

“We choose and sculpt how our ever-changing minds will work, we choose who we will be the next moment in a very real sense, and these choices are left embossed in physical form on our material selves.”

Dr. Michael Merzenich, University of California, San Francisco, brain researcher in the field of neuroplasticity,

CHAPTER NINETEEN

RECOVERY SYMPTOMS: RIGIDITY AND LIMPNESS

RECOVERY FROM RIGIDITY

As noted in Chapter Fifteen, body areas in which Qi has been flowing backwards for years can develop rigidity. In Parkinson’s disease, the areas of rigidity match the portion of the Stomach channel that extends from the back of the jaw to the top of the foot and, in some cases, the portion of the Large Intestine channel that runs from the thumb side of the wrist up to the side of the neck. These areas become rigid, not numb. These rigid body parts may feel hard to the touch or as if they are slightly contracted.

In addition to causing a *rigor mortis*-like muscle rigidity, the long-term backwards running Qi in these areas also inhibits the mind-to-muscle connections for these areas.

The primary zone of rigidity in PDers is along the Stomach channel. This contraction pulls the head forward, hunches the torso, and prevents the leg from moving easily. The secondary zone of rigidity, the Large Intestine channel, may pull the arm into a “bent at the elbow” position, pull the shoulder forward, and even pull the shoulder blade laterally.

BECOMING LIMP

Prior to recovery, many PDers imagined their rigid, even rock-hard muscles, and the anteriolateral leg muscles in particular, to be proof of healthy, well-toned muscle. However, these muscles were *not* “toned.” They were perpetually somewhat contracted and wooden. They could *not* relax. They were *not* vigorous.

During recovery, the tissue in these muscles softened. When the backwards-flowing Qi ceased to flow through these muscles, they lost their rigidity. They often became weak, limp or even mushy, for a while. They weren’t able to tighten and loosen in response to brain commands, for a while.

Actually, they hadn’t responded to brain commands during Parkinson’s, either, but because they were hard, they could be used as supports. The other, still-functional muscles could push off against them or compensate for them; and so many PDers had thought that the rigid muscles, especially those in the thigh, were healthy.

Although the softening was most noticeable when it occurred in the thighs, it sometimes was noticeable in other muscle groups that had become rigid. Then again, some PDers experienced an effortless return to healthy muscle tone in all or some muscle groups, with no noticeable period of limp muscles.

Not a question of atrophy

Some PDers wondered if the sudden flaccidity was atrophy. It was not. The flaccidity was due to the absence of the mind-to-body communication in these areas. Backwards flowing current not only creates rigidity in the area it traverses, it also can cause a disconnect between the mind and the tissues in these same areas. This disconnect is perfectly normal in the case of severe injury: the disconnect prevents a person from accidentally, thoughtlessly using some badly injured body part – a part that needs to be temporarily immobilized during the healing process.

But in people with Parkinson's, this mind-to-injured body part disconnect had very possibly been in place for decades. When the Qi began running correctly, the rigidity went away, but resumption of the mind-to-body part communication did not immediately kick in.

During PDers' recoveries, we could observe that the absence of a mind-to-body-part connection, and not atrophy, was the cause of the limpness: as soon as the mind-to-body connection was restored in these areas, the muscles instantly resumed somewhat *normal* tone. There was never any need for PDers to go to the gym to "build" the limp muscles back up. As soon as healthy awareness of the limbs resumed and the nerve connections ended their dormancy, the muscles suddenly had strength again.

"Conscious strength"

After having a few days to relax and reconnoiter, these muscles usually resumed normal tone and responsiveness. However, sometimes it took several months. I started referring to this resumption of normal tone and responsiveness as "return of conscious strength." It was a resumption of strength similar to that which a person gets when he returns to a fully awake state after having been deeply asleep or in a state of shock.

A most difficult phase

This weakness stage was the most difficult phase of recovery for some people. If a person had become mentally unaware of a particular region of his body, healthy muscle tone did not necessarily revive in that region after the Qi started flowing correctly. Instead, that region sometimes remained limp and non-responsive to brain commands for an indeterminate length of time. During this time, the muscles sometimes behaved as if they were made of limp rags.

We later learned that brain researchers have proven that healthy, non-emergency type movement is preceded by activity in the imagination center of the brain.¹ If a person cannot *imagine* himself moving a certain part of his body, he will not be able to initiate movement in that body part. Some recovering PDers were unable and unwilling to even try to imagine their bodies, or certain parts of their bodies. If they were unable to imagine certain body parts, they could not imagine initiating movement in those body parts. Those parts of their bodies became limp.

Sometimes, a PDer had rigidity in some areas and limpness in others. For example, if his foot injury was healing, he might develop limp muscles in his legs. But if he still had an unhealed neck and shoulder injury, he may have painful *rigidity* in his neck and arm while having such extreme *limpness* in his leg muscles that his legs could barely support him.

¹ The citations for the research are in chapter xxx.

It also seemed as if the relaxation that occurred as the foot started to heal made it possible for the PDer to feel more of his overall pain and rigidity than he had previously been able to feel. This made sense: a person who is locked into sympathetic (fear) mode does not fully feel his body's internal sensations, including his full spectrum of pain. When he relaxes even somewhat and reverts to even a slightly greater degree of parasympathetic mode, he can feel some of the pains that had been shut out during his state of mental, emotional, or physical emergency.¹

When combinations of limp and rigid occurred, it was sometimes extremely difficult for the PDers to know *exactly* what was going on.

Those PDers who could mentally relax were fascinated by these seemingly contradictory symptoms, if they occurred. But the PDers who tended towards living in their minds, which is to say, those who could not indulge in an adequate degree of chest expansion and heart-based sensory appreciation (also known as relaxation), or those who were *obviously* locked into fear, usually wanted to know *exactly* what was happening. Since we couldn't say for certain, some of them were terrified by any seemingly contradictory combination of symptoms.

LIMPNESS IN THE BODY, PART BY PART

Neck limpness

An example: one PDer experienced a softening in the rigid muscles in her neck. Within two days of her neck starting to go limp, she couldn't hold her head up. To hold up her head at work, she placed a stack of law books under her chin so that she could read her legal paperwork. Several days passed before she had enough conscious strength in her neck to use her muscles normally.

But another PDer *never* noticed a time when her neck muscles became weak. She only realized that the neck muscles were no longer rigid when she tried to look to her left side while backing up the car. She was accustomed to turning her head slightly to the left by putting lots of strength into the effort. But when her neck muscles loosened unbeknownst to her and she applied the usual amount of strength, she found herself looking *behind* her when she intended to merely

¹ Although high school level biology classes usually discuss the sympathetic and parasympathetic modes as if they were all or nothing, black or white, this is grossly incorrect. Anytime a person is breathing, he is using sympathetic mode. Any time a person is digesting food, he is using the parasympathetic mode. So a person who is breathing during a meal is clearly using both modes. When doctors casually use the term "sympathetic mode," what they really mean is "*predominantly* sympathetic mode." The same goes for parasympathetic.

Some doctors use the term "sympathetic mode" to refer to the *blast* of adrenaline that occurs during an emergency, a blast that causes an abrupt increase in heart rate, bronchial dilation, urine production, and the opening of the pores. This is a rare event – an event that should only occur during a dire emergency. Oppositely, full-blown parasympathetic mode occurs when a person is *feeling to the utmost*, as opposed to *thinking about*, all his ongoing sensory experiences. This condition is also known as relaxation. Many PDers did not know how to trigger the relaxation mode. Unlike healthy people, whose neurological modes, when awake, are somewhere on the spectrum between mostly sympathetic and mostly parasympathetic, some PDers did not seem to have the parasympathetic option. Instead, when some PDers experienced a decrease in sympathetic mode, they shifted into dissociated mode – a mode that seems very calm because it is the numb mode that kicks in when an animal is near death. Some PDers did have the parasympathetic option. Others could move a *little* closer to parasympathetic as the sympathetic declined. But those PDers who were emotionally unable to allow themselves to experience an increase in internal sensory awareness seem to drift towards dissociation when they had a decrease in sympathetic. In these cases, it seemed as if they were moving into a Nothing Land of not sympathetic and not parasympathetic: a condition similar to the pre-death condition of automatic dissociation.

look to the side. With almost no effort, her neck had pivoted as far as any healthy person might be able to turn the head. She had to learn how to moderate her head-turning strength to accommodate her new neck flexibility. But the point is, her neck muscles never became problematically, or even noticeably, weak or limp.

Another recovering PDer went through several days during which her head pulled to the right. This occurred when the rigid muscles on the left side of her neck began to melt while her right-side neck muscles were still rigid. Her Parkinson's symptoms had first occurred on her right side. Her right side symptoms were more severe, and they were also slower to heal. Several months later, the front and right side of her neck went limp and her head flopped gently forward for several days. After that, she experienced no more neck weakness.

An aside: asymmetry

As noted in the previous chapter, left-right asymmetry of recovery symptoms was quite common in recovery from numbness. Asymmetry also occurred during recovery from rigidity. Many PDers noticed muscles pulling to the left or the right as the opposing muscle group became limp. The less damaged muscle group was usually the one that became limp first.

Ankle weakness

Weakness in the area just above and below the ankles sometimes caused swelling in the ankles. This condition did not seem to be related to poor kidney function or any of the usual problems that might cause water build-up in the ankle. The root problem was *not* water build-up, per se. It seemed more as if the muscles above and below the ankle had become so limp that they did not present enough tension to force fluids back up the legs. Consequently, fluids built up in the saggy areas of the ankles. No exercise of this area was necessary to reduce the swelling: as soon as the muscles of this area attained healthy mind-to-ankle awareness, the ankles soon resumed their slimmer, pre-recovery lines.

Leg weakness

The legs often became *very* limp. Many PDers experienced a period during which their legs were so limp that they could not easily get up from a chair or from the toilet.

This inability to stand up due to mushy muscles *felt* somewhat different from the PDer's previous inability to initiate movement – if the PDer was able *feel* his legs, as opposed to objectively observing the functionality of the legs. The upper legs sometimes felt wobbly, or even like pudding. PDers nearly always decided that this new inability to stand up from a sitting position was more of a problem than their previous inability to initiate movement.

Before, when he still had Parkinson's, the PDer might have had difficulty in figuring out how to make his legs move. When the legs turned to mush, he might still have difficulty figuring out how to make his legs move *and* they were limp, to boot. Many PDers felt, at this point, that they had rapidly gone from bad to worse.

More leg limpness difficulties

Whether the condition lasted only a few days or a few months, the leg weakness was sometimes the most challenging phase of recovery from Parkinson's disease. Many PDers found themselves humiliatingly inconvenienced: needing help with bathing and toilet. This phase was exhausting for some caregivers, especially elderly ones. This phase was the one in which many recovering PDers began to doubt the wisdom of trying to recover.

As our understanding of Parkinson's grew, we realized that those PDers who could feel and imagine movement in their legs rapidly overcame this phase: mushy legs started to firm up in a few days or a few weeks. PDers who were unable to *imagine* their legs moving or who could not *feel* their legs sometimes found themselves stuck in this phase indefinitely. The many PDers who proudly said, "I don't do visualization; that's not who I am," might as well have said, "I don't do parasympathetic (relaxed) movement, that's not who I am."

As for *feeling* the existence of their legs, many PDers did not understand what we meant by the word "feeling." A not uncommon statement was, "I don't understand the concept of noticing how my body feels."

We had to explain that feeling is not a concept: it is a type of sensory perception, like tasting or smelling. Feeling, like tasting and smelling, cannot be *understood*; it must be experienced.

We finally figured out that some PDers did not *want* to be able to actually feel their legs or other body parts. Even more shocking, we discovered that some of these PDers genuinely did not comprehend what was meant by the word "feel."

The non-PDer may not understand what I am talking about. How can a person hope to move his legs if he can't feel them or imagine feeling them? The PDer who is reading this may be thinking the opposite: "How can anyone feel the "existence" of his leg? If someone touches your leg, you can feel that touch, but how can a person *feel* the leg itself if no one is touching it or it has no pain? What does the therapist mean when he says, "feel the existence of the leg"?"

- *Taking the stairs two at a time: an aside*

Prior to the relaxing of the leg muscles, many a PDer had been proud of his ability to mount the stairs two at a time, using his legs like rigid rods to hoick himself up. To mount the stairs in this fashion, a PDer leans forwards, getting his center of gravity over the stair riser that is *two* steps up. This is easy and natural, because the PDer's torso is already somewhat hunched forward, bringing his whole center of gravity forward. The PDer then thrusts his leg up and forward by pushing/pulling with the leg muscles that are not along the Stomach channel). Then, when his foot is on the riser that is two steps up, and his forward leaning body is centered over the higher riser, the PDer pushes down against the riser with his forward leg. The downward-pushing motion, which he *can* do easily (since it uses muscles that are not on the Stomach channel, serves to raise the leg that is still resting on the lower riser. As the lower leg swings up and forward, the PDer can very often use the follow-through of this movement to swing the leg up two risers, instead of just one.

Non-PDers, who use the balls of their feet and a forward leg swing to mount the stairs, may be a bit baffled by the above description. But I've described the above to many PDers. They have usually chuckled, saying, "I never thought of putting it into words, but *yes*, that is what I do."

During recovery, when PDers' legs began to go limp, they were no longer able to do this splinted form of leg lifting on the stairs. This special way of using the leg relies on the steel rod-like rigidity in the anteriolateral muscles of the leg. When these muscles became limp, the PDer could not brace against them for his pushing-down motion. For that matter, he very often was not able to lift the legs a fraction of an inch. Going up stairs was out of the question.

Some PDers appreciated that they were changing. Others, insistent that their two-steps-at-a-time feat was a sign of strength, could not accept the idea that most PDers, *even those with very advanced Parkinson's*, can usually mount stairs very well. Even when PDers can barely walk across the room, they can usually do stairs easily – even two at a time. As Parkinson's worsens, the ability to move only when challenged or stimulated makes it almost *easier* to mount the stairs two at a time than a mere one at a time. The very mild sense of challenge and concomitant adrenaline release experienced when confronted with stairs seems to *help* many PDers to mount them two at a time. A few patients with very advanced PD even told me (incorrectly) that their PD must be in the very earliest stage *because* they take stairs two at a time.

(There are exceptions to everything. We did have a very small number of PD patients who'd *never* taken the stairs two at a time.)

When a PDer abruptly lost his two-stairs-at-time ability, it was often deeply upsetting, leading to an immediate worsening of mood-related symptoms (slowness and tremor). On the other hand, it was sometimes – less often – appreciated as being a radical departure from his previous Parkinson's disease pattern.

Another aside: feet sticking to the floor with rigid or limp legs

The inability to lift the legs due to weakness in the anteriolateral muscles of the upper leg was different from the Parkinson's symptom of "feet sticking to the floor." PDers' feet might stick to the floor whether the legs are rigid *or* mushy.

The foot stuck-ness of Parkinson's can be caused either by aberrant Qi flow set in motion by an injury on the foot, *or* by a particular electrical pattern in the feet that is *supposed* to kick in during automatic dissociation – an electrical pattern that causes a terrified person to be "frozen to the spot."

If a person is even somewhat emotionally dissociated from his body, his feet may stick to the floor whether or not the injury is gone. In this type of sticking, the foot can feel as if it's actually attached to the floor, as if drawn by a magnet. Sometimes, the foot feels as if it is being sucked *into* the floor.

Bona fide *weakness* in the legs can also make it difficult to pick up the feet. This weakness does not feel as if the foot is glued or magnetically attached to the floor. This latter situation just feels as if the leg is too limp to raise the foot.

Differentiating between these two situations proved to be difficult for those PDers who could not or did not want to *feel* the sensations in his feet.

Torso weakness

PDers, often well before they were diagnosed, noticed an increased difficulty in rolling over in bed. A recovery landmark that was often disturbing was the *change* in how the PDer couldn't roll over in bed.

Typically, as Parkinson's worsens, a PDer lying on his back may need to turn over in bed in the following manner: he brings the knees closer to the chest and pulls the head further, as if mimicking a fetal position, and then in one strong movement he heaves his whole body, as a single rigid unit, over onto his side. As the Parkinson's progresses, he may need help to do the heaving bit: a strong shove by the spouse will usually shift him.

In recovering PDer, the rigid muscles of the torso became limp. Some PDer became unable to pull themselves into a fetal position. Instead, they could only lie floppy or limp on the bed.

It might not have been too difficult for a healthy spouse to shove a rigid PDer from one side to the other. It was *much* harder for the spouse to shift a PDer who had become limp, whose body felt like “deadweight.”

This limpness while trying to turn over in bed was clearly *not* characteristic of Parkinson’s – a disease that features rigidity. However, the new utter inability to turn over in bed often convinced PDer that they were worse off than before.

Those with a curious attitude and an ability to feel their muscles appreciated that having the muscle tone of mayonnaise was a shift in the right direction. Some PDer reported feeling genuine pleasure from the new awareness of sensation in the muscles of the torso and limbs, whether limp or strong. In the past, they had been accustomed to roll over quickly and efficiently without noticing the body sensations engendered by these movements. They began to appreciate a new way of moving: noticing the internal sensations that movement conveyed to the heart and mind.

These PDer were able to figure out how to turn over in bed, eventually. One PDer described his new “turn over” routine. Starting at the shoulder, he very slowly moved one limp arm in the direction that he wanted to turn over in bed. Then he slowly oozed one leg over the other in the direction in which he wanted to turn. He slowly moved his head to the side. Slowly, moving one body part at a time, he was able to get enough body weight turned to the side so that his hips followed the arm, legs, and limbs, slowly pouring himself over onto his side.

Even doing this “slow motion” style of turn over, some PDer needed help turning the hips until they regained conscious strength in those torso muscles that are used to turn the hips. But in time, these PDer learned how to turn over *languorously*, a movement style that many of them had *never* used since childhood.

Oppositely, those who feared loss of autonomy and loss of control were usually terrified by the worsening ability to turn over in bed. As their minds increasingly raced, day and night, through worst-case scenarios, their tremors sometimes became violent, their slowness became glacial, their rigidity became painfully tight.

Some who rapidly developed worse symptoms of parkinsonism insisted that they were not afraid, that they were calm. But when we did mental exercises to hasten the mind-to-muscle connections, we discovered that they were using the word “calm” as though it were synonymous with “emotionally numb.” And at the very root of this numbness was an enormous, paralyzing level of fear: in some cases, it was the fear of feeling the physical and emotional pain of life itself. Later chapters will share many PDer’s exact words and physical and emotional behaviors that occurred in response to visualization or “feeling” exercises that led us to this chilling realization.

Back weakness

Many recovering PDer had a spate of back weakness. Two recovering PDer suddenly lost *all* muscle tone in the small of the back. They were utterly unable to stand up straight. They might pull themselves to a standing position for a few moments, but within less than a minute they were once again bent over from the waist. In these two PDer, this loss of muscle tone in the back was so severe that the PDer’s torso was parallel to the ground – if he worked at keeping his

head “up.” The work of supporting this overhang of torso required them to walk with their legs severely bent at the knees. They shuffled along with their heads a few feet above the ground. If, feet on the floor, they straightened their legs, their faces were facing their knees.

We did not figure out how to effectively treat this situation. We were never able to figure out how to re-activate their back muscles. These PDerS lived far away – one on the opposite coast and the other in Europe. We only saw them a few times. I wish that we’d had more opportunity to work with both of them.

We hypothesized a cause for this very rare pathology. In Chinese medicine, we recognize that the nerves that activate the adrenal gland enter the spine at the same vertebra as the nerves that activate these particular back muscles. Based on this, we guessed that, when the adrenal gland went into abrupt decline (taking a well deserved rest after decades of overuse), the energy in the entire vicinity of this vertebra, including the energy that activates those particular muscles, was also inhibited.¹

A more detailed discussion of back weakness is included in chapter xxx, in the discussion of the fleeting episode of low back pain that *all* recovering PDerS have experienced.

Working with the doctor when the limpness appeared

Multiple System Atrophy

Sometimes, people who were in the midst of limpness went to a doctor to ask, “What the heck is going on?”

Our patient’s were sometimes told, during this mid-recovery visit, that they evidently never had Parkinson’s disease in the first place: what they *actually* had was Multiple System Atrophy.²

Or, if the doctor was less brazen and less well-informed, he incorrectly decided that, in some people, leg and/or torso *limpness*, not rigidity, were the main symptoms of Parkinson’s disease. Or the doctor simply changed the diagnosis to “parkinsonism” (a catch-all term), or even “*atypical parkinsonism*” (an *extremely* vague catch-all term), and leave it at that.

Multiple System Atrophy is an *extremely* rare syndrome in which a person becomes steadily more limp and weak. Multiple System Atrophy is not in any way related to Parkinson’s disease. But if the PDer reminded his MD that, prior to entering a recovery program, he, the PDer, had problems of *rigidity*, not problems of limpness, the MD usually ignored these statements. Some MDs explained patiently to the recovering PDer that it is always hard to get a firm diagnosis in the beginning. No MDs, in our experience, changed their minds about the MSA when informed that the patient had been *rigid* prior to becoming limp.

¹ This posture was so impossibly bizarre that I found myself grateful for Oliver Sacks’ photos and descriptions of this exact same postural problem. In Dr. Sacks’ patient, the posture occurred, practically overnight, in one of his sleeping sickness patients after she was dosed with high levels of L-dopa. I suspect that her extremely high doses of L-dopa (thousands of milligrams per day) may have caused the energy in the area of her adrenal glands to shut down. The same problem of proximity of adrenal gland nerve and small-of-the-back muscle nerve may have been involved. Had it not been for Dr. Sacks’ documentation of this patient, I might not have believed my eyes when my two patients became bent double from small-of-the-back limpness.

² Although MSA is an *extremely* rare condition, I recall a one-month period in which three of my recovering Parkinson’s patients were re-diagnosed with MSA.

It was hard for PDeers to stand firm in their knowledge of what their own symptoms had been when the MD told them that they'd never had Parkinson's after all.

One of the first PDeers who received the altered diagnosis of Multiple System Atrophy was the neurologist mentioned in the previous chapter (the one who became addicted to his medications). When he started to be as loose as a blob of jelly, he asked his doctor for an assessment. His neurologist told him that he'd never had Parkinson's: he'd had Multiple System Atrophy right along. My patient was also a neurologist. He knew darned well that his previous symptoms had not been characteristic of Multiple System Atrophy. His symptoms had been those of Parkinson's. Even so, when his colleague told him that he had multiple system atrophy, he decided he could not trust his own judgment any more. (This was probably accurate: his mental clarity had become heavily fogged by his antiparkinson's medications.) He was willing to accept that his PD diagnosis *had* been incorrect even though, as a neurologist, he had originally concurred in every way with his diagnosis of PD. We never saw him again. Why would he come see us? He no longer thought he had Parkinson's, after all.

The first time this happened, I was surprised. PD and MSA are very different illnesses. After this happened several times, I realized anew the difficulty that doctors have in accepting the idea that a person can have Parkinson's disease and recover from it.

Now, we tell patients that if they *used* to have rigidity and the usual symptoms of Parkinson's, but following foot therapy they become limp and their doctors tell them that they were misdiagnosed and that what they've had right along is Multiple System Atrophy, it is time to celebrate: they no longer have Parkinson's disease. And in all likelihood, *despite* what the doctor says, they don't have Multiple System Atrophy.

Medical reports are not detailed enough

We had to explain to our patients that it was *not* reasonable to expect an MD, who might not have seen the PD patient in six months, to quickly examine him and decide if his symptoms had changed away from their original condition: most MDs do not make thorough enough notes to be able to tell if a person's symptoms have changed significantly, and memory of a fifteen minute visit, six months prior, is rarely precise. The doctor usually made a diagnosis of Parkinson's based on an overall picture of what seemed to be going on after having ruled out, via MRI, brain tumor and stroke. He may *not* have even noted in his records the exact symptoms or the exact location of symptoms that the patient presented. His notes might merely say something along the lines of "tremor, rigidity, cogwheeling, lack of facial expression." His notes may not even mention the *exact* location or the severity of the symptoms.

Therefore, if a patient has a 75% return of facial expression, but one corner of the mouth still turns down a bit, the MD may look at that corner of the mouth and say, "Continuing lack of facial expression." The MD will have no way of remembering that the condition used to be far worse.

We've had patients who'd lost their voice to PD but who subsequently regained the ability to talk, who'd been expressionless but had regained the ability to smile, and who had lost the use of their hands but had regained it again. They eagerly awaited the surprised look they expected to see on the doctor's face, only to be told by their MDs during their next bi-annual visits that "nothing had changed." If they pointed these obvious changes out to the MD, the MD might say something along the lines of: "You're having a good day today" or even, in the case of

one PDer who had never taken antiparkinson's medications in the three years since his diagnosis, "It's nice to see that your medications are finally starting to work."

We also had to remind our patients that the MDs may be accustomed to seeing *medicated* PDers. In these cases, he will *expect* the PDer to be moving better the second time he sees the patient – thanks to the medication. Therefore, he may not be surprised to see the PDer moving somewhat better than before: it's what he's used to. Even if he is reminded that the PDer isn't taking antiparkinson's medications, the significance of this might not sink in.

One recovering PDer who pointed out to his MD that he was once again making his own meals after years of not being able to use his hands at all, and that he no longer used a walker, which he'd needed for several years, was told, "Your symptoms aren't declining as quickly as before: your wife certainly is taking good care of you!"

"Do you want in increase in your medications?"

One recovering, *unmedicated* PDer became almost frantic when, after showing her MD how she could once again use her hands and how she no longer dragged her foot, was asked, "Do you want an increase in your prescription at this time?" The ex-PDer *restated* that she had never taken any of the prescribed medications and that her symptoms were nearly gone. The doctor then asked her if that meant that she did *not* want an increase in her prescription at this time. The patient nearly screamed at the doctor, "Why would I want an increase in my prescription?! I'm not taking any meds. Do you see any PD symptoms in me?" To which the doctor replied, "Fine," and assured her that he would see her in six months, at which time she could request an increase in her prescription if she so desired.

No amount of vehemence or patient explanations have ever, in our experience, caused a doctor to say that a person was recovering from Parkinson's.¹

To be fair, I must say that a few PDers' doctors have said things like, "Your case is baffling," and, "I would have expected you to be much worse by now," and even, "Your other symptoms are gone. If it wasn't for that one arm still not swinging, it would seem as if you hadn't actually had Parkinson's disease." But these comments, though observant of change and improvement, are not statements as to the reversibility of Parkinson's. Rather, they suggest that the doctor was considering a change in his original diagnosis: the patient had been misdiagnosed.

¹ We do have one exception, a case in which – for political reasons – a group of doctors officially stated that a person "might have recovered from Parkinson's disease." The case involved a French magistrate (judge). The reason behind the statement was this: because her Parkinson's symptoms were waning, she was facing a new diagnosis – a diagnosis of psychosis. From her doctors' point of view, the only possible reason that she could have previously exhibited "false" symptoms of Parkinson's disease for several years would be that she'd been having a psychotic episode that whole time. However, *if* her diagnosis was changed to "psychotic episode," she obviously could not remain in her position as magistrate. Psychotics cannot be judges.

(This was in the years prior to the "discovery" of the syndrome now known as psychogenic parkinsonism. Prior to the definition of this "new" syndrome, a person who recovered from PD-like symptoms was considered to have undergone a psychotic episode.)

The PDer asked me for advice. She was working with the top neurologists in Paris at the time. I suggested that she tell the doctors, in all honesty, that we had some patients in Germany who were recovering, and that the German patients would be more than happy if the first European recoveries from Parkinson's occurred in Germany, not France. When the patient presented this information to her team of doctors, her diagnosis was changed to "possible recovery from Parkinson's." She was allowed to continue working.

A PDer could not expect the neurologist to pick up on *recovery* symptoms and to notice that they are the opposite of PD symptoms. If muscles went limp, the doctor only noticed that the PDer was worse off than before. MDs are trained to focus on what is *wrong*. If a PDer became limp and weak, the MD focused on that, and added to his store of knowledge the incorrect idea that, in some people with Parkinson's, the condition causes limpness instead of rigidity. The doctor often said, accurately, that in terms of movement, the PDer was obviously much worse than before.

Trusting only the doctor

Some PDers who became stuck in partial recovery told me that they would only believe that their physical changes pointed towards recovery, and that they would only then (reluctantly) force themselves to do the visualization and the heart- and mind-retraining exercises “*if and only if an MD concurs that there has been some improvement.*” When the MDs invariably failed to do this, these people usually went into a tailspin of despair – and a rapid worsening of symptoms. Often, after these disappointing meetings with the MDs, their symptoms were “worse than they've ever been before” within a matter of days, or even hours.

On the other hand, some PDers who did the hard mind-retraining work even if it took months or years, and who then had a breakthrough to a healthy mindset, were suddenly able to move easily again. Following this breakthrough, they just as suddenly dismissed the whole subject of doctors. Their new attitude has been expressed, in a few cases, as “Who the hell are they [doctors] to tell me that I've got an incurable illness? What an idiot I was to have been so emotionally influenced by them! Why did I unquestioningly believe them?!” These people were able to feel the burgeoning changes within themselves, and had no reason to rely on any outsider's opinion as to whether or not they were doing better.

I was actually a bit surprised at the level of disgust, even anger, that many recovered PDers felt towards their doctors when they realized that doctors were fallible.

In general, it seemed as if, when the PDer's *minds* and *emotions* became healthy, the PDers knew how their bodies felt. Doctors became superfluous. Oppositely, those who were walled off from their abilities to feel and to imagine themselves moving, and who were therefore somewhat numb to the healing sensations going on within their own bodies, needed outside corroboration to confirm any changes or seeming improvements.

NO MORE ADRENALINE

Another event, that sometimes occurred before, during, or after this time, was a perceptible decrease in adrenaline. Pre-recovery behaviors, including physical, mental, and emotional behaviors, often suggested elevated adrenaline levels. When the foot injury healed, these behaviors often decreased or even disappeared in spite of having been dominant for much of the PDer's lifetime. During this phase, some PDers worried that they would never be as “intense” as they used to be. It appeared as if their adrenaline levels had been turned way down, or even off.

If the limp muscle phase coincided with the decrease in adrenaline, fear-based PDers sometimes were even more doubtful that life would ever again be worth living.

When the adrenaline declined, PDers sometimes found themselves accidentally being calm, even daydreaming. This could be terrifying if the recoverer felt that his very nature was

undergoing a change. During this time, “Who am I?” and “Who am I becoming?” were not unusual questions. This was sometimes a period of adolescent-like self-questioning or, in some cases, despair.

One recovering PDer said that, during this phase, her adult daughter showed up at the house, took one look at her, and asked, “What’s the matter?!” The mom replied, “Why should anything be the matter?” The daughter answered, “You’re sitting on the sofa.” The mom, genuinely puzzled, asked, “So?” The daughter said, “It’s just that I’ve never seen you just sitting around before.”

Another observed herself being so calm and content that she asked her husband and teenage son, “Do you still love me? I’m so different. How can you love me now, when I’m so mellow, if you used to love me the way I was before?”

The son answered, “Mom, we love you. Before, we loved you *in spite* of how you were.”

I have used the above line many, many times to console a PDer who found himself “turning into the people I used to look down on: the slow, inefficient people.” I will suggest to him that, “Maybe people didn’t used to love you *because* of the way you were: always so intense and perfect. If they truly loved you, they loved you *in spite* of it, not because of it.” This remark was sometimes well received. Other times, not so well.

PDers who used to feel that they were The One To Rely On during any situation were sometimes concerned by their new imperturbability and *laissez faire*. Some PDers wondered what would happen should an emergency arise. They feared that their “new” personality would most likely respond to an emergency by saying, “Emergency, shemergency; let someone else take care of it.”

Some admitted that nothing was ever as much of an emergency any more as they’d made things out to be, in the past. Small crises that previously would have been met with intensity and adrenaline were now met with, “It doesn’t really matter; it’s not as if anyone’s going to die.”

Many recovered PDers used the above quote. The phrase, “It’s not as if anyone’s going to die,” spoken with such firmness, by so many fully recovered PDers, actually helped us figure out the core emotion that was causing so many PDers to lock themselves into the semi-paralysis of pre-death, automatic-type dissociation.

Decrease in adrenaline in those who *could* relax

Prior to recovery, many PDers seemed to have been constantly relying on elevated levels of adrenaline.¹

When the injury crisis was over (the foot was healed) and they were able to relax, they sometimes felt as if they could never be in *predominantly* sympathetic mode ever again. Mild emergencies of the past, such as running late or forgetting an appointment, were no longer able to trigger even the merest drip of concern, let alone the heady response of an adrenaline surge.

¹ Adrenaline is sometimes described as the neurotransmitter of fight or flight. This is gross oversimplification. Adrenaline is more often employed as the neurotransmitter of wariness or mild thoughts of concern. Adrenaline activates breathing and heartbeat during times of calm, as well as during times of stress. Appendix xxx explains in great detail the differences between adrenaline- dominant and dopamine-dominant physiology and behaviors.

The sympathetic system, having been overused for years, now seemed to laugh off all petty emergencies.

And even in the few cases when genuine emergencies arose, they were able to deal with them calmly and efficiently, from the perspective of the parasympathetic mode.

Decrease in adrenaline in those who could *not* relax

PDer's who remained negative, cynical, or fear-based, dissociated from their hearts and living in their minds instead of using a blend of mind and body awareness, had a very different experience when the adrenaline decreased. The decrease in adrenaline that seemed to occur when the injury healed was a very large problem for people who were not emotionally able to drop their wariness and shift into parasympathetic, dopamine-releasing, mode.

Prior to diagnosis: using adrenaline every day

Prior to diagnosis and recovery, the PDer may have used his steady flow of adrenaline to power his movement. Some PDer's told us that they had intentionally imagined potential emergencies to get themselves going, if they found themselves slowing down.

For most of the PDer's life, he may have pitted his ability to generate adrenaline against the immobility from the injury (and from any mind-induced dissociation symptoms).

Although MDs still claim that PD becomes apparent when dopamine levels are too low, the truth is that the symptoms of Parkinson's disease become apparent when the PDer can no longer summon up enough adrenaline to override his ever-increasing immobility. When our patient's feet healed, their adrenaline (from injury) levels took a significant drop. If patients were still emotionally locked into fear-based dissociation when their adrenaline levels dropped, dissociation became their dominant neurological mode – not parasympathetic. Dissociation causes rigidity and inhibition of the movement neurotransmitters.

This concept confuses a few people, so I will repeat this: the unhealed injury had provoked a steady slow stream of adrenaline throughout the years.

In the example of a badly injured person running from a bear, it is adrenaline that enables the runner to override the immobility that would otherwise be created by the severe injury. Adrenaline can override the healthy inhibition of the dopamine-release system *and* the activation of the go-to-sleep system, both of which are supposed to be triggered by a severe injury, and both of which are supposed to cause immobility as soon as the injured person gets to a safe place.

When a PDer's injury was gone, his adrenaline levels receded. If his adrenaline levels went down but the mental links to dissociation remained or continued to expand – he found himself with a *significantly* reduced ability to initiate movement.

It seemed as if he no longer had enough adrenaline to keep himself fired up and fighting, but he did *not* have the feeling of safety in his heart that initiates the release of dopamine.

PDer's who fit this model behaved as if they had low levels of both adrenaline and dopamine: a condition that occurs during automatic dissociation. Movement-wise, they were far worse off than they had been just a few weeks before – back when they still had the trauma from unhealed injuries to keep their adrenaline flowing – overriding the tendency for dissociation. And in addition to low neurotransmitter levels, they sometimes had limp muscles.

When some PDers got to this decreased-adrenaline stage of recovery, in terms of movement *and* emotion, they very often perceived themselves to be *far* worse off than before. This was the general trend in those PDers who were unable to relax even after the injury healed and their injury-based adrenaline levels dropped.

DURATION OF LIMP MUSCLES

The amount of time necessary to recover strength in limp muscles varied from one person to another and from one muscle group to another. You probably knew I was going to say that.¹

But in general, recovering PDers could be divided into two groups: the people who recovered very quickly and the people that got stuck in partial recovery. Because the people who recovered quickly can be described very quickly, I will insert a short paragraph here about those people. The section on partial recovery will follow, and will take up a bit more time.

Fast recoverers

The people who recovered the most quickly did so without even *thinking* about it. As they recovered feeling in their bodies, they found themselves consciously enjoying the sensations of using body parts that hadn't been felt *or* used much in the past. Since it was enjoyable, they did it. They didn't have to *think* about doing it: they worked these healing muscles in the same way an infant automatically uses and enjoys his muscles. These fast-recovering PDers may have had limp muscles for a few hours or days, or a week or even a few months, at the most, and then suddenly recovered full function. It was not as if the muscles needed to grow strong: it was as if the nerves that connected the imagination to the muscles needed to be hooked back up.

However, I must note that even those who are peace with themselves, and who are enjoying the curious sensations of their unresponsive limbs, may find this stage to be particularly trying.

PARTIAL RECOVERY

After the Little Project had been up and running for five years, we had to admit that some people stayed in the limp-muscle phase for a long time: even years. That's when we decided to name this phase, if it lasted for more than a few weeks, "partial recovery." We could see, in retrospect, that the onset of the muscle weakness was the most common time for people to slip into partial recovery – even if the muscles did not become profoundly limp.

By the time a PDer began to experience muscle limpness, his body's physiology had usually already been experiencing recovery from numbness and other blatant recovery symptoms such as distinct changes in sleep patterns and other recovery symptoms that are described in later chapters. However, when the more overt recovery symptoms eventually ceased, the mood-based symptoms of parkinsonism sometimes increased with a vengeance.

While trying to discern the difference between PDers who recovered quickly and those who became mired in partial recovery, we observed that the partial recovery patients responded to the limp muscle phase with wariness and fear. It even seemed as if, in some cases, the return

¹ One of my many proof-readers was annoyed by the redundancies in these chapters about recovery symptoms. However, one of the proof-readers who was actually on the Parkinson's team said, "I'm so glad you're starting to be redundant about the most important bits. So many of our patients have been *so* resistant to the key ideas that they need to hear them over and over. So many don't even understand principles such as "each recovery is different" until they've heard it repeatedly."

of awareness of long-ignored body parts triggered or amplified the fear that had allowed or caused the body to block out the knowledge of the foot injury in the first place.

Healthy fear can cause a shift towards the sympathetic system, the release of adrenaline, and an enhanced ability to move with speed and power. Helpless fear, or a sense that one is dying and nothing to be done to prevent it, can cause a shift towards dissociation, the inhibition of both adrenaline and dopamine, and rigidity, slowness, and *weakness*.

When PDerS who were starting to recover experienced an increase in fear, they tended to go towards dissociative mode instead of sympathetic mode.

A few PDerS never even noticed much of a limp phase: they went directly from terrifying pain, which started when the injury began to heal, straight into amplified rigidity, slowness, and weakness. In these cases, it seemed as if the *fear of pain*, together with the decrease in adrenaline, caused an abrupt increase in rigidity. It might have been fear induced by the pain of remembering the foot injury, and/or the fear induced by the tingling in the previously numbed body areas, and/or the fear induced by spontaneous movements in recovering body parts and/or the fear of not being able to recover. Whatever caused it, these people very quickly became *very* rigid, slow, and *weak*. They became almost paralyzed with symptoms consistent with psychogenic parkinsonism and also consistent with frailty – a mentally influenced condition.

In other words, when emotionally restricted PDerS started to heal, they experienced a shift in the *cause* of their rigidity. Previously, their slowly developing rigidity had been caused by injury-induced, backwards-flowing Qi.

During the early weeks or months of recovery, they experienced a return of sensation in their feet and fact, improved circulation, tingling in the nerves that were coming back from dormancy, and spontaneous movement in toe and facial muscles – muscles that had previously been unresponsive. Clearly, these people were healing. But many of them also quickly attained a higher level of rigidity than before.

Weakness

Also, although people who got stuck in partial recovery might or might not notice a limp phase, most of them *did* notice the onset of weakness. Weakness is not necessarily a symptom of idiopathic Parkinson's. People with classic Parkinson's become rigid and slow. They often have problems initiating movement. But they tend to be driven and tense, rather than weak. And yet, people who got stuck in partial recovery often complained about weakness. The weakness usually started shortly after the foot injury healed up.

I sometimes wondered if the weakness experienced by people who were stuck in partial recovery was some sort of long-term variation on the limpness of muscles that was experienced by people who recovered quickly. However, my hunch is that the long-term weakness has to do with the negative mindset that locks a person into dissociative mode, and the limpness is more related to a mind-to-body part disconnect. Maybe some researcher with a SPECT scanning machine will study this someday.

Duration of partial recovery

How long did the partial recovery phase last? It's impossible to generalize. Some PDerS who got stuck in partial recovery steadily slogged through the mind-retraining exercises and recovered fairly quickly, in a matter of weeks or months. Some recovered slowly, over the course

of years. Some have not yet fully recovered. Of the latter group, many dropped out of the program. Others have not.

But the great thing is, some PDers who'd been stuck in partial recovery for more than a year did eventually make the stunning break through to feeling safe, relaxation and healthy sensory awareness of the body. When this occurred, any weakness, slowness of movement, or rigidity promptly disappeared. The sudden return of the healthy ability to move via imagining movement and anticipating the internal sensations associated with movement was as abrupt as the flip of a switch.

When this change occurred – after weeks, months, or years – the muscles had conscious strength. They were not limp. It may be that, during the months of partial recovery, the muscles re-established their mind-body relationship during those moments when the partially recovered PDer was sleeping or momentarily forgetting to be afraid. So when the dissociation ended, the body was ready to go.

At any rate, we suspect that the genuine limpness of recovery actually only lasts a few weeks, maybe a month or so, at most. After that length of time, the nerves that connect the mind and the muscle seem to be restored. Any weakness that remains after that span of time is more likely due to mindset than to a lack of mind-to-muscle neural connection.

Partial recovery could take the form of perennially limp muscles, dissociation-induced rigidity, or some combination of the two. Some PDers dropped out of the program when they got to this point.

Some of these partially-recovered PDers experienced many of the recovery symptoms mentioned in the previous and in the following chapters – symptoms that are the opposite of PD symptoms. Some of them even experienced periods of time – hours, days, or even weeks or months – during which they were moving normally. But at some point, when they relapsed into fear, disbelief of recovery, or revulsion at their new body awareness, they quickly, in some cases instantly, became horribly rigid and slow.

Some spent several years coming to terms with memories of hideous events in their past that they had blotted out. During this time, they might be uncharacteristically anxious, if not paranoid. These negative emotions, in turn, seemed to trigger the rigidity, slowness or movement, and tremor that are associated with Parkinson's disease.

In these cases, the PD-like symptoms were clearly psychogenic. We finally discovered the actual combination of mental and physical mechanisms that these PDers were using to invoke this condition. Based on our work with patients with psychogenic parkinsonism, a condition that looks exactly like Parkinson's but which is mood- or emotion-based rather than physically induced, we realized that psychogenic parkinsonism was exactly the same as what we were calling partial recovery from idiopathic Parkinson's disease.

Both psychogenic parkinsonism and partial recovery go away as soon as a person resumes the ability to experience the vibratory feelings in the chest that expand or contract in response to sensory perceptions. People with either psychogenic parkinsonism or PDers who become stuck in partial recovery will steadily worsen over time if the mind increasingly shuts out signals from the heart.

Most of our PD patients hated being told that their symptoms were the same as those of psychogenic parkinsonism. The word "psychogenic" suggests to the layman that the person is merely imagining his symptoms, which is not the case in partially recovered PDers. The

symptoms are very real, even though they are being triggered by a mental/emotional attitude. PDer's preferred the terms "partial recovery," dissociation, or "mental/emotional blockage." Honoring that preference, this book primarily uses the latter terms.¹

How long can a person stay in partial recovery? As far as we were able to tell, a person could stay in partial recovery indefinitely. There was no *physical* treatment that benefited these people. Those who eventually recovered fully after having been stuck for a while in partial recovery had not necessarily undergone any further *physical* change that opened the door to full recovery.

The people who overcame partial recovery all did it the same way: they *decided* to stop being wary. As soon as they refused to be wary, their bodies behaved as if they were healthy. If they were still processing pain from long-unhealed injuries or other physiological recovery symptoms, they continued processing them. But as for the rigidity, slowness, and tremor, those symptoms were over with.

Sabotaging recovery

As noted earlier, many patients respond to their recovery symptoms with "Yahoo! I don't know what the heck is going on, but it sure as hell isn't Parkinson's!" But more patients told me that recovery symptoms were only a tease, or that they couldn't really be signs of recovery. They were certain that, even if recovery were possible for some people, *they* could not be one of the "lucky ones."

An example of sabotaging one's own recovery

One deeply negative recovering PDer left this message on my answer machine: "I went to a church dance last weekend and for the first time in my life I was moving gracefully. I wasn't rigid: I felt like I was floating, it was glorious. I didn't care who saw me or what anyone thought. It was the best time I've ever had. People were saying that they've never seen me look so good. So tell me the truth: was that the Last Hurrah? From here on out, am I only going to get worse? I can't imagine that I will ever have such a great evening again. Was that the last time I'll ever move easily? Should I admit that I can't recover?"

I was stunned by his twisted thought processes. Movement-wise, he had recently had the best evening of his life. His conclusion, based on the fact that he didn't really think he could recover, was that this was a sort of "Last Hurrah," a spontaneous gift from God, and that, having used up these few hours of grace, he would never move easily again.

This man had been recovering wonderfully. In particular, his facial expression, the function of his hands, his loud voice and his ability to stand up straight had resumed. These were changes that he couldn't hide, even from himself. But he was also getting better at inducing a stunning level of immobility by the simple method of reminding himself that he couldn't really move. As soon as he remembered that he couldn't actually recover, he could hardly move.

He assured me that he believed that some people might be able to recover. But he was equally convinced that *he* could not. He knew that this was so because, during those times when he was *most* certain that he would never recover, his movement was the worst. The fact that he

¹ Western medicine has, for centuries, dismissed psychologically induced illness as "not real" or "less real." Asian medicine recognizes that nearly all illnesses, even susceptibility to germs and "measurable" pathologies such as myopia, have a mental component.

could induce immobility in himself just by dwelling on the impossibility of recovery *further* convinced him that he could not be recovering in *any* way. Despite his tremendous number of improvements, he could not shake the idea that he was doomed.

When he admitted that he had not once tried to do *any* of the homework (an assortment of relaxation or attitude-retraining techniques), he said to me, in all honesty, “Can’t you do that part for me?”

He had been off work, getting disability payments, but he admitted that he was now physically able to return to his teaching job. I told him that returning to work would be the best thing for him, but he replied he didn’t really want to go back to work. He also threw fallacious logic at me to show that he *shouldn’t* go back to work. He pointed out that, when he was in a negative mindset, he had increased problems initiating movement; since teaching *might* provoke some negative thoughts, even thinking about teaching could permanently worsen his condition.

I told him that his *mental* attitude, not his environment, determined whether or not challenges were interpreted as negative or positive, and that there was nothing inherently fear-inducing about going to work. He disagreed.

We’ve seen that PDers who keep working do much better than those who take time off to “focus” on recovering. The ones who take time off usually end up dwelling on their fears and feeling bad because they aren’t “doing” anything.

Throughout our nine months of working together, he had admitted that his extremities were healthier, had better color, were warmer, and had more feeling. He admitted that he had increased facial expression and better posture. He admitted that he had regained the use of his hand and voice. He admitted that, during those times when “I forgot to have My Parkinson’s,” he could move easily. And he consistently denied that these changes signified “any change in My Parkinson’s,” as he called it. There seemed to be a possessive quality in the way he always referred to his condition as “My Parkinson’s.”

Because he was increasingly able to immobilize himself with worry, when his negativity-trained mind took a twist in that direction, he was certain that “My Parkinson’s” was getting worse. In a spiraling fashion, the one thing that was most able to provoke a spate of immobility was thinking about how *he could never recover from Parkinson’s*. This circular bit of thinking, which made him fearful, which then made his movement ever more difficult, confirmed his worst suspicions and assured him that he could not recover, despite all his lasting physical improvements.

When I asked him why he indulged in such thinking, he said that his brain did it, not him. When I asked him who was in charge of his brain, he laughed and said that he wasn’t responsible for his own thoughts and didn’t want to do the work of changing them. He certainly didn’t want to do any work oriented towards positive thinking. He felt that positive thinking, in the face of an incurable illness, would not be “true.”

Once again, he asked me if *I* couldn’t simply get rid of his negative thoughts for him by using acupuncture or herbs, because his negative thoughts seemed to have a mind of their own. Although he laughed when he said this, he was dead serious. I had given him *many* techniques that can get a person out of negative thought loops, but he had never even tried one of them. He had no intention of doing the hard work of becoming the master of his own thoughts. He knew how to mire himself in negativity. He had unknowingly trained himself in it, and he was *very* good at it.

He only saw me one more time after his “Last Hurrah” phone message” During this last session, he denied that he had moved well at the church dance! I asked him why people had told him at the time that he was moving so well. He replied that he didn’t know.

He was also fascinated with the powerful effect that placebos have on PDer. I got the idea that he wanted a doctor to give him some placebo that would convince him that he was OK so that his symptoms would go away. I asked him why he didn’t just work on generating a positive attitude in himself. He laughed and said that he wasn’t interested in doing that much work.

Are these people crazy?

Again, a non-PD reader might think that I am making this up or that, in cases such as the above, I am dealing with a crazy person instead of a typical PDer. However, this man’s thought processes were fairly typical for a PDer stuck in partial recovery. Also, people with Parkinson’s are usually thought of as highly intelligent, responsible, and keenly self-monitoring: not crazy.

PDer who develop such clever ways to prove their expectation that they will get worse are not actually crazy – they are merely applying their long-practiced habits of harm avoidance. And these habits have, in many cases, grown entrenched over the decades. Many PDer have said to me, “I’d rather assume that I won’t recover. That way, I’ll be pleasantly surprised if I do. If I assume that I will recover but then I don’t, that would be painful.”

PDer often think everything through in order to avoid pain. This kind of thinking often means anticipating a worst-case scenario. But many PDer consider themselves clever, not negative.

Many PDer have cultivated for decades an elevated ability to anticipate worse-case scenarios. This attitude, in turn, keeps a person from “risking” the sensations that can occur if a person drops his fears and truly relaxes. Then again, this attitude also inhibits a person’s ability to relax – or release dopamine. PDer need to make a note of this: anticipation of risk or worst-case scenarios in a person whose uses dissociation as his response of choice to anticipated fear or pain will inhibit his own ability to release dopamine. A person who dissociates when he anticipates *not* being able to release dopamine will find that his expectation is instantly fulfilled.

The powerful irony here is that what some PDer perceive to be their greatest strengths, their ability to be analytical and to anticipate worst-case scenarios are, in fact, their greatest weakness and their physical downfall. This ability is a downfall because it has become habitually connected with selective dissociation from the heart; a habit that causes symptoms of automatic dissociation.

It may seem that this section on “sabotaging recovery” is wandering far from the point of this chapter: recovering from rigidity. But I am writing this chapter both to describe what we saw *and* to help future PDer who use this book as a guide to be able to recognize symptoms of recovery. One of the things that can make it difficult for a PDer to recognize symptoms of recovery is that a PDer’s mindset colors the events: he cannot be a neutral observer. A negative attitude may prevent recovery events from being recognized for what they are. Therefore, it is just as important to warn of the negative attitudes that might accompany sensory and movement changes as it is to write about the changes themselves.

PREDICTING WHO WILL RECOVER QUICKLY

There is no way of knowing who is going to stall during recovery. However, in our limited experience with just over two hundred subjects (a small number, by research standards), the five professional musicians in our program all breezed quickly through the phase of limp muscles. So did many others, including dancers and those who were able to enjoy the enhanced sensory experiences that occur during true relaxation.

However, other PDers were surprised to learn that, in healthy people, certain sensations or events might occur during relaxation: the chest might feel a sense of expansion; a feeling of movement or expansion might occur in the chest in response to music or visuals; the mind usually calms down and pays more attention to the perceptions of sensory events; the mind ceases its harried, internal monologue.

Still other PDers who *used* to know that relaxation could induce these shifts, even if they were no longer able to consciously induce them, were not as prone to slide into partial recovery.

Finally, those PDers who had no idea what was meant by the words in the above description of relaxation, who had no point of reference for the idea of palpable internal sensations such as “a feeling of expansion in the chest when experiencing something of great beauty or grace,” or who had no idea that these increased sensations were the hallmarks of true relaxation, and who instead had thought that “relaxation” referred to a welcome *cessation* of sensation – numbness – tended to slide into partial recovery and stay there.

