

CHAPTER TWENTY

RECOVERY SYMPTOMS: DYSKINESIA

Dyskinesia means incorrect movement. Dyskinetic movements may be somewhat constant, like the tension caused by a long-lasting spasm, or they may be intermittent, like a twitch or tic. During recovery, previously disconnected muscles regained a conscious connection to the brain. When this happened, the muscles sometimes behaved dyskinetically for a short period, until correct brain-to-muscle function was restored.

Spontaneous movement

The dyskinetic moments during recovery were delightful, inasmuch as they seemed like the very opposite of the forced, difficult movements of Parkinson's. They seemed to occur when previously rigid or numb muscle began to receive nerve signals once again. When this occurred, the muscle coordination was often poor, even spastic, at first.

When these muscles began to connect to the brain, so that the PDer could feel their existence, they often moved imperfectly, even immaturely: these muscle movements were sometimes like those of a baby.

A baby grimaces asymmetrically while exploring his facial muscles; he repeatedly, helplessly, bangs a spoon on the highchair tray while learning to use his arm. The recovering PDers found themselves experiencing asymmetrical facial expressions, strangely clumsy muscles, or even muscles that initiated repetitive movements much like those of a baby steadily banging a spoon on a tabletop.

We named this spontaneous, usually gentle, non-controlled movement "recovery dyskinesia." In appearance, it sometimes resembled the dyskinesias (non-controlled, and sometimes repetitive movements) that occur in PDers who have taken too large a dose of their antiparkinson's medication.

Recovery dyskinesia sometimes occurred in the large muscles of the chest and legs and sometimes occurred in the small muscles that give finger finesse or facial expression. Some events were one-time spasms followed by perfect conscious control. Sometimes they were gentle flexions and extensions of a single muscle, repeated a few, or a hundred times or so, every day for a few days. And they were everything in between.

Recovery dyskinesia is *not* to be confused with the uncontrolled movement of Parkinson's *tremor*. Fortunately, once you understand the causes and characteristics of each, it is not very difficult to distinguish between them. Parkinson's tremor, whether it is the resting tremor of the fingers, shaking of the arms, legs, or chin, or the "amplified tremor" that shakes the whole body, is always at its worst when the PDer is stressed or thinking of something worrisome, and it ebbs when he relaxes or doses off. Recovery dyskinesia, on the other hand, only occurred when a person was relaxed and feeling safe. In fact, it occurred most often when a person was watching TV in the evening or lying down to sleep.

Another key distinction is that Parkinson's tremor is generally somewhat vexing to the person experiencing it, while recovery dyskinesia was generally described as an enjoyable experience.

Finally, the movements themselves are different: Parkinson's tremor is usually a predictable, rhythmic vibrating or shaking, whereas recovery dyskinesia, as you will find in the coming sections, could be almost *anything*.

In some PDers, recovery dyskinesia was only a fleeting event that happened once or a few times or not at all in any given group of muscles. Some recovered PDers had no recovery dyskinesia.

Examples of recovery dyskinesia

In this section, I will describe only a few examples of recovery dyskinesia. I cannot possibly describe *all* the instances and styles of recovery dyskinesia that we saw and heard about.

Toe wiggling

One of the first places that recovery dyskinesia appeared was in the toes, shortly after the return of sensation. After the circulation in the toes improved and the tingling was over, a few PDers went through a very short phase in which their toes spontaneously wanted to move and stretch. It was as if the toes moved or "wanted" to move without conscious instruction: moving "on their own."

The PDers said that they *could* inhibit the toe movement if they wanted to. But they found it more pleasant *not* to get involved, for a change, and to allow the toes to simply express themselves. Even if the toes got into a mild cramp, they usually wiggled themselves free pretty quickly.

Movement in facial muscles

When PDers' long-dormant facial muscles began to function spontaneously, the resultant facial expressions were much more obvious than the spontaneous toe movements. The fleeting facial contortions often resembled those of an infant who cannot yet control his face.

Anyone who has spent time with an infant knows that babies can make some pretty funny facial expressions. Their facial muscles don't work in a coordinated manner for several weeks. The same immature types of irregular, spontaneous, or even spastic movements of the facial muscles occurred when the PDers' facial nerves reawakened from their dormancy.

While some PDers were scared that they would spontaneously make a goofy face while out in public, this rarely occurred. Again, most recovery symptoms took place at home, when the patient was relaxing or just before falling asleep.

Although some PDers worried about it, none of them experienced facial spasms while giving a presentation at work. It seemed that the body only took liberties with exploring new muscle function when the PDer was in parasympathetic mode: whenever or wherever he deemed himself "safe."

- Recovering facial muscles: an example of "safe"

One recovering PDer, after experiencing all manner of fleeting, small facial tics and spasms over a period of months, found herself having a major "face recovery" moment while lunching at a classy restaurant with her daughter. They were seated on the rooftop patio, the warm sun was shining down, and they were both laughing. She felt at peace with the world. Suddenly, the entire right side of her face went into a powerful spasm. Her right eye was squeezed shut, the right cheek muscles were bulging outward, and the right side of her mouth

was pulled up towards her eye. On the right side of her face, *all* the muscles that should be used during a heartfelt smile kicked in at once – at full strength. These muscles were still a bit clumsy, and hadn't worked together as a unit in over ten years. As the muscles locked into a powerful spasm for over a minute, screwing up and immobilizing the right side of her face, the recovering PDer finished her sentence by speaking out of the left side of her mouth. The daughter replied, and they continued chatting. After the facial spasm had been in place for what seemed like a full minute, the daughter said, "Mom, I'm not sure that that 'look' really works for you," and they both exploded into laughter.

After a few more moments, the spasm melted away. A new sensation of warmth and power pervaded the muscles in her cheeks and the skin of her face. From then on, her face was far more expressive and she was better able to feel the skin of her own face.

I chose the above anecdote as an example because many PDers have been terrified of having an obvious recovery symptom at a "wrong" time or place, such as when out in public, or in front of some judgmental person. The point I am making here is that, if the PDer felt safe, it didn't matter to him if a facial spasm appeared in public. But if a PDer tended to be self-conscious, public places would be "not safe." Therefore, he would be unlikely to experience a recovery event in which the body was playfully exploring the use of some long-dormant nerve group. In the above scenario, the recovering PDer *was* out in public *but* she was not self-conscious at all. She was having fun. She continued to enjoy herself while she temporarily looked ridiculous. She was able to laugh at her own goofiness. Very possibly, the delightful, calm circumstances helped her body choose such a moment for practicing some important muscle recovery work.

PDers only experienced recovery symptoms when they felt safe. Location, per se, did not make a place safe or not. What made a place "safe" was the attitude of the PDer.

A sudden arm stretch

One recovering PDer was practicing piano when suddenly her right arm straightened itself sideways, and extended to the keys at the high end of the keyboard. After a moment, the arm returned to its previous position. This happened several times that evening, and then never happened again. It was *not* a muscle cramp. The movement had been generated by a contraction of the muscles around the ball of the upper arm, where the upper arm sits in the shoulder socket. These muscles tend to be inaccessible to PDers. The movement had been powerful and graceful – and completely unexpected.

A neck pivot

Another recovering PDer was standing up singing in the choir when her neck muscles painlessly but powerfully pulled her head to the left. She found herself staring at the person next to her. The person next to her stared back.

"Cramp in my neck," lied the recovering PDer. After a split second, the neck muscle relaxed and she found herself facing forward again. It had not actually been a cramp. Cramps are overly tight and painful. This neck movement wasn't painful. It had been an involuntary, gentle contraction in a neck muscle that she hadn't used in years. Moments later, it happened again.

"More of a nervous twitch, really," she whispered.

After half a dozen episodes over the course of an hour, it never happened any more. Prior to this event, she had not been able to turn her head easily to the side. After this event, she could move her head easily.

Singing in the choir was one of her all-time favorite activities. She was not embarrassed by the “twitch.” She thought it was funny. *She was relaxed.*

The waving lady on a pancake house

Another recovering PDer described recovery dyskinesia in her arm. “Last night while I was watching TV, my right arm lifted up and started waving back and forth, back and forth. It wasn’t fast. It was like that plywood woman on the roof of the pancake house who mechanically waves back and forth. It kept it up for about ten minutes. Never went slower or faster. It didn’t hurt. I probably could have stopped it, but I didn’t want to. It was bizarre. My adult daughter was kinda worried about it, but I thought it was kinda funny. It felt nice. It wasn’t *anything* like tremor.”

Marching in bed

Sometimes, when sitting on the sofa or lying in bed, a recovering PDer’s leg(or legs) started rhythmically “marching.” Sometimes, the arms kicked in, moving in time with the legs. This was not “restless leg syndrome.” This was recovery dyskinesia.

Fixing the foot

One PDer felt an urge to bang the top of his foot against the bottom of the coffee table. Every evening, relaxing after dinner, his leg “wanted” to bang the top of his foot. So he let it. He would let his leg gently rise up a few inches, causing the top of the foot to get a gentle whack. The movement was steady and rhythmic. Each evening, the foot was whacked at least a hundred times or so. The whacking only stopped when his leg didn’t “want” to do it anymore.

He said it felt really good, as if his leg knew that something in his foot wasn’t quite right, and needed to be gently knocked back into place. The foot had received many Tui Na treatments. The foot felt completely healed, in terms of a return to suppleness and all the other things we look for when treating an old injury. And the PDer had no *conscious* understanding of something in particular that needed to be done to the foot. His leg just “wanted” to gently whack the top of the foot, that was all.

Shortly after the PDer noticed that his toes seemed happier and more flexible, he also realized that his leg was no longer wanting to bang his foot on the bottom of the coffee table in the evening.

Technically, this might not be considered a form of recovery dyskinesia. But the movement felt almost spontaneous, it was repetitive and rhythmic, and so I’m including it in this section.

King Kong

One PDer, relaxing at home in the evening, beheld her alternating fists beating on her chest as if she were doing the “proud gorilla” move in slow motion. Alternating, left, right, left right, her fists pounded her chest for nearly ten minutes. She was a very delicate, petite woman: the next morning she had bruises on her chest. She only had this experience this once, and afterwards, her arms were more relaxed.

Hand positions

In some recovering PDers, the muscles in the hand tightened for a while – never for longer than twenty minutes at a time. This sometimes caused various weird hand positions: dancer-like, stylistic hand positions. One person noted that these hand postures happened most often on her daily walk. Others noticed them while sitting around watching TV.

The voice

Some PDers' voices suddenly reappeared after months or years of being reduced to a whisper. The return of voice was not always a straight line. The muscles that opened up in the larynx sometimes opened very wide, without warning, and an embarrassingly big booming voice issued forth for several minutes – or a day or two. And then, sometimes a few days later, the voice temporarily disappeared altogether. Eventually, the big voice became consistent in those PDers who fully recovered.

One PDer called his sister when his voice returned after nearly ten years of inaudible speech. His sister accused him of being a prankster. “You’re not my brother; my brother only speaks in a whisper.”

Chest muscle spasms

Several patients grew mildly concerned while experiencing recovery dyskinesia in the chest. In Parkinson's disease, the muscles that run down the mammary line of the torso become rigid. During recovery, these muscles sometimes went through recovery dyskinesia: either they tensed up for about twenty minutes and then relaxed, or they tightened and relaxed over and over again, somewhat quickly. Either way, the event usually lasted no more than twenty minutes.

During the tightening up phase, recovering PDers sometimes felt as though they could not take a deep breath. A few PDers wondered if they were having a heart attack. They decided to go to the hospital. By the time they arrived at the hospital, the tightness had ceased. One PDer stuck around at the emergency room for a full heart work up, to reassure himself that nothing untoward had occurred.

An aside: I always told patients to see a doctor immediately if they felt that they were having a heart attack. I did not want them to ignore symptoms that gave cause for concern. If it turned that it was only recovery dyskinesia, and not a heart attack, no harm would have been done. None of my unmedicated patients had heart attacks during their recovery from Parkinson's disease.

During the *relaxation* phase of chest-muscle recovery dyskinesia, the opposite occurred. Any PDer who experienced this felt his chest was so wide open that he hardly needed to breathe. One PDer said, “I was enjoying my shower when I suddenly realized that I hadn't inhaled in a really long time. I was a little concerned, but I just didn't feel any need to inhale. Finally, I did inhale and exhale, and again, a long time passed before I felt the need to take another breath.”

Recovery dyskinesia of the head

Recovery dyskinesia often occurred the neck, the face, and the inside of the head.

Recovery dyskinesia in the tongue

Many PDers experienced a bout of clumsy speech: the tongue felt as if it was moving on its own or it didn't move the way it used to. Some PDers thought, for a short while, that they

might need to relearn how to use the tongue. However, the speaking skills usually came back very quickly. In some cases, the tongue seemed to be positioned differently. This may have been caused by a change in sensory awareness of the tongue or a change in the position of the palate.

Many PDer's bit their tongues and/or the inside of their cheeks during this phase.

One PDer had a curious tongue situation develop during recovery: when concentrating deeply on anything, she would stick her tongue out on the right side of her mouth, ever so slightly. Just the tip of the tongue was visible. She had been doing this for several weeks when she remembered an old photograph of herself playing the violin when she was age twenty. In that photo, her eyes were closed and she wore a look of deep concentration – and her tongue was sticking out the right side of her mouth. She knew that she had not put her tongue out to the side for decades but now she was evidently reverting back to her youth.

After a few months, after her palate lifted and her teeth spread apart, she no longer stuck her tongue out to the side. She was certain that her age twenty tongue-to-the-side had not occurred when she was healthy, prior to age seventeen. She suspected that she had started doing it shortly after the weird buzzing experience on the side of her head at age seventeen, after which she always felt a little more tense inside.

In other words, the age twenty tongue asymmetry and protrusion had been a very early symptom of left-right imbalance and internal tension – a very early symptom of pre-Parkinson's disease – and not a healthy idiosyncrasy. When her tongue started staying inside her mouth even when she was concentrating, she said it felt very good. She could remember her tongue feeling comfortable in her own mouth when she'd been a youngster, prior to her brain shift at age seventeen. ("Brain shift" will be explained in an upcoming chapter xxx.)

Recovery dyskinesia in the palate

A person's upper palate is held in position by muscles. These muscles sometimes changed their degree of tension during recovery. If the muscles above the upper palate gently tightened, lifting the lateral (outer) sides of the upper palate, a gap appeared between the two front teeth, as if the teeth had suddenly moved apart. This sudden, very visible movement of the teeth was painless. The teeth had not actually moved in their sockets: the two sides of the upper palate had lifted up, and the teeth came along for the ride. The roof of the mouth sometimes felt as if it had assumed a new position. Again, this movement in the upper mouth was not painful. Just the opposite: it felt pleasant, if it felt like anything at all. It seemed to be caused by a return of vigor in previously weak cranial muscles.

Sometimes, the lift in upper palate position brought about a welcome reduction in snoring or sleep apnea.

Many PDer's, *prior* to recovering, had experienced a sensation as if the palate was falling down into the mouth now and then, partially blocking the airways and the sinuses. The resumption of healthy muscle tone in the muscles of the palate often cured or improved this problem.

Recovery dyskinesia in the eyes

During recovery, changes sometimes occurred in visual acuity. Many PDer's noticed a sudden, extreme improvement in vision that lasted for a few minutes or a few days, which was followed by a return to normal vision or a temporary worsening of vision.

For example, one patient said, “I swear, yesterday, I could see a bird sitting in a tree half a mile away!” A few days later, the same person was hardly able to focus her eyes. Over a period of a month, this occurred several times. After that, her vision settled back down to exactly what it had been. Based on everything else we’d seen, we guessed that the muscles of the eyes had been going through tightening and relaxing exercises. The muscle tensions had caused the temporary changes in vision.

After this occurred several times in several recovering patients, I started telling patients not to rush off to the ophthalmologist or optometrist for an eye exam or a new pair of glasses if the vision suddenly altered. In our limited experience, once the recovery dyskinesia in the eye-focusing muscles was over, the vision always settled back down to something very close to what it had been prior to recovery.

Not uncontrollable

PDers nearly always wanted to explain to me that they probably *could* have stopped the movements in the arms or legs or hands if they’d wanted to, but they didn’t *want* to. It’s as if some muscle wanted to work out or stay in a certain position for a while, and the PDer felt good when he allowed it to do so. He enjoyed feeling the sensation of the moving limb or vigorous muscle contraction *and* he enjoyed the general good feeling of expansion in the chest that came from paying attention to how the sensation felt.

These repetitive types of recovery dyskinesia usually lasted somewhere between a few moments and twenty minutes. Even the most relentless recovery dyskinesia usually petered out after about twenty minutes.

In most cases, recovery dyskinesia was amusing. If it ceased to be amusing, it soon stopped. It occurred when a recovering PDer was relaxed or enjoying himself. If he stopped being relaxed or became stressed, the movements soon ceased.

Speeding up

Some PDers had the strange experience of the body moving faster than they could control. While doing an ordinary, mundane and repetitive chore, such as chopping vegetables, it felt as if the *correct* arm muscles for the chore suddenly kicked in. The muscles moved very quickly, effortlessly, in a rapid manner. The *effect* was that the knife seemed to be suddenly chopping the vegetables much faster than before. The *feeling* was effortless, as if the arm was “moving by itself.”

This “speeded up” movement happened while PDers were doing all sorts of activities, ranging from practicing piano scales to chopping celery. The commonality was that it only happened while a person was relaxed or enjoying himself.

Then again, not everyone experienced any events in which limbs seemed to move unnaturally fast.

Variations in recovery dyskinesia

I’m about to be redundant: no one experienced all the types of recovery dyskinesia. Some experienced none. Some people had a few very powerful experiences, some had only a few, mild moments. Some slept through their few moments of recovery dyskinesia and were told about it by an amused spouse. Every recovery was different.

Enjoying the body

Recovery dyskinesia is wonderful. Several ex-PDerers have said that they felt as if they were coming back to life when the body starting relearning, on its own initiative, how to feel and use muscles that had been rigid and somewhat numb. The feeling that one is starting afresh, growing a whole new body, is so very delightful that a few people have even said that they feel as if they have lived two lives in one lifetime: they had their first life, and they were dying from it; then they were given a second chance and they got to start again from the beginning – learning what it’s like to *enjoy* having a body, and learning how to *enjoy* using it.

Wanting to have a body versus enjoying a body

Some PDerers have protested my phrase “learn to enjoy having a body.” They have declared that they *do* enjoy having a body, or always used to. Now they just want to get their old bodies back.

I recall one PDer who was adamant that he loved his body. After we’d been working together for about six months, he told me the following anecdote.

The previous weekend, he’d spent an hour floating in his daughter’s swimming pool, lying on one of those floating rafts with arm rests and a holder for a beverage. His mind was blank and the sun was shining down. He felt a wave of peace flood over him, and he realized that he was feeling good. He realized that he could feel the sensation of the sun on his skin, and the sensation of floating. It was a rare moment. He marveled at the sensations that he was experiencing.

Then, his mind kicked in. He immediately wondered to himself if this was the type of “enjoyment from the sensations of the body” that I was always badgering him about. His next thought was, “Heck, I can’t be expected to *feel* this much *all* the time. That’s ridiculous.” As soon as he thought this, he realized that he was no longer able to be aware of the same sensations from the sun and the floating.

The moment of pleasure from body awareness had snuck in to his consciousness as he’d felt it with his body, but he’d quickly brushed it away with his negative thoughts. As soon as he thought to himself, “Heck...,” and re-immersed in negative thinking, he realized that he was unable to feel his body in the same way. He was unable to recapture the sensation of sun, the feeling of floating, and the good feeling inside his own body. He certainly was no longer *enjoying* it in the manner that he’d done a few moments earlier.

That’s when he began to understand why I frequently told him that he must learn to enjoy his body. He had incorrectly thought that his desire for a *functional* body was the same thing that I called “*enjoy* the body.” These were two different concepts, but he couldn’t understand that until he actually enjoyed how he was feeling, for a few seconds, floating on a raft in the swimming pool. That’s when he realized that a desire for a functional body was, in fact, very different from enjoying the sensations of one’s own body for more than a few moments at a time.

But even when he understood what I was talking about, he refused to accept that he could allow himself to pay attention to his body’s sensations just by relaxing, taking the time to notice how he felt, and most of all, shutting out any interfering negative thoughts. He told me that such a course of action would be impossible. When I asked what was impossible, he replied, “I don’t know what to do! Tell me and I’ll do it!” I said that he had to practice relaxing and noticing how he felt, the way he’d done in the swimming pool. Then he yelled at me, “So what should I do? Tell me what to do, and I’ll do it!” I said that he should practice enjoying the sensations of his

body. He threw his hands as far in the air as he was able, and said again, “Tell me what to do so I can do it!”

I have had many patients who have insisted that they always enjoyed their body, who realized, during recovery, that they actually hadn't. They may have enjoyed *using* the body like a tool, they may have enjoyed having the body obey their instructions when they worked it hard during sports, but they hadn't actually noticed or enjoyed the sensory experiences produced by the body, or hadn't in a long time.

For some PDers, the spontaneous, gentle movements of recovery dyskinesia and the heart-felt relaxation that occurred when the injury healed were like beginner's lessons in how to *feel the body* and *enjoy* having a body.¹

An infantile demonstration of repetitive, dyskinetic movement

Once, in the early days of this project, I was on the road, breakfasting in a pancake house. I was musing about the unexpected symptom of recovery dyskinesia that had recently occurred in a few of my patients. At the table next to me, a baby was sitting in a high chair. I watched as he was handed a spoon. He had little control over his movements. As he focused on keeping the haft of the spoon clutched in his fist, his bicep began to contract and relax.

The result was that his arm, and the spoon, started moving up and down, up and down. The rhythmic movement continued for several minutes. The proud parents said that he was banging the spoon on the tray. But I could see that he was not banging the spoon intentionally: he clearly did not have the coordination necessary to bang the spoon so rhythmically on his tray. What was happening was this: his non-controlled muscles were firing off on their own. The muscles in his arm were flexing and extending, flexing and extending. The infant was not doing it consciously. He looked happy and surprised at the movements occurring in his arm.

As he continued helplessly “banging the spoon on the tray,” the proud parents beamed as his movements became more vigorous. His other arm started moving up and down in time with the first. He was clearly not in control of these movements, and he was obviously enjoying himself. Within moments, his legs started moving in time with his arms. His torso started flexing and extending at the waist. All the muscles along the baby's Stomach channel and Large

¹ More than a few PDers have been certain that sensory awareness of the body and/or enjoyment of the body was self-indulgent, or even “not spiritual.” They needed to learn that the sensations generated with a healthy body are, like flowers and beautiful music, something that can and should be enjoyed. The spiritual injunctions against excessive body attachments have to do with the problems that arise from wrong identification: when a person imagines himself to *be* the body instead of being the soul. Also, *excessive* fascination with the inherently restless body, which occurs when the mind is undisciplined, can be a distraction when trying to stay focused on inner stillness or on uplifting activities.

However, the sensations that arise from having a body, which include vision, hearing, taste, smell, and feeling, are not inherently bad. These sensations can be rightfully enjoyed, because they are just awareness of manifold expressions of God's vibratory presence, a presence that underlies and permeates the universe and all objects, even bodies. So long as a person does not *identify* himself as his ever-changing body or become overly attached to it, he risks no sin in enjoying the sensory experience of being able to feel his own arms and legs. Then again, many PDers cannot even fathom what is meant by the phrase, “Feel his own arms and legs.” A lengthy explanation of what is meant by the word “feel,” and instructions on learning how to feel the existence of the body, are presented in later chapters.

Intestine channel were flexing and extending, flexing and extending. After several minutes, he stopped moving. His parents kissed him, fussed over him.¹

He had not been making these moves consciously. His brain was just starting to form awareness of muscle control. The muscles were starting to learn how to respond to signals from the brain. It would be many months before the child would be able to exhibit elegant motor control over his fingers and arm muscles. But the process had to start somewhere.

His spontaneous, repetitive movements, set in motion, perhaps, by the curious sensation of the spoon in his hand or maybe by his desire to imitate the hand-to-mouth movements he had seen performed by his parents, looked exactly like the several instances of arm or leg recovery dyskinesia that I had witnessed.

This vignette makes two points: the repetitive, spontaneous movements that occur in specific muscle groups during recovery from Parkinson's are not pathological: they are perfectly natural; they occur as the brain is becoming familiarized with specific motor functions. Second, with the right attitude, this movement can be fun.

FEAR OF RECOVERY DYSKINESIA

Although I always made the point that recovery dyskinesia felt good, many potential patients were afraid of it. More than a potential patients were far more worried about momentarily "looking like a fool" than they were about having Parkinson's disease.

Some potential patients, having read through the earlier edition of "Recovery Symptoms" concluded that they didn't want to risk experiencing a recovery symptom while out in public. They told me, in all seriousness, that they were afraid that, in a moment of weakness, recovery symptoms might occur that would make them look "stupid," "wrong," or "sick." Several PDers have admitted that they would rather believe that I am wrong – that Parkinson's *is* incurable – than risk recovery incidents in which they might lose face. After all, Parkinson's is a respectable illness.

The non-PDer reading this might think that I am joking. Surely, no intelligent adult would rather be rigid and shaking than have a few moments of perfectly understandable loss-of-control. But be assured, non-PDer, that many PDers are reading these same words and thinking,

¹ The infant was learning to control the muscles of the Stomach and Large Intestine channel: the two channels that are not functional until birth. The muscles regulated by these channels are the last muscles to come "on line" in the developing child. These channels do not even start to be activated until the baby starts to breathe. This makes sense when you consider that these two channels drive the peristalsis of the gut. An infant in utero should have no gut movement whatsoever: any activity in the Large Intestine might eject sticky meconium (fetal fecal matter) into the amniotic fluid. If meconium gets into the fluid, and thence into the lungs of the unborn baby, it can be fatal. The baby has no need for activity in the gut: all his nutrition comes in through the umbilical cord and goes directly into the baby's bloodstream.

All the other channels, the ten primary channels and the eight extra channels, are functional in utero. Only the Stomach and Large Intestine channels are dormant until the first breath. All of the functions that are nearly impossible for a newborn (thumb and index finger control, eye control, arm control, standing, walking, holding the head up, bowel control, and so on, are regulated by these two channels. In contrast, the muscles that move the lungs, the back muscles, even the muscles under the skin that regulate the pores, and so on, are all operational at birth.

It was no coincidence that recovering PDers with long-dormant Stomach and Large Intestine channels found themselves performing movements that brought to mind the spontaneous muscle activities of infancy. It is also no coincidence that a severe injury almost anywhere in the body will trigger a chain of electrical events that cause these two channels to shut down until such time as it is "safe" to heal: until conditions are safe, a person does not want to initiate healing, nor does he want to be distracted by non-essentials such as eating and digestion: activities triggered by the Stomach and Large Intestine channels.

“Yeah. I’d hate to lose facial control or have my arms jerk around while someone was watching. I’m not sure that this program is for me.” I have talked with these people, argued with them, and, eventually, learned to be OK with it when they decided they would rather stick with the Parkinson’s than risk unknowns and potential embarrassment.

For that matter, some PDers told me that they would rather not recover if recovery required a shift in emotional attitude. Having to change long-held fears or give up a lifetime of cynicism would be the same as admitting that they have been holding to an incorrect mindset – admitting to doing something “wrong.” Many have eloquently, if illogically, explained that they would rather stay how they are than make such an admission.¹

And so, after we discovered the mental/emotional component, I wasn’t too surprised when a few PDers said that they would rather believe that I am wrong, and that there is no cure for Parkinson’s, than admit that they have been cultivating a pathological attitude. At first glance, this attitude was wondrous strange. But we had not yet discovered the *nature* of the mental/emotional blockage: a blockage that often includes or creates a dread fear of criticism and fear of being “wrong.”

Some PDers were very resentful when we started broaching the subject of a mental/emotional component. For example, in the first years of our website, we only posted information about the foot injury aspect of Parkinson’s. We were flooded with inquiries. After 2005, when we posted new information on our website that described what we’d discovered about the mental component, the number of PDers making inquiries about our program dropped to a trickle.

RELAXATION: THE PREREQUISITE FOR RECOVERY SYMPTOMS

Or: Department of redundancy department

As you’ve been reading along about recovery symptoms, you’ve no doubt noticed how often the description of the symptoms was followed by something along the lines of, “These symptoms only occurred when the recovering PDer was relaxed or enjoying himself.” In other words, PDers did not have to “take steps” to initiate recovery symptoms: as soon as the PDer was in parasympathetic mode, recovery symptoms occurred.

As soon as the foot injury had healed enough that energy could circulate through it correctly, no prompting was necessary to get recovery symptoms going. All the person needed to do was feel safe and relax or enjoy himself; the recovery symptoms would kick in automatically. It seemed as if, once the foot (and any other significant) injury was gone, the recovery symptoms were wanting, waiting, and willing to manifest. The only thing that could hold them back was the

¹ It never made a difference when I tried to explain that, with a degenerative disorder, people can’t “stay how they are.” I was genuinely shocked at how many people insisted that Parkinson’s wasn’t so bad and that they didn’t mind having Parkinson’s disease, because the symptoms didn’t really interfere with their lives too much. They honestly did not believe that their symptoms would *ever* get worse. I had to wonder what these people didn’t understand about the word “degenerative.” I sometimes asked these PDers if they’d ever been to a Parkinson’s support group. I was often told something to the effect that, “I went once, but the people in the group had a different kind of Parkinson’s.” or “The PDers in the group were a real mess: they weren’t like me. My Parkinson’s isn’t the severe kind, like theirs is. *Mine* isn’t a problem.”

I repeat: PDers are usually considered to be highly intelligent people.

PDer himself. The PDer could prevent recovery symptoms by being in sympathetic or dissociative mode.¹

The body of an injured person does not activate healing processes while running from a hungry lion or while dissociated. In these conditions, healing is put on hold. Ex-PDer, when in fear- or dissociation-mode, seemed able to keep all healing symptoms on hold. PDer who went back and forth between contented and anxious noticed that they did *not* manifest symptoms of healing during the anxious times. But when recovering PDer were genuinely able to feel safe and relax, the recovery symptoms proceeded as quickly as they could.

Not in the car

A PDer should *not* be concerned that recovery dyskinesia will occur while in a stressful situation. It never occurred while PDer were driving or doing any job that triggered the slightest bit of extra adrenaline.

Chapter summary

Recovery dyskinesia can be a pleasant symptom of recovery from Parkinson's. I have dwelt on it in some detail so that 1) a recovering PDer will be pleased, and not frightened, if it occurs and 2) it is so utterly opposite of the controlled, conscious movement of Parkinson's, and was, in many ways, so similar to the movement that sometimes occurred in medicated patients in response to a dopamine excess that it constituted yet another proof that our patients were recovering from Parkinson's – or at the very least, the dopamine was flowing.

When we came to better understand the processes at work in idiopathic Parkinson's disease, we concluded that there is no way that a person will experience recovery dyskinesia *if* he still has idiopathic Parkinson's disease. Recovery dyskinesia is a unique form of muscle recovery that only occurs when the brain begins reestablishing contact with muscles via the long-dormant connecting nerves. The motor movements feel uncharacteristic of PDer motor function: they feel effortless, as if they are being performed with dopamine, not adrenaline.

However – this does not mean that a person who experiences recovery dyskinesia will not be susceptible to the mood-based symptoms of Parkinson's. If a PDer has recovery dyskinesia but, afterwards, allows himself to slip into anxiety, he may well stiffen up, tremor, and find himself unable to use the limbs that, so recently, were moving effortlessly.

If a person was stuck in partial recovery and wondering if he was truly recovering or not *and* he had experienced one or more episodes of recovery dyskinesia (or for that matter, if he'd experienced several other of the other recovery symptoms), he was up against the uncomfortable conclusion that his remaining bouts of rigidity, slowness, and tremor were no longer being caused by an unhealed foot injury. His *body* was healing. His *mind* was still looping through negativity. If the PDer had recovery dyskinesia in some limbs but was increasingly susceptible to mood-induced PD-like symptoms, the logical conclusion was that he *had* genuinely had

¹ Sometimes, in addition to the foot injuries, other body parts had to be treated before energy could run in the right direction. In some cases, scar tissue, which is electrically non-conductive, was straddling one or more channel pathways, impeding the flow of energy. This problem was easily remedied using acupuncture to recreate conductive pathways through the scar tissue. In still other cases, multiple injuries needed to be treated before healthy flow of energy returned. But the larger point being made in the footnoted paragraph, that the body will initiate healing processes on its own as soon as the currents cease to flow backwards and the person resumes the "I am safe" emotional stance of the parasympathetic mode, still stands.

idiopathic Parkinson's, to start with. But now the physiological parts of the illness were healing. What he was left with, at this point, were symptoms of mind-based, psychogenic parkinsonism.

As I have mentioned before, we were not expecting any of these recovery dyskinesia symptoms. They took us by surprise. They also further proved for us that the problems of Parkinson's were *not* just symptoms of dopamine-cell death. These recovery symptoms reflected both a return of brain-to-muscle function in muscles that had not been used in a very long time and the effortlessness of dopamine-based movement.

