"Chiefly the mould of a man's fortune is in his own hands"

Francis Bacon

CHAPTER FOUR

ABOUT THE CASE STUDIES

SOME GENERALITIES

While working with hundreds of PDers, I saw many examples of the same injury-denial pattern that I'd seen in the first dozen people with Parkinson's. The injuries described by my patients were not usually the typical childhood or young adult foot injuries that cause whimpers, tears or screams and which are answered with hugs and kisses. These were *not* injuries from which a person *limped* away with a cheery determination and a defiant cry of, "Don't worry, I'm OK!"

These PD-causing injuries, even at the moment of injury, may have behaved as if they had never happened. They may not have bled outwardly or internally. These injuries may not have swelled up.

The person receiving such an injury may have said nothing at all *or* he may have called out calmly, "Nothing happened." The difference between the PDer and the typical person who calls out with bravado, "Don't worry, I'm not hurt," is that the PDer may have *truly* believed that nothing had happened.

The person who immediately dissociates from an injury may not even be able to cognize that he was injured. And even *if* he was aware of the injury, he may have dissociated from his ability to *feel* the injury: if he had conscious awareness of the injury, he might have felt as if the injury happened to someone else – a numb version of himself.

All of the PDers that we've seen had unhealed injuries in their feet. Very often, the pain, and in some cases, the event, of these injuries had been blocked out of the mind. The injuries have never healed. In *many* cases, the injury had not followed a normal injury pattern of swelling, bruising, bleeding or pain. Instead, the injury froze in place and remained, ever since, as if in a state of suspended animation.

In some cases the complete follow-through of the injuring force never even made it all the way through the injured foot. I have worked on feet in which I found bones that were displaced, frozen into an incorrect position. After such a bone loosened up a bit, *prior* to resuming its correct position, it moved even further in the direction of the injury as if it was completing the follow-through pattern of the blow, before it eventually rebounded back to its correct position, started bleeding internally, and started to hurt.

Lack of a sympathetic hug

Many Parkinson's disease patients feel that they did not have any person in their childhood to whom they could go for sympathy and commiseration in the event of an injury. Others recall sympathy from parents but either hostility towards weakness or praise for "sucking up the pain" from one or both parents.

"Don't show your weakness" was a common childhood theme for the majority of my Parkinson's disease patients. A not uncommon threat in the childhood of many PDers is "Don't cry; if you do, I'll *give* you something to cry about."

Others had a kind and loving guardian, like Katya. As an adult, Katya was very loving towards others and felt strongly the power of the music that she conducted. Still, the violent experiences of Katya's youth and her fear of her grandmother's epilepsy may have been enough to teach Katya to not feel her *own* physical or emotional pain.

Cruelty in the home

Other PDers had situations much worse than lack of sympathy. Many of my Parkinson's patients have shared blood-chilling stories of violent parents, stepparents or guardians.

One told me he had frequently been thrown head first into the wall starting at age five.

Another told me about a game that her father used to play with her in which he would pin her on her back and then force her legs apart, holding her bent knees all the way to the floor until she cried. He called it "tickling" her. The goal of the game was to make her cry. Only when she cried would he stop. She remembers refusing to let him have the satisfaction of seeing her cry. During her recovery, as Qi started flowing through her legs, she became nearly paralyzed for over a year by excruciating pains in her hips.

Finally, after a year of agony, she had a scan done of the hips. The psoas muscles were torn laterally (from side to side), an incomprehensible location for a psoas tear. Though they were not torn all the way through, the area all around the tears was badly inflamed. She took muscle relaxants and pain pills for nearly a year while the psoas muscle rips healed.

Her memory of her beloved father is that he was a good, kind man.

Histories of PDers with wonderful childhoods

Some PDers have told me that they had wonderful childhoods. They too, however, have evidence of an unhealed foot injury. Why did they dissociate from the injury to the extent that the foot was unable to heal? Sometimes the dissociation has nothing to do with family or upbringing: Gus, the PDer with the ammunition-box accident during the war, recalled a particularly wonderful childhood.

One patient who recalled only positive experiences about her childhood did remember not wanting to show injury when she hurt her foot. She was at college, partying with the guys from the swim team. They were trying to do some prank involving a railroad tie. When a car unexpectedly appeared down the street, the boys abruptly dropped the tie. It landed squarely on the center of her foot. She didn't want the boys to think that she was a wimp. She told herself that the injury hadn't happened, and it was as if she'd never hurt it.

Her case had a quirky touch to it: when I first saw her foot, I noticed a tiny shark tattoo on her foot – right over the end of the Stomach channel at acupoint ST-42. I asked why she had chosen that location, and why a shark. She laughed, "Oh, I don't know. I guess I think of sharks as protectors." I asked her why she wanted her foot protected at that particular spot. She replied, "I have no idea. I just did."

Finally, some PDers had no memory of any reason to dissociate from an injury, plus no *overt* indication of injury, such as displacement of bones. Nevertheless, in our experience, he *did* all have some kind of soft tissue knot, muscle tension, or some other sort of foot problem that hadn't healed.

Nails and bicycle spokes

PDers sometimes assumed that their unremembered foot injury must have been something profound or dramatic. This was not the case. Mundane events like nail punctures and bicycle accidents were at the root of many of my PDers' unhealed injuries. Many, many times a PDer has suddenly recalled a nail through the center of the foot while I was holding his foot at ST-42. I can't even guess at how many times I've heard the nail story. What made these nail injuries live on to cause Parkinson's was the manner in which the recipient thought he needed to behave *in response* to the injury.

Another common injury in Parkinson's disease case histories is the foot-in-the-bicycle-spokes accident. Spinning bicycle wheels can exert a tremendous torque on any object that accidentally slips between the whirling spokes. Many patients, during treatment, have suddenly recalled a foot in the spokes injury. But more importantly, they have often recalled a simultaneous embarrassment, shame or lapse into attitudinal training that caused they to deny the very existence of the injury.

The significance of the event isn't necessarily related to whether or not the injury was bizarre or horrendous. The significance is that the PDer dealt with the injury by dissociating from the pain. The result of the dissociation was that the injury could not heal.

A Few Questions That Arise

Before closing this chapter and beginning the chapters that describe how, exactly, reversed Qi flow can cause dopamine inhibition, I want to assuage the most common fears and answer the questions that most often arise when people learn that a foot injury is a causative factor in idiopathic Parkinson's disease.

I hurt my foot once. Am I at risk for Parkinson's disease?

People often ask me if they will develop Parkinson's disease because they recall having received a foot injury at some point. I tell them that it is most unlikely. Everyone has injuries to the feet and ankles, but most people do not develop Parkinson's disease. The problem with the feet in PDers is that they've never healed; the PDer can't visualize his injured foot, he can't imagine light in his foot, he can't really *feel* his own foot – and hasn't really felt it since he *decided* that he should deal with his injury by having it not hurt or not exist.

In and of itself, a foot injury does not cause Parkinson's disease. The inability to process the foot injury and the subsequent electrical changes that occur over decades because of the unhealed injury are causes of Parkinson's disease.

In further answer to the question, "If I hurt my foot will I get Parkinson's someday?" I reply that, even if a person has a foot injury that never healed correctly, if he was *able* to fully feel the pain of the injury, he probably doesn't need to worry. His injury is probably not the type that we see in people with Parkinson's disease. A person who *feels* his long-term injuries and does his best to heal them or favor them or send a little love or attention to them will always have energy flowing to the site of the injury in an attempt to fix the situation.

The problem in Parkinson's is that the injury cannot heal because the mind is pretending the injury doesn't hurt, or doesn't even exist. This is a very different situation than a foot that never heals quite right from a frightening or painful – and acknowledged – injury.

As a purely theoretical aside, the Heartmath Institute of Boulder Creek, California, does research that involves measuring brain and heart electromagnetic wave patterns and heart rate

variability patterns. They have found relationships between these measurable patterns and emotional states. They have developed various techniques of imagining the heart and paying attention to how one *feels* in response to pleasant memories. These imaginings and the increased heart awareness help to entrain the heart and brain wave patterns. When these patterns are entrained, a person is in parasympathetic mode instead of sympathetic: dopamine-releasing mode instead of adrenaline-releasing.

This highly respected organization teaches these techniques to groups ranging from CEOs to fourth graders. They have a very high degree of success. *Ninety-six percent* of the people in their programs are able to perform the simple heart-brain integration exercises, and notice the benefit: a sense of calm and well-being.

I have to wonder about the other four percent. By age seventy, four percent of Americans manifest symptoms of Parkinson's disease. When I asked my patients with Parkinson's disease to try the Heartmath techniques, most of them were utterly unable to understand the very simple instructions. People with Parkinson's tend to be extremely intelligent. But most of my patients had no idea how to even begin *thinking* about following the instructions. As soon as I said the words "heart" and "imagine" in the same sentence, I lost most of them. I have to wonder if the four percent who cannot perform the Heartmath exercises grow up to become the four percent who have parkinson's disease by the time they are seventy.

It may well be that nearly everyone gets foot injuries. The people who get foot injuries who have dissociated from their ability to feel pain may be the ones whose foot injuries fail to heal. These might be the ones, who, if they live long enough, also go on to develop Parkinson's disease.

"I remember hurting my ankle, but not my foot."

The center bone of the foot, also known as the second or "intermediate" cuneiform, is the bone that "travels" the most during every footfall. Due to the interconnected configuration of the foot, injury to almost any part of the foot ends up displacing, at least temporarily, the center bone of the foot. This spot bears the brunt of many foot injuries, whether the point of impact occurs at the toes, ankle, or the sides of the foot.

Due to the elegant precision of the current diversions that should take place at the center bone of the foot, an unhealed foot injury at the very center of the foot can, over time, set in motion a dangerous collection of electrical aberrations. These electrical aberrations mimic the electrical pattern of a severe injury: an injury that requires inhibition of dopamine so that the injured party will be immobilized during the early stage of healing.

While a moderate injury to the thigh, the torso, or the upper arm may be problematic, they will not set in motion backwards flowing currents. If these larger areas are injured, the local currents are able to flow around and past any electrical glitches. An injury in these areas will not set in motion the electrical aberrations that cause Parkinson's disease. An unhealed center-of-the-foot injury, however, might spell long-term trouble. The reasons for this will be detailed in chapter xxx.

"My foot bones are fused and/or wired together. Is there any point in trying to recover?"

The problem is not actually the foot bone displacement, per se. The problem is that the currents that run through the foot are distorted. We've worked with many patients like Chuck, whose feet are not completely "curable." By using Yin Tui Na, we've been able to bring the patient's attention to the foot while not actively doing anything to the foot. We've found that,

when a person's awareness starts to go to an injured area, the body's natural tendency is to *first* heal the patterns of electrical flow in the area. Whether or not the bones or tissues can ever completely heal is secondary. As soon as the electrical pattern ceases to run backwards, the brain's inhibition of dopamine can cease. In other words, if the body can create some satisfactory way for currents to flow past the injured area, the dopamine-inhibition and other symptoms of Parkinson's will cease. But the body cannot create those healed patterns until the mind is willing to pay some attention to the problem.

What if I don't remember the injury? Can I still recover?

Not everyone could remember the injury that set the Parkinson's disease in motion anywhere from fifteen to sixty years after the injury occurred. Many patients racked their brains trying to remember a significant injury. They asked old friends and family members, but come up blank. Some admitted that there were just so many injuries, and they never did pay much attention to any of them, that it would be impossible to single one out as the most likely culprit for triggering the Parkinson's disease.

Some patients felt bad about not being able to remember. Others were concerned that, if they couldn't remember, the Parkinson's disease wouldn't go away.

Actually, remembering the injury didn't seem to matter. If I had to guess at the numbers, I would say that about three fourths of my patients have, sooner or later, remembered their foot injury. Some remembered the injury during treatment. Others have always remembered it. About one fourth never did recall anything in particular. Apparently it is not a requirement of recovery that one must remember the injury that set the channel Qi running backwards.

It appears, thus far in our research, that as long as the Qi of the foot is restored to its correct flow pattern, the electrical currents will be able to run correctly again. Even PD patients who could not recall a specific instance of foot injury are walking around today completely relieved of any symptoms of Parkinson's disease.

Is the injury always visible by X-ray?

Is there any way of proving that there is a physical displacement?" The answer is "sometimes."

I included Lila's case because she had absolutely *no* displacement of bones whatsoever in her graceful foot. The foot moved easily in every position. The tension was in the soft tissue, not in a wrong bone articulation. It was only by holding the center of her foot patiently for a few hours (spread over several weeks) that the holding pattern in the soft tissues relaxed.

As in Lila's case, it is possible for the bones of the foot to be more or less in the correct position relative to each other, even if there is an injury in the area. Sometimes there is only a very subtle displacement. An X-ray may not reveal anything out of place in these cases.

Some PDers feet have glaring displacements. In our patients, the most common displacements were in the bones around the intermediate (2^{nd}) cuneiform bone: the navicular, the proximal ends of the 2^{nd} and 1^{st} metatarsal, and the 1^{st} and 3^{rd} cuneiform. Some of these might have been visible in an X-ray. Other displacements are not uncommon, or may exist in combination with the above "most popular" sites for displacement.

If a person wants radiological proof of displacement, he might want to pay close attention to whether or not any of the cuneiforms have shifted too far towards the dorsal or the plantar side of the foot. These bones are supposed to be able to move up and down. If one gets jammed, it is usually after moving too far up or down and then not being able to drop back into place. Then

again, an X-ray may *not* show proof of injury even though the foot is jammed stiff and the foot bones are clearly unable to articulate correctly.

And while discussing X-rays, another PD patient, during the course of treatment, began experiencing terrible pain in his ankle. He finally had it X-rayed. There was a large *displaced* break in the ankle. He knew how it had happened: he had dropped a box spring mattress on his ankle while trying to muscle the mattress up a narrow stairwell. He and the mattress had both gone crashing partway down the stairs. This had occurred six years earlier. The doctors who did the ankle X-ray after the severe pain started could not understand how he had been bearing weight on that ankle for six years with the bone in that condition.

Isn't denial of injury and emotional pain a sign of maturity?

People with Parkinson's disease typically have tremendous mental control or did when they were young. It requires ferocious mental mastery to *choose* to not feel physical or emotional pain, a mental stance that allows the PDer to "not be hurt."

The PDer may imagine that when he says, "I shall not be hurt!" his body *is* not hurt. But in fact, if an injury has occurred, the body *has* been hurt. Even before we came to understand the dissociation response that makes this denial possible, I pointed out to many PDers that inability to acknowledge an injury is not the same as *not having had* an injury, and it is not the same as mentally *healing* the injury. The denial of the pain of the foot injury that appears to be a commonality in Parkinson's disease can *prevent* the healing of the *very real* damage.

The person who adapts this mental posture is building upon the survival mechanism of holding on to an injury until such time as it is safe to let go. However, he takes is a step further: he never lets go. This is *not* a healthy, long-term solution to injury.

In the days when people only lived thirty or forty years, denial of pain may have been an effective short-term solution. But now we are living longer, long enough that our bodies can exhibit the slow-to-develop side effects of unhealed injuries. Our research suggests that using selective dissociation to inhibit the ability to feel a very real injury can lead to the type of dissociation that shuts down neurotransmitters and makes the body increasingly rigid: ultimately leading to the Parkinson's syndrome, which is far more devastating than the original injury might have been.[1]

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[1] Researchers have pondered the increase in the number of Parkinson's disease cases in the last few decades, and some have made the blind guess that this can be attributed to environmental pesticides. They should look closer to home, on the bodies of the patients themselves. The telltale signs of backwards-flowing Qi have other pathological manifestations besides Parkinson's disease. *Years before the PD was diagnosed,* many of my PD patients and a relatively higher percent of my younger PD patients have had a tumor, cancer, sarcoma or melanoma removed that was located exactly on the narrow route of the Stomach channel, on the same side of the body where the PD eventually appeared.

Irregular electrical patterns of Rebellious (backwards-flowing) Qi can create aberrations in DNA expression. This leads to irregular cell growth. It may well be that the faster-developing types of PD are so electrically powerful that the Rebellious Qi generates electrical aberrations potentially more dangerous and lethal than PD: cancer.

Possibly, until recently, many people with subclinical PD died of cancer long before Parkinson's symptoms were discernible. Now, in modern times, these superficial (skin based) growths are usually detected early and removed. The patient assumes that the growth was just a spontaneous, strange event, which occurred out of nowhere.

In fact, it may be that the reason that there seems to be more PD in these recent years is that other side effects of rebellious Qi, such as cancer, which used to be fatal in the past, are now successfully treated, so that the

Then again, if parents or caregivers for the child were violent enough that the child feared for his life, the child did the right thing, possibly a life-saving thing, in dissociating from his ability to feel pain, and activating in himself an extreme rigidity or stillness during those times when his slightest movements might have triggered or increased the rage or violence.

Some PDers have, during recovery, remembered that they practiced consciously dissociating from their physical and emotional pain as a response to the non-life-threatening pain of school-yard rejection. Whether the dissociation was in response to a life-threatening injury, fear of parental response, or the emotional agony of childhood rejection doesn't seem to matter. If a person practices cutting himself off from his ability to feel his own physical and emotional pain, he may well activate the same dopamine-inhibiting processes that occur during severe trauma. If he practices it enough, it can become a habit.

And if he practices it with regard to an injury, the body will not be able to heal that injury.

CONCLUSION

In our limited experience, every person with in idiopathic Parkinson's disease had an unhealed foot injury. We now assume that denial of the physical or emotional pain of the foot injury allowed the injury to remain unhealed. The gentle treatment allowed the patient to part the veil of dissociation that he had placed around his foot injury. Then, his foot could begin to heal.

Unexpected, even painful, and very often counterintuitive recovery symptoms were not predicted, but patients developed them nonetheless. These *recovery* symptoms, as much as the symptoms of Parkinson's disease, helped us figure out the electrical disarray that causes idiopathic Parkinson's disease.

However, some patients developed intermittent, psychologically triggered symptoms of psychogenic parkinsonism after their foot injuries healed and the symptoms of idiopathic Parkinson's started to go away.

Our researches suggested that these intermittent symptoms had a purely mental or emotional origin, and were being set in motion via dissociation from the body or parts of the body during times of conscious or unconscious stress.

The case study excerpts in the preceding two chapters hopefully showed why we now hypothesize that a foot injury plays a role in the development of Parkinson's disease. Hopefully, they also show why, from the earliest days of our research, we began to suspect that most PDers have, to varying degrees, a mental/emotional component to their illness that may or may not have been set in motion at the time of the foot injury.

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person lives longer. He is thus able to develop the long-term consequences of rebellious Qi in the Stomach channel, which are the symptoms of Parkinson's disease.

Based on our findings, not only is Rebellious Qi in the Stomach channel a problem now that we are living longer, but Rebellious Qi in the Stomach channel is a cancer-causing killer in its early stages, decades before it causes the syndrome known as PD. No wonder the Asians used the word "Rebellious" to describe this treacherous type of Qi.