

PART II

RECOVERY SYMPTOMS

“There’s nothing either good nor bad, but thinking makes it so.”

Shakespeare’s Hamlet

CHAPTER SEVENTEEN

RECOVERY SYMPTOMS: AN INTRODUCTION

As PDers recovered from their foot injuries, many of them experienced unexpected, counterintuitive, and even bizarre physical and emotional changes. In the early days of the research, these events became as much a part of the puzzle as the symptoms of Parkinson’s disease. Although the smaller details of these events varied from one PDer to another, there was a baffling similarity in the changes that PDers reported to us, week after week.

For research purposes, our earliest PD patients almost never met with or spoke with each other: the probability of research “contamination” from patient-to-patient interaction was unlikely. Furthermore, since our hypotheses as to the cause of Parkinson’s disease had not been formed when the first pioneers began to recover, there is no way a patient could have “guessed” at appropriate recovery symptoms, and no way we could have suggested them. We were as stunned as the patients when one PDer after another manifested his own variations on these unexpected symptoms.

We named these events “recovery symptoms.”

When I first started noticing changes in PDers in response to my treating their feet injuries, I had no idea of any theory that might connect the foot injury to the symptoms of Parkinson’s.

In the end, the largest source of information about the cause and development of Parkinson’s disease was the collection of recovery symptoms. The recovery symptoms, together with my understanding of Asian medical theory, provided the clues that allowed us to figure out the processes that lead to idiopathic Parkinson’s disease.

“What the heck?”

The pioneers in our project expected any improvement from Parkinson’s to be pleasant. They assumed that recovery, if that was indeed what was happening, would consist of steady, linear improvements in motor function. They assumed, as well, that any benefits would take the form of a “return to the past.” In most cases, this would have meant a return to the previous way of life: high pain threshold; strong will power; adrenaline-activated thought and movement.

What actually occurred did not fit anyone’s expectations. Every one of the pioneers was shocked by the unanticipated, seemingly negative collection of new symptoms that occurred as their feet began to heal.

But as they began to see the positive flip-side of these sometimes painful or alarming changes, they started to appreciate that something incredible was going on: they were truly recovering from PD, not just feeling better by masking the symptoms. After all, the new symptoms, though weird, were the exact *opposite* of the symptoms of Parkinson’s.

The credo of many in this group soon became “I don’t know what the heck is going on, but it sure as hell isn’t Parkinson’s disease.”

Introduction to physiological symptoms

The physiological pathologies of Parkinson's are those symptoms that are apparent whether or not a person is trying to move. These symptoms may include coldness in the hands and feet, the numbness or lack of muscle responsiveness in the face and toes, the muscle tension that pulls the neck forward and inhibits rotation of the neck, the forward-leaning, shoulder-hunching tension in the overall carriage, and the steely rigidity in the anteriolateral muscles of the neck and legs. These conditions exist whether or not the PDer is trying to move. For example, if a PDer has an absence of musculature along the side of the nose or in the lower eyelid, it will be present whether he is sitting down, lying down, or walking.

The *physiological* symptoms of Parkinson's disease do not change with mood or expectation. They are caused by actual alterations in muscle tissue, nerve tissue, blood supply, and brain-to-muscle connectivity. These symptoms may *contribute* to the poor performance of certain movements, in the same way that a polio-shortened leg or missing thumb may contribute to poor performance. But they do not *cause* the mood-based variations in poor movement initiation or tremor.

The physiological symptoms are *not* improved by the taking of dopamine-enhancing medications because they are *not* dopamine-related symptoms. They are simply the result of long-term changes in nerve and muscle that result from the electrical disarray that is present in idiopathic Parkinson's disease.

Introduction to mental/emotional symptoms

In people with idiopathic Parkinson's, emotional and attitudinal postures that are most likely related to selective dissociation can trigger symptoms of automatic dissociation, which includes inhibition of dopamine release. This inhibition can occur whether or not a person has any sort of foot injury. People with psychogenic parkinsonism do not have physiological symptoms of Parkinson's, but they do have difficulty with rigidity, movement initiation, poverty of movement, tremor, and postural instability. Some people with idiopathic Parkinson's disease have *both* physiological symptoms and the same mental/emotional symptoms that are present in psychogenic parkinsonism.

Similarities between physiological and mental/emotional symptom

In some cases, severe dissociation from the heart can cause symptoms that were listed above as being caused by physiological damage, symptoms such as cold feet and hunching posture. While these symptoms can be caused by physiological damage, they are also characteristic of automatic dissociation. However, when these symptoms are being produced by dissociation, they will vary in intensity, and may even relax a bit while sleeping. When these symptoms are produced by injury-based damage to the tissues, what I am calling physiological damage, the symptoms do not vary.

For example, a broken leg bone is a physiological event. If a person with a broken leg bone is in an emergency, or if he has an overriding flood of dopamine from either internally produced joy or dopamine-enhancing drugs, he might *not* be able to notice the physiological damage. He might be able to move *almost* normally. However, the damage will still be there: the broken leg will not come and go in response to his mental or emotional state.

While a person has idiopathic Parkinson's disease, it can be difficult to determine whether or not a symptom is purely physiological or if it is mental. However, during recovery, the distinction often becomes more clear.

WHY THERE IS NO LIST OF SPECIFIC RECOVERY SYMPTOMS

In the first edition of this book, I included a list of recovery symptoms that had occurred in my first dozen patients. Because I was concerned that some symptoms were purely individual, and not characteristic of PD, I did not include symptoms on the list until several PDers had experienced them. But once I did list the symptom, I included on the list the specific muscle groups and the exact locations in which PDers had experienced those symptoms.

As the project grew, I kept trying to update the information, listing additional recovery symptoms as I observed them.

However, I soon found that the more exacting PDers that were coming into the program were using this information as a checklist. If their own recovery symptoms were not on the list, they panicked. And if a PDer *didn't* experience all of the items on the list, he was certain that his recovery had stalled. We did not yet realize that shutting down the heart can cause a PDer to favor a worst-case scenario.

Now, I no longer publish a list of all the specific muscles in which recovery symptoms have occurred. Instead, I want PDers and their health practitioners to understand the mechanisms involved.

The following chapters list only a demonstrative *sampling* of recovery symptoms, together with explanations of *why* the symptoms occur.

Linearity

In my original list of recovery symptoms, I listed them in order of which recovery symptoms had often, but not always, occurred first, second, and last. I learned that, no matter how many times I wrote "recovery symptoms did not necessarily take place in this sequence," some PDers panicked if their recovery symptoms were not in the sequence in which they had been listed. I repeat, we did not appreciate the inclination towards negativity that many PDers had acquired and/or cultivated.

Therefore, let me point out that toes may recover before fingers, or vice versa. Improvement in sensory function may precede the return of easy movement in some body parts, or vice versa. Toes may regain sensitivity prior to recovering full range of movement. Or vice versa. Oppositely, facial muscles may show increased movement long before full feeling returns to the face. Or vice versa.

The path of recovery was not predictable, and recovery symptoms did *not* follow a straight line.

THE TEMPO OF RECOVERY

Physiological recovery: somewhat slow, measured in days or weeks, not minutes

With regard to the *physical* symptoms, no one experienced a red-letter day when he woke up and said "Ah! The Parkinson's is gone! Today is The Day!"

Please remember, there had never been a distinct day when the PDer woke up and *suddenly* had idiopathic Parkinson's disease. The physiological symptoms of idiopathic

Parkinson's came on slowly. The physiological recovery also took some time. Trying to ascertain a single day on which the physical symptoms were gone was as tricky as trying to ascertain the exact day on which a broken bone is healed.¹

Once the injury has healed sufficiently, the *electrical* disarray can correct itself almost instantly, but repairing the damage it caused during the previous decades can take weeks, even months. It will take time to grow new muscle. It will take time to retrain new nerve connections. It will take time to return to full sensory function.

Mental/emotional recovery: as quick as flipping a switch

The negative emotional and mental patterns that inhibit neurotransmitter release can come and go as quickly as thought. Many PDer's have noticed that following a bit of bad news, such as receiving their diagnosis of Parkinson's disease, they suffered an *instant* decline or rapid daily decline in their ability to initiate movement. Oppositely, if they felt encouraged by some positive idea, they may have had an almost instantaneous, but temporary, improvement in movement initiation or speed of movement; in these cases, their movement almost instantly improved to the extent that their current physiological condition allowed. As soon as a negative thought arose, the movement inhibition returned within a few minutes.

When a PDer who'd been stuck in partial recovery overcame the habit of dissociation that had caused his mind-based symptoms, the tendency to slip into parkinsonism ceased. When the PDer made this breakthrough, the lasting disappearance of the mood-based symptoms of Parkinson's occurred as quickly as the flip of a switch.

How long will this take? How intense will this be?

The amount of time required for healing is variable, and I will not make estimates as to how long it might take for any given individual. I have had patients whose more obvious symptoms of Parkinson's disease were gone within three to five weeks of the foot injury starting to heal. I have had other patients who were still noticing tiny improvements in motor function a full five years after the injury was healed and the major symptoms of PD were long gone.

Also, the intensity of recovery symptoms varied from person to person. The recovery symptoms were sometimes subtle, sometimes not. A PDer might have experienced severe symptoms in some muscle groups and had almost no *noticeable* cues as to the changes that were gently occurring in some other body part.

Some people recovered from the *physiological* symptoms of idiopathic Parkinson's disease in a matter of weeks or months but lingered in a dopamine-inhibiting dissociation or negative mindset for years following the physiological recovery. If so, his symptoms during

¹ Drug- and toxin-induced parkinsonism *can* come on quickly, even overnight. The book, *The Frozen Addicts*, xxx describes the immediate or overnight onset of full-blown parkinsonism, complete with utter rigidity and constant tremoring, that occurred in a group of drug users that used a "bad" batch of synthetic heroin. These drug users suffered immediate, irreversible brain damage. Their condition has *nothing* in common with people who develop idiopathic Parkinson's disease. Nevertheless, *The Frozen Addicts*, and the hypotheses contained therein, was the primary source of the "dead brain cell" theory of Parkinson's. Today, most research on Parkinson's is done on lab mice that have been given drugs to kill their brain cells. These mice are referred to as a "parkinson's model," even though it has since been proven that people with idiopathic Parkinson's disease do *not* have dead brain cells.

In cases of tardive (delayed onset) parkinsonism developing from use of mind-altering drugs such as methamphetamine and use of pharmaceutical drugs such as some anti-depressant and anti-anxiety medications, the parkinsonism from the brain damage caused by these drugs may come on more slowly – in some cases, over decades.

those years resembled the usual presentation of *psychogenic* parkinsonism, plus any other symptoms that his mind had grown accustomed to activating.

One psychology report that I read claimed that it takes five years, on average, to get rid of severe selective dissociations. But we have seen people recover from heart-dissociation very quickly, in a matter of weeks. We have also seen people struggle with the heart-dissociation symptoms characteristic of psychogenic parkinsonism for *more* than five years. In these latter cases, sometimes they understood what they needed to do to change, but were so afraid that taking the first step would leave them vulnerable to emotional pain that they were unable to take the first step. Sometimes, the PDer truly had no idea of how to go about changing his negative mindset without also experiencing a painfully humiliating change in long-held beliefs. Many PDers were genuinely shocked to learn that a person's thoughts are not spontaneous and unalterable, but that research has proved that thoughts and self-control of thoughts are the products of mental training – whether positive or negative.

The format for the chapters on recovery symptoms

No two PDers had recovery symptoms in the exact same order. Even so, the recovery symptoms that tended to occur earlier are in the earlier chapters of this section and the recovery symptoms that tended to occur later on are in the later chapters of this section.

Each chapter has an explanation as to *why* these symptoms occur, a few specific examples of what these symptoms looked or felt like, and an example or two of the fascinating ways in which some PDers have used the recovery symptoms to mentally convince themselves that they were getting worse instead of better.

And did I mention that no two PDers have the exact same collection of symptoms? Each PDer's recovery was also unique.

