

*“He jests at scars, who never felt a wound.”*

*Shakespeare’s Romeo and Juliet*

## CHAPTER EIGHTEEN

# RECOVERY SYMPTOMS: NUMBNESS AND PAIN

### *Numbness vs. rigidity: a review*

The locations of the physiological symptoms of Parkinson’s disease are listed in chapter seven, XXX. Most of these symptoms, it will be recalled, are due either to the absence *or* the reversal of Qi flow in the Stomach and Large Intestine channels. Most of these changes can be characterized by either numbness or rigidity. In areas where Qi flow has become absent, numbness occurs. In areas where Qi flow has been backwards for years, rigidity occurs.

When, in response to Yin Tui Na treatments, PDer’s Qi began to flow correctly in the Stomach and Large Intestine channels, the numbness or rigidity began to melt away. Areas that were previously numb became sensitive. Areas that were rigid became limp.

This chapter will address the recovery symptoms that occurred in body parts where Qi flow had been absent or minimal: areas of numbness. The next chapter will discuss recovery symptoms in body parts where Qi flow had been backwards: areas of rigidity.

## STARTING WITH THE FOOT INJURIES

Most PDer’s wrongly assumed that the healing of a foot injury and restoration of healthy Qi flow in the feet would necessarily be pleasant. The *end* result was pleasant enough, but along the way, many PDer’s experienced pain.

### **The pain of injury**

The FSR techniques, or any other light-touch massage technique, encourage a person’s awareness and even subconscious to revisit a long-ignored injury and thus initiate healing. When the mind decides to acknowledge an ignored injury, the unexpressed, dormant symptoms of injury may appear. These symptoms may include bruises, tenderness, pain, swelling and even heat.

If the PDer’s injury was only a dislocation or sprain, the reawakened pain wasn’t necessarily severe. If the reawakened injury was a broken bone, the pain was sometimes considerable.

As patients started experiencing the pain of forgotten injury, they often said, “My foot hurts! What should I do?” We were surprised by the fear and questions that arose. These people were adults; we thought that they should have known what to do. But even though they might have been capable of helping care for other people who were in pain, they often had no idea of how to care for themselves when they were hurt.

We had to teach them.

## ***How to deal with pain***

The appropriate thing to do, we explained, whatever sort of pain occurs, is to treat the injury the way that it should have been treated in the first place. Use common sense. If, following treatment, the foot hurts, then favor the foot for a few days. Limp a bit. If the foot itches, scratch it. If it wants to be rubbed, rub it. Listen to the body, and give it what it wants. Again, use common sense. Do not be stoic. Treat your “recently” injured foot in the way a well-loved child would treat an injured foot. This may even include (God forbid) asking for and accepting help. If it’s a severe sprain or dislocation, you might want to wrap it up or get a little extra sleep instead of going dancing.

In the rare case where it feels like a bone is broken, don’t be stoic and force yourself to walk on the broken foot. Use crutches for as long as necessary or even stay home and lie on the couch for a few days. Leave the stoicism behind.

We were surprised at the high degree of fear that some PDers had in anticipation of feeling old injuries. Some were afraid to let us touch their feet. One person traveled to Santa Cruz to be treated, knowing full well that the treatment consisted of foot holding. But when I asked her to remove her shoes, she balked. “Not even my husband has ever seen or touched my feet.” She went back and forth for about half an hour deciding whether or not she wanted me to even look at her feet. Then she made up her mind. She left. I never saw her again.

Others were terrified of what they might feel in general if they let their guard down. One PDer spoke for many when she explained to me, “The whole point of life is to avoid pain.”

Those PDers whose stoicism was zero or minimal tended to recover more quickly. They sometimes mentioned that they had been very stoic and guarded at the time of injury, or throughout childhood. But if they had learned, in their adult life, that it is good to experience sensations and that it is not “bad” to feel and respectfully tend for the body’s injuries, they responded more quickly to treatment. Some of these emotionally mature patients had consciously worked at learning, as adults, that it’s OK to ask for help. A few had even taught themselves how to cry. The PDers who were able to cry and mentally focus on the actual sensations of their own physical and emotional pain had fewer problems figuring out how to deal with any pain or bruising that arose when the foot healing began.

Many PDers, when starting treatment, were still proud of their ability to not feel pain. Some had stopped crying in childhood and had not been able to cry since. Some truly believed that non-feeling or perpetual wariness was superior to acknowledgement of physical or emotional pain. In general, these people needed more time with the foot holding before the foot injuries started to manifest. Often, these people were alarmed or at least anxious when the appearance and sensations of an old injury began to manifest. Although the pains were not necessarily severe, a few even veered into bouts of hysteria and paranoia when confronted with pain. It seemed as if they had no ability to face pain and process it. One patient had full-blown bouts of hysteria every evening for several months after he started feeling the injuries in his foot.

Then again, one (and only one) patient, within hours of being *diagnosed* with Parkinson’s disease, developed the same sort of daily hysteria, and it lasted for several months. He developed this hysteria a full month before he heard of our work and started being treated by us. His hysteria finally eased up after many months of foot treatment, psychiatric counseling, prescription-strength anti-insomnia drugs, and homeopathic remedies.

Eventually, we realized that many PDers literally do not know how to deal with pain or fear. They may have never learned the usual pain assuaging mechanisms that young children slowly master during the years from around age three to age eleven (approximately). For many of our PD patients, the only fear- or pain-treatment mechanism they'd ever known was mentally blocking out the pain or fear – pretending that it wasn't there. The concept of *confronting* fear or *feeling* pain and consciously neutralizing it was absolutely new to them.

Looking ahead, chapter xxx explains how a healthy child learns to process pain so that the pain can quickly become mere sensation instead of being terrifying and seemingly life-threatening. Chapter xxx includes instructions on learning to correctly process pain for PDers who truly do not know how it's done. But in the early years of the project, we just gaped in wonder at these strong, competent people who said, in all sincerity, "I hurt! What should I do?"

### ***A lengthy aside: pain from other injuries***

Some PDers experienced pains in *other* parts of their bodies as they began to recover from dissociated foot injuries. These pains turned out to be other injuries that had also never healed. Sometimes the other suppressed injuries appeared at the same time that the foot injury started to show signs of bruising and swelling. Sometimes the other injuries appeared weeks, months, and even years after the foot injury healed.

Very often, the PDer recalled the incident(s) that probably caused the other re-appearing injury(s). I was told things like: "I'll bet this hip pain goes back to when I fell two stories and landed on my hip; it sounded as if a bone had broken but my hip *never hurt*," or "Oh yeah! Eight years ago, when I moved the stove by myself, I thought I twisted something in my neck and I heard something pop, and my clothes have sat crooked at the neckline ever since, *but it never hurt*,"

Then again, sometimes a PDer had no recall of any injury at all in the non-foot area that spontaneously manifested a bruise or soreness. It does not matter whether or not the PDer is able to remember the painful incident. Some PDers have had so many injuries that there is no way they will ever sort out which incident caused which injury. That's fine; this lack of memory will not impede recovery.

Some of the non-foot injuries only showed up as faint bruises with no pain. Some were full Technicolor bruises, featuring blues, yellows, and greens, with streaks of fresh red under the skin. Sometimes there was pain with no bruise. Sometimes there was bruising *and* pain.

Although unhealed broken leg bones were relatively rare, the people who had them experienced a tremendous amount of pain and swelling at the site of the break. Sometimes, in cases of very severe pain from a broken leg, body-wide tremor accompanied the pain and shock for a short time – as it should.

### **Staggered recoveries**

Although some PDers had arm, leg, neck or head injuries that appeared at the same time as the foot injuries came to the surface, it was more common for the various injuries to show up in a staggered fashion.

Research has proven that a person who receives severe multiple injuries cannot *simultaneously* feel the pain of all of his severe multiple injuries. In these cases, the body seems to "decide" which injury is the worst at any given moment, and addresses that one. When

appropriate attention has been given to that worst injury and healing has begun in that most problematic area, a different injury is then able to receive the body's foremost attention.

A person whose fall down a steep hill has bruised his ribs, sprained his knee, scraped skin from many places and thrown his back out, will know what I am talking about. Even though he may have a general sense that he hurts all over, only one injury at a time will *truly* stand out as being the thing that needs to be addressed immediately in any given moment. And as soon as that particular problem starts to feel better, another injury will move to the fore. It is not uncommon for people with injuries in multiple areas from a really bad accident to spend *months* healing. As soon as the neck pain starts to heal, the hip pain might demand attention. As soon as the hip pain starts to resolve, the knee pain might arise. When the knee healing is underway, the shoulder injury may start to squawk.

In some cases, once the PDer started being able to tune in with his body and feel long-forgotten pain, one or two "new" injuries showed up every few months, or once a year. In some cases, this delayed healing continued for several years even after completely recovering from Parkinson's. The recovery from Parkinson's did *not* require healing of all suppressed injuries. The recovery, including the person's ability to experience steady dopamine function, usually started up as soon as energy was able to flow correctly through the foot. The presence of other, smaller injuries – injuries that didn't interrupt the Qi flow in a significant manner – did not usually appear to inhibit the recovery from Parkinson's.

### **Summary of pain**

We saw that old, unhealed injuries sometimes still had their pain trapped inside, as well as their bone breaks, tissue tears, and structural displacements. When the PDer began to mentally pay attention to the injured area, these pains, breaks, tears, and displacements became knowable, feel-able. PDers sometimes needed to learn how to process pain. For some PDers, the idea of confronting pain was terrifying, even life-threatening. For others, particularly those who had consciously worked on learning how to feel safe while experiencing sensations and emotions, the pain was not alarming – it was just pain.

## **IMPROVED CIRCULATION**

Following the healing of the old foot injury, the next recovery symptom was very often an improvement of the blood circulation in the foot. The foot color often improved significantly. Blood vessels in the feet often became larger. Temperature regulation in the feet improved.

Before starting treatment, the skin on the feet of many PDers was mottled, sometimes purplish, or even a ghastly gray, with no or few distinct blood vessels. If a large vein *was* visible, it often formed a semi-circular pattern on the top of the foot instead of flowing all the way from the toes. Some PDers' ankles had severe staining (dark reddish brown discolorations) or angry, bright red varicosities. Following recovery from the foot injury, the skin color became healthier and healthy blood vessels stood out more. The semi-circular vein developed branches feeding into it from the toes or a completely new set of healthy veins appeared that fanned out over the toes. Sometimes, the dark "staining" lightened up a bit and angry-looking varicosities diminished in size and intensity. These changes sometimes coincided with or foreshadowed an improvement in temperature regulation in the feet, or even the hands.

Many PDers who'd had cold feet for years deeply enjoyed the novel sensation of having feet that could warm up easily after having been subjected to cold.

This type of lasting cold in the extremities, also known as Reynaud's syndrome, is not unusual in people with Parkinson's disease. One recovering PDer used to fear getting his feet cold because they remained cold for hours, if not days, after a severe chill. When he started to recover, one of the first behavioral changes that he shared with me was that now he would often sprint barefoot out to the snow-blanketed mailbox to pick up his letters and then scamper back into the house. He didn't mind that his feet got cold; rather, he was thrilled because, after getting back into the heated house, his feet would quickly warm up again! He was as pleased as a child at the novel sensation of his feet getting warm all by themselves after having been briefly chilled.

## THE RETURN OF SENSATION

Another recovery symptom that was often set in motion by improved circulation was the cessation of numbness.<sup>1</sup>

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<sup>1</sup> Prior to entering the recovery program, many PDers insisted that their toes were not numb. As proof, they pointed out that they could feel their toes if they stubbed or touched them.

However, their proprioceptive awareness of their toes and their internal sense of how the toes feel (a concept that many PDers do not even understand) may be completely lacking. Their toes are usually quite numb. I have done many experiments with PDers in which I have been able to prove this numbness. So has Chris Ells, one of my colleagues.

Chris did his doctoral research evaluating numbness of the feet in people with Parkinson's. As part of the research, he also asked PDers whether or not they thought they had diminished sensitivity in their feet. Most PDers felt that they had reasonable, even normal, levels of sensitivity in their feet.

When the side of the body that first developed symptoms of Parkinson's was tested with a longish acupuncture needle inserted into Spleen-3, a famously painful point near the big toe, most of the PDers made rather a proud show of stating that they were able to feel the needle. When a matching needle was then inserted into their other, healthier foot, the typical response was much stronger: a sharp startle response, often followed by the slightly concerned query, "What are you *doing*?" When these PDers were told that the two needle insertions were exactly the same, and had been performed to determine relative numbness, the PDers, often, were stunned.

What they did not know is that, in a healthy person, such vigorous needle insertion at this particularly electrical location should evoke such a strong reaction that, very often, a healthy person lying down, relaxing, will jerk bolt upright in response to rude needling at this point. None of the PDers ever had such a powerful, visceral, *normal*, body-wide response to abrupt, powerful needling at this point (SP-3) until they began to recover.

When I taught a class on Parkinson's at the local acupuncture college, I would often needle new PD patients at SP-3 as part of their intake, to help me determine how numb their feet were. Many a student, knowing the extreme, body-jarring shock of strong needling at this point, would brace himself as he saw me picking up a fairly large needle and jamming it with a lot of power and wristy follow-through into the side of a PDers' foot.

Students usually looked worried, at first, thinking of the pain that I was going to inflict on these patients. The worry changed to stark amazement when the PDer failed to physically react against what should have been a powerful electrical shock. The PDers could overhear me telling the students that I was doing this to check for numbness in the feet. Not knowing the correct response that a healthy person would have to strong needling at this location, they were usually outspokenly proud of their keen ability to detect that I had touched their feet and inserted a tiny needle. Many said something along the lines of "I felt that. I could feel your fingers on my skin and I felt that you were putting a needle in: I'm *not* numb."

The true proof of their numbness came when feeling returned to their toes.

I think my favorite quote on this subject came from the recovering PDer who asked me, in amazement, "Did you know that a person can feel his own toes even when they're inside his shoes?! Did you know that toes can tell whether or not they have socks on *without even looking*?!?" Of course, prior to starting the recovery program, this PDer had assured me that his feet were not numb in the slightest.

The sheer amazement in his face and voice as he asked me these innocent questions told the story: for as long as he could remember, he had never been able to actually know of the existence of his own toes if they were hidden by shoes. He had not been able to feel the soft texture of his socks against his skin. When he had started the program, he insisted that he could feel his feet: if he touched his feet, he could feel the touch of his hand – therefore, he did not have numb feet. However, if he was not touching his feet, he had no awareness of how his feet *felt*.

As PDer's foot circulation improved, foot areas that had been numb, such as the distal (toes) end of the foot and particularly the three more medial toes (the "big" toe, second, and third toes) experienced a return of sensation. In some cases, the sensation was mildly pleasant. In most cases, however, the return of sensation to long-numbed nerves was somewhat painful. Common PDer descriptions of the foot sensations that occurred during recovery from numbness were "tingling," "burning," "pins-and-needles," and "like the pain of recovery from frostbite."<sup>1</sup>

One particular area on the foot tended to experience a very powerful sensation during recovery: the medial side of the ball of the foot (see the acupoint SP-3 in fig. 3.7, page xxx.) Many recovering PDer's reported a particularly strong stinging sensation right at this spot. Patients have said things such as: "I was certain I had a splinter in my foot. I took my shoe off six times to try to find the splinter but there was nothing there," or "I thought a bee was stinging me; I took off my shoe several times but there was no bee. The sensation lasted for hours."

However, some of the tingling that occurred when the nerves come back to life was less site-specific; the sensations came and went or moved around a bit. Many people described the sensations as "ants moving around in my toes." Another description was "someone's dragging a miniature rake back and forth over the top of my foot and my toes."

### ***Interpretations of the "tingling sensation"***

The emotional response to the reawakening of foot and toe nerves varied from one PDer to another. Some recovering PDer's found the tingling sensations to be amusing or even thrilling: proof that change was underway. Others were fearful that the pins-and-needles sensations would only keep getting worse, or even that the new sensations of pain were being caused, not by anything healthy, but by cancer, gout, imbedded nails or broken glass, or some rare and incurable foot disease. Some people enjoyed the reassuring feelings of once again having toes. Others found the awareness unfamiliar and even frightening.

As to the intensity, a few recovering PDer's told me that they were so shocked by or fearful of the stabbing sensations in their feet and toes that they screamed out loud during the more dramatic moments. Others said things along the lines of, "It was no big deal," "You got me worried for no reason," and "It's nothing; why did you even put it in your book?"

I cannot begin to share all of the descriptions and variations on the return of nerve function in the feet and face.

In general, people who were emotionally closed off or mentally oriented towards cynicism, negativity or self-control tended to experience the return of nerve function as terrible, painful, and even excruciating. Those people who were more curious than frightened tended to enjoy, or at least not mind, the sensations.

As the Bard's Hamlet says, "There's nothing either good nor bad, but thinking makes it so." The sensations of recovery from Parkinson's are merely that: sensations. Whether or not they are perceived as augurs of health or omens of suffering seemed to depend entirely on whether or not a person was in a predominantly positive or negative mindset.

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Another sweet remark from a PDer who regained proprioception and feeling in his hands – even though, prior to recovery, he'd insisted that his hands weren't numb, was, "My fingers have eyes again! I can see where my fingers are even when they're inside my sleeve!"

<sup>1</sup> Frostbitten toes are actually painless – so long as they remain frozen. In fact, they often feel perfectly normal until they warm back up. *Recovery* from frostbite, on the other hand, can be quite painful.

### ***Increased awareness of rigidity***

Often, along with a cessation of numbness came an increased awareness of rigidity. This rigidity might have been there right along, but had not been felt. For example, many PDers had not realized that their wrists or ankles had been moving in a cogwheel motion until their doctor pointed it out. They couldn't feel the wrist or ankle very well (they were numb), so they didn't realize the full extent to which the ankle or wrist was rigid.

Due to improved circulation and the concomitant return of nerve sensitivity, many PDers noticed that their bodies were far more rigid than they had realized. As one person said, "I can feel my feet better and I'm walking better and faster, but I never knew my legs were so heavy and stiff!" Another patient said, "I think I'm getting worse. I have a limp." In fact, she had been limping since before she started receiving treatment. When reminded of this, she admitted that, for decades, she had *heard* herself limping, but had never *felt* it before.

## **THE RED RASH**

(This section will take a bit more space than is possibly justified in terms of the percentage of people who get the red rash, but the fungus situation is significant to our project because it provides still more proof for our hypotheses.)

Many PDers have foot and/or toenail fungus. The toenail fungus causes the nails to be thick and gray, or even white. The foot fungus may blossom (present an itchy, red rash or sores) during the summer months or anytime that the feet are hot. The fungus may become dormant when the weather is cold.

In areas where the body is numb, the fungus can thrive, unmolested. When circulation improves, the body becomes able to notice the presence of the fungus. Once the body notices the fungus, it will take steps to kill it.

Fungus is everywhere. Our bodies are constantly being exposed to fungal spores. The white tip of a healthy fingernail is white with fungus residue: fungus is digesting the underside of the nail. But a healthy person's awareness of his body keeps the fungus from establishing itself in the pink, attached-to-the-nailbed section of the nail. The faint, very thin line of deeper red where the nail goes from pink (attached to the skin) to white (free standing) is the red of a biological battle line. These are the lines where a healthy body keeps the ever-present fungus at bay.

However, the immune system cannot not fight very well in those body areas in which a person has little proprioceptive self-awareness, poor circulation or sensitivity. Fungus can thrive in these areas. Because PDers have very little awareness of their toes and feet, they often have fungus invading and becoming established in the nailbed (inside the toenails) and in the skin of the feet.<sup>1</sup>

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<sup>1</sup> The numbness, poor circulation and poor body awareness that allows the fungus to slowly move deeper into the body may start decades before a person is diagnosed with Parkinson's.

For example, one PDer remembered noticing, at age seven, about two years after having her foot smashed in a car door, that she couldn't tell where her *fingertips* ended and the air started. She laughingly admitted to me that, in her twenties and thirties, she had taken this as a sign of her advanced spirituality – her body consciousness was contiguous with the universe. She never even realized that she had no idea where her *toes* ended. She developed toenail fungus in her late forties, just two years before she was diagnosed with Parkinson's. She only had fungus on her toenails, not her fingernails. Evidently, her toes were even more numb than her fingers – so numb that she didn't even know how numb they were.

In addition to having fungus in their toenails, people with Parkinson's often have thriving fungus in the skin of their toes, and the dead skin on the soles of the feet. These areas may break out into an itchy red rash when the weather is hot. If the leg is somewhat numb and there is poor circulation in the skin of the leg, the mycelium ("roots") of the fungus sometimes spreads farther up the skin of the leg, but it is usually not able to thrive and become obvious in areas where the blood circulation is sufficient to keep it at bay. Thus, its presence in the *legs* is generally limited to an asymptomatic sub-dermal invasion, if anything.

During recovery, circulation almost always improved quickly in PDers' feet. As circulation improved, it seemed as if the PDer's immune system began to detect the fungus, if there was any, and initiated battle against it. This often caused a reaction in the feet. The fungus, coming under attack, bloomed aggressively, in a final attempt to produce spores before being killed. The "blossoms" of the fungus were tiny, itchy, red bumps. If there were a lot of the little bumps, they looked like a red rash. Sometimes, if they were scratched enough, the bumps opened up, releasing a tiny bit of fluid.

As the fungus came under attack from the body's immune system, itching red sores broke out wherever the fungus was located. We were then able to see if the fungal infection had pervaded the skin of more than just the foot. In some cases, these sores, also referred to by us as "the red rash," extended up the lower part of the leg(s) and, in a few cases, even up the thighs.

The red rash could be hot and itchy. But in terms of treatment, none was necessary. The red rash always went away by itself. Once circulation was restored, the body was able to destroy the fungus that had snuck into numbed areas over the years. Some PDers found that an athlete's foot salve was somewhat helpful during this time, but others said that it was not. Others found that aloe vera lotion was useful in soothing the heat and itch until the battle is over. Others disagreed.

The red skin rash always ceased eventually. Even the fungus in the toenails often decreased, although this took much longer. Watching the healthy new nails slowly grow in, pushing the diseased toenails out, was a cause for gentle celebration. In some cases, the toenails returned to complete health.

I found it interesting to note that toenail fungus is an illness that doctors consider to be treatable but not ultimately curable – just like Parkinson's.<sup>1</sup>

When our PD patients recovered from poor circulation in the feet their bodies seemed to suddenly recognize that a fungus was lurking. Their bodies waged war against the fungus, and won. The red rash and itching was a bit unpleasant at the time, but the upside was that it showed

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<sup>1</sup> Some patients have asked about the internal (pill form) antifungal medications. Fungus in the toes and feet is not a dangerous condition. Internal antifungal medications, however, are extremely toxic and hard on the liver. In fact, the internal antifungal medications (as opposed to the external-use ointments and salves) are far more dangerous than the fungus itself. Most of the doctors I know personally will not let their own family and loved ones use the FDA-approved *internal* antifungal medications.

When a person uses internal antifungal medication, the *dormant* portion of the fungus doesn't die from the medication. The fungus will resume growth and thrive again within a few weeks after a person stops using the medication. In other words, the anti-fungal medications do not *eradicate* the fungus. The fungus can remain in the body, dormant, as long as a person is taking the medication. Therefore, the medication doesn't actually "cure" the fungus; it just masks the symptoms.

that the body of the PDer was coming back to life. The red rash battle sometimes lasted for a few short weeks. Sometimes it went on for over a month.

Only one PDer had the red rash go all the way to the top of his thigh. He was a neurologist. It was exciting for him to observe this utterly unexpected manifestation of submerged illness. It was clear that there had been something wrong with him that was not related to “dead brain cells,” and that his body was healing from some previously unrecognized numbness. I asked him if he would tell his colleagues at one of the top medical schools in the country about our theories and his treatment. He said that he would not. “They would think I was crazy if they knew I was seeing an acupuncturist.”<sup>1</sup>

In closing off this section about the fungus, I want to mention why I have gone on at such length about such a seemingly unimportant side-event in the big picture of recovering from Parkinson’s. We can only hypothesize as to what is actually going on when a person recovers from Parkinson’s disease. Visible recovery changes, such as improvements in vein structures and the body’s restored ability to recognize and destroy pathogens such as fungus help provide the most objective presentation of what is really going on in Parkinson’s disease. The red rash outbreak on the feet and sometimes legs only occurred in approximately fifteen percent of the recovering patients. But even so, we could use this otherwise inexplicable recovery symptom to support our idea that PD is an illness of unhealed injury and the side effects of injury, including numbness and loss of awareness of the injured part(s) of the body.

## RECOVERY SENSATIONS IN THE FACE: FEELING, TASTE, AND SMELL

### *Tingling in the face*

As with the feet, the first changes to the face were often improvements in blood circulation. This led to improved color and warmth in the skin. The subsequent tingling, mild stabbing pains, and the sensation of bugs crawling under and over the skin lasted for many weeks, and in some cases, months.

Sensation often returned to the face more slowly and mildly than to the feet. But even if the facial sensations were milder, they were usually harder to ignore. Compared to tingling in the feet, the sensations of spiders crawling through the face and even the hair were often less sharp and painful but were far more startling and/or annoying for some PDers.

A stickler, reading this section, might want me to say whether the facial sensations were more like ants or more like spiders. In general, people who were more defensive or more negative tended to feel as if they had spiders and spider webs whereas people who were more curious and grateful tended to feel as if they had ants and loose hairs. I suspect that, in terms of nerve function, the actual sensation being transmitted was exactly the same. Whether the transmission was interpreted to be ants or spiders was merely a matter of perception: thinking made it so.

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<sup>1</sup> We treated him before we understood the risks of the medications. Sadly, this brilliant neurologist became horribly addicted to his medications. During his recovery from idiopathic Parkinson’s, during which time he found himself emotionally unable to decrease his medications, he rapidly developed drug-induced parkinsonism and suffered greatly from adverse effects of the medication, including violent, rapid changes in blood pressure, passing out, and serious injuries from falls incurred when passing out. He was never able to decrease his medications.

### ***When did the tingling occur?***

The sensations tended to be intermittent. As with most of the recovery symptoms, these sensations were at their strongest when a person was awake and relaxed – in parasympathetic mode.

Some PDers were worried that they might have recovery symptoms when they were “in public.” This almost never happened. It seemed to us that, whenever a PDer was worried or frightened – and being in public seemed to be a cause for wariness for many PDers – his mind would switch over to dissociative or sympathetic mode. Recovery symptoms rarely, if ever, occurred during these times.

Bear in mind that in all people, not only PDers, parasympathetic (relaxed) mode is when most healing occurs. This is possibly why recovering PDers noticed the strongest symptoms of tingling or crawling bugs during those times when they were relaxing. Very often, the PDers felt their recovery symptoms most strongly while watching TV in the evening or just before falling asleep.

### ***Numbness of sensory function in the face***

In addition to poor muscle function, other symptoms of numbness and poor circulation in the face can include diminished faculty for taste and smell, and coldness and lack of sensitivity in the facial skin, including the lips. For example, many PDers dribble on their shirtfronts when they drink from a glass or cup because their lips are somewhat numb. They cannot accurately sense *where* to apply lip pressure to the rim or *if* they are applying pressure.

Just as with the denial of foot numbness, many of our PD patients denied that they had any impairment of taste or smell or tactile perception in the face. They assured me that their sense of taste and smell was perfectly normal. Others knew that their sense of taste, smell, or tactile awareness was declining or gone, but assumed that the loss was somewhat recent.

For example, one PDer admitted being humiliated for many years even prior to diagnosis because she was often told that she had a spot of food was sitting on her lip or that she had a “food mustache.” Also, she had increasingly spilled drops of her beverages down the front of her shirt because her lower lip couldn’t actually feel the contours of the drinking glass. She did not realize that her facial skin was more numb than normal. Instead, she had assumed that she was a clumsy eater. Her son-in-law had even asked her once if she was able to feel the bits of food stuck on her face. Ashamed of her “sloppiness,” she had assured him that she could, even though she couldn’t. At the time, she wondered to herself how anyone could *possibly* feel a bit of food stuck on the face. After recovering, she was able once again to feel when her facial skin was accidentally decorated with food.

When recovering PDers experienced the full range of healthy sensation that returned to face, tongue, and nose, they often asked questions like, “Did you know that wet asphalt has a *smell!*?” or “Did you know that different kinds of tea actually taste different?!” These queries suggested that the person’s sense of taste or smell had been numbed for a very long time. Some PDers admitted that they were experiencing common smells, such as the smell of newly cut grass, for the first time in decades. Again, when a person is numb, he cannot be a good judge of how numb he is: he is too numb to know.

Of course, there were exceptions. For example, one of my PD patients with lifelong extremely poor eyesight had a highly developed sense of smell even though her Parkinson's symptoms were coming on strong. Again, no two PDers are exactly alike.<sup>1</sup>

### ***The pleasures of recovery***

Whether the recovery symptoms felt like ants or spiders, nearly all patients loved the *results* of these recovery symptoms: return of sensation and function. I have dwelt so heavily on unexpected recovery symptoms: the pain and the tingling. But the short-term symptoms were worth the effort. It was worth a spot of recovery symptoms to be able to experience the return of facial sensory function, and the ability to use the feet correctly while walking. Even in the earliest days of the project, when we could hardly dare to believe that we'd found a cure for Parkinson's, the patients were thrilled at the improvements in their faces and feet.

Family members especially were thrilled to see the return of full facial expression. One of the articles I published included before and after photos of a PDer who had not had facial expression for over twenty years.<sup>2</sup>

### ***Exceptions to every rule***

Then again, a few PDers grew angry when people suggested that they were moving better or looking better. These supportive compliments were interpreted as criticisms of how the PDer had moved or looked in the past.

I remember one recovering PDer insisting that he'd never had a lack of facial expression: he claimed he had *consciously* refrained from stupid smiles – just like the Buddhist monks that he'd briefly studied with, back in his college days. His face had expressed reserve; it *had* never been frozen.

His wife and I did not argue with him. He could not be argued with. Although he was a brilliant professor of sociology, he had the social skills of a six year old – including stubbornness and temper tantrums. He was emotionally utterly unable to deal with the idea that he had ever been imperfect – especially with regard to his facial expression.

But the fact was, over the last ten years, her friends had been increasingly afraid of him because he always looked as if he was glaring with disapproval. After muscle function returned to his face, he was clearly smiling at people once again, even as he continued to assume his lifelong look of unctuous “reserve.” Her friends were so pleased that he was finally “warming” to them, that he had become “welcoming.” His behaviors were actually just the same. So far as

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<sup>1</sup> In our experience with hundreds of PDers, only one person developed malodoria during recovery. Malodoria is a condition in which *all* smells are perceived as offensive. When, in response to Tui Na treatment on her feet, this patient became able to detect smells, she was assailed each day by whatever the first smell of the day happened to be. For hours, she could not get rid of the stench of that particular smell, and when it finally ebbed, the next thing she smelled would take its place – and would be equally noxious. This patient was extremely cynical about the bona fides of everyone, and sometimes even paranoid. This was in the very early days of our project: she was taking a high level of antiparkinson's medications. When her foot began to heal and simultaneously her responses to her medications became suddenly violent, she tried for several days to decrease her medication, but found herself emotionally addicted. She dropped out of the program. Malodoria is extremely rare. It occurs when a person is deeply entrenched in sympathetic mode or dissociated. The “cure” is a return to parasympathetic mode. The variations in perception that naturally occur in the different neurological modes is discussed in chapter xxx.

<sup>2</sup> *Journal of Chinese Medicine*. Sussex, England. 2002, Vol. 69, pp.43-47.

he could tell, he was still giving her friends the same studied look of benevolent wisdom. So when any of us expressed delight with his new smiles, he grew angry, even belligerent.

He was very intelligent and witty. I'd noticed in the early days of treating him that, when he'd told jokes, his facial expression never changed. As he was recovering, his eyebrows, cheeks, nose, and mouth all danced with expression when he told his jokes and witticisms.

After his face recovered full sensation and the ability to move, the only thing that remained unchanged was his inability to admit that he'd ever had a frozen face – or been imperfect in any way.

His stubbornness and temper tantrums were somewhat unusual in our experience. In general, our PD patients tended to be people-pleasers: careful to not show emotion, and careful to prevent anger rising up in those around them. But then, there was a wide range of variations in the PDers' personalities, even if most of them had the characteristic emotional-harm avoidance traits of the "classic" Parkinson's personality.

## THE SEQUENCE OF RECOVERY SYMPTOMS

There was absolutely no cut and dried pattern for the recovery symptoms. The following example will demonstrate. One PDer's unhealed foot was treated for nearly a year. After the foot healed, over the next many months, she regained feeling in her foot and her facial expression returned. Workouts at the gym helped restore range of movement in her arms. However, she still favored her left knee and hip and she still tremored. I asked her to take a course of homeopathic pills (Arnica Montana). This particular homeopathic remedy can hasten the healing of injuries by drawing one's attention to the injury. After taking the Arnica for about a month, at an *extremely* low dose, a mass of bruises appeared on both sides of her left knee and her left forearm. These bruises were consistent with the foot-in-the-bicycle-spokes knee-torque injury that she'd had at age seven. These bruises went away over a period of two weeks. Three weeks later, she announced, "I can feel my fingernails! They're like wind-chimes!"

Wind chimes? She had never been prone to flights of poetic fancy. Prior to full recovery, most of our PD patients were more comfortable and experienced with analytical thinking than with metaphor or poetry. I had to ask what she was talking about. She explained, "I can feel the tiny weights of my fingernails. I'm aware of my fingertips. It's as if I have ten little bits of weight at the tips of my hands: when I move my fingers, I feel them moving, fluttering like the little noise-makers on a wind-chime."

I'm including this example because she never experienced any tingling in her fingers prior to the return of sensation. Also, there was no specific sequence of events that could have led us to expect a return of sensation in her fingertips following the discovery and healing of a *knee* injury. And she'd never suspected that her fingertips were numb.

### **Recovery without tingling or pain**

Many people recovered sensitivity and function in body parts even though they never noticed any of the negative symptoms of pain, tingling, or unpredictable muscle movements.

If, in this book, I have dwelled more on the recovery symptoms that did occur in some PDers prior to the return of healthy body function, it is not because bizarre recovery symptoms are the "normal" thing to expect. It's just that, in the cases where body part recoveries had no weird symptoms, there is nothing to write up. I have written up far more about the strange things that happened than I have about the things that *didn't* happen. I merely mention this, and will

mention it several times, because so many of our patients insisted on determining whether or not their Parkinson's was going away based on how many recovery symptoms they had.

The non-PDer reader may think that this is ridiculous: the way to know if Parkinson's is going away is that the symptoms of Parkinson's go away. However, many PDers are so out of touch with their bodies that they don't know whether or not a particular symptom is going away unless their attention is carefully drawn to that one problem. And in the same way that "a watched pot never boils," PDers who were fixated on a particular problem might not notice that all the other symptoms *except* for the "watched" one were going away. This seemed very bizarre to us, at the time. Also, many PDers who resumed perfectly normal movement refused to believe that they were recovering unless an MD said that they were recovering. Of course, no MDs ever said that a patient had recovered. Any patient who recovered had been "misdiagnosed."

One PDer who attended the free clinic once a week for just over a year was thrilled when her dragging leg, tremor, bent arms, facial masking, slowness and rigidity slowly went away. However, after her victory visit to her neurologist, she was furious – with *us*.

"My MD said that, if my symptoms went away, my problems must have been caused by something like a pinched nerve. I spent all this time coming to Santa Cruz every week, and all I had wrong was a pinched nerve! I never had Parkinson's to begin with! You people should have noticed that from the start!"

Eventually, after about five years into the project, we slowly began to realize the extent to which many PDers did not have any way of knowing how their bodies *felt* – they relied on visual analysis of their movements or the proclamations of their doctors to assess how their own bodies were doing. Over the next five years, we figured out what was going on in these PDers. But in the early years, we only saw that many PDers clung to the "checklist" of recovery symptoms. They used it so that they could analytically determine whether or not they were recovering: they did not have the capability of *feeling* the changes that were occurring in their bodies, feelings that might have confirmed that changes were afoot and that their symptoms of Parkinson's were decreasing.

## THE DURATION OF RECOVERY SYMPTOMS

### *How long did the increased sensitivity and "crawling ants" go on?*

It seemed as if the period of *heightened*, excessive sensitivity only lasted until the brain accommodated to the new incoming sensations – a few days or a few weeks.

As with recovery from frostbite, the tingling comes to an end when circulation is restored and the nerves are up and running regularly again. After that, conscious awareness of the toes is possible – and is situation dependent.

After the brain became re-accustomed to getting incoming nerve signals from the feet, it behaved as it does in healthy people: awareness of the feet only rose to the consciousness when something significant – positive, negative, or otherwise – was occurring to the feet. For example, a healthy person might not notice his feet during the course of the busy day working at the computer. But when he's on vacation, he might find himself focusing on the luscious feeling of warm beach sand sifting through the toes.

The timing of the tingling sensations was varied. For example, over a period of days or months, a PDer might have experienced a few *moments* of tingling, followed by a period of

calm. Or the tingling might have occurred a few *minutes* at a time. Or there might have been a period of a day or two – or several months – during which the feet or face seem to be feeling stabs of spiders, ants, or pins and needles for *hours* at a time. In other words, anything was possible. Again, the timing of the recovery symptoms had an enormous span, ranging from moments to months.

### **Asymmetrical healing**

Many PDers noticed that most of the recovery from numbness occurred first in the healthier side of the body. If the PD symptoms had started on the right, the recovery symptoms might occur first on the left. It seemed as if, when the Qi started to flow correctly and the body started healing all the damaged bits, the parts that were less damaged recovered first. The recovery symptoms on the more damaged side of the body were often more severe and took longer to heal. Sometimes, the healthier side of the body would be completely returned to health and vigor before the side where symptoms first appeared even started to experience the pains, warmth, tingling, and the new movement that indicated a return to function.

Sometimes PDers were sometimes alarmed that their “healthy side” was tingling or wanting to move by itself. They assumed that their Parkinson’s disease had spread to the healthy side. Considering that the recovery symptoms were the exact opposite of Parkinson’s symptoms, this fear seemed illogical to us. But we still didn’t appreciate that some PDers were better able to anticipate problems than anticipate health or joy.

### **Attitude**

Many PDers, prior to entering the program, have insisted on knowing exactly what their own recovery symptoms will be like. Of course, it was absolutely impossible to guess, and we never even tried. We soon realized that there was no way to predict who would experience what during recovery. We also learned that many PDers were *not* happy with my statements that such and such a phase of recovery may or may not be painful, and may or may not linger for an unknowable period of time.

Some PDers wanted as much hard, precise information as possible. They often wanted to know *exactly* what it was going to feel like and just how long it would last, so that they could be prepared for it. But the symptoms of *recovery* from Parkinson’s seemed to be as variable as the symptoms of Parkinson’s itself. But this just made sense: no two PDers had the exact same set of symptoms, or the exact same mindset.

However, in retrospect, I can say that attitude seems to be the best predictor of whether or not the recovery symptoms will be fascinating or hellish. An attitude of curiosity and gratitude allows one to see the symptoms as wonders, miracles: harbingers of recovery from an “incurable” illness. As for the “pain,” the PDers who felt safe noticed *sensations*, not *pains*. Oppositely, those who were more fearful or negative had symptoms that were ominous, painful, and anxiety-provoking. The latter ones did not think that recovery symptoms were necessarily signs of improvement – let alone recovery. They often told us that, just because they *seemed* to be improving did not mean that they were going to be “one of the lucky ones.”

## DOUBTING THAT RECOVERY IS REAL

### *Fear when the tingling stops*

Some recovering PDerS actually worried when the tingling and/or the *heightened* awareness of the feet and face came to an end. When the tingling stopped, they pessimistically assumed that their feet had gone dormant again. Some even decided that the injury must have somehow returned, and that they therefore would never be able to recover – as they suspected from the start.

When a few PDerS first said things like, “The tingling in my face has stopped, so even though my face has full expression again, and my sense of smell and taste has returned, I guess I can’t recover after all,” we were puzzled. This fairly common tendency to jump to negative conclusions seemed unwarranted and even illogical.

Over the years, after running many experiments, we were able to prove that this negative mindset plays an active role in maintaining the selective dissociation from body parts or from the heart that, in some cases, prevents full recovery. And dissociation from the heart contributes to a negative mindset. This negativity was not present in all PDerS, and it was present to varying degrees in those people who had it. But in the beginning, we were baffled by these strangely negative conclusions. It seemed so strange to hear adamant statements such as, “Since my foot isn’t tingling any more, I’m going to be one of the people that can’t recover,” coming from otherwise intelligent, analytical PDerS.

It took several years, during which we saw the positive-attitude people recover easily and the negative attitude people experiencing weird, mood based, come-and-go symptoms, before we understood the extent to which negative thoughts can become self-fulfilling prophecies.

Since these people had already started experiencing some recovery symptoms, we asked them why they were so determined that they could never recover. We suggested that they could get a foot massage, *relax* (if possible), and really focus on the sensations in the feet. If they did this, they realized that their feet had become far more sensitive than they used to be. Of course, if they were worried or wary, their awareness of sensitivity in the feet naturally and correctly decreased – because their minds were preoccupied with thoughts instead of noticing sensations. But despite the proof that they now could feel more sensation in face and feet by relaxing and paying attention to these areas, many PDerS decided that, when the pain or tingling came to an end, they could not recover.

Also, many quickly forgot that they had ever experienced these changes. One PDer saw me once a month after the foot injury healed and she started to recover. But after about six months, she said to me, “I don’t see why you’re wanting to work on my attitude, you’ve never gotten rid of my foot injury. I’ve never noticed any improvement in my feet.”

I flipped back through her chart to her sixth week of treatment. “Do you remember saying, on June 4, “After the last treatment, my right foot hurt right across the top of the arch?”

“No.”

“Hmm. Do you remember saying, on June 11, “I’ve had a sharp pain at the base of my third toe all week.”

“No.”

“Well, do you remember saying, on June 18, “My foot pain is gone and my feet feel warmer lately, it feels really good.”

“No, but I believe you.”

“Do you remember saying, on June 25, “This last week, I stepped on a small piece of kitty kibble with my bare foot. It *really* hurt! There’s no way I would have been able to feel something like that in the past. It really *hurt!*”

“Well, OK. I’d forgotten about that. So why did I stiffen up when I found out that my grandson was going to prison? I’ve barely been able to walk since then, and my tremor’s gotten much worse.”

“Right. So let’s get back to work on the dissociation mindset you’ve always used for coping with stress.”

Despite experiencing recovery symptoms, the more skeptical PDer usually assumed they would never recover – and they didn’t, except for during those hours or days when, as they usually put it, they “forgot” to have Parkinson’s disease.

Some PDer who had only brief, minimal recovery symptoms decided that they hadn’t been through enough to *really* recover. They were certain that recovery should be dramatic.

One PDer, during his weekly visit, told me that he’d called all his old friends in New York over the weekend and told them that he was getting worse. Minutes earlier he had told me that he was doing much better, and he could hardly believe how much more feeling he had in his feet, and how much his walking had improved. When I asked him why he told his friends that he was worse, he replied, “There is no way I can be recovering so quickly. If I’m actually recovering from Parkinson’s disease just because you are holding my feet, well, I’m not ready to believe that. So I told my friends I was getting worse. I don’t want anyone to have false hopes.”

Some of the people who doubted their ability to recover, in spite of cessation of Parkinson’s symptoms, assumed that the Parkinson’s had merely become dormant. Why? Because they hadn’t experienced as many recovery symptoms as other people. These were the ones whose PD symptoms could go away for a long time, but when some distressing life event occurred, they would manifest their old symptoms again. The resurrection of these symptoms was usually deemed “proof” that they were never going to recover. The emotional blow of this “proof” often resulted in rapid worsening of symptoms.

We had to wonder. In these cases, was the short-term (weeks, months, or even years) *recovery* merely psychosomatic, or was the Return of the Parkinson’s psychosomatic? Something didn’t make sense. If Parkinson’s was based purely on physical problems, it shouldn’t come and go for long periods or be triggered by mood or environment. But if it was purely mental or emotional, how could we explain the similarities in the physiological recovery symptoms that unsuspecting PDer experienced after their foot injuries healed?

And yet, it was clear that PDer who doubted that they could recover also needed more time to recover – or they got stuck in partial recovery.

### **Illogical responses to pain**

A few PDer who were doing well in recovery suddenly fell to pieces when some unexpected place in his body started to hurt with a nagging or a blinding pain. As they experienced the pains from unhealed, long-ignored childhood injuries, some of them started to tremor from pain and fear. They sometimes instituted a high level of body-wide dissociation, setting in motion a high degree of rigidity and extreme poverty of movement. This was somewhat understandable, but not helpful. Sometimes, in response to pain, they panicked and started talking antiparkinson’s medications; this was *not* reasonable.

Taking antiparkinson's medications to deal with severe pain from an old injury is a completely inappropriate use of this mind-altering type of medication. I have seen people start taking these medications to treat pain and then, succumbing to the lure of these extraordinarily addictive medications, cheerfully drop out of the recovery program. I've seen this many times.

The antiparkinson's medications are *not* designed to treat pain, reduce swelling, or accelerate healing. Most of them do not help with tremor, either, unless taken in doses so high that they cause the person to be stoned, out of touch with reality, and even *then* they do not always help treat the tremor. If they *do* ease the tremor, the benefit is short lived, and wears off as soon as the meds wear off. The Parkinson's meds are *mood* drugs, not anti-inflammatories.

Most PDers in our program knew this. But even knowing this, PDers who got slammed with unexpected pain often insisted that the pain must be coming from Parkinson's disease. This makes no sense, based on any reasonable understanding of Parkinson's, and yet the panic that accompanied the pain often led many PDers to conclude, illogically, that the Parkinson's had suddenly returned or suddenly gotten much, much worse.

What the PDer very often could *not* do was say, "I'm in a lot of pain here. I will see some doctor who treats this type of pain (chiropractor, homeopath, acupuncturist, massage therapist, MD or naturopath). I will get an X-ray or CAT scan to learn what is causing the pain. We will figure out the best way to deal with the pain *and* the injury that is causing the pain. I might dash to the drug store for some homeopathic pills for injury or maybe I'll get some aspirin. I might also contact the doctor about something stronger to ease the pain, and maybe even something to bring down the swelling.

It seemed as if many PDers were not even capable of *thinking* about the choices listed above. When a recovering PDer experienced intense pain from an injury he had received decades earlier, he almost never thought of how to *face* the pain and treat it. When pain appeared, many PDers behaved as if death were imminent. Also, some PDers were terrified of other people knowing that they were in pain, as if this would be a great risk. Sometimes they became rigid or tremored in response to the new pain, even if they had recently been becoming more fluid in their movements. They seemed incapable of understanding that most people freeze up, and some even shake, in response to severe pain – they interpreted the new rigidity as a sudden worsening or a reappearance of the Parkinson's.

They assumed that what was needed, after all, was antiparkinson's medications.

Sometimes, despite the pain, the PDer was still able to move better than before. Maybe his tremor was less and he was completely aware that his Parkinson's symptoms *were* ebbing. And yet, purely in response to the *pain*, he concluded that he needed antiparkinson's medications to treat the *pain*. This made no sense, but we saw this many times.

When it came to the ability to process pain, PDers ran the gamut from mature and sensible to immature, almost infantile. The PDers who were able to calmly feel their pain and decide how to treat it were also the ones who recovered more quickly. The ones who flew into a state of panic or who dealt with the pain by ignoring it or mentally blocking it out got stuck in what we eventually named "partial recovery."

Across the board, our Parkinson's patients were extremely intelligent and highly analytical – some of them, excessively so. But with regard to their ability to feel and process their own physical or emotional pain, some of them seemed emotionally arrested. In many cases,

the emotional immaturity was all the more striking because of the extremely high level of intellectual or analytical development.

### ***Emotional immaturity***

When some of the PDer's experienced the symptoms of a long-suppressed injury that dated back to childhood, they responded in an emotional manner that seemed more suited to a paranoid early childhood than to adulthood. Some assumed that no one could or would help them; some assumed that they would be at risk if anyone learned about the injury. It was almost as if these PDer's dealt with pain by using their *childhood* minds. In many cases, their childhoods had not featured a lot of emotional support.

Others responded oppositely, as if the pain allowed emotional doors to be thrown wide and they were finally able to express repressed rage or hurt. Some threw tantrums; others sulked.

One recovering PDer threw furniture at her husband, locked herself in the bathroom, and generally acted like a three year old – the age at which she'd been put up for adoption.

### ***Another example***

Another, according to his spouse, behaved after his birthday party “exactly like a nine-year old.” The PDer had used the *exact* same sentences that their child had used twenty years earlier after his fabulous 9<sup>th</sup>-birthday party was over: “Is that all I’m going to get to do for my birthday?” and “I never get to do what *I* want.” Over several more months, we all realized that this particular PDer’s life-changing shock had occurred when he was nine: at age nine, he’d come home from school and discovered his grandmother, dead of a heart attack, on the living room floor. He got out his Boy Scout book and gave her all the various treatments, including mouth-to-mouth resuscitation. He was still trying to revive her when his mother finally got home. The mother heaped praise on him for not having become emotional or given in to feelings at that time. For the *rest of his life*, his mother regularly praised him for not having given in to any feelings on the day that Grandma died.

Prior to starting to recover from Parkinson’s, this patient could not recall any negative events that might have led to emotional shut-down. To his mind, his behavior with his grandmother had been heroic and a high point in his life, for which he had received regular praise. It was only when he started to recover and started acting exactly like a nine-year old that his wife recalled the dead grandmother event and we put two and two together.

Even as many PDer’s *emotions* responded in ways that would have been more appropriate coming from a child, many PDer’s adult *minds* were fixated on the Dreaded Parkinson’s Disease. Therefore, when they started to hurt, they 1) didn’t know how to comfort themselves and help the healing along, and 2) assumed that all problems must be coming from the Parkinson’s.

Even though most of them had already memorized the list of symptoms that defines Parkinson’s disease, they usually assumed that *any* new problem, including pain from an old injury, must be a symptom of Parkinson’s disease. This made no sense. In most cases, no matter how many times I told a panicked patient that that the sudden appearance of pain and a large bruise in the spot where an injury had previously occurred was *not* a symptom of Parkinson’s disease, he flat out wouldn’t believe me.

Some of these people were convinced that, following a diagnosis of Parkinson's disease, any and all problems *must* be caused by Parkinson's. These were highly intelligent people, people who had read everything they could about Parkinson's disease. They knew what the symptoms of Parkinson's were, but when old injuries appeared, they panicked. These people often decided to drop out of our program and start taking the antiparkinson's medications that their doctors had offered them several months or several years earlier.

The reader may be thinking that this makes no sense, but we saw this over and over. The onset of pain in an area that had previously been numb was just one of the many recovery symptoms that many PDer's chose to misinterpret. But PDer's are not alone in this: some doctors also misdiagnosed throbbing, inflamed, injury-type pain as a symptom of Parkinson's disease – a disease that is characterized by numbness. These MDs should have known better. They should have known that most of the pains that do occur in Parkinson's are due to steadily worsening stiffness and rigidity – they are *not* pains from inflammation and injury.

### ***An example***

One patient who had thought she was recovering developed agonizing pain in both hips. The pain began when she first became able to imagine herself having hips. Instead of seeing a pain specialist, she went to the neurologist who had diagnosed her with Parkinson's. This patient was *not* taking any antiparkinson's medications.

Her neurologist, thinking of her only as a Parkinson's patient instead of a patient in pain, prescribed a powerful anticonvulsant (anti-epilepsy drug). This drug is often used to sedate brain activity in PDer's *whose medications are at excessively high doses*. High doses of dopamine-enhancing antiparkinson's drugs can cause enormously powerful and painful muscle dystonias. To counter the excessive level of brain activity that triggers these spasms, anti-seizure drugs are sometimes prescribed for PDer's *who are taking high, dystonia-inducing levels of antiparkinson's medications*.

This patient was not taking any medications. She was not having dystonias (muscle spasms). She was not rigid: she was exceedingly limp, a recovery condition that you will read about in the next chapter. Therefore, the anti-spasm medications prescribed by her neurologist were completely inappropriate. For over a year, she took the anti-convulsants that her neurologist gave her. The drugs made her even more limp, extremely groggy and confused. Because these drugs inhibit brain activity, they did reduce her pain a little: a *very* little. However, she was determined to keep as active as possible: she didn't want to "give in" to the pain.

After a year during which the almost paralyzing pain continued, she finally went to see a pain specialist. He took CAT scans of her hips, and discovered that both her psoas muscles were badly torn in the hip area – torn right through the middle of the muscle, from side-to-side – and inflamed. He prescribed medications to reduce the swelling and instructed her to minimize activity that used those muscles. As soon as she saw the scans, she suspected that these extremely unusual types of muscle tears had probably been received at age six during her father's "tickling games" in which he would have her lay down on the floor with her legs up in a fetal position. Then, he would force her knees apart to the sides. He would press her bent knees all the way to the floor and not let her get up until she cried. The "game" was to see how long she could go without crying.

This PDer was a highly educated therapist. She told me that she had no emotional feelings one way or the other when she realized that her father's "games" had probably caused

the hip muscle tears. I asked her if those “games” might have been a little inappropriate. She replied firmly, with no apparent warmth, “I loved my father. I looked up to him. *Everyone* admired him.”

Finally, after she started getting appropriate treatment and stopped being so stoic and driven, the muscle tears started to heal. It took more than a year for the lateral tears in her psoas muscles to heal completely.

Back to the point, she spent a full year in agony because she and her neurologist assumed that her pain was being caused by Parkinson’s disease. Her error is understandable: she trusted her doctor. The neurologist’s error was due to the medical professionals’ tendency to see every problem in terms of one’s own specialty. The neurologist, assessing her in terms of overmedicated Parkinson’s, assumed that her hip pain was due to either dystonia (permanent muscle cramp) or the violent spasms that PDer’s often get from excessive levels of antiparkinson’s medications, even though she had *no* muscle cramps and she was *not* taking medications.

I’ve written up the above vignette to demonstrate how patients who had been given a diagnosis of Parkinson’s – *and* their doctors as well – tended to assume that every PDer’s problems and pains must all be due to Parkinson’s. While I’m at it, I should mention that many recovering PDer’s who developed flu symptoms when the flu was going around assumed that they felt worse than usual because the Parkinson’s was getting worse. Sometimes, even if they ran a fever, they still insisted that the Parkinson’s was getting worse. And sometimes, their doctors agreed that the flu symptoms must be symptoms of Parkinson’s disease!

### ***Inability to relate to normal aches and pains***

Let me compare how a non-PDer and how a negative attitude PDer might respond to an ache or pain. I have *non*-PD patients who are middle-aged or older. Sometimes they come to see me because they are stiff or sore after a bout of unexpected activity such as spending all day gardening or from an habitual lack of activity or exercise. They want relief from their pain, so they get a massage or an acupuncture treatment.

But some recovering PDer’s, becoming stiff or sore after doing an unaccustomed activity or after spending several days doing nothing, panic. They called me to announce that the Parkinson’s is suddenly much, much worse.

Many recovering PDer’s have complained of increasing stiffness in their joints. I often ask them if they are doing daily stretching, or yoga, or Tai Ji, or anything to keep the joints supple. They often ask me why they should need to be doing such activities; prior to having Parkinson’s, they didn’t have such pains and stiffness, even though they hadn’t done stretches. When I point out to them that, prior to recovering, they were pretty much numb, using adrenaline, and only felt stiffness if the joint was so locked up that they couldn’t move it, they struggle to understand my point. I tell them that any person who is middle-aged or beyond, who fails to work at staying loose, is going to tighten up. This idea is usually met with disbelief, or the statement that, “I’ll start doing stretching exercises if the Parkinson’s goes away.”

PDer’s need to learn how to feel their bodies. They *also* need to learn that bodies can be stiff and sore for reasons *other* than Parkinson’s disease. Many PDer’s discovered, during the course of recovery, that a large part of their neck stiffness was due to old neck and shoulder injuries. These injuries often responded very well to gentle styles of chiropractic treatment or

craniosacral therapy. Parkinson's disease might have exacerbated these injury-based problems, but Parkinson's wasn't *causing* them. Many PDers said things such as, "That neck injury occurred decades ago and it never hurt. The Parkinson's is what's making the neck injury become a problem. Therefore, since my neck hurts worse than ever [since the foot injury healed and I've become more sensitive], it's proof that I'm not recovering from Parkinson's disease."

Eventually, we were able to figure out that the *fact* that it hadn't hurt at the time was also the underlying problem in Parkinson's: blocking out pain so that injuries couldn't heal was the problem. But we spent years trying to understand why some patients could not even consider this possibility.

On the other hand, increased awareness of body pains can become a real problem for some recovering PDers: they may develop fibromyalgia and hypochondria.

### ***Swinging from stoicism to hypochondria***

Ironically, some of the people that recovered from a Parkinson's went on to develop fibromyalgia or even extreme hypochondria during or shortly after their recovery.

These two illness patterns, fibromyalgia and hypochondria, are syndromes in which a person is oversensitized to every ache and pain. In these two syndromes, a person may be in agony, immobilized, worried, or even fascinated, with every physiological sensation that presents itself.

I do not want to imply that either of these syndromes are purely psychosomatic. However, it is curious that, from a brain point of view, these syndromes are very much the opposite of the stoic, even numbing mindset of Parkinson's disease. In Parkinson's, a person goes through life with a steadily decreasing ability to feel the events occurring inside his body. In hypochondria and fibromyalgia, a person has excessive sensitivity to the events that occur anywhere in his body, and no ability to screen the important pains from the unimportant pains.

Happily, when fibromyalgia and hypochondria did appear during recovery, they were not long-lasting. Within a few months or a few years, it seemed as if the patient's brain centers were reset to a happy medium in terms of stimuli- and pain-recognition.

## **REVIEW OF RECOVERY FROM NUMBNESS**

In review, I will say that, after the Qi blockage had been removed and Qi flow resumed, circulation often improved, and then warmth returned. Tingling or stinging sensations sometimes occurred in areas where sensory nerves had been dormant. Some PDers noticed a rapid decrease in their Parkinson's symptoms at the same time.

It was obvious that these changes did not match up with the old "dead brain cell" theory of Parkinson's disease. These changes made it seem as if one of the causative factors in idiopathic Parkinson's disease might be circulatory changes and dormancy in various tissues and limbs: a dormancy that seemed to be caused by an old, unhealed foot injury; a dormancy that could be reversed when the injury healed up.

