

“And oftentimes, to win us to our harm, the instruments of darkness tell us truths, win us with honest trifles, to betray’s in deepest consequence.”

Shakespeare’s Macbeth

16. STRANGE BEHAVIORS

THE HITTIN’ AND THE CHEATIN’ AND THE LIES

In addition to the expected discomforts (an understatement) during their 10% drug reductions, we also saw uncharacteristic violence, defiance, and deceit creeping into our patients’ behavioral repertoire during their drug decreases. These events were not necessarily bad – in fact, since they happened so frequently, we were eventually able to recognize them as additional signposts in the drug reduction cycle.

What’s going on? PD or withdrawal?

These behavioral changes usually occurred after the ten-day downhill slide into drug decrease was finished and the reduction was in full swing. These changes helped serve as an alert that the patient was experiencing mind-altering drug reduction/withdrawal symptoms. By confirming that a person was in reduction/withdrawal, these uncharacteristic behaviors showed that any parkinson-like symptoms might actually just be stemming from a brain reaction against drug reduction. Therefore, any seeming worsening of Parkinson’s symptoms that occurred at the same time might be safely considered also to be a part of the drug decrease phase and *not* signs of advancing Parkinson’s.

The main question for drug reducers is usually, “Is this symptom a sign of withdrawal or is it Parkinson’s?” These extra clues, unpleasant though they are, can give comfort and assurance that any physical and mood problems are at least as much due to temporary drug reduction trauma as to anything else.

Although from an objective, analytical standpoint, these behavioral changes can be helpful, from the emotional perspective they can be devastating. Anyone planning to embark on this journey should be forewarned about these aberrations. This quick chapter will share a few of these unexpected potholes on the rocky road.

Physical violence

Sonny

Sonny was 61 years old when he joined our project in March 1999. He was diagnosed in fall of 1989. His symptoms at that time were left arm not swinging and loss of dexterity in typing. He developed symptoms on the right side after five years.

His symptoms (when Off) in March 1999 included rigidity in both arms and hands (worse in the left), a little rigidity in the left leg, and lack of arm swing. His feet scuffed the ground. He would trip and fall “maybe once a year.” He had On-Off cycles four or five times a day. Sometimes the Offs were “minor, sometimes major.” During a major Off his voice was faint and he drooled, which inflamed his young (second) wife. His handwriting, always small, had become micrographic.

His medications, when he started with us, included the following.

Daily Medications:

Sinemet: 1000 to 1200 mg levodopa/day (five to six 50/200 Controlled Release)

Sinemet: 50 to 200 mg levodopa/day (half to two of a 25/100 Sinemet)

Permax: 4.75 mg/day

Tasmar 300 mg/day

Klonopin (also called clonazepam and Rivotril. This anti-convulsant, used as an adjunct therapy for schizophrenia and mania, which Sonny described as a “pain killer,” was taken twice a day to reduce his dyskinesias and intestinal dystonia.)

Naprolan (naproxen, an anti-inflammatory pain reliever)

Vioxx (rofecoxib, an anti-inflammatory pain reliever)

After working with me for several months and noticing improvement in his condition, Sonny had begun reducing his medications. After nearly a year of slow, steady reduction, Sonny came in to my office for his weekly visit with a hangdog look and swollen face – as if he had been crying. His wife was drawn up in her stiffest manner. I asked my usual first question, “How was your week?” and settled in for his report.

He quavered, “I need to be committed. I can’t stay at home any more. I don’t deserve to be home. My wife has been so good to me. She’s been helping me move when I get stuck, she’s helping me with everything, she’s helping me with the medication, she’s doing it all for my own good. I don’t appreciate what she’s doing for me, what she’s going through. She deserves better than this. I think I need to stay in a care facility from now on. She shouldn’t have to put up with me anymore.”

There was a silence in the office. We all looked at each other. I sighed inwardly and mounted what I hoped was a professional expression on my face, trying to assemble a look both helpful and non-judgmental, and offered a statement of fact: “So, you hit your wife.”

They shot each other a puzzled look. How had I known? And why wasn’t I more shocked?

“Well, in fact, yes. I hit her...How did you know? I’ve never done it before. I’ve never done anything like it before. We’ve been married twelve years and we’ve never had this situation. I’m turning into a monster.”

“Yes,” I said, “and you’re the second PDer this week who hit his wife for “withholding” drugs. When a couple walks in with puffy eyelids, the PDer is looking guilty, and the spouse is looking like a martyr, that’s usually what’s happened. Were you asking for extra pills and she wouldn’t give you any?”

“Yes.”

“Do you want to talk about it?”

“No.”

The familiar story came out. Sonny had been doing very well, but just two weeks earlier he had reduced his pills yet again. It was his fifth reduction over a period of nearly a year. As the drug levels finished their slide and he began feeling the effects of the most recent reduction, he decided to increase his pills back up; he had felt that they were reducing too fast.

His wife was in charge of the pills, and she wanted him to hold his ground. After all, he was still able to move, his dyskinesia was greatly reduced, and his dystonias had stopped so completely that he no longer needed the anticonvulsants or the Naprolan. He was completely off the Tasmal, and he wasn't even in the weak stage yet where he couldn't get out of bed or a chair by himself. He was still having Ons and Offs throughout the day, as he had been even before they started treatment, but after this last reduction his brain started to crank at him; he wanted those pills. They had gotten into a screaming fight, and to make his point, he'd hit her. As soon as he did that, he stopped in his tracks and announced that he needed to be put away. From what I had been seeing in others at his stage of drug reduction, the violence was pure routine.

I assured them that this was perfectly normal behavior, that I had seen it before, and that it was very hard to reduce medication. They wondered if he would do it again as they continued the reductions. I said I didn't know. His wife offered that if he ever hit her again, she would paste him one. There was a silence, and then I asked the usual second question: "So, how was your sleep this week?" They never brought up the subject of hitting again.

Dishonesty

Shortly after Hjalmar first started reducing his medication, he shuffled into the office for his weekly visit with a benevolent smile and his eyes shining with drug-induced, transcendent love for all mankind. He always took his second pill at 9:00, so his weekly appointment at 11:00 ensured that I would always see him beaming away, like a levitating saint blessing the people. Sophia was snorting steam.

"I have just had it with him, I have just had it!"

Hjalmar continued radiating joy. It seemed that the words "Bless you, my child" were trembling on his lips. In a minute he would've started strewing candy and coins if he'd had any. Sophia kept up her tirade. "He is driving me crazy! What am I supposed to do? Watch him every minute?" Her voice started cracking.

It was the old, old story: the drug sneak. "On Monday I gave him his 9:00 pill, only it was a 150 mg instead of 200. Then he went in the living room to read the paper and I went in the back room. I heard him rummaging around in the kitchen, so I went to see what was up, and he was getting into the pill drawer. He said he needed to take his 9:00 pill, and I told him he'd already taken it. So he went in the living room, and I went in the back room, and ten minutes later I heard him sneak in the kitchen. There he was again, getting out the pills. I told him that I'd just told him he'd taken his pill and that it wasn't funny, and he just acted all innocent, like he didn't remember that he had his pill, and then he said he didn't remember that we just had the same conversation a few minutes ago! And then, after his 11:00 pill, he did the same thing! I've taken to hiding the pills. And now he's going through all the drawers in the house when he thinks I'm not looking. He says he hasn't had his pills yet when he knows perfectly well he's already had them. It's driving me bonkers! I'm ready to kill him."

I glanced at Hjalmar to see how he was taking this. If he had smiled any more broadly he would have fallen off his chair.

"Well, sounds like you are doing the right thing by hiding the pills. Is he having serious problems? Is he freezing up worse than usual? Why is he needing the pills?"

“He’s doing just exactly the same. He’s stuck half the time, but he’s getting around. He brought in the firewood yesterday without using his walker, which he hadn’t done in years. He’s not thrashing around so much in his sleep. He’s doing perfectly well, but he’s lying to me about his pills. I used to think I could trust him! That’s the hardest part; I can’t trust him. (Tears started to roll.) I used to think I knew him so well. (Sobs.)”

“Well,” I said, “he’s stoned out of his mind, of course, and will be until he’s able to safely get down off his meds a little more. He’s medicated; he doesn’t know what he’s doing. He’s not himself.”

“He’d better not be! I’m gonna kill him. I can take anything but not lies!”

“You’re doing a great job, Sophia,” and turning to Hjalmar, I asked, “And how was your week? How are you sleeping?”

These events are so commonplace in the drug reduction stories that I can now tell them without getting shocked. But the spouses are invariably shocked and disheartened by the lying, hitting, and hostility that are part and parcel of drug reduction. I have asked my patients to get together to form support groups outside of their weekly meetings at the clinic, but only rarely have they done so. I suspect that these behaviors are so scandalous that they do not wish to discuss them with anyone.

Lying to the doctor

There is another form of dishonesty that often arises during drug decreases that is much more worrisome to me: lying to the doctor.

Hua To announced in a weekly visit, “I reduced my drugs again this week. Basically, I am feeling much better. I also saw Dr. Pender last week. I told him I increased my medication.”

“Why on earth did you do that!” I gaped.

“Well, basically, he asked me why I was doing so much better, so I told him I had increased my Permax to 13 pills a day from 10. If I had told him that I had decreased, going from 10 pills down to 6, he might have gotten mad at me.”

“Why on earth would he have gotten mad? He noticed that you were doing so well. Why did you lie to him?”

“Because I disobeyed him. He expected me to increase, so I told him I did.”

This is such a common scenario that it worries me. As a primary care physician, though not an MD, I am concerned that there is such a high level of fear towards the medical profession that patients lie to their doctors. Also, these lies go onto patient’s charts. If Hua To ended up in hospital for some unanticipated reason, the staff would understandably give him medications at whatever level was on the doctor’s chart. This had happened in Rose’s case, with a deadly result.

The fear that Hua To felt towards his MD is all too common. I do not know what to do about this problem. This deserves a book in its own right.

My patients at the clinic greatly enjoyed sharing with each other their animosity towards their doctors, especially the many doctors who responded happily to a patient’s visible, apparent improvement but who became outraged when they learned that the improvement corresponded to patient-initiated decreases in their drug regime.

Lying about hallucinations: doctor-appeasing strategy

We did learn one helpful bit of information that, regrettably, belongs here in the section on dishonesty: the only condition under which 100% of the doctors approved of drug reduction was hallucinations. My patients all started taking careful note of the hallucinations or even inventing fictitious hallucination stories so that they could get past the Angry Doctor situation. Evidently, it worked like this:

“Harlan, you’re looking great! (Or, Hunter, you look terrible!) What are you doing differently?”

“I’ve decreased my medication.”

“Why did you do that!” the doctor would reply, with puzzled or angry overtones, on the verge of the Stern Father act.

“I was having hallucinations. Now they’ve stopped.”

“Oh,” the doctor would say, backing down, head nodding in sympathetic understanding. “Well then, OK, that’s fine.”

I do not recommend lying to your doctor. This whole aspect of patient/doctor relations fills me with sadness. However, you may need to be aware of the hallucination gambit.

Bravado

“I can quit anytime!” was Brad’s battle cry after he had quit yet again for a quick three days to prove that his meds weren’t addictive. I had seen this routine many times before in other patients. It usually occurred just after a patient ended the drug reduction cycle and started feeling good again. These boastful assurances were meant to justify an indefinite delay before the next drug decrease.

I can’t tell you how many times a person has stopped taking their L-dopa for three days to show me that they can do it and to prove that everything I quote about L-dopa’s addictiveness is pure nonsense. I see this all the time. Sometimes they even go a full ten days just to say that they didn’t notice any sort of slide. And then they will start taking the pills again and realize that they are not feeling as well as they used to at their old dosage level (because they are slipping into a withdrawal phase, and it will take at least ten days before the pills begin to work as well as they did before). So at this point the person will double or triple their dose in order to get back to the good feeling that they remembered before they quit. When I ask why they are taking so much, the answer is invariably, “I already proved to you that I can quit anytime. I proved that I won’t have any withdrawal symptoms when I quit, so it doesn’t matter if I take the drugs or not.”

To which anyone would logically counter, “Then why did you start taking them again?” (Or else a common variation, “And why did you double your daily dose?”)

And the answer to this is always, “It makes me feel better, and it obviously has no long-term effect on me.”

There is no one quite so predictable as a drug addict.

Irrational self-confidence

L-dopa imparts an unrealistic confidence. I have seen drugged patients take fantastic spills and brag ten minutes later that they never need a walker. I have seen the bruises from breathtaking crashes, and yet these patients never seem to learn wariness or

caution from their experiences. Under the influence of dopamine-enhancing drugs, a person has such confidence that he might not take the simplest precautions to avoid danger.

How many times have I heard the frustrated refrain, “He broke a rib again (or arm, hip, or ankle). He was falling down so much this week. I tell him over and over and over to use his walker. It’s always right there. I put the walker right by his chair, but he won’t use it. He just won’t use it.” A person who is using dopamine-enhancing drugs is not capable of really understanding that he is at risk. He may know that logically he might fall down, and that if he falls, he may hurt himself, and that hurt is a bad thing, but somehow, he honestly cannot bring himself to register that this means he should be careful. The caregiver thinks that he is just being defiant, but the truth is that a person is not capable of normal caution when under the influence of mind-altering drugs – and all the antiparkinson’s drugs are in this category.¹ The limbic area is the eventual resting place of excess dopamine (after about ten days), and when the limbic area is over-saturated with dopamine, the PDer cannot feel fear. He just can’t. This inability to make life-preserving decisions is the very reason that the brain considers dopamine to be the most dangerous neurotransmitter, the reason that so many dopamine-reducing mechanisms are present in the brain, and the reason that the brain performs an addiction response. The addiction response is an effort to save a life, to prevent a person from dying in a foolish act resulting from mindless fearlessness.² And so a person who is taking antiparkinson’s drugs in excess (a tricky amount to determine) will not take steps to prevent falls or injuries, even though advancing Parkinson’s disease worsens balance and motor skills.

The Fear of Reality

This joyous confidence begins to crumble, however, during drug reduction. The opposite of irrational confidence is nameless, primordial dread. This fear that appears during drug reduction may be perceived as a symptom of worsening Parkinson’s disease; it is not. The emergence of fear appears as the veil of drugged delusion is pulled aside. Because this terrifying return to reality may come at the same time as physical symptoms of drug decrease, the combination can be overwhelming. In such a circumstance, the patient is certain that he is worse than he has ever been before, and only a rapid increase in drugs can save him.

I remember the week that Margaret was so pleased, she just gushed, saying, “Mark is having real moments of clarity. I guess it was the medication that was fogging his mind. I had thought it was the Parkinson’s. He used to have such a dry wit. Very acerbic. A little too acerbic for a lot of our friends...but such a sharp wit. It was what first

¹ Every single one of the antiparkinson’s drugs can be found in the book *A Primer of Drug Action, A Guide to the Actions, Uses, and Side Effects of Psychoactive Drugs*. Every one of these drugs is a mind-bender. That is what imparts their power to create movement in a brain that is determined not to move.

² This is not the fearlessness espoused by great souls such as the Mahatma Gandhi, who said that the first step to a spiritual life was fearlessness. For a spiritual seeker, fearlessness means having unshakeable certainty that God is the one in charge, and that under His divine plan, all events in the universe will eventually bring each person back to God, regardless of the seeming paradoxes and apparent tragedies. Faith in God allows fearlessness to perform right action, unburdened by fears of what the future might bring. Drug-addled fearlessness such as jumping off cliffs is not right action – it is merely an arrogant denial of the laws of the universe, including the laws of cause and effect and the laws of gravity.

attracted me to him – you know, we’ve been married over forty years...and lately, he’s got that wit back. It’s amazing. It’s all still there! It just showed up again after this most recent drug reduction!”

So I warned Margaret of what was coming. When a person starts having mental clarity, even for fleeting moments, he may also start having clarity, often for the first time since starting the drugs, as to the actual nature of reality, including his health condition.

Sure enough, the next week, Mark was, for the first time in his life, fearful of being left alone at home, fearful of being abandoned, and fearful that he was unloved. He needed constant consolations and reassurances to sooth his sobs and whimpers.

What we have seen time and again is that a person who was falling down every day and not bothering to use his walker can do an about face almost overnight. Following the drug reduction that allows him moments of clear thinking, he may suddenly become aware that it is very possible, no, likely, that his poor balance might cause him to fall down. He may suddenly be aware that falling down is a very bad thing to do. He might become paranoid about falling. It is as if a gauzy bandage had been covering his mind’s eye, blinding him to the possibilities of getting hurt from falling. Suddenly, at some point during drug reduction, at lowered drug levels, that gauzy, dopamine-veil will get wiped away. With the dopamine gone, frightening possibilities appear, leering at him from all sides.

The support person’s response might be, “Oh good, he’s starting to remember to use his walker.” The patient’s response may be just the opposite: “I am getting much, much worse. I might fall down! When I was taking more medication, I didn’t have fear of falling.” It is the briefest of steps from “When I was taking more medication, I didn’t have fear of falling” to the logical “If I take more medication, I won’t have fear of falling.” From there to “I am undermedicated! I need more medication so I won’t fall down!” is a transition that we see over and over.

If the spouse or friend holds the line at this medication level, the person may start getting very paranoid around his particular fears. It might be fear of spilling food when eating or fear of not being able to express himself verbally. It will be a fear of something that was never considered a problem while under the influence of L-dopa. The drug-addled person might have been spilling his lunch on his shirt front for several years, but suddenly, in the new glimmers of clarity that come with gradual drug reduction, this person might be ashamed and appalled at the soup stains on his shirt.

When a person begins to have awareness of worrisome problems, whether emotional or physical, these problems can inspire an inner voice, a limbic-led voice, to sidle up to his mental resistance and say, “This never used to be a problem when you were taking more medication...”

This serpent-like voice is clever. It will not mention that you were spilling your soup, taking whole body spills, or whatever, when your medication was higher. This compelling voice will only remind you that *it didn’t use to be a problem*. It *won’t* tell you that it wasn’t a problem because nothing could be a problem when you were that stoned.

Lack of Logic

This inner voice is very convincing. Because it is your own voice, coming from your own mind, it alone knows those very arguments to which you will be the most susceptible. Your inner voice knows the guilt-inducing voice, the fear-avoiding voice, all

your intimidating authorities from your deepest psyche, and it can pull them out and your logical mind doesn't have a chance. There is a reason that all the twelve-step programs that help with addiction insist that a person rely on a higher authority than their own logic. Your own subconscious can outwit your own logic every time. Your subconscious knows where all the fear and guilt is hidden, where your weaknesses are. Your logic is relying on your frontal lobe, on the other hand, and when your dopamine levels drop, there isn't much action in the frontal lobe. Logic goes out the window. A person who is left to his own devices, without an external guide, will succumb every time. The external guide can be a spouse, caregiver, friend, or a source of spiritual counsel. But a person cannot easily go this route alone. We have found this over and over.

Memory loss while medicated

Although Margaret was able to recognize the patterns of drug withdrawal in Mark, and drew strength from them, Mark was never able to see the big picture. Not only that, he appeared to be incapable of remembering his previous drug reductions. He had no recall of how he had felt during previous drug reductions, and so, every time he slid down into darkness, it was a new and terrifying experience.

For example, during one reduction phase, one that was, oddly enough, relatively pain free, Mark felt scared and helpless, even though he had to admit that he was standing taller and moving in ways that he hadn't moved in years. For example, he could slide in and out of the car gracefully for the first time in years. Friends were remarking on how his posture and walk had improved. But he still wanted more medication. He couldn't sleep at night and he was unhappy about everything in particular and life in general.

His wife decided to override his demands for a drug increase based on his improvements in motor function. They argued heavily. The following week, as his logic returned yet again, he agreed that she had been right, and he was glad he had not increased his medication. But – and follow me closely here – when they were in the midst of the next medication decrease, they went through the entire dance again.

For Margaret, it got easier every time for her to see that his intermittent, hysterical demand for a drug increase was all part of the drill. “First we reduce, his dyskinesia gets better, and his sleep is better. Then, after a few days, he gets scared. Then, after a few days, he gets paranoid and he says he's getting worse. And then he can't move, and he nearly falls down, and then he's really paranoid. He screams for more drugs, and then, after another week, he is doing better: he admits he's glad he decreased the meds, his mind feels clearer. And then the dyskinesia is back and it's time to start all over again. I'm getting used to it. It's always different, it's something new every time, but I can see the pattern in it.”

For Mark, however, *it was a new experience every time*. When Mark was in the throes, he was incapable of recognizing that he was repeating a pattern that he had played out a month or two earlier. Every bout of paranoia was new, original. Every longing for the drugs was a first. Each time he felt the need to increase the medication, it was because he had *never* felt these sorts of feelings before – these menacing feelings that everything was bad, hopeless, dangerous and wrong. Every time he felt a yearning to go back up to a higher drug level, he was certain that this craving was a unique experience.

Regarding this same problem, Becky made an illuminating remark. Once, during a time when she was completely off drugs and done with withdrawal, she confessed, “I

don't really remember anything from the entire time I was taking L-dopa. I remember there were good times and bad times, but I don't remember any details. It all seems like a strange dream." I have heard this over and over.

Any lack of memory of previous drug conditions is a good indication that the person was taking drugs at a level far too high. If the drugs were so high that a person was not capable of forming accurate self-assessments, then the drugs were also high enough to be causing addiction-type changes in the brain, possibly including cell suicide and changing baseline or threshold. Therefore, this lack of memory, though galling, can be a good warning that the drugs were too high – a psychological weapon to be used against the allure of increasing the drugs back up again, back to where the PDer was mindlessly happy.

Blows to the ego

The idea that pure logic and an arrogant force of will may not be adequate to overcome drug addiction is an especially difficult concept for many PDers. They may have had such a lifetime of over-developed will power, due to their overactive adrenal responses, that they actually believe that they have more will power than others, that they are different from others.

Well, that's true, of course. As long as they are sick, they will have this unnatural will. But as soon as the recovery begins, the will power disappears. At this point, if they are still medicated, they find that they are addicted to the most powerful of all drugs, with the will power of an infant. Their actual will power may be that of the child that they were at the time of the injury that started the PD.¹ Drug reduction adds to these ego blows the reintroduction of fearful reality and the emergence of the wily limbic seducer. This combination contributes to the strange behaviors that can erupt during drug reduction. How many spouses, during these difficult times, have wailed, "It's as if I'm living with a stranger."

Vacillation

Just so you won't think that every story is one of violence and lying, I am thrilled to be able to tell you about the team of Mark and Margaret. They were wonderful. Margaret always wanted to know what was the worst that might happen from week to

¹"Not my will, but Thine, be done," is not just a statement by Jesus about yielding to His Father's will, it is also a statement of ultimate truth. In the end, after we have had our lifetimes of strutting our arrogant will in gleeful opposition to logic or goodness, we must, if we will ever be in harmony with the universe, acknowledge that our own egoistic will has to die. Eventually, God's will, a will predicated on love and directed by perfect balance, wisdom, and fairness, *will* be done.

Many PDers have said that the beginning of their recovery was the realization that their powerful will power, the strongest motivator of which was self-preservation, was beginning to ebb. They say that acceptance, not to death or pain, but to being a part of the human race, was the beginning of their recovery.

I know that by including so many spiritual references in my work I may be building barriers between my work and a few anti-spiritual western doctors. My work is evidently not written for them. It is written for PDers of every faith and of no faith, and they will very likely know exactly what I am talking about. I also know that most of them, in the beginning of their recovery process, will be saying, "But that won't happen to me – my will power is different, it is already coming from a spiritual basis." But any will power, if it has not yet surrendered utterly to the will of God, if it still sees itself as separate and different (as in saying "My will power is *different*"), is an egoistic will.

week and what to expect, so that she would be prepared for it. She'd tell me the preceding weeks' events in great detail.

"He's arguing with me all day long," she would say. "And sleeping. He naps all day. And his ankles are swelling up. But mainly, he vacillates between gratitude that he's doing much better overall than he has in a long time and terror that he's worse than ever, going to hell in a hand basket."

Margaret was eager to learn, dubious about everything, but willing to listen to alternatives. She was also a brilliantly objective observer.

"The back and forths are just like you said. You said he was going to start getting illogical, and oh, brother! Has he been illogical! People are starting to say how good he looks, his posture is so much better, his stride is longer, and most of all, his face is so much better. He doesn't have that twisted face (grimacing) that I just hated. He hears what everyone is saying, and sometimes he'll suddenly say, 'I'm glad I'm reducing the meds, I feel so much clearer in my head.' And then an hour later he'll say he needs to increase his medication back up. During his negative times he sure wants to fight with me about the meds. I'm just glad you warned me."

PREDICTABILITY VS. "STRANGE" BEHAVIORS

As an aside, and to break up this chapter of negativity with a positive slant, let me tell more about Mark's case. Mark started with us shortly after we had assembled our new drug hypotheses and discovered the 10% pattern. I had seen enough cases that I could make an educated guess as to how he might behave in each week to come based on what Margaret told me had happened the week before. As Margaret told me every detail of what he was saying and how he was moving, I found I could predict which of the drug-related scenarios were most likely to occur next based on the experiences of previous patients who had already gone through a similar phase.

Mark did not hear these predictions; Mark was being treated by an intern at our weekly clinic. Every week after his brief intake, Margaret and I would have another intake across the hall while she told me details of the events of the week and I suggested what might be in store for her and shared pertinent case studies with her. The point of this separation of information was that we did not want Mark to overhear my predictions for how he might behave during the upcoming week. Although it is highly probable that Margaret's expectations could be subliminally conveyed to Mark, still, it would have been difficult for him to create the physical changes, such as grossly swollen ankles, screaming for Margaret all night long, and the emotional changes, such as return of wit and lucidity, merely because Margaret had been vaguely forewarned. My suggestions were never about specific symptoms but just a bit of theory, combined with examples of what other patients had been through at a similar stage in recovery or drug reduction.

I also made specific predictions to myself or Mark's acupuncturist when I suspected he was on the verge of becoming maudlin or hostile. This was an intentional experiment. I wanted to see if there was, in fact, some level of predictability in the system. If, after four years of working very closely with PDers who were reducing drugs, I could predict from week to week whether Mark would suddenly bound from undermedicated to dyskinetic, or if I could predict during which reduction he was most likely to try hitting his wife, it meant that these drugs were not unpredictable. Over a period of nearly a year, my predictions were right on. Responses to drug changes were

predictable! I'd had to follow his case like a hawk, and I had to apply every observation I'd made in preceding years, but it was doable.

Weighting the dice

Finally, while some people might say that any sharing with the subject of case studies is “unscientific” and mars the Truth inherent in a double-blind study, I would like to offer this reminder: patients do not live in a vacuum. They do read about other similar cases. They do have expectations based on what they are told by their friends and physicians. If, as these skeptics might insist, Mark only recovered from Parkinson's and was able to stop taking his medication because of my mild suggestions, then maybe what is needed for medicine in general is a more positive attitude from doctors and more time spent telling people how others have fared who have successfully passed this way before.

The meds were not “unstable”

And however important my role was in Mark's recovery, Mark and Margaret's case was also important to me, because it proved that, with enough experience, even the strange ups, downs, and emotional alterations brought on by med changes could become predictable.

The drugs are not acting wrongly, nor are they unpredictable rogues. They are predictable, but only if we understand how they work. There is tremendous benefit in knowing that these drugs are predictable. The difficult times, the dishonesties and illogic, when combined with the moments of lucidity, and added into the data of time frames and predictable drug symptoms, can be used to paint a fairly precise, if encoded, trajectory of just where a person is on his journey with the drugs.

Summary

A PDer who is reducing drugs may protest verbally and physically. The violence and dishonesty may be utterly out of character. The drugs themselves create mental conditions of bravado and irrational self-assessments. The glow of inner love created by the drugs gives way to fearful confrontations with reality when the drugs are decreased.

There may be a thousand reasons why a PDer who is obviously improving and having fewer adverse effects from his drugs will still want to increase his medication on any given day. The most common reason to resume or increase the medications has been, “I’m much worse. I am *not* getting better. Everyone who thinks I am getting better is wrong, and I am torturing myself for no reason.” The second most common is, “I will die soon anyway, and so I might as well die happy.”

It requires good record keeping on the part of the patient and the caregiver, and good analysis of those records, to battle the onslaught of these compelling arguments. The patient may be unable to logically assess his condition. He may not understand that he is getting better, healing deep inside, despite the physical difficulties – including rigidity and shaking – that occur during drug reduction. He may also feel in his heart that he is getting worse due to the emotional torments coming from his limbic area. During times of physical pain, limbic taunts, and self-doubt, the answer will appear to be drugs, the whole drugs, and nothing but the drugs.

Hopefully, by learning about a few of the possible complications such as personality change and relationship conflicts, you will start to appreciate that the 10% solution is not just a simple matter of mathematics. Although there was uniformity of success (as defined by lack of life-threatening heart and lung symptoms, hallucinations, nausea, and irrational terrors) with the ten percent approach, every path through drug recovery had its own, seemingly unique, pitfalls and detours.