

“Canst thou not minister to a mind diseas’d, Pluck from the memory a rooted sorrow, Raze out the written troubles of the brain, and with some sweet oblivious antidote cleanse the stuff’d bosom of that periolous stuff Which weighs upon the heart?”

- Shakespeare’s Macbeth

CHAPTER TWELVE

DISSOCIATION RESPONSES: PART 2

SELECTIVE DISSOCIATION

Selective dissociation is the compartmentalization or separation of certain thoughts or memories away from normal consciousness.

A mild amount of selective dissociation is perfectly healthy. A high level of dissociation can even be thought of desirable in some instances. Consider the “absent-minded professor” type. He is able stay highly focused on his research while selectively dissociating from events such as hunger, the passage of time, and social events or calamities. He may even be highly respected because of his extreme ability to dissociate from any distractions that interfere with his research.¹

¹ Intelligence and the ability to dissociate may have a linked genetic component. PDer’s tend to be highly intelligent *and* have a high capability for dissociating. This suggests that the long-sought genetic link to Parkinson’s disease, if found, may prove to be a genetic factor related to intelligence and dissociative ability, rather than a gene that triggers cellular pathology. If this is the case, the gene is not causing Parkinson’s, per se. Genes that impart an elevated ability to make a choice towards dissociation may be more common in people with Parkinson’s than in the general public. But the gene itself would not *cause* a pathological pattern. The PDer’s *choice* to *misuse* this ability may contribute to his eventual manifestation of Parkinson’s.

If *choosing* what turns out to be a pathological level of dissociation is a part of the Parkinson’s syndrome, we can start to understand why most identical twin studies show that PD is not genetic, even while epidemiological studies show that Parkinson’s tends to run in families. Parkinson’s is not strictly genetic, but the ability to dissociate may be. If this is the case, family values and cultural influences that honor the “stiff upper lip” may reward the person who dissociates from his emotions. A genetic tilt towards high mental capability and its corollary, a high ability to dissociate, *combined* with cultural or family praise for “sucking up the pain” or cultural or family disdain for showing emotion, *may* set a person on the path of dissociating early and often.

Also, to the extent that genetics may play a role in the degree to which a person uses more visual memory or more verbal memory, genetics may also help determine the way that a person processes trauma. People who have primarily visual-based (or possibly any sensory-based) memory function may have a hard time compartmentalizing, mentally organizing, and de-traumatizing horrific events. Oppositely, people who have primarily *word*-based memory function are able to make up justifications, modify facts, and otherwise organize traumatic experiences in such a way as to diminish the impact. Post-Traumatic Stress Disorder (PTSD) occurs primarily in people who use visual-based (or other sensory-based) memory. Traumatized people who primarily use word-based memory are much more able to process their traumatic experiences and organize them into tolerable “memories” that are more compartmentalized and justified, or at least explicable. They tend to not develop PTSD.

Dr. Temple Grandin, in her book *Animals in Translation* (Simon and Schuster, NY, 2005) refers on page 194 to the work of Dr. Ruth Lanius at University of Western Ontario. Dr. Lanius “did brain scans of people with PTSD as a result of sexual abuse, assault, or car crashes and people who had suffered the same experiences without developing PTSD. The main difference she found between the two groups was that one group remembered their trauma visually and the other remembered it verbally, as a verbal narrative. Their [brain] scans backed this up. When people with PTSD remembered the trauma, visual areas of their brains lit up (along with other areas), and when people without PTSD remembered their traumas, verbal areas lit up.” (Continued on next page.)

However, pathological levels of selective dissociation can result in disorders ranging from selective amnesia, at the mild end, to multiple personality disorder (which has actually been renamed “dissociative identity disorder”), at the extreme end. In some cases, if the selective dissociation is somewhat severe, it can cause depersonalization.

(An historical aside: the two “dissociative” conditions that I need to differentiate by the use of the adjectives “automatic” and “selective” were, by chance and at different times, both named “dissociation” in recognition of the depersonalization that can be characteristic of these two otherwise very different events.)

An example of selective dissociation: Numb from the waist down

The following case study involved in one of my patients who had completely recovered from Parkinson’s disease. Five years after recovering, she called me from out of state with a new problem: she was numb from the waist down. Because of our successful work together on her Parkinson’s, she hoped I could help her with this new numbness. She couldn’t get to Santa Cruz any time soon, so we decided to try to fix the situation over the phone.

The numbness had started one week earlier. I asked a lot of nousey questions, and the following story came out. A week earlier, she had decided to enter into a romantic relationship with a man. She had never been with a man; she had been a lesbian. She had broken up with her long-term partner more than a year earlier. Now, in her mid-forties, she had fallen in love with a man. She was considering entering into what she hoped might be a satisfying sexual relationship. But the day after she kissed him for the first time, when she woke up in the morning, she was numb from the waist down.

I asked her specifically about any negative associations she had with regard to male sexuality. She finally remembered one seemingly mild, almost cute, situation. When she was nearly four years old, her mother had discovered her lifting her skirt and “showing my privates to the little neighborhood boys. My mother grabbed me and brought me into the house. She told me that I had made the Holy Mother cry. I was devastated at the time. But now I think it’s funny.”

We agreed that this situation *might* be at the root of her sudden numbness. Since she might have selectively dissociated from the physical pain of being devastated, she might benefit from re-associating with it. I used a re-associating technique, one that is too difficult for most people who still have Parkinson’s, but since she’d recovered from Parkinson’s already I thought she might be able to do it.

Over the phone, I led this woman through a variation on the “soak the problem in the heart” exercise developed by the Heartmath Institute. She imagined how she had *physically* felt at the time she was so devastated. Next, she imagined that her physical heart was floating inside her chest, floating in a sea of supportive waves of energy that were being made by her heart. When she could imagine the feeling of energy waves expanding in her chest, she imagined that the physical pains she’d felt because she’d made the Holy Mother cry were floating in the same

(Continued from previous page.) Most PDers in our study have been highly word-based. We suspect that the ability to selectively dissociate may also be related to the process by which word-based people can more easily “classify,” or “make sense of” painful experiences and thus avoid the more *obvious* symptoms of post-traumatic stress.

waves of heart energy. (This exercise is included in chapter xxx of the Treatment Technique section of this book.)

I talked her through this exercise on the phone, and after about ten minutes of feeling her childhood pain floating in the heart waves in her chest, while simultaneously feeling the waves of heart energy, the pain diminished. As the pain diminished, she felt sensation returning to her abdomen, her groin, and then her legs. The numbness never returned. When she started the exercise, she was surprised at how much *physical* pain she felt at first when she allowed herself to recreate the “You made the Holy Mother cry” episode. Her stomach was knotted and her abdomen was tight.

I wish to make clear that the point of the exercise is not to wallow in pain, but to let the dissociated pain become re-associated into normal consciousness so that the person can accept that the pain did occur, neutralize the pain, which is to say, *heal* it, and move on. *Consciously* remembered, correctly processed events cannot harm the body nearly as much as events that terrorize the body from their secret hidey-hole in the subconscious. Unaddressed pains are nearly always more terrifying than pains that are looked square in the eye and recognized for what they are: fleeting pains. The old adage comes to mind, “Look fear in the face and it will soon cease to trouble you.”

This example demonstrates how the *pain* from which a person has selectively dissociated can lay buried, even while the word-based, conscious mind has created a “laughable” memory of the situation. It also shows how a purely mental dissociation can, years later, have a sudden, very powerful effect on the physiology.

I included this example primarily to make the point that the mind can exercise a fantastic, even bizarre control over the body. Also, that the symptoms that erupt from selective dissociations can come and go: they are not necessarily constant. Pathological symptoms, that is to say, manifestations of subconscious fears from which a person has selectively dissociated, can be triggered or worsened by thoughts, moods, and environment – just like the motor initiation and tremor symptoms of Parkinson’s.

Frequent dissociation

A person who has learned to dissociate easily and often, as many PDers do, may realize, at some point during recovery, that his first line of defense against anything he doesn’t like has been to dissociate from the emotional or physical *sensations* associated with it. As will be explained in more detail in chapter xxx, “sensations” refers to any of the five sensations of sight, smell, taste, hearing, and touch.

Some PDers have realized, during recovery, that they are almost *constantly* selectively dissociating from the physical sensations of non-emergency, physical *or* emotional, events. They sometimes realize that, with worsening Parkinson’s, they have increasingly dissociated from *anything* that interferes with their non-stop stream of mental anxieties. For example, many PDers who *want* to be less anxious have told me that they used to enjoy listening to music, but now they ignore music or don’t like to even have it around: music is too distracting; it distracts them from their mental focus. When I ask what they are usually focused on, they say that they’re

usually focused on their anxieties. In other words, they avoid or dissociate from the very things that would allow them to *stop* being anxious, even though they claim to dislike the anxiety.¹

A few case studies

Depersonalization

After we realized that dissociation might be playing a role, I conducted the following exercise with all my PD patients who were stuck in partial recovery.

The patient was always lying down on the treatment table, relaxing. I said to him, “Imagine your entire body as being filled with light, beautiful, perfect light.”

After the PDer assured me that he was successfully doing this, I asked, “Where is that body of light?”

I did this exercise with healthy people, as well. When I asked the healthy people, “Where is that body of light,” they were puzzled. They always replied something like, “It’s inside me. Isn’t that what you asked me to imagine?”

The PDers who were stuck in partial recover *never* said that. The replies from those PDers ranged from “It’s sitting over there on your office sofa,” to “It’s floating in space about two feet above my body,” all the way to “It’s in Vermont, playing on the sea short, and it’s ten years old.”

Just in case they had misunderstood the question, which I carefully phrased exactly the same way with each subject, I asked them if they could please let their body made of light into their physical bodies. The PDers who were stuck in partial recovery had responses ranging from the fairly common “I can get the head to be in my head but, from the neck down, the rest of the body is floating outside my physical self,” all the way to “No! That would be disgusting! I refuse to even try.”

After much struggle, some PDers were able to force themselves to imagine, briefly, that their “body of light” was inside their own body. However, many of them noticed that one limb – very often but not always the leg with the foot injury – could not be forced into the physical body. Sometimes the imagined *left* leg (if the injury was on the left foot) might be crossed over the right leg, even though the real legs were stretched out straight. Sometimes the imagined right leg (if the injury was on the right foot) might be alongside the physical leg, separated by only a few inches.

Even if partially recovered PDers were able to force themselves to imagine that their own physical bodies could be filled with beautiful light, they were unable to imagine that their bodies could be filled with energy and sensory awareness in *conjunction* with that light. Even if they

¹ When I first meet a PDer, he often insists that he never dissociates. Very often, it is the spouse that points out examples of the PDer’s nearly constant dissociations or long-term emotional non-responsiveness. At this point, the PDer may well reply that he isn’t doing it consciously, so therefore he is not responsible for his actions and can’t be expected to change.

Along the same lines, many PDers in our experience have been proud of their high level of “pain tolerance.” We now suspect that their ability to minimize pain signals is due to their high ability to dissociate from pain. Our patients have usually assumed that their high level of pain tolerance was due to superior nerves or superior will power. They are therefore amazed during recovery when, ceasing to dissociate from their own body in order that foot healing may begin, they find themselves highly susceptible to pain and emotionalism in response to every little ache or twinge. During recovery, many PDers have had to learn how to feel the new onslaught of sensations without becoming emotionally attached or terrified of them: they must learn to recognize that a sensation, per se, is merely a sensation and not necessarily a personal threat that is best countered by becoming “heartless.”

could force themselves to “picture” it, they could not force themselves to “feel” what it was like when they imagined light and energy and vitality inside the physical form.

Healthy people feel a sense of warmth, vitality, or something when they allow themselves to take the time to “see” or imagine their bodies filled with radiance. Partially-recovered PDers were utterly unable to feel anything in response to this exercise.

This type of selective dissociation is a variation on depersonalization, and *all* my PD patients that were stuck in partial recovery had this symptom.

Creation of a non-functional body part

Other manifestations of dissociation in some of the same PDers were more complex than simple depersonalization.

One patient was absolutely unable to move his arms, even though his legs were once again functional. His arms were clamped so tightly to the sides of his body that he could no longer work. His hands tremored violently. A nurse came to his house three times a week to bath his armpits. The nurse needed to use all her strength to create a wide enough slit between his arm and his torso so that she could get a washcloth up to his armpit.

After doing Tui Na and various acupuncture treatments on his arms, neck, head, and spine, I asked him to close his eyes and imagine his body full of light. After he said his body was full of light, I asked him where his arms were. He said that they were sticking straight up in the air, poking out of his shoulders. They were withered and rigid, like sticks from leafless trees in the dead of winter.

I pointed out that his arms weren't actually sticking out of his shoulders, and would he please try to imagine that his arms were inside his physical arms. He made a half-hearted attempt, and was unable to get his “mental arms” to go inside his body.

As an aside, I *was* able to get him to move his whole body, including his arms, by having him pretend that he was a five year-old child pretending to be an airplane. He tried for over an hour, insisting that he couldn't do it. At some point he became furious with me. He screamed, “What do you want me to do? Actually put my arms out to the side and pretend I can fly?” He gave an exaggerated demonstration of a plane banking steeply, and as he did so, his arms lifted gracefully out to the sides. His tremor stopped. He was able to pretend to be an airplane – arms and all. He was so excited that he followed the airplane maneuver with some folk dance routines that he'd done as a young man. For over an hour, he was able to move his arms normally – and did not tremor. After it was over, he told me he'd only been able to do it because I had been there. He just *knew* he would never be able to do it again. And he never did. His mental image of his own arms remained, until his death four years later at age fifty-four, an image of dried, rigid sticks, poking straight up out of his shoulders.

In this case, he had not merely dissociated from his arms or depersonalized his sense of where his arms were. He had created the idea that his actual arms were dead and sticking straight up out of his shoulders. Based on the extraordinary degree of rigidity that he manifested in his arms, I might guess that what he was doing was much more destructive to health than merely imagining his arms were OK, but outside of his body. He was not the only partially-recovered PDer who had created mental images of diseased or decaying body parts.

Situation-specific dissociation

One patient, visiting from Germany, had two weeks of treatment in Santa Cruz. During this time, she became able to move perfectly normally. Her health practitioner had been doing Tui Na on her injured foot for many months and they had both noticed many recovery symptoms. All we did in Santa Cruz was a little additional Tui Na on her leg *and* encouraged her to let go of her negative attitude.

On her last day, I congratulated her that she no longer had Parkinson's. She stared at me in amazement. "I still have Parkinson's," she said.

I asked her why on earth she thought she still had Parkinson's.

She replied, "I don't have it here, but when I get home, it will come right back. I know it will. I don't have it here, because here it's OK to walk around smiling, without a care in the world. But when I get back to Germany, I'm not going to walk around smiling, looking like a stupid American."

I asked her if she might be willing to smile even in Germany, since she felt so strongly that being able to smile had been the *temporary* cure for her Parkinson's. She said that she would not smile when she returned home. So I asked her, "You'd rather be unable to walk than have people think you're smiling too much?"

She replied, "I'll have to think about it."

When she got home, her Parkinson's reappeared.

At this point, she no longer had symptoms of idiopathic Parkinson's disease. What she had after this was psychogenic parkinsonism.

Event-specific dissociation

One patient with a PhD in nutrition never tremored or had any other symptoms of Parkinson's disease while she was eating desserts. I asked her to run a few experiments. She tried eating dessert first, dessert before the main dish, during the middle of the meal, and after the meal. She tried eating only dessert, and eating only the main dish. No matter when she ate it, she never tremored during dessert and she tremored violently during the main course.

I asked her if she had any idea why. She replied quickly, "Of course. It's because desserts don't matter."

When she was eating desserts, nothing mattered: she could be relaxed. But when she ate nutritious food, she was keenly aware of the nutritive value of the food, thanks to her PhD. As soon as she ate nutritious food, she would switch over to "thinking mode," and shut down her heart. As soon as her heart was shut down, she had all the symptoms of Parkinson's disease.

Dissociation from the heart

The intentional dissociations from the heart itself, and/or the diseased images of heart that PDers had created, and/or the situation-, event-, and mood- specific triggers that PDers used to *amplify* the heart shut-down, causing their PD symptoms to appear or to intensify, will be shared in later chapters that are devoted specifically to dissociation from the heart. The above examples were merely presented to illustrate what is meant by body part-, situation-, and event-specific dissociation.

SELECTIVE DISSOCIATION LEADING TO SYMPTOMS OF AUTOMATIC DISSOCIATION

At the beginning of the Little Project, we did not suspect the weird truth: that most PDers had dissociated from their hearts. Even though a not uncommon recovery statement was something along the lines of “Oh. I just remembered when I decided to not be able to feel pain,” we just assumed that they had only blocked out the memory of pain. Because many people *temporarily* block out pain signals and don’t develop Parkinson’s, we did not consider that these statements were hinting at a significant commonality in Parkinson’s.

Only after nearly a decade of research did we begin to suspect what was going on: a *consciously*-induced (and therefore selective) *automatic* dissociation. And it was being activated via *selective* dissociation from the heart’s ability to resonate with pain.

We spent a lot of time pondering the connection between dissociation from the heart and automatic dissociation. During automatic dissociation, dissociation from the heart is normal. But does the reverse also occur? Does dissociation from the heart trigger symptoms of automatic dissociation? We were able to prove that it does, although we still can only guess at the mechanism.

One of our guesses is that the shutdown in the heart is the very thing that triggers all automatic dissociations. Possibly, whether or not the shutdowns are caused intentionally *or* by severe injury or trauma, they all start with a heart disconnection. When severe trauma occurs, the body’s electromagnetic fields become highly destabilized. The heart, strongly resonant with electrical fields, may be the first organ to react. Possibly, it reacts by shutting down its ability to resonate with pain, setting in motion the symptoms of automatic dissociation. If this is the case, it makes sense that mentally *choosing* to shut down the heart’s ability to resonate with pain, intentionally inhibiting the heart to a moderate degree with regard to certain types of pain sensations, might cause some of the same processes that occur when the heart is utterly stunned via trauma.

The reader may be surprised that an electromagnetic shift in the heart could trigger so many reflexive changes in physiology. As you will read later, the heart’s electromagnetic fields drive more body processes than the brain’s much weaker fields. When a person is in parasympathetic mode, brain waves entrain with the much stronger heart waves: brain waves are subordinate to heart waves. Only when a person moves into an adrenaline-dominant state do the brain waves act independently from the heart waves. In a healthy person who is in parasympathetic mode, the heart waves “instruct” the brain waves, and thus determine an enormous amount of physiological behavior. Shutting down the heart, oppositely, forces a person to be brain-dominant, unable to *resonate* with, unable to *feel*, sensory input.

Partial recovery and selective dissociation from the heart

By 2005, we had strong evidence to suggest that many PDers, and in particular those PDers who became stuck in partial recovery, had selectively dissociated from their hearts. By 2007, we had begun to suspect that this rare type of dissociation was the trigger for those constantly fluctuating mood- and thought-based Parkinson’s symptoms (as opposed to constant, unchanging foot injury-induced symptoms) that looked so much like a mild to moderate version of automatic dissociation. We were able to run several experiments that proved that this triggering *can* occur. We were also able to *prove* that this triggering *was* active in those of our

partially-recovered PD patients who were still manifesting thought- or mood-based parkinsonism. Those proofs are included in chapter xxx.

In partially recovered PDers, this triggering of severe heart dissociation occurred either in intermittent lapses, increasingly, or almost constantly. It occurred even *after* their foot injuries healed and they had manifested various recovery symptoms related to the healing of aberrant channel flow.

While we were able to uncover some physiological muscles in the pericardium (around the heart) that can get “stuck,” thus literally holding the heart in a position appropriate for fear or anxiety, we also determined that mental attitude played an enormous role in determining whether or not partially-recovered PDers’ hearts were shut down at any given time.

As we discussed this finding with PDers, many of them wondered at why they might have a fear-based, or “negative” attitude.

Learning to fear

Many PDers often insist that they have consciously worked hard at *not* having a negative mindset, or at least not presenting it to the world. Or they only recall one or two negative experiences. They wonder why they have might have become susceptible to negativity, wariness, or increasing reliance on selective dissociation.

First off, the fact that they have *worked* at fighting off negativity suggests that possibly some negativity or wariness lurks in their subconscious. This negativity or fear may be snuggled in amongst the dissociated thoughts and memories that have been separated off from normal consciousness, but which are still sending out warnings.

For those who do not recall *many* negative or fear-inducing events and therefore doubt that there is *much* negativity or fear lurking in the brain, it might be helpful to consider how the brain handles fear-inducing events. New research on brain plasticity and *animal* behavior explains how one or two mild fears, if not processed correctly using our *human* capability to confront and neutralize our fears, can expand into a near infinitude of fears over time via the wordless, dumb animal, portion of the brain.¹

Learning through linkage: the corn dog event

Because of the way the animal brain builds associations and links, items that were *ever* associated with risk or danger, however peripherally, will have equal “Danger!” status in the brain with all other “Danger!” associations. For example, if a deer is jumped by a mountain lion but manages to escape, the deer will associate every sensory input during the event as something to fear. In this way, the deer will have learned from its mountain lion experience that early morning, high ledges, creek sides, long shadows, the smell of willow, the sound of a plane high overhead, and empty potato chip bags by the side of the trail are not only *all* potential mountain lion-creating risks, they all have *equal value* as potential risks. The deer *cannot* use logic to figure out which of the lion-associated visual, smell, touch, taste, or hearing perceptions were of

¹ When considering the “dumb animal” model for understanding how animals learn to fear, please do not include dogs in your model. Domesticated dogs are genetically different from wolves primarily in that they do not develop characteristics of mature wolves. All their lives, dogs remain more like wolf pups than like mature wolves. Dogs’ ability to learn about danger is also immature. A dog must be horribly abused before he will learn the wariness that wolves develop quickly. Dr. Temple Grandin’s book, *Animals in Translation*, goes into this subject in depth. Please use models such as deer, tigers, geese, or wildebeests when considering an animal model for this section on dumb-animal fear.

greater significance when it came to producing a mountain lion attack. The deer has to remember all of the associations. In the deer's mind, all of these sensory perceptions are remembered and linked to danger.

In humans, this animal brain is at work any time that the human fails to calmly consider a past trauma and process it in a way that sorts out the risk factors from the non-risk factors.

For example, a person who got sick at the boardwalk after eating a corn dog and then going on the Tilt-A-Whirl may find himself with a lifetime aversion to corn dogs.

Then, because of the fear-linking process in the animal part of his brain, this same person may find, ten years later, that he scorns all ocean-side amusement parks. Twenty years later, as the amusement park fear linkage continues to make more links in his brain, he may feel a virtuous superiority towards "the inferior type of person who could possibly enjoy going to 'those kinds' of places."

If this person had taken the time, later that day or during the week of The Corn Dog Event, to calmly recall the events of the fateful day, processing the sensations and embarrassment of being sick *and* also giving careful thought to the situation, he might have ended up with the wisdom that a full stomach and rapid motion don't mix well. He might also have a gentle tolerance or even a soft spot in his heart for kids of all ages who go to amusement parks – especially those who eat corn dogs.

As an aside, I cannot begin to guess how many PDers have told me that they could really relate to the "hating corn dogs and eventually hating everyone who goes to the amusement park" scenario. Though many had never eaten a corn dog, they could recognize that they increasingly tend to dismiss, disdain, or be wary of whole groups of people, despite their conscious efforts to be as loving and circumspect as possible.

As for taking the time to calmly process unpleasant events sometime after the fact, a process called re-association, chapter xxx of this book includes a description of the *physiological* steps involved. An emotionally healthy person *automatically*, without any training, performs these steps as soon as the trauma is behind him and he feels safe. We have found that most PDers are completely unfamiliar with the sensations and thoughts involved in this ordinarily automatic process, the process by which temporarily dissociated events are brought back into normal consciousness and de-traumatized.

Learning through linkage: from car crash to pleasure craft

As noted above, the animal brain "learns" about danger by making linkages. Another example of linkage is the person who is in a near-fatal car accident. The last thing he hears is the sound of a car horn blaring loudly. He recovers, but six months later, strolling past the downtown *pizza* parlor, a car horn blares loudly. He has a panic attack while standing outside the pizza shop. He assumes that he was startled by the loud car horn. But four months later, while vacationing at the ocean side, gazing at the *sailboats*, he walks past the boardwalk's pizza shop, and has a panic attack. This time, he has no idea what caused it. Several months later, in the depths of winter, he is looking dreamily through some Tropical Island Summer Vacation brochures. When he sees the picture of the sailboats, he has a panic attack. At this point, he may just assume that he has become the sort of person who panics easily. But these attacks were not random. His animal brain had been making linkages. He linked the car horn to danger and fear,

he linked fear and panic to pizza, pizza to sailboats, and voilà! He panicked at the picture of a pleasure boat.

People who are even subconsciously determined to selectively dissociate from the things that they fear or dislike do *not* process their fears or dislikes at a later, safer time, nor are they able to take advantage of the human capacity for reason. Worse, their fears can grow: their mentally formed *linkages* to and from dissociated negative experiences may cause them, over the years, to dread *anything* tangentially or even remotely linked to previous fear experiences. Their fears can thrive in the subconscious, busily doing what the animal brain is supposed to do: making linkages. At some point, without knowing why, the PDer who has dissociated from pains and fears may find himself wary or anxious about nearly everything. Or, as in the case of the woman who went numb from the waist down, a dissociated pain can erupt in bizarre, seemingly random manifestation. These manifestations might be somewhat characteristic of a partial or profound fear response, or a protection-from-pain response (numbness) even though the *prompt* for the response seems unrelated to anything fear-inducing.

Learning through habit

People who make a habit of selectively dissociating from anything that might potentially be painful may not even realize the extent to which they are constantly living in fear. It is reasonable to dissociate during a crisis. But if a person doesn't bother to take time, after the crisis is over, to experience his pains and transmute them into an emotionally neutral learning experience, he may find that, over time, his emotions increasingly move towards wariness and away from contentment.

For example, people with Parkinson's who use their tremor as an indicator of their mindset or emotions can usually see how their tremor is triggered more and more easily over time, by smaller and smaller worries. At some point, most PDers with tremor can activate or increase the amplitude of their tremor merely by remembering that they have a tremor, or by noticing that their tremor has temporarily become somewhat smaller or has stopped. The mere thought, "tremor," has become associated with other thoughts of fear, sometimes even a fear of worsening Parkinson's, and so the *thought* of tremor increases or activates the tremor.

This extremely brief section on brain linkages and fears was included to demonstrate for the PDer that dissociation can bring about highly illogical fears, fears that are impossible to "track to the source." PDers who get stuck in partial recovery are usually keen to "figure out" what the "thing" was that made them start dissociating in the first place. Oppositely, those PDers who have fully recovered have *not* worried about whatever it was that first made them dissociate.

Those who have managed to overcome partial recovery and join the ranks of the fully recovered have been those who said to themselves something like, "Heck with it. I don't know, and I can't know. So I'm going to stop being afraid: I'm going to *surrender* control of my safety over to the universe. From now on, the universe is going to have to keep me safe: *I* can't even begin to know how to keep myself safe." And then when they suddenly realize, deep inside, that the universe *has* always been taking care of them, they feel safe. And as soon as they feel safe, the heart kicks back into parasympathetic, the dopamine starts to flow. They start to feel what it's like to be inside their bodies. They can imagine movement, and they can execute that movement. It's very simple, really.

Ironically, after PDerers decide to just surrender and to not worry about which specific event(s) might have set their heart dissociation in motion, and after they have obviously recovered from Parkinson's disease, they very often remember, spontaneously and with mature understanding, an event that was unforgivable or terrifying at the time.

Also ironically, if I had to pick one word that our partially-recovered PD patients really hate, it would be the word "surrender."

Two more example

This example shows how the original cause of fear no longer matters. A partially-recovered PDer was having worsening tremor, especially when eating. As soon as she thought about eating, her tremor became violent. She explained that the tremor amplified because she knew it was going to get bigger.

Chris Ells asked her to focus her mind on a song while she was eating. As soon as she realized that she wasn't focused on the song, she had to put down her spoon and start over. (Brain researchers have found the area in the frontal lobe of the brain that forms a linkage between music and the physical heart, thus "opening up the heart" somewhat.)

It was extremely difficult for her to keep her mind on her song. And everytime she started to tremor, she realized that she'd stopped the music just before the tremor started. Finally, after forty-five infuriating minutes, she fixed her mind with intense concentration and was able to *stay* focused on mentally singing her song. She was also able to eat without any tremor.

When she reported this to Chris, she laughingly said, "It worked, damn you!"

This same person had increasing difficulty in taking a long stride, or even initiating a stride. After her treatment, Chris asked her to *not* think about how far she needed to walk to get to the waiting room. He asked her to only think about the movement that she needed to do in that moment. When she was finally able to understand what he meant, she realized that she could take graceful, long strides. As soon as she started to think "How much farther?" she would start to freeze up.

These two examples show that the PDer was *not* trembling or freezing up because of some deep, dark, long-buried fear. In the first example, her amplified tremor was being caused by her fear of amplified tremor. In the second example, her inability to walk was triggered by her fear that she wouldn't be able to walk far enough. In both cases, a very immediate fear was the one that was causing her to slip into heart shut down mode, which in turn made her tremor or unable to move.

The real problem for her was *not* the original thing(s) that triggered a heart shut-down. The real problem was that she had increasingly taught herself and allowed herself to use the heart shut-down for every possible difficulty. She had gotten to the point where the thought of difficulty caused her to shut down. And when she shut down, her dreaded difficulty came true, thus strengthening her conviction that she was doomed. Her strengthened conviction made it even more necessary for her to shut down.

In PDer who get stuck in partial recovery, the vicious cycle of self-fulfilling need to shut down because of the pain of not being able to function makes the PDer increasingly less functional.

Those people who fully recover decided physically hold their hearts in the open position. They do *not* dig deep into their subconscious and find the original event that caused them to shut down the heart.¹

OVERRIDING AUTOMATIC DISSOCIATION

Getting back to the theory, it's time to discuss why the various types of dissociation don't render the PDer absolutely comatose.

The adrenaline override

A person whose movement inhibition is caused by a severe injury can always override the inhibition by using adrenaline. We see this all the time in nature. For example, when a hungry lion appears on the scene, a deer or a human can run on a broken leg: adrenaline overrides injury-induced movement inhibition.

Likewise, by using adrenaline, a person can learn to override any automatic dissociation that has been *selectively* induced.

¹ The ability to shut down the heart to avoid feeling pain or pleasure may well have a genetic component. Some people believe that genetics are merely physical manifestations of a person's mental tendencies, "selected" prior to birth because those genetics are the best "fit" for the individual's vibrations of consciousness. It makes sense that a person who, in a prior life, developed the mental control necessary for dissociation, would fit best in a body that is genetically suited for high intelligence. Many PDers have told me that they suspect that they were born with the ability to dissociate.

This recalls to mind how, during the dark ages, many well-meaning but misguided religions emphasized the idea of dissociating from pain. Museum pieces such as whips for self-flagellation, and clothing imbedded with shards of metal, are reminders of the dark ages mentality that assumed "higher realms" could only be known by "killing the feelings in the body."

My first group of twelve volunteers had a disproportionate number of professional religious: a retired Lutheran minister, a retired Presbyterian minister, a Catholic nun, a life-time Baptist missionary. The group also included a highly devout Korean Methodist whose father had founded the Methodist church in Korea, a devout student of the Book of Miracles, and two yogis. There is a powerful spiritual streak in nearly all of my PD patients, whether or not they are members of any specific church. Ironically, PDers are often perceived as "cold," because of their reliance on mind instead of heart.

I have to wonder if, in lifetimes past, many PDers have tried to attain to higher realms by teaching themselves to become numb. In answer to these PDers, I quote from Paramahansa Yogananda's translation and interpretation of *The Bhagavad Gita*: "The scriptures and [saints and sages] do instruct the devotee [of God] *not* to destroy the actual senses, but to slay their bad habits. The devotee is not asked to blind his eyes, deafen his ears, nor to paralyze his senses of smell, taste, and touch. He is directed only to dislodge the enemies of optical, auditory, olfactory, gustatory, and tactual *attachments* [preferences; ego-based likes and dislikes – which includes pain: sensation that is disliked] which keep the soul imprisoned, forgetful of its omnipresent kingdom."

At any rate, many PDers have told me that they think that they were born with an innate ability to dissociate from the heart, and that they used this ability in their youth to give themselves a sharper mental focus and to stay impervious to pain. Many also admit that they had terribly painful childhoods, and the ability to dissociate came in handy. One has to wonder if these people didn't choose the "terrible" childhoods into which they were born. By choosing these childhoods, their omniscient souls knew that they would have an opportunity to either indulge in their chosen game of dissociation or to make enormous spiritual progress in learning the correct way to deal with pain. Either way, the Parkinson's presents the logical conclusion to the "trick" of turning off the heart. A person can respond to Parkinson's with more of the same heart shut down. But Parkinson's also can be the logical, if unpleasant, conclusive force that compels a person to finally master the *conscious* ability to open the heart. When the PDer learns to intentionally open his heart despite all circumstances, he starts on the road of truly mastering his heart and overcoming his mind-based attachment to his ego-based dislike of pain or pleasure. This is not to say that a person should learn to *like* pain. A person must learn to perceive pain via wisdom and love. Wisdom and love can neutralize the emotionalism of pain, thus allowing pain to be perceived as what it actually is: vibrations of energy.

Early in their teen years or their early twenties, many of our patients learned how to create almost constant surges of adrenaline in order to override their budding tendency toward movement inhibition: what one PDer called “the push-pull of Parkinson’s.” They learned to activate adrenaline release by staying terribly busy, creating “false emergency” reasons for completing mundane tasks, or actually participating in dangerous activities such as extreme sports.

Adrenaline, the neurotransmitter of fear, pushes the buttons that override movement inhibitions, whether the inhibitions were induced by injury or automatic dissociation. Even a person with advanced Parkinson’s can initiate movement perfectly normally during a *true* emergency.

But after a lifetime of creating false emergencies, or as Aesop would say, “crying wolf,” the PDer becomes too calm or too tired to activate much internal sense of excitement over his false emergencies. Like the villagers in Aesop’s story, the PDer no longer responds to his false emergencies. The PDer’s level of mentally-induced adrenaline release starts to drop. But by this time, he has become too habitually wary to feel safe. So he finds himself in an awkward neurological position: he is wary but he can’t muster the adrenaline to back up the wariness. And/or his movement inhibitions are getting worse, but he can’t muster the increasing amount of adrenaline needed to override the increasing movement inhibitions. At this point, his injury-based movement initiation problems and/or symptoms of automatic dissociation become visible. We then call these symptoms “Parkinson’s disease.”

Parkinson’s disease does not appear when a person’s dopamine levels are too low. The PDer may not have even *been* using much midbrain dopamine for decades.

Parkinson’s symptoms appear when the PDer is no longer able to conjure in his mind a strong enough adrenaline-releasing crisis to override his steadily increasing movement inhibitions. The symptoms also show up when the PDers tendency for chronic wariness is greater than his ability to summon up the adrenaline necessary to support that wariness. Wariness *with* adrenaline makes a person poised, ready to respond. Wariness *without* sufficient adrenaline makes a person anxious, shaky, and vulnerable.¹

Again: we hypothesize that, when the PDer’s *movement inhibition* (which might be physical *or* mental) is greater than his ability to induce an adrenaline-releasing override, he will begin to manifest the symptoms of movement inhibition, rigidity, postural instability, and/or tremor. Also, when his *habitual wariness* and/or *fear* (which are purely mental) is unable to trigger a tremor-overriding amount of adrenaline, he will begin to manifest the symptoms of movement inhibition, rigidity, postural instability, and/or tremor.

At this point, he will *start* showing overt signs and symptoms of Parkinson’s disease. However, he didn’t “just get” Parkinson’s. He’s been slowing developing it for decades, and actively hiding it by using either the low levels of adrenaline that are available to a person in automatic dissociation, or the high levels of adrenaline that are available when a person lives in fear or creates an “emergency” out of everything.

¹ Peter Levine has written an excellent book, *Waking the Tiger*, which discusses the psychological problems that arise in people who, in response to fear-inducing situations, get stuck in the wariness stage and are unable to make the transition into adrenaline-based action. Some PDers, in their early years, had the opposite responses: they responded to *everything* with action. When the Parkinson’s appears, they may find themselves stuck in wariness, but not because they *cannot* let themselves emotionally transition into adrenaline-based action. They can’t raise the necessary adrenaline because the things they are wary of (nearly everything) aren’t really worthy of the *level* of fear that is needed to cause an adrenaline surge big enough to override their movement inhibition.

A few of our PD patients have protested vigorously that they have no fear, and therefore, have not been using adrenaline. We have pointed out that fear of being criticized or judged, fear of being late, fear of making a factual or social mistake, and a thousand other “little” fears are the more typical fears of the PDer. These fears, though small, tip the neurotransmitter balance in favor of adrenaline.

SUMMARY

The basis for our hypotheses

When I first started working with PDers, I was surprised at how many of them had a stoic attitude towards their bodies – one that was combined, in many cases, with a powerful aversion to therapeutic touch.

Over the course of several years, we discovered other emotional similarities in partially recovered PDers, such as an inability to visualize anything with a positive connotation, inability to daydream in a positive manner, or inability to imagine that their own bodies, especially the damaged areas, could be filled with light. The most stunning similarities in PDers who became stuck in partial recovery had to do with their diseased, deformed, caged, or otherwise abnormal mental images of their own hearts – if they were even able to conjure one.

A few partially-recovered PDers, after learning about our hypothesized heart dissociation problem, insisted that they were different, they could imagine having a perfect heart. If they claimed that they had a perfect heart, I only had to ask them to imagine that they were looking at a dear friend or someone they admired deeply. Then, I asked the PDer to imagine what *that* person’s heart looked like. *Always*, the friends’ hearts had qualities of radiance and beauty that the PDer could *not* imagine coming from his own heart.

Also, the strange remarks made by some PDers during recovery, remarks like “Oh. I remember when I started pretending that I couldn’t feel pain,” seemed to fit with the “It didn’t hurt at the time” phrases that young Tim and so many others had used when telling me about their injuries.

It took nearly nine years before we finally connected all the dots and could prove, in experimental fashion, that many PDers have, or had at some point during their childhood, intentionally employed a selective dissociation response to their heart’s ability to feel physical and emotional pain.

In addition to selectively dissociating from the *ability* to feel pain – a condition in which *all* neurotransmitter activity is diminished – many, though not all, of our PDer patients had lived life in a manner that suggested they’d consciously worked at staying in sympathetic (adrenaline-dominant) mode. When these PDers wanted to think about things or get something done, they always tended to think and move with adrenaline, not dopamine. But although they were adrenaline-dominant, their adrenaline *levels* were very often at the low end of the spectrum: they used highly self-controlled types of low-level-adrenaline behaviors. Their behaviors were not so much “fight or flight” as “perpetually wary or alert.” When using the sympathetic-dominant mode, a word-based person experiences his life primarily by *thinking* about it, rather than *feeling* it.

Some of these PDers had no memory of ever having engaged the parasympathetic system; the system in which *dopamine* is dominant and adrenaline is subordinate: the mode in

which a person experiences life through perceiving sensory input and *guiding* the mind via the heart's ability to resonate with sensory experiences and/or the heart's *intuitive* resonance.

Many PDerers agreed that they had experienced life predominantly via thinking. Many of them also had no idea what we meant by the word "feeling" or could not understand how a person's life *could* be experienced via sensory feelings, and via the feelings of the physical heart, in particular.

"Feel?"

One PDerer said that her girlfriend once asked her why, when they went to concerts, she spent her time looking at everyone and assessing what everyone was doing. "Why don't you ever just sit back and enjoy the music?" When the PDerer started being able to *feel* music, during recovery, she told me, "Until now, I'd never had any idea what my friend was talking about."

Another quick anecdote also demonstrates the difference between "feeling" experiences and thinking about them. A PDerer's wife told me about his reaction, or lack of, when they went to Florence to see Michelangelo's magnificent statue of David. As she and many others turned the corner and suddenly found themselves facing David, they were visibly stunned, in a chest-expanding, breath taking sort of way, or even moved to tears. As their hearts resonated with the statue, their chests expanded with a *feeling*, something impossible to describe. The PDerer was physically unaffected by the statue. He was duly impressed at the excellent lifelike accuracy of the lines, made estimates of the size of the body parts, the size ratios of the body parts, and constantly nattered away with questions about the sculpting techniques.

Years later, sitting in my office, venting, the wife stated that her husband had never *really* experienced the statue or, as far as she could tell, any other feelings over the course of their long life together. When she said this to me, the husband was clearly surprised. He didn't understand how she could say that he hadn't experienced the statue: he obviously had seen the statue. What the wife meant, of course, is that he hadn't *felt* the statue, or very much else in their married life together. When she tried to explain to him what she meant, he had no idea what she was talking about.

I have more than a hundred similar anecdotes.

The emotional flatness that frustrates so many PDerers' spouses is difficult to complain about: very often, PDerers, due to their extreme dread of social mistakes or of making trouble, are *perfect* spouses in terms of functionality. The world often perceives PDerers as hard-working, morally upright, generous and kind to others, responsible, non-violent, clever and, did I mention, hard-working? In the eyes of the world, the spouses of many PDerers have *nothing* to complain of. And yet, the growing emotional flatness of the PDerer and his inability to *feel* his own experiences can be very hard to live with or relate to.

The remarks of PDerers, their spouses, and even their children, help us figure out where to look for the underlying cause of Parkinson's disease. Of course, one could make the case that dopamine insufficiency, not dopamine inhibition, is the cause of the emotional flatness. Then again, when we were able to help them heal the foot injuries and taught them how to feel safe, the emotional flatness went away. Sometimes, recovered PDerers felt as if an entirely new world opened out for them, a world of wordless, sensory and proprioceptive self-awareness that they had never suspected was there.

PDerers entering our program usually wanted to regain their physical competence; they wanted to be their old selves. When they recovered, they consistently said that they didn't care so

much about physical competence: they were thrilled to be able to really experience life for the first time in a long, long while – if ever. They were adamant that they *never* wanted to go back to being their old way, ever again.

Those PDers who recovered, and ceased dissociating from their hearts, often said that they'd been given the opportunity of living two lives in one lifetime. In the first life, they had enjoyed mental keenness and had been impervious to pain. In the second life, they learned about joy. They always preferred the second “life.”

In ending this chapter on selective dissociation, I want to point out that some psychologists and psychiatrists feel that the condition is curable. In the Little Project, we found that the selective dissociation used by PDers is, in fact curable. But it takes work.

