

“All happy families are happy in the same way. All unhappy families are unhappy in their own way

Anna Karenina, by Leo Tolstoy

CHAPTER TEN

INTRODUCTION TO DISSOCIATION

The first chapter included passing references to “dissociation” and “mental/emotional blockages.” In order to recover from Parkinson’s, some – though not all – PDers need to consciously rid themselves of their pain-related dissociations. Therefore, the next few chapters will go much deeper into these subjects. This introductory chapter will touch on a wide spectrum of dissociation-related subjects ranging from definitions to our statistical methods.

WHY ARE THE BLOCKAGES BOTH “MENTAL” AND “EMOTIONAL”

“Mental/emotional blockages” are so called because they are *mentally* executed dissociation responses to painful events. These responses are locked in place by the *emotion* of fear. The blockages can technically be referred to as “dissociations.” However, within the field of medicine, the word “dissociation” refers to two very different types of events: one is a conscious or subconscious decision, the other is an automatic, reflexive response. In addition to having a foot injury, PDers have one or the other *or both* of these types of dissociation.

GATHERING STATISTICS: NO TWO PDERs ARE THE SAME

As you may have guessed from the case studies in chapter two, no two of our patients with Parkinson’s had the *exact* same kind of dissociation from the foot injury. Some of them were like Gus, who had merely dissociated from his memory of his war-time foot injury, along with all the other events of that bloody day. Others were more like the frequently abused Lynne, who, at an early age, even before her foot injury, had dissociated from her ability to feel any physical or emotional pain.

There was an enormous range in the degree and breadth of PDers’ dissociation from pain: some people dissociated only if they anticipated severe pain; others dissociated if there was a risk of feeling *any* physical or emotional stimulation. Some people had taught themselves to dissociate from the ability to feel *if* they were in the presence of anyone or anything that possessed qualities that in any way resembled qualities of the person or thing that had first terrorized them; still others had convinced themselves that a heartless dissociation from all physical and emotional sensations was the route to spiritually superiority. Every PDer had created his own rules as to which activities or relationships were potentially pain inducing and which activities or relationships were emotionally “safe.” Because most PDers’ *dissociations* came to the fore or retreated back into their mental dens depending on mood, emotion, and external circumstances, their Parkinson’s symptoms also ebbed and flowed, depending on mood, emotion, and external circumstance. Possibly the strongest examples of these day to day, and even hour to hour, changes in most PDers symptoms are the “safe” activities.

Example of “no two the same”: variations in safe activities

Many case studies are available in the Parkinson’s literature describing PDer’s with one or more “safe” activities. When PDer’s do these safe activities, which might be anything ranging from painting to playing the violin to doing the crossword puzzle, they can initiate movement perfectly *normally*, even if, the rest of the time, their Parkinson’s symptoms are so highly advanced that they are in a wheelchair and/or otherwise unable to care for themselves.

Even our small project had a few PD patients who had safe activities. During these periods of normal movement initiation, they still manifested their purely *physiological* PD impediments such as poor foot circulation and facial numbness. However, like any other person with a few purely *physical* impediments such as a missing leg, they were able to *initiate* and *execute* most movements with normal fluidity and speed. However, as soon as the “safe” activity ended, they immediately reverted back to rigidity and poverty of movement.

Even though these cases, in which a person with very *advanced* PD can still move normally during a safe activity, are somewhat rare, *every* person with idiopathic Parkinson’s disease will confess, if pressed, that his ability to initiate movement or the size of his tremor varies from one day to the next, and even one minute to the next – and that these variations seem to be based on habit, mood, and circumstances: *not* pure physiology.

Even though a majority of our patients consider themselves to be very logical and analytically minded, they have rarely stopped to consider the implications of these movement variations. As one PDer put it, “I’m really mad at my family. They keep pointing out that I can move easily when we’re doing things that I want to do but I can barely move when we’re doing things I don’t want to do. They say there’s a psychological component.”

I replied, “But evidently they’re right, aren’t they?”

She snapped back, “Yes, but I don’t like it when they point it out. It hurts my *pride*.”

“But maybe there’s something psychological that can be rooted out so that you can move normally *all* the time.”

“I don’t want to discuss mental problems. Parkinson’s is a *real* illness.”

(The patient quoted above did talk with her young, well-informed neurologist the next week. She reported back to me that she’s asked him if Parkinson’s had an emotional component. He’d said yes. I asked if she was now willing to work on some of the mental issues. She said no.)

Generating statistics

Because one of the dissociations PDer’s use is *mentally* induced, as demonstrated by the existence of “safe” activities, PDer’s movement and tremor variations are as infinite as the human capacity for thought. Because of the extreme range of variations in our patients, I have been unable to use the statistical conventions so loved by medical researchers. Instead, throughout this book, the words “a few” “some,” “many,” and “most” are used to describe the numbers of people we saw with specific Parkinson’s symptoms or specific recovery symptoms.

Needing a thousand patients

In 1999, a PDer with a degree in medical statistics was frustrated with my lack of precise numbers. He traveled to the United States from his home in Germany to teach me how to create a meaningful assessment of my research. For two weeks, he observed patients at the free clinic, observed the Parkinson’s Treatment Team’s private patients, and was treated himself. At the end of two weeks he announced, “No two of your dozens of patients are anything like each other. They are all going through changes, but no two of them are going through the same sets of

changes. There is no way that you can create any *meaningful* statistics about your program. Your patients all appear to be recovering, but you will probably need to treat more than a thousand people before you can have anything approaching meaningful numbers.”

His words resonated with a warning I had received earlier. When I first started the Little Project, Dr. Fred Jones, our advisor who used to teach medical research, told me, “Parkinson’s is thought of as incurable. Therefore, every single case of a person who recovers will be considered anecdotal, and probably deemed a case of misdiagnosis. You will need to have at least a thousand recoveries before the medical community even considers looking at your work.”

Dr. Jones went on to point out that, in the field of psychology, the single-case study was becoming increasingly acceptable. In recognition of the fact that no two people are psychologically alike, researchers in psychology have always been able to publish and present hypotheses based on what happened with *one* patient. These single-patient reports were increasingly acceptable to researchers in the more “scientific” field of general medicine. Therefore, he encouraged me to write up our findings using examples from single-case studies, while foregoing the statistical side of things until we’d had more than one thousand patients. Because we did eventually find a psychological component to Parkinson’s, Dr. Jones’ advice was particularly appropriate, if not prescient.

He gently encouraged me by adding, “The way I see it, you only have two choices. Either you can keep treating people, and someday folks will say, “There used to be a woman who could cure Parkinson’s disease, but she’s dead now.” Or, you can write up everything you do and everything you know, and try to figure out a way to *explain* what you’re seeing and thinking and what you’re doing so that other people can understand what you’re doing, replicate what you’re doing, and even build on it. And maybe in twenty to a hundred years, the medical community will accept that there is a cure for Parkinson’s disease.”

When he put it like that, I had no choice. With Fred’s admonition in mind, these chapters on dissociation explain what we saw and what we’re now thinking about the psychological component to Parkinson’s disease.

DISSOCIATION FROM THE HEART

I’ve already mentioned that one type of dissociation is a mental decision. This is the type of dissociation that allows a person to mentally not know about his foot or things that happen to his foot, as if his foot does not exist, or he can’t actually feel his foot, or his foot injury hadn’t happened, or if it happened, it didn’t hurt. These are all somewhat normal dissociations.

We slowly figured out, and were eventually able to prove, that a person of great will power and mental focus can perform a different type of dissociation, one that is *highly* specific, in which he dissociates, *not* from the thought or memory of an event, activity, or body part, but from his heart’s *ability* to physically resonate with or register the electromagnetic waves and electrical signals that are created by pain. This type of dissociation might also be described as dissociating from one’s ability to feel pain. Selectively dissociating from the actual physical heart *and* selectively dissociating from pain are actually one and the same thing.

If, in the above paragraph, I had merely written, “Some people dissociate from their heart,” my words might be taken metaphorically; a reader might assume that I was trying to say that some people dissociate from their inner goodness or some such thing. That would be inaccurate. The reason I described this type of dissociation by saying it applies to “the heart’s ability to physically resonate with waves and signals” is because the reader needs to appreciate

that, when I say “heart,” I am talking about the physical organ of the heart and the role it plays in responding to pain signals that come from the brain.

We discovered that this fairly rare type of dissociation, if cultivated and practiced vigorously, can trigger a modified version of an automatic, reflexive neurological state that ordinarily is only activated following a severe loss of blood, severely punctured skin, or a trauma that leaves a person at the edge of death. This well-studied neurological state causes rigidity, difficulty in initiating movement, cold skin and extremities, a shut down of dopamine and a minimizing of adrenaline, and numbness in the heart nerves that communicate sensory responses to the brain. If a person survives the trauma, he may tremor while coming back out of this neurological state. In other words, a body’s condition while in, or while coming out, of this neurological state resembles the conditions that slowly develop in Parkinson’s disease.

Horribly, terribly, confusingly (from a writer’s standpoint), this neurological condition that *usually* occurs reflexively, or you might say “*automatically*,” a condition that in animals and most humans has *nothing* to do with mentally choosing to dissociate from an unpleasant event or memory from normal consciousness, is also called “dissociation.”

To make things easier for the reader and myself, I have named this neurological condition “*automatic* dissociation.”

Now, with this new vocabulary, I repeat: some people can, with one quick mental dissociation from the heart, turn off both the heart’s ability to resonate with sensations and the heart’s ability to transmit information about that resonance to the brain. This dissociation from the heart prevents a person from being able to feel physical pain from injury or the physical pains associated with emotional distress. This *self-induced* numbness to one’s own pain, triggered by dissociation from the heart, can lead to symptoms identical to those of *automatic* dissociation which, in turn, are nearly identical to the symptoms of Parkinson’s disease.¹

Putting it another way, if a person merely dissociated from the *event* of his foot injury, a more common type of dissociation and one that might only prevent him from being able to remember his injury, he might not develop Parkinson’s disease because his body would still be able to know that he had a foot. He might have a limp and a sore foot, even if he couldn’t remember *why* he had a sore foot. His foot would be able to heal even though he didn’t remember the injury event because his foot would still send pain signals to his brain and heart. But if he doesn’t *feel* the foot injury because he’s dissociated from his ability to feel physical pain – a neat trick that requires turning the heart off – he might *never* be able to even know that he has a foot injury. Therefore, he cannot heal from it.

When we finally learned enough to start asking the right questions, we discovered that this terribly strange decision, a decision to rise above pain by the austere method of walling the heart off, killing the heart or rendering the heart unresponsive, or even mentally removing one’s *physical* heart, had been consciously made by many – but not all – of our patients with Parkinson’s.²

¹ Researchers in the relatively new field of neurocardiology have discovered that nerves in the heart, and the electromagnetic heart waves, similar to but much more powerful than brain waves, play an enormous role in sensory perception. The heart, it turns out, is just as much a sensory radio as it is a pump for the blood. More about the findings in this new field that relate directly to Parkinson’s is presented in chapter xxx.

² A few of my PD patients had seen other practitioners of Asian medicine before they came to see me. In two cases, the acupuncturists contacted me, with the patients’ permission, to tell me confidentially that they feared a heart problem was the underlying problem, and *not* Parkinson’s disease (which they assumed was a brain disorder).

By dissociating from their hearts for decades, they had unwittingly set in motion the PD-like symptoms of automatic dissociation: symptoms that exactly resemble those of Parkinson's disease. How true it is, that "truths suppressed lead disconcertingly to a host of errors."¹

Dissociation from the heart, with no foot injury: psychogenic parkinsonism

Before I can actually launch into the discussion of the various types of dissociations that PDer's often have, I must discuss a tangentially related illness: psychogenic parkinsonism. This condition, only recently named "psychogenic parkinsonism," sheds light on the role of the mind in creating symptoms of Parkinson's. People are usually diagnosed as having *had* psychogenic parkinsonism only after they recover from it. Psychogenic parkinsonism is diagnosed in people who recover from Parkinson's disease, people who presumably had idiopathic Parkinson's disease.

If a person manifests increasing rigidity, poverty of movement, postural instability and/or tremor, and is therefore diagnosed with Parkinson's, and *if* this person's Parkinson's goes away, his diagnosis will be *retroactively* changed to psychogenic parkinsonism. In many cases of psychogenic parkinsonism, the patient can recall a traumatic event that coincided with the onset of symptoms, *or* (more importantly) an emotional release that coincided with the cessation of symptoms. Therefore, the current assumption is that some emotional shock causes psychogenic parkinsonism to develop; when the patient recovers from the emotional shock, the parkinsonism can go away.

When I first started the Little Project, Parkinson's disease was supposed to be incurable. At that time, doctors still slapped a label of "neurotic" on any person who had symptoms of Parkinson's disease but who eventually recovered. The assumption was that these people had only pretended to have symptoms of Parkinson's for hysterical reasons of their own. Some of my first patients to recover were told, when their symptoms went away, that they were neurotic, or that they had pretended to have Parkinson's disease.

At about the same time that PET and then SPECT scans became available, the diagnosis for people who spontaneously recovered from Parkinson's was changed from "neurotic" or "pretended to have had Parkinson's" to "psychogenic parkinsonism." I have to wonder if this change came about because people whose parkinsonism turned out to be "psychogenic" had brain scans, during their period of parkinsonism, that showed the *same* pattern of diminished dopamine receptor activity that is sometimes seen in the brain scans of people with idiopathic Parkinson's disease. In other words, even if the Parkinson's symptoms cleared up when the patient ceased being emotionally inhibited, the patient *had* been through a period during which dopamine receptor activity had been *measurably* reduced. If there was a measurable cause, then these people had *not* been pretending – they really had experienced a problem that causes symptoms indistinguishable from the symptoms of Parkinson's disease.

However, since these patients had recovered, and since the Current Wisdom was still clinging to the dead dopamine-cell theory and the idea that Parkinson's was inherently incurable, it was wrongly assumed that psychogenic parkinsonism and idiopathic Parkinson's disease could

By using tongue and pulse diagnosis, they had both detected deficient levels of Qi in the hearts of their PD patients, even though, from a mechanical standpoint, the person's heart muscle was working perfectly normally and was perfectly strong. I had to tell these acupuncturists that modern heart research, and our findings as well, showed that heart nerve dormancy was actually a symptom that nearly all PDer's have in common – even though every PDer's overall *collection* of symptoms is unique.

¹ Paramahansa Yogananda, in his *Autobiography of a Yogi*.

not have anything in common. The strong emotional component for the former was proposed at that time, and remains the medical community's hypothesized basis for psychogenic parkinsonism.

The Little Project had two patients with psychogenic parkinsonism. Their symptoms and personal stories contributed to our understanding of the dissociation processes at work in people with idiopathic Parkinson's disease. One of these patients, who had no evidence of foot injury and who, when her mother had died, more than fifty years earlier, had made a *conscious* decision to *not* have a heart that could feel emotional pain, had a PET scan that showed diminished dopamine receptor activity. Her symptoms of parkinsonism appeared, full-blown, the day after she was diagnosed with osteoporosis (the illness that she most dreaded). However, she only had symptoms of parkinsonism when she walked or was eating: when she might be in danger of breaking a hip or when she might be in danger of the poor nutrition that she presumed was the cause of osteoporosis. At all other times, she could move perfectly normally. For example, when she was sitting down, she could gesture with her arms while speaking, cross her legs without thinking about it, talk rapidly, and move perfectly normally. She had no stiffness anywhere in her body if she was not in danger of falling down or in danger of eating anything "wrong."

Her neurological had given her a diagnosis of Parkinson's disease. She wanted me to agree with his diagnosis of idiopathic Parkinson's so that I could "fix her." Based on her ability to move normally except when she was worried about breaking her hip or eating wrong food, I could not. Also, she had none of the Qi flow aberrations that I had seen in hundreds of people with Parkinson's disease. She then saw another doctor, who confirmed that she did *not* have idiopathic Parkinson's disease, but seemed to have some sort of mentally-induced immobility during certain activities. Her original neurologist maintained that she had Parkinson's, and pointed at the brain scan to prove it.

At every subsequent visit, when she demanded I diagnose her with idiopathic Parkinson's, I mentioned one small, very specific, "classic" symptom of idiopathic PD that she did *not* have. At the next visit, she would conveniently have the exact symptom that I had mentioned. I would point out another symptom that she did not have. At the following visit, she would have developed the next symptom. This went on for two years. She had no foot injury, and clearly had mind-induced parkinsonism. We learned a lot from her that crossed over to our research on people with idiopathic PD.

The other patient with psychogenic parkinsonism had, at age four, after losing four elderly aunts and uncles to heart attack over the period of less than a year, decided that the only smart thing to do was to not have a heart. After that, she was unable to cry at sad stories and events and unable to be shaken by startling circumstances. She was not worried by these attributes, but other children often accused her of being heartless. She often wondered what led the other children to suspect that she had secretly removed her heart. Her first parkinsonism symptom to appear, when she was seventy years old, was stiffness in her arm, and tremor. She had no history of foot injury. She also said that she knew that she needed to stop pretending she had no heart, but that she was terribly afraid to resume having a heart because of the bottled up pains that she just knew she would feel if she did. Her case, and the preceding case, both helped us learn to ask the questions that finally led us to discover the selective heart dissociation in people with Parkinson's disease.

We'd known since 1998 that everyone we'd seen with Parkinson's disease had an unhealed foot injury and aberrant Qi in the Stomach channel. Over the next ten years, assisted by

our wonderful patients, and even the two patients with psychogenic parkinsonism, we figured out the mental angle that was keeping the foot injury in place.

As an important aside, please note that when people with psychogenic parkinsonism recover, they do *not* experience the changes in blood circulation in the face or foot, the stinging or tingling in long-numbered toes and face, the recovery dyskinesia or any of the other purely physical recovery symptoms that are described in chapters xxx through xxx. Oppositely, our patients with *idiopathic* Parkinson's disease, all of whom had unhealed foot injuries, *did* experience some of these physical changes when their feet start to heal.

Foot injury and the various dissociations: two distinct problems

People with idiopathic Parkinson's disease have a foot injury *and* some collection of dissociations. *All* of our patients with idiopathic Parkinson's disease had dissociated to some degree from their unhealed foot injury. *Some* had dissociated from other body parts, as well. *Some* of them had *also* dissociated from their hearts' ability to recognize vibrations that are triggered by various sensory events such as pain. The latter PDers had this heart dissociation in amounts ranging from "a little, now and then, depending on circumstances," all the way to "I do not have a physical heart, therefore I *never* feel physical or emotional pain."

Based on what we've seen and heard, we hypothesize that people with psychogenic parkinsonism have dissociated from their hearts, but do *not* have an unhealed foot injury. In other words, all our PD patients except the people with psychogenic parkinsonism had at least two *major* problems: 1) an unhealed foot injury *and* 2) one or more types of dissociation.

We came to suspect that, because people with psychogenic parkinsonism have only one of the *major* problems instead of two (they don't have the foot injury problem), they can "spontaneously" recover if they come to terms with their heart dissociation that was induced by a fear of pain: they are not locked into Parkinson's by an unhealed foot injury.

Now that I have introduced the idea that there are two *major* components, a foot injury and one or many dissociations, I can begin to discuss the rates of recovery for people with Parkinson's disease. I introduce this "rate of recovery" idea here because the varying tempos of recovery demonstrate the importance of the dissociations.

Recovery from both Parkinson's problems: the foot injury *and* the collection of dissociations

Easy recovery

Some of our patients recovered fully, within a few weeks or months, after the foot injury started to heal. A selective dissociation had evidently been in place, preventing them from being able to acknowledge or fully heal the foot injury. As we brought their attention to the foot, by using very gentle Yin Tui Na, the foot injury healed, sensory feeling improved in the foot, circulation in the foot improved along with better temperature regulation, and mental awareness of the foot improved. These patients had all had an unhealed foot injury and a dissociation: a mild dissociation from their foot injury.

Recovery with some emotional shifts

Other recovered PDers, as their foot injuries responded to treatment, *automatically* underwent changes in their attitudes towards heart feeling and feeling safe. For example, when

their foot injury began to heal, some of them suddenly realized that it was OK to cry in front of other people. Others were *able* to cry for the first time since early childhood. Some, when the foot injuries began to heal, found themselves undergoing emotional maturation with regard to long-held fears or susceptibility to moods. Many made carefree remarks such as “I know I was late for my appointment today, but what the heck; it’s not like anyone’s going to die.” These remarks, which reflected a feeling of “I’m safe *even if I make social mistakes*,” were stunningly uncharacteristic of their previous personalities, personalities that had been remarkable for their projection of responsibility and “correctness.” Others who were obviously healing from the foot injury nevertheless needed to put in a bit of conscious work to overcome some hesitancy when it came to being aware of and expressing the new feelings emanating from their hearts – including the feeling of having a foot.

These patients had each had an unhealed foot injury and dissociations (plural). Their dissociations included a mild dissociation from their foot injury *plus* mild to moderate levels of dissociation from their hearts.

Recovery with some tough emotional challenges – usually slow

Still other patients with idiopathic Parkinson’s disease manifested symptoms typical of recovery from Parkinson’s when their foot injury began to heal, but then started experiencing intermittent bouts of moderate to severe parkinsonism when confronted with specific situations, activities, or people. Very often, the fear induced by these *lapses* into parkinsonism caused these people to panic and/or rapidly become more wary, and less and less able to ever feel safe. As their ability to feel safe diminished and their emotional wariness rapidly increased, sometimes overnight, their fear of being emotionally susceptible and their fear of not ever recovering from Parkinson’s disease seemed to burgeon, as well. Along with these increases came an increase in rigidity, tremor, and other symptoms of Parkinson’s. These increases came about far faster than the expected development trajectory of Parkinson’s.

These people were only able to bring about a *permanent* recovery from Parkinson’s symptoms by teaching themselves how to feel safe *and* relearning how to feel physical and emotional pain and pleasure. (As many PDers finally came to realize, when you make yourself impervious to the sensations of pain, you risk making yourself impervious to sensations of pleasure, as well.)

Based on their eventual complete recoveries and their collections of recovery symptoms, we were able to make the case that, even though these people *recovered* from their foot-injury induced idiopathic Parkinson’s disease and had the usual physical symptoms of recovery, they also continued to have psychogenic parkinsonism. Only when they did the necessary work to heal emotionally, as well as physically, did they *completely* recover from Parkinson’s.

These patients had each had an unhealed foot injury and dissociations (plural). Their dissociations included dissociation from their foot injury *plus* a *high* degree of dissociation from their hearts.

Review of recovery from both problems

When we consider all the variables that contribute to the eventual manifestations of the conglomeration of symptoms that doctors lump together and call “Parkinson’s disease,” it is no wonder that no two PDers have the exact same collection of symptoms: no two people with Parkinson’s disease *could* have the exact same combination of physical and mental/emotional *causes* for their symptoms.

And yet, we were able to construct two generalities:

1) All our patients with idiopathic Parkinson's disease had an unhealed foot injury. Energy in their leg(s) was palpably running backwards, *up* the anteriolateral side of the leg, instead of making it past the injury site and proceeding gaily to the toes. This backwards-running electrical pattern, which matches the electrical disarray that occurs during severe injury, causes dopamine-inhibiting shifts in the electrical signals in the brain. These electrical signals, over time, cause the physiological symptoms of Parkinson's disease.

2) All patients manifested some degree of mental dissociation. These dissociations could be placed on a spectrum ranging from mild dissociation, having only to do with the foot injury, to extreme dissociation, in which a person had dissociated from his physical heart's ability to resonate with sensory stimuli and convey that resonance to the brain. This latter dissociation triggered symptoms of *automatic* dissociation. Automatic dissociation causes symptoms that exactly resemble those of Parkinson's disease.¹

After we digested the above information, we finally realized this: if a PDer had both a foot injury *and* symptoms of automatic dissociation (from dissociating from his heart), he essentially had two kinds of Parkinson's disease occurring simultaneously. He would have to recover from both if he wanted to completely recover.

I know I am being redundant here, but I need to drive this home: the symptoms of Parkinson's disease can be triggered in either of two ways: severe or long-term *unhealed* injury *or* dissociation from the sensory resonance of the physical heart.

Just over twenty of our more than two hundred patients with symptoms of Parkinson's disease recovered after receiving foot treatments and doing *no* emotional work, so we can assume that they *only* had the foot injury and foot-specific dissociation. Two of our patients had psychogenic parkinsonism and *only* had dissociation from the heart and no foot injury. Most of our patients had both an unhealed injury, dissociation from the foot, and some degree of

¹ These two methods, the foot injury and the mental dissociation from the heart, are not the only ways to produce symptoms of Parkinson's. *Short-term* symptoms identical to the symptoms of Parkinson's disease can be triggered in many ways. For example, a person who accidentally gets locked into a walk-in freezer for a bit too long will come out severely hunched over, shuffling, no arm swing but trembling, with poor balance and reflexes, cold skin and extremities, and an expressionless face. The symptoms go away when he warms back up. A person who for several hours has been running a high fever or suffering severe pain from intestinal troubles may struggle out of bed in order to shuffle slowly into the bathroom, with his body hunched over, no arm swing, no facial expression. If, on top of all that, he's got the hot and cold running chills, he may be trembling. The symptoms go away as soon as the fever drops or the pain goes away. A person can also be temporarily rigid, slow moving, and/or trembling following a severe emotional shock. For some reason, most people with Parkinson's never stop to think that these short-term symptoms that we've all seen or even experienced might just have the same biological root as the symptoms of Parkinson's: dopamine inhibition. Because these are short-term events with an obvious cause, they aren't mysterious or even worrisome. And yet, when these symptoms occur over the long-haul, doctors are mystified and wonder what calamitous events must be taking place. But the cause is just the same for the long-term situation as it is in the short-term situation: dopamine inhibition. The difference is that, in Parkinson's disease, the cause is unremembered because it has usually been in place for a long time *and* the person is mentally holding on to trouble that started the dopamine inhibition in the first place. The symptoms of Parkinson's disease appear when the PDer can no longer summon up the adrenaline to *mask* the symptoms. That's when his perfectly natural dopamine-inhibition starts to become obvious. As for the PDer's decrease in the number of dopamine-producing cells in his midbrain, that is the result of the body's very efficient "use it or lose it" policy. Happily, the body also has an "increase the use and you'll increase the juice" policy.

dissociation from the heart. In this latter group, some of their heart dissociations were mild and intermittent. Some of them had constructed heart dissociations as severe as the heart dissociations in our two patients with psychogenic parkinsonism, in which the patients had decided, astonishingly, to not *have* a physical heart.

TWO TYPES OF “DISSOCIATION RESPONSE”

Up until now, I have touched ever-so-lightly on the subject of there being two types of dissociation: 1) dissociation from awareness of body parts, including awareness of the heart, and 2) automatic dissociation. In order to make more sense of the upcoming discussion of both these types, I need to expand on the fact that “dissociation response” means two different things to two different groups of scientists.¹

Animal behaviorists and some doctors use the term “dissociation” to refer to a group of short-term physiological changes that occur following severe trauma. These changes might even be referred to as “pre-death” changes. As mentioned earlier, these changes include rigidity, difficulty in initiating movement, cold skin and extremities, a shut down of dopamine and a *minimizing* of adrenaline, and numbness in the heart nerves that communicate sensory-resonance responses to the brain. I refer to this process as *automatic* dissociation.

If an animal in a state of automatic dissociation manages to pull through, these changes ebb: the animal reverts to normal physiology.

Psychologists, psychiatrists, and some other doctors use the term “dissociation” to refer to the process of mental compartmentalization or separation that allows certain memories or thoughts to be kept apart from normal consciousness.

Some amount of psychological dissociation is perfectly healthy. For example, if, while reading a book, a person “tunes out” a ringing phone or doesn’t realize how much time has passed, he has “dissociated” from the phone or his awareness of time. The degree to which a person can dissociate is directly related to the degree to which he can maintain focus while “tuning out” distractions. The ability to dissociate is considered innate: we are born with it. But some people can dissociate from distractions better than others. In this book, I will refer to this psychological phenomenon as *selective* dissociation.

I repeat: in order to differentiate between these two very different types, I made up the term “*automatic* dissociation” to refer to physiological shifts that occur automatically following severe trauma or loss of blood. I made up the term “*selective* dissociation” to refer to the

¹ Dissociation is a bothersome word! To chemists, dissociation refers to a specific type of chemical breakup. To sociologists, dissociation refers to a person no longer identifying himself as part of some group. To some spiritualists, dissociation describes the attitude a person should have towards his body in the sense that he does not *identify* himself as his body, but identifies himself as his soul. The spiritual man uses his body and feels his body, and takes reasonably good care of his temporary body. He uses the body as a mechanism for interfacing with and feeling *deeply* the Divine presence in everything via sensory experiences: the wholesome sights, sounds, smells, tastes, and touch sensations of the world. But he is dissociated from these experiences inasmuch as they are not actually happening to *him*, to his soul. His soul is able to enjoy them, via his body, in the way that a person enjoys a movie.

Dissociation has too many meanings. But in the world of medicine, dissociation *is* the correct word to describe *both* of the dissociative processes that can be occurring in people with Parkinson’s.

psychological process of keeping certain thoughts, memories, or awareness separated out from normal consciousness.



