

## CHAPTER TWENTY-FOUR

# RECOVERY SYMPTOMS: CHANGES IN PERSONALITY AND ATTITUDE

### *Introduction*

The previous chapters focused on those recovery changes that were related to muscles, nerves, sinews, and even brain hemispheres. Those were physiological changes, changes that had a physical basis.

This chapter describes a few of the recovery symptoms that were more mental than physical: mood and personality changes. Some of these changes, in turn, led to seemingly physical changes: improved attitude and mood often caused a clear improvement in movement initiation, speed and fluidity of movement, and tremor.

In many PDers, the physical changes were harbingers of mental and emotional changes. In other PDers, the mental and emotional changes seemed to come first, leading the way for the physical changes. It was often hard to tell which came first. And truly, it didn't matter. What did matter was that the patients who became stuck in partial recovery were the ones who experienced many of the physical changes but few, if any, of the emotional changes.

In order for PDers who were veering towards partial recovery to experience the floods of new perceptions or attitudes that led to ease of movement and cessation of tremor, some of them had to learn how to access their own sensory experiences. Others had to work at shutting down their inner "Voice of Doom."

Still others were outraged at our suggestions that they "surrender" to emotional vulnerability or take charge of their own thoughts in order to vanquish their chronic wariness or pessimism. Despite having experienced many physical symptoms of recovery and even periods during which they moved perfectly normally until they remembered that they couldn't, many of these people decided that Parkinson's was incurable and dropped out of the program.

For those who were able to automatically experience the recovery symptoms that altered personality and attitude, and for those who worked hard at it and finally attained "feeling safe," these were some of the most satisfying recovery symptoms of all.

### **Crying**

At some point after the foot injury began to heal, recovering PDers often found themselves bursting into tears at the least little thing. Various PDers told me, prior to recovery, that they rarely cried, or that they *never* cried, or even that they *couldn't* cry. During recovery, for a few weeks or months, they often found themselves crying at almost anything.

Typical reports included, "I'm turning into a sap! I saw a little child walking a puppy on a leash, and it was so cute, I burst into tears," and "I caught myself crying at *Oprah*, for God's sake," and "I read the headlines on the newspaper and I was so touched, I started crying!"

Usually, the onset of easy tears was a wonderful feeling, accompanied by a feeling of openness in the heart and an end of a long-time fear that tears would lead to being condemned as a sap, a weakling, or stupid.

Then again, the onset of tears could be very painful.

One PDer who did not recall ever crying since she was six years old started crying one day after a session in which we'd worked on her imagining that her physical body and her "imaginary body, the body that contained her heart" bridged the several-foot gap that usually separated them and merged into one person.

She started crying in my office, saying, "Why are people so mean to one another?...gee. I'm crying." And then she started crying harder. She was so violently wracked with sobs that I suggested she not return to work, that she go straight home and call in sick for the rest of the day.

She assured me that she wouldn't have any problem at work: she had always been able to stay in control of her emotions.

She called me the next day. She had returned to work, started sobbing hysterically at her desk, and actually fell on the floor and was unable to stand up. A co-worker drove her home. She stayed home from work the next day and cried. She was unable to staunch the tears, but more importantly, she was unable to stop the flood of emotions that surged in her breast. She was feeling emotions for the first time since she was six years old. She felt emotionally drained by all the feelings and the crying, but she figured that it was all to the good. Then the worst happened.

Her best friends, a couple that she had introduced to each other, died in a car crash just three days after she'd called me from home. Her friends had been on their way back from Disneyland. Their infant daughter also died. The eight-year old child was injured, but survived.

This PDer, who had not cried *or felt any emotion* since she was six years old, was hit with the full force of real-time emotional loss. She told me, the next week, that when she got the news of her friends' deaths, she cried so hard that her chest hurt, her eyes hurt, her face hurt. Her arms hurt, her skin hurt. At some point, she was in so much pain that she couldn't tell if she was crying because she was in such physical pain or if she was in such physical pain because she was crying. She feared that she might go crazy from the emotional pain, the physical pain, and the crying.

A week later, she told me that, for several days, she questioned whether or not she had been better off back when she was unable to cry, back when she had attended family deathbeds and funerals and experienced no feelings *whatsoever*.

I asked her if she now regretted the changes that she'd been going through, if she wished we hadn't opened that door.

I will never forget her answer.

She looked me right in the eye and said, "You saved my life. I was dying and you brought me back."

She had no regrets.

Nearly all PDers *enjoyed* the sensations of increased feelings and tears. Very often the tears were tears of joy, of connectedness with others. Even in the above case, she was grateful to be able to feel and express the anguish and pain that she was feeling.

The ability to cry is very important. I cannot think of any person who has recovered from Parkinson's who retained his *inability* to cry. Curiously, some of those who recovered easily had actually worked on learning to cry, *long* before they were ever diagnosed with Parkinson's. I highly suspect that their self-taught ability to experience their own heart feelings was one of the main reasons that they recovered so easily.

### *Learning to cry in high school*

Lynne, whose foot got slammed in a car door when she was five, learned to cry when she was seventeen. It happened after one of her teachers referred her to the school psychologist for “the usual senior-year counseling session.” (Lynne only realized decades later that her ferociously stoic demeanor had probably prompted her favorite teacher to set up the unusual session. When Lynne’s own children were graduating from high school, Lynne suddenly realized that none of her old high-school classmates had ever been sent to a “usual senior-year counseling session.”)

During the session, the counselor asked Lynne a few pointed questions about her home life. He remarked on how Lynne seemed to freeze up when asked about her mother. Lynne coolly replied that, “All children should love their mothers. My mother always reminds me that even the worst criminals love their mothers.” The counselor countered, “Not all mothers deserved to be loved. Some mothers chop up their children and flush them down the toilet.”

Lynne was shocked and relieved by the thought that some mothers didn’t merit blind devotion. The counselor then asked Lynne if she ever cried. Lynne replied, “No one likes a person who cries.” As a very young child, Lynne had learned that crying was one of the behaviors that made her mother insane with rage, and always led to a brutal beating with a leather strap. It wasn’t until several years after recovering from Parkinson’s that Lynne realized that her mother had actually manifested orgasmic breathing and body movements while using the strap on Lynne. At any rate, Lynne had learned very quickly never to cry.

The counselor contradicted her, “Everyone cries. Crying is normal. Everyone knows that tears just mean sadness. Maybe your mother doesn’t understand about crying, but healthy people do. If you walked all over school crying, not one person would be angry with you or dislike you; people would most likely just say to themselves ‘she must be sad about something’ and continue on their way.”

Lynne was astonished at this new thought, and told the counselor, “I’ve got to get back to class. But I’ll do an experiment. I will cry and see if anyone gets mad at me.”

She started crying on her way back to class. She had not cried since she was five years old, so it took a while to get started; she pretended that she was an actress who could cry on command, and that got a few tears rolling. Once she started, she couldn’t stop. She did not take her usual seat at the front of the class that day. She sat at the back and cried. To her amazement, no one, not even the teacher, got mad at her. For that matter, she was given a wide berth. Other than that, no one seemed to even notice her. (This had been back in the pre-hug 1960s. If she did the same experiment today, probably many people would have come forth with hugs.) Certainly, no one made fun of her or scorned her. She enjoyed the sensation so much that she sat at the back of the room in her next class, as well, and cried for another forty minutes.

Shortly after that, she left home. From then on, she had made a point of letting herself cry, sing, dance, and emote whenever she felt an emotion welling up in her. Prior to her diagnosis with Parkinson’s disease, she had noticed that it had become increasingly difficult for her to notice her own feelings. She found her self with an increasingly flat affect and mood – but unlike many of my PD patients, she had been very aware of this decline. She fought it vigorously by forcing herself to sing songs that always made her feel better, and which, in turn, temporarily improved her movements.

She recovered from Parkinson’s disease very quickly; most of her symptoms were gone in a few months.

Several of our PD patients described similar stories of learning or teaching themselves how to cry, feel vulnerable, or focus on the feelings their own bodies. Those PDers who had worked on these skills tended to recover quickly. Oppositely, those PDers who were not willing to learn to cry or willing to feel pain were almost certain to become stuck in partial recovery. Again, no PDer who has fully recovered retained his inability to cry.

### **Punctuality**

One distinct symptom that accompanied the change *away* from adrenaline and fear was a decrease in punctuality. I was always thrilled when a previously punctual PDer called me on the phone to say something like, “Ha ha! I guess you figured out that I’m not at my appointment. I’m at the beach watching the birds and I decided not to come to your office. I’ve just realized that I’ve never really sat and watched birds before. It’s great! See next week.”

I loved it when a PDer who had previously been chronically punctual started to recover – and then showed up fifteen minutes late for his next appointment...and laughed it off! It was always a sign of emotional recovery.<sup>1</sup>

### **Panic attacks**

Many people experienced a panic attacks after succeeding in letting go of their anxiety or negativity. These attacks occurred in situations with highly specific parameters: 1) the situation was always supremely *non-important*; 2) a decision had to be made with regard to a *new situation*; 3) because the situation was new, *no precedent* could be applied.

The panic attack was usually full-blown, complete with pounding heart and sheer terror with no way out. A common description was “my mind seemed to be going down a black hole.”

After interviewing the recoverers who had panic attacks – and they only had one apiece, I noticed the following generalities.

The attacks occurred after a person started feeling very good, very comfortable. He could feel himself being more relaxed and less likely to use adrenaline. He may have even noticed that his heart was more calm and that he was sleeping better than he used to.

Then, along came a situation in which he had to make an innocuous decision: a decision that he had *never* had to make before. Some examples of decisions that prompted panic attacks are: Where to put the cat dish for the new kitty’s food? Where to set the knick-knacks that sit on the bookcase when the carpet man moves the bookcase to take up the old carpet? “How do I install a brand new computer game program?” (This was back in the days when every new computer program had its own unique set of installation instructions.)

In every case of panic attack, the person was confronting a *new* situation that was not actually very important. When he calmly tried to think of what to do in this situation, the brain presented an utterly blank screen: no thoughts appeared. He then wondered what was the matter with his brain.

In the past, these PDers had been adrenaline-driven, accustomed to making lightening fast decisions. Now, their brains had gone literally blank. As they tried harder to find some mental thread to grasp, in an attempt to figure out how to do the new task, they realized that there were no mental threads. The task itself became less important. The mental focus was redirected

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<sup>1</sup> I had *one* PD patient who was not compulsively on time. She was consistently, considerably late for everything. Every PDer is unique. There are exceptions to every generality. She was also a musician, and one of the PDers who recovered *very* rapidly.

to the realization that there were NO mental threads. It felt as if all thought processes have been turned off, as if the brain itself was missing.

What was probably happening, based on detailed descriptions that we've heard, is that the person was trying – for the first time in decades or maybe for the first time in his life – to make a decision using dopamine instead of adrenaline.

A recovering PDer may have no remembered experience of making a decision while using dopamine. When he tried to make a decision while being dopamine dominant, the mental “thought screen” showed up blank. This led to the next thought, “My brain is missing!” and from there, into a black hole of terror and a full blown panic attack. At some point, the PDer’s panic forced him to drop back into sympathetic mode – a mental condition that he knew very, very well. Once he slipped into fear mode, he was able to snap out of his panic.

Happily, these attacks only happened once. After that, the recoverer seemed to know how to make decisions without going into sympathetic mode.

We have never known of anyone who couldn't figure out where to set the new knick-knacks after having had his one panic attack.

These panic attacks were very real. The woman who slid into a black hellhole of panic while trying to decide where to put the kitty dish was a NASA researcher, a brilliant woman. She found herself standing in the center of the living room screaming, “Help me! Help me!” at full volume. She said that, even as she was doing it, a part of her brain was thinking, “This must be a panic attack! Cool. I must be recovering!” But even so, the sense of impending doom, helplessness, panic, of needing someone to take over and take care of her, was physiologically *real*. The panic did not have to do with the kitty dish, per se. The panic began when her brain registered “Empty” when she tried to think of how to think about where to put the new dish.

One previously intrepid, world-traveling PDer had a panic attack when his wife proposed that they try the new restaurant in town. He went into a full-blown panic and was soon screaming for help as his wife stood by in amazement. The reason? He didn't know what they would do after they got into the parking lot because he didn't know what they would need to do to find the front door of the restaurant. And when he tried to *think* about how a person might go about finding the front door on a building he hadn't been to before, he couldn't figure out how to think. It was the inability to think, and the feeling that his brain was literally empty, that triggered the panic.

As an aside, our patients with Parkinson's seem to have relied on the emergency form of decision making for most of their lives. This is why they often came across as stronger, smarter, and faster than their peers. They might not have been stronger, smarter and faster than their playmates and peers if they had all been on the same neurological footing – using the parasympathetic mode instead of sympathetic. We are pretty certain of this because, after recovering, PDers were often amazed to find themselves becoming more average in terms of strength, quickness of mind, and speed. They did not become stupid or sloth-like. However, they are only *pleasantly* above average, not super-duper, not driven – and they were OK with it.

Because of their own chronic use of adrenaline and their amped up, emergency-induced thought and physical processes, many PDers had actively resented their “slow” fellow students and coworkers, had dismissed them as “underachievers.” Even since grade school, the mere presence of these “slower and stupider” people had been a real irritant for many of our PD

patients, who, deep down inside, had felt that life was an ongoing emergency, a state of perpetual risk. (More on this subject in appendix xxx, The adrenaline-dopamine relationship.)

Getting back to panic attacks: when the recovering PDer needed to make an innocuous decision, one that was simply too mundane to activate his sympathetic nervous system, he found he had no way to access the decision-making part of his brain and be calm at the same time. He actually got a blank slate when he tried to make a simple decision while under the influence of dopamine. It was always the blank slate that scared him, not the implications of the decision.

As you have correctly guessed, a few PDers have told me that they shouldn't enter into a recovery program because they might have a panic attack while driving the car. You know exactly what my reply was: the panic attacks occur while doing something perfectly dull in a very safe setting. No one in our experience has had a panic attack while in a risk-laden situation.

Then again, one recovering PDer did have a panic attack while driving. He had taken the weekend off and had flown back east to visit his daughter at college. The visit was purely a lark. It was the first time he'd taken off just for fun in a long time. As he was enjoying himself driving along the freeway, he missed the exit. He took the next exit instead and then realized he didn't know what to do next. He couldn't even think of what to do next, so he pulled over and stopped the car. Then, in this perfectly safe, non-emergency situation, in which, on some level, he was actually enjoying himself, he tried to think about what he should do next. He couldn't think. Within seconds, he was in a complete panic because he couldn't think. His heart was pounding, he was sure he was going to die. After what seemed like several minutes but what was probably several seconds, his brain kicked in. He thought of something to do: he called his wife, long-distance. She agreed that he'd just had a panic attack, and what did he think he should do. He said that he needed to pull a U-turn, get back on the freeway, and go back the way he'd come. Duh. He knew what to do.

But he had been thrown into a panic by the fear that had tackled him when his brain had failed to respond in the usual manner. He did get to where he was going, and he never had another panic attack.

The interesting thing about this particular style of panic attack is this: after the person truly begins to panic, the sympathetic nervous system does kick in. He is then able to think in the manner that he has always thought in the past. And so the panic attack ends.

In these and in other cases, it has seemed as if the ex-PDer, in the joyous throes of steady dopamine release, has been reluctant to slide back into using the old familiar sympathetic mode. But decisions can only be made in one of two ways: by using the mind while in predominantly sympathetic mode, or by feeling the preference of the heart while in predominantly parasympathetic mode. The sympathetic system is guided by mind. The parasympathetic is guided by physical heart sensations.

The first time a person recovering from Parkinson's tries to make an unimportant decision using his *mind* (as per his lifetime habit) while he is in predominantly *parasympathetic* mode, he can't come up with a solution. In parasympathetic mode, the heart instructs the mind. If one tries to find a solution to a problem using only the mind pathways, while staying in predominantly parasympathetic mode, he will not get an answer: the mind may present a blank.

In recovering PDer's, the mind system hasn't yet been trained to work as a subordinate during parasympathetic, heart-led decision making.<sup>1</sup> Hence, the panic attack. Happily, our recovered PDer's instinctively learned, after one panic attack, how to think and make decisions while in parasympathetic mode.

### **Guilt or boredom from lack of tremoring**

Another emotional symptom of recovery was guilt. I have already written about the PDer who never tremored again after a side-to-side- head shift and who felt terribly guilty when, shortly after, her mother was in the emergency room at hospital. For years, her hand had tremored during the most mild of crises. As the emergency room clock ticked away and she failed to tremor, she thought to herself, "I must not care about my mother." I've tremored from all kinds of stupid, unimportant things, and now my own mother is in danger and I'm not even tremoring."

She told me about her shame the next time I saw her. I had to assure her that tremoring in a crisis is not necessarily normal.

Some PDer's were ashamed of themselves when, upon recovering, they realized the extent to which their Parkinson's symptoms had been the result of their own mental and emotional blockages. I recall one PDer repeatedly slamming his open hand onto his forehead while saying, "I've been doing this to myself! What an idiot I've been. I've done all this to myself!"

Another type of guilt that sometimes descended on a recovering PDer was the realization that, for a large part of his life, he had increasingly been an unpleasant, demanding perfectionist, know it all, or whatever personality form his fear and adrenaline had taken.

As a healthy level of humility began to take root and thrive, the temptation existed for the PDer to indulge in guilt for having been such a fear-driven, pride-driven (or whatever) in the past. My advice was that indulging in guilt and shame is a variation on pride. Be humble enough to know that *everyone* makes errors. Forgive yourself and get on with your life. No doubt you were nearly always doing what you thought was best.

Another post-tremor weirdness was the feeling of emptiness. As one person expressed it, "I miss the tremor. I know that's weird, but I always felt some sort of internal pressure to look alert. As long as I was tremoring inside, I felt like I was always doing something. Now that it's gone and I can sit motionless, I feel as if I'm not *doing* anything when I'm just sitting around. And I sort of miss that old intensity that wouldn't let me sit still for very long. I'm going to have to find a new motivator."

### **Loss of self-identity**

As mentioned in an earlier chapter xxx, many recovering PDer's have found themselves asking the question that might be more characteristic of an adolescent: "Who am I?"

This may be because, in part, the PDer never really experienced a calm period during adolescence in which he was able to dwell on that question.

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<sup>1</sup> This reminds me of a story about Karl Jung, the famous philosopher/psychologist/ explorer. Jung asked Ochwiy Bianco, chief of the Pueblo Indians, for his opinion of the white man. The chief said white men must be crazy because they think with their heads, and it is well known that only crazy people do that. Jung asked how the Indians thought. The chief replied that, naturally, they thought with their hearts. (From *The Sun*; "Sunbeams (Letters to the editor);" Laurens van der Post; Sept 2007; p. 48)

Or, the PDer may have known exactly who he was so long as he was “on top of his game” and running on adrenaline, but he might have had no idea who he was when he found himself able to relax deeply, feel music, and not caring about the order in which someone else stacked the dishes into the dishwasher.

Who was he when he suddenly realized that most of what he’d been worrying about for years didn’t really matter? Who was he if he was starting to live in harmony with his own feelings, his own heart?

Many PDers valued themselves in terms of what they were able to accomplish, and because they were stronger, faster, or smarter than most everyone else. What they needed to learn was that no one is loved for his accomplishments, and no one is loved because he happens to be strong, fast, clever, or “always right.”

People are loved to the degree that they allow their hearts to resonate. A person with Parkinson’s *may* have a heart that can resonate with others, send love to others. It may resonate well with dogs or small children.

But what PDers also often have is an inability to feel the resonance between his own heart and his own body, or between his own heart and the love that others are directing towards him.

Because of this lack of resonance and ever-increasing reliance on adrenaline, he may have been steadily building protective walls around his own heart until he got to the point that he no longer knew who he really was.

When, during recovery from Parkinson’s, those walls begin to crumble, PDers were often surprised to learn that they were not who or what they thought they were. But all the recoverers were certain that they loved their new self far more than they’d been able to love their old, PDish self.

Prior to recovery, very possibly the hardest thing for many PDers to understand was this: in the past, they were loved, not because of who they were and what they did, but *in spite* of it.

### **Overflowing with gratitude**

A common symptom after recovery is a feeling of contentment and gratitude.

Gratitude is a feeling that *cannot* be easily accessed while locked into sympathetic mode. The gratitude that a person felt when he realized that he was safe and that he had always been taken care of – whether he’d known it or not – was very often the trigger for the feeling of safety that set in motion a brain shift or the first obvious surge of recovery-type (not activity-dependent) dopamine.

Many fully recovered PDers were certain that immersion in “gratitude for having always been safe” was the thing that initiated their new lightness of movement that was characteristic of lasting recovery and dopamine-based thinking.

Many PDers who got stuck in partial recovery assumed that this was impossible: *if, and only if*, they could move easily again or they could have concrete proof that they had dopamine flowing again, would they then be able to feel gratitude.

Many have told me that they have nothing to be grateful *for* because they have Parkinson’s. If and when they recover, *then* they will have plenty to be grateful for.

This sulky stance was common in many of the people who became stuck in partial recovery.

I often tried to explain that, if a person needs a “cause” for gratitude, or if he thinks that having an illness makes gratitude impossible, then he doesn’t understand what gratitude really is. Gratitude is a *feeling*. Gratitude is not a thought process. Gratitude is *not* a logical payment that one makes after having received a favor: that’s a payment – that’s not gratitude.

When a person gazes at a stupendous sunrise over a mountain lake, his heart resonates with the vibrations of color and shape in that sunrise. His chest fills with an indescribable emotion. “Gratitude” is an apt name for that indescribable emotion. The word “gratitude” is related to the word “grace.” Grace is defined in my oldest dictionary as “unearned blessings.” The glorious feelings in the heart that can occur from resonance with a sunrise have not been *earned*. Those feelings simply *are*. We can call those feelings “love.” We can also call them “gratitude.”

### ***Learning about gratitude***

The gratitude exercise is one of the mind-retraining techniques that we offer. One of our long-distance patients had chosen to practice the gratitude exercise every night. He saw Chris again after six months and reported that, every evening, he thought of five things to feel grateful for. Chris asked him *how* this made him feel.

“Feel?”

“Yes. When you feel grateful, how do you feel?”

“Feel?”

“Right. How would you describe the feeling of gratitude?”

“Feeling? I just make a list of five things, say the five things, and go to bed. What am I supposed to be *feeling*?”

Chris stopped the duologue, and slowly led the PDer through the gratitude exercise. The very wealthy PDer picked, for the exercise, one of the things that he’d been grateful for every evening: his toothbrush. Chris asked him to just imagine his toothbrush for several minutes. After several minutes had passed, Chris asked him to mentally give wordless thanks to the toothbrush, and to do so for several minutes. After about three minutes had passed, the PDer sighed deeply and said something like, “Oh.” He had felt his heart open up while thanking the toothbrush.

Gratitude has nothing to do with logic. Gratitude is a feeling. And the feeling of gratitude has been one of the most direct keys for unlocking the brain’s trove of dopamine.

### ***“No one can understand”***

During and after recovery, a PDer who is overflowing with gratitude may find that there is “no one can understand what I’ve been through.”

Once, when we asked a recently recovered PDer to talk with a PDer who was still struggling with negativity, she spoke with him for fewer than two minutes before standing up and saying to us, “There’s nothing I can say to him. He’s not ready to understand. I know that I wouldn’t have been, either. I had to learn for myself.”

I’m just mentioning it here in this chapter on mental and emotional symptoms of recovery so that the recovering PDer who reads this will know that he is not the only one who feels that there is no way to describe what recovery is like, that “no one can understand what I’ve been through.”

### ***Why talk about it?***

This actually brings us to the subject of why so few people who have recovered from Parkinson's have stepped forward. In the first place, in our limited experience, neurologists have been pretty adamant that anyone who recovers from Parkinson's never really had Parkinson's. He was either misdiagnosed or else he was crazy. This makes it hard for a recovered PDer to flaunt his recovery.

But secondly, and perhaps more importantly, people who recover from Parkinson's often say that recovery is not the "victory" that they expected. They can once again move easily because they have become humble, not because they have returned to glory. They have learned to love themselves for the sheer joy of being instead of for how strong or steady they used to think they were. They tend to be sheepish about the way they behaved and thought, prior to recovery. There is no way that they would ever want to be that person again. People who recover often speak of having lived two different lives, with two personalities, all in one lifetime. PDers are smart enough to know that this is not the sort of talk that makes a lot of sense, particularly to anyone who is still stuck in a Parkinson's Personality.

Most ex-PDers admit that there is *nothing* that they can say to a person who still has Parkinson's that would help that PDer recover.

As one PDer put it, "I know that, prior to recovery, I would have dismissed all of the things that have turned out to be most important because I would not have understood what you were saying.

"If you had talked to me about gratitude, I would have assured you that I knew what gratitude was. But I didn't. If you had talked to me about heart, I would have assured you that I knew what love and heart are. But I didn't. And there would have been nothing that you could have said that would have made me understand.

"I had to lay down my weapons of self-protection. I had to surrender to the good that exists in the universe and in me. And surrender was the most hated word in my vocabulary. There was nothing you could have *said* that I could have understood."<sup>1</sup>

And this "Nothing you could have said" can actually be one of the challenges of recovering from Parkinson's: There are no *words* for the feeling that initiates a surge of activity in the substantia and the release of dopamine. The problem is that, prior to recovery, the PDer may increasingly have lived in a world of *words*.

During recovery, he will return to a world in which the heart expansions of joy and silent instructions from the heart will resume their proper place. *Words* will once again be used correctly: as servants that express the feelings of the reigning heart. Even the world's greatest poets work hard to create word portraits of this world of feelings. Most recovering PDers don't even come close to having the skill set that would allow them to use *words* to explain their return to life. But the longer they have Parkinson's, the more likely it is that they can *only* interface with themselves and their world via words.

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<sup>1</sup> Also, those who have recovered *easily* may not have much to offer on the subject. They were never emotionally blocked. They may not understand the heart denial that is characteristic of people stuck in partial recovery. If a person recovers easily, he probably was not highly dissociated. He may not even go through any period of *learning* to reconnect his heart and mind: the reconnection may be automatic. If an "easy recoverer" is asked what advice he has for someone stuck in partial recovery, he may just say, "Huh? Fix the foot! It's easy." The "easy" or "fast" recoverer may not understand what the big deal is all about. Fortunately for this project, several of the pioneers were easy recoverers. If I'd only had partially-recovered PDers to work with in the earliest days of our research, I would soon have abandoned the Little Project.

## **No fear of criticism**

Many recovering PDers noticed a dropping away of their defensiveness.

Of course, not all PDers had been afraid of making mistakes or being laughed at, but many had been. Their symptoms ranged from a protective emotional flatness to abject fear of “what others might think” to the point that they lived every moment as if an invisible critic was offering running commentary. When the inner critic died away, the relief was enormous.

## **Return of the heart**

During the visualization exercises that accompanied the foot treatments, many PDers were surprised to realize that they could not visualize at all, let alone imagine themselves having a radiantly healthy heart in their chest. During recovery, they “got their heart back.” They could imagine themselves having a heart, and they could *feel* the expansion feelings and/or hesitations of the heart in response to their thoughts and activities. They were able to sit quietly and *feel* pleasure in watching the sunset as opposed to *thinking* about the sunset. They were able to enjoy themselves while just sitting on the beach or while just watching trees move in the wind. They were able to stay calm while watching a child attempt some new skill even if the child wasn’t doing it the most efficient way. They found themselves enjoying the experience of being wrong and admitting it or laughing at themselves and having others laugh with them.

These enormous changes suggested a reversal of some of the core psychological processes that are at work in Parkinson’s disease: an end of dissociation and a return to heart sensitivity.

## **Cycles of change**

I will close these chapters on recovery symptoms with one of our most bizarre observations. People with idiopathic Parkinson’s disease have a twenty-three day cycle of movement ability, during which movement goes from good, to bad, and back to good again. A PDer will go from a very good day or days, during which he has a great attitude and feels at the top of his game, and slowly slide, over the next eleven days, down into a pit in which he may be certain that he has never been so rigid (or negative, or tremory, or whatever his current, worst problem is). Then gradually, over another eleven days, he will cruise back up to the top again. The complete cycle lasts twenty-three days. And then it starts again.

The most uncanny thing about this cycle was that all PDers were on the same twenty-three day cycle. All PDers in my experience had their best days on the same days, and eleven or twelve days later, they all had their worst days, and then, by day twenty-three, they all had good days again.

The incredible thing was that this cycle did not just happen to my patients in my office, in my hometown. It happened to all the PDers around the world that had ever contacted me.

Before I realized that there was a cycle, I was often remarking to my family, “Everyone is much worse today, I don’t know what I’m doing wrong. Maybe I’m a fool for trying.” And then a week and a half later, I would be rapturous with glee because “*everyone* is doing so much better.”

My son finally pointed out that I’d been doing this up and down cycle for over a year, and that it was impossible that “everyone” was doing poorly or that “everyone” was doing well. Surely I was exaggerating.

So I went through my charts. I went through the emails that had been sent to me from people I knew *and* from people that I had never met. Sure enough, there was a consistent, twenty-three day cycle in PDers from around the world, even if I’d never met with or emailed

with them before. In fact, I suddenly saw that I tended to get the most emails at the apex and nadir of the cycles.

This was unbiased reporting: the emailers who had never met any of us on the team were *not* being influenced by me or by anyone in the project.

The other thing that was quite strange was that, since starting this project, there were a few times that the low in the cycle was extremely low or the high was extremely high.

I recall that all my patients experienced a *severe* low in the first week of August of 1998. Another one occurred towards the end of January in 2000. I have not tracked enough of these extremely powerful lows and highs to detect a pattern. I did not share this information with PDers at first, because I feared “contamination” of my research data. But once I had several years of data, I did present this information about the twenty-three day cycle to patients so that they could keep their chins up when they found themselves having a rough week or so.<sup>1</sup>

The influence of whatever it is that drives this cycle ceased when a person recovered from Parkinson’s disease. The *physical* symptoms of Parkinson’s and the emotional symptoms of Parkinson’s (if any), the negativity, wariness, self-pity and/or fear or shame of self-pity, and anxiety, were influenced by the twenty-three day cycle.

However, the physical and emotional symptoms of recovery were not influenced by the twenty-three day cycle. The pain and tingling in injuries that were healing, the ability to taste and smell, to sleep long and deep, to cry, the changes in self-awareness and the new found ability to feel one’s own heart’s responses were *not* influenced by the twenty-three day cycle.

## SUMMARY

The people who recovered most easily were those who had never lost their ability to cry or guide themselves using the physical sensations in the chest, or those who had lost these abilities at some point in their lives and had worked to resume them in the years long before the Parkinson’s was diagnosed.

Those people who were able to let go of their selectively rigid emotional habits enough to cry, to stop caring about what others, including the Internal Critic or the Voice of Doom, might think, and to no longer fear the potential emotional pain that comes when the heart is vulnerable were able to recovery *somewhat* easily, even if they were stunned by the flood of long-absent feelings that they experienced when their injuries healed.

Those who were unable to even understand what I meant by the word “feeling of expansion in the chest,” those who remained convinced that the point of life is to avoid physical and/or emotional pain, and those who remained constantly wary of how they are being judged by others usually became stuck, for some period of time, in partial recovery. Those who became stuck in partial recovery could nevertheless recover – but they had to work at overcoming their mental and emotional inhibitions. Techniques for helping change these patterns are included in the section on treatment techniques.



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<sup>1</sup> Several friends of the project have tried to research the probable cause of this worldwide cycle. The only astronomical event with a twenty-three day cycle that might possibly be driving the pattern is a star in our galaxy that emits a strong radio wave in a twenty-three day cycle. This is not a biorhythm pattern. Biorhythms begin on the day a person is born. Therefore, there are 365 potential starting dates for the biorhythm cycles. But all PDers seem to be stuck in the same cycle. It may be that, when they shut down their heart, they fall out of their native biorhythm and into a sort of default cycle that can be influenced by strong atmospheric phenomena.