

“Weep my child, for he who is without tears has a grief that never ends.”

- Mexican proverb

CHAPTER THIRTY-ONE

THE CASE OF THE MISSING HEART

We did not discover a *solution* in 2006. But in 2006, the direction of the visualization techniques changed in a way that led us, eventually, to the heart dissociation. I am including all the visualization techniques that eventually led us to the heart because these techniques are things that PDerers may want to try if they decide to get their hearts open. I do not include the techniques in this chapter in the section on Treatment Techniques. That would be too redundant, even for me. But they still might prove fun or helpful for a PDer. They might also demonstrate the inventive way a person can play around with visualizations while working on feeling safe and getting his heart back.

Gilbert’s neck

On February 10, 2006, I was working with a PDer who was doing very well; most of his symptoms were greatly reduced and he felt increasing vigor. He still had a faint tremor in his right hand but he wasn’t concerned about it. He was more concerned about stiffness in his neck: I was planning to treat his neck with FSR.

Before starting on his neck, I asked him if he could close his eyes and try to visualize light in his neck. He could, and he could also see a spot of darkness in the back of the neck, near the skull. I asked him what the spot looked like. He replied that it looked dark and squashed. I told him to imagine it growing darker and more squashed.

The “Exaggerate the Problem” technique

This technique, in which we ask PDerers to visualize any perceived problem as being exaggerated and far worse than it actually is, developed out of our discovery that PDerers, for the most part, have a very hard time imaging sweetness and goodness, but they can easily and happily imagine a bad situation growing worse. Sometimes, when positive visualization proved impossible, we asked PDerers to pretend to chop off offending body parts in order to allow the mind to venture near to those areas, prior to initiating healing in those areas.¹

¹ I know that the idea of perpetrating mental havoc on an injured or frightened body part flies in the face of all the peace-love-sweetness techniques of modern psychology. But we had found that nearly all PDerers can easily, cheerfully, gain access to forbidden body parts by pretending to mutilate them. So we often started PDerers down the road to imagination by letting them create horrors on themselves. Spouses and practitioners were appalled, but the PDerers got a great kick out of it. Often, after pretending to mutilate or create a worst-case scenario such as cancer or gangrene in a formerly “off-limits” body part, then chopping off the “bad” body part and replacing it with a new imaginary body part from my office cupboard of “imaginary new body parts,” the PDer could actually feel that “missing” body part for the first time in years. The results didn’t last, but many PDerers could walk more easily, for several hours, after pretending to chop off an offending foot.

Knowing about this trick of negative thinking, this “back door for mental access” to mentally forbidden areas, was very helpful, ultimately. Later on, we took advantage of this negative access route to help PDerers make the first step in turning their hearts back on.

We recognized the need for PDers to focus on their fears and apply some mental attention to ignored areas, thus allowing their minds to recognize problem areas and start healing them. It turned out that, in the preliminary skirmish with this type of mental-disassociation problem, it didn't really matter whether one imagined the problem getting worse or getting better. The great thing was, in the beginning, to be able to turn the previously reluctant, even dissociated, mental focus onto the problem area.

This technique does not cultivate a negative attitude, although it may seem like it at first glance. It would be more accurate to say that this technique forces a person to face his fears. By firmly facing his fears, even exaggerating them, a person is often able to soon recognize them for what they really are: small events that have been blown out of all proportion. The power of the fears is thus diminished.

Getting back to Gilbert, by using this technique he was able to look at the dark spot in the back of his neck and imagine it getting bigger, darker, and more bruised and hideous. After about thirty seconds, when he grew bored with this, Gil stopped imagining and allowed the image to go back to its original condition.¹ As is common with this technique, the dark spot became very small and much less dark, and then disappeared.

Please note: even with emotionally healthy people, sometimes several repetitions are required to completely erase or remove the imagined problem from the area. And, as we learned later, if a person is maintaining a dissociative stance towards some body area – a contingency that we didn't know about yet – the dark area will soon return or it will just show up somewhere else. Still, because this technique was helpful for some people, and was better than nothing, we were using it on nearly all the PDers at this time.

I was curious to see if Gilbert was imagining that the injury to his neck had twisted something in the brain stem. I asked Gilbert to imagine that he was looking at his brain. (I have since found that even those PDers who cannot visualize their body are able, in nearly *all* cases, to easily visualize their own brains: they like their brains.)

After he had taken a gander at his brain hemispheres, I asked him to imagine what a perfect brain should look like, so that he could discern in what way(s) he imagined that his own brain differed from "perfect."

Bear in mind that Gilbert is not a biologist and has never studied what a brain should look like. This means that what I was asking him was, based on his own concept of what a healthy brain might look like, how did his *idea* of his own brain differ from his own *idea* of a perfect brain.

Gilbert could see that the left side looked smaller than the other. I asked him to make the "too small" side even smaller and to keep it small for as long as the experience was interesting. For about half a minute he imagined it smaller, almost to the point of disappearance. Then, he relaxed his focus and, to his mind's eye, the brain sides were suddenly symmetrical.

Next, he said that the left side seemed to be setting at an angle instead of facing forward. I asked him to torque the angle even more so. He did this. When he was done, the left side seemed to have aligned itself to its correct position.

The reader needs to bear in mind that his brain side probably did *not* actually realign instantaneously – if, in fact, there was any misalignment. Instead, the significance of this process

¹ Losing interest in the exercise usually signifies that the problem has become, to the imagination, less problematic.

is that Gilbert was sending a signal to his brain saying that, if there was anything skewed – physically or *perceptually* (in his mind’s eye) – it was OK with Gilbert if the body started healing that *problem of self-perception*. Gilbert, by finally paying attention to an area that didn’t, to his own mind, seem quite right, was giving conscious permission for his mind to pay attention to that area – and make his own self-image of that area become healthy or correct.

Where the mental focus is, there the life force can flow – assuming that the heart is turned on and that person is willing to be capable of feeling. The body’s innate healing ability can only work if there is energy, feeling, and self-awareness in the damaged area and the mind has access to the injured zone.¹

This technique – mentally looking around inside the body at various body parts and comparing the findings with what “perfect” body parts might look like – allowed Gilbert to “see” places in his brain that he *imagined* weren’t quite right: places that he had, at some point, actively blocked off from his own awareness or imagined to be “wrong” somehow.

By focusing on these areas, Gilbert was unblocking them or “dis-imagining” the barrier to the problem. If these areas actually *were* injured in any way, they weren’t necessarily instantaneously healed by this game, but they might be once again accessible to the body’s normal healing process.

Up until now, the techniques that Gilbert was doing, under my direction, were pretty much normal for what we’d been having all the PDers do, lately.

Ever since discovering the extreme level of mind-body disconnect in most PDers, I had grown accustomed to doing this visualization technique (imagining the problem getting worse or chopping off the problem area) as a sometimes, but not always, effective method for initiating healing in blocked areas.

But at this point, I suddenly felt inspired to ask Gilbert to do something new, something I had never thought of before. I asked Gilbert to look around in his head and find the place where there was an excessive amount of electrical activity. (Western medical findings show that a part of the brain, a part possibly associated with the tremor of Parkinson’s, seems to have an excessive level of electrical activity.)

Gilbert quickly imagined that he was looking at the place where this was going on. I wasn’t really sure what he should do next, so I suggested that he make the electrical firings worse. He did this for half a minute or so, and then said he was finished. I asked him if the area had changed. He said that the area was still firing off too much, but that it was somewhat calmer.

I cannot explain why, but I then asked Gilbert to look around the perimeter of the excess-activity area. I wanted him to see if all the connections running into and out of the area were correct.

¹ As a fun footnote about the body being able to block off healing, maybe it is worth noting that Vioxx, an arthritis-pain masking drug, was found to prevent the healing of broken bones. I saw this in my own medical practice: a patient who took Vioxx for arthritis pain fell and broke his hip. His doctor could not understand why the hip replacement never “took.” New bone failed to form following the surgery; he was never able to walk on the new hip. A year later, in winter of 2002, I read in a science journal that Vioxx recently had been shown to prevent formation of new bone. I shared this information with my patient, who brushed it aside, saying that if Vioxx caused problems with bone growth, the doctor would have known about it.

This may relate to our subject: *when the body is unable to know that pain or injury is present, the processes that initiate healing may be unable to work properly.*

As the reader probably knows, Vioxx is now off the market. Turns out, it increases the risk of heart failure. And no, most doctors didn’t know about that fact until it made the national headlines.

Again, neither Gilbert nor I had any idea what “correct” should look like, but Gilbert was able to examine this area for “correctness.” He said that all the connections running into and out of the area were healthy and correct, but that there was one place where the connection was missing. Possibly because he was a computer technician, he said that one socket leading into the area was sitting empty. It looked as if one of the “plugs” that should run into the area was missing.

I asked him to look around inside his brain and see if he could find the missing plug. He found it and hooked it up.

Getting plugged in

I happened to be standing near his head while he was doing this. From where I stood, I was able to see that his faint hand tremor had suddenly come to a complete stop. Not only had it stopped, the hand had relaxed deeply. The hand looked different than it did when the tremor merely “stopped for a while.” The hand looked so different. Radiant. For that matter, Gilbert looked different.

I asked him to unplug the connector that he had just plugged in. His hand resumed its very faint tremor and I realized that Gilbert’s face, eyes closed, looked faintly more tense or concerned. Also, his shoulders seemed to draw infinitesimally closer together. His *chest* seemed tighter. I asked him to plug the thing back in. His tremor stopped and he visibly relaxed again.

I asked him how it had felt in his chest when he plugged the thing in. He said that he felt more peaceful and his mind was less anxious. I asked him if he had noticed the stopping of his tremor and he said that he had. He also said that with the plug in place, he had no *internal* tremor. Instead, he felt *consciously* healthy, although, prior to doing this experiment with the plug, he had *not* felt unhealthy.

I asked him to try to keep himself “plugged in” until our next session, and he left.

Another PDer connects with the heart

I was so astonished at the utter change that had temporarily come over Gilbert when he imagined himself reconnected to some random, imaginary plug, that I tried the same experiment on the next PDer I saw that day.

Aggie

Aggie was doing very well. She’d visited our clinic twice before, at six month intervals. Many of her symptoms were gone but she still felt stiff and “unnatural” in her right arm and leg.

She had recently discovered that she could move easily if she skipped. She said that skipping made her feel happier, and that it was just impossible to move stiffly when she was in skipping mode. She was experimenting with mental attitude adjustments to get her mind into this happier state more often, but she felt that there was still some underlying problem that was keeping some body parts stiff.

I repeated the same technique with Aggie that I had done with Gilbert. I started by asking her to pretend that she was looking for anything wrong in her neck, and then we moved on to the brain itself. She imagined that she saw a bruised area in one part of her brain and a flattened area in another part. She increased the bruising and increased the flatness, respectively, in those two areas. Then I asked her to look for the area in her brain with increased electrical activity. It did not take her long to find it. (These games of pretending have no claim to anatomical correctness. Aggie’s electrical-excess area was in a completely different location than Gilbert’s and it looked different, but it was unmistakably, to Aggie, “the area with too much electrical activity.”

We later found that it didn't matter what part of the brain we asked the PDer to look for. It might be the brain area in charge of shoes, or the brain area that "doesn't want to be looked at." Although, at first, I asked people to look for areas with excess electrical activity, we soon learned that this location was not significant. I could get the same results by making hook ups with the imaginary brain area that knows about driving a car or "all your memories from age three." The benefit of the exercise turns out to be hooking the brain up to the heart, not finding a specific problem area in the brain. Now I merely define a brain area to help with the process of imagining some area in the brain that might be disconnected from the heart. Considering that this is a pretty large field for most PDers, it doesn't really matter what area we use.

I asked Aggie to increase the level of electrical activity for as long as seemed interesting. As had happened with Gilbert, when she finished this process, the electrical activity had decreased, but in her imagination it was still more active than her imagination thought that it should be.

I asked her to examine all the connections flowing into and out of the electrically over-active area. She did this and found that a few connections weren't quite right. She mentally imagined them as being worse, and this quickly allowed them to be healthy.

I wasn't sure how to ask the next question. With Gilbert, he had been the one to mention that a socket was empty. Aggie hadn't said anything about a missing connector and I wasn't sure I wanted to put ideas into her head, so to speak. Nevertheless, when she didn't volunteer anything, I asked her if there might be any other connectors lying around loose that possibly were supposed to be connected but weren't. She looked around for a moment and then surprised me by saying that she'd found one.

She hooked it up.

I saw her body relax just a bit. I asked her to unhook that last one for a moment and then hook it back up again. I could see her, almost imperceptibly, tighten up when she unhooked it and loosen up when she reconnected it. When she reconnected it the second time, she also placed her right hand over her heart and sighed. I had her disconnect and reconnect several times. Each time she connected it back up, although I had not yet suspected the heart connection, she would press her hand down onto her left chest and her whole body seemed to relax into the pressure of her hand. She was obviously feeling something going on in her heart area.

I asked her how it felt to connect that plug. She said that her mind felt calm and her heart felt opened up. She felt very good with the connector in place. I told her that I thought it might be the heart that she had just reconnected to her brain, and she said that was exactly what it felt like.

This was the first time that the idea of a physiological heart component had occurred to me. Although many recovered PDers had said that they'd experienced a "change of heart," or an "opening up in the chest," this moment with Aggie was the first time I suspected that some physiological event in the *heart* might be involved in cases of partial recovery. At this time, I was unaware of the research showing a heart nerve dormancy in people with Parkinson's disease.

We did some experiments while she kept her hand over her heart and focused on having her "heart plugged in." The first experiment was with speech. She was starting to tell me something about how she used to focus her eyes differently, and I asked her to start over again, and to tell me as if she were speaking from the heart. Her voice became more resonant and

melodic, and there was a sense of dignity, somehow, as she spoke. After about two sentences, her vocal timbre became thinner and her speech increased in tempo and become less compelling. I asked her if her heart plug had become disconnected. She checked her mental image and saw that, in fact, the plug had fallen out.

Attributing this disconnect to habit, she plugged it back in and continued talking. When she had spoken her piece, she acknowledged that she had felt a shift in her vocal production when she'd become "unplugged" and that she understood, for the first time in her life, what it meant to "speak from the heart."

She also said that she understood suddenly what it meant to "open your heart." She said that she had heard that phrase many times in church, and it always sounded like a noble sentiment, but she had never realized that it was an instruction to be taken literally. Her heart felt open, and it felt wonderful.

Also, her extremely faint tremor stopped while her heart was connected.

I decided to try an experiment. Prior to working on her head, she had said that her main remaining problem was her right arm. In fact, she said that if her right arm was able to move in a relaxed manner, she would consider herself to be essentially recovered. I had, at that time, asked her what it needed to happen in order to get her right arm working better. She had said that she didn't know.

A sudden shift in body awareness

As she imagined that her heart was hooked up to her brain, I asked her again what her arm needed. This time, Aggie immediately replied that the problem in her right arm was coming from her right leg. She focused on her right leg and could clearly see a blocked off area in her hip. I asked her to make it more blocked. She imagined this for less than a minute and then relaxed her focus; the blockage was gone. Without doing any techniques to bring light into her leg, she easily saw, in her imagination, that light streamed past her hip and through her thigh until it came to another blockage in her knee. She repeated the formula and that blockage was gone. Continuing down the leg easily, she saw a small glitch at her ankle. I asked her to make it "glitchier."

(I never told a person exactly what to do with the problem. I always used the same words that the PDer used and just ask that the problem be exaggerated. This way I don't need to understand what a person means when he says the problem is too "bleak" or "too linty," words that often convey nothing to me but which obvious mean something specific to that PDer.)

As soon as the ankle glitch was gone, Aggie could see clearly that the smallest toe was too "dark and bent." I asked to make it darker and more bent, which she did. And then she told me that she was fine; she said that she knew in her heart that her leg, finally, was fine.

Imperfect arm

But when Aggie moved her arm, it still did not feel perfect; it still felt "unnatural." I asked her to make sure that her heart was hooked up. She confirmed that the heart was hooked up and that there were no blockages. At this point, I realized that she might not actually know how to move her arm. She moved it as if arm movement began at the shoulder, as if the arm had no relationship to the rest of her body.

I reminded her that the power for large movement function comes from the base of the spine. Now, she was easily and comfortably able to imagine energy flowing in her body, a new ability that seemed to have accompanied the imagining of a brain-to-heart hook-up. I asked her

to imagine energy flowing up the spine, out through the shoulder, and down to her fingertips. When she moved, she must use her whole body, just as any athlete or musician knows. When one moves the hands while playing a violin or swinging a baseball bat, the movement does not start with the hands; the movement starts in the base of the spine and flows up and over to the arms and out the fingers. The base of the spine is like the handle of a whip; the fingers move like the whip's cracking tip.

Aggie practiced several times imagining that energy was starting at the base of the spine and flowing up and out her fingertips. As she imagined it, she threw her arm outwards and up towards her head, imitating the graceful arm sweep of a ballerina. (Aggie had loved ballerina coloring books when she was a girl.)

She was starting to get frustrated with the arm movements because they still felt stiff and unnatural. I kept reminding her to make sure her heart was hooked up. She kept flinging her arm up over her head (she was lying down on the treatment table). Suddenly, after about the fifth try, something changed: as she imagined the energy coming up her back, her spine moved, as if in time with the impulse. When the energy got to her neck, her neck and head gracefully swayed slightly to the left, balancing the movement of her right arm as it floated out and up.

Aggie opened her eyes. They started to fill with tears. "That felt so good. That felt SO GOOD. That felt *SO GOOD!*"

She continued practicing for a few more minutes. I reminded her several times that it might take some time to overcome her past habit of being disconnected from her heart, that it might be a slow process making these changes permanent. I kept reminding her to check that the heart was still connected. And then, the session was over; another PDer was waiting in the wings.

Lydia

I wasn't sure that I would do the heart-mind connection visualization with Lydia, the next PD patient of the day. I had never met Lydia before. She was forty-three years old. She'd been diagnosed five years earlier. Her close friend from massage school had been her FSR practitioner for the last four months. I welcomed them both into the clinic and began the intake. Lydia shook my hand at the door and hugged me, then thanked me with warm words for the work we were doing. Her stony, emotionless face and body language contrasted with her verbal expressions of warmth.

My first impression was that Lydia's case was quite advanced. She was in a lot of pain from the excruciating rigidities in her legs and hips. Her face was nearly expressionless: her right-side face could not move; she spoke out of the left side of her mouth. Her arms were bent at the elbow, and all her small motor movements were painfully slow and rigid. She labored to remove her shoes. Her right foot was grey, as if it belonged to a corpse that had been a few days in the water. Her voice was not resonant. Her tremor was not particularly large, but there was clearly a faint tremor, especially throughout the right side of the body.

She told me that she had never used PD meds, but that she had, three weeks earlier, started using muscle relaxants once or twice a week. She used the pills because the rigidity in her legs was so painful that she had been unable to sleep for three nights in a row. That's when she had gone to the doctor for the pills.

Then, before I had a chance to reply, she announced defiantly: "I have *not* done the visualization exercises in your book. I don't do visualization; I'm not a visual person. I can't do it. Besides, you didn't do a good job of explaining what you meant. Was I supposed to be imagining that I am looking at my legs from the outside or the inside? I have no idea what you

were even talking about.” She continued in this vein for quite awhile, emphasizing that she was not a person who did visuals.

I asked if I might determine the direction of Qi flow in her legs and arms. (I do this by holding my hands a few inches above her skin, using my hands as Qi detectors.) She agreed, and lay down on the table.

Backwards Qi times three

Lydia had Qi flowing backwards in all three of the leg channels that flow from the head to the toes. The Qi in the other three leg channels, the ones that flow from the toes to the torso, was extremely diminished. The Qi in her arms was flowing backwards in two of six channels on both arms: each arm had *different* channels that were running in reverse.

I felt her feet. They were like the stone feet of a gargoyle. They looked dead. Aggie’s practitioner piped up for the first time: “I think Aggie’s feet look a lot better than when we started.”

This was an advanced case.

Should I try the heart-brain connector idea? She had already told me that she couldn’t visualize. I decided that Lydia had nothing to lose, so I told her, “I want to try something with you that I haven’t done before with someone in such an early stage of treatment.

“I’ve been working on a new technique, but it requires visualization skills. The other two people I’ve done it on have been working with me for a while, and their leg Qi had already been corrected. Their Qi was flowing the right way through their feet prior to my doing this technique with them. But if you’re game, I’d like to try it with you.”

Lydia and her practitioner had written in their brief patient-history notes that recently, on three occasions immediately following an FSR session, Lydia had felt somewhat less rigid. The looseness did not last more than a day, but nevertheless, this temporary experience with loosening up gave me reason to suspect that, even though her feet looked like death, a narrow pathway might have been cleared in the feet. This pathway possibly allowed Qi to flow correctly for a short while until the overwhelming trend of the blocked up legs caused the Qi to revert to “backwards.” This was the only encouraging news that they had, but still, it seemed promising.

Lydia was willing to try the new technique.

I started out the same as I had with Gil and Aggie. I asked her look at her brain and see if the two sides were symmetrical and aligned correctly. She could do it easily. As noted earlier, most PDers, even if they “can’t visualize,” can easily pretend that they are looking around inside their heads. Then again, for a few PDers, even thinking about getting ready to try to visualize any body part is frightening; visualization itself is nearly impossible.

In Lydia’s case, one side of her brain was too big and the other side was too small. I asked her to work on them one at a time. I asked her to make the small one smaller until the exercise was no longer interesting and then let the image drift back to whatever it was going to become. When she was done, it was a little bigger, but did not match the other side. So I had her work on the other, “too big” side, making it bigger.¹

¹ For some reason, over 95% of all the PDers we’ve tried this on have imagined that the left side of the brain is much too small or the right side is much too big. This does not conform to any brain scan findings. This does not fit with the idea that the logical side of the brain, the left side, is the side most used by PDers. This also does not have anything to do with the side of the body that first developed symptoms of Parkinson’s. Based on

When I explained to her, briefly, that PDers usually don't like to imagine good stuff happening to their bodies, but they are great at imagining bad stuff, she laughed out loud – her first physical manifestation of positive emotion since she'd arrived.

We continued imagining the brain, finding a few imaginary bumps and bruises and enlarging and exaggerating them until they diminished or disappeared.

Next, I suggested, “Now find the place in your head where there is too much electrical activity.”

She found it quickly. I told her, “Increase the amount of activity as much as you can.”

She did that. She said she increased it so much that “smoke was coming out of her ears.” When she stopped doing the exaggeration and the smoke cleared, she still imagining that there was a problem in the “electrical activity” area.

I said, “Look all around and see if the connections going in and out are all in good working order.”

She told me that there were a specific, modest number of connectors, and that they were all frayed and rotting.¹ (At this point in the book, I will not tell the PD reader how many connectors she imagined, lest the reader think he too must see the same number of connectors. Some PDers see five, some see dozens, some see a great mass of connectors. It doesn't matter how many or how few a person imagines.) I asked her if she wanted to fix them straight out or first make them worse, following our “make it exaggerated” gambit, so that they could then rebound into health. She told me that she was going to rip them all out and let new ones form.

I was holding her feet as she did this. I sat there for about a minute, giving her time to tear out the old connectors. Then I asked her if they were now in better shape. She said that they were now doing fine. I waited to see if she had, on her own, noticed that anything was missing. She hadn't.

I asked her if possibly there was one connector missing, or if there was room for another one, or if there was a connector floating around, not plugged in to its correct spot in this area. She said, “Maybe.” But she didn't see one readily.

I then took the initiative. I told her that very possibly there was a connector that was coming from the heart, and it was supposed to be connected to this area of excess electrical activity. She said she would try and find such a connection.

subsequent findings, I have to wonder if the left side of the brain is usually imagined to be smaller, darker and more foul because the left side of the body is thought of as housing the heart – an organ that was usually imagined to be too small or too dark or too diseased, and certainly not capable of being beautiful.

Also, as we discovered later, the Qi flow in the portion of the left-side Stomach channel that courses over the heart is often running backwards or at a standstill in partially recovered PDers, even if the rest of the channel is flowing the right way. This electrical pattern over the heart occurs to varying degrees in any person who is in sympathetic mode. We do not know, but conjecture that this electrical pattern may be the reason that most PDers have more difficulty imagining the left side of their brain.

¹ I hardly want to mention how many connectors she saw, for fear that PDers will think that they need to imagine the same number. However, I find it curious that the most frequently imagined “correct number of connectors” for brain areas were five, six, eleven or twelve. It seems to me that this number possibly relates to the five senses and the heart types of connections: six in all. Maybe people who mentally imagined eleven or twelve were simply having paired connectors for each sensory function and the heart function. Again, the correct role of the mind is that of a secondary processor for sensory feeling – not the “seat of ego and cleverness.” If a person needs information, the heart, attuned to Wisdom, can always supply it. However, if the mind is chronically dominant, Wisdom is rarely available. Instead, bits of accumulated information have to take the place of Wisdom. PDers are often keen gatherers of information and trivia.

Lydia gets hooked up

About a minute later, she told me that she'd found the wire that was supposed to go to this area, but that it wasn't even in her head: it was down by her heart. She had had to bring it up from her heart. It couldn't pass through her body: she had poked the wire out through the chest wall, run it alongside the neck, and then poked it into her head behind the ear. Then she had hooked it up to the place where it was "supposed to go." (Strangely enough, this imaginary pathway is very similar to the route of the vagus nerve, the parasympathetic nerve that communicates between the heart and the brain when one is feeling contented.)

I then asked her to temporarily disconnect it, notice how she felt, and then connect it again.

She said that, with it connected, she felt that her mind was calmer and her heart was bigger.

That was good enough for me. I asked her to please try and keep it connected while we did some mind-body visualization work. She agreed, and we started.

I asked her, with no preparatory explanation, to imagine light streaming through the inside of her left arm (her one functional limb). There was a pause, and then she said that she had done it; there was light down to her fingertips. I compared this ease of light flow with her flat-out statements, not twenty minutes earlier, that she could not do visualization, that she didn't know what I meant by visualization or by the phrase "imagine light in your body."

Next, going for broke, I asked her to send light down into her right leg (her worst limb).

After a short pause, she said that she couldn't get the light any further than the inguinal groove (the groove where the leg meets the torso). I asked her why not, what prevented her from visualizing her leg.

She reverted somewhat to her previous attitude about visualization. She said, "What do you mean? What am I supposed to be looking for? Am I supposed to be looking for my guts? My bones? My muscles? What?!"

I said, "Make sure the heart is still connected."

She replied, "Oh. Yeah. The connection fell out. I'll put it back."

I then prodded her to continue by asking her once again to try to get light into her leg.

This time, she said, "I can't. It can't get through."

I asked her why not. She told me again that it couldn't. We went back and forth a few times: me, using various vocabularies, me asking her why not and her replying simply that she couldn't.

Finally, I asked what was there that was preventing her from getting the light through. She replied (in a tone of voice that suggested "well, duh! It should be obvious to *anyone...*"), that there was a wall in the way.

"Oh. A wall," I said. "Of course. Go ahead and make it more wallish. Exaggerate it."

She was quiet for about a minute, and then she chuckled. I asked her what was going on. She said that the wall had turned into a wad of string. I suggested she make it more string-ish and more wad-ish. A few moments passed and she giggled. Then she explained, still with her eyes closed, "The string turned into a ball of lint, so I blew it away. It's all gone now."

The rest of the journey into her leg was difficult but doable. Filling the leg with light was slow going. The leg was thick and murky. She ended up using a roto-rooter type of drill to cut through the muck. Please bear in mind that twenty minutes earlier this person insisted that she did not do visualization and did not even understand what I meant by the word.

Based on my previous experiences with PDers I felt certain that, if she had not first connected her brain to her heart, she would not have been able to visualize the injuries and obstructions inside her leg. This type of visualization, in which injuries become recognizable, is extremely hard for most PDers, even those that have tried for months and who can create spurts of imaginary light in various areas. I was baffled as to what role the heart-brain connection was playing. Why could Lydia easily detect the “wall” in her inguinal groove after hooking her heart up to her brain? Aggie, too, had easily been able to tell where her problem spots were – after she pretended to connect her mind to her heart. Was the heart somehow the missing link for people who were stuck in partial recovery? And of course, the heart wasn’t actually missing. Were recovered PDers somehow creating a mental construct in which they were pretending that their brain and hearts were disconnected?

At this time, I was not aware of the physiological shifts in the neural circuitry that essentially disconnect the heart and brain wave patterns during times of crisis. Nor was I yet aware that, by virtue of neural reciprocity, a person could create this same shift in circuitry by pretending that he is cut off from his feelings.

An unexpected Qi flow shift

Even before she got down to her feet, I realized that Lydia’s legs looked different somehow. They looked not just more relaxed, but energetically changed, almost as if they were brighter, more alive.

I reached out and felt the Qi flow in her legs. It was running correctly in all channels. Evidently, the “wall” at the inguinal groove had been obstructing Qi flow enough that, even with the work her practitioner had done, there was not enough Qi momentum to get the Qi running consistently through the channels in the correct direction. Now, with the “wall” gone, the Qi was able to flow easily and correctly. I was stunned. I had never seen such a rapid correction of Qi flow.

The Qi began streaming through the Stomach channel points on her face as well, no doubt because the healthy pattern in the Stomach channel was now allowing the arm Large Intestine channel to flow correctly over her face. Her face lit up in a smile.

I could hardly believe my eyes.

This was the fastest I had ever seen the face part of the channel make the transition from Off to On. Admittedly, reconnecting the heart and mind was not the only work she’d done; she’d been getting regular FSR treatment for four months. A few times, recently, following an FSR treatment, her face had momentarily exhibited expression. But this time, the entire face was lit up.

Evidently, the previous FSR on her foot had been invisibly working, even enabling her to experience brief moments of corrected Qi flow, but it had not addressed the “wall” in her inguinal groove. Possibly, she was still dissociated from her heart with regard to some inguinal groove injury. Maybe the “wall” was a part of that dissociation. The “wall” might have been the mental construct that caused the Qi flow to be minimal and caused it to keep reverting back to its old, wrong path.

I asked her about the wall. She said that she recalled no injury, but that ever since she was a young child, every sneeze or cough had caused a painful pulling sensation in that area. Also, every time she ran, even as a small child, she would get a “stitch” in that spot. Probably, through the years, her mind had walled off that area to prevent the pain. She may have used dissociation

from her heart to perform the walling off. At any rate, with the wall gone, Qi was once again flowing through her feet.

As for her feet, right there before our gawking eyes, they were changing from grey to pink. Her practitioner, thinking that this was the sort of marvel we saw all the time, said how impressed she was with these techniques. As for myself, I needed to sit down.

Her session was over. I reminded her that she should make sure, over and over, that her heart was plugged in, gave her a hug, and sent her on her way.

Later that day

Laura Walter, a member of the PD team, called me that evening. Laura had been the very first team member to see Lydia. Laura's phone call interrupted my talk with my husband, as I was excitedly, no, frantically, told him of the day's events.

Laura opened the phone call with "We've got a problem with the new person." She went on to say that she'd never seen such distorted Qi flow, such a severe frozen-face on such a young person, and that the feet reminded her of one of our earliest PD patients – the one with "the worst feet ever."

Laura went on, "I think we need to be honest with her: I don't think we can help her. Her Parkinson's is advancing so fast, I think we should tell her that she's too far gone."

I turned off the excited, soprano voice I'd been using on my husband and assumed my most casual tones. With a voice almost too bland, I assured Laura that all those problems were going away: the face was now practically normal; the feet had turned pink; and the Qi was running correctly. I agreed that her body was a mass of injuries and that it might be a long, painful journey as she discovered and healed all her injuries and relearned normal movement. But I assured Laura that the Parkinson's patterns had been turned around and that the worst of the job was behind us.

After Laura laughed at me, I told her what I'd been doing all day. I gave her all the details. She hesitantly thanked me, expressed polite surprise, and rang off.

The next day

I saw Aggie first. In case you are wondering why I was seeing these PDers two days in a row when we usually recommend once-a-week treatment, Aggie and Lydia were from out of town. They were visiting Santa Cruz and seeing various members of the PD Team every day for a week. Both Aggie and Lydia were receiving treatments twice a day, from two different PD Team practitioners each day. That was especially valuable to me today, because it meant that I would have a team member to corroborate what I was doing.

I'm not sure what I expected from Aggie, but I was surprised by her. She walked in and announced, "I had a meltdown yesterday."

She went on to say that she was angry with her beloved husband because he could shower so quickly. She was frustrated with herself and angry that it was taking so long to recover. She was resentful, sad, jealous, and boiling over with emotions. The worst emotion was the rage she felt at herself because of her failure to keep the heart plugged in. She kept checking to see if it was plugged in, and it usually was not. Also, she was bitterly disappointed that, upon awakening this morning, she was still moving the slow way that she usually moves in the morning. She was blaming her failure to keep the heart connected with her seeming inability to move in the normal fashion that she had done yesterday for a few minutes.

The most strange thing about all this was that, until this morning, she felt that her emotions had always been in control, and that she had been contented and faithful that everything would somehow be all right in the end. Suddenly, today, she was feeling anger, disappointment, jealousy, frustration.

I talked to her about how slow it can be to make new habits and overcome old ones. I pointed out all the positives: twenty four hours earlier she didn't even know she had a heart connector, and now she could find it easily and work with it. Plus, despite her slowness that morning, she could not deny the fact that, for several minutes the day before, she *had* moved normally. I didn't mention that many people experience childish emotions when they first get their heart working again. I didn't mention it because we didn't yet know it. She was one of the first to demonstrate this phenomenon.

We talked for a long time about realistic expectations. I thought she was making great progress. Despite my reassurances, she was uncharacteristically emotional: wailing over the fact that she hadn't permanently retained her ability to perform loose, relaxed movement.

So, I had her get up on the table. I asked her how her legs looked from the inside. She said that various spots here and there still wanted some work, so I held those areas while she imagined every situation being worse than it was, and pretty soon she had calmed down.

I asked her if she wanted to try a habit-changing technique that works by mentally cauterizing the brain cells associated with a bad habit. She did it and then felt a warmth coming from the side of her head where the heart disconnect problem was located.¹ She also mentioned that she remembered this technique from a class I had taught a year earlier in St. Louis. I asked her if she'd ever actually tried it before today. She said she hadn't.²

¹ This technique and other helpful attitude-changing techniques are included in the appendices.

² I used to be astounded at most PDer's disinterest in doing the techniques that I share in this book and in my classes – even those PDer's who are certain that this program is the answer to their problems.

Sometimes PDer's come to our program from a long way away, even from other continents. They usually say they have read the material several times. They claim to be keen to “get started” with recovering, and can't wait for us to get to work on them.

But when we ask if they have tried to get started on their own, if they have imagined light in their body, tried to open their hearts, or done any of the attitude-changing techniques in the appendices, they usually say that they aren't interested in doing that stuff on their own; they want to work with us, in person, because we are “the pros.”

This attitude was puzzling. These people have usually been, for much of their lives, extremely “can-do:” so competent, so capable. But when it comes to actually changing their own negative or fear-based mental habits or learning positive ones, they often were not interested in initiating the work. We now understand that, with a dissociation response in place, the mind is hardwired to not visualize, not open the heart, and not imagine positive outcomes. These instructions are part of the survival mechanism that is part and parcel of the dissociation response.

Now, when working on changing a PDer's mental habits, it is helpful for us to behave as if we are working with a child, not an adult. The types of fears we often find at the root of the dissociation can, in some cases, suggest that we are working with people who have severely arrested emotional development, in terms of facing fears, even while they have overdeveloped mental aptitude for word-based logic and negativity. We now suspect that it is this childlike inability to confront a large fear, combined with an enormous mental ability to control one's own body processes, that spurs some people to consciously maintain a dissociation response, preventing it from turning off in the normal time frame.

We suspect that some PDer's wait until they are with us to start practicing having a heart because they feel, on some level, that we can best perform the role of supportive adult: the adult that a child clings to when he doesn't feel safe.

I asked her if she wanted to try moving in a loose way again today. She was uncertain, but finally decided to try it. Yesterday it had taken her some minutes, maybe five, to figure out how to integrate the base-of-the-spine “whip cracking” imagery. Today, it took only about two minutes until she was once again moving gracefully. As she practiced waving her arms and neck and torso gently side to side with her eyes closed, I pointed out that all the things she’d done yesterday she had done again today, and she had initiated them more easily. When she stopped forming ballerina moves with her arms, I pointed out that she had maintained the relaxed movement for about four times longer than the day before. I think that it was starting to sink in that she was, in fact, making steady progress, but that she was not going to switch from unhealthy to perfectly healthy overnight.

She agreed that her expectations had been unreasonable. She also agreed that, with her heart plugged in, she could do all the visualization work much more easily, her mind was calmer, and she could see how her recovery was accelerating. I left her on what I thought was a high note.

Only later did I begin to wonder at the sudden appearance of so many conflicting emotions in what had always been a person of calm self-control.

Lydia again

Lydia strode in next, looking great. She was still fairly rigid all through her body, but not painfully so. She was grinning from ear to ear. Through the two-hour session, she asked, at twenty-minute intervals, “Am I still smiling?” (Her husband was going to fly in to town to join her the next day, and she had not told him about her new smile. She was planning to surprise him. As an aside, when she had first seen her own smiling face in my office mirror the day before, she had been, at first, disquieted by the unfamiliar image. Then, as she kept looking at herself, the smiling face became “strangely familiar.”)

Lydia’s Qi was still running correctly. She had slept well; her legs had not slipped into that extremely painful rigid contortion. Her heart kept coming unplugged, but she kept plugging it back in.

I asked her how her legs were, if she could fill them with light. I also asked her to notice, as she did so, any way in which her body or legs differed from what “perfect” body and legs should look like. She started to fill her body with light but only got as far as the hip. There was a problem with the pelvic bone. In her mind’s eye, it was sticking out of the side of her body. I asked her to make it stick out further. She enlarged it so that, mentally, it was hitting the wall of my office, and then it shrank down and, to her mind’s eye, was unblocked and “correct.”

She wanted to know why there had been a problem in the hip today, even though she had gotten rid of the wall yesterday. Not only that, she could also “see” and feel other problems in her leg that she hadn’t noticed the day before. I had to point out that the wall had merely prevented mental and/or emotional access. Now that she could actually feel her own leg, she might be finally able to notice that there were lots of areas in the leg that were in need of healing.

We had seen in other recovering PDers that once access was gained into an area, a whole collection of long-forgotten, unhealed injuries often appeared: sprains; strains; and even bone breaks. Unremembered injuries or injuries that “hadn’t hurt” at the time they occurred are often exposed after the Qi starts to flow (after the primary Qi-blocking injury has been rectified). The events that caused these injuries are often clearly remembered once their pain kicks in.

Of course, as long as the area is mentally blocked off, and especially after Qi stops flowing correctly in the area, neither pain nor healing is able to manifest correctly. After Qi begins to flow correctly, the pain of old injuries can begin to register. Then healing can begin. Usually, the injuries will surface in a gradual sequence. One injury will make its presence known, and then begin healing. Sometime later, another one will show up.¹

Lydia had lived an unstoppable, dynamic lifestyle. Keenly aware of Lydia's long list of *remembered* accidents and injuries (none of which had hurt at the time) and suspicious that there just might have been some others that she hadn't even written up in her list of injuries, I gently warned Lydia: now that she had mental access to her leg, forgotten injuries were probably going to be calling for attention for some time.

Even though she could now imagine or pretend to visualize her body with ease, this did not mean that her body was completely healed from every past insult or injury. She was disappointed. I think she had imagined that she should be recovered completely, all symptoms gone, in a day or two, simply because the Qi was now running the right way. I had to explain that the pathological Qi flow pattern was gone, but that she now needed to heal.

We started working on some leg injuries that were now quite "visible" to her. They were also painful. It seemed that every few minutes she discovered a new ache or pain. Two days ago, she had been paralyzed with general rigidity and dystonias. Now, instead, she was feeling the pain at the places where the motorcycle had fallen on her legs (which hadn't hurt at the time). She addressed the problem areas one by one by focusing her attention on them until they seemed less bruised (to her mind's eye) or felt slightly less painful. Frequently, she started to tremor a bit and I would ask her if her heart was plugged in. She would replug the heart, the tremor or rigidity would stop, and we could continue.

She finally got frustrated with the heart becoming unplugged. She examined the wiring carefully and saw that there was a toggle switch near the heart that was causing the plug to be

¹ This pattern, in which the body almost always recognizes the most urgent pain, and can ignore lesser pains until the urgent one has stopped, has been long recognized in studies of pain perception. This may be why, in recovering PDer, they are not able to notice all their injuries at once.

One recovered PDer, years after having completely recovered from Parkinson's, woke up one morning with the bridge and sides of her nose badly swollen and painful, with a faint darkness under one eyelid. She said that it felt as if she'd broken her nose. It was swollen and painful for several days. She had not bumped her nose recently. But she did recall a faint, junior high school-age memory of saying to someone, "Don't worry. I'm fine; it's no big deal: everyone gets their nose bashed once in a while." She could not recall the context of that statement, made 40 years earlier. But when the swelling of her nose subsided, there was a small, permanent discolored line across the dented place on her nose, the type of marking that one would expect from a broken nose.

Curiously, she had long been vaguely aware that her nose had a strange dent in the long ridge, as if it had been broken, but she had never had any awareness of having received a nose injury. A review of her school photos showed that the misshapen nose had appeared in junior high school.

Since recovering from Parkinson's, she'd had many similar incidents in which bruising and soreness showed up, and seemed to trigger the memory of some long-ago injury. She found the nose injury fascinating because she could see the proof of injury in her school yearbook photos. She was certain that she had never had any pain or swelling on her nose during those self-conscious junior high years when such a disfiguring bruise would have been noticed and mentioned by her schoolmates and herself.

The point here is that, after recovering from Parkinson's disease, many of her other forgotten injuries had "appeared" and then healed – all of them several years prior to her body deciding to spit on its hands, haul up its socks and get to work on the broken nose bone. We must conclude that the subconscious mind, left to its own devices, may pick and choose when and where it is going to heal the body's non-emergency injuries.

It is also important to note that she had completely recovered from PD even though she evidently still had an assortment of unhealed injuries. The anxious PDer can take heart from this: it means that a person can recover from Parkinson's even if there are still lots of unhealed injuries.

connected or not. She installed a metal bar over the toggle switch to prevent the switch from being thrown, and told me that, from now on, the heart would stay connected.

Habit being what it is, I was silently dubious, but hopeful. About five minutes later, while working on her leg, I noticed that she seemed taut and mildly shaky again. I asked her if her heart was connected. When she checked it, she found her heart disconnected in a new way; her habit of needing to shut out her heart (emotions, feelings) when confronted with physical problems had found a way to get around the toggle-switch stabilizer. In her mind's eye, a stick was now poking directly into her heart, preventing it from working correctly. The imaginary stick protruded out of her chest and up into her nose. Lydia actually thought it was pretty funny. She got rid of the stick and acknowledged that very possibly the habit of heart disconnection was going to take some time to unlearn.

I then held her feet for a while. They were still pink and healthy. The grey had never returned. Some of the foot bones moved a modest amount. She asked every twenty minutes if her smile was still there: the innocent, happy and excited tone of her voice reminded me of a child who keeps asking his mother if his tooth is loose enough to pull out yet.

Later on

That evening, I called my son, a PD-team member. When I expressed my surprise that Aggie had been so emotional, Clay chided me, "Mom! She has a heart again. She has feelings. She's not used to that. She hasn't really had feelings for who knows how long. Of *course* she had a meltdown."

"Oh." I replied. "Right. I hadn't thought of that. Tell her that tomorrow when you see her." We talked a bit more. I briefed him on the new heart-mind connection idea. I hung up and the phone rang again. It was Laura, with whom I'd spoken the night before. I will paraphrase her words:

"Omigod. I'm in shock. I didn't believe you yesterday. I didn't believe you. I didn't know why you were saying all those crazy things about Lydia, saying that the PD had already turned around.

"I have never seen such a change in a person. Her feet, I swear, the worst of the varicose blood vessels were disappearing beneath my hands. Maybe it's because she's so young and so healthy, but I've never seen anyone change so fast. Her face is normal! Her feet are healthy-looking. They are still a real mess, structurally, but there's life in them!"

Laura went on and on, describing what she'd seen. Then she wondered if possibly a heart-mind disconnect was the reason that so many PDers seem to get better in many ways and then get hung up on some part of the recovery.

Curiously, a partially recovered patient with whom I'd worked for two years had recently said, several times, "I'll never be able to recover. I know my foot doesn't hurt anymore and I can walk more easily, but there is something wrong with my *heart*. I can't access my feelings. I know that I'll never be able to feel emotions like a healthy person. Maybe this is why I'll never be able to recover."

Laura went on to say, "Won't it be wonderful if, by reconnecting with their emotions, *all* of them can recover in the same time frame as the easy recoveries, five weeks to a year?"

Listening to her excitement, I was relieved: I hadn't been imagining things when I'd seen Lydia's lightning-fast changes. Laura, too, had seen the same dramatic changes that I had seen. Despite my studied calmness when I'd spoken to Laura previously, I had been almost afraid to

credit my own observations. Laura said that I'd better call all the team members and inform them of what was going on. I agreed, and we hung up.

I was almost ready to be certain that we had found a magic key. But I still had to wonder what the next day would bring.

The third day

I did not see Gilbert, Aggie or Lydia on the third day. Instead, I got reports from two of the team members. Clay saw Aggie first, and called me on the phone afterwards to say, "Why is she coming here for treatment? There's nothing wrong with her."

I pointed out that this was his first session ever with Aggie; he'd not seen her a year ago when she first came. I also asked him if he had noticed that her walk was still hesitant and she was very, very slightly bent forward at the waist. He agreed on those points, but also said that he had done some slightly Yang (vigorous movement) Tui Na on her shoulder blades and that she had loved it. More importantly, the shoulders remained relaxed when he was done.

He had supported her leg and hip, and she had rotated her leg in huge circles. The rotations started up in the low back and were smooth and languorous.

He had done some craniosacral work on her neck and her neck loosened up and became nearly two inches longer – and stayed longer. He felt that she was no longer in need of our services; all that she needed from here on out was a little "clean up work."

As for Lydia, he reported, after seeing her for the first time, that she was a "real piece of work," but that her Qi was flowing well. He said that she was a mass of injuries, but he saw no reason why she wouldn't respond well. He went on to say that she was really determined to do the work. When she'd walked in, she had told him that her heart had stayed connected for three straight hours. She was upbeat, smiling, in a lot of pain, but not especially rigid.

Another set of opinions

Laura had also worked with Gilbert, Aggie and Lydia that day. She called me later that evening.

In Gilbert's case, she asked if it was possible that he had grown two inches taller. He was doing so well, she thought that maybe we didn't need to see him any more. He had been nearly recovered anyway, but she felt that he'd made some quantum leap forward in the last two days.

She also said that both Aggie and Lydia had been extremely discouraged: every time they went to check on the heart to see if it was connected, it was not. They were starting to feel that they could never overcome their habit of being disconnected.

Laura is a quick thinker. She had asked both of them, "Do you say to yourself, 'Uh oh, I'd better check to see if my heart's disconnected.' And then, when you've looked, it was, just as you'd feared, disconnected?"

They had both agreed that this was the case. So she had told each of them to never again ask whether the heart was disconnected. Instead, she wanted them, whenever they thought of the heart connection, to say, "Ahh. My heart is connected!" and then, having said that, they should mentally look to see the connection.

They both reported that if their connection check-up was preceded with "My heart *is* connected!" then, when they actually looked (with the mind's eye) to check, the heart was, indeed, connected. They played with this concept. When the thought that preceded the check-up was "Uh oh," or "I wonder *if* my heart is connected," the answer was always "no."

At this time, we incorrectly assumed that this thought repatterning, getting rid of the “uh oh,” was merely a matter of habit. We were wrong. As we were to learn eventually, so long as the dissociation response is in place, the brain will try to revert back to a disconnected-heart mode. Turning off a “stuck” dissociation response must happen at the heart, not at the brain. Although most sympathetic responses are regulated by the brain, the dissociation response goes much deeper; it shuts down the thrill of being alive – a heart function, not a brain function – and prepares one for death.

Even if the dissociation response was originally induced consciously, as it is with many PDers, the dissociation process, in a healthy animal, is designed to turn itself off in a short time, or when the highly *imminent* crisis is over and the animal feels safe. Feeling safe is a heart function, not a brain function.

A *consciously*-induced dissociation response in a human evidently does not necessarily turn itself off at the proper time – especially if the person wants to be free from emotional or physical pain. In such a case, the normal mechanism for ending the dissociation response is consciously instructed *not* to work. Despite temporary mental overrides, the heart dissociation response remains in place.

Overseas corroboration

Thinking that I’d discovered The Answer to something, I still needed to see what would happen if distant PDers tried to re-establish a heart-mind connection 1) via working from the printed page and 2) working with someone other than me. Replication of an experiment by another researcher is a crucial part of research.

By great good fortune, Chris Ells happened to be the Netherlands helping to christen the new “Yin Tui Na Centrum Amsterdam.” This meant that, in addition to me trying this technique on our local PDers, Chris could try it on his European PDer patients, quickly widening our subject base. Also, Chris would be working only from the emailed material I had sent him about my work on Gil, Aggie, and Lydia. Chris and I had not yet had a chance to discuss this new technique in person: Chris would have to try to replicate my results working from a written instruction. For scientific purposes, this made the experiment more valuable.

To keep the process somewhat objective, Chris did not share any expectations for the new techniques with his PD patients, explaining only that he wanted to do something new. Also, Chris made sure that the PDers he worked with were not aware of each other’s responses.

Here are his results from the four people that he saw the next day (the treatments each lasted two hours):

The first person did not see wire-type connectors going in and out of the area of excessive electrical activity; she saw doors and windows. One of the windows was stuck and could not be opened. She decided to throw a rock through it. This allowed wind to blow through the area: she had always felt most at peace when she was out in the wind. After “opening” the window, she felt calmer in her heart. Chris said that she seemed more radiant somehow.

The next two people on whom he tried it saw wires going in and out of the area of excess activity. However, there were no missing connections. On closer observations, however, they both saw that the wire coming from the heart was not in good shape, so they replaced the wire. After replacing the wire, they felt more peaceful.

The fourth person could see that all the connectors were in good shape. Even the connector to the heart was good. Chris asked her to look at the heart itself. The heart had blue spots on it that didn’t look right. She made them bluer and bigger. She became very quiet. Chris

asked her how it was going, and she said that the whole heart was blue. (Chris told me there was deep sadness in her voice when she said her heart was blue.)

Chris suggested to her that she relax her focus on her heart. Her mental image of her heart, instead of reverting back to a heart with blue spots, became one of a healthy heart, completely “the right color.” After the heart became the correct color, she felt very calm.

Ease of visualization

Possibly the most important development was that, in all four of Chris’s cases, their new relaxation and calmness was immediately followed by an significant improvement in their ability to feel and/or visualize their bodies. This new awareness then enabled them to direct Chris to areas of the body that needed work. For example, one person suddenly perceived a walled off area in his knee. Another realized that what her toe problem needed was some work on her ankle. Also, with their hearts “hooked up,” they were all able to respond much, much more quickly than usual to the FSR work that Chris then did on these body parts.

After years of having worked with PDerers who, typically, have no idea that there is anything actually injured and cannot really “feel” what is going on in their bodies, Chris felt that the transformation was stunning. Then Chris said to me, “It just makes sense. How could they have feelings about their body if they didn’t have feelings, period? Feelings come from the heart.”

Over the next few days, Chris worked with many more PDerers. Their responses were, for the most part, extremely gratifying. Chris also invented variations on the technique to fit the various PDerers.

One particularly noteworthy variation involved a PDer who was utterly unable to visualize. He was so adamant that he could not do this technique that Chris decided to try a different approach. Chris wrote to me in an email that he asked the PDer to place his hands on his heart and just “look around in the area of your heart.”

In Chris’s words, “This guy can’t visualize squat. He really tried. He could not form any visual image in his mind’s eye. His wife asked if he could try to visualize the painting that’s in their bedroom. He replied, ‘Why? I see the real one every day.’”

For the next hour, Chris held his foot. Every five minutes or so, Chris would say something like, “You’re doing fine, keep it up.”

After the PDer had “looked” at his heart for about forty minutes, Chris felt a sudden stillness in the PDer’s leg, right at the spot where Chris was holding. A moment later, the knee, in Chris’s words, “unsprang like a spring-loaded slingshot and the PDer blurted out a sudden, brief yell/cry.” For the remaining twenty minutes, Chris repeated a few words of encouragement every five minutes or whenever he sensed the PDer becoming “scared, anxious, inept, or in any other way intense.” This time was “characterized by some pretty cool (but way short of completely done) releases” in the PDer’s leg.

More experiments

Over the next few days, while Chris was doing this, I tried the heart reconnecting technique on several more PDerers. Some had results similar to Gil, Aggie, and Lydia. But many were still struggling with the idea of merely imagining a brain. Adding a heart to the picture was out of the question.

I’ll share the results of two of the cases that could *not* perform the heart-brain hookup.

Hope: no excess electrical activity

I asked Hope to do this exercise. Hope could see nothing wrong with her head. I insisted that she keep looking. She said that the electrical activity level in her frontal lobe seemed greater than in other brain areas, but it did not seem excessive. The heart appeared to be connected. She mentally looked at her heart, looked at all the connections, and everything seemed to be in place.

I stopped worrying about the mind-heart connection and took up where I had left off the previous week: working on her visibly torqued knee and hip. Interestingly, and possibly due to my suggestion that she be on the lookout for excess electrical activity, Hope suddenly became aware of something new. She “saw” an area in her neck that she had never been aware of. This area in her neck was definitely manifesting too much electrical activity. She could also feel, for the first time, that the place in the neck was sort of painful. As the session came to a close, she wondered if the neck place was connected with the old knee injury that we were working on.

Most significantly, Hope did not have a major breakthrough. The new technique was just one more exercise that she was more than willing to do.

But after several sessions with Hope, during all of which she had no problems imagining herself as beautiful and bright inside, I remembered her Mirror Image. She didn’t want to look at the brain of the Mirror Image. When she finally steeled herself to do so, she saw a brain with an area of excess electrical activity, a heart that was black with barbed wire, broken glass, and nails around it, and a collection of brain areas that were walled off or hidden in caves. Hope was willing to do the work of getting rid of her mirror imagine, but she was understandably uneasy at first about connecting to her own body that agitated brain and that formidable heart. In fact, her Mirror Image’s heart specifically told her not to do so. Hope’s mind had to overrule Mirror-Hope’s mind.

Over the next half year, Hope was able to do this exercise. It was terrifying and painful at times. I’m including Hope’s story to make the point that connecting the brain and the heart was not a snap for all PDer.

Refusal to connect the imagined body and physical body

In that first, exciting week there was another PDer, Sarah, who also did not respond to this new technique with a new sense of inner calm, a cessation of internal tremor, and increased awareness of her physical body.

When Sarah first started looking at her brain hemispheres, she saw that the one on the left was a “complete mess.” It seemed to be a whirlwind of dust and chaos. Confronting it or exaggerating it did not change the mess in any way. Sarah was unable to imagine an area of excess electrical activity for quite a while. Finally, I asked her to just *pretend* that she was imagining it. With the mutual understanding in place that she was only pretending to imagine, she was then able to see the place.

In her mind’s eye, she pictured her brain as brown and dried up. Connections were missing, but hooking them up did not help; the area was too brown and dried up. I asked her to look at her heart to see if the connections were OK at that end. Her heart was black. When she exaggerated the blackness, it stayed the same blackness as before. It never changed.

During the session, Sarah said that she felt much more calm and her tremor slowed down. She insisted that the ability to attain calmness was of no significance and that the tremor had, of course, slowed down because she was calm.

Deeply disconnected

When the session ended, Sarah mentioned casually that the images of her brain and her heart had not been taking place in her actual brain or heart. She had imagined both the brain and heart to be about three feet out in front of her body, a good safe distance away. I was disappointed.

Sarah and I had worked many times on her refusal to even try to integrate her mental image of her leg with her actual leg. I had told her how important it was, but she had never been interested in integrating them, though she frequently complained that I wasn't doing a good job of curing her Parkinson's. (She also complained to me that her anxiety was getting worse. When I asked her what mental exercises she was doing to overcome her anxiety – I had suggested many – she said that she wasn't doing anything. Fixing the anxiety was my job.)

Early in our working together, Sarah had told me, adamantly, that the reason she was so anxious was because of all the things going on in her life. Actually, her life was extremely uneventful. Her husband made a good salary. Sarah had very few interests or daily activities.

Still, Sarah was anxious about "everything." Many times, she tried to blame the Parkinson's on "all the things that are making me anxious." For example, she was anxious when her adult daughter, who lived on the opposite coast, drove to a bed-and-breakfast for a weekend getaway. Sarah called the bed-and-breakfast to make sure that her daughter had arrived safely. (Sarah said, "I didn't call my daughter's cell phone, I called the bed-and-breakfast directly because didn't want her [the daughter] to know I was checking up on her.") I repeat, Sarah blamed every external event in her life for "making her anxious." She was not interested in working on changing her attitude: *she* did not consider that she had a problem. Nevertheless, she wanted me to cure her anxiety.

I asked Sarah if she could possibly visualize her brain and heart inside her body. She was not interested in doing so.

I asked her again why she was refusing to work on the problem of integrating her mental leg-image and her physical leg: the leg that had been hit by a car when she was sixteen. She then made a revealing statement: "Well, I just felt so stupid. How stupid is it to step out into the street in front of a moving car? I felt like an idiot."

Evidently, she was not going to do the work of reconnecting her mental image of her leg and her actual leg because bringing up the subject still made her feel stupid. After a year of working with her, this was the first time she had informed me of the ego-based emotional content behind her disinterest in working with most of the techniques that I presented. She half-heartedly did the various mind-body reconnecting techniques with me, but she thought them stupid and pointless.

She really liked her own idea that I should be able to treat her with needles and make her anxiety "go away" without her needing to get personally involved. A few times, she told me to use needles for anxiety instead of using FSR or other PD treatment techniques. The benefits of these treatments were not long lasting. This idea of hers – that all she needed was acupuncture needles – had never panned out but, even so, she clung to it.

Although her foot injury was gone, her Qi was running correctly, and her facial expression and the energy in her foot had improved tremendously, she was increasingly

disappointed in my “system” due to her increasing anxiety and continued tremor. She was waiting passively for some acupuncture needles to “cure” her.¹

Meanwhile, while she was waiting, she was taking no steps to change her glaringly negative and cynical attitude about anything and everything. My sense was that she was waiting for the world to change so that she wouldn’t need to be anxious. The idea of doing the hard work herself of changing her attitude did not seem to be, for her, an interesting option.

At any rate, despite what I sensed was her determination that this technique could not work, she had, just the same, felt more calm and tremored less while doing this “failed” experiment.

MORE FRUSTRATION

Over the next few months, I had all my Parkinson’s patients try this mental imagining. Some PDers could not yet connect an imaginary brain to an imaginary heart. Many of those who could found themselves in physical pain or terrified. But some were able to temporarily improve their symptoms by using this imagery. We hoped that this new visualization technique would permanently cure the problem of partial recovery. It did not.

Over the course of the next year, the heart reconnection exercise was experimented with, refined, and simplified. As PDers shared the feelings and fears that welled up when the heart became connected, we compared these phrases and explanations with what the quick-to-recover PDers had said.

In people who recovered more quickly, there was less resistance to the idea of opening up to the heart to the potential joy *or* pain of the universe. The people who had the most difficult time opening the heart or keeping it open were also the people for whom the word “surrender” most stuck in the craw.

There was one phrase that we heard frequently as partially recovered PDers experienced the sensation of a “connected” heart. As the tougher cases learned to open their hearts, often with much anger, frustration, or tears along the way, it was not uncommon for them finally to calmly remark, as if remarking on the weather, “Oh. I just remembered when I decided to pretend to be this way.” However, remembering the origin of the mental game did not necessarily give a person the tools necessary to keep the heart connected.

Also, some found that the initial joy of connecting the heart and brain soon diminished. Also, the heart did not stay connected unless the person was consciously telling the heart to connect. Most significantly, most of the PDers were still unable to *feel* their own bodies. By pretending that their minds were connected to their hearts, they became able to activate their visual imagination centers in their brains. They were also able to visualize old injury sites and recognize areas in their bodies that were mentally inaccessible. However, they were still, for the

¹ She was not the first person I had met who was had decided that acupuncture was a cure-all. My students at the acupuncture college often feel the same way. It can sometimes take years before they come to realize that there is a place for all the different types of medicine. The best medicine for a given illness is the one that works: one that reverses the problem that is causing the illness.

A person who is *choosing* to have a closed heart can only reversing his condition by choosing to open his heart. There is no acupuncture needle big enough to change the mental posture of a person who is choosing to be emotionally shut down.

most part, unable to consistently feel the joy and body awareness that triggers dopamine-based movement.

During this time, we also tried other “heart opening” exercises, including the exercises developed by the Heartmath Institute. The PDers who had the hardest time imagining the heart being wholesome-looking and mentally connected to the brain were also unable to do the Heartmath visualizations that involve the heart.

Restoring healthy function to the five senses

As an aside, we were becoming increasingly aware of our partially recovered PDers’ inability to fully experience sensory function. As western doctors have noticed, PDers often have impaired senses of taste and smell. We had noticed years earlier that PDers’ sense of touch was greatly impaired. More recently we were starting to understand that even sound and vision, though usable, were nearly always interpreted by the minds of PDers in a negative way. It was as if all of their sensory function was somehow under the influence of inhibition or negativity.

We’d seen that fixing the foot injury usually restored energy to the nerves around the nose and mouth. This allowed for the return of sensory function of smell and taste in those PDers who had lost them.

But what about hearing and touch? In partially recovered PDers, their hearing, in many cases, seemed to still be stuck on “heightened alertness.” As for touch, many partially recovered PDers would readily admit that their proprioception was poor. And we knew that, during full recovery, PDers noticed profound changes in the way they saw the world. For example, they could suddenly see imaginary images in clouds, they could imagine seeing faces in the leafy shadows of trees. This type of vision had been unavailable to them while they had Parkinson’s, and remained unavailable to many people who were stuck in partial recovery.

To give a point of time reference, this was happening while we were still wondering why the professional musicians with PD had all recovered quickly, in a matter of a few months. There was clearly something going on between the way that a person with Parkinson’s used his sense of hearing and the way he communicated with the rest of their body. We discovered that answer to that story in spring of 2006, when we learned about the proximity of the brain’s frontal lobe area that tracks melody lines and the frontal lobe area that connects to a certain type of nerve signal from the heart. The professional musicians in our program, possibly by dint of constant stimulation of the melody line association area, had essentially forced their hearts to stay open and receptive to *nearly* every aspect of feeling with the exception being their dissociation from their foot injuries. This confirmed our idea that a healthy heart-brain connection was important for full recovery from Parkinson’s. But we had not yet figured out what process the PDers were using to inhibit this connection.

The worst fear: feeling

Lack of feeling and proprioception, we finally realized, were the biggest problems: some people whose bodies could function almost normally, who could taste and smell and use facial muscles and whose rigid bodies had softened and healed still could not really feel their bodies. Using the technique explained in this chapter they could eventually, sometimes after much work and the killing off of their alter egos, imagine their hearts becoming bright and beautiful. They could finally visualize light streaming through their bodies. But very often, they had no sense of what their bodies actually felt like or how their hearts “felt” while filling the body with light and

joy. Sometimes, if their eyes were closed, they still could not be certain where their body parts were located. If they still had bruises or injuries, they could not feel them.

When we asked, now and then, what it *felt* like to have light streaming through previously dark and murky legs, the PDer was most often stunned by the question. “What does it *feel* like?” “Feel?” “What do you mean, *feel*?” We might reply, “Does it feel good? Does it feel bad? Does your foot feel warmer or colder, or do you feel happy to have light in your foot? How do you feel when you do this visualization exercise?” And the PDer would say, “Feel? What do you mean, *feel*?”

A short case study about fear of the word “feel”

One PDer could be utterly relaxed while I did Yin Tui Na on his feet, only to break into a two-minute spate of tremoring every time I conversationally used the word “feel,” “felt,” or “feeling.” When I realized the connection between my words and his intermittent tremor, I did an experiment. Without explaining what I was doing, I started on a seemingly mindless verbal ramble. He was busy making sure that his heart and brain were connected.

I discussed the weather. When I said, “It *feels* to me like it’s going to rain soon,” he started tremoring. Two minutes later he was calm again. A minute or two later, I said, “I don’t eat a lot of eggs, but this morning I *felt* like having eggs for breakfast.” He started tremoring.

After half an hour of this, his wife, watching from the sofa, was trying to restrain her giggles. She saw exactly what I was doing. He never suspected a thing. I kept it up for most of the entire one-hour session. I would be talking gently of this and that, and every four minutes or so I would slip some form of the word “feeling” into a sentence. He would immediately start to tremor. After two minutes the tremor would calm down. I would wait until a few minutes passed, and then I would say a sentence with a form of the word “feeling.” The tremor showed up.

At the end of the hour, he was deeply confused. He said that he usually felt very relaxed after our sessions but that on this day, he had no idea what had been going on for the last hour. He had almost no recall of anything we had said or done.

I then told him what I’d been doing. He didn’t understand why I’d done it. I replied that he was adamant that he had no emotional blockages and that he was extremely sensitive and well-adjusted. I had done the experiment to demonstrate that his tremor was connected somehow with his inability to feel, his inability understand what I was talking about when I asked him questions such as “how does your foot feel when I hold it this way?” After I explained the above, he still had no idea what I was talking about. He asked again, “What do you mean, *feel*?”

Still looking for answers

We had to admit that we had not yet cracked the case. Most partially recovered PDers, even some of the ones who could imagine their hearts being connected to their brains while consciously working at it, were not able to feel their own bodies.

(Given that the heart-brain connection exercise wasn’t the final answer, why did I include so much information about it? Because getting a mental image of the heart turned out to be a necessary first step to turning off the dissociation response, and I want the reader to appreciate that this is not necessarily an easy step. Also, I wanted this chapter to do double duty as instruction in the technique, as well as sharing information about possible pitfalls.)

By now, we were deeply discouraged. We knew that PDers were mentally unable to do mind games or imagine themselves consistently having a *feeling* heart, and yet we couldn't get rid of these inhibitions. What we still didn't realize was that, in many cases, PDers had learned to mentally dissociate from anything that frightened them. In retrospect, we realized that PDers couldn't feel anything in their body because they had dissociated from their entire bodies.

Many PDers had already told us that, when they had received their diagnosis, their dominant thought was a variation on "my body has betrayed me." Betrayal is a horrible thing. When "betrayed" by their bodies, PDers, from years of habit, had dissociated from their traitorous bodies. Later, when we realized that we were working with expanded variations on the selective dissociation response, we could see that the very act of being diagnosed often expands on a PDer's ongoing preference for the dissociation response: even if, prior to the diagnosis, the dissociation had been limited to an injured area and a few mental areas, the entire body became an enemy, or at least a threat, when a person received a diagnosis of Parkinson's disease. The PDer, upon diagnosis, performs his usual method of dealing with his fears: he dissociates from his heart with regard to that particular fear.

And what is the core purpose of the dissociation response? Shutting down one's ability to feel. What happens if a person dissociates from his body? He cannot feel his body. Many PDers protest that they *can* feel their bodies, that they are very sensual or sensitive. They are wrong. We know that most of them have only the crudest sense of body awareness: when they do recover full feeling they are usually stunned that such an extent of proprioceptive self-awareness and feeling is even possible.

