

“...So near, and yet so far.”

- Alfred, Lord Tennyson

CHAPTER TWENTY-EIGHT

DISCOVERING PARTIAL RECOVERY

Hurrah! ...sort of

I started the Little Project in 1998. After a year of thrilling changes and even recoveries in many patients with Parkinson's, and by puzzling over possible Qi contortion scenarios, I had been able to put together a particular set of channel confusions that might conceivably develop from an unhealed foot injury at the center of the foot. These particular channel confusions *should* cause a specific collection of physical symptoms. These symptoms matched the symptoms of Parkinson's disease, right down to the dopamine dormancy in the brain.

I wrote about these channel irregularities in chapter five xxx, and supported this idea further in chapter seven xxx, with the map of symptom locations. Once I knew to look for these backwards flow patterns, my colleagues and I could easily, with our hands, detect them in my PD patients. I figured I was onto something.

I now had a satisfactory answer as to *why* some of my PD patients recovered when I treated their foot injuries.

I felt much better after I'd figured this out. I have never liked purely anecdotal medicine. To my mind, there needs to be a reason, a cause and effect relationship going on, to explain an illness and its cure. Otherwise, any so-called cure is a hit or miss event. An anecdotal cure might work some times, it might not work other times. But when I had objective observations of distorted Qi in the feet of PDer's, obvious indications of an old unhealed injury, a logical explanation of how PD pathologies could get set in motion from an unhealed injury, *and* the rectification of these PD pathologies when the injury healed, that felt right.

The local neurologists were not impressed

I was certain that the treatment was reversing the course of Parkinson's. Of course, I didn't get any support from local neurologists. Right from the beginning, I ran head-on into the MDs' rule that “anyone who recovers from Parkinson's must have been misdiagnosed.”

Some ex-PDer's were bitter about this. Others assumed that the doctors were correct, and that they had, in fact, been misdiagnosed.

But I suspected that the MDs might be wrong. My strongest proof came from the medicated patients; I had worked on people who'd had PD for years, who, prior to their treatments, had responses to their medications that were typical of PDer's responses to high-ish doses of antiparkinson's medication. When, following treatment, these people's Qi started running correctly and their PD symptoms started to fade, they suddenly started having reactions to their medications that corresponded to what happens when *non*-PDer's take the meds at high-ish levels. These responses were pretty terrible, and led to our no longer working with anyone who has ever used the meds, but the reactions were undeniable, nevertheless. This suggested that a genuine, *chemical* change was occurring in people whose Qi was once again flowing correctly. These people had *not* been misdiagnosed.

When MDs starting writing into the charts of recovered PDers phrases like, “I don’t know why this patient pretended to have Parkinson’s disease for the last six years, [because she now has no symptoms of Parkinson’s]” my hunch that I’d found a cure for Parkinson’s was confirmed. I was almost ready to notify the press and call for a celebration.

Then came the unexpected changes in some of the PDers who’d been recovering. The happy ending of my Little Project was put on hold.

More than just a foot problem - sometimes

When this project first got going, some people recovered completely in response to the techniques we used to heal their foot injuries. As expected, some people recovered more quickly than others.

I also saw that some people, after recovering from their adrenaline-producing foot injuries, began exhibiting new, extreme levels of anxiety or depression. Sometimes, the new levels of anxiety were overwhelming. Other times, the anxiety showed up once in a while, in a format resembling a panic attack. These attacks were accompanied, in some cases, with a temporary return to Parkinson’s-like movement problems. However, the movement problems were usually far, far worse than they had ever been in the past.

Local interest in the Little Project began to stir, and a few other local acupuncturists had started treating PDers. I was glad of this, especially when some PDers starting having unexpected outbursts of anxiety or panic. My colleagues were able to confirm from their own experience some of the unexpected outcomes I was starting to see.

PARTIAL RECOVERY

We had treated more than fifty people at this point, and six of them had fallen into some sort of weird condition in which structural symptoms appeared to be improving, but anxiety, movement initiation, or tremor had become worse. In some of these cases, the worsening symptoms were intermittent and clearly related to spates of anxiety. In other cases, they came on hard and fast and accelerated beyond anything associated with the expected pace of steadily worsening Parkinson’s disease.

Because they had all shown significant, lasting physical improvement before their anxiety or severe slowness set in, we referred to the condition of these six people as “partially recovered.” None of these people had ever used medication. We set out to figure out what was going on with this group.¹

¹ Since then, after working with hundreds of PDers, we know that the percentage of people that collapse into a condition of “partial recovery” is much higher than our original six out of fifty. At that time, we were still treating mostly medicated PDers. The medicated PDers were more likely to go the other way during recovery: euphoria, rapid addiction to the medication and weekly, sometimes daily, increases in dose. Then, at the new high levels of the drugs, horrible problems set in: hideous, excruciating dyskinesia, insanity and in a few cases, death. However, as long as they were high on their drugs, they weren’t susceptible to anxiety and motor inhibition. Therefore, we didn’t notice partial recovery symptoms in medicated patients.

After we stopped working with medicated PDers, we could generate more accurate numbers. We then realized that a *majority* of our unmedicated PDers developed symptoms of partial recovery. Then again, the people who came to me for help with their “movement problems,” who had clearly had symptoms of Parkinson’s, but who had *not* received an official diagnosis of Parkinson’s, *all* recovered easily; none of the people who lacked an “official diagnosis” became stuck in partial recovery.

I even recall one of these patients laughing merrily while discussing the curious fact that I mostly worked with people with Parkinson’s. She chortled, “Wouldn’t it be funny if it turned out that that’s what *I* have?” She

Although each of the partially recovered had his own set of mental rules for events that should, to his mind, cause the temporary return of Parkinson's disease, a commonality ran through these cases. Most of their structural symptoms were gone: some had return of facial expression, return of arm swing, return of the atrophied muscle between the thumb and index finger, return of handwriting ability, and/or return to good posture: improvement all along the Stomach and Large Intestine channels. However, they were increasingly the victims of lack of interest in life, or anxiety, or even panic attacks. And when they were the most blasé or anxious, they had severe movement initiation problems and/or tremor. If they were anxious almost all the time, they might only move well during the brief periods when they were accustomed to be anxiety-free: during safe activities such as walking in the woods, doing the laundry, or sewing.

These easy-to-move moments did *not* necessarily occur when doing tasks that are generally easy for people with Parkinson's. For example, sewing, with its small motor requirement, is usually not possible for people with advancing Parkinson's. But in one partially recovered PDer who enjoyed sewing, she might be tremor-free while sitting at the sewing machine. On the other hand, this same PDer (who could once again ride her bicycle and go up and down stairs easily and turn doorknobs and smile radiantly) would tremor violently if she did anything having to do with alphabetizing or adding up numbers. (It seemed significant to me that these two latter skills were probably learned when she was around age seven, which corresponded to her age at the time of foot injury.)

Another PDer was convinced that she was getting worse. Even though her handwriting was becoming large and easy, and her arms and legs were relaxed (no longer stiff), and her facial expression had returned, she was increasingly subject to self-pity. When I asked her if she thought she was recovering, she told me that she didn't deserve to recover.

She got so that, by the end of the day, she was exhausted from dragging her limp (no longer rigid) body around. When it came time to get into bed, she was simply too tired to even figure out how to climb into bed. In order to get into bed, she had to pretend that she didn't have Parkinson's. Then, by pretending, she could easily get into bed, adjust her pillows and get the blankets just how she liked. Then she could go back to suffering from the heavy weight of her weak and limp body: suffering from her Parkinson's disease. When I asked why she didn't pretend to not have Parkinson's all day long, she looked at me with surprise. "That wouldn't be honest," she replied.¹

actually had a somewhat advanced case, had almost no use of one arm, had no facial expression, a moderately bad tremor and was using a walker to assist with her tiny, shuffling steps. I assured her she did not have Parkinson's disease. She recovered very quickly and easily. I asked her to see a neurologist after she recovered, and to tell the neurologist all her symptoms. I was curious as to what the neurologist might say. The neurologist listened to her list of symptoms and told her, "If you actually had the symptoms you've described, and your acupuncturist got rid of them, then you were neurotic." This same neurologist told another PDer who was recovering that "There is no way a foot injury can affect your brain. I'm going to see about having your acupuncturist arrested for practicing medicine without a license."

¹ This same person decided to take my advice and pretend that she didn't have Parkinson's. After several days, she was feeling so good that she went to play tennis with a friend. She hadn't played tennis in years. She told me in an email that she loved the feeling of once again whacking the tennis ball with all her might and that she really enjoyed playing. However, while using some fancy footwork to return a tricky shot she tripped over her own foot and fell down. She stopped playing right then. Her email to me concluded by saying that falling down was proof that it wasn't safe to pretend that she didn't have Parkinson's. She needed to have Parkinson's in order to be safe.

In the past, these people had at least tried to use their formidable wills to conquer any anxious thoughts. But now some of them were plunged into powerful anxieties or depression, sometimes around the clock. Of course, increasing anxiety can be a symptom of Parkinson's disease. But some of these people, despite obvious indications of physical improvement, were flinging themselves headfirst into the anxiety pit and they just *knew* they could never climb out. What had happened to these previously confident people, with their early, mild cases of Parkinson's disease? When a few of these people tried taking low doses of Parkinson's medication to ease their difficulties, the medications produced dyskinesias within a matter of a few weeks (an adverse effect of the drugs that should only start after several *years*). Evidently, these people could no longer tolerate dopamine-enhancing drugs. They didn't actually have Parkinson's any more. What did they have?

Had we created a monster?

And more

Then, as time passed and our caseload grew, we noticed that a few more people were starting to behave as if they too were heading in the direction of partial recovery. Many cases were only mild: a person would recover from half a dozen symptoms of PD and then announce that he knew he couldn't actually get better, and from then on, he would be stagnant, getting neither better nor worse. What was going on?

Here is a typical email from a partially recovered PDer. The email arrived after we started telling our patients that we suspected a negative attitude component in cases of partial recovery:

"My foot injury is long since gone and I am nearly back to health. I am doing Tai Chi exercises every day. However, lately I am in an up-and-down state, not sure how else to describe it. Often it seems I am losing ground, motion-wise, but then I do something in less time than usual, like a sink full of dishes or preparing dinner.

"A few days ago I couldn't get my feet to cooperate driving the car (a standard shift), then yesterday, I thought, "I can do it!" and drove to get groceries with little trouble. Sometimes if I've been sitting awhile I get caught on the couch, but the next minute I'm fine or am walking about on the spongy cushions, closing the blind with flawless balance. I seem to be able to do what I decide I can do (I hear you chuckling), but the deciding has become the tricky part!

"I've been watching my thought patterns and was surprised, well, not that surprised [after talking with you], to note how often the thoughts spun off into disaster scenarios.

"Another thing I might add regarding wariness; one of my nicknames around here is "The Disaster Forecaster" which ought to be self-explanatory."

This patient was extremely intelligent. She was also a therapist. However, she could not see her own illogical and self-serving behaviors in the same clear light with which she viewed the quirks of others.

The main reason she felt that she deserved to have Parkinson's was that, when she was first diagnosed, she had immediately thought to herself, "Good. Now everyone else will have to do all the work for a change." She had immediately been consumed with unforgivable guilt over having such a thought. After many months in our program, as she began to experience symptoms of recovery, she felt guilty about it and realized that she "deserved" to have Parkinson's for life. This and other types of negative thinking are normal when a person is locked into sympathetic mode. However, at this time, we did not yet understand the mental component underlying Parkinson's; we could not understand how a person might be once again capable of movement but not able to emotionally avail himself of it.

Not yet understanding that the underlying problem was one of dissociation from the heart, we assumed that these people merely had ordinary anxiety-type problems. We hoped that maybe, if we helped them overcome their anxiety, their situational or intermittent problems would go away. After all, we could help them deal with their anxieties using standard anti-anxiety treatments based on Asian medicine. If that didn't work, there are dozens of techniques available these days for helping people overcome their buried, subconscious anxiety triggers. We would find something. No problem!

Our research continued but the solution evaded us.

We knew we needed to do more than figure out the problem; we needed to find a solution. Only by reversing the *all* the symptoms of Parkinson's, curing the whole problem in all or in nearly all PDers, could we convincingly state that we had found a consistently effective cure for Parkinson's disease. Some of our patients were distrustful of our hesitancy to make press announcements and "go public" with our findings. But we needed to figure out the hang-up in partial recovery before we announced a cure for Parkinson's.¹

¹ The editor of the *American Journal of Acupuncture*, before publishing my first article, told me that I needed to go slowly and not blazon our discoveries too early. I paraphrase her words, "You only get one chance. Your hypotheses will step on a lot of toes. If you go out with a theory that is too specific or too definite, and a person is able to find one small error in your wording or your phrasing, the whole body of your work will be dismissed and even ridiculed on the basis of that small misstep. You will never again be taken seriously. So go slowly."

She had been publishing the journal for twenty-six years. As I spoke with her on the phone prior to sending her my first article, she said that her heart was telling her this: the reason that she had founded the highly respected journal twenty-six years was to someday publish my research. She said that my findings had implications that went far beyond Parkinson's disease. Her kind words gave me hope for the Little Project and added to my sense that this project was a part of something more important than my curiosity. Her words also gave me a clear picture of just how careful I needed to be to not go off half-cocked.

When, four years into the project, we realized that medicated patients might be far worse off by recovering than they would be if they just stayed their course with their medications, I repeatedly said prayers of thanks to that editor's word of advice and caution. By going slowly, by not prematurely creating publicity for our ideas, we had saved countless medicated patients from potential harm.

Later, when we fully understood the significance of the mental/emotional component and the unique problems of people stuck in partial recovery (they usually cannot tolerate antiparkinson's medications if they are partially recovered, and so are left without treatment options if they fail to recover completely) we were able to better screen patients in terms of their interest in and potential ability regarding overhauling their personalities. Attempting recovery from a mental/emotional disorder is not for everyone: it can't be done merely because a spouse desires it or because a person doesn't want anyone to know that he is fallible: many people have wanted us to "cure" them extra quickly and even secretly so that no one would ever know that they had a "problem." These frightened people are not good candidates for recovery.

When we understood the significance of the dissociation response, we were again grateful that we had held off on prematurely making a big public splash about our ideas.

I would like to take this moment to thank that brilliant editor, B.G. Grace. In its day, the *American Journal of Acupuncture* was the most highly regarded of all the English language peer-reviewed acupuncture research journals. In the early 2000s, When the National Institute of Health first decided to include research on alternative and complementary medicine in its web-based open-to-the-public search engine, the *American Journal of Acupuncture* was the only acupuncture journal with academic standards rigorous enough to be included in their database.

B.G. Grace was thorough. I was amazed when, just before publication, she called me to question the page number that I had used in a footnote reference; she had found a copy of the edition I quoted and my page number was incorrect. She had personally verified my every footnote, right down to the page numbers in the specific edition! She had also, she confessed, spoken to a physics professor to have my statements about parallel electrical circuits confirmed.

Coming up next

The next chapters track the developments of our struggles with partially recovered PDeers from the beginning of the Little Project up until early 2008. We collected thousands of bits of data that confirm our hypotheses, but as I fly through the following chapters I will touch down at only a few crucial points, giving specific examples from only a few case studies.

I have chosen a chronological format for the next few chapters, and not just to keep the reader hanging in suspense. The chronological format helps me keep everything straight and, hopefully, a time line format will emphasize the ongoing nature of our work: this project is very young and is very much still a work in progress. Also, following a time line allows me to answer a few frequently asked questions about the formation of the Parkinson's Recovery Project and the Parkinson's Treatment Team.

Finally, my husband, who teaches writing at the local University and who has helped the project enormously by proof-reading my writing and by teaching me better writing skills, likes the time-line format. He says it adds a touch of "you are there."



She correctly anticipated the fuss that would ensue even from my small article in her journal. She told me that she would not run the article until I got an unlisted phone number and a post office box, thus creating a barrier between my personal life and my research. (These measures turned out to be inadequate, but were still helpful in keeping all but the most aggressive at bay.) She was very concerned about what flack might start to fly if and when my research ever hit the big news media. Antiparkinson's drugs are a multi-billion dollar industry. Parkinson's research on the already disproved dopamine-cell death model brings in megabucks in research grants to researchers. She wondered how the drug companies and western researchers might respond to my hypotheses.

She said to me, maybe jokingly, "They're going to have to kill you."