loved one, even imagining that you're talking to each other. And the whole world just seems like a better place."

Even if a person isn't in love, or doesn't think he will *ever* be in love, he can still achieve the same brain stimulation by talking to a Friend. So please don't think that this Friend relationship has to be something mysterious and/or spiritual. It is as common-sense and every-day as love should be.

What my on-pause patients discovered was that, if they taught themselves to cultivate a constant, trusting, two-way conversational relationship with someone or something with whom they could laugh and be unguarded, they eventually experienced perceptions in the chest as if the pericardium area was increasing in energy and size. Sooner or later, when they were able to feel that the Friend was actually present, right there in the room, listening to them, talking to them, then their brains eased up on their constant negative monologues. They began to feel safer.

As was also noted in the 2020 edition of *Recovery from Parkinson's*, those people who had a very quick, nearly instantaneous and *lasting* turning off of pause mode, what I call the "epiphany recoverers," did so while talking *more* fervently, openly, and honestly than usual with a deceased loved one, or with God, or some representative of the Divine with whom they *already* had a long-time habit of talking, at least intermittently.

In the first chapter of this book, I referred to mechanically re-constructing the brain circuits that make a person feel safe, if the normal, healthy *on*-switch for these circuits is stuck in the "off" position: stuck in the pause position. Talking constantly with the Friend is what flips the switch and restores or re-constructs those brain circuits.

Cultivating a *constant*, *laughing*, loving, conversational relationship with a Friend is the simplest way to do a brain by-pass of the self instruction that originally triggered self-induced pause. The self-instruction was a command of something along the lines of "feel no pain" or "feel nothing." By stimulating the striatum via almost *constant* communication with a loving Friend, the striatum can be activated enough that the brain registers "feeling safe." This fulfils the requirement of step 2 of the Five Steps for turning off pause: confirm that you are now safe. Once the brain confirms that the body *feels* somatically safe, pause mode, whether biological or self-induced, can be turned off. Of course, in people with self-induced pause, after turning off pause, pause mode will turn back on again, from habit, in response to the next negative thought that comes along. But every time pause turns off, even momentarily, in response to enjoying a conversation with the Friend, the new "I'm safe" habit grows a bit stronger.

Heart-brain communication

Another important biological event that is associated with increased activity in the striatum is improved communication between the heart and the brain. As mentioned in chapter 4, the straighter the mid-brain flow of the Du channel, the greater the electromagnetic resonance with the heart and the *less* the influence of the fear-based aspects of the ego. This section will expand on that subject.

You will recall that, in pause mode, most of the Du channel qi cannot run up into the head: it is significantly blocked at the back of the neck. In order to turn off pause, restoring the flow of the Du channel through the head – which passes right through the striatum and flows through the spot between the eyebrows – is crucial. Some of the

upcoming techniques for turning off pause will involve this part of the Du channel, so it might be helpful to learn a little more about it.

When a healthy (not on pause) person is awake, the head portion of the Du channel travels from the back of the head, through the mid brain to the forehead and to the spot between the eyebrows, and then down into the mouth.

The third eye

This section introduces the importance of the spot between the eyebrows, where the Du channel emerges from the brain. This point between the eyebrows has nearly worldwide importance. This is also the area a person should be gently focused on while talking to a Friend. If the eyes are open, one can imagine a small spot of energy glowing at this point. If the eyelids are closed, the eyes can also be gently lifted, as if gazing at this point.

This spot is known in Chinese as Yin Tang: meeting point of the channel energy. It is also called the Third Eye.

In Sanskrit, this location is the Kutastha Chaitanya (literally, the location for "the consciousness that remains unchanged": the immortal aspect of the soul.)

In English translations of eastern philosophy, this area is often referred to as the Third Eye.

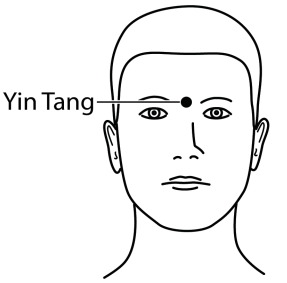


Fig. 6.1 The upper part of the Du channel. The location between the eyebrows is Yin Tang, the "third" or "single" eye.

The five-pointed white star that can be seen during profound, relaxed focus at this spot located on the front, or "eastern", side of the head is also referred to as "the star that shines in the east." In the Christian "mystic" (personal relationship with God) tradition, the brightness that can be seen during deep concentration at this spot is referred to as the "single eye."

In the famous Arabic story of the genie in the lamp, the genie is a metaphor for the all-conquering soul awareness that becomes knowable when the "lamp," the brilliant light of the third eye, is stimulated, or "rubbed." As for the three wishes imparted by the genie, this is a reference to power that a spiritually focused person can wield over the three aspects of creation. The three aspects are 1) the material, tangible realm; 2) the realm of matter-creating and -influencing wave energy (light, sound, and gravity waves); and 3) the realm of pure ideas, or pure consciousness. This power over the three creative aspects of energy/consciousness is imparted to those who can perceive the light glowing from this divine "lamp" at the point between the eyebrows.

Paramahansa Yogananda (1893-1952), a Hindu, widely considered the "Grandfather of yoga in the west" translated the Hindu name for this spot into English as "the Christ Consciousness Center."

The spiritual significance of Yin Tang is so nearly universal that the atheist Chinese government, in their determination to get rid of God, officially removed Yin Tang from the Du channel when they created their modern, twentieth century point-numbering

system. Unlike the other acupoints on the Du channel, Yin Tang does not have a sequential, numbered name that starts with the word "Du." For example, other Du points are named Du-1 through Du-26. But Yin Tang, located in between Du-24 and Du-25, has been reclassified, "demoted," to a mere "extra point." Although it is located on the path of the Du channel, acupuncture students in China are taught specifically and illogically that it is *not* on the Du channel. It is merely an "extra point."

As mentioned in chapter 4, in the late 1990s, brain scans of people who are more intelligent and focused show a narrow line of activity through the midbrain and ending in the vicinity of Yin Tang, the third eye, when doing problem solving, as compared to those who are slower thinkers, whose entire brain might light up with increased activity while frantically searching high and low for answers.

Building on that finding, subsequent research showed that people with a long history of professional-level meditation (monks belonging to various eastern religious orders) who include focus at the third eye as part of their meditation process had the same type of brain behaviors as the "quick intelligence" group: highly focused neural activity along a thin line through the midbrain, ending at Yin Tang.[24]

Vedic and Chinese texts explain this phenomenon: when the *sides* of the brain are engaged (when the Du channel "meanders" through the brain, as it says in the ancient Chinese medical texts), the brain is ego-based and inefficient. But *when* a person has learned to keep his focus on the Third Eye, so that the Du current moves through the head in an almost straight line from the back of the brain to the front, the brain waves have a high degree of coherence with the heart/pericardium waves.

The brain is not wise. It can only know what it has already been told or shown. Most of its learning is through inference, not attunement with Truth. The pericardium, however, has access to vast stores of information: all the wisdom of the universe. And when the Du channel goes straight through the brain, right through the middle of the striatum and thalamus, and emerges at Yin Tang, the brain's pericardial attunement is maximized.

Through practice, one can learn to attune the pericardium to specific aspects of Truth and Wisdom in the same way a cell (mobile) phone can be attuned to a specific electromagnetic wave signal. To help understand this, consider how a phone works. A specific phone will only receive the calls directed to that specific phone. The phone is "attuned" to the electromagnetic waves that are specific for that particular phone's number.

Now consider the pericardium. It can attune with specific, desired electromagnetic waves in the same way, but its ability to receive and transmit specific information uses a "technology" that is vastly more sophisticated than the attunement mechanisms in a phone. The pericaridium's "search engine" can be directed by the signals from brain in the vicinity of the third eye. Since ancient times, eastern medicine, philosophy, and spiritual

[24] Going into the third decade of the twenty-first century, with much more sophisticated technology, other brain areas have been found that are also highly stimulated during single-focus meditation. For example, cortical thickness in the hippocanthus is increased in people who meditate regularly. This area, close to the midline of the brain, is involved in emotion, motivation, learning and memory. Also, the anterior insula, an area that is proposed to be a center for thoughts of generosity and gratitude is also seen to be stimulated during meditation.

knowledge has recognized that the center-front part of the brain's frontal lobe – right behind the third eye – regulates will power and mental focus. Recent brain research in western medicine belatedly agrees: even in Wikipedia, we read that the frontal lobe is now recognized as regulating "higher level executive functions. Executive functions refer to a collection of cognitive skills including the capacity to plan, organize, initiate, self-monitor and control one's responses in order to achieve a goal."

With practice, a person of great mental calm and focus can direct his heart to behave as an instant search engine on specific subjects, solving problems and gathering information as needed, or communicating with others, across time and space – and even with his *own* subconscious and superconscious minds. And he can use his heart for communicating with invisible, but very *real*, Friends. As one's focus on the attuned heart increases, the Du channel flowing through the head is increasingly straight and narrow. The corollary is also true: As the Du channel through the brain is trained to become narrow, as it is in single-focus types of meditation, one's ability for heart attunement increases.

The straight and narrow path

The importance of working towards a "straight and narrow" path through the middle of the brain is referenced in many world scriptures. In Islam, Allah tells Muslims to be on the middle way, the *straight* path, and not to go upon the 'other paths'. Jesus points out that "narrow is the gate, and straight is the way." Buddhists also describe their path as "the middle way." World scripture can be understood on many levels. Many people consider that these injunctions to stay "straight" or "in the middle" are merely commands to follow religious or cultural precepts of correct social behavior. But scripture has lasting power because its messages can be understood on many levels, according to the listener's understanding.

One might conjecture that all of these great teachers are promoting moderation in social behaviors and are *also* making a cryptic point for those in the know about the importance of training oneself to focus the consciousness intensely at the third eye. Focusing on the third eye creates a straighter, narrower path through the spine and brain: the straight, narrow, and "middle" way. As Jesus says several times in the New Testament, "He who has ears [wisdom], let him hear…" And the great world scriptures all point out the importance of devotion, as well, in order to feel the presence of the Divine. Devotion, in this case, means tuning in with a loved one or with the heart and perceiving, actually experiencing, *knowing*, that one is in the presence of joy and the Divine. As it says in Jewish scripture, "Be still, and *know* that I am God" (Psalm 46:10). This could also be expressed as "meditate (in the stillness of single-focus meditation, straighten out the Du channel) and you will *feel* your connection with your Divine beloved or someone/something that personifies love and joy." When you do this long enough, you will *feel* the increase in your heart attunement; you will *know*.

If you feel this conjecture regarding a deeper, mystical meaning of the phrase "straight and narrow" or "middle path" is absurd, ask your Friend and/or your heart whether or not there might be something to this idea.

"Single-focus meditation" refers to meditation in which a person becomes as still as possible and powerfully focuses the mind on a single specific such as a mantra (word or phrase), a part of the body, the breath and/or control or observation of life-force energy, to

name a few possible points of focus. The popular notions of “walking meditation” or sitting calmly while letting the mind wander are *not* types of single-focus meditation. While these types of relaxation can be soothing, they do not reshape brain patterns into the more keenly focused “narrow, middle” path.

Bringing it all altogether, constant communication with a Friend, a form of devotion, stimulates the striatum. Increasing activity in the striatum helps pull the Du current towards the middle of the brain – *away* from the sides. A straighter Du current has more resonance with the heart. Your heart, when resonant with your brain, can give you answers to all sorts of questions, including questions about your health and how to improve it.

So talk to your Friend.

"The invisible friend technique works like a charm now. It eliminates my tremor instantly and changes my mental state from fearful to relaxed/happy."
– Email correspondent who recently changed his Friend from God to his beloved mother.

Chapter seven

Choosing a Friend

The Friend can be someone who has passed on: a beloved friend or relative. It can be a deceased pet: Fluffy or Fido. Many people find talking to a deceased dog to be more *fun* and therefore more helpful in generating a feeling of being safe, than talking to any of their deceased human loved ones. The friend can be a fictional character. Some of my patients have cultivated warm, solacing relationships with Yoda, the diminutive Jedi knight in the Star Wars movies. In several cases, their connection with Yoda successfully pulled them out of pause mode. Some of my patients have had totem animals such as Raven or Bear that served as Friends. The Friend might be a saint, sage, or guru. The Friend is most effective if it is *not* a person who is currently alive.

Although the cultivation of a healthy, loving parasocial relationship might be referred to in Christian terminology as "practicing the presence of God," it turns out that using God or some *perfect* deity as the Friend usually doesn't work well for turning off self-induced pause. For that matter, if a person actually has a trusting, loving, gratitude- and *laughter*-filled, mutually conversational relationship with God, he probably won't be using self-induced pause in the first place.

Very often, I've seen the opposite: many people who are stuck on self-induced pause do not want to "bother Divine Mother" or "disturb God" by talking to the Divine about their personal issues and problems. In the early years of my research I was stunned by how many religious professionals with Parkinson's carried this bizarre conception of a God that didn't want to be bothered. In the words of one Lutheran minister, "God is busy running His part of the universe, and I'm supposed to be running my part. I shouldn't bother Him with what's going on in my life, in my part of the universe. He's already busy." To me, this consistently apart-from-God relationship with Divine Love held by nearly *all* those of my PD patients who were highly intelligent, deeply sincere religious *professionals* was *far* stranger than their come and go, clearly *mood*-based symptoms of Parkinson's disease.

As mentioned earlier, if you don't like the idea of god, that's fine. Please use the word "love," instead. And, if you *prefer* to talk to God in spite of the warnings in this chapter, please do so. You've got to figure out what you are comfortable with.

Sometimes, while cultivating an intimate relationship with a Friend such as a deceased cousin, a person on self-induced pause who considered himself to be deeply spiritual or religious discovered that he didn't actually *trust* God – at least not enough to confide his deepest fears and confessions: "I can tell my late cousin Rhoda things that I would *never* tell God or my guru." Many of my paused patients who are deeply religious, including religious professionals, who considered themselves to have been constantly,

obediently talking to God have discovered, while in conversation with a deceased grandparent or cousin, that they are actually afraid of, angry, or bitter at God, or at their saviors or prophets of choice. So it's almost always better for the Friend, at least in the beginning, to be some trustworthy, loving, and supportive person or animal, remembered or fictional, who you can *laugh* with, instead of some perfect but somehow distant, maybe even judgmental, aspect of the Divine.

One of my patients had a Friend that combined "fictional character" and "animal." Severely immobilized with Parkinson's, he discovered he could move perfectly, effortlessly, when he imagined himself communicating with or *being* Sammy, the River Otter, a character from one of his favorite childhood books.

A Friend from a different faith

It's OK if your friend is from a religion other than your own. I had a Jewish patient who was deeply concerned because the person she automatically chose as her Friend was a classic image of the mother of Jesus. Another patient, a devout Catholic, was worried because the Friend who popped into her head and for whom she instantly felt utter love and devotion was the blue-skinned Krishna. Many patients who are deeply connected to one faith have found themselves having a loving Friend who represented a different faith. Please, if you find yourself in this situation, just enjoy the experience. It's the underlying love and trust that matters, not the dogma of one particular faith or another.

The laughter requirement

You *must* be able to laugh with your Friend. Your Friend *has* to be able to laugh at you and still love you, and maybe tell you that your ideas are ridiculous – and you might be willing to argue for awhile, or maybe *change your mind* eventually and agree with your Friend. Most importantly, there will be no hard feelings no matter who says what to whom. You have to be able to tease your friend, and share your darkest secrets. Most of my patients on pause have *not* had this type of relationship with God, no matter how much they "believed" in God.

Focus on the single eye to help stay in touch with your friend

Throughout the day, while being constantly aware of the presence of your Friend, also try to imagine that there is energy glowing or gently throbbing just behind the forehead, between the eyebrows, just under the skin. The more you can learn to keep some amount of mental focus at this third-eye point while you go about your activities of daily living, and especially during prayers or meditation, the more quickly you can develop the habit of staying focused on your Friend and on positive thoughts and feelings, even as you go about your day. The habit of entertaining pause-driven negative thoughts is a powerful one. Also, your ego inherently *loves* to stay focused on negative thoughts – that's how the ego-using parts of the brain are designed. So you will want all the help you can get in overthrowing the habit of focusing on pause-based, negative, and fearful thoughts. You can help yourself learn healthier thought habits by always imagining at least a small amount of energy glowing at the point between the eyebrows: at the third eye; the single eye; Yin Tang; whatever you prefer to call it.

Do *not* keep your focus at this point when you are trying to fall asleep. Focusing at this point helps stimulate consciousness and might prevent you from being able to drop off. Remember that, during sleep, most of the energy in the Du channel does *not* travel

through the brain, but diverts to a pathway over the top of the head, thus allowing the waking aspect of consciousness to turn off.

God is usually a poor choice for a Friend

Many people assume that the "most spiritual" figure must be the most effective Friend. For many of my patients on pause, God was the *only* Friend they were *willing* to consider. God was the only one "perfect enough" to be trusted. In my experience, most people I've seen who have been stuck on self-induced pause are, in their deepest minds, afraid of or angry at God or don't trust him. This means that thinking about God is going to stimulate the brain's *amygdala* – not the striatum. The two amygdala are the fear and rage centers in the brain. This increases the amperage in the UB channel. It decreases the amperage in the Du channel. Talking to a god that stimulates these areas will make pause-related symptoms *worse*.

I've had deeply devout patients who have proclaimed to me that God doesn't laugh, and even that God doesn't *like* laughter. So many people who are stuck on self-induced pause have such skewed ideas of what God is like that I advise patients to *not* use God as one's Friend, at least in the beginning. On the other hand, if one is always in a state of bliss, always immersed in the joy of the Divine, then it's OK to have God as one's best friend and constant companion. But if one is stuck on self-induced pause, then one needs a *non-judgmental* Friend that one can *laugh* with. In most cases, that Friend is not God, or at least not the God that the person grew up with.

I repeat: my patients on self-induced pause who have insisted that they have a very close relationship with God have, in almost all cases, had a relationship, but it's turned out to have been a bad one, in certain critical respects. Almost always, the people who insist on only talking to God or some supreme religious figure because no one else is good enough or trustworthy enough or perfect enough, don't actually feel playfully close enough to God or to their religious figures to have a healthy parasocial relationship with them.

Many of my patients who chose God to be the Friend assailed me with an impossible number of questions about Parkinson's and recovery, and insisted on the uniqueness of their own situations, to the point that they couldn't use the "generic" instructions in my books. When I replied by asking, "Have you asked your Friend these questions?" the answers were most often along the lines of, "I wouldn't talk to God about something like *that*." When they switched to human or animal Friends, they were better able to ask their Friends the questions that overflowed their minds.

Genuine utter trust in the love of a Friend enables a person to ask the deepest questions of the heart, no holds barred. You should be able to badger your Friend for answers just as relentlessly as a young child badgers his mother to be picked up and held. The relationship must be so trusting that you can yell at, cry to, demand of, confide in, and berate the Friend, while the love and trust between you remains unchanged, perfect.

Many times, through the agency of the Friend, a patient has come to realize that he/she was resenting God, even hating God, even while spending a lifetime going through the motions of being extremely religious. This can be a heart-opening realization, and can often help a person make rapid progress in turning off pause. "Rapid" can be a few days or a few years, depending on how long it takes before a person begins to truly trust his Friend. Even in my patients who took years to develop a meaningful relationship with

their Friend, they were amazed at how positive and joyful their lives became when they finally trusted their Friends more than their own minds. And when pause turned off, they have always been so surprised, in retrospect, that they had been so resistant to these positive changes for so long. The resistance was coming from their habit of using of pause mode or from their Blocker-guide that first initiated the use of pause mode. The brain is very resistant to change, even resistant to changing away from bad habits that make one sick.

I have had priests, nuns, pastors, rabbis, rimpoches, and lamas among my self-induced pause clients. In every case, their ideas of God were of someone noble, but detached and/or hard to please. There was often a sense that "God feels differently about *me* than he does about others" or "God is judging me more harshly, He expects more from me than He does from others," and the very popular, "I am loyal and true to God even though God has not been loyal and true to me." Others used a similar theme: "I am there for God, serving Him selflessly, but He isn't there for me in the same way." Essentially, the person is saying, "I'm better than God." Or, "Maybe no one's perfect, but I'm more perfect than God." The unexpressed foundation of many of these various plaints is, "I help others, but when I was helpless or in pain, God didn't step in and rescue me in the way I *wanted* to be rescued."

Many devout spiritual seekers who are using self-induced pause have patiently explained to me that God is Love and that He loves every one of His children just the same. But eventually, as they begin to cultivate their Friend relationship, they have realized, and shared with me, that they've long been harboring thoughts such as "*I'm* not good enough to be loved by God," or that "God doesn't actually like *me*," and even, "God loves everyone else, but he *hates* me."

They are wrong, of course. These delusions are, in many cases, created by their ego and then amplified by having their consciousnesses *outside* of their bodies, with their striatums and pericardiums being somewhat shut down. When the consciousness is outside of the body and/or the striatum is significantly blocked – which usually occurs during pause mode – one usually doesn't have much depth of resonance, much "heart-feeling" or "heart attunements," with others, or with Divine Love and Wisdom. In these situations, God's presence cannot be easily felt or heard.

Many of my patients whose striatum was shut down so that they could not imagine communication with the Divine or with a Friend have come up with specious stories or reasons to explain why, in their own *personal* cases, God is distant, incommunicado, or even displeased with them. These people might agree that God is loving and communicative with *others*, but not with *them*. *They* are different.

Exceptions *might* be present in people who have spent a significant amount of time – years – in single-focus meditation or other specific types of *communication*-based, rather than rote-based, prayer.

For purposes of turning off self-induced pause mode, or for figuring out if one is dealing with biological pause instead of self-induced pause, or for diagnosing and treating many other medical situations, a person is better off having a constant, silent or out loud, two-way conversation with a *buddy* – someone or something he loves and trusts. Even if the Friend doesn't say anything for the first few days, months, or years, it's still better to be thinking of someone you can laugh and joke with, instead of choosing to talk respectfully to a unlaughing, moody, or perfection-demanding God.

When a person is stuck on self-induced pause, it's often because during a moment of severe trial, he felt alone and abandoned. He felt that no one, including God – or Universal Love – was there for him. While understandably focused on his overwhelming pain, the person couldn't *feel* that the Divine was there for him. No one was there to help. As the pain became too much to bear, the person commanded himself to not feel pain: he induced pause mode in himself. In this mode, it can be hard to feel close to or resonant with almost anything and anyone. After this, thoughts such as "God wasn't there for me/ didn't protect me when I needed Him" or "God didn't do what I wanted" come easily.

As an aside, God or, if you prefer, Universal Love, *was* there. If the "God wasn't there for me" line of thinking has imprisoned you, please consider reading up on subjects such as "Why bad things happen to good people." Or consider the possibility of karma, also known as the scientific law of cause and effect: for every action there is an equal and opposite reaction. These laws of conservation of energy can extend beyond a single lifetime. We rarely remember our previous life-time actions that started the karmic consequences of the present life. And please, keep in mind that not all karma comes about because we were "bad." Sometimes, *seemingly* negative karma comes to us from previous acts of goodness.

Consider this: is it possible that, in a previous life, you prayed fervently that someone you loved be saved from some terrible malady? Maybe you even prayed that you could take on the malady so that your younger or more fragile loved one could be spared. And your loved one *did* recover, in response to your prayer. And now, in this lifetime, you are experiencing that malady – just as you *requested* in your prayers of a previous lifetime. You might have no conscious recall of that past life. The malady might *seem* to have arisen spontaneously, to have come out of nowhere. But physical situations don't arise out of nowhere.

Events in this universe are consequences of previous events. The laws of physics apply to the infinitely complex wavelengths of thoughts as well as actions, and extend over vast reaches of time and space…and even to health situations. Possibly, your seemingly "bad" health karma in this lifetime had its origin in a distant, heroic act of kindness or selflessness, not an act of malice, in a previous life. If you can't understand why you or others are suffering a particular affliction, assume the *kindest* possible explanation. By doing this, you will very often be closest to the truth.

Returning to the main point, a *majority* of my self-induced pause patients have told me, at first, that they will *only* use God for their Friend, because they can only trust someone who is *perfect*. This obsession with perfection is often directed at themselves, and others, as well. Possibly, on some deep level, a person on pause imagines that he can stave off the constant sense of impending doom or death by being "perfect" in the arenas that matter, or by trusting only those who are perfect. This can be part of a pattern of constant, relentless fault-finding or suspicion directed at self or others. Part of the Friend relationship is learning to value love, self-acceptance, laughter, and forgiveness *more* than perfection.

In some cases, they already have a formulaic habit of "talking" to God, very often one that is suggested by their religion, but in most cases they don't have the type of laughing, "buddy" or "confidant" relationship that one needs to have in order to learn how to feel safe.

Again, while I have seen a few exceptions, *most* of the people I've worked with who were stuck on *self-induced* pause have *not* had good results with using God as their Friend. They might be devoutly religious. They might insist that God is the only one perfect enough to be able to help them. But they usually get nowhere, or even go backwards, in terms of healing.

Remember, brain scans show that focusing on a God who is perceived as critical or unfair activates the amygdala: the fear and rage centers in the brain. The ensuing fear and rage, however repressed on the outside, can nevertheless push a person ever more deeply into pause mode. The brain scan research reported in the book *How God Changes Your Brain* found that people with an angry, judgmental, or unforgiving god, and those of their research subjects who were members of the Pentacostal faith, were very likely to have stimulation of the amygdala when thinking about God. Anyone who embraces the idea that God is vengeful, chooses favorites, or limits the number or type of people who can be loved or "saved" should not use God as a Friend in a parasocial relationship: focusing on this kind of God will make the brain increase its focus on negativity, fear, and the "imperfections" that supposedly anger God. Again, thinking about or communicating with *this* type of God will *increase* brain activity in the fear and rage centers in the brain. It can *increase* the amount of energy that is being used to sustain pause mode.

Talking to God made symptoms worse

I had a patient with Parkinson's who used his deceased, childhood dog as his Friend. For nearly a year, he was having increasing duration times of feeling good, laughing with the family, crying at sappy movies, and moving more easily. He was making so much progress, and his symptoms of Parkinson's disease were so nearly gone that he decided he should "improve" himself and use God as his Friend. Within two months of making this shift, his symptoms of Parkinson's had returned, conditionally. His symptoms could be severe on work days, and might be completely gone on weekends. Often, as soon as he got home from work, he was symptom free, until he fell asleep.

After two months of using God as his Friend, his Parkinson's symptoms were rapidly becoming increasingly severe if he was worried about anything – and yet he was now symptom free when he felt safe. He also started complaining that he could no longer feel a connection with his heart – which had felt "opened up" when he had been constantly talking to his deceased dog. He noticed that the Blocker had shown up – a voice telling him all the ways in which he was bad. I pointed out that all these problems arose when he made the switch to using God as his Friend: his symptoms started getting worse, his heart connection was lost, and the Blocker had resurrected. At first, he didn't want to believe me. He had been raised Catholic. He was certain that talking to God and using God as his Friend would be superior, somehow, to talking to his dog. He grew silent for a few minutes, doing the math and thinking about how his symptoms had changed over the last two months. He looked up at me in surprise. "You're right. I started getting worse when I started talking to God."

But he didn't want to keep talking to his dog, although that had helped him enormously. As we were discussing other possibilities, he suddenly stated, "My father! I want to talk to my father." Prior to his many months of talking to his dog, he had not been able to even consider talking to any of the humans that he had known or loved. That's why he had talked with his deceased dog. He assured me that his father had been a good man,

and had loved him very much. He was able to transition immediately from God to his father, and immediately felt relief and resumed having bouts of recovery symptoms – but he went back and forth with his recovery/ relapsing. He never returned to the steadily increasing level of safety that he'd felt when he used his dog as his Friend.

Most of my patients who had *started* out using God as their Friend and constant companion informed me that they switched to some other friend – someone who was easier to laugh with and banter with. Oppositely, some patients have started with a deceased, beloved pet or relation and, through learning to open the heart to the pet or relation, have *revised* their childhood notions of God. Some have eventually transitioned to having their *new* understanding of God or some Divine representative serve as their constant Friend. Their new God or Divine representative was far more loving, playful, and understanding than the idea of God that they grew up with. *Who* one chooses doesn't seem to matter. What matters is that there is someone, real or imagined, who is honest, who loves you, flaws and all, and has a *sense of humor*.

Friend Luca

One patient's Friend was someone she'd never met. She'd been talking to Jesus for over two years and was not yet feeling safe in his presence. She chose Jesus because she wanted to "go straight to the top." She had been a huge Star Trek fan when she was a child. After a couple of years of her constantly talking to Jesus, I asked her what Jesus was like. She replied that he was like Mr. Spock, on Star Trek. I playfully asked, "Don't you mean Kirk, the resolute and compassionate Captain?"

She replied, "Oh no! Captain Kirk is bad! He kisses girls!" She looked startled as she realized the significance of the words that had automatically come out of her mouth. She then started laughing. She told me she was surprised to hear these catholic girls'-school words come out of her fifty-five year old mouth. She told me that she had no idea where she'd learned that Kirk was bad, but evidently it was a strong conviction, deep in her psyche. She had never embraced her parents' Catholicism, and had been happily married with children, but deep in her mind, consciously *unrealized* until this moment, was a conviction that a man who kissed women and was fun and loveable was bad. Spock, stoic and without emotion, was good. Therefore, Jesus, who was good, must be like Spock: without emotion.

Shortly after this realization on her part, a realization that she was still carrying around weird, catholic school ideas about what makes a person good or bad, she stopped talking to Jesus. She talked to no one in particular for a few weeks but soon found herself in the company of a guardian she had never before met. He dressed in ancient Roman armor. His name was Luca. Luca was a soft-spoken but powerful guardian angel. Luca didn't talk much, but he was always there: loving her unconditionally, protecting her, and succinctly answering her questions. He liked it when she laughed. She didn't understand *why* she felt safer with Luca than with Jesus, but she did.

"I got no one"

For those people on pause who have absolutely no one that they can think of to talk to, I usually recommend starting with either St. Francis of Assisi or else Yoda. If you can't think of *anyone* who you can trust, either of these two could make a good Friend. They both have a self-deprecating, delightful sense of humor, and have loving insights

into our human foibles. They've seen it all. They understand. They love you no matter what. If you are unfamiliar with these two, you can learn about them online.

Most of the suggestions above for choosing a Friend are for people who are stuck on self-induced pause. I have seen patients stuck on *biological* pause – *biological* pause – who have already cultivated, or were able to easily cultivate, a deeply trusting, confiding, laughing and loving relationship with a deceased loved one or a saint, a guru, or God. My patients stuck in biological pause didn't need as much advice from me when it came to choosing a Friend as did the people who were using self-induced pause. Then again, even some people on *biological* pause have started out with God as their Friend and eventually switched over to feeling comforted by and more intimate with great-aunt Margaret. Or the reverse: they might start with the rascally, late cousin Larry, who makes them laugh. But over time, they might find themselves constantly conversing with and feeling safe – and laughing with – Divine Mother or baby Krishna.

What you're looking for is a connection with Universal Love and *joy*. Love and joy, and the laughter they bring, might present itself in any form that is dear to the individual.

Fact or fantasy

So far, this discussion of invisible Friends might be read as if the Friend is always a fantasy, just a reflection of a person's own thoughts. This understanding is incomplete. Although the Friend might be just a fantasy in the beginning, the Friend nevertheless serves as "training wheels" for a more profound type of communication. As one learns to listen *more* to his heart and *less* to his ego-driven brain, one *can* learn to communicate with other souls and with a higher wisdom. One can receive signals from nature. When, with highly focused practice, the ego becomes hushed to a high degree, a person can even receive sublime insights and guidance from deceased loved ones, divine personages, or even the impersonal Divine.

Many of my patients told me when they first started communicating with their Friends, "I feel like an idiot. I'm talking to empty space." I point out that this is normal, when starting out, and encouraged them to keep it up.

Those patients who kept up their conversations in what they presumed was an imaginary mind game invariably came to my office after a few months, or a year or more, with a new concern. "My Friend is actually there. He's listening to me! I can feel him listening! Now I truly must be going crazy!" Although they often express alarm when this shift occurs, they also admit to feeling strangely safe in the presence of the Friendly Listener. This means that the person is actually starting to decrease his internal, negative, circular and wary monologue, and engage with someone other than his own mind. In response, the heart might be starting to open, or open "wider" than before. The patient begins to trust that the Friend, the heart, or both, are listening…and always have been. The relationship with the Friend starts to become more real and more nourishing.

This transition point might mean that a person feels safe enough to destroy the old habit of using pause mode. How can a person know if he's ready to do the techniques that can destroy the pause habit and replace it with a new, "feeling safe" habit? Ask the Friend!

In the beginning, don't worry about whether or not you are *truly* communicating with your Friend. Just keep some mild amount of mental energy at Yin Tang and silently

talk, talk, talk to your Friend. Even if, at first, you are not *actually* communicating with a deceased relative at the outset, at the very least you *will* be establishing closer communication with your own heart as you talk to your Friend. And your heart is much closer to the truth than your mind will ever be. Eventually, as you re-learn how to attune with and be obedient to your heart instead of your brain, your Friend will eventually become a channel through which your heart *can* attune to loved ones and to information beyond that stored in your own mind. You might begin to have access to wisdom and love far greater than your limited human *brain* can understand, but your heart will embrace this wisdom and love as if it is an old friend.

As Jesus put it so succinctly, "The kingdom of God is within you." (Luke 17:21) By "Within you," he was referring in part to the heart or, more exactly, the soul-directed energy flowing through the connective tissue around the heart, the pericardium channel qi, which serves as a portal to the kingdom of God. You can think of your pericardium as similar to your WiFi satellite dish and your router, only much more powerful. The pericardium is capable of pulling in almost every signal in the universe. As Jesus also said, "When thy eye is single [all the energy focused at the third eye with the Du channel flowing in a straight line, rather than meandering through the brain], thy body will be full of light" (Matthew 6:22.). "Full of light" refers to the radiant glow emanating from the electromagnetic energy of the heart/pericardium when the heart is fully "open" and when the light of the third eye shines steadily without wavering(without distractions from the ego).

This chapter just brushes the surface of the subject of Friends. Later chapters will give in-depth instruction on how to go about cultivating this type of relationship if, from lack of experience, a person has no idea how to get started.

For now, just be aware that the Friend is a powerful tool for helping to open the pericardium and activate the striatum. It is also a tool for finding information buried in the subconscious mind that the conscious brain doesn't want to know about. It is also a tool for accessing the truths known to the superconscious mind.

Getting answers

The more a person can learn to use the heart as a true/false detector, the more easily he can learn what, exactly, is causing a failure to heal or a failure to turn off pause – and what needs to be done about it.

Returning to the birthdate lie-detector test in the previous chapter (p. 68), you will recall that you applied this test by making simple statements. The heart responded with expansion if the statement was true. It responded with contraction if the statement was false.

As your heart/ pericardium becomes increasingly activated via your relationship with your Friend, you can start asking meaningful questions of your Friend or your heart.

Keep the questions simple. When you're just getting started, use statements, not questions. You can create a pair of opposite *statements*. For example, if you are wondering about the source of your back pain, you might say to your Friend these two statements: "My back pain is being caused by a hip problem." Followed by, "My back pain is *not* being caused by a hip problem." If the reply you get from your Friend or from your heart's expansion or contraction is no, the back pain is *not* related to the hip, then keep up your inquiry using a different pair of statements: "My back pain is related to my

neck injury" and "My back pain is *not* related to my *neck* injury." Using a pair of opposite statements is often the easiest way to get answers. If you don't get any answer to either statement, change up the statements altogether. Sometimes, the phrasing of the statements is the problem – the statements might be too open-ended and not specific enough.

One patient told me that when she started to really focus on being with her Friend, in order to get answers to questions, she got a Yes (heart expansion) response to *every* question – even the false birthday question. She told me, "I realized that my heart expansion wasn't in answer to my questions – it was in response to paying close attention to my friend. So I waited until my heart was really expanded and relaxed, about five minutes of just hanging out with my Friend. *Then* I asked questions, and the answers made sense. Then, the false birthday statements got the correct, negative response."

The speed of the answer

Once you are really settled in with your Friend, maybe spending a good long minute or two saying hello and bringing your Friend up to date on what you've been doing in the last few hours, if you've been apart, then you will probably soon notice that you get an *immediate* yes or no from your Friend, or an *immediate* expansion in your chest when you make a true statement, and an *immediate* contraction in the chest when making a false statement. Answers are *immediate.* Sometimes you will receive the answer before you finish mentally stating the question. This is because your heart already knows your full question as soon as you have the thought of it, several seconds before you are able to mentally express all the words.

If you do not get a response within a few *seconds*, then you missed the answer or there wasn't one. Ask again, or try rephrasing the question.

Non-verbal responses

As you get better at this, you can start making simple Yes / No questions instead of a pair of opposite statements. Sometimes the Friend or the heart might answer with what seems like actual words. Other times, the answer might be visual, or a shift in perception. Your Friend and/or your heart might *not* "talk" via words, per se.

For example, one patient complained to me, "I keep asking my Friend and my heart what is the origin of the stabbing pains in my eyes and it won't give me an answer. Instead, I keep finding myself looking at the back of my neck, where I had that injury after falling down the stairs." This patient was getting a *visual* response, rather than words. The patient insisted he wasn't getting any answers because he was waiting for words even though, in response to his questions, he was repeatedly directed to the unhealed injury at the back of his neck.

Another patient, during a session with me for treatment of his ferocious, chronic-for-decades back pain, insisted that he wasn't getting any answers from his Friend about the cause of his back pain. He was a stuck on biological pause. He did not have Parkinson's. In response to the patient's questions about imminent death, his Friend kept saying no, he was not on the verge of imminent death. But when I asked the patient if he was on the verge of imminent death, he kept answering "yes!" He told me that he was at risk of imminent death more than fifty times, even as his Friend told him more than fifty times that he was not. So I had him ask his Friend *why* he felt he was on the verge of death.

He asked his Friend Jesus and his heart at least six times each, rapid-fire. After each time, he said to me, "Jesus won't answer," or "My heart won't talk to me." Suddenly, in mid-sentence he screamed, "Oh my God! Our helicopter! We're hit! Ground-to-air missile! We're gonna die!" He opened his eyes and turned to me, but didn't see me. His eyes were staring right through me. He continued talking, as if he were talking to someone I couldn't see. "I saw pure Evil that day…" And then he blinked and said to me, dejectedly, "My heart still won't say anything, Jesus won't say anything…"

I told him that Jesus *had* answered him. He had been *shown* the event that had put him on pause: a terrifying helicopter crash. His communication with Jesus, or with his heart, or with something, had allowed him to feel safe enough that his wall of dissociation around that event had been taken down. He had been able to see and remember the part of his history that was keeping him stuck on pause, unable to heal from his fairly simple, but excruciating, vertebral displacements and back pain.

Once I assured him that his visual experience was the answer he'd been asking for and that his Friend Jesus *had* answered him, he told me he suddenly felt better now about his relationship with Jesus and with his heart. Then, after a few minutes of silently staring into space, he exulted to me, "I survived! I survived. I'm *not* gonna die. I survived! I survived." He relaxed deeply. I did gentle Yin Tui Na on the bones in his back that presumably had been locked into the positions they'd assumed during the crash. Within twenty minutes, he had *no more* back pain. He was even able to put on his socks. He could walk easily around the room. He hadn't been able to do these functions in years. Prior to the treatment, he'd had no idea that the idea of imminent death was still in charge of his brain. He thought he'd gotten over the old trauma. He had wrongly attributed his nightly, screaming panics and nightmares to his chronic, severe back pain.

The point is, you have to be ready for whatever manner your heart uses to "speak" to you. Accept whatever the heart tells you, whether it uses words, visuals, new thoughts, or old memories.

Sometimes, you won't get an answer because your question truly doesn't matter.

A dear friend of mine, a monastic swami, shared with me a question that was brought to him by a man seeking spiritual counseling. The swami explained to me, "The man always asked his heart before making important decisions. He was very concerned because he regularly had one hugely important question and he never got an answer. He was the coach of his son's Little League baseball team. His question was how to best set up the batting order in order to win the most games. I told him that God doesn't take sides in that manner. The fates of those boys will play out correctly no matter what the batting order is. The batting order isn't a True or False question that will get an answer from the universe." The swami smiled gently at the memory and continued, "The man did *not* like my answer."

My mind is forcing me to have negative thoughts!

Many people, as they've started trying to change their long-term thought habits by talking to a friend, have felt as if there is an active force in their brains, resisting their attempts at change. Many, many people have said to me, "There's a devil in my mind! It's forcing me to have negative thoughts." A reference to a devil or evil spirit lurking in the mind has been stated by many of my patients who do not even believe in devils, angels, or anything invisible. Many atheistic patients have found themselves using religious

language in trying to describe the powerful forces in the mind that do not want to give up a long-term habit.

Warning

As a word of warning, a person who is troubled by unwanted voices, threatening voices, or hallucinations, or has been diagnosed with schizophrenia or bi-polar disorder, should *not* try cultivating a loving Friend relationship until he has addressed and removed these types of problems.

Cognitive Behavioral Therapy and the internal battle

Many types of unwanted, negative thoughts, including those associated with depression and major depressive disorder can be removed by using cognitive behavioral therapy. Cognitive behavioral therapy can be a self-administered therapy. You do *not* need a therapist to work you through the simple self-change steps of cognitive behavioral therapy. One can work effectively from a book to do cognitive behavioral therapy, a process called "bibliotherapy" (therapy by working from a book). The original book of cognitive behavioral therapy is *Feeling Good: the New Mood Therapy*, by Dr. David Burns. The examples in the book are are a bit dated (1980s), but the presentation is very clear and the process is extremely effective. If you are susceptible to depression, whether or not you are stuck on pause, I strongly suggest reading this book and applying its precepts.

Cognitive behavioral therapy can *also* be used for eliminating or "exorcising" the types of negative thoughts that are associated with the feeling that a non-physical entity is imposing itself upon the patient. And while we are on the subject of exorcism, many people who are stuck on pause feel as if there is an actual force or an intelligence inside their heads that is fighting against their own will power. For that matter, many people, after turning off pause, have said that they feel as if they'd just had an exorcism. They say things like "Something in me that was making me so sick and negative has disappeared. It's been cast out." Very often, the "entity" that was cast out was the *self*-created Blocker personality: the aspect of self that initiated the use of pause mode. (See: *Recovery from Parkinson's*, p. 98.)

Oppression and possession

If one feels strongly that he is being oppressed by some non-physical entity – one that is *not* of his own making – he might avail himself of professional or spiritual help. Most major world religions have protocols for addressing problems that call for exorcism of "negative energy," "oppressive" thoughts, and even "possessive" thoughts. If your Friend or your heart tells you to pursue these avenues, please consider doing so. Then again, although the nasty comments made by the Blocker might seem to be coming from some free-floating entity, the Blocker, in all the cases of my experience, was the creation of the patient's own mind. It was part and parcel of the self-protection instruction given at the time that pause mode was induced.

The subject of destroying the Blocker will be discussed in the same upcoming chapter that addresses getting rid of other bad habits, including the habit of thinking that you can't talk to a Friend. But bear in mind, a person with a Blocker – a long-time, possibly out-of-control mental coping mechanism – can't *lastingly* get rid of it until he has an effective replacement: a solid relationship with the Friend. This concept will be

addressed in this next section, a brief introduction to the science of hypnosis and self-hypnosis.

Hypnosis

The use of a Friend as opposed to a "Guide"

In the psychology subfield of hypnosis and self-hypnosis, an invisible "someone" to talk to is usually referred to as a Guide. The Guide is typically an aspect of one's *own self*, not a person *other* than the self. A Friend is therefore different from a Guide.

My patients who were habitually using self-induced pause had zero interest in acquiring anything called a guide. In fact, they tended to be averse to the very idea of allowing something – even an aspect of the Divine – to guide them. I suspect this is because most people using self-induced pause are already engaged with the Guide that they created to get themselves into pause mode. However, they were usually willing, albeit sometimes reluctantly, to accept the idea of having a Friend.

Again, in the field of modern hypnosis, the Guide is usually some aspect of the patient *himself* – some aspect that can be talked to, that can make changes in the brain's perspective and responses, and knows what's best for the patient.

For people who have become stuck in the habit of using self-induced pause, they do already have a guide, in this self-hypnotic sense. Their Guide-selves were invoked during the original trauma. At that time, their Guides made the decision to *block* the pains or fears rather than seek *healing* from the pains or *be comforted* away from the fears. This is what triggered self-induced pause mode.

I'm going to repeat this, because *changing* a person's chosen mental pathway is at the root of recovering from self-induced pause:

At the time of the original trauma, the brain was commanded to *block* the pain or the fear rather than *heal* the pain or *be comforted* away from the fear. The aspect of the mind that gave the instruction is similar to and possibly the exact same thing as the "Guide" principle used in modern self-hypnosis.

At the time the self-hypnotic decision to not feel pain (to inadvertently use pause mode) was made, the person might not have had the knowledge of *how* to promote healing from the pain. The person might not have had awareness that he *could* seek comfort from an inner power, a higher power, or an invisible Friend. Having no understanding of how to seek the comfort that might allow healing or diminish the fear, the person used an aspect of himself, a "guide," to command himself to block the pain or fear. And has continued using that guide's particular coping mechanism ever since. Unfortunately, the helpful Guide might become a tyrant Blocker if the person tries to turn off that coping mechanism.

A joyful Friend is a completely different type of helper. A long-term Friend can help a person learn to identify and heal from trauma. The Friend can offer genuine heart comfort: a *healing* mechanism instead of a short-term emergency coping strategy.

Don't take away the lifeboat

In the field of psychology, an emergency coping mechanism is sometimes referred to metaphorically as a "lifeboat." A lifeboat is a *short-term* safety device that one uses during an emergency until one gets to a bigger, more stable boat, or until one reaches dry land. It is recognized that you should not try to remove a person's psychological lifeboat,

however faulty it might be, until the person has a replacement lifeboat, a better lifeboat, or a genuine solution. A person's mind will protest violently if you try to remove the only lifeboat he's got if there is no replacement lifeboat, or if he is still far from the shore of safety. The Friend can help a person develop the healthy mental skill sets that he did not have at the time of the original trauma: a two-way, loving, parasocial relationship, a connection to heart wisdom and the subsequent feeling of being safe. When this skill set is strong enough, then the habit of using the old instructions from the original guide, and even the guide himself, can be destroyed. But only when the person feels safe can the old lifeboat be discarded.

Even though the symptoms of severe pause mode or Parkinson's disease can be painful and frightening, they are part of a self-protection system, a "lifeboat." When this self-protection system was first put in place, it offered more benefits than disadvantages. After decades, the negative side effects of habitually using pause mode might make a person want to let go of the habit. However, in my experience, *most* people using self-induced pause have only wanted to let go of the unhappy side effects such as rigidity or tremoring, and not the underlying *cause* of those side effects: using pause mode as a way to be numb, wary, or safe from pain. Until a person has a sturdy set of new "I am safe!" habits for going through life, he will not be able to get rid of the old habits and…he might not really *want* to. In fact, his mind should *not* be asked to get rid of the old habits until he is confident that his new behavioral pathways are strong enough to direct him through life. A person should not be asked to abandon his lifeboat until he is safe on dry land or is being taken care of on a bigger boat.

How can a person know when his new mental habits are strong enough that he can abandon his long-time mental lifeboat? He can ask his Friend.

The Blocker

Some people with self-induced pause run up against a powerful personality when they try to prematurely stop using pause mode. I've named this personality The Blocker. The book *Recovery from Parkinson's* goes into great detail about the Blocker and the terrible mind behaviors that the Blocker can produce if a person becomes stuck in partial recovery. The Blocker might be the original guide: the one that directed the mind to block the pain and fear of the trauma. This guide is trying to continue doing the behaviors that were set in motion, usually decades earlier, in response to trauma. When a person tries to stop using pause mode *before* replacing it with a healthier way of dealing with life, the guide can become a monster, threatening the person, sometimes even audibly (audible to only the person, not to others), *commanding* him to continue using pause mode. Prematurely trying to destroy a person's pause habit is like trying to take away a person's lifeboat before he is safely ashore.

As for the constant, internal monologue that people with self-induced pause are always using, those can be thought of as conversations with their Blocker / guides.

In therapy sessions, a person doing self-hypnosis is usually working with a professionally trained advisor. The advisor's job is to make sure that the person knows he has choices in how he decides to direct his mental behaviors, and to help the person make choices that will best serve him over the short- or long-term.

A person who started using self-induced pause by himself, in secret, in response to trauma, had no trained advisor. The self-commands, the self-hypnosis that allowed him

to induce pause mode, were performed because the trauma was unbearable. The self-commands provided an immediate reprieve. However, as a long-term strategy, developing a habit of using pause mode as a coping mechanism is *not* healthy.

Using hypnosis to turn off pause

I am often asked about using hypnosis to turn off pause. People who are stuck in the habit of using self-induced pause are already under the influence of self-hypnosis. This section will help explain a little more about what hypnosis actually is, and why professionally guided hypnosis has *not* been helpful for my patients who are using self-induced pause mode.

Hypnosis, or being "under hypnosis," is a *very* common mental state. The term refers to any trains of thought and behavior that were triggered by a high degree of focus, accompanied by a powerful suggestion by an authority figure.

For example, if a person goes to the emergency room because of extreme pain because of what feels like a broken bone in the arm, the doctor might hold the arm in several positions, trying to ascertain the nature and exact location of the injury. If, in each of the positions, the doctor says, "Is this position painful?" then the patient is being asked – by an authority figure – to focus on pain. By the time the doctor has repeated his question, "Is this painful?" half a dozen times or more following each arm re-positioning, the patient is "under": he is "under hypnosis"; under the influence of a mental suggestion. The patient has been asked to focus on the possibility of pain. The doctor, in his white coat and position of knowledge, is a powerful authority figure. By the time the doctor is done with his questions, the patient's brain is on the lookout for pain and maybe finding hints of pain *everywhere*, in a subconcious effort to please and/or obey the authority.

Oppositely, if every time the doctor moves the injured arm, he says, "Can you be comfortable in this position?" the patient's brain will very soon be "under the influence" of the doctor's suggestions: under hypnosis. The patient's brain will be looking everywhere for "comfortable." He will be finding comfortable in as many positions as possible. Only the actual, highly specific, localized pain from the injury might not be "comfortable." Although, if the doctor projects enough authority, and the patient is focused enough, the arm will be comfortable and might not hurt even at the very site of the injury.

The patient, in either case, is highly focused and working with an authority figure, what you might call a guide or, if using the most recent terminology, a "leader." Without even being aware of it, the "follower" part of the patient's brain is trying to please the doctor, please the authority. Technically speaking, the patient is almost immediately "under hypnosis." The more intelligent the patient is and the better he is able to focus his thoughts, the more easily the patient will create a hypnotic state in himself: the better his awareness of pain or comfort will be able to reflect a subconscious desire to please the authority.

Sadly, most doctors are not familiar with the problems of suggestibility, and their questioning tends to follow the pattern in the first example: essentially hypnotizing the patient to be over-focused on pain instead of the possibility of comfort.

As an aside, a person *can* be taught to focus on the positive aspects of sensation to the extent that he can undergo surgery without anesthesia. All of the sensations of the surgery will be processed by the brain as being not dangerous and not painful.

The larger point is this: a person with a high capacity for mental focus is likely to alter his brain responses when confronted with a trusted authority figure. This alteration in brain responses is called "hypnosis."

People who have developed a habit of using self-induced pause usually are extremely intelligent and capable of a very high degree of focus. During a time of duress, they created their own internal guide, or authority figure. This is perfectly normal and healthy. However, the choice made by the guide to block pain and fear (by using pause mode) instead of dealing with it in a manner that might lead to healing or comfort has long-term, unhealthy consequences, if it is allowed to continue.

The more intelligent and capable of intense focus a person is, the *more* easily he can be hypnotized. Also, the more intelligent a person is, the more he might incorrectly imagine that he is *not* susceptible to hypnosis, when the opposite is the case. A person with a strong relationship with his heart is less likely to be susceptible to hypnosis. His heart serves as a higher authority than the brains' hypnotic experience with an authority figure.

A hypnotic suggestion of Parkinson's disease

When a person with a strong ability to focus is told that they have an incurable illness, that suggestion is very likely to take on the strength of a hypnotic suggestion.

From the very beginning of my Parkinson's research I have seen that people who have not yet been given a diagnosis – even if their symptoms are fairly severe – might recover *very* quickly, within one or two sessions of working with me. If a person has received a diagnosis of Parkinson's from a medical professional, he might need two to three years to turn off the habit of using pause mode. And even then, he will go through mental anguish, over and over, because a voice in his head is telling him that he can't really be recovering – even if his symptoms are nearly gone due to increasingly being in the presence of his Friend – because his subconscious mind has heard from an *authority* that Parkinson's is incurable. And due to this conflict and the doubt it creases, he might once again call on his brain to use pause mode.

For this reason, I never give a person a diagnosis of Parkinson's even if the case is glaringly obvious. Even if I were to tell the person that Parkinson's disease is *curable*, the person might consult the authority of Wikipedia, an MD, or some other voice that will have enough authority that the person will not be able to believe he's recovered from his symptoms – even if they are *already* gone.

Also, many people, when given an "official" diagnosis of Parkinson's, experience a very accelerated worsening of symptoms. As I mentioned in another book, one patient, within six months of diagnosis, went from mild symptoms to barely able to walk. When his wife introduced him to the website of the Parkinson's Recovery Project, within one day he was back to the mild level of symptoms that he'd had when he was first diagnosed.

People with Parkinson's are *extremely* susceptible to suggestion. This might be related to the high level of mental acuity and focus that is part of the Parkinson's personality. A scatterbrain is likely to be less susceptible to hypnosis than a person with a powerful ability to focus. And in my limited experience, my patients with Parkinson's are highly confident that they are *not* susceptible to suggestion.

Having Parkinson's is so unfair!

From the thousands of hours of interviews I've had with people with Parkinson's from self-induced pause, it almost seems that they were going through life fairly content with their use of pause mode. It's a coping mechanism, and in many cases using pause mode has shaped their life and personality in ways that they are proud of: they feel almost invincible, in a way. So when they are told that, in spite of their sacrifices and invincibility, they have "come down with" Parkinson's, the main feeling they experience is that of betrayal. They have worked so hard, and been so stoic, so if anyone should be rewarded with good health, it should be *them*.

In fact, among the more common remarks that friends and family members have made upon learning of their loved one's diagnosis with PD are, "But he/she is so *good*!" or "Such a *hard* worker!" or "So generous!" or "So positive!" I have heard countless times, "He/She is the *last* person that this horrible disease should happen to!" from friends and loved ones, when telling me about a person's diagnosis with Parkinson's.

The patients often agree with their friends' assessment of the unfairness of them having this syndrome. Patients often have a strong feeling of resentment because they have been so stoic, so nose-to-the-grindstone, and sacrificing so much compared to the general hoi polloi who are off going to bars and clubs and concerts and parties, squandering their lives in self-centered pleasures and yet *not* getting Parkinson's. Many, maybe most of my patients, have been bitter about this seeming unfairness. They often have the idea that their bodies have betrayed them. Not only has God betrayed them, back when they first started using pause mode because God wasn't there to save them from trauma, in the way they *wanted* to be saved. But now their own bodies have betrayed them! Though un-proveable, it does seem to me, in my limited experience, that the stronger the patient's feeling of betrayal or unfairness is, the more quickly his symptoms worsen after receiving the diagnosis. And the more one feels betrayed, the more he is likely to withdraw even more into his monologue with his Guide, his bitter self, the aspect of himself that created the coping mechanism (using self-induced pause mode) in the first place.

The terrible sense of conflict and betrayal that many of my patients have felt when receiving their diagnosis fits easily with the idea that their own, carefully constructed brain behaviors that were supposed to keep them safe were a failure. And now, their own brain is now committed to the hypnotic suggestion that they have an incurable illness. All the more reason to increase, to double down on, using pause mode!

Over the decades, as I watched my recovering patients fighting against their convictions that they could not recover, and even refusing to believe that they had recovered when their symptoms went away completely, I could not make sense of what I was witnessing. Only after I learned more about the potential brain conflicts in a partially-recovered person who is still under powerful, doctor-induced hypnotic suggestions of "incurable illness" was I able to make sense of what I observed, over and over, in my recovering patients.

In the early days of my Parkinson's research, potential volunteer patients for the free clinic usually wanted to first meet up with someone who had recovered. I arranged for meetings. After nearly every meet-up, the patients with PD told me words to the effect of, "I'm not going to recover. That person I spoke with isn't like me. They were one of the lucky ones. I'm not like them." In nearly every case, a patient's conviction of incurability

was *enhanced* by meeting someone who had recovered! This was *such* a common response that I stopped arranging for recovered patients to meet with or speak with potential patients. I found myself increasingly annoyed by patients' illogical insistence on "I'm different. What works for everyone else won't work for *me*."

A research breakthrough: I'm different; I can't recover like other people

Actually, an important break-through in my research was related to this. In the hours after I was diagnosed with Parkinson's, I tried telling myself not to worry: I had seen people recover from this syndrome. I knew what to do. But louder than any voice of reason was an inner voice that took me by surprise. It kept saying, "I won't be one of the lucky ones. I won't recover. I'm different…"

When I realized I was hearing, inside my own head, the exact same words that so annoyed me when I heard them from my otherwise logical and intelligent patients, I actually stopped my pacing and stood stock still. "What if this weird, self-defeating voice is part of the Parkinson's disease syndrome?" I asked myself.

My mind started racing. "This attitude is utterly not like my normal personality. What if this new, negative voice has something to do with Parkinson's disease? I would never have heard this nasty, negative, illogical voice if I didn't have Parkinson's disease myself." I just had to wonder, "What if my having Parkinson's disease is going to help me figure out what's at the root of the backwards flowing channels and the bizarre mental attitudes of my patients with PD? What a fantastic opportunity for learning about the mental state of people with Parkinson's!"

I was simultaneously *grateful* to my spiritual teachers for the opportunity to further my research by having Parkinson's myself, and *dismayed* by what I knew would be the end of my life as I knew it. Because I *knew* I was not going to recover. I would *not* be one of the lucky ones. I was wrong, of course, but I couldn't know that at the time.

I sat down and thought this through. I had always been displeased when patients wallowed in self-pity and negativity. It was obvious that their own attitudes could prevent them from healing. But that's what I was doing now! Deeply concerned by my new, negative attitude, I decided that I must immediately go into my meditation room and talk to my guru until I was absolutely grateful for the life-cards I was being dealt. I would not come out of that room until I had destroyed the new pessimism. I couldn't have known, at the time, that I was hearing a Blocker-produced phenomenon, one that was suddenly distinctly audible in my own mind.

A few hours later, following a knock-down, drag-out verbal battle with my guru over all the things I had resented for almost my entire life, the negative voice disappeared. The fight ended with me admitting that the love of my guru was always with me, would always be with me, and had always been with me. He had been with me even during the scary times when I thought I was alone and had made myself numb. I had to admit that he was right there, still loving me, as he always had been. Tears of gratitude and love poured down my face. Strangely enough, I longer had Parkinson's disease. I also no longer had any interest in being strong, stoic, and independent to the point that I was apart from humanity. I had a supreme disinterest in the voice of the Blocker. Those things suddenly felt like distant history.

Getting back to the negative, inner voice

As I learned more about the Blocker from patients in partial recovery, it seemed to me that the Blocker was the source of the negative voice saying things like "You're different; you can't recover." I began to wonder if maybe the Blocker was an old self-hypnotic guide that had gone rogue. The Blocker is explained in detail in *Recovery from Parkinson's*. One characteristic of the strengthening Blocker is an inner voice commanding a person to not listen to people who disagree with the hypnotic suggestions he has embraced. This self-created inner voice, which can grow more despotic, over time, might be the source of the darting eyes, situational deafness and amnesia that is exhibited in people stuck in partial recovery. The reader who has not experienced the completely bizarre, mental avoidance behaviors that can resemble aspects of Dissociative Identity Disorder, that are seen in people stuck in partial recovery might have a hard time believing what I describe in my books – that's how bizarre the behaviors of a person can be when the Blocker takes over the mind.

I have also seen people under the influence of temporary, "parlor game" hypnosis. They exhibit the same kind of eye darting and selective listening that I have seen in people who are stuck in partial recovery.

We are all influenced by suggestions made by "authorities." We have all developed powerful mental habits and behaviors in response to off-hand, overheard comments made by childhood teachers, bullies, or random radio show hosts. The field of psychology increasingly recognizes these subtle, often fleeting but mind-altering influences as forms of hypnosis.

The old-fashioned types of hypnosis, dating back to the 1800s, in which the hypnotizer has the subject focus intensely and the hypnotizer becomes the guide, is not particularly healthy, and is not widely practiced these days, at least not in the western medical model. Instead, modern hypnotherapists tend to teach patients how to self-hypnotize: how to create their own guides. The patient, using his Guide, then figures out a healthy way to modify brain patterns that he doesn't like.

Commands from a hypnotizer can easily backfire, or might not be turned off correctly, leading to serious problems. For a quick case study of how hypnotism can go wrong, a person in my home-town was hypnotized by her dentist so that she didn't need anesthesia during a tooth removal. Months later, noticing that the painless swelling on the side of her face was so severe that her eye could barely open, the hypnotized patient went to her family doctor. The doctor immediately sent her to the hospital. The painless infection in her mouth had spread up into her sinus cavities and was putting pressure on her trigeminal nerve. When the patient explained to the hospital staff it couldn't be too bad because it didn't hurt, and that she'd felt no pain in her face since she'd been hypnotized by her dentist, the hospital staff called the dentist in to "de-hypnotize" her. The dentist had forgotten to cancel the "no pain" suggestion following her dental surgery. It took the dentist *hours* to turn off the suggestion. The dentist expressed surprise at how long it took to turn off his hypnotic suggestion in this patient. He guessed that it took so long because she had been under the influence of the suggestion for several months.

Most of my patients using self-induced pause had been using it for decades, often since childhood. It is no wonder that they usually needed months, or even years, to *start* turn it off, by cultivating a strong, overriding relationship with a loving Friend.

Another example of hypnotic suggestion

In his *Autobiography of a Yogi*, Paramahansa Yogananda recounts how his teacher, Swami Sri Yukteswar, was recovering from a severe illness. As soon as he was well enough, Swami Sri Yukteswar made a visit to the home of his guru, Lahiri Mahasaya, and explained that he had been sick. Below, I combine paraphrase and remembered quotation:

Lahiri Mahasaya replied, "I see, Yukteswar, you made yourself unwell." This was not the reply that Sri Yukteswar expected. The guru added, "I'm sure you ought to feel better tomorrow.

The next day, Swami Sri Yukteswar felt much better. He extolled his improvement to his guru, who replied, "Yes, but your illness was serious. Who can say how it will be tomorrow?"

The next day the swami could barely drag himself to his guru's home. The guru remarked, "Once more you indispose yourself."

The swami became angry. "You are ridiculing me. I do not see why you do not believe my truthful reports!"

The guru laughed. "Your thoughts have made you alternately weak and strong. Your health has exactly followed your expectation."

This back-and-forth healing and weakness in response to alternating suggestions from his guru is an example of what a modern hypnotist would call being "under." The swami was under the hypnotic influence of the guru. The guru wanted his student to rise above positive and negative suggestive influences and instead develop a connection with his *higher* consciousness: his superconsciousness, which is connected to the heart. The *sub*conscious mind *can* be hypnotized. The superconscious mind, connected to the heart via the third eye, *cannot*. It can govern behavior and thoughts based on what is right and true, rather than what is suggested, or habitual, or induced by fear.

Swami Sri Yukteswar's guru added (and here, I am quoting), "Thought is a force, even as electricity or gravitation. The human mind is a spark of the almighty consciousness of God. I could show you that whatever your powerful mind believes very intensely would instantly come to pass."

Some spiritual authorities warn that letting oneself be put "under" by a hypnotist can weaken one's own, wisdom-based, heart-based will power. The above vignette demonstrates the guru's disapproval of his student being easily hypnotized by suggestions.

Using a professional hypnotist

In the case of a person wanting to turn off the habit of using pause, a professional hypnotist might think it enough to merely place a layer of "healthy," non-pause behavior over the top of the pause-inducing behaviors, thus creating a layered mess in the mind.

I discussed the stuck-on-pause situation with a retired, *highly* esteemed pediatric psychologist who had worked with some of the top research doctors in the field of hypnotherapy. She had years of experience in helping her hospitalized, traumatized pediatric patients create a self-hypnotic situation, complete with a guide, in order to help her patients find effective, safe ways to deal with the traumas that had put them in hospital. However, she had no experience at all in turning *off* a long-established, unhealthy self-hypnotic state.

I shared with her what I was seeing in people who had commanded themselves to use pause mode and had become stuck. She was fascinated, and said that it definitely sounded as if they had unwittingly created a self-hypnotic suggestion, which over the years had become unmanageable. I implored her to consider what a person might do to turn off a long-forgotten hypnotic suggestion that had, in many cases, taken over the person's mind. She had absolutely no ideas as to how to even begin to go about addressing this type of situation.

The solutions that I have eventually arrived at are the result of working with the many people who "by chance" have successfully turned off pause, and the many, many people in the earlier days of my research who shared with me their eventual successes and their many, many failures in getting to the root of being stuck on self-induced pause.

My patients who have worked with professional hypnotists to "turn off the Parkinson's disease" have *not* been successful. However, those who have worked with a focused mind and a loving, wise, and trusted Friend, have been able to eventually replace the pause habit with healthier coping habits, and have then successfully destroyed the remnants of the old habit of using pause mode. [25]

Upcoming chapters will have more instructions about cultivating a relationship with a Friend. For now, this is enough information to move into the next chapter, where we discuss how to diagnose whether or not a person is on pause. As you probably suspect by now, the Friend already knows the answer to this.

Whether or not you are stuck on pause, if you do not already talk frequently and earnestly, lovingly, laughingly, with a Friend, it's time to start cultivating such a relationship. Now. Today. Put this book down. Set a timer for ten minutes, and start talking. If you absolutely can't think of *anyone* you could talk to, then talk to the one you would scream out to for help if you are trapped in the trenches when the bombs start to fall. As goes the old saying from the first World War, "There are no atheists in foxholes."

---

[25] Psychologists have recently come to recognize that all people have "leader" aspects and "follower" aspects in their brains. A pathologically high level of the "leader" aspect can lead to a narcissistic personality. A pathologically high level of the "follower" aspect can lead a person to be unable to form his own opinions: he will blindly follow a leader. Researchers have hypothesized that during self-hypnosis, a person uses the leader aspect of his personality to instruct the follower aspect. This is all highly theoretical and has nothing to do with turning off pause mode. However, I find the recent flood of new brain discoveries and theories to be fascinating. You can learn more about leader/ follower behavior by doing a search on "leader follower theory." The following is a short quotation on the subject from a scholarly article from a highly respected research journal:
"Leadership and followership have evolved to facilitate information sharing and coordinated group action in a wide variety of species. Humans are apparently adapted for complex cooperative behaviors that require high levels of expertise, coordination, and solutions to collective action problems, and it would not be surprising if they, like so many other species, have also evolved psychological adaptations for leadership and followership."
"The evolution of leader–follower reciprocity: the theory of service-for-prestige"; *Frontiers in. Hum. Neurosci*.; 04 June 2014. https://doi.org/10.3389/fnhum.2014.00363.

Talk to your Friend. If the Blocker tries to dissuade you, don't engage with it. Don't negotiate, don't make accusations, don't offer explanations. Just gently tell the voice of negativity, "Not now." and then ignore it.

And then talk to Yoda. Or great aunt Margaret. They are waiting to hear from you.

Diagnosing Pause Mode

This chapter shares some simple diagnostic tests that can determine whether or not a person is stuck on pause. Much of the material in this chapter has been taken from chapter seventeen in my book *Recovery from Parkinson's*. The *Recovery* book is specifically directed towards people with Parkinson's disease. However, many people are stuck on pause and do *not* have Parkinson's (or do not have it yet). My first three case studies in this book very intentionally featured people who were stuck on pause and whose health problems were *not* (yet) characteristic of the symptoms of Parkinson's. *This* book is looking at the larger picture of pause mode in general, and not just Parkinson's disease.

As an aside to acupuncturists or other health professionals, any patient that has a "mysterious" or "incurable" syndrome should be examined via channel diagnostics to determine whether or not he is stuck on pause. Even if a person does *not* have Parkinson's, he might be stuck on pause. Also, misdiagnosis in the field of Parkinson's abounds – both ways. If a person has reason to believe that he has Parkinson's disease or has been told by his doctor that he has it, he should first confirm *that* diagnosis using the information from chapter fifteen of *Recovery from Parkinson's*: "Diagnosing Parkinson's Disease." After that, he can next determine if he is on pause (either type) or *pseudo* pause. The diagnostic exercises in chapter *seventeen* of the recovery book that determine this are *repeated* here in this chapter. These exercises can be used to differentiate between pause and *pseudo* pause. Again, pseudo pause is usually set in motion by a dissociated – and therefore unhealed – injury. Treating pause and treating *pseudo* pause requires different types of therapy. As for figuring out whether the pause is *biological* or *self-induced*, that subject is addressed in the next chapter of this book, chapter nine.

For people with pause-like symptoms who aren't sure if they are actually on pause, the tests in this chapter can confirm the use of pause mode. These tests can be used for *any* person, Parkinson's or no, who thinks he might be experiencing symptoms of pause and wants to be certain of his diagnosis. Because the diagnostic tests in *this* chapter can differentiate between true pause – both biological and self-induced – and *pseudo* pause, they can filter out the 5 or 6% of people with Parkinson's who have *pseudo* pause, and re-direct them to appropriate treatment for their situations. If one concludes that he *is* on pause, the *next* step is to differentiate between biological pause and self-induced pause.

Most people with Parkinson's, around ninety percent, have *both* self-induced pause *and* pseudo pause from a foot, ankle, or leg injury. Others have self-induced pause and biological pause. Once a person becomes stuck on pause mode of either type, *subsequent* physical injuries might remain dissociated and therefore fail to heal. If they are not life-threatening, they might lead to pseudo pause. If they are life threatening, they might lead to biological pause. Either pseudo pause and/or biological pause might be found *together* with self-induced pause.

When a person is on pause, with his body behaving neurologically as if he is on the brink of imminent death, he does not waste energy in addressing ongoing or subsequent *non*-lethal injuries. When staying alive is the predominant concern, a person's

other, smaller, health crises might be pushed to the back burner and remain mostly unhealed and dissociated. Even if superficial healing occurs on the skin, aspects of the underlying injury or illness might linger, dissociated and unreachable by the mind, until pause turns off.

If a person has both pause and pseudo pause, it is *crucial* to treat pause first. Only after turning off pause is it safe to work on treating the injury or trauma that is holding *pseudo* pause in place. (See: *Recovery from Parkinson's*: Partial Recovery.)

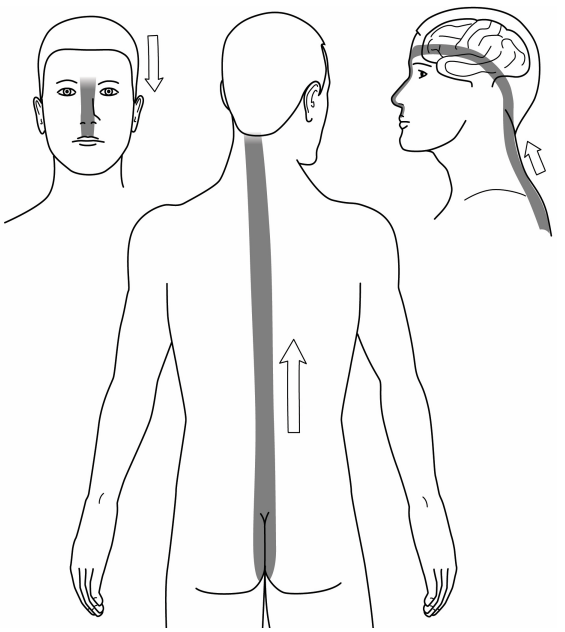
Then again, if a person has self-induced pause and biological pause, *biological* pause should be treated first; self-induced pause is treated second.

Diagnostic test #1: temporarily inducing pause mode

This test has two parts. It can make clear what it feels like to 1) *be* on pause and 2) *not* be on pause. The exercise allows any person to *temporarily* experience pause mode, and feel some of the accompanying physical sensations or lack thereof, as well as feeling some of the mental/emotional shifts that might occur on pause. A friend or family member, if any, who is going to work or even spend time with a person with PD can also do this test, to learn what it feels like to be stuck on pause.

- If you are *not* already stuck on pause, you will be able to temporarily experience and compare pause and not-on-pause by doing the following exercises.
- If you *are* stuck on pause, you will probably not be able to feel much difference while doing the two parts of the exercise – that's how this exercise is a diagnostic test.

Part A) <u>*Not* on pause:</u>



Close your eyes. Imagine a current moving up your back, from the lowest part of the back up into the neck and head. The current is about an eighth of an inch under the skin and about half an inch wide. This current follows the path of the Du ("Governor") channel.

Your imaginary current can be made out of anything moveable: light, electricity, wind, water, warmth, coolness, or a tingly feeling – anything at all that you can imagine as moving. Imagine you can feel this energy as it flows easily just under the skin that lies over the spine. Imagine that the energy travels from the bottom, the "base," of the spine, up to the neck, into the neck vertebrae, up the brain stem, and through the center of the brain over to the center of the forehead, at the third eye.

Fig. 7.1 The Du channel in parasympathetic mode

Imagine the energy emerging from the brain at the forehead and flowing down the face, staying just under the skin, down to the upper lip and into the mouth. (See Fig. 7.1) This is the pathway that the Du channel follows when a person is in a high degree of parasympathetic mode. If you are *not* on pause, this should be very easy to imagine. You shouldn't have to make much of an effort.

If your immediate response to these instructions was "I can't do visualization," you are probably on pause – either biological or self-induced. But even if you can't usually do visualizations, give it a try. You might be surprised at how well you can visualize Part B, even if you couldn't imagine Part A.

Part B) <u>On pause</u>:

Repeat the above exercise but *this* time, imagine you are *stopping* the flow of the Du channel 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 along your spine, but don't allow it to move up into the neck or head.

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, you might start noticing the changes in your muscles, your facial expression, and your thoughts. Notice the vague sense of oppression, constriction, or numbness in the vicinity of your heart. This constriction is the opposite of the expansion in the heart area that accompanies joy. Within just a minute or two, your muscles might feel as if they are tensing up a bit. Your arms might even be bending at the elbow, pulling in, becoming rigid along the biceps.

Your facial muscles might be getting saggy, if relaxed, or stony, if concerned. Your thoughts might be wary, and might include notions such as "I *really* don't like doing this" or "This is horrible; I feel like I'm dying." *Or*, oppositely, you might be thinking, "This feels normal."

Your sense of having a resonant area in your chest that expands or contracts with joy or sorrow, respectively, will feel increasingly deadened the longer you keep this up. In this book, this resonance is referred to with several different phrases, including heart feeling, heart awareness, and heart sensations. Although I use the word "heart" in these phrases, the sensations actually arise in the pericardium, the connective tissue *around* the heart. These terms do *not* refer to heart palpitations, which are the worrisome, tangible sensations of your heart's *muscular* beating.

Note: the drawing of the Du channel on pause has *no* arrows showing directional movement. For a nice metaphor, we read in the ancient Chinese description that when this stoppage occurs, the Du channel ceases to be a river and becomes "like a reservoir."

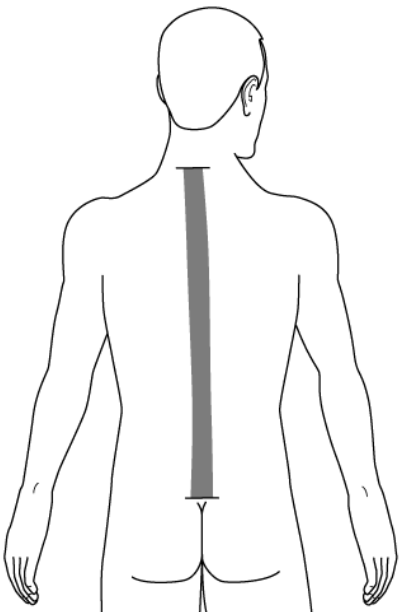


Fig 7.2 The Du channel in pause mode: blocked at the neck.

As you continue to imagine that no energy is able to move from your back up into the neck, you might want to add a second channel blockage in your neck. Ordinarily, the energy on the back of your head in the Urinary Bladder (UB) channels, slightly to the left and right sides of the Du channel, flows just under the skin, from the head down into the neck. Then staying just under the skin, the channels flow down into the back upper torso, then dive under the scapulae (shoulder blades), and end up flowing down to the feet.

The Urinary Bladder channel during pause

When on *pause*, the UB channel *usually* cannot flow easily in its usual path down into the torso. Instead, the UB channel usually becomes blocked at the neck, just above UB-11.

If you want to make the pause-like experience more intense, 1) continue to imagine that Du channel energy *cannot* travel up into the neck *and* 2) imagine that the energy in the UB channel, on the left and right *sides* of the Du channel, *cannot* flow *down* to your torso. Instead, imagine it flowing outward into space from just above UB-11. After a minute or two of this, you might notice that you now perceive yourself as being slightly outside of your own body. A common "outside" location is an inch or so behind the back of the neck.

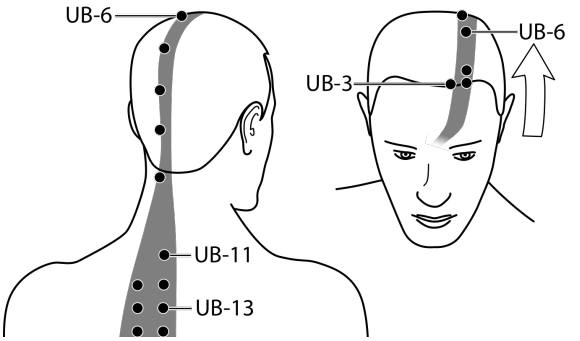


Fig.7.3 The healthy, parasympathetic head and neck portion of the left-side UB channel.

The left-and right-side UB channels, after departing from the point between the eyebrows, are just off to the *sides* of the Du channel, and flow from the head down to the toes, flowing in the opposite direction of the healthy Du.

The neck blockages of the Du channel and the right and left side UB channels, along with the increasing rigidity in the body, the oppression in the chest around the heart, and the sense of being outside of one's body are all symptoms of being on pause.

By imagining that energy cannot traverse the back of the neck in either direction, you will be able to make temporary blockages in both the Du and the UB channel. This blocked channel qi behavior is *normal* during pause mode.

Have you felt for long enough what it's like to be on pause? Let the currents resume moving through your neck and head again.

Please don't worry about getting stuck on pause just by doing this exercise. As soon as you resume the flow of energy through your neck, with both the Du flowing up into the neck and the UB flowing down from the head, staying *under* the skin all the way down into the torso, all those weird pause symptoms will go away…assuming you were *not* already stuck on pause before you started this exercise.

Assessment

Here's the diagnostic part: if you are stuck on pause, you might *not* have felt much difference between the physical sensations of part A and part B.

Oppositely, if you could *easily* imagine a current moving up into the neck and head in part A and if it felt good, normal, and even automatic, requiring almost no mental labor on your part to make the current go into the neck and head *and* if you felt uneasy or strangely inhibited during part B, then you are probably *not* stuck on pause.

If you have confirmed that *do* have Parkinson's disease according to the information in *Recovery from Parkinson's* but are *not* stuck on pause according to these tests, meaning that Part A felt normal and Part B felt unusual, then your Parkinson's symptoms are most likely due to you being stuck in pseudo pause. That means you have *only* Type II or *only* Type III PD. You will want to read the book *Yin Tui Na* (available for free download at www.pdRecovery.org) to learn how to heal from this condition. Be sure to read chapters 5 and 6 in the book *Yin Tui Na*.

More details on the Part A response

When doing part A, imagining healthy, parasympathetic current moving up your neck and into your head, if you felt a little giddy at first from an unaccustomed surge of dopamine release that won't last, you are probably stuck on pause. If doing part A made you feel even *more* wary than usual or more vulnerable, or maybe experiencing the thought, "I shouldn't be doing this" or, if you felt a tightening or discomfort, or even the fear of *potential* discomfort, in your heart, stomach, throat or other area, you are probably stuck on pause. If you simply felt "not normal" while imagining energy flowing up your neck and into your head, you are probably stuck on pause. If it takes mental *work* to imagine energy moving up into your neck and head, as opposed to just observing that energy is, in fact, already flowing in this path, you are probably stuck on pause. If you *can* imagine energy flowing up into your head *but* you sense that the energy stops flowing into your head as soon as you stop forcing it, you are probably stuck on pause.

When doing part B, preventing current from going up into the neck and head, if you felt more "normal" or more "natural" or it's "easier" when you *prevent* current from going into your head, you are probably stuck on pause. If you feel more familiar with *allowing* the current to stop at the base of the neck or skull, you are probably stuck on pause.

If you simply could not do the exercise of imagining energy flowing up your neck and into your head, you are probably stuck on pause. If you couldn't feel, imagine, or visualize anything, or can't understand the assignment, you are probably stuck on pause.

For that matter, if you do not know what is *meant* by the words "the resonant area in your chest that expands or contracts with joy or sorrow, respectively," you are probably stuck on pause and might have been for a long, long time. 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, you are probably stuck on pause. You'll want to focus on turning off pause before you think about dealing with pseudo pause-causing injuries, if any. Even if you also have old injuries that you are certain are contributing to *pseudo* pause, you'll want to turn off pause *first*, to prevent sliding into the nightmare of partial recovery.

Semantics – an aside

As mentioned earlier, the pericardium is the highly conductive connective tissue around your heart. The pericardium generates and regulates the sensations of heart feelings such as joy, compassion, and soul-satisfying peace. The heart sensations associated with peace and joy (sensations that are usually elusive to a person on pause) include a sense of vibratory or etheric expansion in the chest. This is not the physical expansion of the chest that comes with inhalation. It's a subtle feeling as if the electrical field of influence around your heart has gotten larger. When truly joyful, you *might* notice a gently thrilling, almost electrical or static-y rippling sensation starting at your heart and spreading throughout your body.

Feeling peaceful does *not* mean experiencing numbness or drowsiness, as many people using self-induced pause wrongly assume. Feeling peace in your heart is a distinct, expansive sensation. It is *not* the absence of sensation. When on pause, *awareness* of the sensations generated by changes in the pericardium is inhibited.

The phrases "open your heart" or "be open-hearted" are instructions to redirect more of your awareness towards the actual *sensations* of electromagnetic, resonance-driven expansion of awareness in the chest caused by increased amperage in the pericardium. By paying attention to, by "attuning" with the heart, you increase the amperage in the pericardium and expand the number of electromagnetic frequencies with which the connective tissue around the heart can literally "tune in."

If you think that phrases such as "be open-hearted" mean "think good thoughts" or "be nice," you might be stuck on pause. The reason you probably don't associate heart-feeling phrases with the actual sensations in the chest is because you don't feel these sensations. You might have been going through life assuming that references to heart feeling or being "open hearted" are metaphors or poetic references to being good or kind. They aren't. They are meant literally. The pericardium acts like a radio receiver/transmitter. These phrases refer to paying attention to *perceptible* shifts in the pericardium's amperage and range of frequencies received and transmitted *and* making them as expansive as possible. An emotionally healthy person can usually feel these shifts in the heart radio. A person who is stuck on pause might think of himself as deeply spiritual, very self-controlled, and emotionally healthy, but if he is stuck on pause, he is actually not as emotionally or physically healthy as he imagines himself to be: he's not fully experiencing his pericardium sensations.

I'll repeat this because this concept can be new and even unsettling – or even skipped over or denied – by someone long on pause. I have spoken with many people with PD who told me, "I read every word of your books, except for the heart stuff, which doesn't actually have anything to do with Parkinson's." The subject of heart-feeling *is* related to the subject of pause, including Parkinson's from self-induced pause. The terms "heart feeling" and "open-heartedness" have to do with feel-able changes, subtle sensations of expansion and contraction, in the heart area. These sensations are driven by the changes in the electrical field around your pericardium that occur in response to thought and mood changes, and especially in response to activity levels in the third eye and striatum.

Then again, if you have always known that "open your heart" means "tune in to the sense of expansion in your chest as you focus on something joyful," or something along those lines, you are probably *not* on self-induced pause. You *probably* aren't on

biological pause, either, unless it is of such recent origin that you still remember what heart feelings are. If you have always known what these phrases mean and can still feel the expansion and contraction of an "open" or "closed" heart *and* you also have PD, you might only have pseudo pause: PD from *dissociation*, not from the use of pause mode. Or you might be on pause and experiencing a tiny, micro version of heart awareness or heart feeling. You might be telling yourself, "I *can* feel joy, so I *can't* be on pause." But after turning off pause mode, a person with this kind of thinking might be astonished at the vast increase in heart feeling that is suddenly accessible.

In my own case, in spite of my stoicism, I was certain that I was always feeling the full range of emotions. After recovering from Parkinson's disease, I was astonished at the unexpected depths and breadths of emotions and feelings that I could experience. To steal a metaphor from Sir Isaac Newton, I had been wiggling my fingers in small tide pools of heart feeling, and never been aware of the surging ocean right behind me.

Diagnostic test #2: outside the body

This test will help you determine if you go through your moments of self-awareness by *feeling* your body from the inside *or* by *looking* at yourself from some location outside of your actual body.

The inside or outside the body test

Close your eyes. Imagine you are walking down a lovely tree-lined street. It's a beautiful day. Birds are chirping. A gentle breeze is rustling the leaves. The sky is blue.

Take ten to twenty seconds to imagine this. Then ask yourself this question: were you experiencing the stroll from *inside* your body, *feeling* your sensations of walking and *feeling* the pleasant expansion in your heart area as you hear the birds? Or are you numbly *looking* at your body as you stroll down the street?

If you are outside of your body, looking at it, can you equally easily imagine yourself inside your body, experiencing the sensations of stride and well-being from within? If you are *unable* to imagine yourself inside your body, or it takes a bit of work, or it's hard to make your sensory awareness *stay* inside once it's put there, you are probably on pause.

If you imagine that *most* of your self-awareness is inside of your body but one arm or one leg, or maybe your heart area, or some combination of specific body parts are observed from the outside, or maybe your feet or some other body parts are "missing," you might be *dissociated* from those body parts, but you are very likely *not* on pause. The body parts might not be missing entirely. My patients have told me of various "not quite right" situations with visualized "ghost" arms sticking up in the air, or an imaginary arm rigidly crossed over the chest, or otherwise seeming to be "present," but in no way related to whatever their actual, *physical* arm happened to be doing. With pause, one usually perceives himself as outside of his body *altogether*.

For example, very often, my patients who were on pause, if asked to imagine that they had a beautiful body filled with light, perceived that their "good" bodies, bodies full of sparkling energy, were standing nearby, or maybe sitting on the sofa across the room. One patient on pause, lying on the treatment table in my office, could imagine he had a body, one full of light and energy, and it was still age nine…and living at the lake three thousand miles away where he'd gone to summer camp. That feeling of being out-of-body altogether is more characteristic of pause than of dissociation. Returning to the subject of

dissociation, with dissociation a person might imagine one or a few specific body parts as being inaccessible, viewable only from the outside, or being in some strange position that has nothing to do with the actual physical location of that body part, but the *rest* of the body is able to feel that its light and energy is inside, rather than outside, the body proper.

If you tend to observe or think of your body as if you are completely outside of it, looking at yourself instead of *feeling* your existence by using the brain's thalamus and/or the resonance of your heart (pericardium, actually), you are very likely stuck on pause.

Why do this test?

This test serves two purposes. The first is diagnostic: most people with self-induced pause or biological pause perceive themselves as *outside* of their bodies. If you have symptoms of PD *but* sense that you are mostly *inside* your body, you probably have *only* Type II PD (from dissociation) or *only* Type III PD (from self-induced dissociation).

The other reason I do this test is to help patients with self-induced pause realize that they are, in fact, using pathological self-perception. Many people with Type I PD, the type caused by self-induced pause, are adamant that they have *no* psychological factors involved. Sometimes, the realization that they perceive themselves as if outside of their bodies is just weird enough that they start to *consider* that they *might* in fact have a problem in the mind as *well* as in the body.

Variations on "outside the body"

If, when you speak, you imagine the words being typewritten as you speak or spelled out on the "video screen" of your imagination, you might be stuck on pause.

If you mentally use *words* or *logic* to self-assess how you are feeling instead of checking in with your wordless *sensations* of expansion and contraction in your heart area you might be stuck on pause.

If you move by mentally *commanding* your body to move rather than by enjoying the vibrant or languorous sensations of motor actions that occur automatically and immediately in response to thinking about or *imagining* moving your body, and especially if you don't know what this sentence means, you are probably stuck on pause.

If you have no idea what I mean by "*feeling* your body from the inside" or "heart feelings" you are probably stuck on pause.

Yoga and Qi Gong responses – more variations on "outside the body"

Consider your experiences, if any, with yoga, meditation, Qi Gong, or Tai Ji Chuan (aka Tai Chi). If these self-awareness techniques have not increasingly brought you the promised heart feelings of peaceful, expansive joy, you might be on pause. If you have done years of the above practices and have done them without feeling a steady increase in child-like joy and playful sensations of energy flooding the various body parts as they are moved or are focused on, you might be on pause.

If you do the above types of movement or stillness while trying to make your body and/or its movements symmetrical, uniform, mechanical, or "correct," as opposed to noticing and enjoying the pleasant or even gently tingling sensations of life force moving around inside you, you might be on pause.

On the other hand, *if* you enjoy doing these types of self-improvement exercises because they help you turn off your internal monologue and let you 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 into your head and heart, and your increased awareness of somatic resonance with joy in the deep stillness of your body, you are probably *not* on pause. If you do have PD and feel these joys while doing these exercises, you probably have *only* Type II or *only* Type III: pseudo pause brought about by an unhealed or incompletely healed injury from which you have dissociated.

Then again, if you like doing the yogic "corpse pose" because it lets you "turn off" and/or pretend you are numb or dead, you may well be on pause.

Of my Parkinson's patients who have steadily practiced the movement and meditative arts (a surprisingly high percent), most have told me that their decades of silent meditation, yoga asanas, Qi Gong forms, Tai Chi or other "spiritual" movement exercises have *not* led to increased awareness of inner joy or heart resonance. Just the opposite: they have felt less and less joy and/or less heart feeling over the years, despite decades of doing these supposedly "uplifting" exercises.

Also, many of them have said that "corpse" is their favorite yoga pose because it lets them relax into feeling *numb* – the *opposite* of the real purpose of the corpse pose.

Only pseudo pause, with no actual pause

In test #2, if you felt the sensations of walking down the street as if you were inside your body, imagining the sensations of your arms swinging and/or legs striding, you are probably *not* on pause. If you find the above descriptions of doing yoga or Qi Gong as mechanical exercises laughable or bizarre because you do them for the playful or sweet sensations of energy moving around in your body, you are probably not on pause. If, in Test #1, you could easily imagine Du channel energy going up into your neck and head, that's further confirmation that you are probably *not* on pause. If you also can't relate to the Parkinson's personality at all (see: Recovery from Parkinson's, chapter 16, p. 193-214) and if your spouse says "Nah, that's not you," you can be pretty certain you are *not* on pause. If you are not on pause but have idiopathic PD, it is most likely from pseudo pause causing either Type II or Type III.

The brain's visualizing behaviors

The previous two tests looked at body-wide behaviors. Sometimes it can be helpful to know if an injury or numbness at a *specific* location is unable to heal because of pause or because of dissociation. This can also be helpful in looking for the location(s) of injury that is keeping *biological* pause in place, causing Type IV PD.

Determining if a localized area is unable to heal because of pause or because of dissociation can be done by *mentally* looking at the locations where injury has occurred or where energy seems to stop flowing along the path of a given channel.

When trying to visualize unhealed injured or traumatized areas by imagining light and/or darkness inside the body at these areas, the brain tends towards two distinct types of mental images. One type of mental image is set in motion by being dissociated. The other type is set in motion by being on pause.

Dissociation

When a person is dissociated from a body part, if he tries to imagine that body part first filled with light, and then filled with dark, he finds it easier to imagine it filled

with dark. The darkness will manifest as being still, motionless, maybe even invisible. Or it might keep moving evasively. The person might find himself saying, "I don't know what I'm trying to look for…"

That's because the brain is saying, as per previous instruction, "I can't see anything there; I can't imagine that body part. That body part does not exist."

Pause

If a person is on pause, when he tries to imagine light and then dark in some part of his body where he can't imagine the channel qi flowing easily or his channel-detecting friend or health practitioner cannot feel the channel qi flowing, the person usually finds it easier to imagine that part or even all of his body is filled with dark rather than with light.

However, unlike the deep stillness, evasiveness, or invisibility that is perceived in body parts from which a person has dissociated, the area(s) of the body associated with being on pause will appear to be dark and *agitated*. This imagined visual perception of agitation can take the form of tiny movement, as if the atoms are moving too quickly back and forth. Or as if the capillaries are moving in an agitated manner. Or the perception of movement in the dark area might seem like static, or drifting smoke, or sludge: you can see it, but it's not behaving "right." The point is, there is a sense that something isn't settled. The area is *not* rhythmically or peacefully calm.

Sometimes, the agitated area is *not* in the same location as the injury. For this reason, I often refer to the area in question as "the agitated area" rather than the "injury area." For example, following near-drowning, the agitation location is usually found at the base of the spine, in the sacrum. Again, *unsettled* movement of *any* type within the imagined darkness can be referred to "agitation," and indicates that a person is on pause.

This perception of agitation is related to the normal, healthy brain processes for coming out of pause. The first step in turning off pause is assessment. The brain has to pay attention to the injured and/or pause-inducing area. When you bring your attention to or mentally imagine looking at a body location associated with being on pause, your brain tells you that this area isn't settled: it's agitated. This sense of agitation is a call for attention. The sense of agitation is produced in the part of the *brain* associated with that body part, *not* in the actual body part. People with a *missing* limb can mentally perceive this type of agitation in the limb that isn't there. Again, the agitation associated with a traumatized body part when doing visualization is actually coming from the brain, not the body part.

This brain behavior is *supposed* to keep your attention on or bring even *greater* attention to the traumatized part of the body. The agitation signals help the brain focus on the area, assess it, and move forward with its healing, once the life-threatening situation has been stabilized.

People who are stuck on *biological* pause are mentally avoiding, ignoring, or disregarding these "agitated" brain behaviors that are supposed to serve as attention getters. If the traumatized area is still being imagined as agitated even though the life-threatening damage from the trauma has been stabilized, it means that the brain is stuck in an avoidance behavior – ignoring the area that is agitated. If the brain is gerntly forced to pay attention to the area, it will notice that the area is agitated – still causing the body to be on biological pause even though the traumatized location has long since stabilized. In terms of treatment, turning off a situation in which a person is stuck in *biological* pause

will begin by focusing on the area(s) that appear agitated. The first case study in this book described this. The patient imagined he was looking at the place on the side of his head where he had been slammed by the soccer ball. The area appeared to the patient as if it were vibrating (p. 17).

Assessing motionless versus agitated perceptions at a specific location that is easier to imagine being dark rather than light is a simple way to determine whether a person's avoidance of dealing with an injury or trauma is being done via dissociation or via pause.

Body-wide trauma

Not every pause-inducing trauma is site-specific. Some people go into biological pause while nearly dying from a *body-wide* trauma such as an anaphylactic response to a bee sting, a near-drowning incident, sepsis, or some other near-death, physical or emotional shock that hits the whole body. In these cases of body-wide trauma, the areas that become perceived as agitated (when imagined) are often areas along the spine: the sacrum, the area of the spine near to the heart, the base of the neck, the brain stem's medulla oblongata, and/or somewhere in the brain.

In some people who are stuck in biological pause, a sense of agitation might be present in an injury-specific site *and* in various areas along the spine and neck.

The next two sections explain a little more about *why* an agitation situation develops in people on *biological* pause, and how it can be treated, thus allowing biological pause to turn off. This tangential information temporarily veers away from the main point of this chapter, which is the difference between pause and pseudo pause. But the information will prove helpful later on.

Paying attention to the agitation

In a healthy response to a trauma, keeping one's attention on the injury site or areas that the brain registers as agitated helps process the injury. The mind, while focusing on the agitation location, can decide whether or not the biological disruption from the trauma has stabilized enough. When the brain and heart determine that the trauma damage has healed enough to stabilize the body, so that life is *possible*, the agitation signal is then turned off. Then, the body takes the last three steps for turning off pause. When pause turns off, the deepest levels of healing commence in the damaged area(s).

In animals, a sense of agitation *perceived* as coming from the damaged area induces the animal to lick and rub the injured spot, thus optimizing blood flow in the vicinity and speeding the healing. Again, once the area is assessed as stable and the brain determines that the perimeter is safe, the sense of agitation turns off. This allows the body to go through the remaining three steps for turning off pause.

In people who get *stuck* on biological pause, as in the first two case studies in this book, they haven't yet brought their conscious attention to the traumatized or mentally agitated area, or they're mentally telling it "not now," or they just don't know how to begin going about processing the trauma. For whatever reason, the body isn't able to clear the trauma signals from this area, the brain keeps perceiving the area as agitated, the person keeps ignoring the agitation signal coming from the brain, and the body stays stuck on pause.

Contrast this with the brain's perceptions of a dissociated area: there's darkness and stillness because the brain's pretending there's nothing there – just like it's *supposed*

to do after a significant injury, until one can get to a safe place. In a healthy person, dissociation *should* occur after significant injury or trauma if the person is not in a safe location. Dissociation *should* continue until he comes to a safe place. Then, when the person confirms that he is safe, his body can re-associate with the pain of the injury, and start the healing process. But if he never finds a safe place, the area might *stay* dark and dissociated in his brain. Or, in cases of *self-induced* dissociation, the area might not re-associate because he *told* himself to not acknowledge that body part or the injury.

"You're going to be OK"

Humans trying to stabilize after trauma can benefit from being told by someone, anyone, "It's OK; you're going to be OK." Offering words that confirm "You're going to be OK" is an almost *automatic* human response to someone, to even a complete stranger, who has just experienced a trauma and is conscious but somewhat dazed.

Usually, we can hear this "I'm going to be OK" message coming from our own hearts. But if we are in a high degree of pause, we might need to hear this from someone *outside* of ourselves. If we don't hear it from our own hearts shortly after the injury, we might hear it from a stranger, a loved one, a nurse, or a guardian angel. We *need* to have a sense of confirmation that we are safe, or that we are going to soon be safe. If we don't feel we are safe, we might stay on pause or dissociation indefinitely.

If we have previously shut down our heart by commanding ourselves to not *feel*, initiating self-induced pause, and then we get a new injury then we're in a bind – we have no automatic body response to initiate the *feeling* of safety that's needed for initiating healing of the injury. Also, on self-induced pause, one usually can't *believe* the external or internal voices that tell us that we are now safe. The self-hypnotic suggestion that makes a person start using pause mode for dealing with life also, as a side effect, might tell us that we can never trust anyone who tells us we are safe. This may well be related to the way that people with Parkinson's tend to respond to a person who has recovered from PD by saying, "But I'm different. I can't recover even if every one else can." Maybe what these people are actually saying is, "I won't ever be able to feel safe…"

In surgical recovery rooms, where people are trying to come out from under the effects of anesthesia, patients often cry out, "Help me! Help me!" or "Am I OK?" Even if someone replies, "I'm right here, you're going to be OK," which is the correct thing to say, the patient might slide back into the effects of the anesthesia for a while. As he comes to the surface again, he might say, "Help me!" again, having no idea that he's already said it before. This can go on for quite a while. Still, the correct response, every time, is "You're OK" or "You're going to be OK." That's what the brain is needing to know. When the body has been on the verge of death or in a coma, the brain *needs* to be told by the heart, or by some person such as the nurse standing by, or by the imagined voice of a beloved pet dog, "You're OK. You're going to be OK." This allows the body to start taking the steps that turn off *biological* pause.

I have treated many people who never felt "right" following a general anesthesia event. In every case, they have been stuck on pause, with an agitated area in the sacrum, the base of the neck or both. After walking them through the Five Steps, they "snap out of it" and the post-anesthesia weirdness is completely gone.

Many people who are *stuck* on biological pause were never certain at the time of injury or never assured by others that they were alright, or were going to be alright. Just

the opposite: they weren't given time to fully process their trauma. They were on the verge of death but were jerked rudely back into activity, requiring activation of a norepinephrine response (emergency override for pause). This was the case for the first two case studies in this book. The soccer coach and the playground monitor both forced the concussed persons to get back up and get moving before the injured persons had come out of pause mode. Pause never got a chance to get turned off. Decades later, these two patients were dealing with painful symptoms caused by still being stuck on pause.

Death of a five year old

Going off on another tangent, when I was seven years old, my Girl Scout (brownie scout) troop leader shared a recent newspaper story with us during our unit on First Aid. A young five year old girl, happily showing off her new, slippery soled, patent leather shoes, slipped on the sidewalk and landed on her head. Her mortified grandmother pulled her quickly back up onto her feet. Three days later, with no warning, the girl died. An autopsy determined that she had received a significant concussion, with some bleeding inside the brain. The point my scout leader was making was that a person with a blow to the neck or head should be allowed to stay quiet, not moving, until they are determined to be safe by a medical professional. I was profoundly moved by this story at the time and, since then, often noticed it drifting through my thoughts. More than sixty years later, I find myself writing a book on near-death phenomenon, and wondering at the connection, if any.

Diagnosing pause by feeling the channels

Back to the main point, the tests described so far can be done by the patient, with no need for a health care practitioner. In the extremely rare case where a health practitioner is available and knows how to detect channel qi flow, you might indulge in further confirmations of your own diagnosis.

Some acupuncturists have mastered the art of feeling channel qi. Most have not. Most have never even spent time *reading* about channel theory, let alone mastering any practical applications. And for any acupuncturists reading this book, please note: neither tongue nor pulse diagnosis is going to help you in the slightest when it comes to diagnosing pause or pseudo pause. As it points out in the *Su Wen* portion of the *Nei Jing*, chapter 13, feeling the actual flow of the channels reveals "the sun": what the patient's underlying source energy is doing. The tongue and pulse diagnosis only reveal "the moon": the always changing, superficial energy of the passing moment. This subject is discussed further, with citations from the *Nei Jing*, in *Tracking the Dragon*.

When I was in Chinese medical school, I was definitely in the invisible throes of both self-induced and pseudo pause, and just starting to have a faint tremor once in a great while. My class did a unit on tongue diagnosis. My professor, a highly acclaimed, brilliant teacher from Guandong, China, announced that, among all the students, I had the only perfect tongue. So that should tell you something about the authority of tongue diagnosis. My channels, I am certain, were running in the pause patterns – which is why I screamed or sometimes even passed out when practicing students inserted acupuncture needles into the channels that were running backwards.

Even if a person is skilled in feeling the channels, he must bear in mind that *sometimes* the Stomach channel qi runs backwards *not* because of pause, but because of pseudo pause. The Stomach channel's path might be blocked from scarring or injury. The

injury might be a long-forgotten, dissociated (and hence unhealed) foot or ankle injury. Less often, it might have been a significant leg, hip, or torso injury. Or the channel might be blocked from surgical scars such as a C-section, hernia, mole removal or appendectomy scars, or even from the lingering pause or dissociation that was used to deal with the physical or *emotional* pain of problems such as C-section, or appendectomy. If you're feeling the channel qi to make a diagnosis, you'll need to figure out *what is causing* the Stomach channel to flow backwards. If a person is *not* on pause but the Stomach channel is flowing backwards, causing pseudo pause, you'll want to figure out why.

In order to diagnose pause using the channels, it's best to assess not only the Stomach channels, but also the flow of the Du channel and UB channels – especially the channel qi behaviors at the base of the neck.

Variability in channel behavior in self-induced pause

Unlike with biological pause, a person using self-induced pause might present with channel behaviors that are typical of parasympathetic mode for short periods when feeling deeply safe. This can make diagnosis challenging.

If you suspect a person has Parkinson's disease or is stuck on pause but the Stomach and/or Du channel qi seems to be flowing correctly, you can try this: assume a serious demeanor and, while feeling the channel qi, say something like, "Uh oh," or "I was afraid of this," or some other phrase that can knock your patient out of his temporary feeling of comfort. In response to your ominous words, a mentally *healthy* person, one who is *not* using self-induced pause, might switch over to a higher degree of *sympathetic* mode. If he does this normal, healthy response, the Stomach channel qi flow on the leg will run *more* vigorously in the correct, down-the-leg pathway, and flow from St-42, on the top of the foot, over to Sp-3, on the medial side of the foot. A healthy person, one who does *not* use the mode of near-death (pause) in response to every-day stress, will *not* suddenly present with backwards-flowing Stomach channel qi in response to your ambiguous, slightly ominous mumblings.

Oppositely, if the channel qi was running fine while the patient was deeply relaxed but abruptly runs backwards or seems to stop in response to a mild stress such as the words "Uh oh!" being muttered, then the person is using self-induced pause, not sympathetic mode, to deal with the slightest challenges of life. Even if pause mode does turn off once in a while, this tendency to lurch back into pause mode, rather than sympathetic mode, in response to negative thoughts or at the first sign of stress, is still referred to as being *stuck* on pause.

If you are an acupuncturist trying to make a diagnosis, other gambits that might help make the Stomach channel qi show its true colors is turning off the piped-in music or the comforting sound of the water fountain in your medical office. You can leave the overhead lights on so that the patient is mildly stressed by looking up into the lights as he lies on the treatment table (or treatment couch, as it is called in some countries). You can find some way to make the patient just uncomfortable enough that he will stay in his habitual channel patterns of pause mode and *not* make a *temporary* slide into parasympathetic mode while you check his channels.

A person on pause might appear perfectly normal

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 might 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 social behaviors flow somewhat naturally, from the heart, the person who is running pause in the background *might* be performing these behaviors somewhat consciously, using a norepinephrine override for pause and using, for the most part, brain-based logic and self-awareness based on brain assessment, even though he might be *talking* about intuition, heart and love.

Acupuncturists are not trained in diagnosing pause

After I retired, I referred a would-be patient to one of my colleagues. The colleague, who I'll call Sam, was a past student of mine. His skills at feeling channel qi are superb. The patient, who I'll call Jane, had recently been diagnosed with early Parkinson's disease, but she wasn't sure that's what she had, and wanted someone to do channel diagnostics.

When Jane arrived at Sam's office, he started her treatment as he starts all his treatments – with a quick shoulder and neck massage to get the patient relaxed. His office has beautiful wall hangings and soft lighting. She responded to the setting and the massage by relaxing deeply. He noticed waves of static coming from her pericardium area, so he did Yin Tui Na on her back, near the heart area, for a while. He noticed that her feet were tense, so did Yin Tui Na on her feet for several minutes. She relaxed even more deeply. When she was nearly dropping off into sleep mode and feeling very, very safe, he started to assess her channels, as per her opening request.

They were running perfectly normally. He told her that her channels were running fine, and therefore she didn't have Parkinson's disease. She was baffled. In a panic, she sent me an urgent email as soon as she got home asking what she should do next.

According to the chapter on diagnosing Parkinson's *based on symptoms* in my *Recovery from Parkinson's* book, she *did* have Parkinson's disease. All of her symptoms pointed to a diagnosis of Parkinson's. She didn't have a questionable case of PD; she had a very solid, no-doubt-about-it case of Parkinson's.

I phoned Sam and asked what he'd noticed. When he told me all the things he'd done to get her relaxed before assessing her channels, I laughed. Given the powerfully relaxing treatment, I wasn't surprised that her channels had temporarily flipped over into parasympathetic mode or maybe into pre-sleep mode. The body of a healthy person switches into a high degree of parasympathetic mode just prior to sliding into sleep mode. When bedtime rolls around, a person using self-induced pause during the day might nevertheless be capable of sliding into parasympathetic mode and then sleep mode.

- (As a fun aside, the body jolt, or jerk, that some people experience just as they are dropping off to sleep occurs when the Du channel qi switches too abruptly from flowing through the midbrain [awake Du behavior] into the over-the-top-of-the-head path [sleep Du behavior] of the Du channel.)

Jane went to see Sam again. Sam didn't do *any* relaxation techniques. Her Stomach channels were running backwards, her Du channel was stopped at the neck. He was able to confirm that she was using pause mode. Even though she could evidently slip

out of pause mode temporarily, while under *highly* relaxing conditions, she nevertheless jerked back into pause at the least provocation. This is *not* healthy or normal. Pause mode is a dire, near-death mode. Ordinary stresses of daily life should be dealt with by using an increase in *sympathetic* mode, not pause.

Two helpful things came out of her experience. First, her second session confirmed that she had Type I PD from self-induced pause. (Biological pause is constant, it doesn't come and go to the same extent.) Second, the experience served as a reminder to me to be sure and make a note of this phenomenon in this book.

Ten minutes of heaven

On the subject of self-induced pause being able to temporarily turn off under conditions of extreme safety, I remember clearly one episode in my young adult life when pause mode temporarily turned off. I had been on pseudo pause since I was five years old and self-induced pause since around age two. However, I was still susceptible to emotional pain, evidently, because, in high school, my emotional pain level was so high that I intensely stared in a mirror while commanding myself to stop feeling. I was actually frightened by the look in my own eyes as I made this transformation, and I felt as if I had tapped into something powerful, but evil. I was so alarmed, I had to look away from the mirror. But I didn't retract my command.

A few years later, after a year of grueling intensity, a series of circumstances found me spending two weeks with a wonderful friend of a friend. He lived on a remote coastal beach. It was summer. The friend was working every day. I was free to stroll the beach and body surf to my heart's content. I had the entire beach completely to myself. I had nothing to do but feel and listen to the expressions of nature all around me. For two weeks, I had no cares. There was nowhere I needed to be. I still had two more weeks before heading back to university. There were no people around, so no one was going to hurt me. One morning, strolling along the deserted beach, without realizing I was doing it, I dropped my guard for the first time since I was very young child.

Suddenly, the world shifted. The sky was sparkling! The ocean was sparkling! I could feel the air against my skin! It was warm and silky. I felt physically lighter, almost as if I could fly. Walking along the sand was absolutely effortless. I didn't have to think about moving – my legs just moved on their own, as if there were wings on my heels. My heart felt as if it might explode with joy. I felt happier than I had ever felt in my life. This experience did not last long, no more than ten minutes, probably. I never forgot my "ten minutes of heaven." After that, for decades, until I recovered from Parkinson's, I would often recall to my mind the experience of those ten minutes to help me get through the inevitable challenges of life. When I was most discouraged, I could keep myself going forward with a smile by saying, "Maybe heaven's going to happen again, and you never know when…"

When I lastingly turned off my use of pause mode, nearly thirty years later, "heaven" (a very high degree of parasympathetic mode) returned. Since recovering, I am always in a blend of parasympathetic and sympathetic, *not* pause. I have learned that I can nudge myself closer to the *high* degree of parasympathetic mode/ *low* degree of sympathetic mode almost any time I want. I focus on my third eye and silently say to my constant Friend, "Let me *feel* your presence." And I instantly shift into a significantly

higher degree of parasympathetic mode, and it lasts as long as I stay aware of the tangible presence of my Friend.

The point is, I was habitually using self-induced pause to go through life. Even so, during a fleeting time during which I felt *completely* safe, my body shifted into a high degree of parasympathetic mode. I did NOT lastingly turn off pause during this episode. I merely took a break from my long-standing instruction to feel no pain. But as soon as I went back to what I thought of as my normal, carefully crafted, *seemingly* happy-go-lucky and secretly wary personality, I was back on self-induced pause. Colors reverted back to what I thought of as normal. My body went back to being obedient to my mental commands for movement.

Biological pause does not vary like this because there is or was an actual, potentially life-threatening trauma that has either not been healed enough or assessed and cleared for recovery. Self-induced pause *might* vary, even *temporarily* sliding into a high level of parasympathetic mode once in a while, because it's a mental habit that *might be* temporarily ignored, when conditions are right.

While working on recovering from Parkinson's, many people on self-induced pause have temporarily experienced a few minutes, a day, or even a few weeks during which they are convinced that they have recovered because they have a break from self-induced pause. However, until they learn to feel *consistently* safe and completely overthrow the habit of using the self-protective mental tricks they've created, they will be at risk of resuming their habitual use of self-induced pause at the first sign of trouble, or when they allow negative thoughts and fear to dominate.

This subject will be discussed in more detail in chapter ten.

Placebos and miracle cures

As an aside, people with Parkinson's are known to be extremely susceptible to the placebo effect. This is why studies show that most people with Parkinson's who are already accustomed to the empowering feelings created by their antiparkinson's medication can be given a placebo (sugar pill) and the pill will *work*: the person can feel his "power" surge back on in response to a sugar pill, in the same way that he's used to feeling a response from his antiparkinson's medication. (See citations in *Recovery from Parkinson's*.) Based on my *own* observations, this powerful placebo response only occurs in people who have Type I PD, from self-induced pause.

In the same way, some people with PD who are convinced that some vitamin or supplement will cure Parkinson's might see their problematic symptoms completely go away in response to the vitamins or supplements – until they have some new life crisis or indulge in a negative thought. As soon as the negative thoughts re-appear, the Parkinson's symptoms, the symptoms of self-induced pause, will resume. Unscrupulous companies take advantage of this fact by promoting their "special" anti-parkinson's vitamins.

When I started researching Parkinson's, in the late 1990s, Co-Q10 was the popular magic cure. In the early 2000s, glutathione was hyped as the miracle cure for PD. It only worked if you got the injection from the doctor in Florida who had "discovered this cure." In 2021, as I write this, hyper-dosing on vitamin D is the latest popular "magic cure for Parkinson's disease" being advertised by certain vitamin companies. There are also *multi*-vitamin "cures" being advertised online.

These so-called cures are based entirely on the placebo effect. Because self-induced pause is a mental posture, and not an actual physical insufficiency of vitamins or any other particular chemical, it can be turned on and off in response to a person's thoughts. If a person believes strongly that these vitamins will cure his Parkinson's, he might get several weeks of reduced symptoms by taking the magic cure. However, the miracle will cease when negative thoughts or challenges resume.

The internet ads for these miracle cures are very convincing. They nearly always mention that the reason the doctors do not know about the miracle cure is that the pharmaceutical industry is suppressing the facts. In fact, there are hundreds of PD researchers who are *not* in the employ of the pharmaceutical industry. They would just love to have an effective cure for Parkinson's be so simple. They would get fame and fortune if they could prove that any of these miracle pills actually worked. But the "miracles" only last for a short while...and even then, only if the person fervently believes in them, and only if the person has Type I PD, from self-induced pause.

On the other hand, if a person does have a short-term "miracle cure" response to these kinds of pills, this is helpful information: it means he is using self-induced pause. Not biological pause, and not pseudo pause.

Diagnosing pause with the help of a Friend

One of the fastest ways for a person to figure out if he is on pause is to ask the Friend.

Close your eyes, and focus your attention at the third eye. To do this, gently lift your closed eyes as if gazing at the point between the eyebrows. That's enough to bring your attention to the third eye and increase the amount of energy flowing there. Then, if you don't always *feel* the presence of your invisible Friend, and you aren't sure that your Friend is there with you, silently ask your Friend to be there with you and to listen to you.

Then, you can ask your Friend: "Am I stuck on pause?" or "Am I using self-induced pause?"

The answer is usually immediate. Do not wait more than a few seconds for a reply. If you don't get a response in the first few seconds, wait for a moment, and ask again two or three more times. If you still don't get a response, spend some time talking to your friend and try again the next day or so. Until you have at least a budding relationship with your Friend or your heart, you might not get any response. Then again you might get a response that is a visual or a memory. You might experience a heart expansion/ contraction. You might get a sense of the word yes or no. Or you might get a combination of responses, or even all of the above.

Again, after your statement or question, you are noticing the very first thought that comes into your mind, or the *immediate* sense of expansion or lightening up of your chest (yes) or contraction (no). That first, immediate response is the reply you were seeking. Do not confuse chest expansion from breathing with the subtle, rippling waves of expansion that are signals from your pericardium. If you have forgotten what a chest expansion of "yes" feels like, repeat the birthdate exercise in chapter five, using a false birthdate and then a true birthdate, and feeling the difference in your heart.

The answer might come *before* you have completely finished phrasing the question in your mind. After all, your Friend and your heart know your thoughts even before you are able to fully express them.

Summary

Being stuck on self-induced pause usually *starts* with a mental alteration, not a physical one. That's why there are no *chemical* tests that can determine if a person is on pause mode. Getting a good diagnosis requires figuring out what the mind is up to.

Doing the diagnostic channel exercises in this chapter can help a person figure out what his mind is doing because a person's thoughts are *reflected* in the ways that the channels are moving and the ways that the body behaves – and vice versa.

Using a Friend is probably the easiest and fastest way to get accurate answers about what the mind is doing. When diagnosing a syndrome that is driven in large part or in all by mental processes, it makes sense to take the most direct route possible when seeking a diagnosis. By asking questions of an invisible, loving Friend or the heart, a person can get accurate answers about how the mind is working and what kinds of thoughts are dominant.

It's important to know which kind of pause one is using. The treatment for turning off biological pause is a quick, simple therapy session that is described in the next chapter.

The treatment for turning off self-induced pause involves chipping away at a long-term, constantly re-enforced thought habit that might have started in childhood, and replacing it over and over and over with a new, healthy thought habit until the currents running through the brain are permanently re-routed into a new, healthy, non-pause pattern. Or, this habit *might* be lastingly turned off all at once during an "epiphany" type of recovery, during which the person changes some core *understandings* about himself that cancel the mental instructions that triggered the use of pause. When the pause instruction is canceled, the brain pathways instantly revert back to the healthy pathways: normal use of parasympathetic and sympathetic modes for everyday living.

The epiphany recoveries are less common. For most people, it's more likely that years of "two steps forward, one step back" will be required to build healthy new brain routes.

This chapter covered a lot of material. The reader might be feeling as if there is just too much information. Please just do the exercises in this chapter, and then keep reading. The material might seem overwhelming at first in part because every page might have new concepts, new terminology, and constant reminders that no two people will have the exact same combination of causes and symptoms. There might seem to be so many options because humans each use their own mind a little differently and respond to trauma a little differently.

Tweaking a line from Tolstoi's *Anna Karenina*, we can say, "All healthy people are healthy in the same way. All unhealthy people are unhealthy in their own way." This book has a lot of material because it needs to cover all the possibilities for how people might have gotten stuck on pause: each in their own way. But however it was a person got stuck, that person can also get unstuck.

Diagnosing Biological and Self-Induced Pause

No brain scan can differentiate between biological and self-induced pause. No chemical test. No symptoms are markedly different in these two forms of pause mode. Biologically, chemically, and electrically, there is not much difference in the body between being stuck in an electrical pattern of imminent death or being stuck in an electrical pattern activated and re-activated by an habitual self-command to avoid pain. Diagnostically, the difference in symptoms between these two ways of activating pause mode is *very* subtle.

For over twenty years, I have sought some *objective* test for determining which type of pause a person is using. As mentioned many times already, biological pause mode is triggered by biological damage and/or autonomic instability that might very soon result in death. Self-induced pause mode is triggered by a command to not *feel* some overwhelming fear and/or heart-rending pain, or to be apart from a hostile world.

Western medicine, these days, is generally opposed to any sort of diagnosis that can't be proven in a lab. Most of my patients would greatly prefer to have some sort of diagnostic test with results that can be printed out on a sheet of paper. I wish I could offer that, but I cannot. I am aware that my next sentence will disappoint many people.

The best way to differentiate between biological pause and self-induced pause is to use the patient's own mental and/or intuitional tools.

Asking an invisible Friend or asking one's heart is the fastest and most accurate way to learn which type of pause a person is using. As one gets better at using these tools, the answers are almost immediate. My patients and I have seen that the answers received are highly accurate. Scientists and lawyers are trained to be very careful with words like *always* or *never*. That's why I will not say that the Friend's response to a question is *always* right. I can say that, in my *own* limited experience, my patients' Friends *have* always been right – often much to the chagrin of the patient, at first.

Consciously *or* on some deeply buried level of the mind, a person knows if he is still struggling with an unhealed, life-threatening injury (biological pause). Likewise, a person's mind has memories, often inaccessible at first pass, of putting himself into pause mode (self-induced pause)…if that's what he did. If one wants to know what triggered one's use of pause mode, the obvious thing to do is to ask the Friend, ask the heart, or ask some aspect of the Divine.

As an aside, for the rest of this chapter, when I say "ask your Friend," any of the following three options can be used: the Friend, the heart, and/or some aspect of the Divine. The Friend is probably going to be the easiest to access. Feel free to spend a few moments tuning in with the Friend before starting to ask questions. Enjoy the feeling of being with the Friend. Maybe even ask your Friend how he/she/it is doing, and take time to listen to the answer.

The following instructions are for determining if one is in biological pause mode and/or self-induced pause mode. Keep in mind, one can have both types of pause at the same time.

At first, the following diagnostic and treatment instructions might seem impossibly complicated and confusing. But if you just take the questions one at a time and follow the flowchart instructions, you will find that the process is actually very straightforward.

Again: except for those people who *are* actually still at risk of imminent death from an unhealed trauma (a subject that comes up on the next page), we *aren't* concerned with the nature of a person's trauma. The nature of the trauma *doesn't matter*. Most of my patients really, really want to go on and on talking to me about what they think is the original trauma that got them stuck on pause…and why it's *not* their fault. But they are wasting time on a subject that doesn't matter. It doesn't matter. They are missing the point. In recovering from being stuck on self-induced pause, people need to address and alter their *responses* to the trauma, so that they can move forward with healing. It doesn't *matter* what the actual trauma was. People who really want to dwell on the horror or the unfairness of what they think was the triggering trauma for using pause tend to have a hard time recovering. Oppositely, those people who are no longer interested in blaming others for their problems, who might have actually forgiven their previous "bad luck" or their tormentor(s) and moved on, seem to recover from self-induced pause much more easily.

If you think you might be stuck on pause, the first issue you'll want to explore is which type of pause are you stuck on. This chapter will explain how to make that diagnosis.

Introduction to the Diagnostic Flowchart

Before starting on the flow chart, please know that *most* people who are stuck on *biological* pause are *not* at risk of imminent death from their old injury. In my experience, *most* people stuck on biological pause have already healed from their injury(s). They are *mentally* stuck on pause, but their injury is gone. Very, very few people on biological pause are still carrying a potentially lethal injury. The *most* common situation for *biological* pause, option II on the flowchart, is very quickly treated, and doesn't have as many discussion variables as option I, the option for people who are still at risk of imminent death.

As for the most common type of pause for people with Parkinson's disease, approximately 95% are using option III, self-induced pause. This is the third and last option on the flowchart, even though was is the most common, at least in my patients.

The flowchart starts with the least common type of pause: Option I, biological pause with an ongoing, unhealed injury. Starting with this option allows me to present the most information about biological pause in the most logical manner. This is primarily a physical problem. Next, the flow chart will segue into Option II, which addresses situations that have a combination of a somewhat healed physical injury in the past and a mentally or electrically stuck situation continuing on into the present. Option III addresses a purely mentally-induced situation: self-induced pause.

I'm foreshadowing where the flow chart is going this so that you won't worry too much about memorizing or completely following all the material – all the potential situations that might arise in any of the three options. This flowchart has an enormous amount of material, so that it can cover every pause possibility. Instead of trying to learn all of it, I suggest you read it through quickly and lightly once, just to get a sense of it.

Then, go back and pay closer attention to the sections that most likely apply to your own case. An overview of the flowchart is on the last page of this chapter, page 142.

Diagnostic flow chart

This flow chart has lots of questions that you will need to ask of your Friend. When talking to your Friend, do not strain or *try* to get answers. Do not spend more than a few seconds waiting for an answer. The most immediate answer you get, even if you haven't finished framing the question, or even if the answer seems unlikely, is probably closest to the truth. If you don't get an *immediate* answer, talk with your friend for a few minutes, or at least until you feel loved and safe. Then ask again.

Question #1: Ask your Friend if you are using pause mode.
If he says YES, continue on to question #2.
If he says NO, but you have symptoms of pause, go to question #6.

Question #2: Ask your Friend if you are dissociated from the parts of your body that are keeping you on pause. If he says YES, go to **IV: Dissociation Plus Pause**, page 140. If he says NO, go to question #3.

Question #3: Ask your Friend if you are risk of imminent death.
If he says YES, go to **I: Biological pause**: *injury not yet healed*, on page 130.
If your friend says NO, continue on to question #4.

Question #4: Ask your Friend, "Am I *stuck* on biological pause?" This question refers to being stuck on biological pause even though the injury has healed.
If he says YES, you are stuck on biological pause but *not* at risk of imminent death. Go to **II: Biological pause**: *the injury has healed but the person is still stuck on pause*, on page 138.
If he says NO, you are *not* stuck on biological pause, continue on to question #5.

Question #5: Ask your Friend, "Am I using self-induced pause?"
If your friend said YES, you *are* using self-induced pause, then go to section **III: Self-Induced pause**, on page 140.
If he says NO, go on to question 6.

Question #6
Ask your Friend if you have an injury from which you have dissociated.
If he says YES to this question, go to Appendix I, page 227, which discusses dissociation.
If he says NO, meaning you are not on pause *and* you are not dissociated from an injury, then you'll need to look for answers to your health problem(s) elsewhere than in pause and dissociation.
For example, congenital, environmental, genetic or pharmaceutical or other drug damage might be playing a role in your symptoms, whatever they are. For further guidance, feel free to ask your friend more questions. Or you might want to go back to the top and repeat the questions. If, the second time through, you get to this question and you

still get a NO here, ask your Friend questions that might direct you to a non-pause diagnosis.

I. Biological pause: a life-threatening injury has not healed

Unhealed, life-threatening injury

If your Friend said YES to question #3, then you still have unhealed damage from a potentially life-threatening injury. In *every* case I have seen, the ongoing problem has been in the head, neck, or spine.

Ask your Friend *where* in the body the unhealed injury is. If your Friend shows you or tells you, then have someone supportively hold that area using FSR (Forceless, Spontaneous Release, an extremely passive type of Yin Tui Na). This area might want to be held for up to an hour at a time, an hour per day, if possible, or one hour per week, until relaxation occurs and healing begins. If you can't get a clear answer from your Friend regarding the location, go to capital letter **C** with the heading "*Finding the location of the trauma,*" on page 136.

If your friend did tell you which area needs work, imagine that area filled with light and then imagine it filled with darkness. Which was easier? Was it easier to imagine the area filled with light or filled with dark? Do not *try* to force the area to be filled with light. Light is not *better* than dark. Both light and dark are of equal worth. You're trying to *assess* your body, not force it to be light if it doesn't want to be.

Assessing the trauma location: motionless or agitated

The area(s) that is easier to imagine being dark needs to be assessed (one area at a time, if there is more than one dark area) to determine whether the area is easier to imagine as 1) dark due to being on pause or 2) dark due to dissociation. Then notice whether the area is agitated, moving in any manner other than a healthy, gentle rhythmic one, *or* if it is motionless and maybe even invisible. Agitation is associated with being on pause. Motionlessness is associated with dissociation.

It's possibly that the area is both stuck on pause *and* dissociated. If so, dissociation will appear as the dominant situation. The dissociation must be treated first. Gaze steadily at the darkest center of the dark area and imagine it being as dark as possible. Assess the darkness for agitation or motionlessness/invisibility.

What is meant by agitated

If agitated, the movement might appear as if the capillaries are moving too quickly, or the atoms are moving too fast, or as if there is electrical static in the area, or the area might appear as if sludge is moving around, or maybe the darkness seems to be like drifting smoke. Whatever it looks like, it will be *moving*, and in an unsettled manner that doesn't seem quite right.

As mentioned earlier, the agitation might not be in the same location as the injury. With body-wide injuries or trauma, or ongoing risk of imminent death the dark-and-agitated area will probably be in the head, neck, or spine.

For example, being on pause from anaphylactic shock from bee stings in the *armpit* might show up as agitation at the base of the spine, the base of the neck, or both. Drowning and general anesthesia can also cause a person to become stuck on pause with agitation in the low spine, base of the neck, or both. Concussion might have agitation in

one or both of these two places, and also somewhere in the head, sometimes at the point of the original impact. Or the original injury might have been on one side of the head but the agitation can appear on the *opposite* side of the head because this is where the bones got displaced from the force of the blow traveling through the head to the opposite side.

If the dark area seems agitated in any way, continue on to section **A**, below.

Oppositely, if the dark area is motionless, heavy, or is invisible and you find yourself saying, "What is it I'm looking for?" you've dissociated from that area. Dissociation can prevent a person from knowing that the area is *also* agitated and stuck on pause. If the area is motionless or invisible, go to to section **B**, on page 135.

A. *Agitated*

If there is an unhealed injury that is related to your being on pause, and that injury is keeping you at risk of death – should the displacement become any worse – you will need to treat that injury. The best way to treat it is to bring the mind's attention to it. To do this, have someone hold the injured area. The way to hold it is described in the book *Yin Tui Na*, and is also described briefly in Appendix I.

Your support person or health practitioner should hold the injured area or the vicinity of the agitated area while you and your Friend gaze at the agitated area. After a few minutes or an hour the area might relax, either ever-so-slightly or a lot. Then, the bones and/or soft tissue in the area might move around. They might move a few microns or they might move a jolting eighth of an inch. Have your support person continue with the holding until you experience a shift in sensory perception, muscle relaxation, sense of emotional release, or find yourself taking an unexpectedly deep breath or the degree of agitation decreases. Several one-hour sessions might be needed to get to this point.

If you don't have a friend or family member who is able to do this holding, try to find someone who does craniosacral work. Ask the craniosacral practitioner to use NO movement, as opposed to the usual movement with 5 grams of pressure that is often taught for this protocol. The health practitioner should only use firm, supportive, *pressure* via his hands, not *movement* of his hands. Also request that he firmly hold *only* the area in question rather than doing the more tradition entire spine-and-head protocol.

Because the injury is locked down and life threatening, it is going to want support, not movement, until it decides it is safe enough to relax and then reposition itself closer to its correct alignment. If your craniosacral practitioner doesn't understand this and wants to go whipping quickly through the usual craniosacral protocol, find another practitioner. [26]

When the injured area restores itself to a healthier and safer position and you, the patient, are feeling relaxed in that area, or maybe strangely different, notice again the

[26] Many massage therapists are trained in light touch cranio-sacral therapy. (Not chiropractic cranio-sacral therapy, which can be, in some cases, a completely different type of treatment.) If there is no one in your area who has trained in this modality, simple instructions for this technique are available in the book, *Yin Tui Na (Chapter twelve, Head and Spine)*, available for free download at pdrecovery.com.

Don't be afraid of learning these techniques. FSR (taught in Chapter one in *Yin Tui Na*) is just supportive holding until the patient relaxes. This work is NOT technically exacting. A child can master it. Doing this work is simple and relaxing.

degree of darkness and agitation in the injured area. If the area is just as dark as when you started, it might need more holding. If the darkness is growing lighter and the agitation is diminishing, then the area in question is now capable of healing and might have already started doing so. If you aren't sure, ask your Friend question #7.

Question #7: Ask your Friend if you are still at risk of imminent death.

If he says YES, then you still have more holding to do. Or maybe, there is another agitated area that needs to be worked on. Ask your friend if the area addressed thus far still needs more holding and/or if there is another location that also was traumatized that needs support.

If he says NO, you are no longer at risk of imminent death, then it is safe for you to turn off pause. It's time to do the Five Step protocol for turning off pause.

You have already completed the first two steps for turning off pause: 1) the injury has been acknowledged and the interior of the body has been confirmed as stable and 2) your Friend is there, so the exterior of the body is now safe. This means the situation is now safe enough to turn off pause. Since you've completed steps I and 2, you can go on to **i.** *The Three Remaining steps*. These are the last three of the Five Steps for turning off pause, described below.

i. *The Three Remaining steps*

- Step 3. Start by telling yourself, "What a relief! Since I'm no longer at risk of imminent death, I can take a deep, *audible* breath: a *loud*, heartfelt sigh. Then do so. Take several.

- Step 4. Wobble the head, left ear to left shoulder, right ear to right shoulder, several times, alternating sides. If you cannot do this, have your support person *gently* wobble the head for you. The wobble movement might feel forced, at first. Your support person can do the head wobble as many times as it takes before a slight change occurs and your head suddenly feels as if the wobble is natural, rather than forced. If it feels forces or unnatural, don't do the gentle wobble for more than a few minutes a day.

– *If the neck cannot move and the injury is no longer life-threatening*

The body is designed to *not* allow movement of the neck in cases of potentially fatal injuries to the spine, neck, and head. This is a hard-wired, build-in safety response. It's associated with the pause-mode blockage at the neck that stops the upward flow of the Du channel and causes the Urinary Bladder channel to exit out of the body from the neck.

The body might need a few hours to turn off this long-time neck rigidity if this protective mechanism has been in place for decades. Sometimes, it will automatically turn off as soon as the traumatized area relaxes and the visualized agitation ceases. Sometimes, the body has genuinely forgotten how to move the neck in the bobble manner, and help from a health practitioner or friend is needed to "prime the pump." Several days might pass before the neck can do a head bobble easily without physical support from the hands of your support person or from your own hands.

If there is still another life-threatening injury somewhere in the head, neck, or spine that has not yet been treated, the neck will *not* be able to perform the bobble

movement. The neck will continue to use its biologically correct lock-down position until *all* life-threatening injuries to head, neck, and spine have been addressed.

If your head is wobbled for more than five minutes and it still feels forced and unnatural to bobble the head, ask your Friend if there is still another trauma location that has to be addressed.

If the friend says YES, there is still another life-threatening trauma to be addressed, then ask the Friend where it is or look around for another agitated area in the head, neck, or spine, or even a dissociated area in these three areas. Go back to I. Biological pause: a life-threatening injury has not healed, on page 130.

Address the new agitated or dissociated area(s) in the same way as you did for the first one.

If the Friend says NO, there is no longer a life-threatening injury, then ask if the agitated area in question needs more holding. If your Friend says YES, then do more holding in the area that was previously agitated while your Friend gazes at the area with you. If your Friend says NO, the injury is no longer life-threatening and it needs no further supportive holding, then ask if you should just continue to do the gentle head bobbling.

The problem now is that the neck is unable to relax and is behaving as if you are on pause, even though the injury is no longer life-threatening.

Ask your Friend if you should move on to the next situation: II. Biological pause: The injury has healed but the person is still stuck on pause, on page 138.

If he says YES, then do that. If he says NO, then ask if you should just continue to do the head bobbling for five minutes or so, every day or so, until the neck relaxes.

It is also perfectly possible that the person has had a completely unrelated neck injury that prevents gentle bobbing of the head. If this might be the case, if there is neck stiffness and/or *back* stiffness from a different injury or an over-use problem, find a craniosacral practitioner who can help realign the back and neck, or else have a loved one or friend do the craniosacral protocol in Chapter twelve of the book *Yin Tui Na*. A low back injury can create a tension in the neck, and vice versa, so do treat any back problems that present, as well.

When the neck starts to bobble easily, move on to Step 5.

- Step 5. Encourage a shiver to travel down the back. If it is impossible to even imagine a shiver traveling down the back, the support person might need to firmly grip the patient's shoulders in two hands and *gently* rock the shoulders back and forth in an effort to get these long-locked muscles to loosen up and be able to perform a visible shimmy or shiver traveling down the spine. Once the shiver occurs, it might happen spontaneously several times, even twenty or more times. This is healthy. This shivering down the spine is turning your spinal nerves back on. The shiver cannot occur if the body has forgotten how to do it, from being stuck on pause for so many years. The shiver cannot occur if there is still a neck injury, even one that is not related to being on pause mode, that is preventing relaxation in the neck. The shiver cannot occur until the UB channel stops exiting the body at the neck, and resumes correct flow under the skin from the head to the torso.

With my patients who have trouble initiating a shiver down the spine, I automatically do a craniosacral treatment to make sure that the neck bones are correctly aligned. Sometimes I find that the neck is actually OK, but that there is a displacement in the lower back, maybe in the lumbar vertebrae, a displacement that is causing the neck to

be locked down. The instructions for craniosacral treatment in the *Yin Tui Na* book address the lower spine, as well as the middle and upper spine (neck).

ii Special situations

The next two sections discuss situations in which turning off pause does not go smoothly. The body might just need extra time to come to grips with the new injury-is-recovering status, or there might be some further steps that need taking.

a. If nothing relaxes after an hour

After an hour of the general vicinity of the "dark and agitated" area being held with someone's hands, usually with the supportive hands in approximately the same position for an hour, while you (the patient), and your Friend are gazing at the agitated area and asking, now and then, if you are still at risk of imminent death, if nothing has yet relaxed, take a break. The area can be held again the next day for an hour, and again the next day, or else for one hour once a week, until something moves or relaxes. I repeat: have someone hold (supportive, FSR holding) the agitated area for an hour every day or week until the area relaxes, or the darkness begins to lighten, or the perceived agitation stops, or the Friend suggests holding another place. When you notice a positive change come over your mobility in that area, or a shift occurs in your sensory perceptions, this shift indicates that you have moved into a high degree of parasympathetic mode: colors might appear brighter, and your body might feel lighter and more graceful.

Instructions for this type of firm, supportive holding are in the first chapter of *Yin Tui Na*, available for free download at www.pdRecovery.org. An introduction to this type of therapy can also be found in this book, in Appendix I.

b. You cannot shimmy the spine

If, after many attempts over several days, you still cannot get your spine to move in a shimmy motion *and* your Friend confirms that all the injuries have been cleared up, your Urinary Bladder (UB) channel qi might be stuck in a habit of flowing incorrectly – even flowing in an "escape pattern": flowing outside of the body. When on pause, the UB channel qi often exits the body at the back of the neck.

As an aside, the return of the UB channel qi to its correct, healthy pathway following a mild startle or a severe shock is the thing that causes a *healthy* person to feel a shiver travel down the spine. A person might even feel this type of shiver after leaving the theater following a scary movie. It's a healthy, normal sensation that resets the body back to the normal blend of parasympathetic and sympathetic modes.

The healthy path of the Bladder channel is shown in Fig. 4.3, on page 48.

If all blockages are gone and the support person has repeatedly, over days, manually, *gently* moved the shoulders back and forth for several minutes to initiate a feeling of a shiver traveling down the spine, but you still cannot execute even the slightest shiver-type motion, then ask your Friend if you have some displacement on the head or spine that is preventing the UB channel qi from flowing in the correct pattern. If he says YES, ask for the location of the displacement or blockage. Treat this location with FSR holding, as described in the book *Yin Tui Na*, until the displaced area relaxes and the UB channel qi starts flowing correctly.

If the Friend says that nothing is blocking the UB channels, then you merely have an incorrect electrical habit. You can do this: imagine that the UB channels are traveling

over the top of the head, starting at the forehead, as pictured in Fig. 4.3, page 48. As you imagine the UB channels traveling down the back of the head and down the neck, keep reminding yourself "Keep the energy *under* the skin." Imagine the energy staying under the skin all the way to the top of the shoulders and then down the back. The UB channels should go *under* the shoulder blades, between the shoulder blades and the ribs.

The process of mentally restoring the flow of channel qi to its correct position is called Medical Qi Gong. It is a valuable medical technique. I use it with a majority of my patients. I find that having the patient mentally adjust the incorrect flow of channel qi gives a far more lasting benefit than having me, the acupuncturist, adjust the incorrect flow with acupuncture needles. Needles might temporarily make a correction. When the patient uses his own mind to make the correction, the brain has gotten involved. The brain will be much more likely to support the correction over the long run if it has been involved in the healing process.

Getting back to the flow chart: still not able to turn off pause mode

If you go through the three remaining steps several times, but you do *not* feel the urge to take a deep breath, bobble the head, and allow a shiver to run down the spine, you might still be on pause mode. Ask your Friend question #8.

Question #8: Am I still stuck on pause even though the injury is no longer putting me at risk of imminent death?

Being stuck on pause even though one is ***not*** at risk of imminent death is the *most common* situation for people who are stuck on biological pause.

Being at risk of imminent death is actually fairly rare, but still, from a logic perspective, we had to start with that question, and either rule it out or treat it. But in nearly all of the people I've worked with who are stuck on biological pause, the injury has already healed *enough* so that the person is not at risk of imminent death, and yet the person is still using pause, unnecessarily.

If he says YES, you are still stuck on pause even though you are not at risk of imminent death, go to **II. Biological pause: The injury has healed but the person is still stuck on pause** on page 138.

If he says NO, you are not on pause, then you can repeat the last three steps for turning off pause a few times a day: deep breath, bobble the head, and shiver the spine. If, after several days, you feel that you are still stuck on pause, repeat the questions, maybe from the beginning.

If your Friend says NO you are not on pause, but you are not feeling any relaxation from your pause-related tensions, consider that you might be *dissociated* from an injury, which might be keeping you on pseudo pause. Ask your friend if this is the case.

If yes, go on to **B**. *Dissociated*, below.

B. *Dissociated*

If the dark area you are looking at appears *motionless*, *invisible*, or *evasive*, you are dissociated from this area. The area might *also* be the location of a pause-triggering, life-threatening, unhealed injury, but you can't perceive the agitation of pause mode because you've dissociated from the area, rendering the area hard to stare at: seemingly invisible; unknowable by your conscious mind. If this is the case, your Friend would have

answered YES to question #2, and you will have already read the section on how to deal with this situation before being re-directed here.

Regardless of whether or not you are also on pause, you will need to re-associate with the area in order to proceed with turning off pause or pseudo pause. To turn off the dissociation, have your support person firmly and supportively hold the area using FSR while *you* perform the mental techniques for turning off dissociation that are discussed in chapters 5 and 6 of my Yin Tui Na book.

Again, *Yin Tui Na: Hands-on Therapy for Traumatic Injury* is available for free download at www.pdRecovery.org or for purchase at www.JaniceHadlock.com.

i. *The injured area is now light*

After the dissociation has turned off, the area might appear light and bright instead of dark. The area might be painful. The pain is important – it shows that you are acknowledging the area instead of telling yourself to not feel the pain. The awareness of pain is helpful – it serves to keep your brain focused on the area and initiate healing in the area.

If the area is now re-associated and filled with *light* as opposed to dark, then pause, if any, might be able to turn off by itself, as soon as adequate healing of the injury has occurred. When pause does turn off, you might notice yourself having a deep breath, a neck wobble, and a shiver traveling down your spine. If this does not happen – even though it seems that the injury has presented itself, felt a bit of pain, and then healed, you might want to go through the last three steps for turning off pause. See: **Ai,** *The Three Remaining Steps*, on page 132.

ii. *The injured area is still dark*

If the area is still dark, it might now appear agitated instead of motionless to your mind's eye. If this is the case, the pause situation has been re-associated with and is now visible to your mind's eye. Before, the pause problem was being hidden from you via dissociation. Now that the dissociation is turned off and the agitation that indicates pause mode is visible to your imagination, you can use the techniques for turning off biological pause. The agitated area, if agitated due to injury, might be in a place where bones or soft tissue have been dangerously displaced. Supportive holding of these areas will allow them to relax and then restore themselves to a healthier position. This will allow your body to no longer be at risk of imminent death from a dangerous displacement. If pause was from a body-wide pattern, the agitation will most likely be at the base of the spine, the base of the neck, or in the head. To treat the paused area, go back up to the start of the flowchart and begin with question #1 on page 129.

C. *Finding the location of the trauma*

If your Friend does not seem to tell you where the problem is located, you can look for the area on your own: mentally imagine looking inside the spine, neck, and head. Observe one section at a time. Each section might be about four inches or so in diameter. One section at a time, imagine the area filled with light and then with dark. You are looking for areas that are *easier* to imagine as dark. If there are no dark areas in the head, neck and spine, then start looking through the rest of the body, one sector at a time. If you

notice that your brain tries to skip over a sector, that's probably a place with a problem. Force yourself to look at it.

Again, do not *try* to force an area to be filled with light. Light is not *better* than dark. Both light and dark are of equal worth. You're trying to *assess* your body, not force it to be light if it doesn't want to be. Just note whether light or dark is the *easier* one to imagine. If light is easier, move on to the next area. If it's easier to imagine the area in question being dark, assess it for being motionless or agitated, as described in the section on Assessing the Trauma on page 130.

You can either treat the dark area now, or else make a note of the location and continue looking in the body for more places that are easier to imagine being dark than being light. To treat it now, if the area seems motionless or dense or invisible, you are dissociated. Go to Appendix I. If agitated, start supportive holding and asking the Friend if you are at risk of imminent death from the injury at *this* location.

If your Friend says YES, go to **I. Biological pause: a life-threatening injury has not healed** on page 130.

If the Friend says NO, that means your body is behaving as if you are on pause even though the injury is no longer a danger. In this situation, go to **II. Biological pause: The injury has healed but the person is still stuck on pause** on page 138.

If you want to find all the trouble spots before you start doing treatments, ask your Friend if there are multiple areas that need work. Or repeat the previous "looking around" process: go on to the next section of the spine, neck, head, or other body areas. Imagine the area is filled with light, and then with dark. If the dark is easier, assess it for being motionless or agitated. If motionless, you are dissociated. Go to Appendix I. If agitated, start supportive holding, or continue looking for more places. If there are more than three dark places, stop looking for more. Start working with the places that you've already found. Very often, after addressing just one or two of the agitated and/or dissociated locations, all the others will automatically clear up.

Again, there might be more than one location that is dark. You might need to treat all the areas that are dark, but maybe not. Very often, especially if the dark areas are all associated with the same trauma, when one dark area is treated and reverts to being filled with light, other areas become light at the same time.

You can also ask your Friend at any time in this process if there is more than one location that needs attention. If there is more than one area, ask which area to treat first. If you don't get an answer, that means it doesn't matter where you start. After all, it's not the traumas that are keeping you on pause. It's your mental reluctance to address and deal with the trauma that's keeping you on pause. As soon as you change the way you are dealing with the trauma – which is probably avoidance or denial – all the trauma areas and the associated areas might all start healing, even if you're only focused on one of the areas. Or you might need to address each area, one at a time.

If the *entire* body is dark and your Friend has said that you are on pause, the agitated area(s) will most likely be along the spine, neck, or head.

At this point, if you are going to start working on the agitated areas you've found, you might want to go back to Question #1, on page 129. Ask your Friend, "With regard to *this specific agitated* area, am I on pause because of it? Am I at risk of imminent death because of this specific, agitated area?" And so on, this time asking all the questions with regard to the *specific* area you are focusing on.

II. Biological pause: The injury has healed but the person is still stuck on pause

If your Friend replied "YES" to your asking if you are on pause, and "NO" to your question, "Am I at risk of imminent death?" then your injury/trauma is no longer life-threatening. Ask your Friend where the location of the agitation is. If you don't get an answer, read the section titled ***C****. Finding the location of the trauma*, on page 136.

If there are several places that are agitated, ask your Friend which one to focus on first. If you get no reply, that means it doesn't matter where you start.

Once you have the agitation location in mind,

1) Mentally focus on the agitated area. Gaze at it lovingly and unconcernedly.

2) Invite your Friend to be in the room and gaze at the agitated area with you.

Begin the dialog described below. You and your Friend *both* keep gazing at the agitated area throughout the dialog. You will notice that the questions and statements from the coach do not vary. The responses from the patient might be all over the place, but will generally conform to the basic ideas that are presented in the following dialog.

This dialog can be done by yourself alone, or with a friend or family member. For ease in writing up the script, I will assume that you have a friend or family member helping you do this. I will call that person "coach." If you don't have a coach, you will get to play both roles by yourself. If you are doing both parts by yourself, your "coach" lines may be said silently. But please state your yes or no "patient responses" out loud.

The Dialog

Coach: Silently ask your Friend if you are at risk of imminent death, and tell me what he/she/it says.

Patient: He says no, I'm not at risk of imminent death.

Coach: Tell me what *you* think. Do you think you might be at risk of imminent death from your old injury, death in the next two or three minutes?

Patient: Yes. (This is by far the most common reply from a person who is stuck on *biological* pause whose injury has already healed enough that the person is no longer at risk of death from it.)

Coach: Ask your Friend if you are at risk of imminent death from your old injury. Tell me what he says.

Patient: He still says no.

Coach: Tell me what *you* think. Do you think you might be at risk of imminent death from your old injury, death in the next two or three minutes from the injury to (name whatever body part) that happened years ago?

Patient: Yes. Well, probably.

Coach: Ask your Friend if you are at risk of imminent death from your old injury. Tell me what he says.

Patient: He says no, I'm not at risk of imminent death.

Coach: Tell me what *you* think. Do you think you might be at risk of imminent death from your old injury, death in the next two or three minutes?

Patient: Well, sure, yeah, I *might* be.

Coach: Ask your Friend if you are at risk of imminent death from your old injury. Tell me what he says.

Patient: He said, "I already told you. No."

Coach: Tell me what *you* think. Do you think you might be at risk of imminent death from your old injury, death in the next two or three minutes?

Patient: How should I know?

Coach: Ask your Friend if you are at risk of imminent death from your old injury. Tell me what he says.

Patient: Now he's laughing at me.

Coach: Tell me what *you* think. Do you think you might be at risk of imminent death from your old injury, death in the next two or three minutes?

Patient: I know I'm not, but I can't get the words out to say so.

Coach: Ask your Friend if you are at risk of imminent death from your old injury. Tell me what he says.

Patient: Now he's rolling his eyes. He says no.

Coach: Tell me what *you* think. Do you think you might be at risk of imminent death from your old injury, death in the next two or three minutes?

Patient. I dunno. Probably not.

Coach: Ask your Friend if you are at risk of imminent death from your old injury. Tell me what he says.

Patient: I think he's getting tired of this. He said no.

Coach: Tell me what *you* think. Do you think you might be at risk of imminent death from your old injury, death in the next two or three minutes?

Patient: (laughing uneasily) No, of course not.

Coach: Ask your Friend if you are at risk of imminent death from your old injury. Tell me what he says.

Patient: He said no.

Coach: Tell me what *you* think. Do you think you might be at risk of imminent death from your old injury, death in the next two or three minutes?

Patient: No. No, I'm not.

Once the patient can *convincingly* state that he is absolutely not going to die in the next minute or two from his long-ago injury or trauma, then he can go through the three remaining steps that turn off pause. (See page 132, **Ai**, The *Three Remaining Steps*.)

The above is a fairly quick version of how the patient might respond. I've had patients who kept saying, "I *might* be about to die from my old injury" for more than twenty rounds. Eventually, if the Friend is saying no, you are not at risk of imminent death, the patient *will* eventually agree with the Friend, although it might take awhile.

i. If it takes more than twenty interchanges and the patient still can't agree with the Friend, take a break from the above dialog and ask the Friend a different question: Can you show me *why* I still think I'm at risk of imminent death? Ask this question several times, until the Friend gives an answer or the patient has a realization or a thought of why he feels that he is still at risk. Focus on the answer from the Friend or the thought of *why* you think you are still at risk. Ask yourself, "Did I die from the incident?" The answer, obviously, is no. Say out loud, several times, "I didn't die, after all." Say it until you actually believe it. Then repeat the dialog from the beginning. This time, you should be able to eventually come into agreement with your Friend.

A patient might have a terrific level of brain resistance to admitting that he is no longer on the verge of death. The patient might be *wanting* to say, "No, I'm not at risk" but the words *physically* might *not* be able to come out. At this point, the patient is fighting with his own brain. After all, the brain might have been clinging to this fatalistic story line for decades. If this is the case, just keep repeating the coach's question in the dialog until the patient is able to get the words out, "No, I'm not at risk of imminent death." This might take a few one-hour sessions, one a day, spread out over several days.

If after several hours of going through the dialog, if the patient still cannot agree with the Friend, go back to **i.**, two paragraphs above, and repeat.

ii. After the *patient* has *powerfully* confirmed *several* times that no, he/she *absolutely* isn't going to die in the next few minutes from the injury or the area that was agitated, have the patient look away from the agitated area momentarily and then look at it again. The agitation should be starting to diminish. The darkness will be lightening up. Ask the patient to tell you, out loud, how the area now appears. Is it as dark as before? Is it still as agitated as it was before? It can be helpful for the patient to answer these questions out loud, so that he can hear himself saying that the darkness is lightening up and the agitation is gone.

When the patient can see that the agitation is going away, this means that he has completed steps 1 and 2 in turning off pause. Now he can do the remaining three steps. Go to page 132, to the section titled ***Ai**: The Three Remaining Steps*

iii. If the injury is no longer considered by anyone to be life threatening but has not yet *fully* healed, the injury might begin healing on it's own, or it might benefit from some supportive holding as described on page 131, in the section titled ***A.** Agitated.* Ask the Friend if this would be helpful.

III: Self-induced pause

If your invisible friend says "YES," in response to question #4, back on page 129, you are using self-induced pause, you will need to change your thought stream in a manner that stimulates your striatum instead of blocking it. The easiest way to do this will be to cultivate your relationship with your Friend. Several upcoming chapters discuss what this means and how to work on it.

IV: Dissociated and on pause

If you have dissociated from the part of your body that is keeping you on pause, you will not be able to *perceive* the agitation that's in that body part. Instead, you will see the area in question as dark, motionless, dense, invisible, or evasive. First, you will need to re-associate with this area. You will want to follow the instructions in this flow chart starting at **B.** *Dissociated*, on page 135.

After you've re-associated with the area, then go back to question #1 and start over. Your Friend will direct you to the part of the flow chart that corresponds with what type of pause you are using.

Chapter Summary

Your Friend, and its connection to your heart and your superconscious mind, already has the answers to whether or not you are on pause, and if so, if you are on biological pause and/or self-induced pause. It knows where the injuries are and whether or not they have already healed.

Your questions for your invisible friend are not limited to the questions provided in this chapter. You can ask any questions you like. The script for the questions that is offered in this chapter demonstrates how simple the questions should be: simple yes or no questions. When you are able to communicate easily with your Friend, your questions might become more complex. But in the beginning, keep it simple. Yes or no questions will be the best.

If you were so keen to learn about differentiating between the two types of pause that you skipped over chapters five and six in your hurry to get to this chapter, you might want to go back to chapters five and six to learn about parasocial relationships and what is meant by "an invisible friend" or just "a Friend" with a capital F.

I appreciate that skeptical readers might be unhappy with a medical diagnosis that is arrived at without benefit of blood work, brain scans, or a list of *definitive* symptoms. For years, I have sought some *tangible* method for differentiating between the two types of pause. But in the end, over and over, the fastest and most accurate answers have come from the patient's Friend and/or the patient's own heart and his deeper level of consciousness: a level of consciousness that can be most easily accessed in the presence of a loving, wise, and affectionate Friend.

To review: If you are stuck on biological pause, you need to determine if a) you are *still* at risk of imminent death and therefore using pause correctly, or if b) the injury has healed and you were merely *stuck* on pause.

The treatment for a) consists of holding the traumatized area until it relaxes deeply and/or adjusts itself, and/or your Friend says that you are no longer at risk of imminent death. You can then go through the steps that turn off pause.

The treatment for b) consists of going through the dialog and then, after you can agree with your Friend that you are no longer at risk of imminent death, you can then go through the steps that turn off pause.

If you were stuck on biological pause, you need go no further than this chapter. If you've done the exercises and gone through the dialog to its conclusion, your situation should already be improving. Pause has been turned off.

If you are using self-induced pause, and not using *only* biological pause, continue on to the next chapter, where you will start to learn about how to turn off self-induced pause.

Some people who are stuck on biological pause *also* are using self-induced pause. If that is your case, and your Friend says that you have now turned off biological pause but are still using self-induced pause, continue on to the next chapter, where you will start to learn about how to turn off self-induced pause.

Flowchart outline

"Every time you meditate deeply…beneficial changes take place in the patterns of your brain." [27]

– Paramahansa Yogananda

Chapter ten

Self-Induced Pause: a Habit

Using *self-induced* pause is a mental *habit*: a learned behavior. It is *not* an automatic, neurological switch that is flipped on or off in response to a near-death biological event. Getting rid of the habit of using self-induced pause requires retraining the brain. The habit of using self-induced pause *might* have started with a specific incident of short duration. Once a person has put himself into self-induced pause the first time, it might be easier to summon up the altered state the second time – *if* the use of pause mode *did* chance to turn itself off. In people who develop an entrenched habit of using self-induced pause, the mental command that sets pause in motion might have been used over and over, with ever-increasing ease, after its first successful application. Eventually, its use can become automatic: using pause mode becomes the default system.

Then again, some people might have activated pause mode just once and phrased the triggering command in such a way that pause never turned off. Others might have used pause mode several times, on an on-off basis, before commanding themselves to stay this way "from now on." The "command" might not have been a conscious instruction to go into an altered state. It might have been something simple such as "Don't feel this pain!" "Ignore this pain!" or "Rise above this situation!"

Some benefits of using self-induced pause

Being on pause mode can have benefits. It numbs the emotions somewhat, for one. Being on pause can make the thought processes more focused. Heightened wariness can be perceived as a helpful self-protection mechanism. The numbness, heightened focus, wariness, and the norepinephrine release (immobility override) can make a person feel stronger, smarter, and less vulnerable.

These sensations can be strangely comforting when a person first starts using pause mode. The weird *comfort* of emotional and physical numbness and the increased mental intensity of pause mode can consciously *or* subconsciously *encourage* the continuing use of pause. In the early days of using self-induced pause mode, there might appear to be no downside to using it as much as possible. A person's preference for using pause mode to deal with anguish, pain, or even normal daily stress can quickly come to seem like the smart, or even clever and/or morally right thing to do. For the first few decades of using pause, going through life on pause mode might even seem like a life-*enhancing* behavior.

For example, cutting, also known as self-slashing, usually done on the inner arms with a razor, can trigger pause mode. Cutting fits the description of "excessive perforation

[27] Quote taken from "Inspiring quotes from Yogananda," in the January 2022 online newsletter of SRF. https://yogananda.org/self-realization-fellowship. I just happened to be writing this chapter the same week that the newsletter appeared. Perfect timing!

of the skin," which has long been recognized as activating biological dissociation and triggering some mild symptoms of biological pause. People who engage in, and even become addicted to, self-cutting do so because it lets them feel numb and out of their bodies: the *comfort* of emotional numbness: a benefit of using pause mode.

In spite of the seeming "benefits," the downsides to habitually using pause mode are real. The underlying problem with using pause mode as a coping mechanism is that this process commands the brain to *block* a traumatic pain or fear, rather than *flee* from or *heal* from the pain or fear. Paramahansa Yogananda, my teacher since I was in my twenties, writes in his *Autobiography of a Yogi*, "Truths suppressed lead disconcertingly to a host of errors." Using pause mode is a way of *suppressing* pain, not truly escaping from it or healing from it.

Attitude change before and after recovering from self-induced pause

Prior to recovering, many, many of my patients told me that their stoic, even numbed way of not dealing with pain or trauma was a spiritual or a morally *superior* way to rise above pain and put mind over matter. In truth, being *unafraid* of pain and not taking it personally is the more spiritual, or wisdom-based approach: pain is a signal to the brain that something needs attention. Wisdom tells us to pay *attention* to pain. Pay attention in a calm, impersonal manner, and take appropriate, healing steps. One can direct one's loving, healing energy *towards* the source of the pain, in order to encourage and speed healing. And even while putting "mind over matter," one should remember to always put heart over mind. Going into denial by using pause mode can diminish or turn off the ability of the heart to regulate the mind. When this happens, fear and ego-based analytics, rather than understanding and mind-body harmony, can predominate.

As an aside, suppressing pain is not necessarily a natural behavior; it might be cultural. When I was in college, I accidently banged my toes hard on a piece of furniture. When my housemate offered sympathy, I replied, "I'm OK. I won't acknowledge the pain, and then it won't hurt."

My housemate replied, "The Chinese don't ignore pain. If they feel pain, they focus on the painful place, so that it will heal more quickly."

I snapped back, "If they choose to focus on pain, then they must be stupid!" Little did I know.

After recovering, every person I know who had been stuck on self-induced pause was elated. Most of them said things like: "What an idiot I've been!"; "I feel so alive!" and, the most common; "I *never* want to be that way again." Many added, "And I didn't even know I was doing it." If, after recovering, a person is inclined to berate himself, I always point out that he is *not* an idiot. He did his best to keep going in the face of unbearable pain, and accidentally got caught or emotionally seduced into a biological trap. A person needn't feel shame for having used self-induced pause in the face of inescapable trauma. Never.

But when the downsides become greater than the benefits, it's time to get rid of the pause habit. When the symptoms of Parkinson's disease or other symptoms of being on pause begin to dominate one's life, it's time to turn off or stop habitually using self-induced pause as a lifestyle.

An adjunct to self-induced pause

While using self-induced pause, an adjunct brain habit is the creation and maintenance of a dynamic sense of constant, mild emergency. This stimulates the release of norepinephrine for the immobility override. You will recall, the norepinephrine override can provide emergency motor function in a person whose dopamine-motor area is inhibited. In order to sustain the norepinephrine override, a person using self-induced pause usually learns to sustain two sets of thoughts. The first is a constant sense of emergency. The second is a powerful, can-do set of motivating thoughts that allows the person to take action against the constant, imagined or self-created emergency.

This contributes to the Parkinson's personality. People with Parkinson's disease are considered by many researchers to very often have a personality with an unusually high level of "drive" and "intensity of purpose." This sometimes obsessive level of drive can be construed as a powerful benefit of using pause mode…until the concomitant health problems appear.

Everything depends on ***me***

A powerful thought stream for many people who are using self-induced pause mode is self-oriented, even isolationist, thinking such as, "It's up to me," "I'd rather do it myself," and/or "If it's going to be done *right*, I'm the *only* one who can to do it."

Being on pause decreases dopamine release in the middle of the brain, but it increases dopamine-based activity on the *sides* of the brain, in the *risk assessment* area, and it stays increased until the brain decides that the situation is safe. Remember: a person on pause, including a person with Parkinson's, has *plenty* of dopamine. Its release is *inhibited* in the feel-good areas and movement areas of the brain.

With increasing use of pause, the self-oriented/ isolationist thinking that comes from the inhibition of the striatum is combined with thoughts influenced by the risk assessment area of the brain. The risk thus tends to be understood in terms of the self: "There's a problem! And *I'm* the only one who…can fix the problem…can do it the *right* way…knows what's really going on," etc. A very common theme in people with Parkinson's is, "If *I* let my guard down, *nothing* will turn out right." These self-oriented thoughts are typical for people using self-induced pause, as they work together with the self-created, amplified sense of constant risk *created* by the use of self-induced pause mode: a spiraling trap.

Feeling apart

As noted earlier, when the striatum is inhibited, a person feels as if he *cannot* talk to God, to a guardian angel, or to his late grandmother. When the thalamus, tucked inside the striatum, is also inhibited, as it is during pause, a person *feels* strangely *apart* from others. He might even feel horribly alone, on an existential level.

Most of my on-pause patients have filled the emotional isolation with plentiful but somewhat superficial relationships, good works, and a strong sense of duty. Because it can be hard for them to relax and enjoy themselves, and because they might not *feel* the happiness that many people derive from self-indulgent amusement, they often spurn "shallow" amusements and might therefore be perceived as stoic and/or highly moral. People with Parkinson's disease are often perceived by others as self-disciplined pillars of society, sometimes regarded as untouched by emotions and therefore *highly* spiritual, and sometimes even viewed as self-sacrificing heroes. In fact, they are likely to be hiding from

some trauma, increasingly numb, and with some of their noble endeavors powered, at least in part, by a self-centered sense of emergency, compulsion and/or fear.

When on pause, a person might be *surrounded* by loving friends and family members, but still feel somehow apart from them. He literally might not be able to resonate with them at the deepest level, at the heart level. Because of being emotionally somewhat numb, the *pain* of being emotionally distant from most other people isn't as painful as it might be to a person who *isn't* on pause. Some of my patients who were chronically using pause mode, though certainly not all, have bragged that they don't need other people. Some have patiently explained to me that being emotionally *untouched* by others is a sign of their spiritual superiority. They might not have known that they were on pause, but they felt that their stoic, un-emotional posture was praiseworthy, beneficial.

The channel patterns, which is to say the non-neural electrical systems, of a person on pause are in-between those of a living person and dead one. This can be a profoundly lonely place. However, the numbness might render the loneliness less painful. If you are stuck in this electrical pattern, you might feel as if there is no one to "relate" to, or no one else who can *understand* your sense of being apart and isolated, or who can *accomplish* what *you*, with your superior focus, can get done. If you're a person in this situation you might not be able to just relax and non-judgmentally savor the companionship of others, or enjoy the simple pleasures of life such as listening to music or relaxing into a warm bath. Instead, you might feel compelled or enticed to stay powerfully focused on what *you* need to do to keep yourself, your loved ones, and/or the world "safe" at all times. A person in this situation might be extremely altruistic. He might be performing all his actions in order to help others or keep *others* safe. But there still might be a strong sense that, "If *I* don't do it, it isn't going to get done…" or "…it won't get done *correctly*."

For those readers using self-induced pause who have read the above and are thinking, "*I* don't feel apart from others. She's wrong about *me*," that's great. I'm happy for you that you don't feel apart. But many of my patients on self-induced pause have told me that reading the above information was "like looking in a mirror."

This "It's all up to *me*!" type of thinking is extremely welcomed by the ego-driven part of the brain – another seeming benefit of staying on pause mode. These "benefits" of being on pause that I'm describing here all help to explain why the habit of using pause mode can be so hard to break.

Also, there is the familiarity and comfort of any long-established habit. Over decades, using self-induced pause as a way to "safely" interface with the world can become a deeply entrenched brain habit. By the time that chronic use of self-induced pause mode, combined with an eventual decrease in norepinephrine levels, finally starts producing side effects of immobility, tremor, and other unpleasant symptoms, the brain might have become so accustomed to using pause that it can't easily turn it off – or even want to turn it off. And the next section introduces what might be the biggest reason of all for why it is so hard to let go of the habit of using pause mode: the brain likes *new* things, but doesn't easily get *rid* of old things.

Turning off the habit of using self-induced pause requires 1) making a new set of brain habits and 2) *using* them until they become the default mode. But the brain does *not* automatically get rid of old habit patterns even as it grows new ones.

Making new brain habits.

Making new brain habits that *don't* use pause-inducing thoughts and practicing the new habits until they become the dominant pathways in the brain is a process very similar to the highly acclaimed treatments for *depression* that use brain retraining. Retraining the brain to stop using depression-causing thoughts is the essence of the original type of cognitive behavioral therapy (CBT). Because of the similarities of method between CBT and turning off self-induced pause, and because there is so much literature available about CBT that people stuck on pause might find helpful, I've inserted the following short introduction to CBT.

Cognitive behavioral therapy

Cognitive behavioral therapy, or CBT, is the dominant non-drug therapy in the USA and, increasingly, the world, for treating depression and a host of other thought-influenced pathologies ranging from insomnia to schizophrenia. CBT for treating depression works by teaching a person to be on the lookout for specific types of thoughts: the thoughts that develop the brain pathways that create depression. With CBT, when a person catches himself using one of these types of thoughts, he immediately replaces that thought with a thought that redirects the brain circuits to a healthier path.

For examples of the types of thoughts that people are on the lookout for during CBT therapy, here are the ten main types of fallacy-based thinking that can lead to depression: all-or-nothing thinking (dichotomous thinking); overgeneralization; mental filters that focus only on the negative; disqualifying the positive; "mind-reading" (assuming that other people are having negative thoughts about you); magnification and minimization (of negatives and positives, respectively); emotional reasoning (If I *feel* like a failure, then I *am* a failure); labeling (creating a negative self-label based on your errors); and personalization (feeling guilty for other people's mistakes: "If I was a better daughter, my father wouldn't be an alcoholic.").

You don't want to memorize the above categories. I just included them to demonstrate how very specifically "fallacious and negative" thoughts are described in the CBT research. If you are curious, detailed descriptions of each of these thought categories can be found in Chapter 3, Cognitive Distortions, in the book *Feeling Good: The New Mood Therapy*, by David Burns, MD. In the 1999 edition, this is on pp 32-40. This book is the original "grandfather" book from which nearly all subsequent CBT books are derived. For more generalized information, visit the website of the American Psychological Association, www.APA.org, and search for cognitive behavioral therapy.

When a person who is practicing CBT to treat his depression catches himself having a thought that fits one of the above categories, he needs to stop his mental train and replace that thought with a positive thought. To use an example from Dr. Burns' book, suppose a straight-A student gets a B and thinks to himself: "I'm a *total* failure." This is an example of all-or-nothing thinking. A more correct thought, a possible replacement thought, could be, "I got a B."

A person following the CBT protocols will want to notice if he has a particular set of fallacious, negative thoughts that he uses a lot. He will write these down. He will also write down alternate thoughts – healthy and correct thoughts that he can use to replace the fallacious thoughts when he catches himself making them.

A person does *not* need a therapist to do CBT. He can work on his own, from a book. Studies suggest that people who work on their own, without a therapist, actually get better, faster results. This is also what we've seen in people working to recover from Type I Parkinson's, as well: people make faster progress when they work on their own to stop using self-induced pause, than when they insist on having a therapist to guide them and do some of the heavy lifting. Of course, merely *reading* about CBT will *not* change a person's long-practiced thought patterns. This therapy only works if a person actually *does* the work.

The brain's electrical system responds to negative-attitude thoughts by moving in specific pathways. This leads the brain to release or inhibit specific neurotransmitters. The neurotransmitter behaviors that are released in response to certain kinds of negative thoughts create the brain patterns of a negative mood. By steadily, repeatedly replacing the types of thoughts that cause depression with more objective, less self-defeating thoughts, a person can turn off depressive thinking in a relatively short period of time. Paying constant, conscious attention to one's thoughts and replacing the negative thoughts with realistic, accurate, positive, honest thoughts *redirects the currents in the brain* so that neurotransmitters for *positive* moods are released.

The role of the Friend

Getting rid of the habit of using pause-sustaining thoughts is a similar process, but with a significant difference. One watches his thoughts and replaces his accustomed, pause-supporting thoughts with the words and thoughts of *the Friend*.

The powerful, pause-driven habit of using a train of *self*-focused, *monologue*-driven thoughts is the reason the Friend plays an oversized role in retraining the brain to break the habit of using pause. In CBT, one uses his own mind to create new brain pathways, moving his brain's function *away* from the sympathetic mode end of the healthy, "awake" neurological continuum, and closer to the parasympathetic end.

A person stuck on pause mode isn't even using the healthy and awake neurological modes of parasympathetic and sympathetic, or is only using them a tiny bit, maybe once in a while. Instead, he is using the "verge of death" mindset. This mindset is designed to *not* let a person change his negative thinking. If a person is on pause because he's actually on the verge of death, he should *not* be able to change out of his emergency-based thinking until the emergency is over. After all, if a person *is* on the verge of death, changing away from "staying alive" thinking might rapidly lead to his demise. So for a person on pause, CBT-type thought modifications that use *self*-created replacement thoughts might not work very well. Instead, a person wanting to end the habit of using self-induced pause mode might have better success if he replaces his pause-based, negative thoughts with positive thoughts that stem from feeling safe while in the presence of his *Friend*. Also, a person can ask his Friend at any time if his current thoughts are healthy or unhealthy. He can ask his Friend to let him know if and when his thoughts are going in the wrong direction. One can ask *anything* of the Friend. One can ask the Friend for replacement thoughts that can displace the habitual negative thoughts.

How habits work in the brain

The specific thoughts that activate and sustain self-induced *pause* are different from the thoughts that activate non-pause depression. But the *way* the brain creates and sustains brain *habits* is the same for both.

The use of the relentless internal *mono*logue sustains and widens a specific set of pause-mode pathways in the brain. Over decades, these brain grooves can become very solidly established; their use becomes habitual. It can become extremely hard to use any other thought patterns. But the brain is plastic. It changes based on how it is used. Talking to the Friend stimulates the striatum. This creates a very specific, striatum-traversing pathway for channel qi: one that flows right through the middle of the brain and *further* activates the striatum. Eventually, when the striatum is activated enough, it releases dopamine for motor function and creates positive expectations. With a high level of striatal stimulation, the thalamus, located on the same pathway as the striatum, also becomes stimulated. When it is stimulated *enough*, a person feels safe. When the body feels somatically safe, it shifts into a high degree of parasympathetic mode. Self-induced pause turns off. At least for the moment.

But any negative thought that subsequently arises might shift the brain currents away from the new, tentative, "I'm safe" pathway and re-employ the deep, well-established pause-mode grooves in the brain.

In a mentally *healthy* person, the brain doesn't use pause mode unless potentially on the verge of imminent death. When awake, a mentally healthy person uses a blend of sympathetic mode and parasympathetic mode. The healthy brain will respond to a negative thought by moving closer to the sympathetic-mode end of the parasympathetic / sympathetic continuum. Sympathetic mode, the fight or flight response, should *increase* in response to negativity or fear. At the same time, the use of parasympathetic mode should *decrease*, until such time as the fear or negativity diminishes or ceases.

Habitually using the mode for *imminent death* as a response to negativity or fear, instead of just moving towards a higher amount of sympathetic mode, is *not* mentally healthy. Despite all the seeming benefits, using pause as a way to live is deeply pathological. Eventually, it can make you physically sick.

The progression of recovery from self-induced pause

After some period – it might be hours, it might be years – of talking to one's invisible, loving Friend, one starts to feel as if the Friend is actually listening. The person who is using pause mode but talking constantly to his Friend will eventually experience the awareness that "I am not alone!" This is a somatic feeling – a physical sense of being connected to someone else. This feeling further stimulates the thalamus and striatum and creates a sense of being safe.

Immediately following this sense of being safe, a person might also feel physically lighter, due to the release of dopamine in the *mid*brain. His movements might be smoother. If he is tremoring, the tremor might decrease significantly. For a moment or two, or a day or two, or for some period of time – until the next wave of negative thoughts arrive – this person will be using a *Friend-activated*, "I am safe" set of brain grooves: grooves that drive parasympathetic mode. These are very different grooves, or pathways, than the ones that direct self-induced pause. But when the next wave of negative thoughts occurs, the brain can easily slide back into the old familiar habit groove that drives all the physiological symptoms of pause.

During the first stunning moments of feeling physically lighter and relaxed, a person might think he has switched off pause for good. After all, when a person uses *biological* pause, a genuine neurological response to the possibility of imminent death,

when pause turns off, it turns off for good…or at least until the next time the person is at genuine risk of dying. But self-induced pause is a condition sustained by a *brain habit* – not by an actual, biological near-death situation. The habit might have started with a command to not feel pain. But there was never any actual physiological condition of imminent death. Neurologically, it's as if the person told his brain to *pretend* to be dying, to feel *as if* he were dying. And the brain obeyed and gradually became very, very good at it.

And here's the main point of this chapter: even if a person experiences some moments, or whole weekends, of lightness and joy, and it feels as if he is no longer using pause mode…those habit-grooves in the brain that inhibit the release of dopamine, cause tremor, and generate risk-based thoughts associated with pause mode are still *there*.

The brain loves habit. The brain especially loves habits that feed the ego and the sense of self-importance and power. The ego-associated part of the brain *likes* using those pause-mode grooves. Also, the brain resists change. A person might begin to establish a new, non-pause route for the currents in the brain in response to feeling safe. But at first, the pause grooves are deeper and smoother than the new, narrow groove of healthy neurological behavior. This is how the brain "resists" change. At the first sign of familiar, negative, pause-sustaining thoughts, the brain will happily revert back to its comfort zone. It will use the wide, well-developed electrical pathways of the old habit: the paths of least resistance.

When this happens, the person who thought he had switched off pause for good is baffled: "Darn! I thought I was recovering!"

He *is* recovering, sort of. He's made the first, shy foray into using thoughts that *don't* support pause mode. However…the old, well-established brain grooves for self-induced pause still exist *and* they are easier to use than the new ones.

The preceding sentence might be the most important one for understanding why recovery can appear to be "two steps forward and one, or maybe two or three, steps back."

Making new grooves: four possibilities

Talking silently, constantly, with a Friend, either creates a new set of healthy, parasympathetic mode grooves in the brain *or* activates use of pre-existing, but dormant, healthy grooves. These healthy, new or re-awakened grooves stimulate activity in the striatum. When the striatum is stimulated, it releases dopamine for motor function and the anticipation of positive outcomes. After decades of being almost continually on pause, when this new pattern flows through the brain, it can feel glorious. But in most cases, the old heaviness, rigidity, and/or tremor all come roaring back. Going forward from the first interlude of ease and lightness, and the disappointing reversion back to self-induced pause, the person faces four possibilities.

1) After having a few moments, or an hour or two, or a few days, of physical lightness, relative ease of movement, and softening of rigid muscles, but then reverting back to the previous status quo of rigidity and/or tremor, a person might continue working on cultivating a constant relationship with his Friend. Eventually, in a subsequent moment of once again feeling safer than usual, he will have *another* episode of relatively healthy mental thinking. He will again immediately experience the physical lightness and

relaxation that comes with using a healthy blend of parasympathetic and sympathetic mode.

As the person continues to work with his Friend, eventually learning to trust the Friend more than he trusts his own mind, he might find himself having *predictable* periods of good movement. He will notice that these good periods correspond to positive thoughts. He will also notice that his periods of "bad movement" or "symptoms are worse" are always immediately preceded by some sort of negative or isolationist thinking. He might be shocked by this realization.

Many people who are making a mild effort to recover from being stuck on self-induced pause don't believe or don't want to fully accept that their own minds actually have been creating their problems. This disturbing concept can be in direct conflict with the person's idea that his mind is extremely smart and clever and his powerful will has been the only thing making him successful in life or even keeping him alive. But when his brain has been modified enough that he has *two* viable thought tracks in his brain – the pause track and the "safe" track – and he vacillates between them, he can start to see the relationship between his thoughts and his symptoms or lack of symptoms.

This *proof* that his own mind was creating his horrible symptoms of immobility, rigidity, and tremor is often a moment of great dismay. This let down is sometimes followed by the gleeful realization that, if his health problems are only coming from his thoughts, he *will* be able to heal himself. This person continues, or even increases the intensity, of his steadily deepening relationship with his Friend.

I refer to people taking this path as "recovering."

2) Some people, usually those who have altered the biological playing field by fixing dissociated injuries (pseudo pause) *prior* to turning off self-induced pause, might experience a panicked sense that something is very, very wrong. Their friends and spouses might notice soon after that the person on pause seems to have developed an alternate personality. This new personality might appear at greatest strength when a well-meaning friend or loved one says *anything* about the person's health situation. The switch to the new personality, the Blocker-driven personality, might be preceded every time by eyes darting from side to side and the person *literally* not being able to hear the words being spoken by the friends or loved ones who are talking about his health. A person in this situation might find himself with a voice in his head warning him *never* to turn off pause, and even making terrifying death threats. These thoughts and internal voices, which I have named the Blocker, can sometimes completely take over the person's mind.

I have described this phenomenon in detail, with many examples, in chapter 15 of *Recovery from Parkinson's*. The book also carries strong warnings for people who have both pseudo pause from an unhealed injury *and* self-induced pause. This combination of pause triggers is *very* common. My books warn *against* treating any injuries contributing to pseudo pause *before* self-induced pause has been fully turned off.

The person might go through a phase, immediately after turning off *pseudo* pause – if he is still using *self-induced* pause – where he is *certain* that he has completely recovered, just prior to the appearance of weird personality changes and the resumption of pause-mode symptoms. I call this challenging situation "partial recovery." I probably should have used a more descriptive or even negative term, something like stymied recovery, or maybe blocked recovery. Maybe when I re-write new editions of all my

books, I will change this term. Then again, I don't want to suggest that a person stuck on partial recovery can never recover. He just might need to work even *harder* at talking with his Friend and ignoring his own mind than might a person who does not have a vigorous Blocker personality. This situation *can* be overcome.

Never give up hope, no matter how loud and determined the Blocker is. You created the Blocker, you and you alone can learn to ignore it by building new habits. The body is designed to heal. The brain grows new neural routes based on one's thoughts and actions.

The motto for recovering from any illness, including a mental one, can be the Latin phrase, "*Dum spiro spero*": So long as I am breathing, I can hope.

3) After initially turning off self-induced pause, a person might experience a profound sense of intimacy with the universe, his Friend, or some distant memory of joy, any of which make him feel so safe and loved that he never again uses the old pause-inducing thoughts. In my book on Parkinson's, I refer to these people as having an "epiphany" type of recovery. They have an insight into their relationship with the universe or with being inherently safe that leaves their brain permanently reverted back to a healthy way of thinking. Pause is completely turned off, for good.

With regard to the subject of epiphany recovering, I want to make one point clear: some people who had an epiphany recovery spent years having *no* signs of progress prior to the epiphany. And then, in a moment of emotional, loving clarity, pause ceased and did not return. So what do I mean by an epiphany? I call it an epiphany if, *when* the change in brain attitude occurs, it occurs all at once and never backtracks. I am not saying that an epiphany recovery happens within minutes of reading this book, or within minutes of the first fleeting feelings of being safe. The patient described on p. 32 who found herself exclaiming to God, "I do want to live!" had been following my protocols but struggling with worsening symptoms for *years* before she had her epiphany, after which she never back-tracked.

4) The fourth possibility is, because of the resumption of the pause habit, the person decides he is obviously not capable of recovering, and gives up.

"Pay no more attention to the mind than you would to the ravings of an idiot"

– St. Teresa of Avila

Chapter eleven

Habits

Links in the brain

You might be familiar with Pavlov's famous experiment. Every day when his dogs were fed, he rang a bell. Over time, the dogs associated the bell ringing with food. Eventually, when they heard a bell, they would begin to salivate. There is no inherent biological connection between bells and salivation, but the dogs' brains had made a link between bells and food: new pathways in their brains had been created.

When I was first studying biology, back in the 1960s, the brain was still assumed to function like an un-alterable switchboard. One was born with certain brain connections, and robot-like, the brain went through its pre-installed behaviors. Pavlov's stunning outcomes in 1897 were the first hint of the coming revolution in the field of brain plasticity, but nearly one hundred years would pass before the full implications of Pavlov's research became apparent. Today, in the 2020s, the plasticity, the changeability, of the brain is common knowledge.

Starting around the end of the twentieth century, brain research using scans showed that the brain is *always* changing and growing based on what is asked of it. For example, brain scans of people who are bilingual show that their brains' areas devoted to speech and language are nearly twice as large as that same area in people who speak only one language.

For another example, in one study, a group of college students learned to juggle. Their brain scans showed that, after six months, the areas of the brain that are activated while juggling had gotten larger. Half of the jugglers were then told to not juggle for the next six months. The other half was asked to continue. After six more months, the brain areas of the ex-jugglers had gone back to their pre-juggling sizes. Those who kept juggling maintained the increased size in the juggling-related part of the brain. I do not have a citation for these two brain studies (bilingualism and juggling) that I read about *many* years ago, but books on the subject of brain plasticity abound.

If a certain skill set is no longer being used regularly, the brain will reduce the size of the area that is dedicated to that skill. But this is very important to remember: the brain will *retain all the links* that are needed for using that skill: the people who stopped juggling *still remembered* how to juggle, even though they were no longer as technically refined as the ones who had never stopped juggling.

A person who has ever ridden a bicycle never loses the motor knowledge of how to bicycle. A person who has once learned to ride a bicycle might get on a bike after decades of not riding and find that his muscles are rusty but his body automatically remembers how to balance and operate the bike. The brain *retains* all the brain links to that dormant skill set.

Another beautiful, fairly common example of link retention might be seen in an elderly person whose posture is now stooped and who moves cautiously, fearful of falling. If this person ice skated as a teen or young adult, even if he hasn't skated in many decades, he might lace himself into a pair of skates, step onto the ice, and soon be moving with all his old grace and elegance, amazing himself and all onlookers. Of course, afterwards, he will be stiff and sore, but during his return to the ice, his brain will have applied its various brain links for ice skating in exactly the same way it did the last time he went out on the ice, maybe half a century earlier.

Probably my favorite story of brain links was written up by a museum guard who worked at the Musée Rodin, in Paris. While he was on duty in the room with Rodin's statue "The Kiss," a very elderly man shuffled up to the statue. The visitor stood motionless, gazing at the statue for a long, long time. The guard observed that, as the man stood there, his bent back slowly straightened. He grew taller. His legs seemed to grow stronger. His tired face took on an ethereal expression. After nearly twenty minutes, the man turned around and left. The guard observed that, as the visitor departed, his stride slowed, and he slowly caved back in on himself. And the guard suddenly realized that the visitor's face, though aged, had keenly resembled that of the man in the statue.

The brain links generated by a person who has habitually used pause for years *don't* go away. A person who has steadily learned (has made brain links) to connect his use of pause mode with more and more motor disfunctions, for example, tightened biceps, dragging one foot or the other foot or both, increased salivation, and his own unique location(s) and rhythm(s) of tremor, will *retain* all these highly personalized brain links. When pause is commanded to start up again, even after a long break, *all* those brain links will still be there. *All* the symptoms and behaviors and attitudes associated with pause might kick in even if they haven't been used in days, weeks, or years.

The brain doesn't create wisdom. It remembers experiences. It makes links. It can easily make new links, enriching the existing link-set. It loves habit. *It doesn't get rid of learned behaviors.* The brain *saves* the old material. Pavlov's experiment demonstrated not only that the dog brains made *links* between a bell ringing and the appearance of food: the dogs continued to respond to bells with salivation even after the bell-food connection ended.

One of the most important things to bear in mind while recovering from self-induced pause is that the brain has not only created an easily accessed, well-worn route through the brain for using pause mode, it has made links to all the symptoms and thought processes that a given *individual* has accumulated in association with being on pause. That person's brain routes, including *all those links*, will *not* disappear even as he is creating a new "I'm safe now" route through the brain.

When a person has cultivated the self-induced pause habit for a long time, the brain has linked this mindset with countless related, deeply personalized habits, including an individual's unique habits of immobility, pain and fear. These related habits might include muscle rigidity on one side of the body more than the other, tremoring more in public than in private, feeling more paralyzed than usual at a certain time of day, and/or a vast collection of other individualized learned habits that might accompany a given person's use of self-induced pause.

As for uniqueness, be aware that no two people with Parkinson's disease have the exact same constellation of symptoms. And the collection of triggers for worsening

symptoms are not the same for any two people with PD. For example, for some of my patients, thoughts of sex made their symptoms worse. For others, thoughts of sex reduced their symptoms. Because Type I Parkinson's disease is mentally created and sustained, the symptoms of each person reflect the fears, injuries, and cultural impositions of the individual.

Redundancy: The brain doesn't ever forget how to ride a bicycle. That complex bit of coordination is preserved in the brain and can be activated *in full* if called upon. The same goes for the individualized conglomerate of symptoms that a person slowly and steadily creates when he habitually uses pause mode. His brain will never forget them.

Flip-flops

A person who is slowly but steadily recovering from the habit of triggering self-induced pause might be astonished by the flip-flops his body goes through before he is completely recovered.

Imagine this scenario: A person feels unusually relaxed one morning after an inspirational reading of Marcus Aurelius, the deeply spiritual emperor/ philospher of ancient Rome. He has no symptoms of pause. He thinks to himself how lately, he has been free from pause symptoms for an increasing number of minutes every day. Due to his recent ability to relax more and more often, he assumes that he is truly making progress. He says to himself that, surely, his pause-related symptoms are diminishing. He tells himself, incorrectly, that the recent episodes of milder than usual symptoms are *proof* that he is recovering. He is inwardly delighted: everyone will soon notice how much better he is doing. What praise shall soon poor in!

But then, looking out the window, he sees his detested, gloomy cousin-in-law unexpectedly coming up the walkway to the house. He knows that this critical and negative person will be looking for *any* sign that the Parkinson's symptoms are not going away. Instantly, the person's rigidity and tremor reappear and with seemingly *heightened* power. Dismayed, he concludes that he has made no progress at all! He is getting worse, not better! His thoughts of progress were wrong: he has been deluding himself. He is *not* recovering, after all. He is *worse*!

This *incorrect* negative conclusion can be utterly paralyzing. This paralysis can increase the person's conviction that he is doomed, and this thought further enhances his need to use pause mode – his accustomed mode for emotional self-protection.

In fact, the person's healthy, *I'm safe* pathways might be steadily growing stronger. However, *all* the links to the brain's pause behaviors are *still there*, inside the brain. All of them. As soon as a person again uses the brain pathways associated with pause mode, *all* the old links might be activated. If you haven't ridden your bicycle in a long while, you might no longer have your strong bike riding muscles, and it might feel a little strange at first to be back on the bike again, but you will have *one hundred percent* of the brain information and linkages necessary to ride that bicycle. When you climb on the bike and start pedaling, *all* the brain linkages associated with riding a bicycle will kick in. All of them.

Just like all the old skills for riding a bicycle will be activated when you climb on a bike, no matter how long it's been since the last bike ride, when a person's gotten good at using pause mode, all the old brain skills for riding the "pause bike" will always still be there, patiently waiting to be activated. When you re-activate self-induced pause, after a

break of a few minutes, hours, or weeks, all the pause-based brain linkages might become fully activated.

My patients have all assumed that recovering means having fewer symptoms in a somewhat *linear* fashion: symptoms should steadily decrease in frequency and strength, as a proof of recovery. In the early days of the Parkinson's Recovery Project, I assumed this as well. I was thinking of Parkinson's as an affliction like the flu or a torn ligament – remove or fix the cause, and the symptoms will slowly melt away. This understanding was not correct, because Parkinson's disease *symptoms* are not the real problem. The symptoms are a *side effect* of using pause mode. A person's varying *intensities* of symptoms can be related to the *intensities* of his pause-activating thoughts, at any given time.

Again: the real problem is *not* the symptoms: the real problem is the underlying cause of those symptoms. In the case of Type I Parkinson's disease, the underlying cause is the habitual mental activation of pause mode.

"Recovering" from this type of Parkinson's, or from the habit of using self-induced pause, means that a person uses pause mode less and less often, until he stops using it altogether. But even as he is training himself to use thinking that evokes the "I'm safe" mode, *all* the linked motor and mental behaviors in the brain that are associated with pause will still be lined up and ready to manifest. Again, "Complete recovery" is *not* about the cessation of symptoms.

I'll say it *yet* again. Complete recovery is *not* about the cessation of *symptoms*. Symptoms will occur so long as pause-activating thoughts are active. Complete recovery means never again using the pathological mental habit of inducing pause mode as a way of interfacing with the world in a non-emergency situation. Complete recovery means that the person no longer uses pause mode thinking, period. The neural pathways for the pause *symptoms* such as tremor, rigidity, slowness of movement and so on might *always* remain in the brain. But if pause mode is no longer being activated, those symptoms, the pause-related "skill set," can then lie dormant.

When a person is slowly recovering from Parkinson's or the habit of using self-induced pause, he might be feeling much lighter and relaxed for longer and longer periods of time when he is talking with his Friend and feeling safe…and then he might experience *one hundred percent* of his old symptoms when pause mode kicks back in. A person who is starting to recover might go through swings: going from safe and moving easily, to being on pause and being tight, tremoring, and with inhibited movement. A person might have these swings several times per day, or even per hour. Whether or not one is recovering is not a question of the Parkinson's *symptoms* getting weaker – it's a question of whether or not a person is increasing his use of a new, healthy, mental posture of being safe *or oppositely*, is continuing and/or even increasing the use of his pause habit. When he uses the fear-based mindset, *all* the linked symptoms of pause might re-appear, as strong as they *ever were*, even if he's using them less often. The actual strength of the symptoms, at any given time, will vary in intensity, just like they did *before* the person started working on recovering. If the person on pause is somewhat relaxed, the symptoms might be minimal, if present at all. As tension or stress mounts, the intensity of the symptoms will increase. After all, this was the case *prior* to starting recovery, and it will be the case *during* recovery, whenever a person uses pause mode.

Of course, everyone is different. Some people, after taking a break from using pause mode and having enjoyed a spell of the relative lightness and the relaxation of parasympathetic mode, might have *all* their symptoms re-appear when they use the pause mindset. Others might notice that *some* of their symptoms are becoming slightly less powerful as they use pause less and less. Then again, some of their symptoms might temporarily be *stronger* than usual in response to unsettling circumstances: just like the range and variability of pause symptoms *used* to behave *before* starting on recovering.

If a person is starting to use a *blend* of pause mode and parasympathetic mode now and then, *all* the linkages to pause might not be as *completely* activated, or as *powerfully* activated, each time. As everyone using self-induced pause knows, the *symptoms* can be quite variable from one minute, or hour, to the next. When using pause mode, that mood- and expectation-based variability in symptoms will continue, even after one starts developing new, healthy brain pathways.

And every person's recovery is different.

In my own case, about two years after I had completely recovered from Parkinson's disease and hadn't had a symptom in all that time, some situation arose that was alarming, but not actually life-threatening. I don't remember what it was: it might have been an action movie. But I do remember that I suddenly found myself tightening up, curling forward, and feeling as if I could tremor if I let myself. I observed these changes coming over me and started laughing. It was so funny! Immediately, I told myself I didn't need to be afraid in the old, "need to become numb" manner. All the symptoms immediately ceased, as quickly as they had come on. I have never had symptoms of Parkinson's since that time. And it was laughably easy to turn it off.

If you understand how the brain works, how it retains its links and its habits and how *symptoms* don't *necessarily* weaken or diminish, but might reappear full force every time that the pause mindset kicks in, you will understand what is happening if you take a "step backwards": when a negative thought triggers all the usual, detested links. You won't need to panic that you're getting worse or that you have made no progress. You aren't getting *worse*. That's not the case at all. If you've had even a few interludes of safety and lightness, if you are improving your relationship with your Friend to the point that you sometimes feel safe, you *are* making progress. The sudden reversion back into your old mindset and the concomitant re-appearance of symptoms might have been jarring *because* you're starting to be comfortable with the new way of thinking. You're starting to enjoy some time when you are genuinely relaxed and maybe going through recovery symptoms now and then. So any return to the Bad Old Ways will be even more alarming than it used to be. Don't let that alarm overtake your mind. You need to resume talking to your Friend and working on feeling safe. If you were starting to have moments of feeling non-paused, so that your temporary reversion felt worse than ever, then you are making progress. If and when you fall off a horse, you need to just get back on. Don't choose to fear all horses.

For most people, recovery comes about by steadily, repeatedly turning off the aberrant *thinking* that triggers activation of all the old brain habits that are related to pause. Nearly all my Parkinson's patients, at first, just wanted to stop the *symptoms*. But we didn't realize, in the early days, that the symptoms are only a side effect. The actual problem in Type I Parkinson's disease is the a mind-set habit*:* the habitual use of pause-activating thoughts that activate the brain pathways that activate the symptoms.

The pause pathways through the brain

The well-established, eight-lane Pause Superhighway through the brain that was built and fortified during a person's years of using pause mode is linked to all the symptoms that developed in response to that individual's use of pause. When the neural currents in the brain send electrons hurtling down this familiar highway, the brain merrily connects with some or all of the links it has cultivated over the years, including links that activate the despised, humiliating symptoms that can eventually accompany being stuck on pause, and the links to still *more* negative thoughts that will encourage *further* use of pause.

While recovering, the *new* brain habit of feeling safe in the company of a Friend might have created a small ruffle in the brain – the beginnings of a faint path. This new brain behavior might need several, or thousands, of repetitions before this new "I feel safe" path can compete effectively with the well-established pause pathway and all of its links to rigidity, poverty of movement, tremor, postural instability, and fear- or risk assessment- based thinking.

Musings

If I'm allowed to generalize, I've noticed that most epiphany recoverers mainly wanted to change their attitudes and their personalities for the better: change who they *are*. The slow recoverers usually wanted to get rid of their troublesome symptoms, but *not* change who they are.

One of my favorite quotes from a completely recovered patient is, "When I started working with you, I just wanted to go back to who I used to be before I had all that Parkinson's stuff. Now, I never want to be that person again. I was miserable, and I didn't even know it."

In my own case, which ended with an epiphany type recovery, I declared out loud to my teacher, over and over, "Change no circumstance of my life. Change *me*."

The above quote is from a great saint, Sri Gyanamata (1869-1951), whose motto was "God Alone." I deeply admired her "Change me" prayer, and had used it often, prior to my diagnosis of Parkinson's disease. After I was diagnosed, during that afternoon while I "had it out" with my spiritual teacher and instantly recovered, I found myself saying this phrase, over and over, and genuinely meaning it: "Change no circumstance of my life; change *me*; change my attitude and mind-set."

I was devastated that I had Parkinson's disease, but if that is what God felt I needed to have then, by golly, I was going to learn to be grateful for it. If God needed me to have Parkinson's disease, well, He had His reasons. He could mold me as was best. I would just lean on my guru more than ever to help me through it. No doubt I would learn from the experience. I was determined to be grateful for having this dreadful, terrifying syndrome. As I spoke with my Friend, I was *not* looking for a way to control or reduce my symptoms, or to slow the progression of the syndrome.

Most of my patients with early-stage Parkinson's comforted themselves with thoughts such as, "I'm lucky, my PD symptoms aren't so bad. I can live with it." Unlike them, I had no delusions about my symptoms continuing to stay somewhat mild. I am a doctor and had seen many people with highly advanced Parkinson's. In fact, although I had already seen some of my patients recover from Parkinson's disease, I assumed, as

most people with PD do, that I would not be one of the "lucky ones." I assumed I was special, different from other people, and therefore *I* could *not* recover.

I knew what profound suffering and physical limits my future probably held. Even so, I did *not* ask my Friend even once to help me recover from my symptoms. I asked for understanding and the ability to be grateful. And a few hours later, having been assured by my Friend, my guru, that he would always be with me and that he *had* always been with me, I found myself feeling *profoundly* safe, connected with love in a way that I hadn't considered possible before and, coincidentally, no longer using pause mode. Period. I was free from the fear that drove me to use pause mode. I was permanently safe with my teacher by my side. In case you are wondering, my teacher passed in 1952, before I was born. So I was not relying on the physical presence of my teacher. I was conversing with him via my heart. He was my Friend.

I also wonder if people who, like me, have an epiphany recovery, an all-at-once, permanent turning off of pause mode, might already have an existing, workable brain path for feeling safe. They might have consciously developed it in childhood, or through years of spiritual study and practice in this or a previous lifetime. Prior to recovery, they weren't *using* that path, but like the brain path for riding a bicycle, it never went away even though it wasn't being used.

I wonder, do people who do *not* have a vigorous, pre-existing path for feeling safe and love need to build one almost from scratch? Or does everyone have a brain path for feeling healthy and safe, but with varying degrees of disuse and inaccessibility? I don't know. But I do know that while feeling safe with their Friends for a few minutes or hours every day, the old pause path will *not* be diminished just because new paths are being created or widened. But whatever its starting point, if it is being regularly used, the safe path *will* be growing wider and smoother.

My own spiritual teacher, Paramahansa Yogananda, repeatedly made the point – back in the 1930s and 40s, when the brain was still considered by western doctors to be an unchanging switchboard – that our thoughts create corresponding "grooves" in the brain, and that we can change our brains' behaviors with our thoughts. In the USA, at that time, this was a radical, seemingly unscientific statement. It was based on teachings of the ancient saints of India. This premise is now one hundred percent supported by brain researchers using scans. Yogananda also made the point repeatedly that one might work for a long time on changing one's thoughts and meditating regularly *and yet* observe no *obvious* progress, in the beginning.

He insisted that in spite of the apparent lack of change, the new thoughts were laying down tracks of new brain pathways that can eventually support new, improved mental, emotional, and physical behaviors. Eventually, when those new routes become wider and deeper, they will become the paths of least resistance. The brain will start using the new pathways in preference to the old ones. Yogananda sometimes referred to this process with the metaphor of growing new "soldiers" of right thoughts and actions. If one practices regulating one's thoughts and behaviors, then when the time comes to wage war against habits that one wants to change, one will have been silently growing oneself an army. I call it growing a new path of least resistance.

He also emphasized the fact of slow, subtle brain change with regard to techniques of meditation. Whether or not a person gets quick "results" of inner peace or wisdom, the process of regularly doing meditative techniques can silently, steadily, alter

the brain. It might take weeks of meditation, prayer, and right living before one notices any real change. More likely, it will take years, decades. But if the mental techniques, prayers, and right living are being practiced, changes *are* occurring. Someday, the new routes in the brain will become the paths of least resistance. The preferred thoughts and behaviors will become the *new* default system. The new ways of thinking will become automatic: habitual. The old-habit routes will cease to dominate. They might still be there, if they haven't been consciously destroyed, but they will be dormant.

Desire, and the path of least resistance

The flow of electrons through the brain will *always* follow the path of least resistance. This is why changing a habit can be so hard. In order to overthrow a bad habit, a person has to not just stop doing the bad habit a few times. He has to make a new, different habit. He also has to rid himself of the *desire* to use the bad habit. The *desire* to do the bad habit is what shunts his brain currents into the on-ramp of the well-traveled highway that links all the parts of the bad habit. This smooth highway is a path with almost no resistance. It's easy to find oneself *automatically* performing a habit, even if one has told oneself *not* to do it. The brain *automatically* chooses the easiest path, the familiar path, the well-established electrical path of least resistance.

Being on pause *does* give a person many benefits: heightened focus, intensity of purpose, and a feeling of being stronger, smarter, and faster than others. Of course, over the years, as the ability to sustain an effective level of mental emergency wanes, these "benefits" diminish. By the time a person is bedeviled by the negative side effects of being on pause, he is not actually stronger, smarter, and faster. But his brain might very likely *tell* him that staying on pause is nevertheless keeping him "better than other people" or keeping him "safe." Therefore, another thing a person might do to stop using pause is to stop desiring the "benefits" of using pause: those benefits might have included feeling in charge; feeling compelled to be right in matters of judgment or morality; feeling powerful; feeling untouched by physical and emotional pain. So long as a person *wants* to have the benefits of being on pause, his brain will continue to opt for and further fortify the electrical brain circuits that support the habit of using pause.

I wonder if the people with an instant, epiphany-type recovery have, maybe even without consciously knowing, decided that their relationships with their Friends were more desirable than whatever benefits they got from habitually using pause mode. Did their *desire* to be supported by the Friend and let their *Friend* be dominant instead of their fear, allow them to easily, *utterly* abandon the pause habit *permanently*? In my own case, I made a conscious decision to listen to my Friend, my guru, and to stop trusting in my own arrogant self-confidence. I didn't know this would cause me to recover. I just thought it would make me a better person.

For whatever reason, the people with epiphany recoveries changed, and changed almost instantly. Permanently. Certainly, when we *truly* no longer have any desire for a given habit or the side effects of the habit, the habit ceases instantly. It just stops. This point has been made by various swamis of my acquaintance.

And maybe, possibly, when one "surrenders" (destroys or gives to the Friend) one's ego-based desire to be clever, stoic, or safe via *self*-protection *and* instead allows the Friend and/or the Friend's "higher connections" to keep one safe, choosing the *new* brain pathway becomes *instantly* easier – even during times of stress or trauma.

When you've got a new brain habit established

When a person is truly ready to give up his habit of using self-induced pause, and he has created a replacement brain route thanks to episodes of feeling close to his Friend, there are techniques that can help accelerate, or even execute in one fell swoop, this desired change of making the new habit be dominant. The next chapter shares a heart-based, brain altering technique for quickly, sometimes instantly, *destroying* bad habits, including the habit of using self-induced pause.

In the case of self-induced pause, this technique should *not* be used until after a person has already experienced many episodes of relaxation, easy movement, and a shift in the mind-set, however brief. If this technique for destroying the brain's on-ramp for the neural highway of the pause habit is used *before* a new, healthy habit has been somewhat established, then when the next set of worries or negative thoughts show up, the person will have *no* options on how to behave. He will *most likely* subconsciously command his brain to create a *new* brain on-ramp to get back onto his old, still-existing pause highway, with all its linkages. That instruction will allow all the old pause habits to kick in. Because he didn't have a viable option lined up in advance, any fear or stress will force him to get back on the old brain path. A person needs to have *some* way to go through life. If pause mode is the only working brain route, then that's what will be used. In this situation, even if the person has done the techniques that destroy the "on ramp" to the pause habit (taught in the next chapter), the person will end up having to create new on ramps to the pause-habit super highway. That's the only mode he knows. He'll end up right back where he started. In the field of psychology, this scenario might metaphorically be referred to as "trying to take away the person's life-raft before he gets safely to shore."

But if a healthy replacement route has become reliably available and the Friend is standing by, a person can do the technique in the next chapter for getting rid of a pernicious habit, and can then immediately mentally install the *new* habit as the default mode.

Recovery symptoms

The book *Recovery from Parkinson's* has eleven chapters describing the physical and mental changes that can occur while recovering from Parkinson's. A person who is starting to use healthy brain patterns now and then might start to experience some recovery symptoms now and then. This can make the person more distraught than ever when he finds himself suddenly using what seems like full-fledged pause mode once again. For example, if a person is starting to use healthy thinking once in a while, he might start having the pins and needles of returning nerve function in his face or feet. He might, for example, be having some spontaneous recovery dyskinesia and sleeping twice as much as usual. *But* if his mind jolts back into pause mode because of something unexpected or mildly threatening, he might suddenly manifest every single pause symptom that he's ever had. When this happens, which it usually does many, many times while taking the slow route of getting rid of the pause habit (as opposed to the epiphany), the person might imagine that he's made no progress at all. He might assume that his recovery symptoms were false promises.

What does this mean for a person who is working on recovering?

It means please don't worry about the set backs and the moment-to-moment stuff. You can think of changing your brain habits as a process that sometimes appears to take

two steps forward and *three* steps back. Any backward step might *appear* to be stepping all the way back to the beginning: to the very worst symptoms.

People tend to assume that a "step backwards" should be a step into *milder symptoms*. But it's not. Recovery is not about *symptoms*. The "step backwards" is resuming the use of pause-inducing *thoughts*, thoughts that *re-activate* the pause symptoms. Once activated, the symptoms themselves might be full strength, hooking up all the old brain linkages. The improvements of recovery, as one works on changing his thoughts, will not necessarily be a *decline* in the *strength* of the troubling symptoms, but in the *decreasing* frequency and tenacity of negative thoughts that activate the pause habit. The improvements of recovery, what you can call the steps forward, is that a person is using his Friend more and thus might be using new, "I'm safe" brain pathways more. A "two steps forward" means using parasympathetic mode thinking, Friend-based thinking, for an even longer duration than before, or more frequently, or both. At first, the duration of positive, parasympathetic mode thoughts might be fleeting. Over time, with continued development of the Friend relationship, the *duration* of positive thoughts can gradually increase. That *increase* of the time spent with a positive attitude is the "two steps forward." Using healthy, "I'm safe" thoughts is the "two steps forward".

The *underlying* problem for people who are having horrible symptoms from using self-induced pause mode is *not* the symptoms. The problem is the mindset that triggers those symptoms. A changing of *thoughts* is what must happen to bring about recovery – not suppression of the symptoms. The symptoms are merely a side effect of brain pathways being activated by pause-inducing thoughts. "Two steps forward" refers to increasing the duration and frequency of feelings and thoughts of being safe enough to be alive.

When you're working on recovering, the symptoms of pause are your helpers.

Rigidity, tremor, and poverty of movement are blatant reminders that you that you have resumed using pause-based thinking. *Thank* your Friend for the gift of your symptoms: they are indicators of what your mind is doing. Without them, you might not realize why you are heading down a rabbit hole of negative thinking, joylessness, and feeling alone in the universe.

Pinocchio's wooden nose, which grew longer when he told a lie, was a gift. The lengthening nose was NOT the underlying problem. The lengthening nose showed him, in a most visible way, that he was doing something wrong. The same with the symptoms of Parkinson's.

As mentioned earlier, most of my recovering Parkinson's patients expected the hated symptoms to steadily ebb away, like a fading heat rash. But that's not how brain-based habits work. Ask any cigarette smoker who's tried to quit. He might have gotten himself down to only one or two cigarettes per day, but his desire for those two cigarettes might be just as passionate as ever. His desire, his mental habit of loving the nicotine hit, is still well-established in his brain. Only after his brain makes a switch and decides it doesn't like smoking, not at *all*, and he no longer sees himself as a smoker, so that his brain no longer prefers the path that links up to all the aspects of the cigarette habits, *that's* when he stops being a smoker.

Once again, because many people really struggle with this concept, the thing that will go two steps foreward and backwards one will *not* be your visible symptoms. The

visible symptoms might continue to be all or nothing, or all *or* partial, as per a person's usual, pre-recovery swings, *or* a person might spend more and more minutes of the day being symptom free. But what is really going forward and backwards is the use of "safe" thoughts or negative thoughts – the triggers for the new brain pathway being built *or* the triggers for the old pathway. Two steps forward refers to getting stronger at using a brain habit of "safe" thoughts, which in turn activates a healthier motor system. A "step backwards" refers not to symptoms, but to using, *yet again*, from sheer habit, the thoughts that activate pause mode. And those thoughts might activate all the symptoms of pause mode that you've ever had.

Self-assessment

If you want to assess your progress – and this pathological need to always be constantly assessing yourself instead of trusting your Friend and just being alive is part of the pause mindset – the only accurate measures are 1) how *much* you are now communicating with your Friend compared to before and 2) whether or not your Friend is starting to seem more real to you. If you are having fleeting moments when you feel that your Friend is actually listening, then you are making progress. If you are starting to have moments when you feel lighter and more flexible in your movements, then you are making progress – but it's because your *mindset* is "I'm safe." Even though *all* your pause-using habits still exist in the brain, and might turn on full force as soon as you have a negative thought, you are making progress if you are building a new path. You are building "soldiers": links to "safe" and healthy thoughts. If you are talking to your Friend and sometimes feeling his presence, then even when you can't see the progress, you are building a new pathway in your brain.

What's the best way to know if I am making progress?

Before I answer this question, I want you to think about this for a moment.

People who have been reading this book carefully up until now who are *not* using self-induced pause might be waving their arms in the air crying out, "I know! I know! Call on me!" People who are accustomed to using self-induced pause are very likely saying, "Oh come on. I have no idea. Just tell me."

Here's the answer: ask your Friend. Ask, "Am I making progress?" or "Am I moving towards recovery?" Or, if feeling more dramatic, "Is there any hope for me?!"

One patient, who needed two years before he was even willing to *try* talking to a Friend, complained to me, after his Friend started talking with him and answering his questions. "My Friend always says yes to those kinds of questions. He's just a yes-man."

So I asked my patient to silently ask his Friend if he needed to have Parkinson's for the rest of his life. My patient did so, and then laughed out loud. "He said no. I guess he's not a complete yes-man. But he's still just saying what I want to hear…"

So I had this patient repeat the birthdate exercise from chapter five, p. 68, to remind himself that truth is different from falsehood, and that the difference can be *felt*. He could *feel* whether or not his Friend was telling the Truth. He then admitted that his Friend wasn't being a yes-man; his Friend was telling the Truth. But he *still* didn't want to admit that his Friend was always right because, so often, the Friend's answers pointed out that most of his health problems were, ultimately, of his own making.

There might be *many* times when the Friend says something a person really doesn't want to hear. To test this principle, one might ask the Friend if one will have to

make changes in his brain habits if he wants to stop using pause. Most people, in my experience, don't actually want to have to do this. But if it will be necessary to change brain habits in order to stop habitually using pause, then you can be sure, if you pose this question, that your Friend will tell you the hard truth, whether you like it or not.

Once you are at the point where you *can* bring yourself to talk to your Friend, you can make use of the upcoming chapters that give suggestions for the conversational tone and the kinds of things you can and should share with your Friend. (Everything.) Eventually, when in spite of your being on pause *most* of the time, the striatum has a sufficient level of activity due to your communication with your Friend, you will notice that sometimes you feel safe, your thoughts are positive, and you feel lighter. At some point after you begin to sometimes spontaneously feel safe enough, you might even notice yourself taking a deep breath, wobbling your head and shivering your spine now and then. You will notice the other shifts that have already been described, brief or lengthy shifts into parasympathetic mode. This, in addition to changes in symptoms, can indicate that you are making progress.

But my main point for this section is, the intensity of your symptoms at any given moment doesn't tell you whether or not you're changing and improving. The *Friend* can tell you if you're making progress even if you can't see it, or if you are burdened with doubts.

Review: slow recoverers and epiphany recoverers all recover, in the end

For some people, the ones I call the "epiphany recoverers," *permanently* turning off pause can occur in a few moments of intense communication with the Friend. But for *most* of my patients who have been stuck on self-induced pause, the process of learning not to use the pause habit has taken weeks, months, or most often, years. Those people who needed years to *lastingly* turn off self-induced pause have often felt brief periods of parasympathetic mode behaviors even early on in the recovery process, but these periods have usually ended abruptly at the resumption of the habitual negative thoughts.

Eventually, sooner or later, a person with Type I PD who is working with a Friend will be able to suddenly see with utter clarity that his periods of pause-type behavior such as symptoms of Parkinson's disease are 100% correlated with negative thoughts. He can also see that his periods of decrease or cessation of pause symptoms correlate 100% with positive thoughts and/or feeling safe. After this realization, the person is often overwhelmed with a gratifying awareness that his mind is causing his problematic symptoms and that *therefore*, he *will* be able to learn how to make them stop for good. He usually finds, after this, that it is easier to work more consistently at changing, via an ever-closer relationship with the Friend. Maybe he can ask the Friend for help, ask the Friend to teach him how to change his thinking. The Friend might be able to help with cognitive behavioral therapy-type thought replacements, for replacing negative thoughts with positive ones. He can ask the Friend, "This attitude I have towards [insert some emotional challenge], is it healthy? If not, what thoughts might I use about this challenge that will be more helpful and healthier?" If a person keeps the questions simple, the Friend will be able to answer.

In the patients who have spent years turning off self-induced pause, this revelation that they can control their symptoms by keeping their mind focused on thoughts that they are safe and in the company of their Friend might accelerate their recovery trajectory. But

there is no way for me to guess with a given patient how long recovery might take. It's up to the patient.

So many of my patients, after *years* of grudgingly talking to their Friends, at my stubborn recommendation, have finally noticed the connection between their thoughts and their problematic symptoms. Many have literally slapped themselves, usually on the face or the forehead, and said to me, in utter amazement, something along the lines of "I've been doing this [having Parkinson's symptoms] to myself! I've been causing my own symptoms with my mind!"

Even after this realization, they might sooner or later slip back into pause mode for a while. While doing so, they might have *all* the usual symptoms that they've trained themselves to have. But from this point, they know exactly what they need to do: keep talking to the Friend and making the new "safe" pathways even stronger.

And at this point, when one has a sense of what it's like to *not* use pause now and then thanks to the presence of the Friend and feeling safe, there's one more thing a person can do: use the techniques in the next chapter to destroy the habit of using pause. And after that, using a variation on the same technique, they can immediately command themselves to *replace* the old, destroyed pause habit with the new habit that they've been building ever since they started talking to their Friends: the new habit of knowing that they are safe enough to be alive: no longer needing to pretend that they are on the verge of imminent death.

"A bad habit rarely disappears miraculously; it's usually an undo-it-yourself project."
– Abigail van Buren, author of the advice column "Dear Abby"

Chapter twelve

Destroying a Problematic Habit

The techniques in this chapter can be used to destroy a wrong habit and install a healthy habit.

These techniques should not be used to turn off the habit of using pause mode until a person has experienced several instances where he's felt physically lighter and more psychologically positive than usual: distinctly different from his "heavy," wary, Parkinson's personality. After a few times of feeling lighter and more positive in response to spending time with a Friend, a person can ask the Friend, "Am I ready to work on destroying the habit of using pause mode?" A variation on this question might be "Am I safe enough to stop using pause mode?" You don't need to use the exact phrasings that I suggest. Just talk with your Friend in the language of your heart.

You might want to have a dialog similar to the one in chapter nine, in which the Friend is asked a question, and then the patient is asked the same question. The question might be "Am I safe enough to stop using pause mode?" If the Friend says yes but the patient says no, this is a situation where the patient's brain is trying to ignore his heart's truth. You can ask the question back and forth, over and over, until the brain, inevitably, comes into eventual compliance with the heart. If the brain agrees with the heart right from the start, that's great.

If not, please do not be discouraged. You can ask your Friend if you shall *ever* be ready to work on destroying the pause habit. If your Friend says yes, but that you are not yet ready to destroy the old habit at this time, then just continue talking and listening to your Friend as much as possible, until your Friend says you are ready to get rid of the pause habit.

More tips for feeling safe

Try to recall the thoughts that preceded any episode of feeling a little lighter and less "paused." If you notice that you're feeling a bit better than usual, take a moment to recall what your thoughts or actions were just *prior* to feeling a little lighter. If you can't recall your thoughts or actions that preceded feeling lighter, gently tell your mind to pay attention so that *next* time you will be able to remember. Also, you can ask your Friend what it was you were thinking or doing just prior to feeling lighter. You can also ask your Friend to help you, next time, to recall what you were thinking and doing just before you felt a little lighter.

After the first episode of feeling lighter and more positive, continue talking to your Friend as much as possible. Please do not be discouraged if the moment of feeling lighter and more at peace was only fleeting, lasting only a few minutes or a few days. If you keep up your constant conversation with your Friend, you will eventually have

another episode of feeling a little lighter and less paused. It might be a few hours after the first episode. More likely, it will be a few weeks. Once again, take note what you were thinking and doing just before you felt a bit lighter. After you've figured out what types of thoughts or actions precede your moments of feeling lighter and more relaxed, repeat those thoughts and actions now and then. How often should you intentionally repeat those pause-reducing thoughts and actions? Ask your Friend. Most likely, your Friend will suggest that you practice those thoughts at least once a day. Maybe once an hour. Or maybe "all the time." I have no idea what your Friend might say. Your Friend knows what will be best for *you*.

Again, in response to your question, "Am I ready to start getting rid of the pause habit?" your Friend might say yes, he might say no. Your Friend knows that you do *not* want to get rid of the brain behaviors that activate pause mode *until* you have a vigorous, non-pause pattern in your mind that can take its place.

Don't be impatient with your Friend. If your Friend thinks you are not ready, you are not ready. Stop trying to be in control. Stop trying to call all the shots. Needing to be in control or trying to force some "mind over matter" change is classic self-induced pause behavior.

Once your Friend says that you are ready to start destroying the brain habit of using pause and replace it with your new habit of not using pause, you can start doing the following technique.

Technique for destroying a wrong habit

Relax in a quiet spot, sitting or lying down.

- 1) *Define* the brain habit that you are going to get rid of.

You might define the habit by saying to yourself: "I have a habit of using pause mode." Or "I have a habit of making myself numb," or "I have a habit of not feeling safe, and using pause to protect myself."

By clearly defining in advance of doing the technique the habit that you want to destroy, you will be able to simply use the words "get rid of The Habit" during the technique. You will instruct your brain, over and over, to get rid of "The Habit." If you have already defined the habit that you want to get rid of, you can simply say "The Habit" each time, instead of going into a long verbal description every time about what it is you are trying to get rid of.

- 2) Choose a short affirmation that confirms that you are part of something larger than yourself. Examples of this type of affirmation are "(Universal) Love and I are one."; "I am part of the loving universe."; "My Divine Mother and I are one."; "I am one with the Force," "I am one with the Tao."; "I am one with the Great Spirit."; "My spiritual teacher/ guru/ prophet and I are one…" or "…are connected." Jesus famously used the mantra, "I and my Father are one." In Sanskrit, one might say "Hong sau," (I am That.)

- 3) Close your eyes. Gently lift your eyes as if they are gazing at the third eye. Do not strain the eye muscles: the eye-lift can be very gentle.

- 4. Start *silently* saying your short affirmation over and over. Really think about the words you are saying. Again, your affirmation is one that confirms that your self, or your "soul" if you wish, is connected to some aspect of Universal Love or the Universal Soul.

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. Notice how your heart area feels. If you are using pause mode, you might not *easily* be able to notice how your heart area feels, and might even wonder what I mean by these words. Still, try to notice if you are feeling any sense of relaxation or enlargement in the chest. And keep saying your short affirmation.

Calm

After you've said this affirmation for at least thirty seconds, or even five to ten 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.

Peace

At some point, a few seconds or five to ten minutes later, you will start feeling peaceful. Peace is a more dynamic feeling than mere calm. Peace allows the heart area to feel as if it is expanding, or even able to project its somatic (physical, in the body) *feelings* outward, into the universe. It's good that you are feeling peaceful, but that not's good enough. Be pleased that you are feeling peaceful, but continue saying your affirmation.

Joy

At some point, twenty seconds to twenty minutes later, never letting the intensity of your mental affirmation waver, you will start feeling joy and a definite sense of relaxation and expansion in the heart area. Joy is expansive, radiant and, well, joyful. You will know when you are feeling joy. Joy is *powerful*, even more powerful than peace. When you truly acknowledge that you are one with the Infinite, then you have access to an infinite amount of power. Feel how powerful and joyful you are as you continue to affirm that you are one with some universal aspect of love

Note: if you are stuck on pause, you might *not* be able to fully experience a feeling of joy because your use of pause mode is trying to make you *avoid* feeling the sensations in the heart area. Then again, if you started this exercise by feeling a connection to your Friend, *probably* you will be able to, even if you are *usually* using the pause habit. You might need twenty minutes of the affirmation instead of five, depending on how long its been since you've felt real 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. Have your loving, joyful self speak silently from the heart, sweetly and compassionately giving this command to your brain: "Destroy the brain cells of this wrong Habit."

Give this instruction lovingly, as you would instruct a little child who has made a mistake in judgment through no fault of his own. When you see a young child about to

play with a skunk or pick up a sharp knife, you will use your steadiest, most loving voice, so as not to upset the child, *but* your voice will also be powerful and adamant: the child does not have the option of saying no in reply. That's the same kind of voice your heart can direct towards your brain: loving, confident, and absolutely firm.

Gently, lovingly, and imbuing your silent heart-voice with all the joy-filled power of your soul, give this instruction to the brain over and over. "Destroy the brain cells of this wrong habit."

Pause, feel the joy in your heart, and then, imagining that the words are coming from your heart and are joyfully directed at your brain, again send the message to your brain: "Destroy the brain cells of this wrong habit."

You can do this for about ten minutes, or until you feel something shift inside your brain, or in your body. You might feel strange sensations in your head, as if one or more areas in the brain are becoming warm. If so, mentally focus on those areas and continue having your heart issue its loving command to that area. Don't worry about the heat. The heat will soon dissipate.

If you feel that you might benefit from doing this technique every day for several days, or once a week, go ahead and do so. If you are unsure of yourself and don't know if you're doing it too much or not enough, *ask your Friend*.

For that matter, you can ask your friend to join with you in commanding the brain to destroy the brain cells of this wrong habit. The brain *must* obey the heart's instruction. That's a biological law. When you are *certain* that you no longer want the pause-supporting cellular behaviors and your heart tells the brain to destroy them, they will be destroyed. They might be destroyed all at once, or a few at a time, with each repetition of the technique.

The source of this technique

This technique is presented in a book on Eastern meditative science and yoga theory. The author, Paramahansa Yogananda, suggests that the joyful self use the phrase: "Cauterize the brain cells of this wrong habit." [28]

"Cauterization" is medical burning, with exquisite precision, of cells that must be killed. He also suggests doing this brain-changing technique in the morning, when the mind and will power are freshest.

Kill my own cells?!

Many of my patients have been 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 your neurons were cancerous would you hesitate to destroy them? No. You would cheerfully cauterize any cancerous brain cells.

These few brain cell that you created in order to pretend you were in pause mode need to be destroyed. These cells, like cancer cells, are *not* working in your best interest. You created these behaviors in a moment of emergency or in error. Now, it's time to get

[28] This technique is in a book of short essays on yoga: *The Divine Romance*; Paramahansa Yogananda; published by Self-Realization Fellowship; second edition; 2000; p. 56. In this book, in essay #5, "What is Fate?", sub-heading, "How meditation changes your fate," the author discusses man's ability to make modifications in his brain, modifications that were considered impossible in the 1930s when these essays were written.

rid of them. If you created neurons that are now creating mischief in your brain, it is *reasonable* and *beneficial* to destroy them.

Think of it as cheerfully mopping up after spilling milk. It's *not* a big deal. Don't worry about the loss of a few misguided brain cells. We have billions, and don't even use *most* of the ones we have. Don't worry about running out of brain cells: your brain is always growing *new* cells and making new links. Thanks to the neuroplasticity of the brain, you'll be able to construct any new brain links you need.

Installing a new habit

Immediately after doing the technique to destroy or cauterize brain cells of your wrong habit, install a new habit.

You can refer to your new habit as "the feel-good habit," "the parasympathetic habit," or "the habit of knowing I'm safe." Or make up one of your own names. Remember, you won't begin work on destroying the pause habit until after you've experienced a feeling of being lighter and moving easily several times. However you mentally refer to this "light and easy" feeling, that's the name you can use when you loving command your brain to choose the new habit, from now on.

For example, I wrote about my "ten minutes of heaven" in Chapter seven. "Heaven" was the name I used for this feeling. I could have said to myself, "Use the Heaven feeling from now on, instead of pause." (I didn't actually need to say this, because I had an epiphany-type recovery. My use of pause mode turned off *instantly* during a knock-down drag-out argument session with my invisible but definitely present guru. During my silent rage at him, I poured out all my anger, resentment, self-pity (lots of it), and demanded to know why he hadn't helped me with all the hardships in my life.

He replied that he'd always been right there with me, and that everything horrible that happened to me had happened for a reason. He even said that I had agreed in advance, before I was born, to go through all the unpleasant experiences that resulted in my activation of pause mode. I had agreed to go through those experiences because there were things that I needed to learn. I needed to have these negative experiences so I could shut myself into pause mode, get Parkinson's, and then turn it around when I stopped being so guarded and wary and bitter. When, during that session with my guru, I embraced his constancy and honesty, and his promise that I was safe, I stopped having any interest in being "strong and independent and stoic." And I stopped being on pause. But the main point, from which I have strayed, is that I had a name for my safe mindset. I called it Heaven.

A case study example

The first time I used this habit-destroying, brain cell-killing technique, I was mad at myself because of my years-long habit of falling asleep within a few minutes of sitting down for a meditation session.

After catching myself falling asleep, yet *again*, I performed this technique, which I had just read about. I spent about five minutes silently saying to myself and my Friend, "I and my Father are one." I found myself growing calm. I spent five to ten minutes getting peaceful. I then needed a full ten minutes to build up a sense of joy.

At some point, I realized I was overflowing with joy, so I stopped repeating the affirmation. My joy-filled heart lovingly commanded my brain to destroy "The Habit" (falling asleep when sitting to meditate).

I lovingly, joyfully commanded, over and over, "Cauterize the brain cells of this habit!" I imagined my heart had a little mouth on it, and was speaking upwards towards my brain.

After a few minutes, I 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 few times when I have been over-tired or over-fed. These few times were not sleeping from *habit*. They were due to my fatigue or physical grogginess.

A gift from my Friend

I stumbled upon this technique in a curious way. I was rushing out the door to lead an inspirational service for our small meditation group. I had forgotten to select an uplifting essay to read for the service until it was the very last minute. Running late, I grabbed a back issue of *Self-Realization Magazine* at random from the shelf that held more than twenty years worth of these journals.

For many years leading up to this day, I had been deeply concerned about a problem that many patients of the Parkinson's Treatment Team (1998-2013) were having: they could tell that their brain was stuck in a habit of using pause but they could *not* find a way to stop doing it. The Team members were testing all the current theories on self-change that we could find. *None* of them had been effective. For years the Team members had been seeking answers to this problem. Myself, I prayed daily for inspiration and guidance regarding this problem.

On the evening in question, when I got to the point in the inspirational service where I do a short reading, I opened the journal at random and started reading out loud. The passage I was sharing was excerpted from the book *The Divine Romance*, cited on page 170. It contained the instructions that I have written up here for destroying a habit. As I realized what I was reading, literally an answer to prayer, waves of gratitude washed over me. I burst into tears.

More than one session might be needed

The case I presented above, in which a habit of falling asleep during meditation was completely gone after one powerful session of self-instruction to "destroy the brain cells" of the wrong habit, is an example of a fairly simple habit change.

Possibly, if you have already been working on creating new brain habits by spending time with and communicating with your Friend to the point where you've had a long, extended periods of feeling strangely light or relaxed, then doing this technique even once might allow the new brain routes to become dominant.

However, a *long-term* habit or self-instruction *might* need to undergo this technique every morning for weeks, or even longer, for as long as necessary, until the habit is completely gone. Also, after a few sessions, you might want to redefine your habit, making the definition either more specific or more general. Fine. Change it up as often as you like. You, working closely with your Friend, get to be in charge of how your re-shape your brain pathways.

What is this type of technique called?

You can refer to this type of self-healing and bad-habit removal as medical qi gong, if you favor the Chinese terminology.

Or you can refer to it as a yogic technique, if you prefer the Vedic approach. The word yoga means union, usually in reference to union of the soul with God. Yoga can also mean union of the soul with the mind – which is what you are doing when your joyful heart commands your brain to change. In the case of physical (hatha) yoga exercises, the point is *feeling* the conscious union of the mind and soul with the body's physical energy and movements.

The Jesuits, an education- and introspection-oriented monastic order within the Catholic church, also recognize this type of almost instantaneous brain-change experience in response to conscious reflection and the feeling that one is in a safe relationship with something larger than oneself. They have named this seemingly spontaneous brain alteration a "conversion experience." A conversion experience is considered to be a not uncommon event. It can occur when a person powerfully turns his mind towards the greater perspective – that of a higher power with whom he can have a personal relationship. By allowing this larger perspective to lovingly alter or destroy old habits, a person can find himself "changed" almost instantly.

Whatever you call this technique, it's basically just a way to consciously bring some bad habit or fear-based mental behavior under the control of your peaceful, heart-resonant consciousness or superconsciousness, and get rid of it at the source.

The technique described in this chapter is also described in my book on *Yin Tui Na*, in the chapter on treating self-induced dissociation. Anytime a person instructs his own mind to behave in an irregular manner, including avoidance or denial behaviors, and forgets to rescind the instruction when the need is over, he can use this technique to destroy the brain cells that he created in order to activate and/or sustain the habit of avoidance or denial.

It doesn't really matter what you call this technique. The main things to remember are: 1) You can use your heart to quickly change your brain habits. 2) No one else can do it for you.

As an aside, many people have asked me if hypnosis would work to destroy the brain cells in the same way. No. A hypnosis-induced suggestion is essentially another type of Blocker, possibly preventing you from having access to your own thoughts. Most modern types of hypnosis invoke the subconscious mind to help you look around in your head. It is more effective and uplifting to use your heart. Of course, some people who do hypnosis instruct a client to use the heart as the "guide." There are so many variations on "hypnosis" these days. I haven't seen any Parkinson's patients who have had success using hypnosis to turn off the habitual use of pause mode. Besides, I always prefer the simplest possible treatment for a problem.

Turning off pause

How you phrase your definition of the habit you want to get rid of doesn't really matter. Your heart and your brain both know what you are trying to get rid of, even if you have a hard time articulating it. For example, you might choose to define your habit as anything that's *associated* with using pause. OR you might want to address the habit of *triggering* pause. Or you might want to destroy the habit of using pause to deal with fear

or anger. You can use any phrasing you want, and after you've decided what you are getting rid of, you can go forward with just saying "The Habit" when you tell your brain to destroy the brain cells of The Habit.

Or you might have some completely different ideas about how you want to phrase the habit you want to get rid of. Please do not obsess over what words to use. Your brain already knows what you are thinking, even if you aren't sure of the syntax.

You can ask your Friend what wording would be best. If your Friend doesn't answer, or rolls his eyes at the fuss you making over this, then it doesn't matter. Again, you can also assume that your brain *knows what you are wanting to get rid of*, so it doesn't really matter *exactly* which words you use. You can even say to the brain "You know what I'm talking about: everything associated with the habit of using pause mode" or "everything associated with Parkinson's disease," or whatever habit you are wanting to get rid of.

Please don't command yourself to destroy all the brain cells associated with the legitimate, life-saving use of pause mode. Be sure that you are commanding your brain to destroy the cells of your *habit* of using pause mode. This is a habit that, like the use of cigarettes or opioids or methamphetamine, helps you temporarily avoid pain. Like those habits, using pause mode to avoid pain is addictive: a nasty, addictive habit. The habitual usage of pause as a way to deal with pain or discomfort is a bad habit, and it can take over your life. However, the use of biological pause mode during a life-threatening circumstance is healthy. You might want to clarify this when you first define your "habit," before you even start doing the exercise. Or you might not need to. Your brain actually knows what it's doing, and it knows what you want to stop doing. It also remembers that you have told it to use pause mode, in the past. So be clear with your own mind: you did start this habit, you are now wanting to get rid of the habit. The heart will lovingly command the brain to destroy the brain cells that were created in order to support this habit.

Another bad habit: the inability to talk to a Friend

Being able to talk to a Friend is enormously helpful for activating the brain's striatum – the master switch for positive mood and uninhibited motor function. But some people who are habitually using self-induced pause have decided that they cannot or should not talk to a Friend. Or they can't even think of anyone who could possibly serve as a friend. This is a common side effect of pause-based thinking –and it can become a bad habit.

If you have cultivated this incorrect habit, please know that every time you have the thought, "I cannot establish a relationship with an invisible friend," you are making the habit stronger, increasing your brain's attachment to this thought. You can use the technique in this chapter for destroying a wrong habit of thinking that you can't talk to a Friend. You can destroy this myth.

Many of my patients have been attached to the notion that they can't talk to an invisible, loving friend. The technique taught in this chapter can destroy that evil fallacy. Before starting out, you might define your Habit as "thinking that I can't talk to someone who isn't tangible" or whatever phrase you want to use. Confirm several times that this is the habit you are referring to. Then, say your repetitive affirmation regarding your connection to something greater than yourself. Repeat it until you feel calm, then peaceful,

and then joyful. Then use your joyful heart to instruct your brain, "Destroy the brain cells of this wrong Habit.'

Doing this type of bad-habit removal, what I think of as mental house cleaning, is a rewarding job. You can do it throughout your life.

Case study #7

One patient struggled with the very idea of talking with a Friend for over three years. His Parkinson's symptoms kept worsening. He had people in his life who he'd loved deeply who had passed on: parents, a sibling, friends. But he simply could not imagine himself talking to them for more than a few seconds before the conversation would peter out and he would be overwhelmed by thoughts that talking to an invisible anyone was stupid, not real, immature, and bad.

After three years of trying, unsuccessfully, to talk to someone, anyone, I encouraged him to do the exercise in this chapter. He defined his "wrong habit" as his inability to talk to someone "who wasn't really there." He didn't think he could do it on his own so I walked him through it.

The next time I met with him, we didn't discuss this subject, right away. Instead, we talked about some symptoms that were getting worse. I asked him to imagine someone was there in the room with us, and to silently ask that person if he was still at risk of imminent death, and then tell me what his Friend had said.

He closed his eyes to talk with his Friend. Within seconds, the patient told me no, his Friend said he wasn't at risk of imminent death.

I then asked him to ask his Friend a few more questions, such as whether or not the car accident was related to his symptoms, if the facial surgery from the tooth infections were related to his symptoms, or if his hip injury was at the root of his symptoms.

He quickly, effortlessly, told me his Friend's replies.

I was secretly excited by his sudden ability to talk to someone and get answers. I was also aware that my patient didn't seem to notice that he was suddenly conversant, *easily* conversant, with an invisible Friend, so I didn't mention it, yet. I just kept asking him questions to ask of his Friend, some of them completely unnecessary, because I wanted him to keep the relationship with the Friend going for as long as he could.

After about half an hour, I asked my patient, "Do you realize that you are talking with and getting answers from a Friend?"

He fired back an immediate response: "No. I can't do that."

I pointed out that he'd been getting answers for the last half hour to all sorts of questions from some invisible source. He thought about this for nearly a full minute.

He slowly replied, "You're right. It's easy. It's automatic. I just think the question, and then I get an answer. It's like there's someone right here, talking with me."

I didn't ask him who his Friend was, or anything about his Friend. It didn't matter. The main point here is, after having done the exercise in this chapter for destroying the habit of *thinking* he couldn't talk to a Friend and get answers, he was now talking to a Friend and getting answers.

After that he was finally able to work on getting rid of using pause mode, starting with the technique of constantly talking to a Friend.

How often should I destroy the brain cells that activate the pause habit?

Some people need to destroy the cells of the old habit and install the new habit only once. They will immediately feel a *lasting* sense of increased lightness and a lasting shift towards more positive thoughts. Their symptoms of Parkinson's might start to diminish, although recovery symptoms are almost never a straight line. Still, there might be a sense that the pause habit is turned off, and what's happening after that is recovery.

Some people feel only slightly altered by doing this exercise. They find that it's helpful to do it every morning until they are completely recovered. If you find you need to do it more than once, please do not obsess about it. Every morning, just do the exercises of destroying the brain cells of the habit of using pause and commanding your brain to use the pathways that allow you to feel lighter and more positive, and then get on with your day – while constantly talking with your Friend.

Destroying the reason for the thoughts behind a problematic brain habit

If the situation(s) that caused the person to create the pause habit has not yet been addressed, the thoughts that arose during that situation might have to be addressed. For example, if a person is still nursing a grudge from a cruel situation that occurred forty years earlier, that grudge might keep re-creating the habit of using pause no matter how many times he destroys it.

Getting rid of the thought behind a wrong habit, and not just the brain cells

Sometimes, even after doing exercises to get rid of the brain cells that *drive* a wrong habit, the *thought* of *needing* to retain the wrong habit remains lodged in the consciousness or subconscious mind: in the causal aspect of a person's make-up, rather than the physical aspect. You can think of it as an electromagnetic signal that has become attached to the electromagnetic "instructions" that drive your life force.

Getting rid of a trouble-making brain cell is like fixing the hardware of your computer. Getting rid of a trouble-making thought is more like fixing your WiFi reception.

The technique for destroying the brain cells of a wrong habit can be altered to address lingering, negative thoughts.

Do the technique in the same way as before, but your heart's instruction is addressed to the brainwaves in the mind, rather than the physical brain cells. Loving command your mind, "Detach from my soul and mind those negative thoughts that are triggering my use of the pause habit" or "…are keeping me stuck on pause."

After issuing this command for a few minutes, you might actually have the sense that something subtle is lifting out of your head. Whether you feel this or not, after a few minutes of issuing this command, say the following to those negative thoughts: "You are not welcome, and you must leave." Say this three times. Finish by saying, "Leave this body, leave this building, and leave this county. Return to Divine Mother (or whoever you feel close to). Immediately engage in a lively talk with your Friend. If you have a favorite short prayer or mantra that always picks you up or helps you feel safe, start saying the prayer or mantra over and over, for at least several minutes, or until you notice that you are feeling safe and loved.

If you have any sense that the negative thought wants to argue or engage with you because it prefers to stay attached to you instead of leaving, keep in mind these three points: no negotiations, no explanations, no accusations. You have decided that you are no

longer interested in having *any* relationship with the negative thought that you have been harboring, the thought that leads you into initiating the use of pause. Continue your lively and honest talk with your Friend.

Habitually using pause mode did not start in a vacuum. It started for a reason. If that reason is still there, your brain can re-create the pause habit and reconnect with all the old links, as many times as you get rid of it. Sometimes, you need to destroy the *thoughts* behind the original reasons, as well as destroying the brain cells.

Wanting to know what first caused those negative thoughts

Most of my patients have wanted to "figure out" the reason that they started using self-induced pause or got stuck in biological pause. They do not want to get rid of their negative thoughts until they know what those thoughts are, exactly, or what started them.

Those people who recovered had stopped focusing on the past, and had started working on living in the present. The Friend can help with that.

You might be able to use your Friend to help you discover the underlying reason. You might not. Very often, you can't discover the reason until *after* the pause habit is dead. It is far more important to work on developing a deeply trusting relationship with a Friend than it is to figure out exactly why you created the pause habit. In my own case, I was able to turn off pause through my utter surrender: deciding to trust my Friend's judgment more than I trust my own. I didn't discover the underlying reason I had started using pause mode until nearly two years later, when the memories suddenly appeared in my mind – no longer terrifying, no longer able to make me choose pause mode in order to cope.

If you find that you keep slipping back into pause even though you have made some new, good brain habits, you've destroyed the brain cells that serve as a route for self-induced pause, and you've installed the new habits, then you might want to consider this technique as "exorcising" the thoughts that are still in your mind, those thoughts that triggered your use of pause in the first place. Sometimes, thinking of this technique as an *exorcism,* wherein there is something actively wrong in your mind that is making you behave in a manner against your will can be stimulating: thinking this way might help a person be even more focused and determined to get rid of something to which he's grown attached, but which really needs to be cast out.

Again, you do not need to know what those thoughts are. Just do the techniques in this section in order to separate these thoughts from your mental WiFi broadcasts.

Some illustrative case studies, and why a therapist cannot help you

For a change of subject, many people are convinced that they must work with a therapist in order to do the techniques described in this book.

I no longer meet with people with Parkinson's. I have learned that, so long as I am there to act as a foil for their emotional release, they usually will *not* do the work of talking to a Friend or changing themselves. I've written up everything I know into books. People can follow the suggestions in the books or not. I am no longer willing to be part of the person's venting program – and it never helped them, anyway. Those who recovered did it in response to their own steady work and changes in understanding. Please know, for those of my patients who have recovered, I might have been the witness, but I was never the "curer."

He knew he could only recover via my presence.

One patient was absolutely certain that he could only recover if he met me in person. I was traveling through southern France anyway, so I agreed to visit him in his charming village. His symptoms were fairly severe. He had recently retired from his career as an MD because of his nearly immobilizing symptoms.

When I arrived, he was running up and down the stairs getting things ready for my short stay. His wife drew me aside and said, in cynical tones, "He's been moving perfectly normally, with no symptoms of Parkinson's, for the last three days, in anticipation of your arrival. He hasn't moved like this in years."

I asked him why he was moving so well. He replied that he didn't need to have Parkinson's anymore because I had come to see him. I asked him what was going to happen when I left. He looked alarmed. "I don't know. Maybe you can extend your visit. I think that, if you leave, I will have to have Parkinson's again."

By the end of my three-day visit, his symptoms were returning. He decided that if he had symptoms even when I was present, he couldn't recover after all, and descended quickly into his previous degree of severe immobility.

This is only one of hundreds of cases that helped convince me that my personally working with people with Type I Parkinson's is not helpful. For that matter, it can delay the work that the patient needs to do. I have heard from many other health practitioners who have tried working with people with Type I Parkinson's and they all say the same thing.

The patient described in Chapter three who had an epiphany recovery while screaming to God that she *did* want to live, after all, had been working for years with a brilliant acupuncturist / craniosacral practitioner in Germany. She had not made progress despite her years of weekly sessions. It was only on the day that she started having a terrifying new symptom of severe headache and was home alone, as *everyone* had left the house for the day, that she became desperate. She started talking to God passionately and honestly – and experienced an epiphany recovery.

I cannot emphasize enough that people with Type I Parkinson's disease do NOT benefit from working with a therapist. When these people first induced pause mode, they created a secret, private situation with their own minds. The only thing that will conquer that secret mindset is *personally* developing a good replacement habit, then destroying the bad habit, and finally installing the new habit as the preferred mindset.

No therapist can help you do this. You alone have the authority to exercise this level of control over your own heart and mind.

I had one patient who said he only wanted to recover so that he could shove his mother's face into the fact that her abuse is what caused him to have Parkinson's. He did not want to start working on a relationship with a Friend because that would take too long. His mother was quite elderly and he needed to recover right away so that he could show his mother how horrible she'd been to him: she's caused him to have Parkinson's disease.

When I explained that it might take some time, and that he would make faster progress if he stopped dwelling on his mother's unfairness and abuse and instead started focusing on feeling safe and loved, he exploded at me. He was not interested in feeling safe. He only wanted to recover from his symptoms so that he could make his mother suffer the shame of knowing that her abuse had caused him to have Parkinson's disease.

He wanted me to cure him. He wanted me to do whatever I could to stop his symptoms so that he could shame his mother. He had no interest in changing anything about his thoughts or his attitude. He stopped coming to see me after two sessions because my methods for recovering were going to take too long…and required him to change, which he didn't want to do.

Most of my patients have not been so extreme. But most of them wanted to see me week after week, hoping that talking with me would somehow cure them. I would spend the hour talking with them about needing to learn to feel safe, about talking to a Friend, about everything in this book. And they would feel a bit better. They would feel a bit safer, knowing that I had the key to their recovery. And their symptoms would ease up for an hour or two, or a day or two.

The temporary easing of their symptoms convinced nearly all my patients that meeting with me was the right thing to do. They had fewer symptoms immediately after talking to me, therefore, talking to me was the thing that was going go eventually get rid of the Parkinson's.

In all my years of working with hundreds of people with Parkinson's, only one actually took my advice and started talking with his late grandmother instead of talking to me. He had an epiphany. He was completely recovered from the use of pause mode. He still had to experience the recovery symptoms, but he never again used self-induced pause.

And me being in the room had nothing to do with it. He opened his heart to his grandmother, and realized that he was safe and loved.

St. Teresa of Avila

I have studied the lives of many of the saints, western and eastern, of various faiths. St. Teresa of Avila (1515-1582) was a great Christian mystic and a Doctor (philosophical authority) of the Catholic church. In her early adulthood, she developed symptoms that today, we would call Parkinson's. Her physician said her physical problems were due to "problems of the heart."

Our current understanding of the heart, initiated by Dr. William Harvey, didn't occur until the century after St. Teresa's passing. In St. Teresa's day, "problems of the heart" would be a reference to emotional problems stemming from one of the Four Humors, an ancient Greek theory of medicine that was still used up until Dr. Harvey's discovery of the role of the heart in pumping the blood. The writing up of the symptoms of the "shaking palsy" by James Parkinson in 1817, what we now call Parkinson's disease, was done centuries after Teresa had all those symptoms. But because of her important role in the church, we still have excellent, detailed records of the progression of her symptoms.

The symptoms of Teresa of Avila progressed fairly rapidly. She became so utterly rigid that she could not feed herself, or chew food. She was kept alive by her fellow nuns who dripped sugar water into her mouth. Even in her state of complete rigidity, in a fetal position, she silently continued her required prayers. But over time, her silent prayers shifted away from the rote prayers that she had been taught. Instead, she increasingly found herself in constant communication with what she called "the formless Christ": her invisible Friend. Eventually attaining a state of bliss from her constant communication with her beloved, formless Christ, she unexpectedly found herself completely and permanently recovered.

After her recovery, she was no longer "heavy." People with Parkinson's will know what I mean by feeling "heavy." Instead, her sense of physical lightness was so overwhelming during her raptures, when she lost herself in communication with her beloved Christ, that she often levitated. Her levitations were a source of embarrassment to her. She asked her sisters to hold her down when they occurred.

Following her recovery and subsequent raptures, and an investigation by the Pope as to whether she was bewitched or truly in Divine ecstasy, the head of the church commanded her to write up her methods for communing with Christ. She wrote in her autobiography the following:

"I became whole when each breath silently began to say the name of my Lord.

Two case studies

If you are feeling that you can't compare or compete with a famous saint, consider these email reports from patients I've never met or spoken with. In both cases, they were working only from my written materials. One is from India, the other from the Netherlands. So far as I know, neither of them is a saint. If they are, they haven't mentioned it.

Px #1

Px #1 May 20, 2022: "I no longer have an invisible friend. Just meditation and affirmations."

My reply 5-20-22: "As you have probably heard, countless times, meditation and spiritual techniques are only half the path. Devotion is the other half. Devotion, in the context of your spiritual path, means constant thinking about and talking to some aspect of the Divine until you have a personal relationship. Your rejection of the idea of devotion is why you aren't recovering."

Px #1 5-21-22: "Would it be OK to choose a loving, kind, forgiving merciful God with a sense of humor as my invisible friend? Thanks."

My reply 5-24-22: "What does He look like? People who insist on using God as their friend tend to NOT be successful.

The Divine has given us so many saints, sages, friends and loved ones so that we can have a personalized relationship with his Love.

Some of the world's greatest saints have been able to communicate with the formless Divine, but that's pretty advanced. A majority of my patients with PD have thought that they were very spiritual, or even spiritually advanced, but after recovery, they realized it was false pride. In light of the Eight Steps of Patanjali [one of the most esteemed of India's philosophers. He lived between the 5th and 4th century BC.], most people are at the very first step: they are still learning how to tell the truth and not hide from fear.

May I respectfully suggest that you find some ambassador from the Divine and use that person/ thing as an intermediary between you and the Divine. You'll get better results, you'll have more fun with the person, and in this way better learn that God has a sense of humor, as well as a loving heart."

Px #1 5-23-22: I finally chose my beloved late mother as my invisible friend. Conversing all day. Loving it. Mental state improving. Thank you…"

My reply 5-24-22: "Good work!"

Px #1 6-11-22: "The invisible friend technique works like a charm. It eliminates my tremor instantly and changes my mental state from fearful to relaxed/happy. Am I on the right track?"

The second correspondent initially wrote to tell me he discovered he could now move easily *if* he was dancing.

Px #2

Px #2 March 2, 2022: "I can flip the switch anytime so this state is accessible. The only practical problem is that I can't go dancing around in the bathroom, in bed, while driving, or in a shop. I immediately revert to pause or, to put it better, I'm on pause for 99% of the time. I do feel the difference between deliberate and spontaneous movement and I am sometimes surprised by movements going spontaneously. It looks like these movements occur more frequently. But I am very careful to claim victory : -) It is very helpful for me to have this feeling since it encourages me to continue the healing process. And that it confirms that Parkinson's is a mind game.

"I've gone through some bad times. So bad that I was on the verge of taking medications to seek relief. At that time I spoke to [a person in his online Parkinson's support group]. He encouraged me to start journaling. It makes me feel grateful to look back on the day. Now I am in a state of trust and patience."

Px #2 6-12-22: "It has been three months since my last update report. A lot has happened. And I have great news to share!

I believe I went off pause for a few *hours* on Friday. [Italics mine.] I felt light, not worrisome, moving and acting fluently. It felt like I had no Parkinson's! I could walk very well, get in and out of the car, fuel up the car and walk to the cash register and back, do some shopping and cook a reasonably complicated meal. My entire being was without a second thought, fluent as I have never felt in years. Acting on the urge instead of thinking about the next move.

It was so joyful! I cried happy tears! As if God showed me a sneak preview how far is possible to go! It definitely reinforced my belief in recovery. I am grateful for every little thing that went well, and every little thing that goes well. Gratitude has an important part in my life at the moment. It seems to me that that is the key to recovery so I will keep that up, combined with the exercises, meditation, and a lot of time outdoors.

I just wanted to share the joy with you :-)

To close this chapter, I share this thought: I am often asked how many times a day a person who wants to recover should toss a thought or two in the direction of his invisible Friend, and what should a person say to his Friend. If you are having this question, I suggest that you let your Friend be such a part of your life that, with every breath, you are

aware of your Friend. I suggest that you know, by the presence of your Friend, that you are protected and loved.

Chapter thirteen

More Tips for Talking to a Friend

In my years of working with patients in person, most of them wanted more tips and anecdotes for talking to a Friend. That's the main thing they wanted to hear about. Theoretically, I've already written up everything a person might need to know. But since this seems to be a main topic for people who are struggling to get started talking to a Friend. This chapter shares even more observations on the subject. Please forgive redundancies of theme. I've learned that often, the same idea, with a different phrasing, can help a person suddenly understand.

"I can't decide who to talk to"

Many people using self-induced pause struggle enormously with the unimportant question of who they should talk to. It doesn't matter. 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 who you trust and love, someone who is your friend as well as a protector. It might not be anyone you know by name. And please don't waste time making a search through spiritual books so that you can be sure you are getting the "right" or a "safe" 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 or else he will make problems for himself. But this is merely the wary mind over-thinking the issue. It is also characteristic of an over-active risk-assessment area that a person thinks he should "do it myself" rather than relying on anyone else, ever. But this is fear speaking, not wisdom.

It doesn't matter with whom you start talking. Just get started. If you don't believe me, ask a temporary Friend whether "who" matters or not.

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 or Yoda. The simple, straighforward moral precepts of St. Francis and Yoda are usually acceptable to people of almost any faith, and also for people of little or no faith, so they are reasonable starting Friends. Also, St. Francis is known for his constant talking to Jesus, so he can be a good example, as well. And Yoda is always communicating with people who are far, far away.

But 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. If you really feel the need to be reassured that you are talking to the right person, ask a temporary Friend whether or not the person you've chosen is OK. You might be surprised when something in your heart says yes or makes a helpful suggestion. And if you get no response from your heart at all, still start talking to someone remembered or imaginary who makes you feel good. If necessary, invent a Friend.

Fear of choosing the wrong person, or an evil person

Many people who are stuck on pause have developed such a high degree of wariness that they are afraid they might accidentally choose a person who is secretly evil, a Friend who will hurt them in the long run, or who will even take over their mind. They are terrified of choosing "the wrong person." If you aren't stuck on pause and you think

this is ludicrous, I can assure you that many of my patients have had this concern. Their question is, how can I know that I'm talking to someone who is good, and not someone who is going to manipulate me?

Happily, here is a wonderful law of the universe: when you want to talk to Divine Love, or a loved one whom you trust, or some saint or sage, you just need to establish, from the start, that your intention is to be talking to someone good, and not someone who is affiliated with evil. If you just make that clear from the start, you will be safe from any weird or dangerous thought patterns or influences, or any brain habits that will distort your own thinking.

I'm not going to get metaphysical here. But rest assured, if you are choosing to talk to someone who is good and noble and loving, you *will* be talking to someone good and noble and loving. If you want, you can also affirm to your Friend that you *don't* want to have anything to do with anyone who will lie to you or harm you or use you in anyway. Just to put your mind at rest.

Keep in mind that much of your concern around "who to choose for a Friend" is being created by your own hyper-developed wariness, or even your blocker personality, if any.

If you do hear unexpected voices that don't seem right, you can simply say to them, "Not now," and continue talking to your Friend.

Having the blocker unexpectedly take voice, or in the case of several patients, literally holding up little, visible warning signs in the imagined brain or heart, can be terrifying. Many patients in partial recovery have told me things like, "There's a devil in my head telling me not to do this!" (Not to talk to his Friend or to someone loving.) This self-created "devil" *cannot* control you or influence you if you keep your focus on your Friend instead of on your fears. Tell the negative voice, "Not now" and resume talking to Your Friend. Drown out the nagging voice with increased focus on Your Friend.[29]

Talking "outside" yourself

Talking to *anything* outside of yourself is also helpful at creating a new, anti-monologue habit. You can talk, silently or out loud, to passing birds, flowers, the sky.

[29] The mental pathologies such as schizophrenia, in which people "hear a voice or voices" inside their head and *imagine* they are being talked to by an uninvited God follow a very different pattern from the brain pathologies that are present in people with self-induced pause.

Please don't be worried about "hearing false voices" or how to know if you're talking to a Friend or something evil, if your belief system leans in that direction. Besides, if you haven't talked to a Friend in a long time, you probably won't be *hearing* the replying voice of the Friend anytime soon. If you've been indulging in a self-absorbed monologue for decades, rest assured, your Friend probably isn't going to start blathering at you, right away. If you are just now starting to talk to a Friend, it will probably be a one-way street for quite a while.

The blocker, on the other hand, might be eloquent. You may find yourself needing to yell to your Friend *out loud* in order to drown out your blocker. Fine. Do it. The blocker knows you don't like to make a spectacle of yourself. Defy the blocker. Cry out to God or your trusted Friend to help you, hold you, talk to you. As for the blocker, never give it more than a brusque "Not now." Then resume your conversation with your Friend. As for the blocker, remember: no negotiations, no explanations, no accusations. You simply can't care about or engage with the blocker, or with any thought stream that tells you that you can't or shouldn't talk mentally with someone loving.

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, you can 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, is *not* coming from your wise heart. That self-conscious feeling will diminish eventually. You might not be used to talking like this, if you're using pause mode. But many people do think and talk this way. They are emotionally and mentally healthy and well-balanced.

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 switch over to talking to someone other than self.

Even as you get better at addressing your thoughts to someone/something outside of yourself as much as possible, you can still work on also developing a *continual* conversation with a Friend. 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 and ego."

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, should be recognized as being directed towards Your Friend. Just realizing that your Friend hears your every thought can be helpful.

Yet another aside

Some patients, certain that they shouldn't have to talk to a Friend, have pointed out to me that lots of people are self-centered and not oriented outwardly, don't have an invisible Friend, and yet 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 kick the habit.

If a person is in sympathetic mode, being self-centered might make him a miserable codger, a greedy but seemingly successful businessperson, or just plain "normal." But it won't make him rigid, make parts of his body numb, or prevent healing in his skin and organs or prevent feeling in his heart.

A person using self-induced pause, including most people 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 might have to make a drastic change in his mental habits 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 a Friend, start talking to things outside of himself, and ignore 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 might 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 might *appear* to be engaged in a conversation with someone, but his primary, interior 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 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 what to say and when!"

The best way to stop your nattering, self-damaging internal monologue your constant judgmental attitude towards self and others is to direct your full attention and silent conversation at something or someone who is outside yourself, someone who knows everything you know and more, and who doesn't use *your* thoughts as the measure against which all others are judged.

Not just for recovering from Parkinson's

The technique of having a deceased loved one nearby in order to open the heart is widely used in arenas other than spiritual and Parkinson's recovery. I was listening to a TED talk about teaching people how to listen to classical music: partway through, the lecturer asked everyone in the audience to imagine that a deceased loved one was sitting next to him/her when he played a Chopin étude. The audience reactions to the subsequent music were profound.

It's a beautiful TED talk. It might have you in tears. It's Benjamin Zander's talk, "The transformative power of classical music," TED2008.

https://www.ted.com/talks/benjamin_zander_the_transformative_power_of_classical_music?language=en

Pay attention to your Friend

As you talk to your Friend, *don't* be simultaneously saying to *yourself,* "How am I doing? Am I getting it right? How long will I have to do this?" If you *need* to have your behavior assessed, ask *your Friend* how you're doing. Don't ask yourself. You clearly don't know. Maybe wait for an answer for a moment or two. Even if you don't get one, you will have been actually paying attention to someone outside yourself.

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 your full attention.

Informality

Many people assume that "talking to your Friend" should be done as repetitive prayers, or should be formal. Nope. Talking to your Friend can be as casual as talking to a best friend. Here's an example from a scene in the play *You Can't Take It With You*:[30]

Grandpa sits down to the family dinner and starts the prayer before food: "Well, God, here we are again…" Just picture that.

Grandpa is demonstrating the intimate, easy-going, comfortable conversation you can have with God, or your Divine Friend, your totem animal, or with The Force. The playwrights who gave Grandpa these lines did so because these words instantly establish Grandpa as someone who is at peace with his own heart: someone who feels safe, someone who talks to a Friend.

How long will I have to "talk to God"?

Below are two case studies that show a range of time frames.

Case study #1

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 an invisible Friend, or to some saint or sage, was drastically *new* to her, despite her education in Catholic schools. I gave her the suggestions in this chapter for talking to a Friend.

About a month later, she told me, "I'm still trying to direct my inner conversation to someone outside myself. I must be getting better at it because now when I do it, I don't feel as stupid as I did when I started."

By the way, "feeling like an idiot" when first starting to talk to "no one" is a very common initial response. It's part of that constant judgmental behavior that's so insidious.

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 impossible.

[30] *You Can't Take It With You*; Kaufman and Hart; 1936.

"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 towards her perfectly intelligent employees, 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 towards "the idiots at work," I waited a few months before asking her again if she was still working on directing her thoughts towards a Friend, rather than mentally talking to herself. I try not to get too pushy when a person's working on developing a relationship with someone outside of the self. I never ask who or what a person communicating with, although of my patients have volunteered 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…I can *feel* that he's there."

This example shows that the process can be somewhat slow. She needed almost two years before she felt safe enough to start having pause-free moments.

Case study #2

A patient who was stuck on self-induced pause, who had debilitating pains that came and went in response to upcoming, potentially negative situations, did *not* have Parkinson's. I asked her to start talking to an invisible Friend.

A week later she reported, "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 always talking with was God. He was separate from me, but he was also an extension of myself. I talked to Him all the time. He was my *best* friend. This week, trying to do your assignment, 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, for the next seventy years, I only addressed my inner thoughts to myself, until this last week when I started talking to Him again. It's wonderful!"

In case study #1, above, the patient needed nearly two years of steady, constant talking to a Friend before she *felt* the comforting presence of a constant, listening friend. In case study #2, the person felt a return to a long-forgotten relationship in less than a week.

Learning to habitually talk with and trust the universe after shutting it out for decades can take weeks, 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 and told the cabbie to drive him to 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 a *knowable* God. So when it comes to timing, you just never know.

One thing is certain: you can speed things up by getting the conversation going, and keeping it going no matter what.

One with nature

"Feeling one with nature" is a term sometimes used to describe the "connected" 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 a Friend" can be a similar feeling. This *feeling* triggers increased activity in the brain's thalamus, 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 a greater presence, which in turn can lead to even more increased activity in the thalamus. A positive spiral of feeling good, connected, and safe can ensue.

Devotion

At some point, you might want to make the transition from merely talking, to talking with devotion. What is devotion? Leaving the religious connotations aside, devotion means having a *strong, consistent,* relationship, one that engages the heart (actually, the pericardium).

For example, if you are *devoted* to your young children, you are *always* thinking about them. This doesn't "take time" away from your other activities. You just always think of them. And you don't think mechanically, as if you are mentally reciting irregular Greek verbs. You feel something in your heart as you think of them and mentally engage with them.

You might laugh with them, get annoyed with them, discipline them, sing to them, help them, let them help you, and so on. You might be physically close to them or you might be miles away, but they are always in your thoughts *and* thinking of them is associated with an increase in energy in the vicinity of your heart.

This understanding of devotion can be a good starting point for people who have no idea how to feel "devotion" to something as abstract as an invisible Friend. Just think of devotion as a constant, important relationship that engages the pericardium. It doesn't matter if the relationship has emotional ups and downs or there is no *physical* contact.

Devotion does *not* necessarily mean doting, being servile, or giving ecstatic praise. Devotion is constancy in a relationship, together with engagement of the pericardium.

If you are going to work at conversing with a Friend to the point where you feel *safe*, you are going to have to become devotional, meaning having a *constant relationship* with whomever you are talking to. The goal here is to train yourself so that when something happens that unnerves you, you will automatically call out, mentally, to your

Friend, which will automatically stimulate your heart area, rather than using your previous *modus operandi* of shutting *down* the heart and essentially playing dead, physiologically and very often emotionally.

A person with self-induced pause has created in himself an electrical pattern that greatly *decreases* the energy flow to his heart's pericardium and activates reliance on his own risk-assessment and brain analytics. And it's more intense when he's worried or startled. A person who has learned to first call out to a Friendin times of being stressed or startled *increases* his heart connection during these times and reacts with wisdom, not fear.

In order to turn *off* self-induced pause, a person has to relearn how to stay alive, actually feel alive, during times of stress. In order to do this, he will have to learn to increase energy flow to his heart's pericardium and learn to talk to his Friend all the times, *including* during periods of fear or pain. He only needs to do this until he feels safe enough to lastingly turn off the brain habits of pause that he set in place so long ago. After that, he can go back to doing whatever he wants, so long as he doesn't, again, re-command himself to feel no pain.

When a major earthquake hit in Santa Cruz in mid-afternoon in 1989, my friends and I all experienced the same first thought: "Where are my children?" That's devotion.

Your relationship with your Friend can get to this level. You can to develop the habit of talking to your Friend so constantly that when any negative thought arises, you immediately, reflexively, without thinking, automatically say "Friend! Help me!"

Building this type of reflexive relationship requires talking to your Friend *constantly*. Tell him jokes. Share stories with him. Talk to him always. Eventually, when you are scared, angry, or uncertain, your first impulse will be to talk to him, not to yourself.

This will take practice because you are out of the habit. It's completely do-able. It's perfectly natural. It's how most of humanity gets through the day.

The day I personally knew that I had truly recovered from Parkinson's was not the day that my symptoms were gone. About a year after completely recovering from Parkinson's, I was navigating the living room, in the dark, with no lights on, not knowing that someone had moved the ottoman. I tripped over it. As I went flying, my first thought was "Thank you, Guru!" As I picked myself up from the floor, I had no idea what I had thanked him for, but I felt an overwhelming sense of my guru smiling at me, so proud of me. I smiled back. I felt such waves of joy! In response to an unexpected challenge, I had chosen my guru instead of a fear response. I knew I wasn't using my sick, Parkinson's, self-oriented mindset anymore. I knew I was free.

There is a reason that the saints and sages of every faith emphasize the importance of devotion. Devotion means, at its core, having a rock steady *relationship*. And this opens the heart. The great spiritual teachers have all emphasized that devotion is more important than spiritual techniques if you are trying to bring your soul into attunement with its highest capabilities.

Keep talking to your friend. Keep the relationship going.

At some point, you might be able to add an even more powerful technique than simply talking. This would be telling your Friend that you want to *feel* his/her presence. You can tell you friend over and over, as often as you think of and talk to him or her, in

addition to your other thoughts, "I want to *feel* your presence." Imagine that this plea is issuing from your heart.

When a person is devoted to someone, he thinks of him constantly. He mentally directs his thoughts to the object of his devotion. And he wants to be with the loved on, he wants to *feel* his presence.

An example of a devotional 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 awareness that his guru was tangible to him, a strnger connection with the Divine, and an overwhelming sense of joy.

Biologically speaking, you could also say that, by *talking* to his Guru, his striatum was activated, and immediately following that, his thalamus (a *feeling* relationship with God) was activated.

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 using self-induced pause is going to want to develop. He can develop it by constantly talking to a Friend. 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, the Friend, the 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, or even die, the Friend 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 your Friend do *not* need to be spiritual or uplifting. They can express anger, fear, bitterness, and cynicism. You can say to your Friend, "I hate you!" and the Friend 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 your Friend. You don't need to *change* your thinking or develop special thoughts. Just share them. You'll find that, by constant sharing, the nature of your thoughts will begin to change on their own. The way you *feel* can begin to change.

Sulking in silence

Which teenager would you rather have? The one who comes home from school and, while eating the snack you prepared, 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 him in his room and doesn't say a word to you or anyone, and doesn't talk to you aside from perfunctory responses, maybe 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 himself in slow motion.

It is far healthier to get a relationship with a Friend going, even if it's an angry relationship, than it is to hold your breath until you pass out, which is essentially what a person is doing when he decides to be numb to pain and fear by pretending he's not alive.[31]

---

[31] 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 an Internet chat group for people with Parkinson's who had "bad mothers." A patient told me how the members tried to outdo each other with stories of maternal cruelty. None of them wasted words on how their own mental attitudes might be contributing to staying stuck in Parkinson's. These people were thrilled to have a website for sharing, and besting, each other's tales of abuse. No one in the group wrote about what they were doing to move on from their past traumas. I was invited to join, but refrained.

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," justifications for why the person now has Parkinson's: the drunken parent; pervert uncle; overly rigid religious expectations, abuse, criminal abuse, genuine horror stories. But the writer is mistaken: I am not fascinated. Please don't send me these heart-wrenching accounts. I have heard these stories from hundreds of my patients and countless correspondents. They seem to *love* dwelling on this subject. Very often, these stories are sent to me to show why the writer will *not* be able to recover or why recovery, in their own special case, will take a very, very long time or might not be possible. These people are not helping themselves, which always makes me sad. They are certainly not assisting 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 de-activated memories, they might have a hard time feeling safe.

Curiously, norepinephrine is thought to play a role in long-term memory. I have to wonder if excessive use of norepinephrine (needed for motor fuction while on pause) might contribute to the difficulty that people who are stuck on pause seem to have in letting go of the past, or at least putting the past in a healthy perspective.

Please do *not* send me essays long or short justifying why you have Parkinson's. If you recover, then sure, you can write to me about the ugly past from a place of wise reflection. I would love to hear about that.

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: honoring the lessons of the past, living in the present, advising for the future.

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. A person must make his own good habits by doing them. If bad habits are very entrenched they can be destroyed by techniques such as "destroying brain cells of wrong habits," as described in a previous chapter. But it's just as important to make new good mental habits as it is to destroy old, bad ones, so that you have something to replace the bad habit with.

Increasing electrical flow to the pericardium: lips on the heart

A simple technique for increasing electrical flow to the heart's pericardium while talking to a Friend requires a bit of visual imagination. This might be difficult for a person who is stuck on self-induced pause, because pause can inhibit a person's ability to visualize positive things.

Still, if you can do *any* visualization, this suggestion might be very helpful, and might accelerate your ability to start feeling safe. You might be surprised at your ability to do this particular visualization: it might be far easier to do than visualizations in general.

Imagine that your heart has a mouth on it. Actual lips. When you are talking to your Friend, imagine that these lips are forming the words. Your words come out of your heart, not the left side of your brain.

When you image that the mouth on your heart is forming the words that you say to others or to your Friend, you will be increasing the electrical flow in your pericardium. Within a very short time, maybe even a week or two, you will start to notice that you *feel* different while you are "speaking from the heart." The strange sensation you are noticing is related to the feeling of being safe.

Driving down the freeway

Once, as an experiment, while driving the car on a busy freeway, I practiced saying a simple phrase, "Oh, Divine Mother." I alternated between imagining that the phrase was coming from a mouth on my heart *or* from the left side of my brain.

I was driving the car on a busy highway, a mentally vigorous and physical activity, because I wanted to be prove to myself that my lips-on-the-heart technique wasn't all-consuming, or something that "took up precious time."

The mental talking was strictly background thoughts that I could perform while doing my "outer work" of driving. By the way, patients frequently complain to me that they don't have time to talk to a Friend, or they don't have time to imagine a mouth on their heart. In my own case, my Friend is always with me. When I'm driving alone, he's sitting in the passenger seat. If there's someone sitting in the passenger seat, my Friend is perfectly happy to sit in the back.

We all think background thoughts while driving. I decided to consciously "place" my thoughts at my heart, and alternate that with directing my thoughts using my mind.

I had practiced the mouth-on-the-heart technique before, so it wasn't too difficult. While going back and forth between generating words from the heart and then from the brain, about two minutes at a time each, I noticed something: when I did the words from the heart, I could feel a subtle shift in neurotransmitter behavior.

When speaking from the heart, I noticed a distinct decrease in muscle tension, an increase in stomach relaxation, and the feeling of safety: indications that I was using a higher degree of parasympathetic mode. When I went back to using the brain as a source of my words, these relaxations ceased. As I kept alternating, I became increasingly aware of the immediate, physiological shifts that accompanied speaking from the heart or not.

I suspect that I usually, without thinking, slip into an unnecessary level of sympathetic mode while driving in the horrible bay-area freeway traffic. But I had to admit, my driving felt more alert and more pleasant when I was in parasympathetic mode: talking from my heart. Surprisingly, I felt as if my reflexes were faster when I kept my heart engaged.

There is a biological benefit from speaking from the heart. If you don't normally do this, or you are not familiar with the sensation, start by imagining a mouth on your heart forming your words. You can do this while talking with anyone – not just your Friend.

Please do not imagine that this technique is "silly." If you don't usually talk from the heart, a very natural and human behavior, you need to learn to do so, and this is the easiest, fastest technique I have ever come across for learning how to do this. Eventually, you will not need to do the imagery. You will become familiar with the sensation of increased energy in the pericardium. Then, when talking to your Friend, or anyone, if you notice you are becoming mechanical in your speech, you will be able to imagine the words coming from lips on your heart or simply direct your energy to the chest to re-create this sensation of increased pericardial energy and power. Your words to your Friend will will resume their devotional quality.

Brother Lawrence

Possibly some of the most straightforward, early western writing on the subject of talking to Divine Love 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 safe again. [32]

[32] 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 important, you are reading catholic doctrine, and not Br. Lawrence.

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 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. For English readers who would like to read his *Spiritual Maxims: Practicing the Presence of God*, I translated his very short book into English and included it as an appendix at the back of this book.

Another *great* resource for learning how to talk to God is a DVD recording of a lecture given by Brother (Swami) Bhaktananada. 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. I learned the technique of imagining a mouth, with lips, on the heart, from this talk.

Swami Bhaktananda includes this technique as a helpful part 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, like many American English speakers, you choke on the word "Master", remember that this word is the English language equivalent of socially acceptable words like Maestro or Maître.

When Br. Bhaktananda speaks about "the lessons," this is in reference to very low cost 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 and on meditation 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 or his representatives – most often, my guru or Divine Mother. Admittedly, I talked with resentment, flippancy, and sometimes bitterness, until I was diagnosed with Parkinson's. Then, my habit of constantly talking to God and his reps paid off. I knew to whom I must 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 life with my guru, who had passed away the year I was born, I was finally able to piece together, from my life experiences, proof that he knew best, that he'd always loved me, and that the "unfairness" of events in my life had in fact been fair, though I couldn't always know how or why. *He* knew what was going on. *I* didn't. I didn't know anything. I needed to rely on him, not on me, for the big picture, as well as the details of my life.

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.

Again, for those of you who skipped the previous footnote, a translation of Br. Lawrence's book is provided as an appendix at the back of this book.

More thoughts about talking to your Friend

Decide that your Friend is always present and able to hear you. That he/she/it is capable of loving you and *laughing* with you: joyful love, not severe or judgmental love; capable of being loved by you; 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.

While talking to your Friend, you can imagine that the words are coming out of a mouth, or lips, located on your actual, physical heart.[33]

Be patient

Just talking to a Friend or to things outside of yourself such as the sun, a passing bird, or a cloud will *not* necessarily bring about a feeling of safety right away. It *will* start modifying brain behavior so that the feeling of safety will come about more easily.

In retrospect, I had been blessed by my decades of yogic training that included practicing the presence of God, even though, at the time I only did it because 1) I'd been told to and 2) doing this allowed me to pride myself on doing a "spiritually superior practice."

[33] I did not plan on including "lips on the heart" in this book. Although I had personally used this technique and benefited by it, I felt it was too silly or "unprofessional" to include in a book. It is actually a form of medical Qi Gong, energy control. But I feared that my readers would dismiss this technique as childish or worse.

During the weeks that I was working on this chapter, I was signed up to lead an inspirational service at church. As usual, I didn't take the time to prepare anything in advance, but instead grabbed an old issue of *Self-Realization Fellowship* magazine as I was running out the door. It was from summer of 2016. As I opened the magazine at the podium to read the main article out loud, I saw that the article was based on a talk by Swami Bhaktananda. In the talk, he describes the mouth/lips on the heart technique. Then, three weeks later, at church, the service leader (who had uncharacteristically missed the service where I'd been the reader) read the same article! As I was leaving after the service, I heard the woman ahead of me say to the reader, "Thanks for that reading. You know, I'm the reader next week, and I was planning to use the same article! It's a good thing I attended today."

This got me thinking. One of the points Bhaktananda made in that talk was, his own guru had three times given group talks to all the monks about practicing the presence of God. Bhaktananda said that it wasn't until the third time the guru brought it up that he realized, "Oh! He actually wants us to *do* it!"

I suddenly had the conviction that I was going to hear this talk read to me over and over until I included it in this chapter. "Oh! My guru wants me to *include* the lips on the heart technique!!" That's when I did the experiment of using this technique while driving, so as to observe in myself the physiological shifts that take place while doing it. There were distinct shifts. I then added this technique to the rest of the "talking to God" work that my patients were doing, and many felt a benefit immediately. So, here it is, in this chapter. Don't wait until you read about this three times. Do it now.

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.

Also, talking to your Friend will not make you feel safe if you are determined to 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 loving safety net of having a loving, constant Friend, or a saint or a late grandparent or Yoda is up to the individual. A person can stand at the edge of the precipice, *resisting*, fighting back against the feeling of safety without jumping, for as many lifetimes as he wants.

There is NO mechanical technique or physical exercise that will shift a person's consciousness into *admitting* that your soul or higher consciousness were *always* safe right along and that maybe there is a loving universal plan that knows what's best, after all. But admitting that your Friend might know what's better for you than you do is a great way to encourage the budding feelings of safety.

Even if you disagree with these ideas, if you just talk to your Friend long enough, you might get a different perspective on things and start feeling safe.

A person who has decided to stay on pause may have spent years or lifetimes sulking and resisting the idea of Universal Love or a Benevolent Universe because some terrible event occurred. At the time, the event(s) seemed to be unfair. Due to the common human inability to conprehend the big picture of the universal design, the person got his back up when he was scared or miserable. Maybe he's still resentful. I know I was. Until I was diagnosed with Parkinson's disease, I dutifully loved God because *I* was determined to be good in spite of 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 right thing by them. At some point in the past, they were "so innocent" or "so good" and yet God didn't protect them. He abandoned them. They "didn't deserve what happened." They are not ready to forgive Him or talk to him. No way, not gonna happen.

They might love other people, and *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, or of prayer. 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. [34]

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.

[34] A popular gag in many spiritual congregations is "If you feel apart from God, guess who moved…"

That brings me to the next subject.

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.

While he might often perceive the underlying fairness of the universe, and even say about a nasty person, "Ha! He got what he deserved!" he might not be able to have the same wise perspective when unpleasant or bad things happen to himself.

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 selective memory 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 have it out with the universe rather than sulk in silence?

Yet 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 "thank you," "Om, Krishna" or "My Lord, my Lord." He might say, "God, you are great!" or "Mother Mary, come to me."

The idea is to get a short, rhythmic phrase 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 that you associate with Love and being connected to Love, 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, can be considered an aspect of "practicing the presence of God."

In one of Br. Bhaktananda's talks, he says, "My Guru said that God does not *have* to respond to words, but He *has* to respond to love. That is His law. …and the heart is the center of feeling and love."

He continued, "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." [35]

Summing up

You can practice talking to a Friend or to things outside yourself, thus developing a new habit that is not a negative, internal monologue.

You can realize that every thought you have is being shared with your Friend.

You can talk to your Friend "in the language of your heart," or while imagining your heart forming the words.

---

[35]"Practicing the Divine Presence"; *Self-Realization Magazine*; Self-Realization Fellowship, Los Angeles, CA, Summer 2016, Vol. 87, #3; p.26

Share *all* your thoughts with your Friend, including the angry and bitter ones, accusations and fears.

You can choose a short, rhythmic phrase (You, you, you!" or "Thank you, thank you.") and play it over and over, constantly, in the background of your mind.

What do you call this kind of therapy?

In Chinese medicine, all of these "Talking to a Friend" techniques are considered forms of Qi Gong: energy control. These are all ways to improve the way you direct the energy flow in your body and brain.

In the world of biology, these techniques can be thought of as ways of stimulating the neuroplasticity of the brain: making changes in the brain's "wiring," making brain changes that automatically occur when thoughts are steadily, intentionally, altered to form a new network of thoughts.

In spiritual communities, these same techniques can be considered helpful steps in learning to feel increased joy, love, or inner peace, *or* to grow closer to God – which some religions consider to be one and the same thing.

Whichever way you choose to regard these techniques, as energetically, biologically, or or spiritually helpful, 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, anger, and risk assessment areas on the left and right sides of the brain.

These practices can override the "on pause" electrical brain habits that make you feel wary. They bypass the "on pause" electrical blockage and *directly* stimulate the part of the brain that makes you feel safe.

The practice of engaging the heart, by imagining that you literally speak from the heart, can augment these practices.

Give these ideas a try.

Appendix I

Dissociation

This appendix gives a brief introduction to some of the ideas and techniques that are shared in the book *Yin Tui Na: Techniques for Treating Traumatic Injury*. This book is available for free download at www.pdRecovery.org. This introductory appendix is included for the reader who is caught up in this book and isn't able to immediately get to the above book.

This appendix is still being edited. It will be posted online when it is finished.

Appendix II

Spiritual Maxims

From the writings of Brother Lawrence

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 is widely known as the monk who created the phrase "practicing the presence of God": having a constant relationship with the invisible Divine.

This English translation of the *Spiritual Maxims of Brother Lawrence: writings and interviews on practicing the presence of God*, was taken from *Frère Laurent de la Résurrection: Ecrits et entretiens sur la pratique de la presence de Dieu*, an edition with an introduction by Conrad De Meester, Carmelite, Les Editions de CERF, 2007.

The following introduction was also translated and greatly shortened from the above:

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, cosmic intuition 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 hometown.

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: The following translation begins with a "chapter one" which, in the more traditional, Catholic-church modified presentations, is considered chapter two. The more commonly printed 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.

Spiritual Maxims

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 on 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].[36] 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 word 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 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

[36] In the 1996 edition of Frere Laurent de la Ressurection; *Ecrits et entretiens sur la Practique 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].

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.

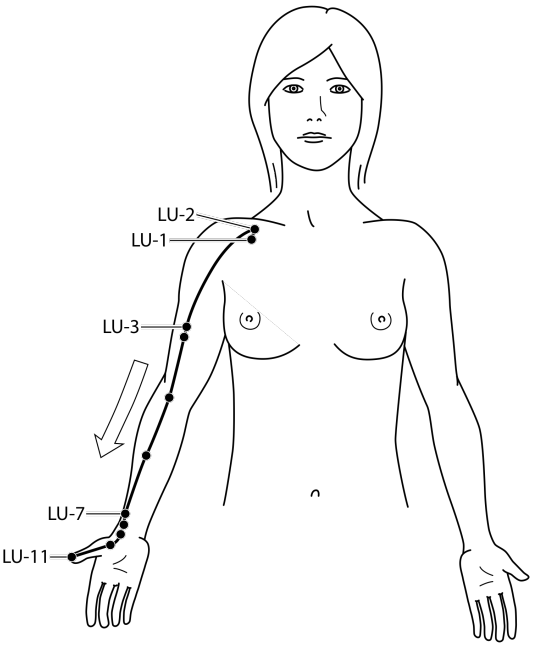
31. By the presence of God, and by this interior awareness of this presence, the soul becomes familiar with God in such a way that it spends nearly all it's time in continual acts of love, worship, contrition, confiding, thanking, offering, asking, and actions of all the most excellent virtues.

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.

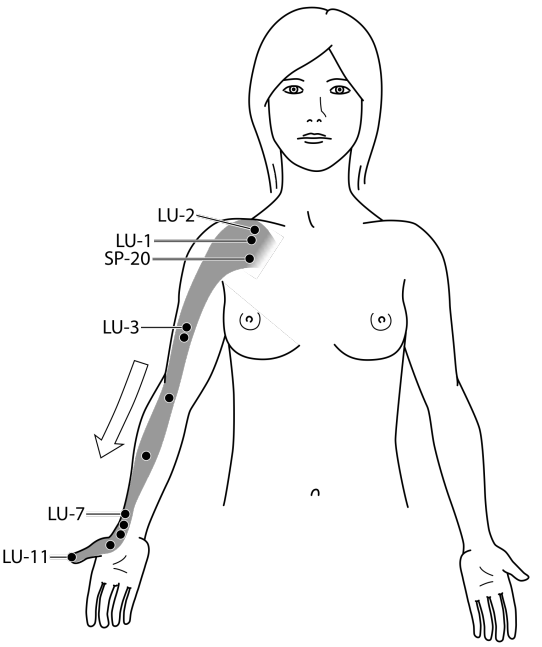
32. I know that one finds few people who attain this degree of the divine presence: the stillness. This degree comes through the grace of God, who favors only certain, chosen souls. Then again, this practice in simple awareness is itself a gift from His generous hand. But I shall say, in order to give 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.

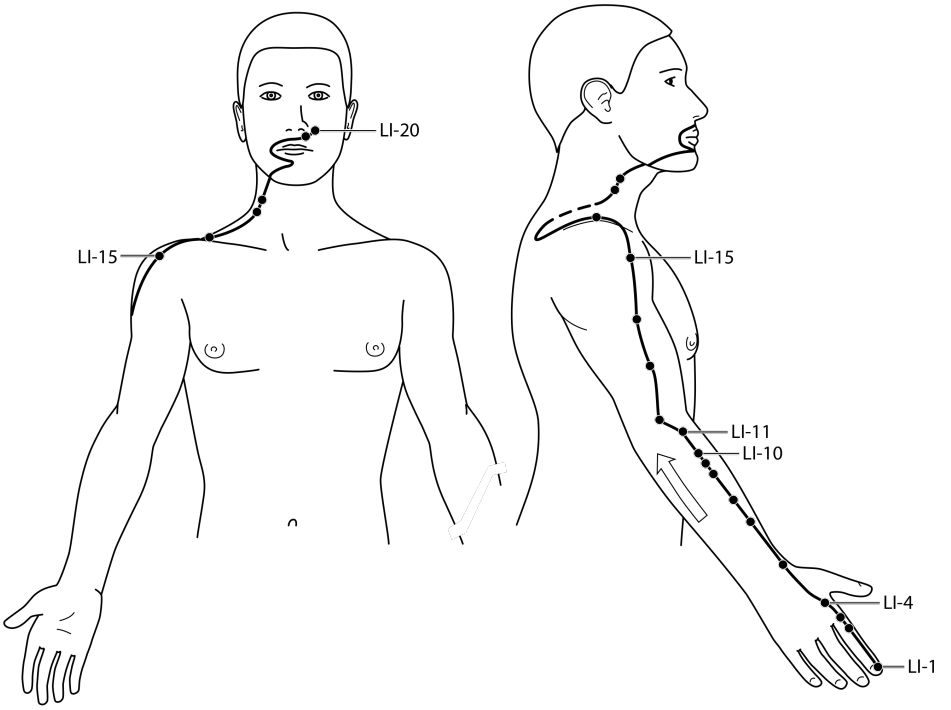
Traditional Lung Channel



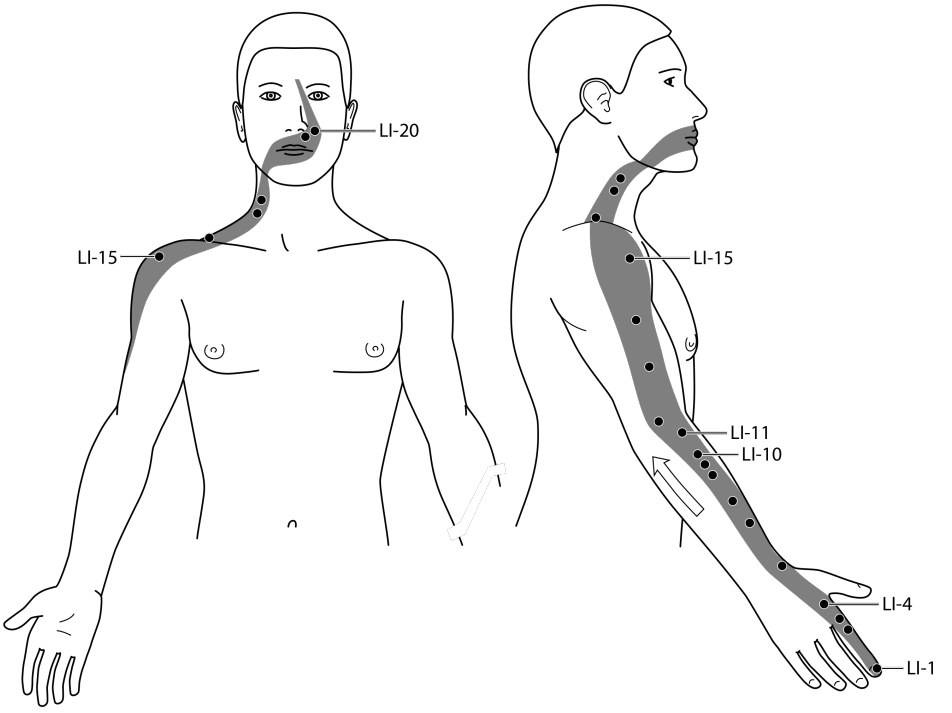
Actual Lung Channel



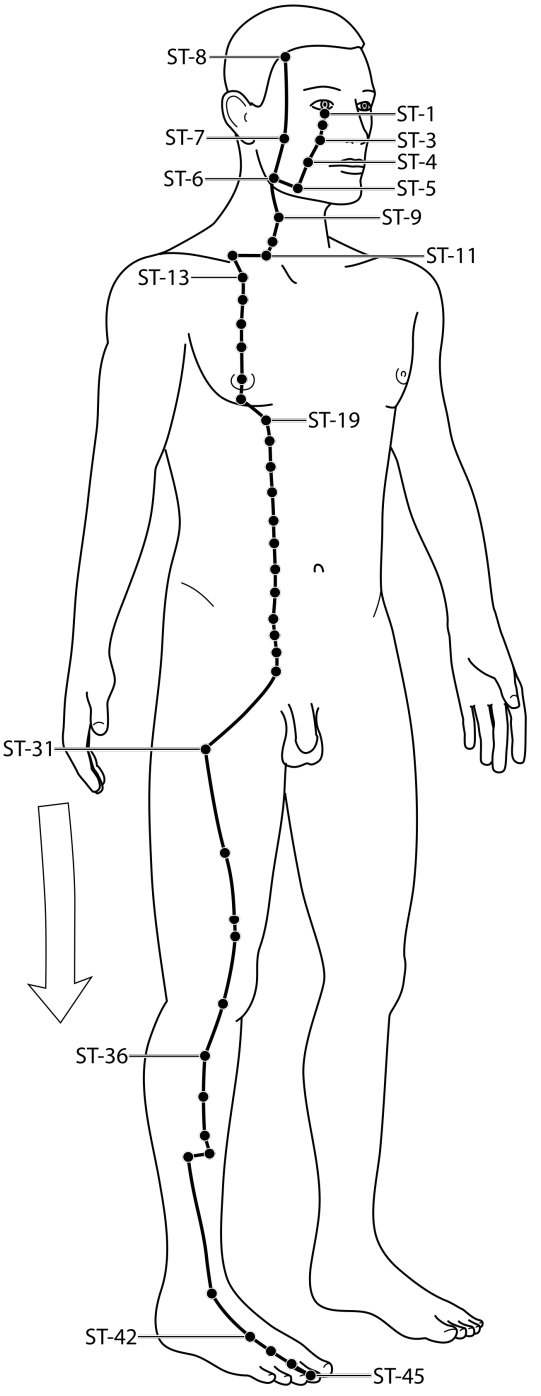
Traditional Large Intestine Channel



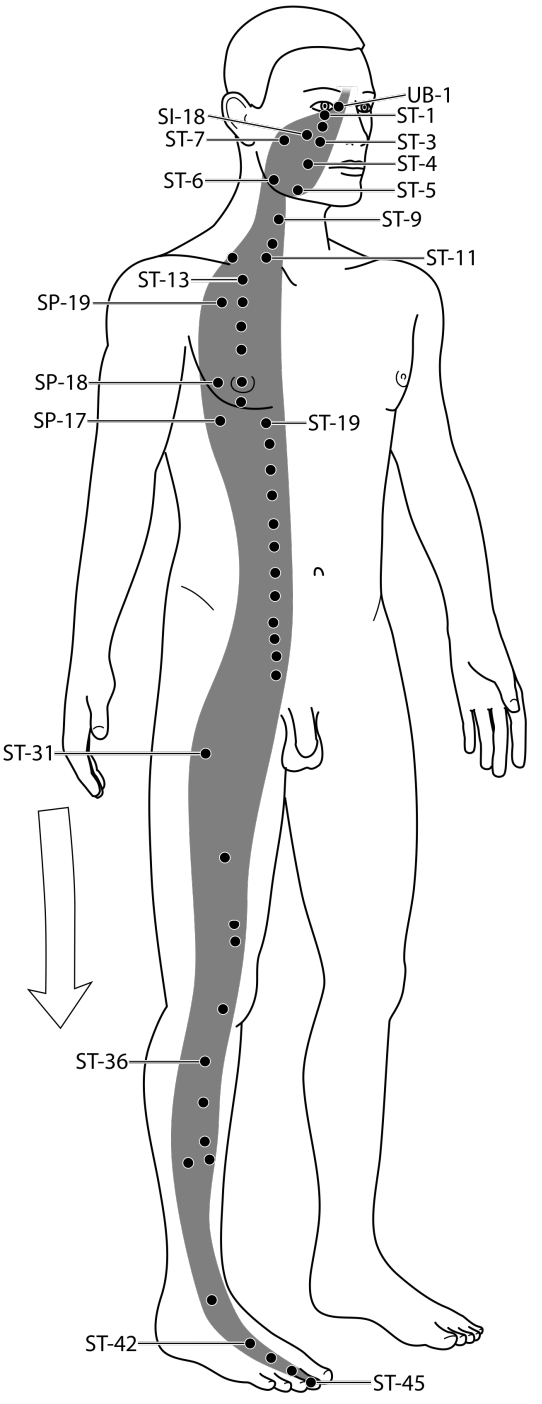
Actual Large Intestine Channel



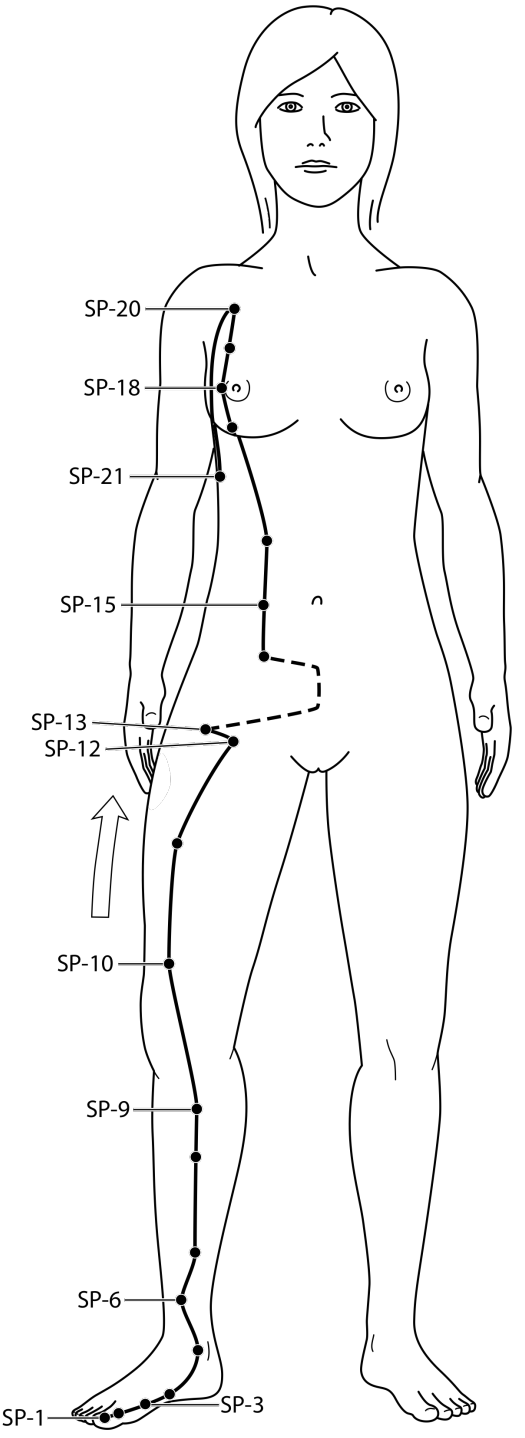
Traditional Stomach Channel



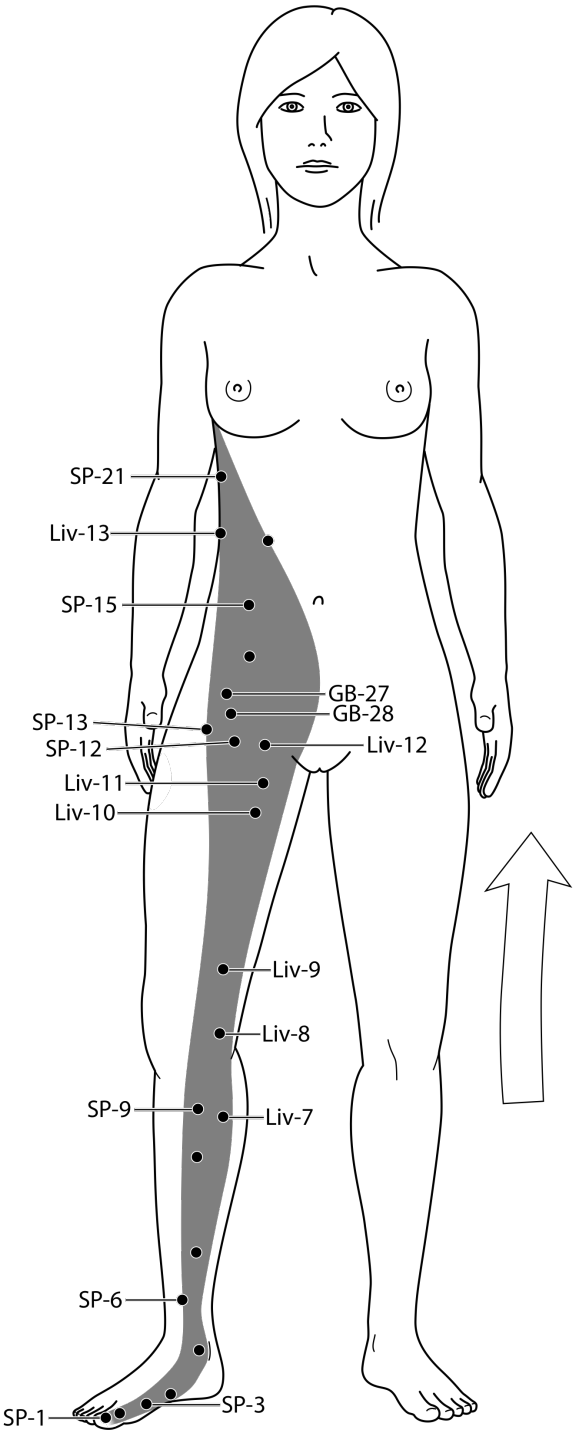
Actual Stomach Channel



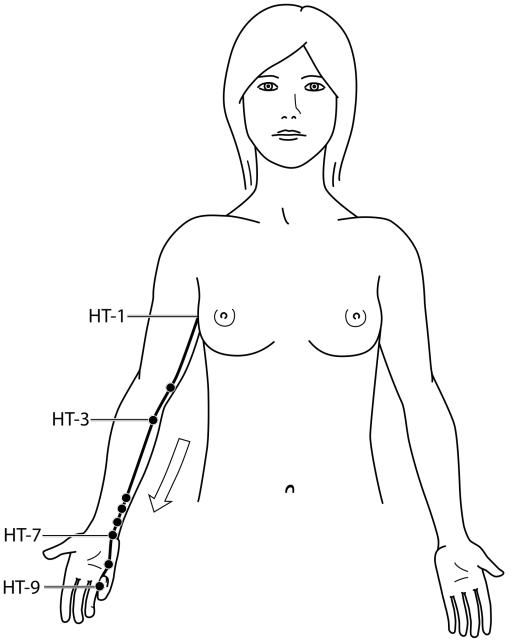
Traditional Spleen Channel



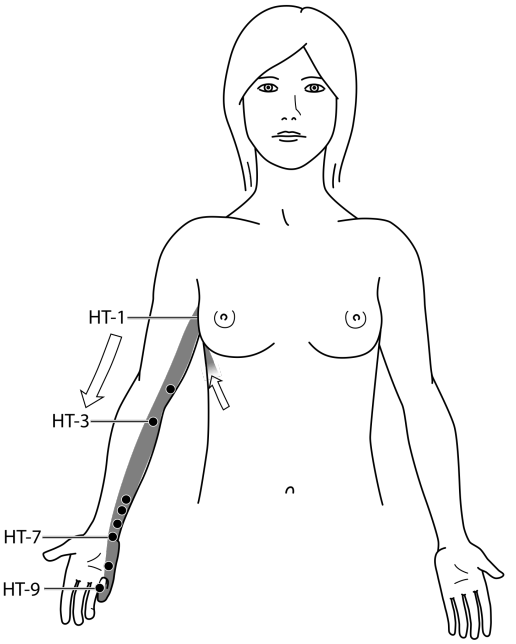
Actual Spleen Channel



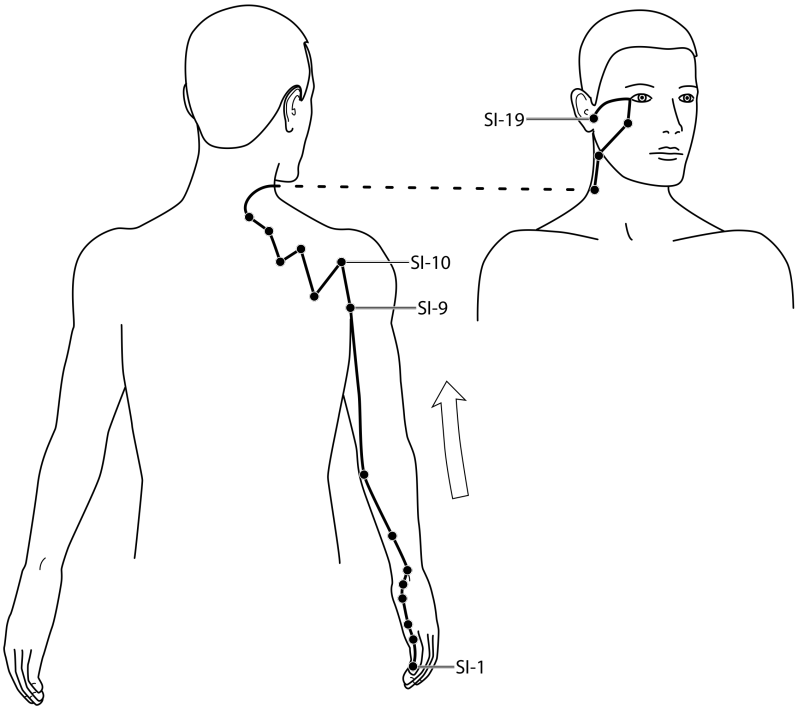
Traditional Heart Channel



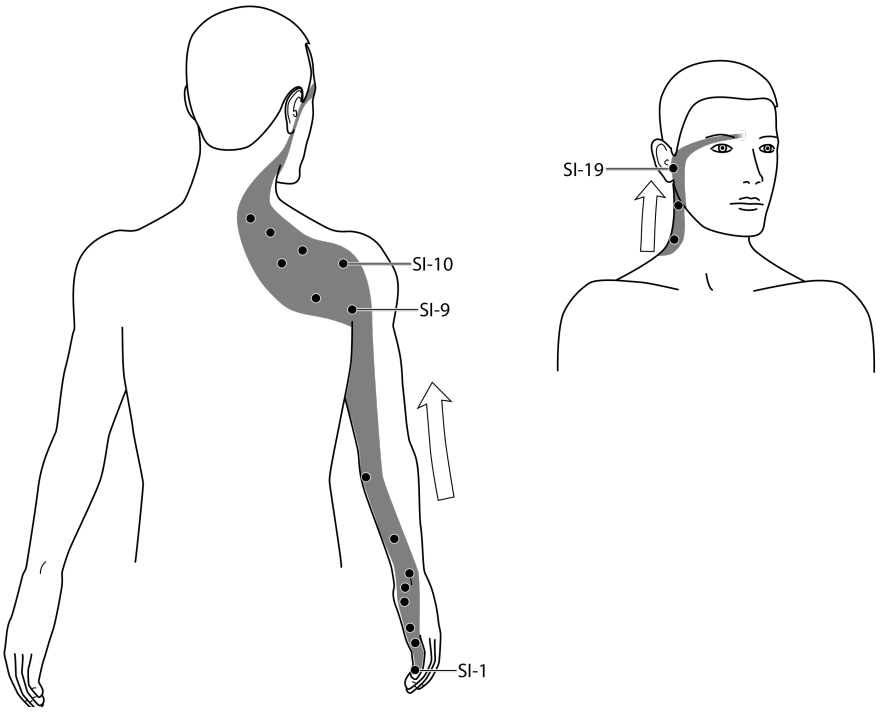
Actual Heart Channel



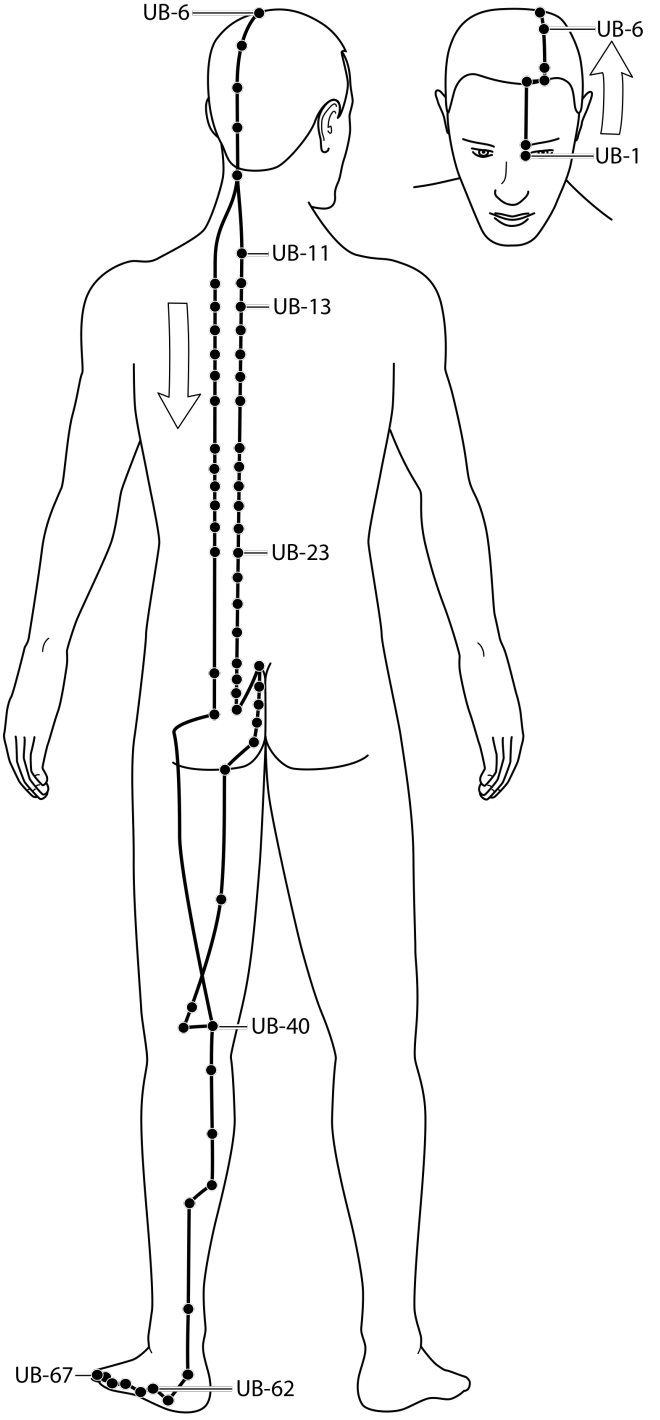
Traditional Small Intestine Channel



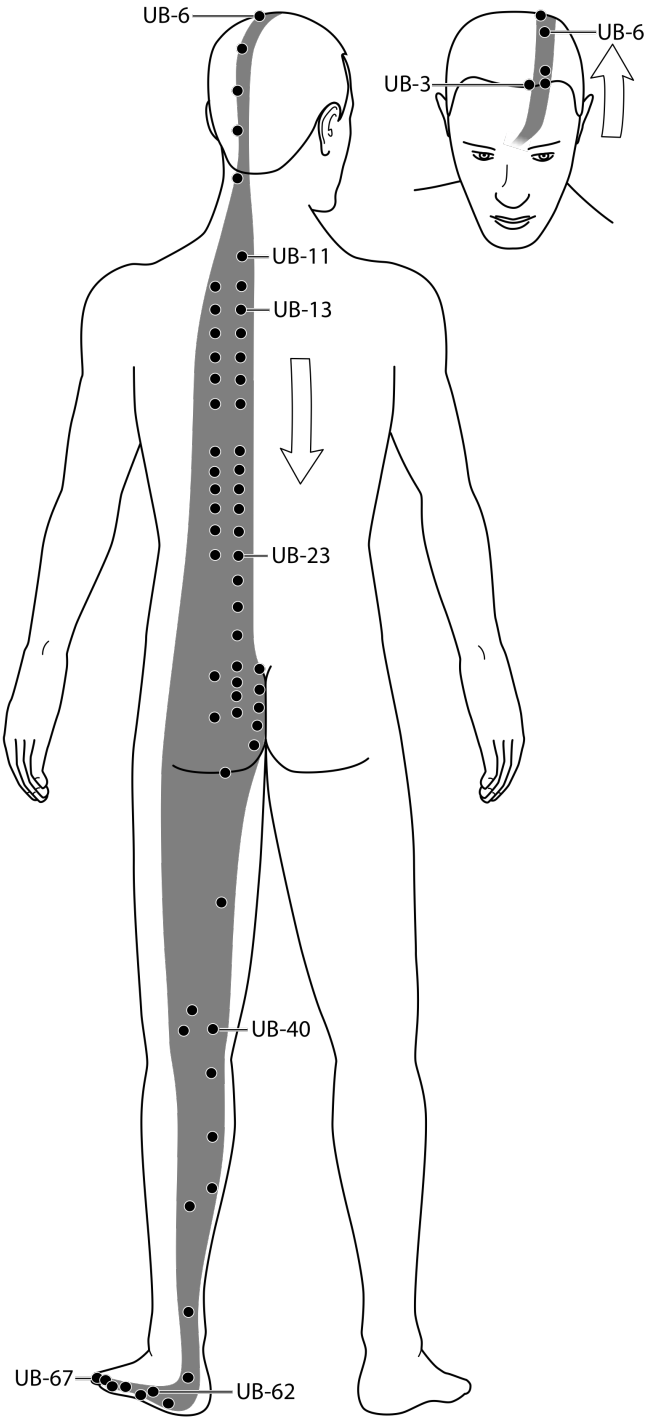
Actual Small Intestine Channel



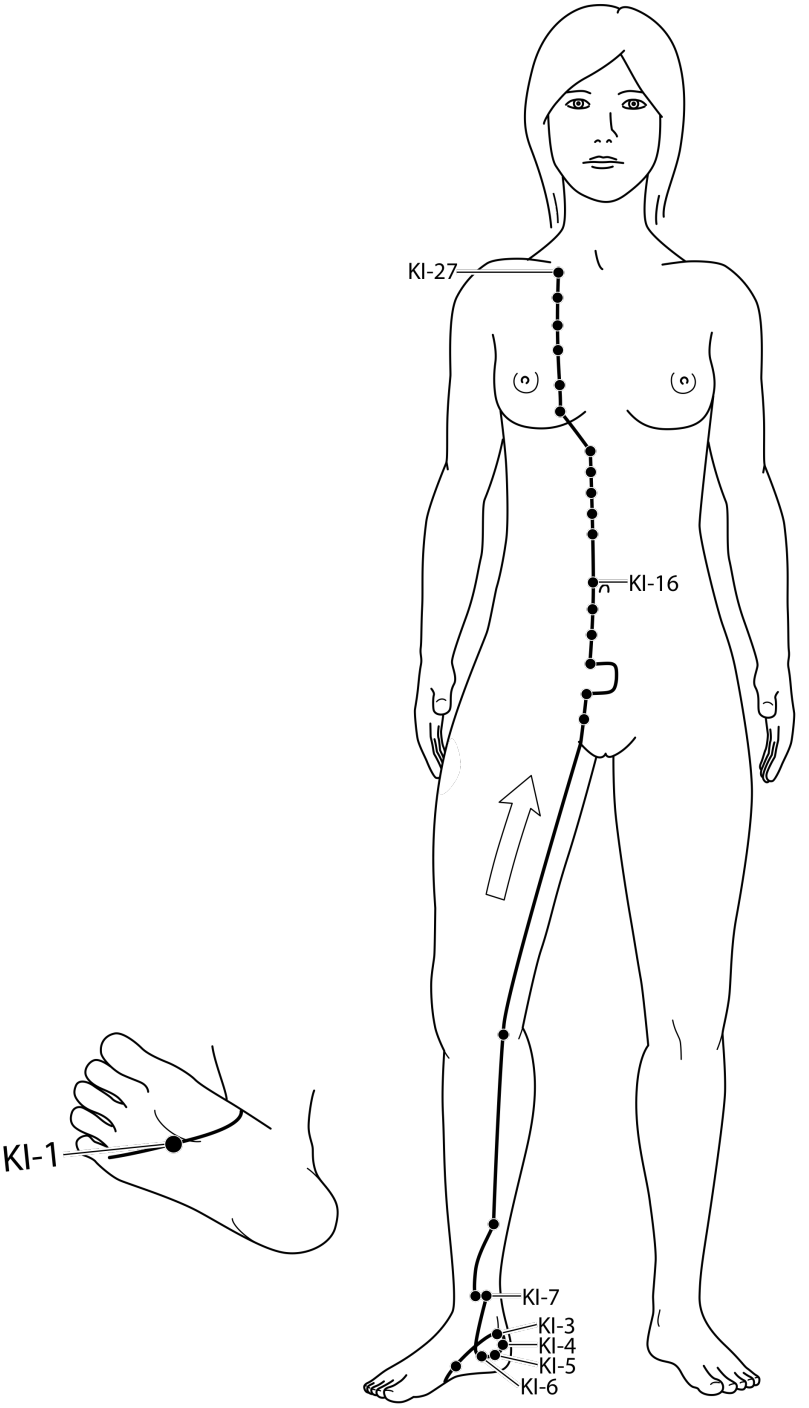
Traditional Urinary Bladder Channel



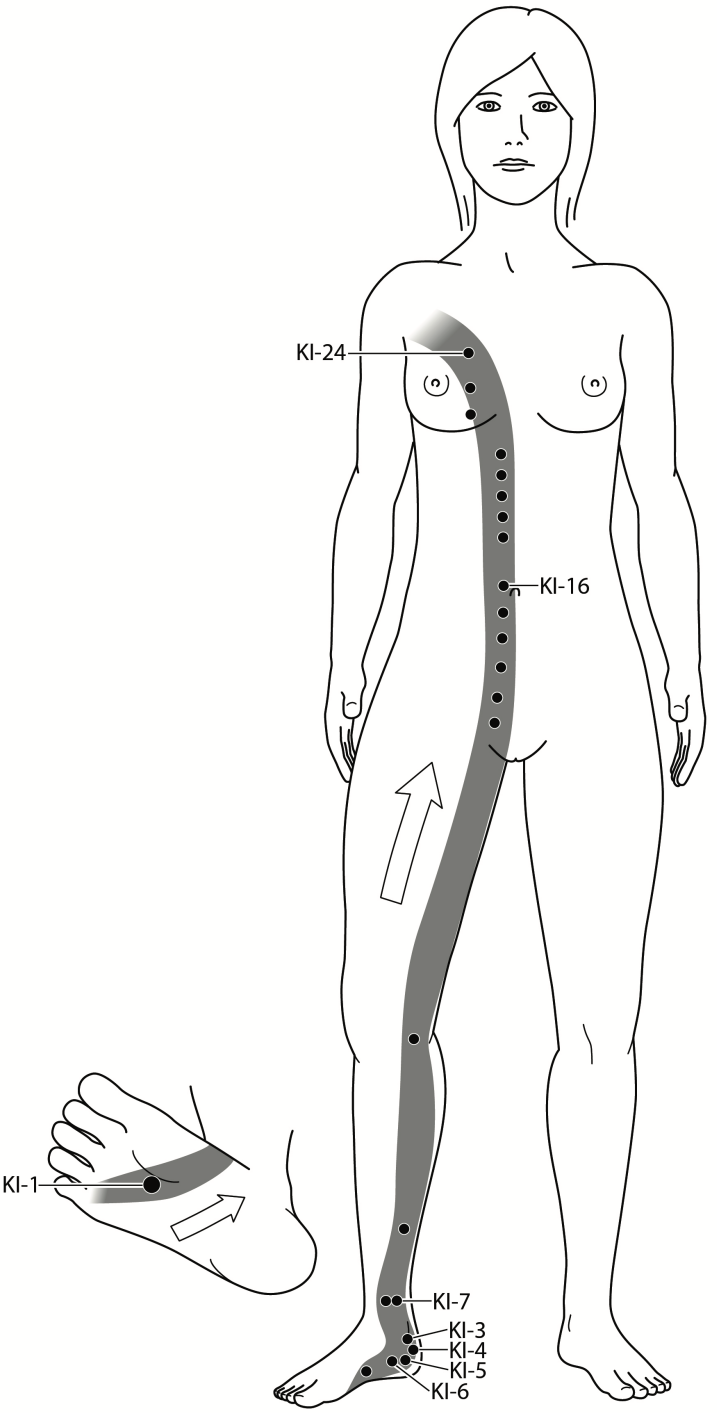
Actual Urinary Bladder Channel



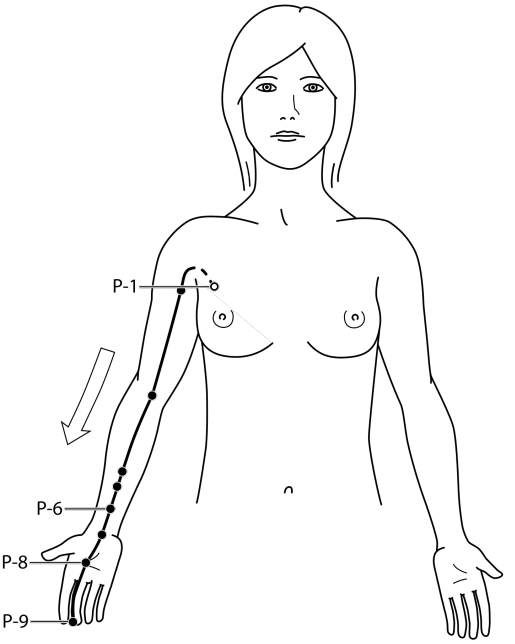
Traditional Kidney Channel



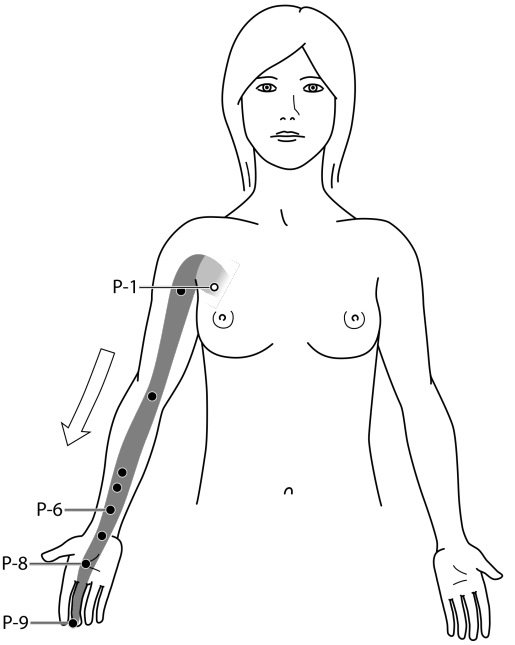
Actual Kidney Channel



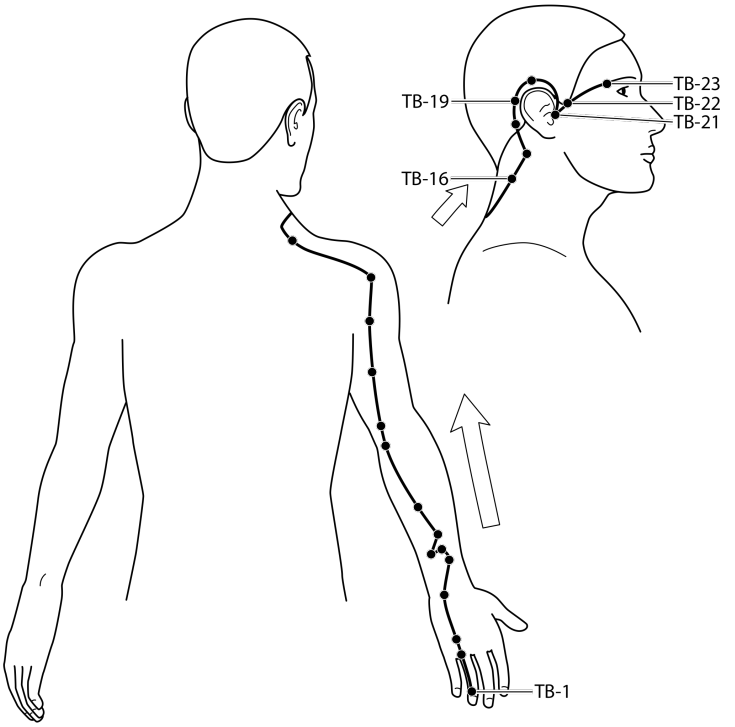
Traditional Pericardium Channel



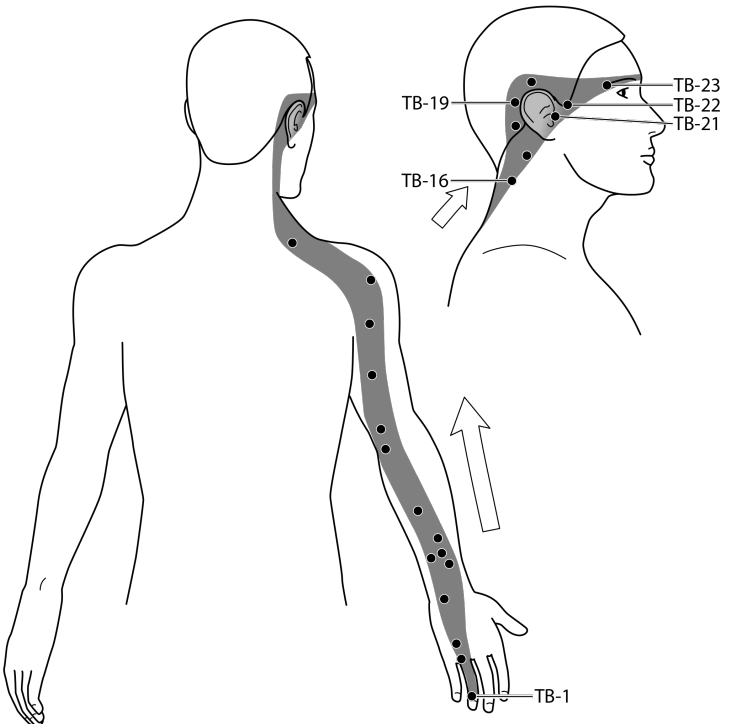
Actual Pericardium Channel



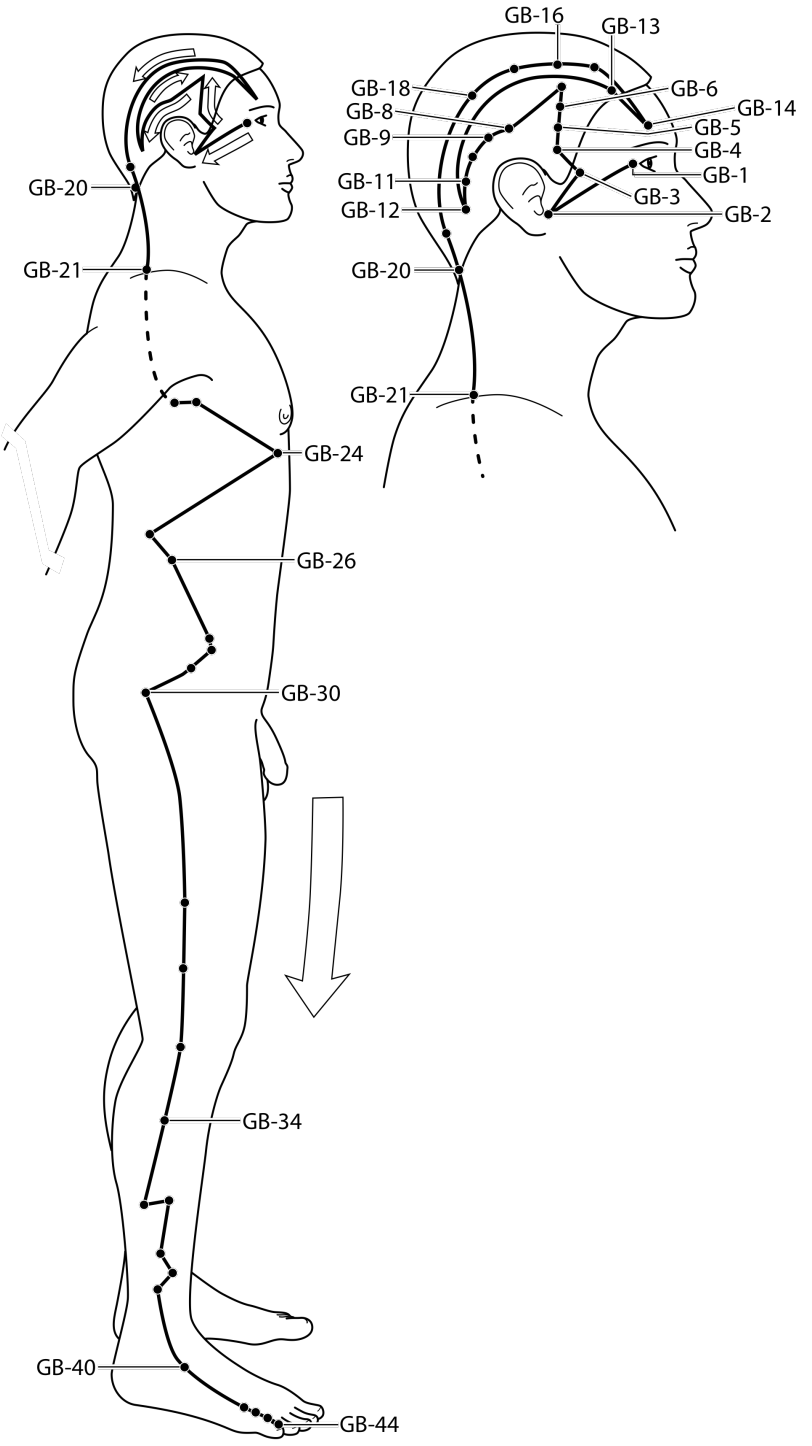
Traditional Triple Burner Channel



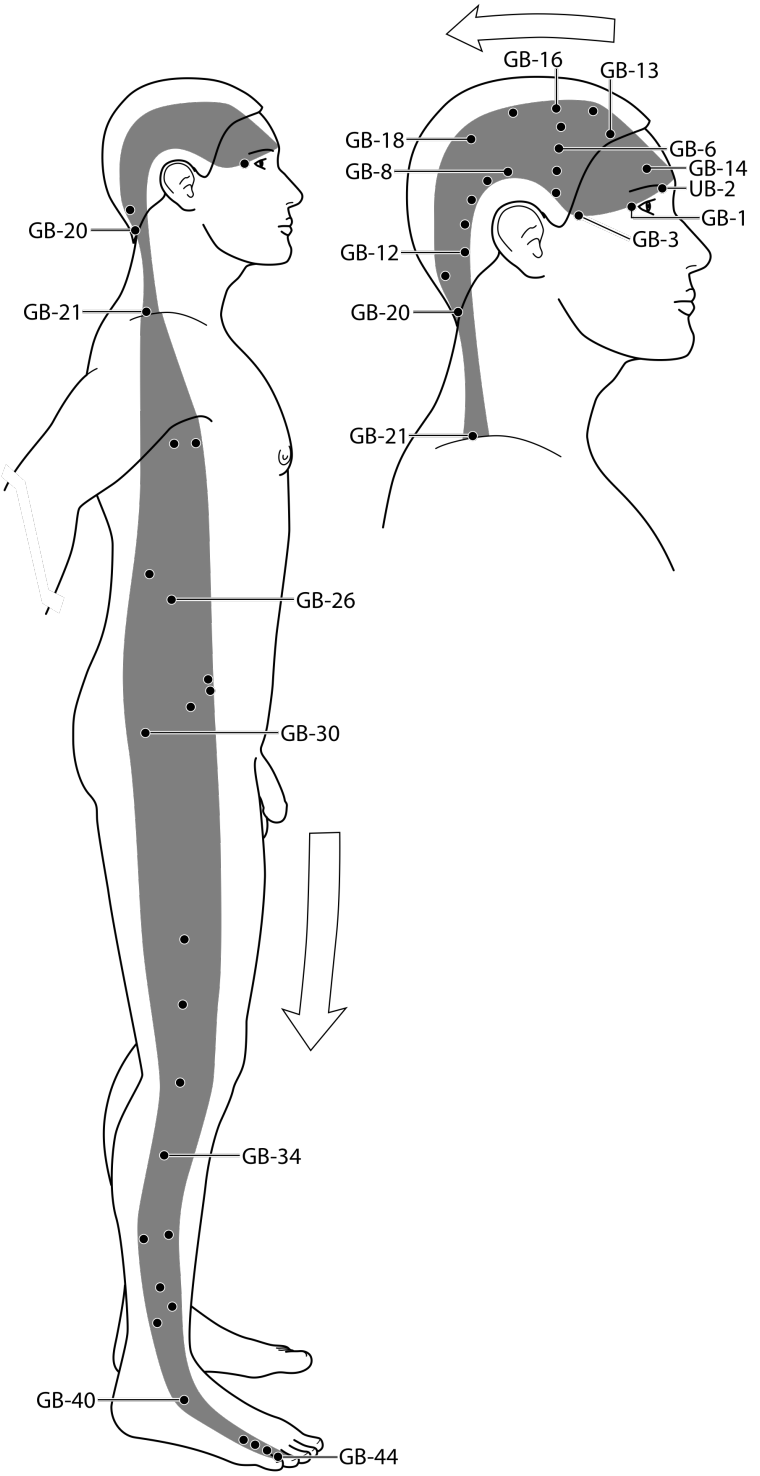
Actual Triple Burner Channel



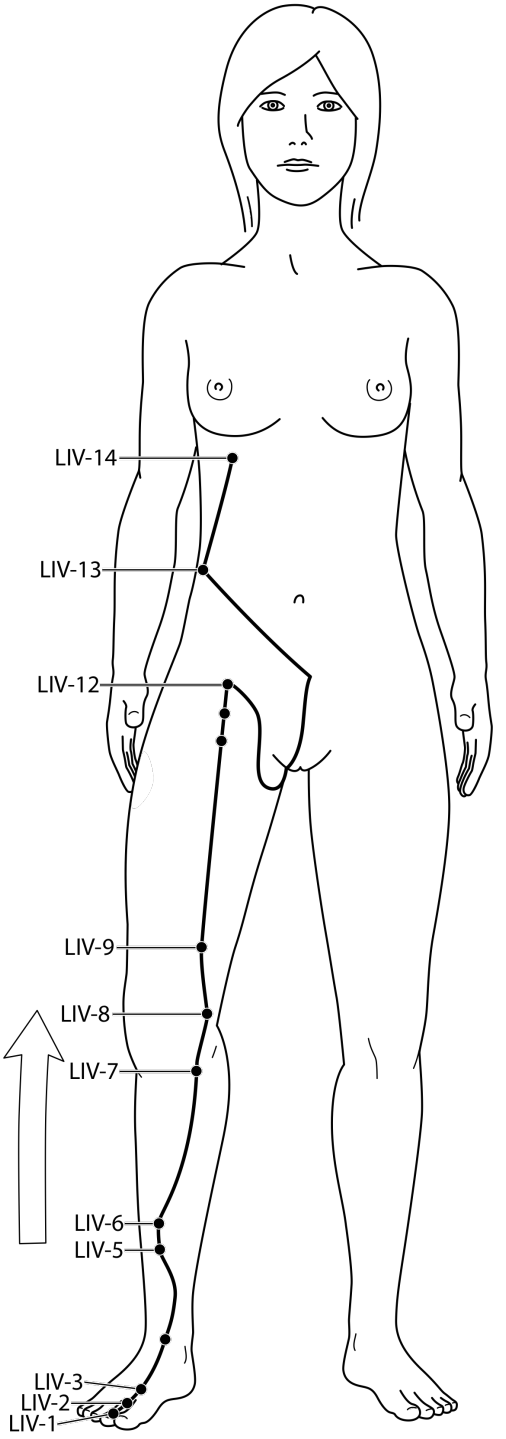
Traditional Gallbladder Channel



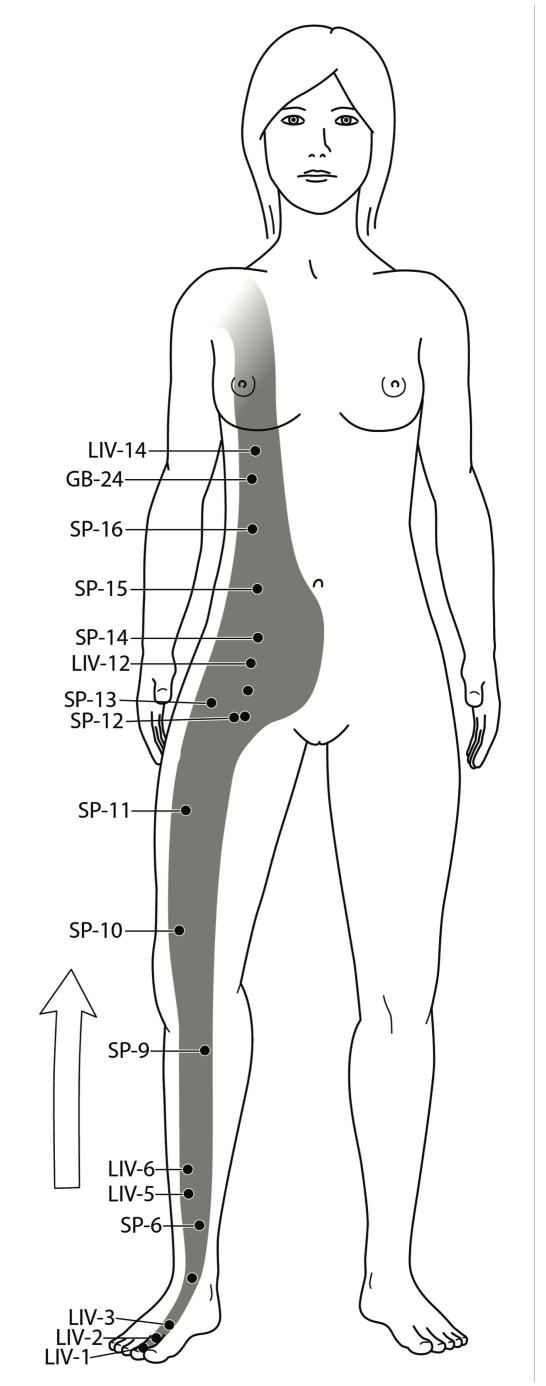
Actual Gallbladder Channel



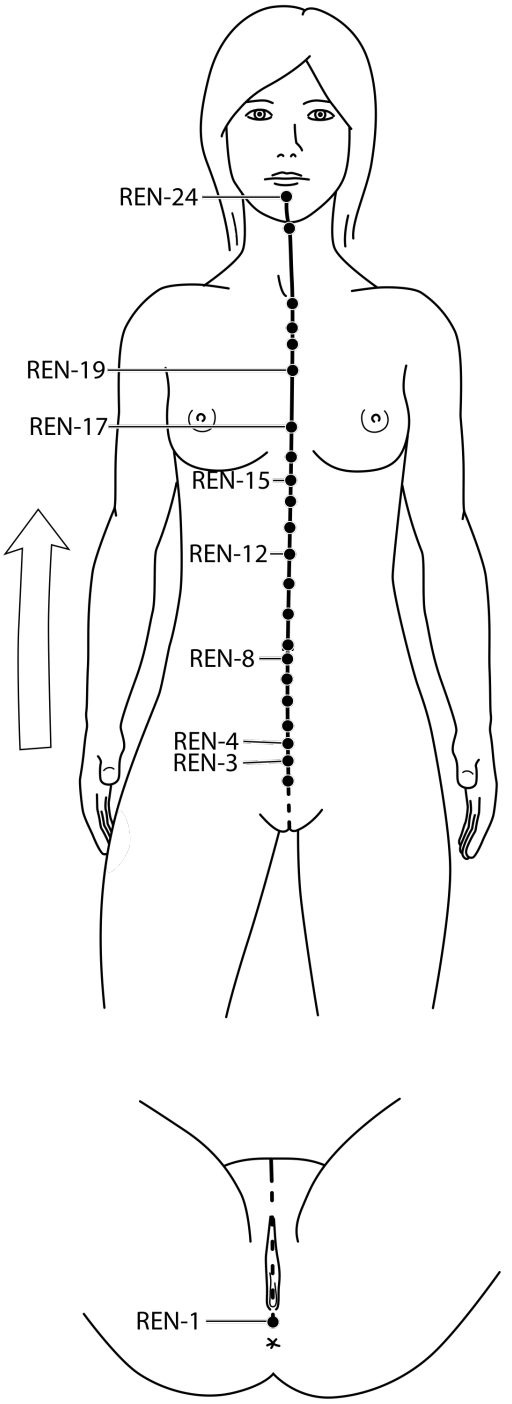
Traditional Liver Channel



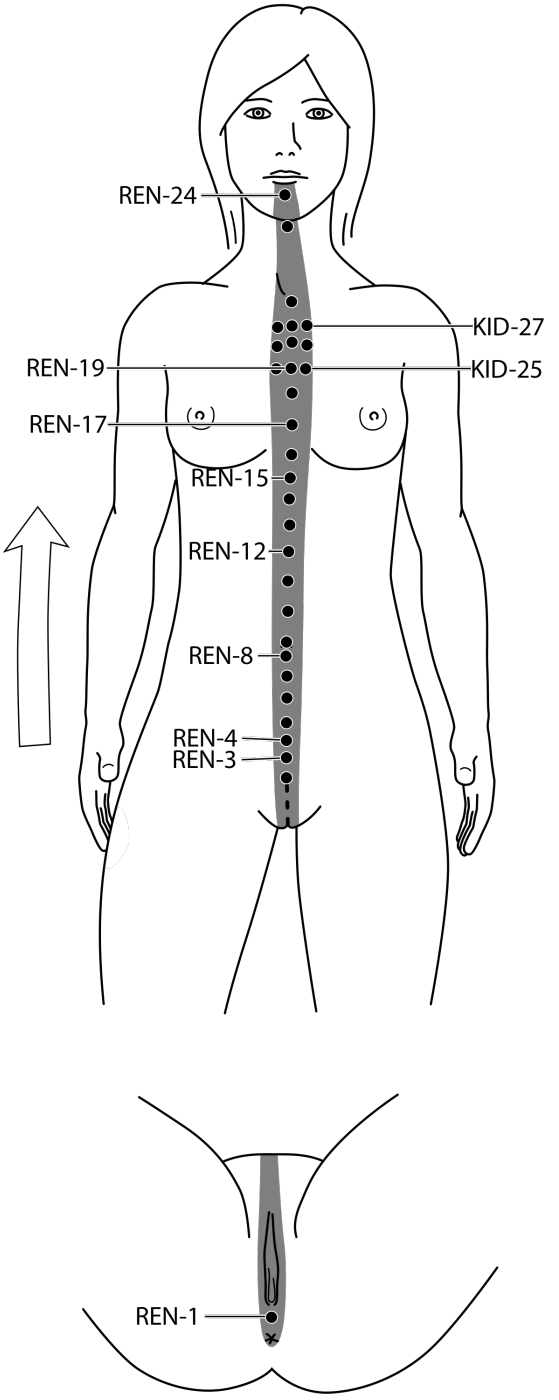
Actual Liver Channel



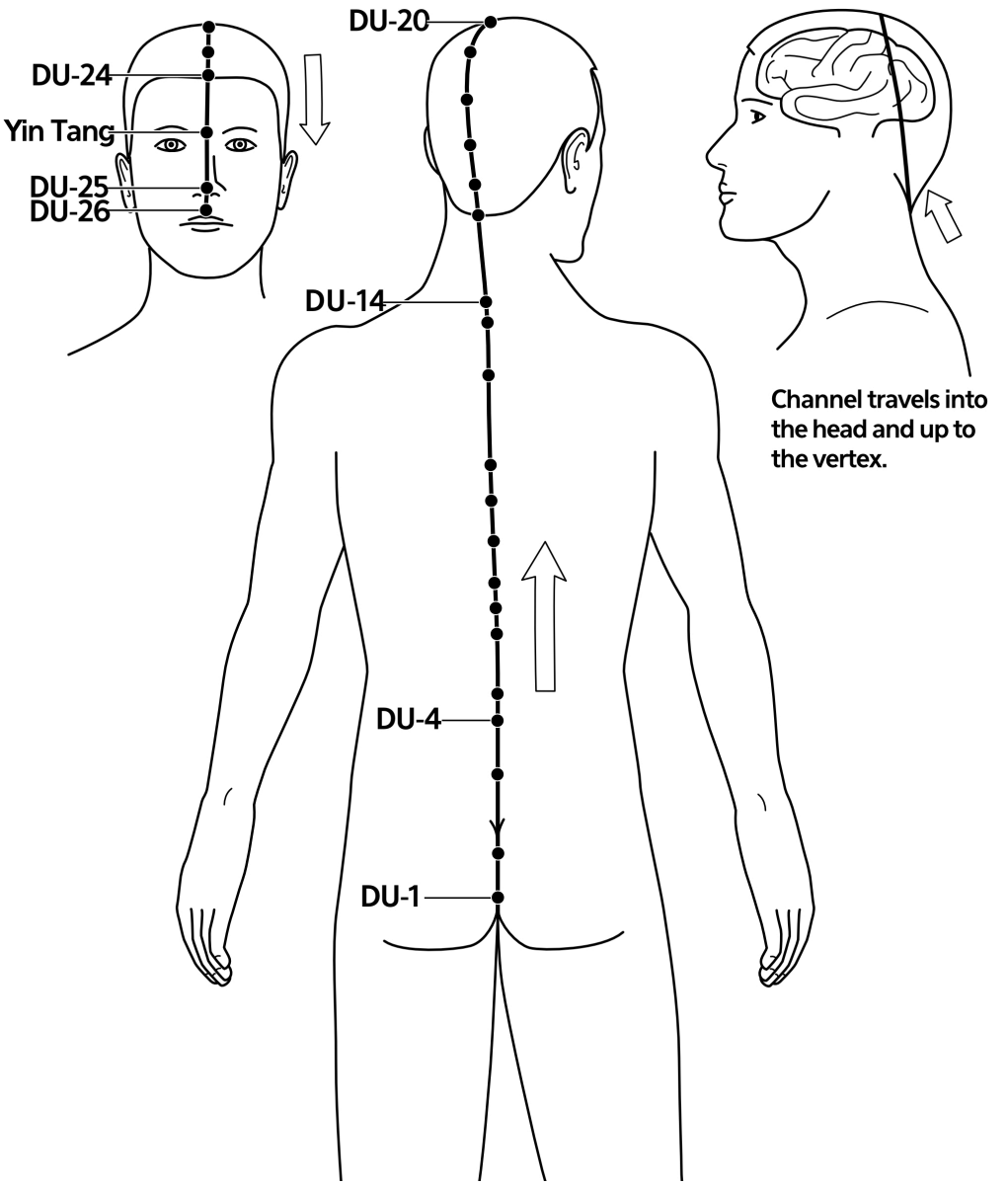
Traditional Ren Channel



Actual Ren Channel

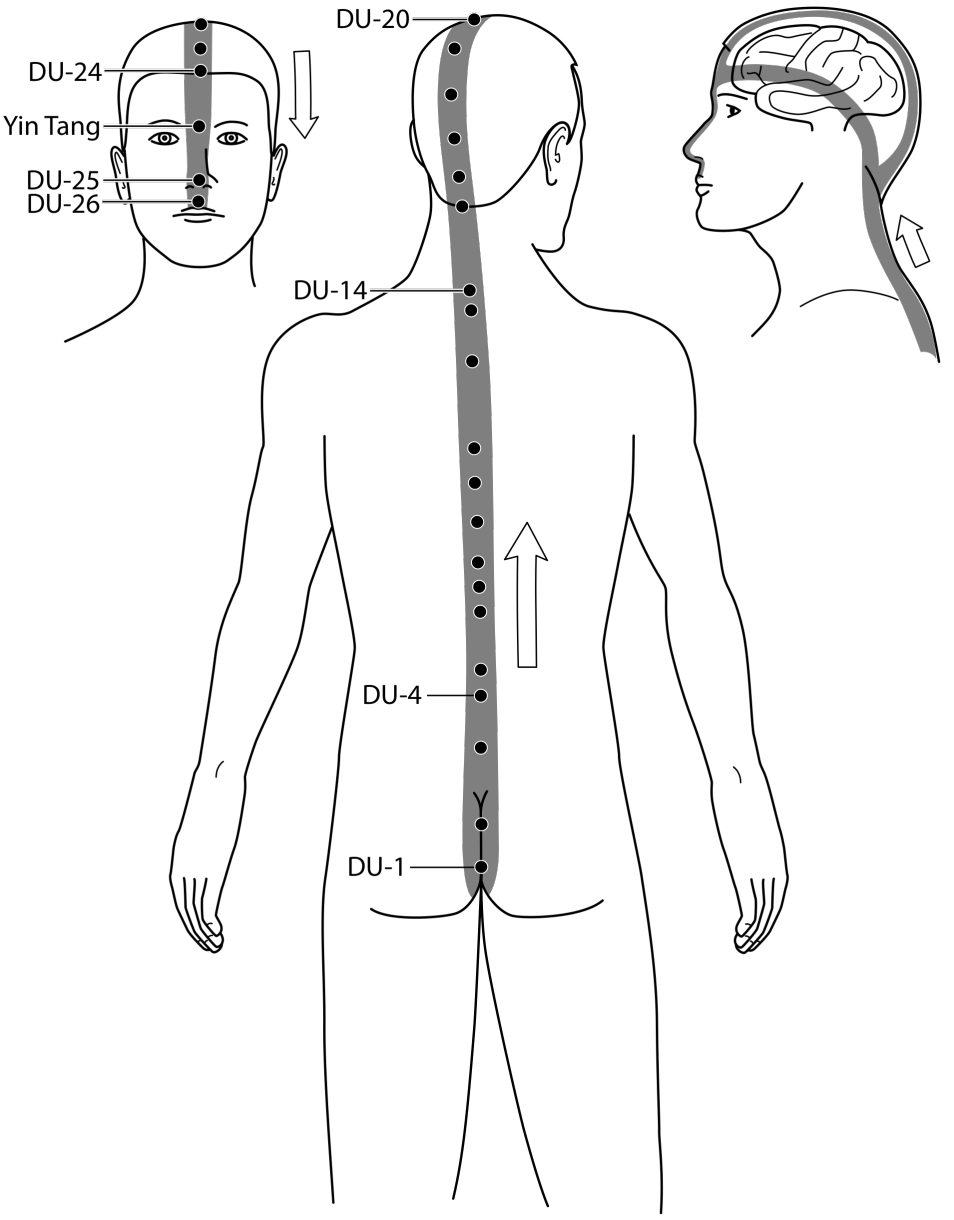


Traditional Du Channel

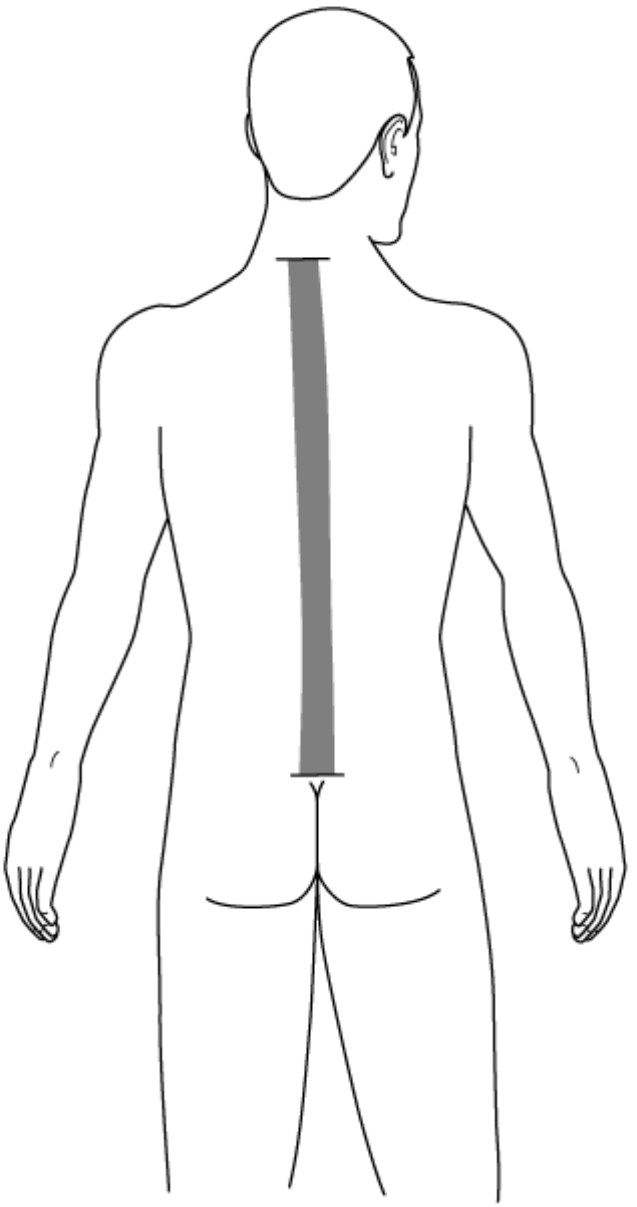


Traditionally, the main branch goes to the vertex then "meanders its way to the forehead (not shown)." But the Chinese word translated as "vertex" (highest point) might actually have meant the highest point of the brain stem, not the top of the head, since this is where the channel actually diverges. The assumption is sometimes made that this translates to "The channel then flows from the top of the head and *over* the top of the head from Du-20 to Du-21, to Du-22, and so on, to the end of the Du channel.

Actual Du Channel and Over-the-Head branch



Du Channel on Pause



Appendix IV

An Important Message for Acupuncturists

Even if you aren't an acupuncturist, you might want to read this appendix. It might provide a few insights into some of the challenges facing people whose work involves the recently (mid-twentieth century) "modernized and westernized" version of Chinese medicine that was created by the People's Republic of China.

Treating Excess conditions

In acupuncture school, we learn that pathologies must first be diagnosed as being due to either Deficient or Excess conditions. Deficient conditions are problems such as starvation, dehydration, or old age: cownditions that originate from a *lack*: lack of nutrition, fluids, or life force.

Oppositely, problems such as trauma, pathogenic illness, emotional stress, and toxins are considered to be, at root, Excess conditions. "Excess" means that something is "too much". Excess means that some physiological process, some pathogen, or some toxin, some *retained* force or physical residue of an injury ("Blood Stagnation"), OR some emotional trauma ("Qi Stagnation") needs to be removed or turned off.

Rebellious (backwards flowing) channel qi is a type of "Excess" channel qi behavior. The blockage that stops the Du channel at the base of the neck during pause is an Excess condition. The pause mode circuitry that causes the Ren channel to drop deep inside the body during pause mode is an Excess condition. The use of pause mode is an Excess condition.

On pause, although the body might be weak, rigid and/or even unconscious, the channel qi shifts that create these *seemingly* deficient conditions are *not* caused by Deficiency. These patterns are all Excess patterns. The rules for dealing with Excess will apply. You should NOT use a tonifying treatment (use needles, moxa, or strengthening herbs, in most cases) on any person who has the channel qi flow patterns of pause. Doing so will *strengthen* the pause patterns. The goal, in treating someone who is stuck on pause mode, is to *turn off* pause mode. The goal is *not* to reverse the backwards flow of qi. The backwards flow of channel qi per se is *not* the problem. The backwards flow of channel qi is a *side effect* of being on pause or having an unhealed dissociated injury. The channel qi will almost always straighten itself out when pause or pseudo pause turns off. The *goal* is to turn off pause or pseudo pause *at its source*.

Whether it's biological pause, self-induced pause, or pseudo pause, it is an Excess condition. Its true origin is nearly always displaced bones and/or soft tissue, or else being stuck *mental* pattern: fear of imminent death, fear of physical or emotional excruciating pain, or mental dissociation from an injury: *mental* habits, brain-circuit re-routing habits. Neither displaced bones nor powerfully self-induced mental patterns can be turned off with acupuncture needles, moxa, or herbs.

A person on pause might *also* have Deficiency. For example, a person might have blood deficiency if he has recently experienced severe blood loss. An elderly person on pause might have the usual, almost inevitable decrease in life force that comes with aging. But even if these deficiencies are present, the forces causing the channel qi to move in the

pause patterns are Excess conditions. If both Excess and Deficiency conditions are present, the Excess problem should *always* be treated first, until it's resolved, and then the Deficiency, if any remains, can be addressed. If the deficiency is addressed first, the increased energy will be used to amplify the Excess problem.

In our acupuncture clinics, we are unlikely to see a patient who is in a coma, for any reason. Most of the people we see who are stuck on pause will only be manifesting pause-type channel qi flow patterns to a *mild* degree and/or only in *some* parts of the body. Or they might be using full pause mode. If so, and if they walked into the office under their own steam, they are probably using a norepinephrine override or medications that elevate dopamine levels – another form of override. But in any of these pause-related situations, even if the person is *physically weak*, the underlying problem, pause mode, is an *Excess* condition, not a truly Deficient one. Therefore, needling will be inappropriate, even harmful. The health practitioner must first get rid of the underlying reason for any pause-mode channel qi behaviors before doing a needle-based, and therefore tonifying, treatment.

Although we learn the phrase "Draining Excess Qi" in acupuncture school, the needles do not actually get rid of an underlying "Excess condition." The use of the word "drain" is a reasonable translation from the Chinese. However, many English speakers assume "drain" in this context means "get rid of" and imagine the acupoints that "drain" channel qi get *rid* of the channel qi. This is completely wrong. Drain actually means drain in the sense of clearing a blocked drain. The phrase "Drain Excess" refers to using needles to provide a conductive path through an area that has been blocked by scar tissue, surgery, burns, chemical burns, toxins (such as snake bite) or other *physical* blockages. The blockage creates electrical resistance. The resistance, like a dam, causes channel qi to accumulate on the upstream side of the blockage or spill over its "banks" into other, nearby channels. This is a *localized* "Excess." Using needles to traverse the blocked area can allow the accumulated channel qi to flow along the conductive needle surface and move past the blockage, thus relieving the localized Excess situation. The needles can create a physical opening in scar tissue that allows the channel qi to continue flowing along the sides of the opening even after the needle is removed.

But there are no acupuncture needle treatments that *remove* or "drain" channel qi from the body in general. Channel qi in and of itself is never Excessive except for extremely rare situations such as lightening strike. Channel qi flow patterns, if blocked, can create a *localized* condition of Excess: channel qi build-up in the wrong place, and a corresponding channel qi *insufficiency* downstream from the blockage. I repeat, needle treatments that are said to "Drain Qi" or "Drain Excess" merely clear the accumulation of channel qi at a *localized* blockage, an accumulation that constitutes a "*localized* Excess." The treatments move thechannel qi a short distance past the blockage, to where it can resume flowing in its correct path.

Needle technique for clearing a blockage

If you want to drain a localized accumulation of channel qi (a local "Excess") by helping the channel qi flow past a blockage, insert the tip of the needle slightly *downstream* from the blockage.. Then, gently move the needle tip "upstream," through the blockage, keeping the needle just under the skin. Gently push the needle through the blockage area and keep moving it upstream until it taps into the blocked up channel qi. At

that point, the current can flow down the needle, moving past the blockage and resuming its flow in the correct path. If you've practiced feeling channel qi, you will be able to instantly detect if you have gotten the channel qi moving past the blockage.

Acupoints indicated for "draining channel qi" might more accurately be described as locations slightly downstream from where channel qi *tends* to get easily blocked. Needling correctly at the site of the local blockage will allow the channel qi at that location to resume flowing past the blockage.

These "draining points" do *not* drain *anything* if there is no blockage at that specific acupoint. Again: needling a draining point does not *reduce* the overall amount of channel qi, nor does it turn off or reverse an underlying Excess condition such as the mental and emotional effects of trauma and/or injury, or the divergent channel qi that is an essential part of using modes other than parasympathetic.

Never insert a needle into channel qi that is running backwards. The needle will, of course, attract more channel qi into the situation, causing an *increase* in the amount of backwards-flowing channel qi and making the situation worse. If the channel qi is flowing backwards, the needle might also cause the patient to jerk violently, break into a cold sweat, or experience an "electrical pain," even to the point of whole body shock, and maybe even passing out – which we are taught to call "needle shock." We are also taught to blame the patient for this, as if something in the patient is responsible for the violent response to our inappropriate needling. Needle shock is nearly always the result of inserting a needle into a channel that is running backwards or is somehow blocked. Whether the patient feels pain or not, inserting a needle into backwards-flowing channel qi *always* constitutes Tonifying an Excess condition – something we are instructed in first semester acupuncture college to never, never do. Needle shock is *not* "Getting the qi." It is injuring the patient. If done intentionally, it is abuse.

If you have a patient who becomes light headed or passes out in response to needle insertions, the patient is probably stuck on pause. Figure out why, and treat *that* problem. The superficial symptoms that brought him to your office will very likely clear up by themselves once you help the patient to turn off pause or teach him what he needs to change in himself to turn off pause. Put away your needles!

If you use needles inappropriately in these Excess situations, the patient's aberrant channel flow will be made worse, not better: exactly as you should have learned in your first semester, if you attended a school with a rigorous, well-organized, traditional curriculum.

When teaching clinic, I see that this first semester instruction is widely ignored. I work with many idealistic acupuncturists who 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 the statements in the historic books of Chinese medicine contradict each other. Many even believe that a patient cannot be harmed by acupuncture needles, and even consider acupuncture to be non-invasive! Acupuncture, done correctly, can be powerful medicine. When done without regard to the laws of physics and biology, acupuncture can be a waste of the patient's time, or make the patient worse.

You cannot *reverse* the flow of channel qi with a needle. You must turn off the *cause*, whatever it is, that is *making* the channel qi flow backwards. As soon as you

remove the cause, the channel qi might very likely resume flowing in the Primary (parasympathetic) pathways all by itself, with no need for needling.

Teachings from the Dark Ages

As for the ludicrous teachings from the dark ages that say things like: "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 about the movement of electrons. Prove for yourself that "needling backwards" does not "drain" a channel in the sense of "getting rid of the channel qi," and also confirm that acupuncture needles should *never* be directly inserted into the part of a channel that is running backwards, diverging due to blockage, or moving in a standing wave. Again, if you want to get the channel qi moving past the blockage, insert the needle downstream from the blockage, where there is a deficiency of channel qi. Slowly work the needle up through the blocked area and into the "reservoir" of blocked channel qi. More instruction on this subject is available for free download at www.pdRecovery.org. Click on Publications, click on *Tracking the Dragon*, click on the chapters on treating scar tissue.

Health problems with "no known cause"

Side effects of being on pause are often what bring a person to my acupuncture office: the person might have 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, the patient's MD has told him there is "no known cause" or might have diagnosed the problem as "purely psychological."

Not just physical symptoms, but emotional symptoms can 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.

If a patient comes to my office with what I determine is a pause-related problem, based on symptoms and the flow of his channels, no amount of acupuncture is going to help him. For that matter, acupuncture will probably make him worse.

- If I find that the person is stuck on biological pause but his pause-causing injury has already healed, I can lead the patient through the Five Steps necessary to turn pause off.

- If the patient still has a head, neck, or spinal injury and the patient is on pause because the body *and the invisible friend* consider the injury to *still* be potentially life-threatening, I treat the injury area with Yin Tui Na. When the trauma area re-associates so that healing can begin, the patient might manifest behaviors such as profound relaxation in the injured area or the deep audible breath. These shifts suggest that the injury is no longer life-threatening. Or the person might get confirmation from his invisible friend that the injury is no longer life-threatening. He might then go through the Five Steps automatically. If he doesn't, I will direct him through the Five Steps.

- If the person is stuck on self-induced pause, I will get him started on talking to an invisible friend and/or cognitive behavioral therapy. If he also has injuries that might be contributing to his pause-mode symptoms, I will *not* do Yin Tui Na for any unhealed traumas on his torso, arms, or leg that are causing *pseudo* pause. I *will* do Yin Tui Na

and/or craniosacral therapy on any head, neck and/or spinal injuries that might be keeping him stuck on *biological* pause.

- If the person is stuck in *only* pseudo pause, with no trace of self-induced pause, I will do Yin Tui Na on the injury or surgery site and at any other sites that might have gotten twisted or blocked while compensating for the injury. The dissociation from the unhealed injury cannot be turned off by invasive treatments such as acupuncture, Yang Tui Na, or moxa. Instead, the motionless, very supportive treatments of Yin Tui Na can help support the trauma site, creating the sense of a "safe place" at the point of injury. This can allow the person to re-associate with the injury. After re-association, a person's innate healing processes, long-stalled, can kick in.

- If the patient has scar tissue that is blocking some crucial channels, I *will* needle those areas in order to break up the keloid tissue, which is non-conductive. But that is the only needling I will do.

Whatever type of pause the person was dealing with, as soon as pause mode or pseudo pause is turned 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. I do *not* waste the patient's time by treating his *symptoms*. The symptoms are merely side effects of being on pause. Again: if the patient's channel qi flow suggests that the patient is stuck on pause mode, I treat whatever is keeping him stuck on pause, not the overt symptoms.

In the very first case study in this book, the patient was suffering from knee pain and from horrible, irremediable itching over his entire body. I did not treat either of those conditions. I did not use needles. I treated the underlying problem: he was stuck on biological pause from a head injury. In Chinese medicine, we are supposed to treat the underlying cause, *not* the superficial symptoms. Sadly, we are *not* usually taught *how* to do this in our schools of Chinese medicine. Please move beyond the introductory and often wrong material that you learned in school. Learn how to make meaningful diagnoses by learning to feel how the channels are moving. The *Nei Jing* says that, in most cases, diagnosing using the Qi Se is more accurate and valuable than tongue and pulse diagnosis. Qi Se refers to electrical currents, electromagnetic energy, and other lightwave-related energy. The term Qi Se, literally "energy of light" is usually mistranslated into English medical writing as "Color." This is in keeping with modern Chinese governmental thinking. In the People's Republic of China, teaching about channel qi as if it has medical value is illegal. The idea of channel qi is too close to other Taoist teachings. In keeping with the atheist policies of the current government, the subject of channel qi might only be taught as a "historical superstition." For more about this, please read *Tracking the Dragon*, chapter 22.

How an acupuncturist can be of use to a person on pause

An acupuncturist trained in channel diagnosis can help confirm a diagnosis of "stuck on pause." Be aware that people with *self-induced* pause might temporarily manifest normal, parasympathetic-dominant channel qi flow if they are feeling unusually safe or relaxed. Because acupuncture offices are often designed to relax the patient, people using self-induced pause might temporarily shift into parasympathetic mode while in your office. However, as soon as they become even mildly concerned about anything, they can quickly revert back to the channel qi patterns of pause mode. I test for this by feeling the flow of the Stomach channel while they are lying down. I wait until the patient is getting

nice and relaxed and then, while holding my hand over the leg portion of the Stomach channel, I say, "Uh oh," or "oh dear," half under my breath. A bit louder, I might add, "There seems to be a pretty serious problem here…" I then wait for a few seconds. If the person tends to slide into self-induced pause, his Stomach channel qi will usually start running backwards in response to this gambit. And then you have your *correct* diagnosis: self-induced pause.

Craniosacral therapy – not acupuncture for biological pause

In cases of biological pause, *acupuncture* will not be helpful. If you have trained in *Yin* Tui Na (not Yang) or in craniosacral therapy (which is a type of Yin Tui Na), those protocols might be extremely helpful. If slow, supportive hands-on work is not a part of your practice, please tell your patient that simple holding by a family member or friend of the parts of the head, neck, and/or spine that were injured might be extremely helpful and might allow the bones and tissues to re-associate and then re-align themselves. Also let the patient know that craniosacral therapy might be helpful, as those protocols can help restore the skull and neck articulations following a head, neck, and/or spinal injury, including concussion. (See: *Yin Tui Na*, chapter 15, "Head and Spine.")

A note to patients: *chiropractic* "craniosacral" treatments are *not* the same as the extremely subtle and supportive craniosacral therapies performed by trained craniosacral therapists. Many massage practitioners have trained as craniosacral therapists. If you do work with a trained craniosacral practitioner for turning off pause, explain to him/her that the underlying problem is dissociation from an injury. Ask the person to please just hold the injured area rather than whipping through the usual, full-body protocol while using five grams of pressure. In the case of a pause-causing injury, the goal of the practitioner is *not* trying to move or adjust the injured area – the goal is helping the patient re-associate with the injury. If the patient can re-associate with the injury, the patient's healing system can begin to address the injured area. Then, the patient's body can heal itself.

Back to you, acupuncturists: The Five steps for turning off biological pause might be helpful *after* the injury displacements are treated. But not acupuncture. The wary mind of a person on pause will often perceive acupuncture as another form of *attack* on the paused body, a threat by "excessive perforation of the skin." An acupuncture treatment might make a person on pause dig in deeper into pause.

As for cases of self-induced pause, the patient must 1) learn to create the somatic sense of feeling safe, usually by using his invisible friend, 2) destroy the habit of using self-induced pause, and 3) replace the old habit with the sense of feeling safe. If the patient doesn't want to do the work involved in making these brain changes and instead relies on therapists, including counselors, acupuncturists and herbalists, this reliance can delay the patient's doing the necessary mental work. I've seen that patients often prefer to hope that a therapist can "fix" his mental habits. But a person who has intentionally created mental habits that are making him sick must change his habits. No one else can do it for him.

Temporarily calming a pause-related tremor

Acupuncture treatments might *temporarily* calm a patients's tremor, or generally relax a patient, but over the course of months and years, the symptoms of Parkinson's will worsen faster than the symptoms of a person with PD who does *not* receive acupuncture treatment. This was the finding of Dr. Ming Qing Zhu, the late, very famous Chinese

neurology-specialist acupuncturist who developed the art of scalp acupuncture. I once shared an office with him when he worked, briefly, in the late 1990s, in affiliation with Five Branches college of traditional Chinese medicine in Santa Cruz, California. For decades, in China, he had worked with hundreds of people with Parkinson's, and found that those who received acupuncture treatments experienced temporary relief and, over time, faster worsening of symptoms than those who simply let the syndrome follow its natural course. He was fortunate in his research because most of his patients were not using antiparkinson's medications, so he was able to see more clearly the deleterious effects of acupuncture on the progression of Parkinson's disease.

Terminology

Yin departing; Yang departing

In Chinese medical terms, a severe degree of pause mode due to loss of blood is called "Yin (tangibles) departing Yang (spiritual energy)." The clammy perspiration on the skin might be thick and warm from Yin Xu heat (heat from decrease or lack of body fluids). If the consciousness steps outside the body but body fluids aren't lost, the condition is "Yang departing Yin." The clammy sweat might be watery and cold.

Poor translations

The translations from the Chinese characters that most western acupuncturists learn in their schools of Chinese medicine are sometimes misleading and often outright wrong. These poor translations, historically generated by well-meaning British scholars who used the poetic meanings of Chinese characters rather than their traditional medical meanings, has led to the use of completely meaningless diagnostic phrases being used by western practitioners of traditional Chinese medicine. For example, consider the popular but meaningless (in English) diagnosis of "Liver Wind Rising". The correct *medical* translation of the Chinese character that can *also* mean wind is "erratic, or unexpected." The *medical* translation for the character for "Liver" is "Liver channel qi." The correct English translation for the phrase made up of these characters is "Liver channel qi is moving erratically: it's going "up" to the head instead of into the Lung channel. This phrase makes perfectly good sense in English. The phrase "Liver Wind Rising" does not.

When the Liver channel flows in the parasympathetic route, the "Primary route," it flows laterally at the shoulders and goes into the Lung channel, on the arms. The phrase "Liver channel qi moving erratically: going up to the head" describes when happens when a person is under emotional stress, which first affects the pericardium. If a person is experiencing pericardial static from emotional duress, then when the Liver channel passes by the pericardium on its way up to the Lung channel, the Liver channel is redirected by the static. Instead of all the Liver channel qi going to the Lung channels, some of it travels up to the head, to the amygdala. The *amount* of Liver channel qi that flows up to the head depends on the *amount* of stress being manifested by the pericardium. After the Liver channel flows "up," it is shunted into the head portion of the Bladder channel. The Bladder channel flows over the amygdala. A boost of channel qi from the Liver channel into the Bladder channel increases the *amount* of the rage or fear response in the amygdala.

This diagnosis, "the Liver channel qi is moving erratically: going up to the head and stimulating the fear/rage response" actually describes something meaningful. It is

helpful in both Chinese and English. The English mistranslation, "Liver Wind Rising" is not.

You are also taught in school that Liver Wind is the reason behind "erratic and/or unpredictable movement." This phrase refers to "movement" that comes seemingly out of nowhere: sudden muscular paralysis or limpness following a stroke, a muscle-twitching tic that might come and go out of the blue, or muscle spasticity in response to some toxin, pathogen, emotional stress, or other trigger.

Parkinson's tremor is not "Liver Wind"

The tremor of Parkinson's is a rhythmic, healthy motor event that is a normal part of the second step for coming out of pause mode. When people are *stuck* on pause, they are stuck in the second of the Five Steps. The tremor becomes chronic, even powerful. But it is not an unexpected, out-of-the-blue, erratic muscle event, nor is it a pathology. It also has nothing to do with the flow of the Liver channel qi. The tremor that occurs when a person is stuck on pause is part of a healing sequence that has become stuck on one of the steps. You can use Liver Wind treatments for years and the tremors will NEVER be cured. You will be wasting the patient's time. The same goes for scalp acupuncture.

The actual Chinese diagnostic "Pattern" for a person stuck on pause, including the symptoms of tremor, is Pericardium Yang Xu, or Pericardium Yang Insufficiency. The Pericardium Yang (Pericardium channel qi) is insufficient because the person's Pericardium Yang is outside of his body (biologically dissociated). If you want to help a Parkinson's patient with his tremor, you can direct him to material that will help him turn off pause, self-induced pause, or dissociation, as needed. You will *not* help him by sticking needles in him. Inserting needles, causing "excess perforation of the skin," will temporarily *increase* his degree of pause mode. This will temporarily calm the tremor. The tremor is "calmed" because, in a deeper level of pause, the body senses it is being further destabilized, and so *decreases* its push to try and come out of pause mode. The tremor happens because it is a part of the process for coming out of pause. If a person backslides into a higher degree of pause, the body will temporarily give up on trying to come out of pause. This greatly reduces the tremor…until a few hours or maybe a day or two after the needles come out. Then, the patient's body tries again to go through the steps for coming out of pause. It starts with Step One, moves on to Step Two, and once again gets stuck in Step Two, the turning-off-tremor stage. The tremor still won't be able to stop. It might hammer away with even greater intensity, in response to the temporary worsening of pause mode – caused by your needle treatment.

In a *high* degree of pause mode such as coma, the diagnosis is Yang departing Yin due to Pericardium Yang deficiency.

In summary

Please do not use needles or moxa if a patient has an overall Excess condition, including but not limited to the use of pause mode. The patient needs to get rid of the underlying condition. In cases of unhealed trauma, supportive-type Yin Tui Na will probably be the most effective treatment. For patients who have activated self-induced pause, medical qi gong is the most effective treatment. "Medical qi gong" means the patient uses his own mind to direct his energy and thoughts in a healthier manner. Cognitive behavioral therapy, working with an invisible friend, and learning to use the heart instead of the brain to manage one's thoughts are all variations of medical qi gong.

After the Excess pattern is gone, then needling might be used if the channel qi fails to resume its correct flow patterns automatically. Usually, needling will not be necessary.

Never insert needles into channel qi that is flowing backwards or "going back and forth" (in a standing wave). Please do not use needles on people with Parkinson's disease other than for breaking up scar tissue.

A person with Parkinson's might want your help assessing the flow of his channel qi in order to confirm that he has Parkinson's disease. That's about all you can do for him. Other than that, if you treat the person and you don't know what you're doing, you stand a very good chance of making him worse over the long run.

More information on the subjects of what is not currently taught or is taught incorrectly 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 not just acupuncture students and practitioners, but for anyone with an interest in medicine.

Hacking Chinese Medicine is *not* available at the pdRecovery.org website because it does not directly relate to Parkinson's disease. It *is* available at my bookstore website: www.JaniceHadlock.com. It might be available in your acupuncture college's library.

Many, many experienced, long-practicing acupuncturists have told me that this introductory book, together with the more advanced text *Tracking the Dragon*, enabled them to understand for the first time what they were actually doing with their patients. They love being able to explain to their patients what they are doing without talking in gibberish. They often comment that since reading these books and learning to feel channel qi, they get powerful results instead of the hit-or-miss results they got in the past from using the formulaic, one-size-fits-all treatments that they learned in school.

I offer the above paragraph not to sell more books, but because I am passionate in my determination to bring relief to acupuncturists – and their patients – who are struggling through the mistranslated, misunderstood, and just plain wrong information that is currently being passed off in western acupuncture schools as "Traditional Chinese Medicine."

Index

(to be constructed)