

“Through Thy grace the sudden shafts of wisdom will dispel error accumulations of countless centuries.”

- Paramahansa Yogananda's Whispers From Eternity

CHAPTER TWENTY-NINE

PURSUING ANSWERS: 1998 TO 2003 – THE YEARS WITH MEDICATED PATIENTS

1996-1997

After treating the old foot injuries of three people who happened to have Parkinson's-like symptoms, the PD symptoms went away. None of the three had ever taken antiparkinson's medications.

1998

As noted in chapter one, I did a pilot study, published an article, and started a website.

The website query asked if any one else could feel the same reversed Qi flow patterns that we'd felt in the Stomach channels of PDers. It also asked if anyone else had noticed a Qi problem at ST-42 that might suggest an unhealed injury at that point. The 40-page query was, at that time, addressed to acupuncturists. I was hoping for some sudden shafts of wisdom to show up in my email inbox.

Although FSR treatment can be performed by anyone and the treatment program does *not* usually require the use of acupuncture, acupuncturists are more experienced than most at feeling energy currents, and they understand the channel jargon I was using. So my queries were addressed using lingo of traditional Asian medicine. Almost immediately, responses started coming in, along with questions. The questions, their answers, and results from continuing research were added to the webpage.¹

As early as 1998, a few more PDers had recovered. My excitement over their recovery was tempered by my frustrations that these PDers were then told by their doctors that they must have been misdiagnosed.

1999

We noticed a mental/emotional shift that followed the foot healing.

Some PDers who recovered from Parkinson's disease experienced an unexpected flood of emotion and a different type of *mental* competency. Some noted changes in sensory perception.

¹ I was hesitant, at first to mention one of the strangest findings: many PDers had been cancer survivors, and that their cancer removal scars were on the Stomach or Large Intestine channels on the side of the body that had first showed symptoms of Parkinson's.

I shared this strangeness with my advisor, Dr. Fred Jones. I told him that it seemed very possible that backwards flowing or otherwise aberrant electrical currents might someday prove to be responsible for many types of cancers. He agreed that this might be a logical conclusion of our findings, and wouldn't that throw a wrench into the current paradigm for treating cancers of "no known origin." Then he said, laughing heartily, "They're going to have to kill you."

In some cases of sensory perception shift, colors were suddenly brighter, sounds were more pleasant.

In terms of mental competency, some found themselves, without even trying, imagining faces and figures in passing clouds or in the leaves of trees. Some found that, after nearly a lifetime of not being able to imagine or visualize positive or playful images, they could now create these mental images effortlessly.

As for emotions, many experienced “losing control:” dissolving into tears when confronted with situations that had previously been perceived as banal, such as the sight of a young child walking a small dog, or while watching the evening news’ “human interest story.” The strange thing was, they didn’t mind losing control even though they had been, in the past, somewhat reluctant to give free rein to their feelings.

In many cases, these emotions and abilities to visualize had not merely been missing during the few years since having been diagnosed with Parkinson’s disease; very often, the emotions and imaginings felt utterly new, as if they had not ever been felt during the PDer’s adult life. It was not uncommon for a recovering PDer, smiling through his sobs, to confess that he had never before been able to cry.

On the other hand, some PDers whose feet were restored to normal function and whose physiology showed reversal of Parkinson’s symptoms (return of smile and other facial muscles, correction of posture, return of blood flow and warmth to previously cold and inflexible feet, ability to sleep deeply, return of senses of taste, smell, etc.) did *not* experience any change in their perceptions or mental imagining abilities. Some of these partially recovered people became drastically *more* anxious or emotionally wary. And despite their physiological improvements, they sometimes had rapid worsening of movement inhibition and tremor.

As in the case of the PDer with the dentist phobia that I described in chapter three, I saw that *some* of the people in this latter group had no Parkinson’s symptoms – as long as no emotional issues loomed on the horizon. However, after experiencing intermittent periods of days or even weeks with no PD symptoms, these people could suddenly collapse into complete paralysis or teeth rattling, body-wide tremor if an unexpected call was made on their fears and/or emotions. Others dove into a complete free-fall of anxiety, panic, and immobility with no periods of relief.

The people who could move normally when they were in a good mood clearly did *not* have a neurotransmitter deficiency. But their ability to initiate the types of mental processes, the types of thoughts, which *release* neurotransmitters for correct motor function had become extraordinarily mood dependent.

We had no idea what was at the root of this weird behavior, but there were distinct differences between those who recovered easily and those who slipped into partial recovery. Those who recovered easily experienced a major shift towards positive imagining and capacity for feeling. Those who became stuck in partial recovery became suddenly *much less* capable of positive imagining and feeling.

So a mental/emotional component was hypothesized and added to the foot injury/electrical disarray hypothesis. The emotional component was evidently not present to the

same degree *or direction* (inclined towards getting better or inclined towards getting worse) in all PDers.

We spent at least an hour a week talking with each PDer in our program. We probed their personalities and life histories and, in many cases, interviewed their spouses. As PDers recovered or got stuck in partial recovery, we looked for correlations between their emotional posture and their rate of recovery.

In addition to the already mentioned differences between people who recovered easily and those that got stuck in partial recovery, we noticed something else: the professional musicians recovered very easily and quickly. We had five professional musicians with Parkinson's, including a composer and a conductor. They all recovered very quickly, with no emotional glitches.

Stymied

The people who were partially recovered were frustrated, and so were we. It was clear that the partially recovered PDers had some emotional rigidity, but we couldn't be sure how emotion could contribute to Parkinson's. Also, if emotions did contribute to Parkinson's, did that mean that the foot theory was incorrect? (At this point, the term "psychogenic parkinsonism" had not yet been coined.) Did this mean that the reversed Qi problem that we'd seen in all the PDers in our program wasn't actually the cause of Parkinson's disease?

True, at this point in the program, we had seen *some* people recover from Parkinson's disease simply by having the foot injury addressed. But we clearly had not yet figured out the way to help people whose physical symptoms were melting away in response to foot-injury therapy but whose minds were now and then being pulled, as if by an intermittent or constant tractor beam, into paralyzing negative emotions. Since we did not have a way to reverse this mental condition, we could not *prove* anything about its relationship to the accompanying movement initiation problems – problems that looked, in some cases, like *accelerated* symptoms of Parkinson's disease. Even though many of these partially recovered PDers had many improvements in the physical condition of their bodies, that didn't count for much if they couldn't consistently move, or if their tremor became an intermittent monster.

We certainly couldn't say that we'd found a one-size-fits-all treatment for Parkinson's.

GROWTH OF THE INQUIRY

In one year, the little Internet inquiry grew from forty pages to nearly ninety. I kept adding pages of writing, describing the treatment therapy that I was using and noting recovery symptoms that seemed to support the original hypothesis. The number of emails coming my way from PDers and acupuncturists continued to grow.

A majority of the emails from PDers were about problems with their medications. At that point in time, a local neurologist had laughingly assured my patients that, if they ever recovered, they could just stop taking the medications at that time. No problem.

I naively assumed that the doc was correct, and was still working with medicated PDers.

Creation of a non-profit organization

I was still scratching my head over the channel theory portion of the problem when some forward-looking friends got after me to form a non-profit organization to pay for the website. A PDer from San Francisco whom I'd met only once spearheaded the formation of the non-profit.

He moved back to Chicago and I lost touch, so I can't give him due credit by name. I'm sorry. He was a real live wire. He came up with the name "Parkinson's Recovery Project." He arranged for his lawyer son-in-law to do the incorporation paperwork for free.

By the end of 1999, the Parkinson's Recovery Project had, and still has, tax-exempt status with the United States IRS and can accept tax-deductible donations.

The Parkinson's Recovery Project's mission is educational and charitable. The organization provides the vehicle by which we can keep our publications and updates available, for free download, on the Internet.¹

2000

The "Other" side, the injured side of the body

Numbness and poor proprioception

Many PDers had poor proprioceptive awareness of the injured foot. (Proprioception is the ability to know where a body part is even if the eyes are closed.) Many a PDer, when sliding a foot into his trousers, can't really be sure where his foot is from the time the foot is seen entering the cloth until the foot is seen coming out the bottom of the pant leg. Sometimes, this decrease in proprioception extends to the hand and arm on the injured side of the body. As one PDer explained it, "I don't have eyes on my hands anymore; I can't see where they are unless I'm looking at them." In fact, it was only his *right* hand that couldn't "see" when he was trying to get his arm through his sleeve. He was always able to know where his left hand was. His PD had first shown up on the right side. (Eventually, as the Parkinson's becomes bilateral, the loss of proprioception extends, somewhat, to the healthier side.)

Also, even though many PDers had a high level of numbness in certain areas on the injured foot, it took us several years to realize that PDers rarely knew that they were numb. I first discovered the alarming level of foot numbness when I tried to get some Qi moving through the foot by needling the famously sensitive SP-3, near the ball of the foot. After noticing that all the

¹ Unsolicited donations help to cover the expenses of keeping the website running, hiring a web professional once in a while to make the website updates, and paying for the mailbox fees, the odds-and-ends office supplies, a small computer and printer and a desktop photocopier. It's a shoestring operation, but it's a beautiful, optimistic shoestring: it does the job. Hopefully, someday when funds allow, we can hire someone to do videotaping of our patients and our treatment techniques. These videos could be made into an instructional CD that could accompany future editions of this book.

Our greatest dream is to get adequate funding to pay for before-and-after PET scan analysis of at least twenty of our PD patients. These scans may provide a hint of objective confirmation of what appears to be a permanent reversal of all Parkinson's symptoms in our fully recovered patients. Such a project would require hundreds of thousands of dollars.

At present (2006), our only funding is unsolicited donations from individuals and the donations of the PD Team, which gives a percentage of its fees to the non-profit. We usually rack up a few thousand dollars a year: just enough to cover costs. A few unpaid volunteer acupuncturists, including myself, do all of the office, correspondence, and collaborative research work. I write the books in my "spare time" and publish them for free download on the Internet.

All of us involved in the Project feel honored to be doing this work. It sounds corny, but the Little Project is a labor of love.

PDers who still had foot injuries were nearly numb at this point, I tested many PDers for numbness.¹

The numbness was nearly always worse on the side that first showed symptoms of Parkinson's. Needling the injured foot usually got a poor response, but needling the healthy foot at this point very often got a lively response. By this means, we were able to determine that most PDers have some degree of numbness on the injured-foot side, even though they almost always insist, at first, that their feet have perfectly normal sensitivity.

The numbness and the poor proprioception on the injured foot side were not *too* surprising, given the foot injury and the blocked flow of Qi. What was surprising was what we discovered next: the mental blocking of the *awareness* of the *existence* of whichever side of the body first showed symptoms of Parkinson's.

Diminished mental awareness of the existence of the injured side, the “other” side

Most of our PD patients seemed unable to fully cognize the *existence* of whichever side of their body had first manifested symptoms of Parkinson's. They had less mental awareness of the existence of that side of the body.

For example, if a PDer was asked to imagine light in both sides of the body, the side that had first manifested PD symptoms was considerably dimmer – if there was any light at all. The injured foot, often, was mentally inaccessible and/or could not light up at all. More strangely, if a PDer had injured himself on some other part of his body, long ago, on the same side of the body that had the injured foot, he could not recall which side of the body had been injured, even if the scar made the location obvious. However, he might have normal recall of the locations of any injuries that had occurred on the healthy (non foot-injury side) of his body.

For that matter, many PDers had trouble relating the word “left” or “right” to the injured left or right side of the body. Their healthy side of the body could be identified as being the left side or the right side. The injured side was usually thought of as “the other side.” This is a bit tricky to explain. I will give an example.

A Pledge of Allegiance example

One PDer whose PD started on the right side of her body when she was in her late forties told us that, since she was six years old and had to say the classroom's daily Pledge of Allegiance to the flag while holding her right hand over her heart, she always had to perform the

¹ The following example may further illustrate the PDer's inability to feel parts of his own body. I had one PDer with a grossly displaced set of ankle bones on her right foot. She had never noticed any pain in the ankle. In fact, she had been skiing on this impossible ankle for years.

Week after week, I held her ankle. After each FSR session on her ankle, I would ask her, “How does your ankle feel now?”

Her reply was always the same: “How should I know?”

I kept trying to explain to her that she, and no one else, should and could know how her own ankle felt, but she never understood what I was talking about. And then, after more than a year of once-a-week sessions, her ankle relaxed deeply and the bones slid back into place. The next morning, this PDer called me at five a.m. on my home phone.

“I knew you'd want me to call any hour of the day or night with such big news,” she said, inaccurately. “I woke up this morning and my ankle is swollen to three times its normal size. It's black and blue; it looks just horrible. I can't even walk on it. But the amazing thing is I can really feel it; it hurts like hell. I knew you'd want to know, I just knew you'd be thrilled. I finally understand what you've been asking about when you ask me how my ankle feels. I'm feeling my ankle!” Even after the ankle healed, she continued to be able to feel the existence of her ankle.

following mental steps: She would look at or mentally acknowledge her left hand. She was certain that her left hand was not the hand that should be used for the Pledge, so she would place her “other hand” over her heart. She was not stupid. She was an honor student throughout school, and she was right-handed. She had excellent motor skills and had enjoyed sports. However, she realized during our work together that she was always momentarily uncertain about which hand to use if someone asked her specifically to use her right hand, or which way to turn if she was told to “turn right.”

She also told me that, despite her experiences with driving in both the US and in England, she had never been able to understand what was meant by the phrase, “In the US, they drive on the right side of the road.” “After all,” she explained to me, “a road is a road. A road doesn’t have a right side, does it? Right relative to what?”

It wasn’t until she recovered from Parkinson’s that she understood what was meant by the “right side of the road.” After recovering, she also realized that she had never actually acknowledged the right side of her face when she looked in a mirror.

“Which side did the Parkinson’s symptoms show up on?”

Surprisingly, many people whose Parkinson’s has slowly, after a few years, become somewhat bilateral cannot even state with certainty which side of their body first manifested symptoms. They may know for certain that their PD symptoms did *not* appear first on the (relatively) healthier side, but they can’t be sure if the symptoms *did* appear first on the “other” side. These people are not stupid. They are extremely aware of their physical problems. They just can’t say on which side of the body the symptoms started.

“Which ankle?”

For example, if a PDer said that, in the past, he frequently twisted his ankles, I asked him, “Which ankle, the left one or the right one, did you usually twist?” It was not uncommon for the person to answer: “I don’t know. Maybe both. Probably both.”

If I have already observed that his PD symptoms are primarily on, say, the *right* side of his body, I will follow his “I don’t know” with a pointed question: “Do you ever sprain your *left* ankle?” Very often, this specific question will make the person pause a moment, stare at the healthy ankle, and then reply, “No.” In fact, he may continue, he’s pretty sure he’s *never* sprained that left ankle. He may even state, “No, that’s my good ankle, I don’t sprain that one.” From there, I can ask him if he usually sprains his right ankle. In response to this side-specific question, he will usually answer yet again that *he doesn’t know* which side it is that gets sprained, but he does know that he sprains his ankles a lot. And it’s not the left ankle; possibly, he might conclude, it’s the “other” one.

This non-awareness happens even with memorable, terrible injuries or broken bones. Many times a PDer has told me he recalls a *severe* ankle injury, one that kept him on crutches for weeks. If I ask, “Was it on the (name of whichever side the PD first manifested) ankle?” He may answer that he just can’t remember which ankle it was. Then I change my question and ask if it was on his (name of *uninjured* side) ankle. “Oh, no, my (name of *uninjured* side) ankle has always been fine, that’s the strong one.” He may have a *strong* memory of a severe injury, but he may be vague as to location; it’s as if the location of the injury was in a place that, possibly, because of diminished awareness of that side of his body, does not fully exist.

This very common and powerful demonstration of mental disassociation from the injured side of the body was often repeated in further inquiries with the same patient. After enough questioning, the PDer may start to understand that he has two kinds of awarenesses for the two sides of his body: he has the healthy side, which he can identify with the word “left” or “right,” and he has the side on which PD symptoms first appeared, a side that he might call the “other” side. The PDer doesn’t know much about the “other” side; when the “other” side gets injured, he might only know that he’s been injured – but as soon as the overt symptoms of the injury clear up and the visual or pain cues are gone, he may not be able to conjure up a clear memory of the location, especially with regard to *which side* of the body had the problem.

Yet another example of the “other” side situation

When working with a new PD patient, I need to determine for certain whether or not the person was correctly diagnosed, whether or not he actually has Parkinson’s disease. I like to ascertain on which side of his body the PD symptoms first appeared so that I know where to start feeling for the Qi disorder and where to start with the Tui Na therapy. I often employ a simple test.

I start this test by asking the PDer a few distracting questions about whether or not he has asthma or digestive problems, and then, if I suspect the Parkinson’s disease started, for purpose of example, on his *right* side, I will, without warning, calmly ask the patient to raise his *right* arm. If his Parkinson’s did start on the right, he will usually perform the following response: he will pause, then he will look at his *left* arm or move his head slightly to the *left*, as if he is thinking about his left arm. He will mentally acknowledge that the left arm is the left arm, and therefore not the right-side arm, and then, by process of elimination, conclude that the arm on the other side of the body must be the right arm. After a telling head turn (to the left) and a pause, he will then raise the arm that is *not on the left* side of his body.

The PDer’s mental process of first ascertaining that the left arm is an arm, but somehow not the arm I am asking about, was often quite visible via his body language.

Every once in a great while, the patient would even *raise* the left arm in immediate response to the instruction: “Please raise your right arm.” He might then quickly add something such as, “Oops, you said ‘right, didn’t you,” after which, he would lower his incorrect arm and put the correct arm in the upright position.

After this, even if the PDer doesn’t know which side his symptoms started on, at least *I* have a pretty good idea.

By the way, to check the validity of this testing method, I sometimes asked a PDer to raise the arm on his healthy side, instead of the PD side. When I asked about the healthy side, PDer’s didn’t pause, didn’t look at the opposite side. They simply raised the correct arm. Of course, if I then wanted to also check his PD-side response to this test, I had wait at least ten minutes to catch him unawares.

Clumsiness of the “other” side

PDer’s have often injured themselves repeatedly on the side of the body where symptoms first appeared, on their “other” side. Because they do not have good body awareness and self-perception on that other side of the body, that other side might often hit the doorframe when going through a door. That other side might have the elbow that always bangs into the edge of the table. That other side may have the hip that bumps the furniture while crossing the room.

Because there is limited mental awareness of the existence, let alone the size and location, of that other side, that other side of the body is often the “clumsy” side. However, if you ask the PDer which side of his body is the clumsy side, he will say that he doesn’t know, or that he doesn’t think that one side is clumsier than the other. Only when you point out that his assortment of scars and stitches and the various injuries that he *does* know about are certainly not on his “good” side might he realize that he doesn’t have whole-body clumsiness, but has, in fact, one-sided clumsiness.

We noticed that people who recovered easily also regained “other side” awareness easily. The ones who were getting stuck in partial recovery usually had “other sides” that remained elusive, even non-existent to their closed eyes, despite healing of the foot injury and the resumption of correct Qi flow!

When we first discovered the “other” side unawareness in PDers, it was all very interesting, if not downright bizarre. In one person, we might have dismissed it as a personality quirk. When nearly all PDers manifested some level of unawareness of the “other” side, the PD side, it seemed significant. Of course, we were completely clueless about the best way to approach it. We tried dozens of techniques and exercises that we hoped might restore awareness to the “other” side.

None of them worked.

The expanding website

The number of pages of information on the website continued to grow. However, it was mostly a hodgepodge of short case studies and ideas, posted in four major spurts of additions and revisions. Each flurry of writings incorporated the previous bits but added new material, mostly in the form of Frequently Asked Questions and Answers. I referred to these updates as “editions.” In late 2000, I assembled the material together into more of a book format. This 350-page version of the growing body of material was titled *Recovery From Parkinson’s: A Practitioner’s Handbook*. This book was posted on our website and was available for free downloading.

This 5th edition of our research piled together all of our writings on the subject up to 2000. This book had a chapter format and some donated, professional artwork. It had no index and we still had many unanswered questions. This edition was the first one to be addressed to the layman as a How-To-Treat handbook rather than as a query to professional health practitioners.

2001

Inability to visualize self or scenarios with positive outcomes

We were beginning to realize that partially recovered PDers had more than just anxiety problems and an inability to acknowledge the injured side of their bodies. Their capacities for imagination seemed to be stuck in “Negativity or Nothing” mode. We discovered this when we tried to get partially recovered PDers to help their own healing process via visualization.

In part because we realized that these people often couldn’t cognize the injured side of the body, and partly because visualization is supposed to be a good healing tool, we had started asking PDers to visualize light in their injured feet. As we kept plugging away at this task, we came upon another PDer commonality: an aversion to and/or difficulty with visualization of light in the injured area.

Darkness inside

In the early days of our research, we did not ask patients to be actively involved in the treatments that we were doing on their foot injuries. This was because, as researchers, we wanted to know the extent to which the treatment could be effective whether or not the patient's consciousness was involved.

In the earliest stages of our project several patients had recovered – so far as we knew – from *passive* acceptance of Tui Na therapy. These earliest recoverers had not been actively involved in any sort of mentally therapeutic processes during the treatments– at least none that we knew of. When we started trying to establish the simplest common denominator for effective treatment, we did not want to introduce the variable of patient involvement.

However, after we realized with a certainty that most patients' foot injury could eventually respond to Yin Tui Na whether they were awake or sleeping during the treatment session, we started experimenting with having patients becoming involved in the process. We hoped that patient involvement might accelerate the foot-healing process.

It is not uncommon in physical therapy work for a therapist to ask the patient to mentally focus on the area being treated. This mental focus can be provided by many means, including imagining the breath flowing into the area, imagining the area being filled with light, or even mentally talking to the area with reassuring tones.

After a few years of working with PDers, during which *some* PDers had completely recovered with no specific, pointed mental involvement, but others were stuck in partial recovery, we decided to add a new component: asking PDers to participate in their own recovery process. While performing FSR therapy on our PD patients, we asked them to try to visualize light, energy, breath, or some form of vitality in the areas that we were working on.

The responses that we got from most of the PDers – people of strong will power and determination – were decidedly unexpected. In a majority of cases, we were told things like “I've never been able to do visualizations and I don't want to,” “I can't make light go into my foot and that's that,” “The foot area is murkier than the rest of the leg and I can't change it,” or “Visualization is not a part of my personality and I'm not interested in changing,” and even “Visualization is a sin.”

Despite verbal encouragement and repeated attempts at lighting up the foot or body part in question, most PDers who were willing to at least give it a try usually found that they were simply unable to imagine light in an injured area. Benton's case study makes a good example of this.

Benton

I was holding the ankle of Benton, a PDer. I had started by holding his leg at the knee and had slowly worked my way down to the ankle. I stopped at the ankle. Not only was there no Qi flowing in the ankle, it felt like the ankle of a corpse. That ankle was stony, cold, and absolutely unresponsive. It felt to my hands as if there was a big, black hole in the middle of his ankle. The hole was about two inches high and an inch and a half across.

I asked Benton to mentally picture some light in his left ankle. He tried for about fifteen seconds and then said he couldn't picture his left ankle. He couldn't even picture his own left leg.

Benton was a professor of anatomy. He had written a book on anatomy. The book was full of pictures. I asked him to mentally imagine a picture of a left ankle from his anatomy book. He tried, but he still couldn't even picture a left leg, let alone an ankle.

I asked him to just imagine a left lower leg and ankle floating in space, not related to him in any way. He couldn't do it.

Meanwhile, I was still holding his ankle. It felt like there was a big black hole in the middle of his ankle.

Benton's wife was sitting on my office couch, watching us. I asked Benton to mentally picture his wife's left leg. He couldn't do it. He could imagine her from the face down to the knees, but his mental picture of her stopped at the knees.

I asked him to try to think about his daughter. Could he picture her playing, or running, anything that had legs involved? He tried, but his mental images of her all ended at her knee. Meanwhile, I was marveling at what felt like a big, black hole in the middle of his ankle.

I asked him if there was anyone in the world whom he might be able to think of as having a leg and an ankle.

Benton was getting a frustrated. He was an anatomy professor, for goodness' sake! He didn't want to talk about it any more. I stopped talking to him and silently continued holding his ankle. It still felt as if there was a big, black hole in the middle of his ankle, but I hadn't mentioned that to Benton. I didn't want him to know about the big black hole, but I did hope that he could figure out how to see it in his mind's eye so that he could start healing it: **one can't heal what one doesn't know exists.**

Finally, after about five minutes, he opened his eyes and said, "I've just thought of someone whose feet I just know I'll be able to picture. I have been sitting at my guru's feet once a week for twenty five years." (Benton belonged to a spiritual community in New York.)

Benton closed his eyes again. His voice softened, and he continued, "I can picture my guru's feet. I have spent so many hours sitting at my guru's feet; I can picture them perfectly. I can see them when I close my eyes." He started describing to me what they looked like as he conjured up the mental picture. "They are soft, they are supple, they are so perfect. His feet are golden brown, I can see them perfectly...and (Benton's voice filled with horror), *there's a big black hole in the middle of his ankle!*"

Not just the feet

Some PDerS were unable to mentally observe, fill with light, or otherwise acknowledge other injured body parts, not just the injured foot. I recall one PDer whose mental image of his own body showed the lungs being filled with blackness. When we talked about this, he recalled that when he was five years old, he had been sick in hospital with pneumonia and given up for lost. The priest had been called to the hospital to administer last rites.

Now, forty years later, and with no conscious worries about his lungs, he could not even imagine a single ray of light penetrating the thick murkiness that appeared when he tried to visualize his lungs. Also, as he tried this exercise, he was aware of fear in his heart that was associated with both this imagined blackness of the lungs and his PD tremor.

Very often, a PDer can imagine light flooding down a limb until it comes to the part of the limb that was injured long ago *or* it arrives at a body part that is no longer functional due to encroaching Parkinson's. Therefore, many people with no history of hand injury, but with a hand that has recently started trembling, may find that they can only imagine light halfway down the arm. As their mental searchlight nears the area of the tremor, an area of relatively new fear (fear

due to tremor and loss of physical control), they find that they cannot penetrate the Stygian darkness.¹

All excited over a dead-end

When we realized the extent of PDer's inability to visualize, we wondered if we'd stumbled on the answer to the partial recovery problems. Were these people anxious *because* they were mentally missing a body part? It seemed plausible enough that a person might have anxiety about using a body part that didn't exist. Maybe, on some deep down level, the missing body part was itself the source of the anxiety.

If this was the case, we could gently, slowly, help these people to acknowledge the missing body part, and the anxiety would go away! Hooray!

But fixing the visualization turned out to be problematic. Even if we struggled for an hour or two each week, helping the person with word and deed to create a mental image of light in his "off limits" area, the following week the area would be sealed off even more tightly. If we asked the PDer to practice during the week the visualization exercises we did in session, they usually reported, during the next week's session, that they had been unable to do it on their own.

Something else was going on that was causing these areas to be mentally inaccessible. Merely opening them up wasn't enough: they usually shut right up again *even harder* within a few hours, or certainly within a day or two.

It was curious that, during the moments of visualization, recovering PDers could often move much better than usual. However, the improvement in movement subsided as soon as the day came to a close, or sometimes as soon as the person left the treatment office.

Techniques that didn't work

After we realized that many PD patients were unable to acknowledge certain body parts, we set to work on finding ways to clear away their mental blockades. For over two years, we worked on asking PDers with "blacked out" areas to enter into their forbidden zones via an assortment of loving, friendly, self-accepting methods. We had them visualizing light, breathing into the area, asking their heart to heal their feet, imagining the area expanding or radiating with vigor – you name it. We tried all sorts of techniques.²

¹ We had to wonder whether or not the inability to imagine light in PD-damaged areas (areas of atrophy or rigidity from aberrant Qi flow) came about because of the cellular damage from wrong flowing Qi or if, conversely, that body part became more susceptible to aberrant Qi flow because the PDer was slowly, subconsciously adding body parts to his collection of off-limits, unknowable, unlightable body areas. Our findings now suggest that it's some of both.

It appears that events such as tremor are able to begin when a body part, due to disarray of Qi, finally severs its mental connection. In the case of tremor, when the atrophy in a limb becomes great enough and the disassociation becomes severe enough, the limb begins to move in time with the long-standing internal tremor. Experiments in which some PDers have been able to successfully integrate a "detached" body part back into the fold show that the tremor in that body part can cease so long as the mind maintains conscious awareness of that body part. However, if an internal tremor is still lodged in the brain, the tremor will return as soon as the consciousness reverts back to "normal."

² Because I am often asked specifically about NET and EFT (Emotional Freedom Technique), I will note that we did have a number of PDers try these techniques repeatedly using various practitioners. The results ranged from fleeting to zero. These techniques help a person get past certain feelings that were creating emotional blockages or pain. But as we were to learn later, PDers who had dissociated from their hearts didn't feel that they

Most PDers spent hours struggling to do these techniques. Most of them hated the processes or were even repulsed by them and refused to do them. Others really tried their best at it but their hearts weren't in it, so to speak. Even those who were able to finally fill an area with light, talk to their injured feet or insert images of healing icons into their off-limit places found that these exercises were pretty much a waste of time; within a matter of hours, the dark places would be inaccessible once again or the darkness would be discovered lurking somewhere else nearby, having migrated. Some people struggled mightily to get light into an area and were somewhat successful. However, we soon realized that, in most cases, these people had merely created an imaginary layer of light and sweetness over the dark areas.¹

We were no better off than before. This discovery of inability to visualize seemed, at the time, like a dead end.

The Parkinson's Treatment Team

Continuing on with the chronology, about this time a group of Santa Cruz (California) acupuncturists, students, and I formed what later became the PD Treatment and Research Team, also known as the PD Team.

One purpose of the team is to provide, for a moderate fee, a week or two of treatments for PDers who want to travel to Santa Cruz to briefly experience first-hand the protocols we use. A

had problematic feelings or blockages; they didn't feel much of anything. And as for the simple *heart*-calming techniques of the Heartmath Institute, they were completely incomprehensible to the PDers who on whom we tried them. PDers couldn't even figure out how to follow the directions. Too much visualization was involved.

¹ Because the reader, especially if he has Parkinson's, may be saying to himself right about now that these mind-body disassociations must only be problems for "really messed up people" and therefore will not apply to him, I want to share one quick experience with a PDer's inability to perceive light in her mildly tremoring arm.

One sunny afternoon, I was describing the inability to mentally visualize injured body parts with a PDer whom I had just met at a reception. She had been working with an FSR practitioner for a few months and felt she was making some progress. I wanted to let her know about some of our latest findings, especially the significance of what we were calling at that time "a mind-body disassociation."

She told me, in no uncertain terms, that if a person can visualize the healthy side of his body but not the PD side, then that person must be crazy, probably even psychotic. "That's completely ridiculous," she sneered. She then told me, with a bit of a swagger, that if anyone could recover from Parkinson's disease, it would be her, "...because I'm a Buddhist. I meditate." She was blond haired, blue eyed, and her native-California accent was bold with certainty. She had in full measure that self-confidence part of the Parkinson's personality that assured her that she could master any difficulty if she really put her oh-so-forceful mind to it.

So I asked her if she could imagine light glowing inside her nose. She paused, crossed her eyes, closed her eyes, and mentally focused on her nose. "Yes, of course I can imagine my nose full of light. I meditate. I'm a Buddhist, like I said."

"That's fine, that's great," I replied. I had noticed that her right hand tremored but not her left.

"Can you picture light in your left arm?"

There was a pause while she closed her eyes and focused on imagining light in her left arm. Then she declared, with faint exasperation, "Of course I can. I meditate every day."

So then I asked her if she could do the same with the right arm. She assured me she could, and then closed her eyes. A few seconds passed, and then a few more. After a longish pause, with her eyes still closed, she announced, "Well, I can tell I have an arm." I asked if she could imagine light in her arm. There was a longer silence.

"Well, it's harder than the left, but I can do it." She remained very still, with her eyes still closed. Her breathing rate slowed, as if she was concentrating deeply. Then she said, very slowly, and with a voice that had lost much of its brashness, "I can't see anything. There's nothing there. There's nothing but darkness."

more important function of the Team is that we include, with the treatments, free training for the patients' accompanying health practitioners.¹

Another very important function of the Team is our weekly Team meetings. We discuss the visiting cases and our own difficult cases from our private practices. We plan treatment strategies and work on honing, simplifying, and translating into common English our explanations of the treatment principles we're using. Visiting practitioners can attend these meetings and learn about the individualized way we approach each case.

The goal of these meetings and the treatments we provide is not to cure as many people in the world as possible: we are too few, and people with Parkinson's are too many. Our goal is this: by experimenting with variations on treatment techniques, by experimenting with ways of training the visiting practitioner, by finding the best ways of communicating what we know about the cause and treatment of Parkinson's, by understanding to the fullest the core underlying cause of Parkinson's *and* the sources of its individual, seemingly infinite, variations, we hope to learn as much as possible and share our findings with as many people as possible – via our free web-publications.

Our hope is that this book will allow the greatest number of concerned friends or health practitioners to become self-trained in the simple art of Yin Tui Na and the techniques we use for helping PDers overcome their mental/emotional blockages. In this way, the greatest number of people can be treated.

Our goal is *not* immediately to challenge and overthrow the way that western doctors understand and treat Parkinson's. We understand that changing any medical treatment paradigm takes at least twenty years: long enough for the medical students of today who stumble across radically new research to become the med-school teachers of tomorrow. But for people who have Parkinson's disease today, twenty years is too long to wait. So, although challenging the current medical paradigm is not our goal, we do feel that those who are looking for alternatives should be able to avail themselves of our findings. Therefore, our approach is to make freely available, via the Internet, research that PDers themselves can use today.²

¹ For more information about the PD Team, please visit the website at www.pdtreatment.com

² Dr. Fred Jones, in his continuing role as advisor to the project, assured me that, because our work is so counter to prevailing thinking, and because there are no definitive tests for Parkinson's disease, all of our recovered patients will be considered, by western doctors, to have been misdiagnosed. Therefore, we should not promote any one patient or any ten patients as being "proof" of our findings. As he pointed out, "All it would take is one doctor, a doctor who's never even met you or the PD patient, broadcasting to the media that your patient was obviously misdiagnosed and the world will take his word against yours – every time.

As mentioned earlier, Dr. Jones advised that, although the single-case study is a valid method for reporting one person's response, we must, to change a paradigm, rely on large numbers: when we have a thousand people who have recovered, we can make a strong case for our findings. Until then, every person who recovers will necessarily be considered, from a western standpoint, as an anomaly: a case of misdiagnosis.

The "large numbers" method is a not uncommon approach to changing a paradigm. When Pasteur was being widely ridiculed for his germ and immunization theories, his first victories against infection were considered circumstantial. It was not until he inoculated an entire flock of sheep that his theories caught on. His inoculated sheep grazed in the same infested pasture as a non-inoculated flock. *All* the non-inoculated died. *All* the inoculated remained healthy or suffered only mild, passing symptoms of the disease. Even this did not convince everyone – especially not the doctors – but farmers began lining up for the inoculations. After that, the doctors fell in line whether they believed or not.

Large numbers and patient demand are what change paradigms, not excellent logic or proof on a limited scale. The other thing that changes treatment paradigms is, of course, money: advertising a product whether it works or not can quickly change a paradigm. But there is no product of profit to be made for anyone in our findings: the

The clinic: 1999 through 2002

The PD Team was an outgrowth of the free Parkinson's clinic that I started up in Santa Cruz.

From spring of 1999 to December, 2002, I ran a free Parkinson's treatment clinic at the acupuncture college where I teach. At this clinic, student interns from the college provided free treatments for local people with Parkinson's. The clinic also hosted one guest per week from outside of our local area. Guests came from around the world to present their Parkinson's symptoms to the class and be treated by student interns.

The clinic patients, our private patients, and other patients from afar with whom we worked closely, if intermittently, were the basis of a four-year observation project in which, without planning to, we came to understand the workings of the Parkinson's medications in a much more intimate and accurate way than *any* prior scientific study.¹

We kept close observations (at least an hour per week of interview in our offices – and many patients also kept logs and charts) on over a hundred patients who were being treated, of whom over 65% were medicated. We discovered alarming, in a few cases, fatal, differences in the recovery patterns of medicated patients when compared to unmedicated patients.

This project culminated in our decision to *not* work with PDers who had ever used any dopamine-enhancing medications for a period longer than three weeks. The results of this project led to a book, published in 2003, which describes in extreme detail our discoveries about the workings of the various anti-parkinson's medications.²

In late 2002, we established a new policy: we would not perform, or provide informational support for, recovery therapy on medicated patients. I thought at the time that the new policy was very clear. I thought that it explained the unreasonable risks involved in recovery

treatment is easy and can be done by anyone. The fact that there is no big money to be made from our findings will probably slow, rather than speed, any paradigm shift in the treatment of Parkinson's disease. On the other hand, PDers tend to be self-starters, so possibly they will simply leave the MDs behind on this one.

In order to promote our findings, we assume that we must work at the grassroots level until a thousand or more PDers have recovered or until western doctors agree on a definitive diagnosis for Parkinson's. If and when they have such a thing, we should be able to prove that we are reversing PD by showing a reversal of the test parameters in those PDers who recover. (In case you are wondering, PET scans, though helpful, are not yet accepted as definitive by the medical community. The results of PET scans often conflict with doctors' diagnoses of Parkinson's disease.) And so, as yet unaligned with the western medical community, we continue to work towards our goal: doing research and providing information so that the most people can be healed in the least time.

¹ Based on a new understanding of how these drugs work in the various brain areas, we became able to predict exactly how and when the various side-effects and On-Off patterns would be triggered in any PDer taking the drugs. Prior to our new hypothesis that the drugs were uptaken and released in three different brain areas at three different rates, the onset and wear-off timings of the drugs and their side effects had always been considered unpredictable, especially when changing dosages. Using our new hypotheses, we were able to make accurate predictions several weeks in advance about the upcoming changes in On-Off timings and side effects of the drugs in response to changes in dosage – predictions which were then borne out by the un-notified PDers.

² Walton-Hadlock, JL, *Medications of Parkinson's Disease or Once Upon A Pill: patient experiences with dopamine-enhancing drugs and supplements*. Parkinson's Recovery Project, 2003. 638 pages. Available for free download at www.pdrecovery.org.

of PDerS who had ever used dopamine-enhancing medications for more than a few weeks: PDerS in whom drug-induced brain changes had most likely already occurred.¹

However, despite my strong warnings, many PDerS who had been taking medications for a long time chose to believe that what I actually meant in my book was that we *would* help them if they *stopped* taking their medications.

To counter this wrong thinking, we placed a draconian statement on our website in 2005 stating in no uncertain terms that we would not work with any person who had *ever* taken dopamine-enhancing medications for more than three weeks.²

This policy change marked a major step forward in our research. Up until late 2002, we'd spent most of our time dealing with the horrors that developed as medicated PDerS found out the hard way what we meant by "hideously addictive," as in "After the foot injury heals, the medications may, within 72 hours, become hideously addictive. Even if a person has already stopped taking the medications, the unaccustomed physical and emotional pains of recovery may cause the PDer to look back with longing at the medications. Thinking that, because he got off the drugs easily the first time, he can start or stop them again without a problem, he may find

¹ Putting it very simply, the risk is this: after a person has brain damage from the drugs, he may always have symptoms of drug-induced parkinsonism – and there is no cure at this time for this syndrome. This syndrome is a degenerative one and may not be obvious in the early stages. Eventually, a person with this drug-induced parkinsonism may need to take dopamine-enhancing drugs to ameliorate his condition. However, the drugs are much more dangerous, more addictive, and sometimes even deadly in a person who does *not* have *idiopathic* Parkinson's disease.

The drugs can be somewhat benign *if* dosed correctly *if* a person actually has idiopathic Parkinson's disease. The drugs are quite dangerous in a person who does *not* have *idiopathic* PD, **even if he does have drug-induced parkinsonism**. A person who *does* have idiopathic PD and who has been using the drugs for more than a few weeks may have already sustained some drug-induced brain damage. Therefore, he may need some amount of drug help down the road to help with his degenerative, steadily worsening *drug-induced* parkinsonism. These drugs will be less dangerous if he still has idiopathic PD. A drug-using PDer may therefore be better off in the long run – at lower risk for drug-induced mental illness or drug-induced agonies – if he maintains the brain-protective qualities (protection from the drugs) provided by idiopathic PD.

This is why we say that a PDer who has ever taken dopamine-enhancing drugs for more than a few weeks may be better off, in the long run, if he does not try to recover. We also say that every person is an individual and must follow his own heart with regard to drug use. While we would not dream of telling a person what to do or not do with his drugs, we will not treat nor give any advice whatsoever about treatment to a PDer who has ever used dopamine-enhancing drugs for longer than three weeks.

PET scans in the famous EllDopa study of 2002 compared the levels of brain change in recently diagnosed PDerS who took low, medium, or high levels of a dopamine-enhancing drug for a period of 40 weeks. The amount of brain changes at the end of 40 weeks corresponded directly with the dosage level of drug. The control subjects who were taking placebos had only the very low amount of brain change that is expected, over time, in people with Parkinson's disease. Those at the highest levels of drug use showed the most brain change (damage).

On the other hand, a person who takes the drugs who does *not* have *idiopathic* PD can experience *very* rapid, *very* dangerous levels of brain change, and may, in some cases, be visibly suffering from the side effects of the drugs within a few months. Although the drugs do cause brain damage in people with idiopathic Parkinson's, they cause much more damage, much more quickly, in the brain of a person who does not have, or who no longer has, Parkinson's. Therefore, because people with (currently) incurable brain damage from drug use may someday need to take antiparkinson's medications, we will not work with people who have ever taken the medication for more than a few weeks.

² Even so, we still get inquiries from people who have taken the drugs for many months, or even more than a decade, asking if we will make an exception and work with them if they get off their drugs.

that, in his changed – and in some cases, seemingly worse – condition, the drugs will have become hideously addictive.”

Although we continued to work with a few recovering PDers who were already in our program and who had gotten off the medication, we never again knowingly took on a new PD patient who had used antiparkinson’s medication for more than three weeks.

This meant that we no longer had a mishmash of euphoric (recovering and drugged) and panicked (partially recovered) people in various stages of recovery. With the euphoric ones gone, now we could see clearly that the unexpected mental changes in our never medicated, partially recovered PDers were not related to the overmedication psychoses that we had seen.

We were seeing in partially recovered PDers the unexpected problems of poor proprioception, partial numbness, lack of injured-side-of-body awareness and the mental inhibition of positive imagination and/or positive visualization.

We were seeing these problems steadily, and we were seeing them whole – we thought. Attempts at directly addressing these problems seemed, in many cases, to make them worse instead of better. Clearly, these problems were not root causes, but were stemming from some deeper form of illness.

We had no idea what to do about it. But at least we were no longer dealing with the distracting complications from antiparkinson’s medications.

Placebo research and an increased emphasis on positive attitude

At around the same time, I started reviewing placebo research related to Parkinson’s disease. This research suggested that dopamine release in PDers was highly susceptible to positive or negative mental suggestion. Positive expectations cause dopamine release; negative expectations inhibit dopamine release.

People with advanced Parkinson’s who had been in sugar-pill placebo studies were often able to move normally if they thought – mistakenly – that they had been given their usual antiparkinson’s medication.

Based on the findings of placebo researchers, we were increasingly concerned that PDer’s reluctance or inability to imagine their own body or, for that matter, any positive outcome involving the body, might be perpetuating the inhibition of dopamine release. Even if the foot injury was healed, Qi was running correctly, and dopamine release was potentially possible, dopamine could not be released if a PDer had a negative attitude about his body or his ability to expect joy.

We started asking patients with increasing fervor to try to visualize their own bodies and to work on their attitudes.

They often responded vehemently against to our suggestions for cultivating positive attitude and expectation. The best way to summarize the dominant attitude was “I don’t want to change. I want you to fix me so that I can go back to being exactly who I was.”

Patient responses to the placebo findings

I clearly recall what happened when I made these suggestions to a patient whose major complaint was that the new pain in her hip prevented her from taking a normal step: she had to

drag her leg because any movement in the hip joint was excruciating. I'd been working with her for nearly two years and she had made much progress. Energy was once again coursing down from her neck, over the torso, past the hips, and through her foot. The nerves in her body were coming back to life. The more feeling she got in her foot, the more feeling she got in her hip, as well.

Her hip had evidently been injured at some point in the past. Before we started treating her Parkinson's, her hip had been numb. As the nerves in her hip began to resume function, the nerve signals coming from her hip were extremely painful.

In the past, I'd treated her while she passively rested. Because of our new concerns with patients' negative attitude and patient inability to imagine or feel a connection with body parts, I asked her to please try and focus her attention on her left hip while I supported the hip with Yin Tui Na.

She said no.

I said that her hip wasn't going to be able to heal very easily if she refused to acknowledge that she had a hip.

She lashed out at me, "No way! What don't you understand about pain? I am *not* going to think about anything that hurts. The whole point of life is to avoid pain. The whole point of life is to not have pain. You must be crazy if you think I am going to make myself think about the very thing that I'm trying to avoid."

I suggested that maybe, if she sent her attention to hip, she might find that the pain was slightly less. Pain is a call for attention. Very often, if a person calmly focuses on his pain, the pain signals decline. Oppositely, when a person frantically seeks distractions from his pain, the pain becomes more insistent. I suggested again that she might need to pay a little attention to it.

She exploded with rage. "I just told you, the *problem* is the hip! I am *not* going to focus on a problem. My whole game plan is about avoiding even knowing that I have a hip. Your job is to fix it, my job is to not know it's there."

I replied that the body can't heal something that it doesn't know exists, that it is consciously denying. She countered that her job was to find the doctor, the doctor's job was to heal the problem.

She never came back.¹

¹ As a curious aside, this patient felt, as many PDers do, that she was deeply spiritual, a deep thinker. I asked her if her spiritual seeking ever led her to join any particular religious group. She replied that she had gone to a church once, but as she looked around the people in the pews, she could tell at a glance that none of them were perfect, and why should she spend time with people who weren't perfect? So she never again went to a church. I asked her if she was perfect, and she replied that she didn't know, but that *she* was at least trying to be.

While this little vignette may seem like a silly response from one individual, her responses were actually very revealing, especially because they were so similar to the responses of many other PDers. The idea that other people are potentially "bad" and that the PDer is nobly trying to be good despite obstacles, is not uncommon amongst PDers. I have to suspect that the sympathetic nervous system, which requires one to maintain vigilance, which elevates the ego to a position of importance over the heart, and which gives out a steady stream of "be good and be careful" commands, is the culprit.

These people are not purposefully trying to project spiritual arrogance: their out-of-control ego, being commanded by the perpetually "operating at full bore" sympathetic nervous system, has no other way in which to operate. The parasympathetic system, which allows a person to be relaxed, amused, and observe himself as a tiny part of an enormous, and perfectly fair and balanced universe, is barely operational in PDers. When PDers recover, they experience a glorious personality shift. Some even say that they have become human again, for the first time in decades.

Other PDers also dropped out of the program when we shared the placebo information and introduced the idea that patient attitude played a role in triggering dopamine release. We suggested that, maybe, the patient should take some responsibility for his attitude, or that he must be willing to do a little work, if necessary, to mentally acknowledge that his injured body part did actually exist.

It seemed reasonable to us. But many patients dropped out rather than participate in exercises designed to help with positive expectation.

Meanwhile, a PDer in our program had created an Internet chat group called PD Recoverers. Some wonderful friendships had developed through the chat group and, though I had never visited the site myself, it seemed like a great resource for PDers.

My understanding was that it was started as a site for people who were in our program so that they could compare notes. When people started dropping out of the program when we suggested that they might need to make mental or emotional adjustments, quite a few of them turned to the chat group.

A few of my continuing patients told me that, thanks in large part to Recovery Project dropouts, the chat group had taken a very negative turn.

Over time, even as the chat group remained a wonderful source of mutual information and support for some PDers, it also became a regular forum for hostility towards our program.

This type of discussion is all a part of the lively give and take that accompanies all scientific inquiry. But PDers who were just discovering our website often visited the chat group as well. Then, when they communicated with us for the first time, they often opened their queries to us with, “Before I learn any more about your program I want you to explain all the bad things I’ve heard in your chat group.”

We had to explain that we have nothing to do with the chat group, and that we have not even visited the site.

But this just added to our ongoing frustration that some people had recovered and others had not. And it even seemed as if those who were the most adamant that they shouldn’t have to cultivate a positive attitude or expectation were the ones who had the worst experiences in partial recovery, in mood related lapses into movement inhibition and tremor.

“I need to talk with someone who’s recovered”

Another emotional stumbling point for many PDer was their conviction that they *needed* to cultivate negative attitude to prevent the development of false hope. Many of these people told us that the only way to counter this negativity was meeting up with people who had already recovered.

The pioneer patients had recovered without any examples of people who had recovered. But as the project began to grow, many PDers told me that they could not have a positive attitude unless they met someone who had recovered. In the early years of this project, this seemed logical to me. I made arrangements so that most of the PD patients who came to visit in the early years met at least one person who had recovered from Parkinson’s.

However, despite their statements that they needed to meet a recovered PDer in order to have a positive attitude, the negative-mindset PDers uniformly had *no* shift in attitude from meeting a recovered PDer. Instead, they became *more* doubtful. Their remarks were usually

something like “Just because that person recovered doesn’t mean anything about me. I’m different,” and “That person seems perfectly healthy: obviously he never actually had Parkinson’s disease. He must have had a very mild case, or else he was probably misdiagnosed.”

I quit arranging meetings with people who had recovered.

Where are the recovered people?

Some PDers were highly suspicious of the program because recovered PDers weren’t making speeches or appearing on Oprah. I explained the problem: people who recover may be told by their doctors that they had been misdiagnosed; the ex-PDer might be told that he’d only had a pinched nerve or a bad case of Bell’s Palsy. They might be told that their Parkinson’s symptoms had been manifestations of neuroses. Certainly, they will not be told that they recovered from Parkinson’s disease.

It is rather daunting for a person to stand up and say, “I know in my heart that I recovered from Parkinson’s, but my doctor says that actually, I’m just a nut case.” Instead, people who recover have two choices: they can be bitter towards the doctor who “misdiagnosed” him and who made him worry and seek alternative treatment unnecessarily, or he can rejoice privately because he knows that he actually was successfully treated for a condition that is *not* and never has been incurable.

Also, the dominant emotions of people who recover from Parkinson’s are not necessarily feelings of pride or victory. Sheepishness, humility and gratitude are often the strongest feelings for many people who recover. They may go into the program intending to be victorious. But during recovery, they may realize the extent to which they have lived a life dominated by a drive for victory, intertwined with intentional numbness and negativity (which never seemed negative at the time, but seemed like heightened logic and efficiency). In the end, they are humbly grateful for recovery – but they are more sheepish than proud.

The end of 2002

We were relieved that we weren’t going to have medication horror stories any more. We were grateful that some people had recovered from Parkinson’s. We felt that we had somehow failed the many partially recovered PDers who had dropped out. We were pleased that some members of the Parkinson’s Recoverers chat group had formed supportive friendships. We shrugged off the news that some members of the chat group were posting bitter remarks about our program. We were concerned that so many people were hostile to the very solid western research showing that dopamine release in PDers is almost completely mood and expectation dependant. We were determined to continue.

We did not yet realize that PDers were locked into sympathetic (danger) or dissociative neural modes. We did not know that, in this mode, a person *cannot* visualize happy endings, cannot easily access the creative, imagining, pretending parts of the brain, cannot let his guard down. We did not know that the most important symptom of the dissociation response was the numbing of the flesh and the resulting inability to truly feel, to the fullest, the existence of the body. (In a selective dissociation response, the numbness can be, in the beginning, limited to just an injured area. Over time, more body parts may become incorporated into the “off limits” area of the brain.)

We did not know that a person who is locked into a dissociation response with regard to one arena of his brain will often learn to subconsciously use dissociation in response to other, less threatening negative events.

We did not know that a person receiving a diagnosis of Parkinson's disease often feels betrayed by his body. Then, since his body has betrayed him, the PDer mentally applies the same dissociation technique to his body that he applies to anything he doesn't trust: he dissociates from it. We didn't know that the rapid decline that some people experience following diagnosis with Parkinson's disease was a part of the same process of dissociation and denial that they use for anything they don't like. There was much we didn't know.

Also, the placebo research was strange and powerfully suggestive of a mental/emotional angle. And though most of our partially recovered patients deeply resented or struggled mightily with the impossible idea that they needed to cultivate a more positive attitude, we wondered, nevertheless, if something in the mind or emotions might hold a clue to the mystery of the partially recovered PDers.

