

“No rule is so general, which admits not some exception.”

Anatomy of Melancholy, Robert Burton (1577-1640)

24. VARIATIONS IN ADDICTABILITY

SUSCEPTIBILITY: A SLIDING SCALE

Although some medicated patients flipped out after manifesting signs of recovery, many patients who were still using drugs after starting to recover never exploded into frenzied motion or crazed addiction. Why?

For example, Olli, from chapter two, showed considerable improvement in his Parkinson’s symptoms prior to starting any drug reduction. Yet he easily stopped taking Eldepryl during this time. Subsequently, after his frightening fall on the first day that he stopped his 500 mg/day levodopa (Sinemet) cold turkey, he never tried to make any further decreases in his medication. Within a year he started having problems related to adverse effects of the drug, which he, predictably enough, treated by making increases in his Sinemet, but these problems, for the first year, were only some moderate increases in dyskinesia, grimacing, and ticcing. He never went hyperkinetic in the way that Viktor and a few others had done.

We had to wonder why Olli and others like him had such a gradual increase in sensitivity to the medication, when Euclid, Brad, Angus, and Viktor had apparently flipped out overnight.

Secondary injuries

In Olli’s case, although his foot responded well to treatment – his foot-dragging walk, feeble voice, and absence of facial expression (all of which symptoms are located on the Stomach channel) recovered completely and his tremor stopped – he also had a significant injury in his shoulder. This shoulder problem had chronologically preceded his foot injury. At the time that the foot-related PD symptoms began to ebb, the shoulder problem had not yet been addressed via our treatment protocol.

It appears in retrospect as if the unhealed shoulder problem helped his body retain a partial condition of injury, which in turn prevented the medication from becoming as addictive as it was in those patients who had completely recovered from all major injuries.¹

¹ I am not suggesting that every single lingering, unhealed injury must be detected and treated in order for a person to recover – absolutely not! Very often, when the pre-existing fear that prevented the foot injury from healing is assuaged and the foot begins to heal, other injuries that occurred *subsequent* to the initiation of that particular fear/foot injury (either/or) combination may spontaneously surface and self-initiate the healing process. Possibly the brain may store certain associated “Fear: Do Not Heal” signals and injuries all together in the same brain compartment. Once the compartment is unlocked, the body may have healing access to any and all unhealed injuries stored in that particular collection. However, in Olli’s case, his neonatal shoulder surgery long preceded the foot/leg injury that he received at age six. They may both have failed to heal at the time that they occurred, but for significantly different reasons. Possibly, the non-healed shoulder injury was based on different fears than the foot and leg injuries that we had treated using FSR.

His shoulder problem appeared to have derived from a huge birth mark/mole that had been removed in his infancy. The doctors had not used anesthetic during the surgery, a typical pediatric practice of the day. He had never used this arm much, even as a child, and the shoulder still bore a deep, five inch by four inch scar.

When Olli decided, in spite of glaring improvements in his Parkinson's symptoms, to not make any more decreases in his medication, I was reluctant to rid him of any more blockages: without telling him my reasons for doing so (which legally might have constituted an opinion about the medication), I redirected my efforts away from his shoulder and focused primarily on maintaining the restored Qi in his feet.

Over the next year he started increasing his medication to address new problems that were arising: dyskinesia, grimacing, and ticcing (problems of overmedication). After he learned from the standard physicians' drug reference books that the meds were probably contributing to, or even causing, his new problematic symptoms, he planned to decrease his drugs. He tried to reduce for over a year and failed to ever maintain a pill-per-day decrease for more than one day.

After almost a year with no success in reducing his drugs, symptoms of drug-induced parkinsonism began to appear, joining his symptoms of overmedication. One of his most noticeable symptoms was partially losing his voice each day. His voice was fine in the mornings, at its worst by the end of the day – a Build Up, obviously, but at that time we hadn't figured out that these drugs had a cumulative effect. He felt that the abrupt loss of voice each evening forty-five minutes after taking his 7:00 p.m. pill was due to increasing PD. In addition to the evening voice loss, his balance became worse, and his walk was more uneven. His facial grimacing worsened (this symptom was also the most severe 45 minutes after taking the pills and worsened in intensity over the course of the day), and the ticcing became non-stop.

By the end of a year of these worsening "symptoms," he succumbed to his MD's suggestion that Mirapex be added to the Sinemet to try to control the increasing dyskinesia, grimacing, and other drug-related problems. Olli knew that these were side effects of medication, and not necessarily an increase in Parkinson's, and he was angry with himself for not having reduced earlier. He began having On-Offs. He dropped out of the program after a few weeks on the Mirapex. He assured me that he was utterly unable, at this point, to reduce his medication, and he also realized that he had probably done himself enough damage with drugs that he would now need ever-increasing medication in order to treat this damage. Sadly, if you will recall from chapter two, Olli was a professional counselor who worked with drug-abusers, and had assured me from the start that he, of all people, would have no problem reducing his medication when the time came.

And yet, my point here is that, although Olli's condition declined over the course of the year following his improvements in his PD symptoms, (and the decline was probably due to taking drugs that he no longer needed) *despite the excess drug usage*, he never flipped out as Viktor had done. Olli's mental clarity remained high,¹ though he became more subject to moods. Most significantly, he only *gradually* declined into drug-induced parkinsonism and worsening adverse effects of the medication.

¹ Mental clarity was still OK the last time I saw him. I have not seen Olli since he dropped out of the program.

Yves

Yves was taking 1000 mg/day levodopa (five 50/200 CR Sinemet) when he started in our program. He was 73 years old and had been diagnosed five years earlier. He had mild dyskinesia from the medication. He was treated, with good results, by one of the student interns; he began to have improved sensation and gait in his affected foot. He correspondingly reduced his medication slightly, by 100 mg/day, down to 900 mg from his starting level of 1000 mg.

As he continued to notice symptoms of improvement, such as improved function in his ankle, improved sleep and a decrease in rigidity, he continued to make gradual decreases, decreasing by approximately 100 mg every month. He was one of our earlier patients, back before we had any theory or experience to fall back on. He was reducing slowly, not because we'd seen any good experiences with slow reduction, but because, though he wanted to save money on the medication and reduce his dyskinesia, he was, by nature, cautious about making changes.

Over the next nine months, he reduced his medication until he was down to 300 mg/day. By then he was moving well and had very little dyskinesia. Yves felt that he was taking "next to nothing." But Sharon, his student intern, could still feel the characteristic "Sinemet snakes" crawling under Yves' skin when doing Tui Na. Although Yves had an old neck injury that troubled him now and then, Sharon was doing Tui Na only on his legs. At this very early stage in our research we were still looking only at the foot/leg Qi situation in our patients.

Yves professed to be very pleased with the program and was grateful to be taking so much less medication. However, he told Sharon that he didn't think Parkinson's was curable and didn't intend to decrease his medication any further. Sharon asked why he had entered the program, if he didn't hope to recover. His reply was that the medication was so expensive, and he wanted some treatment that would help enough so that he could reduce his medication. He surprised us by announcing that he had never intended to "recover," and he had never planned on completely getting off the medication.

At this time, we had no idea that the medication was addictive, could cause parkinsonism, or make any lasting brain changes. We couldn't see any reason why he should not continue with the program, even though he no longer had any apparent Parkinson's symptoms with the "minimum" dose of 300 mg/day. He continued to come in for several months, during which time he expressed satisfaction with the program. Sharon noticed that the snakes under his skin were getting stronger, not weaker, and asked him if he was going to ever make a further reduction in his medication. He replied that he was happy with 300 mg/day – it was an affordable level, and it felt right to him.

Two months later, the snakes were growing more insistent, and Sharon told Yves that she felt he might be overmedicated. In my role as intern supervisor, I had to interfere at this point. I spoke to Yves, while Sharon was standing there, and apologized for her remark, adding that, as an acupuncturist, she could not make any comment that might be construed as offering advice, or even a suggestion, about Yves' medication. He must work with his doctor if he wanted any advice about his medication.

Two months after this, still taking 300 mg/day levodopa and starting to have marked dyskinesia again, Yves dropped out of the program. He thanked Sharon for her time and said he was well pleased with the results. He said he'd attained his primary goal: he'd gotten his pills down to an affordable level.

Because his previously slight dyskinesia had reappeared, and with more force than before even though his drug level was supposedly “next to nothing,” and because the snakes under the skin were getting stronger, Sharon suspected that he had actually started increasing his medication and lying to her about it. But possibly he was having more dyskinesia because he no longer needed his drugs. In either case, we would have no way of knowing.

But our question here is this: how was it possible that Yves could be increasing his medication or even staying at the same level without becoming violently addicted, when others who had taken the drugs while recovering had erupted with grotesque dyskinesias, new ticcings, or mental aberrations? Clearly, after PD symptoms began to fade not everyone responded to their medication in the same way. After reviewing the cases, we now suspect that multiple injuries may be a factor.

Multiple injuries

A growing hunch on our part is that people who have multiple injuries may have slightly more time to get off their medication than people who have only the one characteristic foot injury. As we have already suggested, very probably the sympathetic/parasympathetic switch is not an all-or-nothing toggle, but a sliding scale. Certainly, when the foot and leg patterns are restored, patients seem much more susceptible to addiction. *However, not all patients become addictable at the same rate.* In Asian medicine, this difference between humans is perfectly acceptable. But for some reason, maybe due to my training in western sciences, I wanted to know the mechanism that might account for these differences. While the old-fashioned (1950’s) “one neurotransmitter = one neural response” theory still adhered to by some greybearded MDs didn’t offer any answers, it seemed as if Asian channel theory might provide some clues.

DU CHANNEL THEORY

The Du channel, which runs through the midbrain, is the channel that most directly affects dopamine production in the brain. I must introduce a little channel theory at this point so that by the end of this chapter you will understand the special relationship between the Du channel and the Stomach and Large Intestine channels. The Stomach and Large Intestine channels, due to their intersection with the penultimate point on the Du channel (on the philtrum of the upper lip), an intersection not found among the other of the twelve Primary Channels, may very likely be the strongest drivers of the upper part (head portion) of the Du channel – the portion of the Du channel that regulates the midbrain.¹

The significance of this intersection may be that it gives the Stomach and Large Intestine channels almost an adjunct role (adjunct to the Du) in susceptibility to addiction. Conversely, other channels, while able to affect the Du, may play a lesser role. Damage to channels other than the Stomach channel may influence addictability, but not to the extent to which a rebellious Stomach channel can. This may help to explain the variations we saw in the rate at which patients became overwhelmed by their medication.

If you will forgive the inclusion of eight pages of Asian medical theory at this point, we can consider a channel theory explanation that might account for the variations in susceptibility to addiction that we observed. Let's go.

Du channel location

The Du, or Governor, channel is one of the extraordinary channels, or Master channels. The Du channel runs from the base of the spine up through the medulla oblongata. The medulla oblongata is the group of tissues that make the connection between the nerves in the spinal column and the neurons in the midbrain. The Du channel divides at the medulla, with one branch running over the top of the head and the other running through the midbrain, below and somewhat parallel to the upper branch. These two branches come together again, meeting and merging on the forehead at the point between the eyebrows.

¹ All channels help to push, pull, or otherwise drive all the others. The anciently known schematics of the body's subtle electrical patterns show that all the currents are interconnected. They cycle in endless, interwoven loops through the body. It is not a closed system: excess static can be discharged at the skin, especially the fingers and toes. The system is also plugged into and constantly recharged by an external source of energy. This life force invigoration is purely energetic, and is different from the energy derived from food. After all, man lives, not by bread alone, but by the external Life Force, or, if you want to get scriptural, "The word (sacred vibratory energy) that proceedeth from the mouth of God." The medulla is the place at which outside energy flows into the body. For a fun aside, note that this is the location at which the bodies in the metaphorical movie *The Matrix* were tapped in order to integrate the character's "real" self with a worldly, world-like delusion.



Fig. 24.1 The upper (over the head) portion and inner-head branch of the Du channel

This meeting point is named Yin Tang, or “Meeting Hall of the Yin.” The name Meeting Hall refers to the fact that this Du channel point is also the end of three Yang primary channels and the beginning of three others.¹

¹ The three Yang *arm* channels terminate at Yin Tang, and the Three Yang *leg* channels commence from this spot. This point is called *Yin Tang* because it is the meeting hall of the Yang channels on the *Yin* (front) side of the body, as opposed to the meeting of the Yang channels at Du 14, which is on the Yang (back) side of the body.

The nomenclature also has a spiritual meaning. Although the Divine energy enters in at the back of the neck (medulla), the Divine energy is most often perceived, not at the back of the neck, but as the light of the third eye, the spot on the forehead. (To pinpoint the location of the entry point, see any good book on embryology and note the hole at the back of the neck out from which all growth in spine-bearing organisms proceeds, and which only begins to fill in after the organism has sufficiently formed.) The light in the forehead is only a mirrored image of the Divine light that enters at the back. It is like the moon – having no light of its own but mirroring the light of the sun. The moon is Yin, and the sun is Yang.

As for looking directly at this source energy, the energy that enters through the back of the neck, most men could not withstand beholding the blinding “light of a million suns,” as Krishna describes it to Arjuna in the *Bhagavad Gita*, which pours into them directly from the Source and transforms from Love into light and matter. Instead, most seekers of Truth must satisfy their spiritual questing by focusing on their own small part of divinity, the mirrored reflection in their own forehead of their own small spark of Divine soul. This moon-like reflection, the “Moon of my delight that knows no wane,” of Omar Khayamm’s *Rubaiyat*, is Yin (further from the sun) in relation to the brilliance that can be perceived by great souls at the Yang (closer to the sun) meeting point of the Yang channels just a few inches above Du 14 on the back of the neck.

The pictogram for Yin in the point name Yin Tang is a character that means Self, Self Identification, or Stamp of Identity. This word “Yin” is also a homonym for that word “Yin” which means opposite of Yang. The word play here is wonderful. Yin, while meaning further from the sun (sun also meaning source, or God) can also refer to the individualized self, as opposed to the greater Self, or Yang identity, that recognizes its oneness with all things. The richness of having all these meanings converging in the point name allows the point name to be simply understood as “forehead, where the person’s identity meets with the outside world,” more deeply as “the meeting point of the channels on the Yin side of the body,” or the most profound, “the meeting of the energies that define this person’s identity, that mark him as an individual, delusively separate from other beings.” (Footnote continued on next page.)

Yin Meeting Hall of the yang channels

For an example of these Yang channels seamlessly ending and starting at Yin Tang, consider the Large Intestine channel discussed in chapter 5. The Large Intestine channel, one of the six yang channels that commingle at the center of the forehead, travels up the arm and ends its journey at Yin Tang.¹ (See chapter five, figure 5.1.)

(Footnote continued from previous page.) As for the character (pictogram) that is now assigned to this point, one must keep in mind that the point was first named in the oral tradition, and a picture assigned to the point name in later centuries.

For acupuncture channel purposes, the following meaning is most useful: Yin Tang, or Yin Meeting Place, is the meeting of all the Yang (meaning more spiritual and transformational, less material, less dense) channels, on the *Yin* (front) side of the body. This understanding of the point name was effectively banned by the 20th century Chinese government, which decreed that all spiritual meanings should be removed from the literature of Chinese medicine. However, while these meanings have been officially forbidden, they remain obvious to anyone who actually probes these channels to their depths.

¹ The drawing of the Large Intestine channel in chapter 5 (fig. 5.1) only shows the channel up to acupoint LI-20, at the side of the nose. This drawing is based on the modern, government-approved, all-spiritual-references-removed version of the channels. In this sanitized version this channel and the other Yang arm channels do not extend all the way up to Yin Tang, but stop abruptly and disappear into thin air after the last named/numbered acupoint on each channel, an inch or so away from Yin Tang. Each of the arm Yang channels supposedly is followed by its paired Yang leg channel. However, in the modern, official version of channel mapping, these subsequent paired channels begin abruptly, out of nowhere, an inch or so away from Yin Tang. The channels that flow towards the center of the forehead stop a few inches away from Yin Tang and the channels flowing away from this major energetic point begin a few inches away from Yin Tang, thus conveniently (for the sake of politics) bypassing Yin Tang. Amusingly, the Chinese government-approved maps of the channel schematics show that *no channels meet* in the point named “Yin Meeting Hall.”

This practice of modifying history willy-nilly for political reasons and then insisting that this new policy or condition has been unchanged since time immemorial is called revisionism, and is part and parcel of the Chinese political system.

For an even more glaring example of the fear that the current Chinese government has about Yin Tang, consider this: although the points were understood to be major vortices along the channels, the points historically were not named or described by their channel location. Their names referred more to the function of the energy at the particular acupoint, and point names did not include channel references. When, in the wave of modernization, the collection of known acupoints were assigned designation by a combination of channel name and number denoting the sequence of the points along the channel, the point Yin Tang was not included in the Du channel group, but listed at the back of the book as an “extra point.”

Even though Yin Tang is a major point along the Du channel, and the most famous Du channel point from a spiritual perspective, it was not assigned a number or channel, but floats in a nether zone in between officially numbered Du-24 at the top of the forehead and Du-25 on the tip of the nose.

When I asked several of my China-born and -trained colleagues the reason that Yin Tang is not a numbered point on the Du channel, they all ingenuously suggested that Yin Tang must have been discovered after the numbering of points was done in the 1970's. When I point out that Yin Tang is referred to in texts going back hundreds of years, they say that I must be wrong about Yin Tang being on a channel, any channel. Their proof? Their government-approved medical books list Yin Tang as an “extra point,” not related to any channel. When I suggest that the government might not have maintained the medical information to a high degree of historical or biological standard, they are uniformly appalled. I paraphrase their response, “The government cannot change history! Chinese history is the truth. History never changes. Chinese medicine has not changed in two thousand years. We learn the same medicine as our ancestors, only we add to it with new research. Yin Tang must be a modern point. It may function as if it is on the Du channel, and even be located on the path of the Du, but it is not numbered as a Du point in our books, so it obviously cannot be on the channel.”

Actually, although the three that flow into Yin Tang are considered to end at this point, in fact, the channels themselves continue on, merely bearing different names, so that we can say that three channels (coming from up the arm) flow into Yin Tang and three channels (moving down the leg) flow out from it.¹ The Large Intestine channel changes name and direction when, after having traveled up the arm and arriving at Yin Tang, it flows out again from Yin Tang, heading down the face towards the foot. This now downward-moving (that is to say, heading for the foot, although previously upward moving and coming from the hand) branch of the unending loops of channel Qi is called the Stomach channel.

The Du channel, continued

The Du channel, the one that flowed over and through the head, continues down the center of the face after its intersection with the six Yang channels at Yin Tang. It goes down the ridge of the nose, the philtrum (groove) on the upper lip, and then dives inside the body via the upper palate, whence it travels through the gastrointestinal tract and reemerges at the anus, before repeating its upward journey through the spine. It forms a complete loop. (By the way, the Ren channel, an Extraordinary channel, like the Du, rather than a Primary channel, does the same sort of loop up the *front* of the body and down through the mouth and digestive tract.)

Because of the power and location of the Du channel, particularly as it courses over and through the head, the Du channel plays the largest role of any of the channels in creating and regulating brain function. The electrical and magnetic forces generated by this particular loop of current are most likely the triggers that stimulate the various genetic expressions of the cells of the spine and brain.²

¹ Some rivers change names when they cross a border into a different country. The river doesn't necessarily have any awareness that man has renamed it; the river simply flows from place to place regardless of political boundaries or name. In the same manner the body's one primary magnetic field and its corresponding electrical current, or "channel," and that channel's side streams and branchings all flow continuously. For the sake of study and communication, we give each major division (primary channel) its own name as the Qi flows from one area to another.

² Very likely, most DNA instructions are generated via current/channel flow. The currents influence the closings and openings of the paired DNA molecules (genetic material), expressions of which vary from one body part to another. From the main currents of energy that flow through the body, smaller currents branch off, and from these, still smaller ones branch again. Subtle magnetic field variations, partners of the smallest iterations of tiny channel currents that bathe every cell of the body, influence the DNA in the various body-part cells over which they flow. These magnetic fields affect the DNA within the cells, and thereby determine genetic expression.

(There is a seeming chicken and the egg interwovenness between the cells, which provide a substrate for the electrical currents, and the currents, which direct the development and function of the cells. However, in pre-communist Asian medicine, there is a distinct causative factor to the "which came first, the chicken or egg" question of this interwoven cycle. The Qi, the energy field, precedes the structure. This would possibly translate, in English, to "the soul precedes and guides the development of the body; the body provides a substrate in which the soul can physically manifest and grow." A deeper understanding might be that Love creates an individualized soul which directs the formation of a physical manifestation, and then, in that manifested form, has the opportunity to perform actions that grow yet more Love. In Chinese the ancient expression is "The Qi is the leader of the blood; the blood is the mother of the Qi.")

While various bits of biochemistry may induce changes in the DNA expression process, it is likely that they do so via the electrical field alterations that their presence sets into motion. To paraphrase the Chinese adage above, the electrical field is the leader, the chemistry is the substrate on which the "leading" takes place. And this leading, in turn, is directed to the building, maintenance, or decay of more substrate!

The following diagrams portray the frontal points of the Du channel, the intersection of the Stomach channel and the Du, and the intersection of the Large Intestine channel with the Du. Although three arm and three leg channels intersect the Du at Yin Tang, only the Large Intestine and Stomach channel intersect at both Yin Tang and *again at Du-26*. The significance of this will be explained later. For clarity of demonstrating the Large Intestine's left-right (and vice versa) cross-over, only the right-hand Large Intestine channel is shown. Both left and right Stomach channels are shown – these channels do *not* cross over.

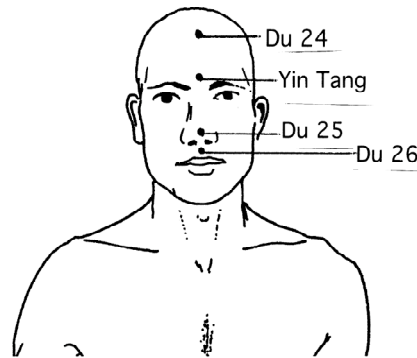


Fig 24.2 Frontal Points of the Du channel

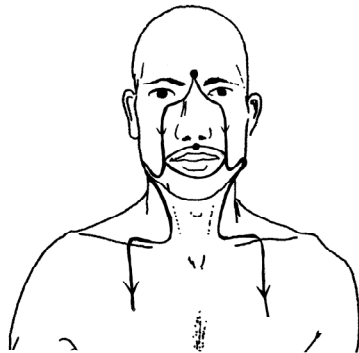


Fig 24.3 Face and neck portion of the Stomach channel

Note: a branch in both the Stomach and Large Intestine channels skirts the mouth.

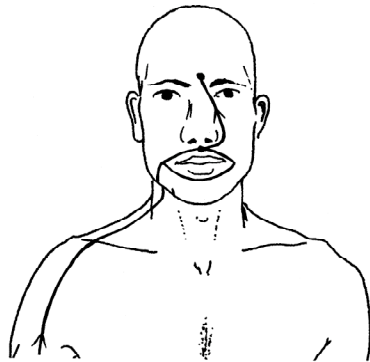


Fig 24.4 Arm and Face portion of the Large Intestine channel

The Du channel is associated with the parasympathetic system. Meditation is most closely connected with the Du channel. Whether focusing on the third eye (Yin Tang) or the Thousand Petaled Lotus (Du 20), observing spinal energy or the chakras, or controlling the breath, the net result is a diversion of energy out of the Primary channels (arms, legs, and torso) and into the Du channel. When modern doctors tell their patients to meditate for a few minutes every day to decrease their blood pressure and calm their heart, they are actually telling them to increase the energy flow through their Du system. Dopamine, the parasympathetic system, and the Du channel are associated with calmness, even serene fearlessness.

The Kidney channel – opposer of the Du

The adrenal system (the sympathetic nervous system), on the other hand, is regulated by the Kidney channel, one of the “Primary” channels (the Primaries are derived from and subordinate to the “Extraordinary,” or “Master” channels). The Kidney channel is the channel most closely related to fear and sexual energy – a juxtaposition that provides much food for thought, but which is, of course, beyond the scope of this book. I will just note here that dopamine is the neurotransmitter of fearlessness and adrenaline is the neurotransmitter of fear.¹

¹ There are many obvious relationships between adrenaline and dopamine. One well-known relationship is this: they both seem to influence our perception of time. During a life-threatening powerful emergency such as being ejected at high speed from a moving car or bicycle, the moments before impact are filled with a vast number of thoughts, far more thoughts than can ordinarily be processed. Time seems to extend forever, and it can seem as if minutes, rather than seconds, transpire before the point of impact. It has been assumed that this is a function of adrenaline. The opposite may also be true – it may be a function of a concomitant decrease in dopamine.

Recently, it has been found that the same extension in the perception of time occurs during drug deprivation. A recent study compared the ability to estimate the passage of time among smokers, non-smokers, and smokers denied cigarettes. After a 45 second interval had passed, both non-smokers and smokers guessed fairly accurately the number of seconds that had passed. When smokers were deprived of their cigarettes for a day, and tested the following morning, they guessed that the 45-second interval was much longer – at least 50% longer, and in some cases up to three minutes! (Laura Cousin Klein, *Psychopharmacology Bulletin*, spring quarter, reported by Santa Cruz Sentinel, May 14, 2003, p. C-5.)

We already know that the neurotransmitter most altered by nicotine is dopamine. In the case of cigarette deprivation, dopamine levels decrease. It may be that the dropping away of dopamine gatekeepers from the incoming sensory nerves allows more sensory information to pass into the brain and creates a sense that more time is passing.

Such an increased sensory input can be helpful in an emergency, when we need as much information as possible in order to make fast decisions. However, this response is historically associated with adrenaline – dopamine was never considered to play a part in emergency neurotransmission. But it may be that the actual change in time perception is not from adrenaline per se, but from a simultaneous decrease in dopamine. If so, this would add weight to the validity of the idea that adrenaline and dopamine are two ends of a seesaw; when one goes up, the other goes down.

A corollary might be that a saint, ever immersed in his dopamine-drenched calm, perceives the timeless aspect of the world. Time can cease to exist for such a one if he so chooses. He may focus, breathless, for hours on a single thought with no impinging awareness of the passage of any time at all. Not only gravity, as discussed in an earlier footnote, but time itself is, to the saint, a relativistic plaything.

Another aspect of the opposing natures of adrenaline and dopamine is the perception of pain. Under the influence of high levels of fear and adrenaline, a person temporarily cannot perceive pain – the pain section of the brain is inactivated. (Footnote continued on next page.)

Du channel relationship with addiction

What does this have to do with addiction? I have already proposed that addiction occurs when the parasympathetic system is dominant over the sympathetic system. I propose further that it is when the Du channel is running optimally that the dopamine-related systems, including the propensity to addiction, are running at full-bore.

On the other hand, when, due to fear or sexual stimulation, the energy is directed towards the animal centers in the lumbar regions (the lumbar chakra, the area around acupoint UB-23, and/or the energetic center of the Kidney channel), there is an increase in adrenal stimulation and a simultaneous decrease in energy in the Du channel and the dopamine system. Fear “scatters” the Qi, as we learn in first semester Asian medical theory.¹ A saint, during his moments of motionless, breathless mystic union with the Divine, has his Qi concentrated in one place – most often, curiously enough, Yin Tang. When a person must interact with the world, moving about and breathing, he must have at least some small, minimal level of fear (he must awaken the adrenal glands), and “scatter the Qi” throughout his body.²

(Footnote continued from previous page.) When the body is saturated with dopamine, there may also be a cessation of pain, but it comes from the opposite source: fearless consciousness of the relativistic nature of pain; an accurate assessment of the pain can be calmly made; pain is seen as a mere signal of body inharmony.

When fear is uppermost, pain is blocked via adrenaline. When joy and dopamine are ascendant, pain is acknowledged and then either treated appropriately with effective treatment (a bandage, a stitch, a kiss on the bruised place, or some other appropriate treatment that acknowledges the injury and activates healing in the body) or embraced – even with gratitude or at least spiritual understanding – and observed from a higher realm of Wisdom (transcended).

Most PDers have always imagined that by denying pain they are proving their superiority to it. In fact, they are merely up to their eyebrows in adrenaline and fear. Transcendence (as opposed to suppression) of pain and fear is a facet of spiritual growth. Denial of real and present pain and fear is the key to the Parkinson’s personality.

¹ I cannot find this in my translation of the ancient Nei Jing, but it is taught as one of the basic precepts. Part of the difficulty of mixing Asian oral tradition and western footnote tradition is the lack of published references and the lack of uniformity among the translations.

² The Qi must be spread throughout the body if one is to engage in breathing and other physiological functions. Inhalation is impelled by the adrenal glands, not merely the lungs, and occurs due to the “fear” of suffocation.

If a person is dominated by fear to an unhealthy level, his Qi will be so utterly scattered that he will even lose his focus, both mentally and physiologically. We would say he acts “like a chicken with his head cut off,” and various body functions, including such famous ones as bladder and rectal sphincter control, may become embarrassingly “confused” or unreliable. This is a pathological, excessive scattering of the Qi, as opposed to the healthy level of “Fear scattering the Qi (away from the divine centers at Yin Tang)” which is necessary to engage the adrenals and maintain normal physiological function.

It is far, far removed from the scope of this book, but it may be interesting to note that some practitioners of the self-disciplining arts of Tai Qi, Qi Gong, and some of the martial arts focus their energy on their lower (belly) centers, thus attaining control of their fear and their animal energy.

In higher levels of Tai Qi, Qi Gong, and martial arts practice, and in transcendental practices such as Raja Yoga and original Christianity, energy is focused at Yin Tang or other head/upper spine points. The point that we call Yin Tang in Chinese has been known for millennia in India as the “third eye,” or the “single eye,” and even “the star of the east.” Riveting the interior focus on these upper spine points, and Yin Tang in particular, rather than on the two (dualistic, delusion-oriented) externally facing eyes, can help one along the path of attaining, not mere physical power and control over the inner animal, but control over the ego and the Self, or soul. The goal in lower Du control is vitality and long life. The goal in upper Du control is timeless peace, intuitive wisdom of universal truths, and eternal communion with God.

Stomach channel regulates the Du channel, and the reverse

The significance of all this in relation to Parkinson's disease is that the Stomach channel, the main channel affected in Parkinson's, plays a major role in setting both the vigor and the shape of the Du channel. It appears that when improvements are made in a long-damaged Stomach channel, the health of the Du channel is simultaneously improved. The PDer, following treatment, may return to a healthier condition in which he is somewhat less dependent on adrenaline and therefore more dopamine oriented – hence, more addictable.

However, if such a person still has some remaining injuries, these remaining glitches, *whatever* channel they may be on, may help to moderate the recovery of the Du channel, preventing full addictability and creating, instead, the conditions that allow for our multi-injury patients to have *mild, creeping* increases in their drug addiction and drug-induced parkinsonism symptoms instead of full-blown, all-or-nothing, bug-eyed addiction and violent adverse effects. Let's look at how this might play out.

First, let's see how the Stomach channel is influenced by the ups and downs in Du channel Qi. In western biological studies, one of the most common tools used in explaining the parasympathetic system to school children is the image of a cow chewing her cud: when Bossy is relaxed, she can make best use of her stomach/gut function. But in times of stress, according to western medical theory, the stomach shuts down to some extent. In times of high stress, the body may even evacuate the stomach and gut by whatever means possible, so as to be better prepared to Fight or Flee. The stomach and the parasympathetic have long been linked in western theory.

This meshes nicely with the Asian theory; the Stomach and Large Intestine channels are doubly (relative to other channels) connected with the Du (parasympathetic-governing) channel. These two are the only channels that meet twice with the Du channel on the face instead of once: not only do they intersect the Du at Yin Tang, but they meet *again* when the Stomach and Large Intestine channels skirt the lips, circling the upper and lower lips on their trek across the face. At this mouth location, they have their second intersection with the Du channel.

Left-Right coordination

The skirting of the lips, as the Large Intestine channel crosses over from one side of the body to the other, is what drives left-right coordination in the body. The *left* Large Intestine channel crosses the philtrum and surges up the *right* side of the face, into Yin Tang, and then becomes the *right* Stomach channel, and vice versa. This rhythmic pulsing of current around the mouth helps do two things. It drives left-right coordination, in which a swing of the left arm activates a subsequent swing in the right leg. In Parkinson's, the decrease in Qi flow over the face plays the major part in the loss of arm swing; this is proven when Qi flow is restored through this area. A more critical role of this second, lower-face junction of the Du channel with the Large Intestine and Stomach channels is the alternating Large Intestine and the Stomach electrical surge that directs the Du channel more vigorously towards the mouth, down from the forehead.

Consciousness

The throbbing of the Large Intestine and Stomach channels as they cross over the upper lip exerts a pull on the Du channel, drawing the Du channel Qi down to the mouth.

The left Large Intestine channel crosses left to right over the midline of the body at the upper lip, and then a moment later the right side Large Intestine channel crosses right to left, and then once again the left side channel crosses left to right, repeating the pattern over and over, driving the right-left balancing of the brain and body. The Stomach channel branch that also skirts the lips at this point is also stimulated by this left-right rhythm. Without this throbbing, electrically driving influence from the Large Intestine and Stomach channels, the Du channel Qi will not descend down the face to Du 26 at full force. If the Large Intestine and the Stomach channels are not flowing or only barely flowing, most of the Du channel can become backed up, slowed, or diverted at Yin Tang. Most often, if the Stomach or Large Intestine channel is not flowing, the Du channel will flow from the back of the neck up through the midbrain to Yin Tang and then disperse to a large extent into the other channels, most likely the Gall Bladder (sleeptime) channel. When the Du channel is in this deep brain, non-gastrointestinal mode, the mind dwells in either the subconscious or superconscious.¹

This throbbing of Large Intestine and Stomach channel Qi around the mouth pulls the Du channel Qi down to the mouth, both awakening in one a consciousness of the physical body and its needs and activating the gastrointestinal tract. In turn, this additional intersection of the Du channel with the Stomach channel provides the latter with the extra surge of energy needed to activate this most crucial, life-giving channel. Again, the Du flows into the Stomach channel at two points, the upper lip and Yin Tang, rather than at just the one intersection at Yin Tang allotted to the other channels.

Prevention of backwards-flowing Qi from the Stomach into the Du

This powerful mutual influence of the Du and Stomach channels may account for the presence of the unique, Du-protecting, backflow-prevention overflow valve of the Stomach channel. The Stomach channel is the only channel that has, to my knowledge, the protective, channel-altering path that activates when Stomach Qi is running in reverse (Rebellious Qi).

This special path, a backflow prevention channel, runs from ST-6 on the corner of the chin up to ST-8, on the side of the forehead, where it ends right alongside the GB channel.² Should the Qi in the lower Stomach channel begin to flow in reverse, this

¹ This is the condition of a baby *in utero*. Before birth, the Large Intestine channel is not yet functional; if it were, it would propel meconium into the amniotic fluid, killing the baby. The Stomach channel is also not yet functional; all nutrition comes in through the umbilicus. The gastrointestinal tract of the fetus is unmoving. The GI tract has enough Qi to form itself and stay alive, but not enough energy to move in a peristaltic (gentle squeezing) motion. The baby is at this time, with his Qi focused at the third eye, either subconscious or in a state of superconsciousness (soul awareness), depending on the child's nature.

At birth, it is the abrupt transition to mouth breathing that stimulates the Du channel to drop down to the mouth, where it intersects with and triggers the full-strength flow of the Large Intestine and Stomach channels. These channels in turn pull on the Du channel, tugging it even more completely down from the third eye at Yin Tang, down the face, and into the mouth, thus establishing the newly-awakened *conscious* awareness of both the body and the body's need for food from an outside source.

² For you students of Asian medicine who learned that acupoint ST-8 on the forehead is on the normal path of the Stomach channel, I propose you perform this simple test: use your hand to feel where the various channels of face Qi are and which direction the Qi is moving. You will notice that Stomach channel Qi flows from ST-1 to ST-2. From ST-2 it broadens out and flows into ST-3 and ST-7. From here it continues down to ST-4, ST-5, and ST-6, and then into ST-9.

protective channel is activated. If this protective channel were not in place, backwards-flowing current from the Stomach channel would interrupt the orderly movement of the Du channel at both the lip and the forehead. This could possibly deflect or decrease the current in the Du channel so much that a person could lose consciousness. If Qi runs backwards through the head, going from Yin Tang backwards to the neck via the midbrain, consciousness ceases, and death can possibly ensue.

To prevent this calamity, backwards running Qi from the Stomach channel cannot flow into the face portion of the Stomach channel. This deadly possibility is instead deflected; rebellious Stomach channel Qi coming up the torso and into the neck is shunted into the diversion channel at ST-6 (a Stomach channel acupoint on the corner of the mandible), and is redirected to the sides of the forehead.

Backwards-flowing Qi that is coming up the Stomach channel can get as far as the neck before it flows, not across the lips and up the face backwards to Yin Tang, but instead, up the side of the face towards the Gall Bladder channel.

It is activation of this protective circuit, which redirects Qi from the Stomach channel to the GB channel, which sets in motion the substantia nigra changes of PD.¹

Stomach channel flow powers the Du channel

In healthy times, the Stomach channel helps drive the Du channel. A decrease in Stomach channel Qi will decrease the power of the Du channel. In this case, the *force of the pull* on the Du channel is decreased, though the amount of Qi in the Du system overall remains the same. A parallel example would be a decrease in the power of a waterfall that occurs when the distance of the drop is decreased. The amount of water in the river stays the same, but the power generated by the drop is lessened. A change in Stomach channel Qi alters the power and distribution pattern, though not the amount, of Qi in the Du channel.

The dopamine connection with sleep

In western medicine, as noted, the stomach and the parasympathetic system are connected: we are taught that the parasympathetic system is dominant when an animal is chewing and digesting food. So too, in Asian medicine, the stomach and parasympathetic system are strongly connected. They have a special, double electrical relationship via the second meeting of the Stomach and Du channels at the mouth, after the connection at Yin Tang. And remember, the Du channel regulates dopamine and the parasympathetic system.

The Asian system takes this integration a step further – at night, the stomach very nearly shuts down (never go to bed on a full stomach!) and the consciousness goes deep within, into the subconscious. The food-processing, parasympathetic state ceases; breathing and heart rate settle into a sedated pattern – a pattern much less responsive than those that are active when awake. Western science has not yet named this condition, merely considering it a subset of the parasympathetic state.² As the stomach shuts down

¹Please read further explanation in chapter two, *Recovery from Parkinson's Disease: A Practitioner's Handbook*.

² Which is wrong! In the parasympathetic, blood flows to the gastrointestinal tract, heart, and lungs in a manner that best digests food and distributes food energy. During sleep, flow of blood and energy decreases in the gut and skeletal muscle and goes deep within, engorging the liver, gall bladder, and

at night, the Du channel power is being decreased due to the increase of Qi in the Gall Bladder channel. The GB channel runs the opposite direction of the Du; an increase in the GB channel causes a diminishing of power in the Du. The gastrointestinal tract becomes stilled and dopamine levels drop steeply, while the subconscious reigns and “knits up the ravelled sleeve of care.”¹ During this nonsympathetic phase, also known as sleep, the brain dopamine level – and we propose, the entire dopamine system – drops precipitously.²

Stomach and Du channel during sleep or Parkinson’s

During Parkinson’s, the rebellious Qi of the injured Stomach channel, for reasons explained in *Recovery From Parkinson’s Disease*, decreases the power of the Du channel and amplifies the nonsympathetic (nighttime) pattern, one that is associated with the subconscious rather than the conscious brain. Anthropomorphically speaking, the injured channel does this to encourage the injured person to go to sleep, to surrender the injured body over to the deeply restful mental state in which healing can occur; healing is a process that does not occur during adrenal-driven, fear-based wakefulness. During sleep, adrenaline and dopamine levels drop.

However, due to the pathological level of fear in a person with Parkinson’s, this healthy retreat, this surrender into true, non-adrenal slumber, does not occur. Surrender is scarcely a part of the PDer’s vocabulary! Although the PDer may dip every night into a sleep, it will never be the willing, surrendering sleep of the trusting child; it will remain ever the sub-alert sleep of one who is in a state, not of peace, but of emergency. Therefore, healing does not occur.

This means that the injury is, in the decades after the Qi starts flowing backwards from the injury site, sending a perpetual signal to the brain that causes Du channel deflection and a nighttime (no dopamine) signal to the midbrain, and all the while the adrenal system is maintaining hypervigilance. Eventually, the dopamine-producing cells, not having received a “make dopamine” signal for decades, slowly revert back to a more basic form of undifferentiated cell. These cells are not dead, but they are no longer receiving “make dopamine” signals from their surrounding electrical flow. The overworked adrenals slowly dig themselves an early grave. When the adrenaline source finally starts to give out due to decades of overuse, the concomitant absence of dopamine becomes apparent. The damage wreaked by the injury, which for decades has blocked life-giving Qi from flowing through the Stomach channel correctly, can no longer be hidden by an adrenaline override because the adrenals are exhausted. The long-term dopamine dormancy is revealed. Parkinson’s “appears.”

lung tissues. This is not a reference to the arterial or venous blood that flows through the liver passageways or through the aeration portions of the lungs, where it is cleaned or oxygenated, respectively. This is in reference to the blood that supplies the tissues of the liver, gall bladder, and lungs themselves. During this state, very different from the parasympathetic, peristalsis is slowed, as are heart and breathing rates. This condition should more aptly be called the nonsympathetic, if the “sympathetic” nomenclature (poor word choice, but now well-established) is to be followed. A better choice might be to abandon the “sympathetic” system altogether... a subject far beyond the scope of this book!

¹ Shakespeare, *Macbeth*.

² As recently as the late 1990’s many doctors still held to the theory that dopamine levels are highest during sleep. This outmoded theory has been disproven. Dopamine activity is at the lowest levels during sleep. (See appendix 6.)

Stomach channel and Du channel during sympathetic (adrenaline) excitation

In a healthy person, the positive relationship between the function of the stomach and the parasympathetic system is paralleled by the decrease in both during times of stress. During stress, when the sympathetic system prevails, the stomach processes are stilled or diminished. Again, “Fear scatters the Qi,” decreasing Du flow at Yin Tang and sending Du channel Qi surging into the Yang channels via Du 14, at the back of the neck, rather than from the forehead. When this back-of-the-neck source of Du Qi distribution is used, rather than Yin Tang distribution, Qi flows equally through all the primary channels – as opposed to the parasympathetic condition in which the Stomach channel gets a double hit. During non-emergency, a person’s Qi is distributed via Yin Tang and the Stomach channel receives twice the energy of all the other channels.

In the fear condition, the Stomach is no longer the favored channel. A person’s primary energy source, the Du channel, surges out into the arm and leg (primary) channels from a point on the back of the neck even before the wise frontal lobe is stimulated. A person so activated behaves more like an animal. His primary channels, rather than the extraordinary channels, are predominant as he fights or flees. This is the opposite of how he acts when the Du channel is controlled, unscattered, dominant over all other channels. In a condition of fear, when the Du is “scattered” through the other channels, man is more like an animal. Only when the Du is calmly focused at the frontal lobe can one act as a Man, the highest bridge between heaven and earth.¹

Addiction and the Du channel

Healing the Stomach channel restores the midbrain

This relationship between the Stomach channel and the Du channel helps explain the differences in addictability that we saw in our patients.

When awake, during parasympathetic time, a well-tuned Stomach channel allows for fullest possible movement of the Du channel through the midbrain, which in turn creates the largest possible amount of dopamine-related activities – including addiction. When the Stomach channel is injured, the parasympathetic system cannot flow very well, and a person is not very addictable. If the Stomach channel is restored, the Du channel springs back to life, and addictability and other parasympathetic functions are simultaneously reactivated.

This could explain why people with Parkinson’s disease who have only one major unhealed injury, the classic PD injury on the foot, appear to spring from a condition of non-addictability to one of extreme addictability, practically overnight, once the Stomach channel is restored.

Stomach channel restoration increases addictability

Therefore, any improvement in the flow of Stomach channel Qi will move the marker on the sympathetic/parasympathetic continuum strongly towards the parasympathetic, addiction-prone end.

¹ Please, this is not a comment on gender. The word “man” in this sentence is used to signify any elevated being, male or female, who is aware of his relationship with all creation, with the Tao, with Love. From the eastern perspective, it can even be argued that all humans are female. Pure thought, in this usage, is the only male aspect in the universe. Our English vocabulary is sadly lacking...

Injuries on other channels

However, those with complex Parkinson's, those who have injuries in other areas besides the Stomach channel, might not become so immediately addictable. Possibly they might not spring back to full Du function when their foot injury begins to heal. The remaining injury may also suppress the Du, although not via the same mechanism.

Stomach channel rebellious Qi decreases Du flow

The Du decrease stemming from the foot injury seen in idiopathic Parkinson's is due to the constant electrical diminution of the Du, a diminution that should normally occur only from 11:00 p.m. to 1:00 a.m. – when the Gall Bladder channel is scheduled to run at full bore. In the case of Parkinson's, however, the Gall Bladder channel runs at pathologically higher than normal levels twenty-four hours a day. This excess Qi in the Gall Bladder channel results when Stomach channel Qi flows rebelliously up the channel and is shunted into the Gall Bladder channel (from ST-8 to GB-4) to prevent backflow (rebellious Qi) into the Du at points Du 26 and Yin Tang. This constant overload into the Gall Bladder channel creates an unending nighttime/sleeptime (no/very low dopamine activity) condition in the midbrain. This leads to the dormancy of the substantia nigra cells and their eventual reundifferentiation into neutral, embryonic-like cells.

Other injuries decreasing Du flow

All Yang channels connect both with the Du channel at Du 14 (at the back of the neck) and at Yin Tang. Impedance on any of these channels will cause a diminution in the Du channel flow. Therefore, an injury to any part of the body will influence the nearby channels and decrease Du channel flow. In this way, injuries can send signals of distress to the brain and activate the sympathetic system. While these other-channel injuries in and of themselves cannot trigger classic Parkinson's (lacking as they do access to the facial muscles, anteriolateral leg muscles, muscles along the mammary line, and left-right coordination, to name a few zones which are regulated most specifically by the Stomach channel, and which help to characterize Parkinson's), they can certainly raise the sympathetic flag, acting as a drag on the addiction process.

When Qi irregularities from other, non-Stomach channel injuries send distress signals to the brain via the Du connection and also via their own brain connections, these non-Stomach channel injuries may pull the sympathetic/parasympathetic continuum marker slightly in the sympathetic direction. While these latter Qi irregularities would not affect the midbrain portion of the Du channel as directly or for as many hours a day as a Stomach channel back-up, they could still exert a moderating influence. Again, the influence of the Stomach channel over the Du is greater than any other channel because of the driving, pulsing push given mutually to the Du, the Large Intestine, and the Stomach channels via their intersection at Du 26 at the end of the Du channel.

Even the modest stimulation of the sympathetic system from injuries on channels other than the Stomach channel may help to decrease that susceptibility to addiction which is a part of the parasympathetic system. Therefore, a patient with multiple injuries might have more time in which to safely recover from medication. Such a person might be able to notice a decrease in his Parkinson's symptoms as the Stomach channel resumes normal function. Even while taking medication, the decrease in rigidity, increase in sensation, and feeling of internal peace might signal to him that his Parkinson's

symptoms are diminishing. And yet, his other injuries might provide him a somewhat safe shelter from the most rapid (seventy-two hour) addiction processes that we have seen. A person with multiple injuries will still become addicted if he is taking antiparkinson's drugs when his underlying Stomach channel injury is resolved, but the addiction may come on somewhat more slowly, somewhat less violently.

It might be dangerous to assume such a safety net, however – we have seen in many patients that the healing mode, once started, might travel throughout the body, addressing many if not all unhealed injuries. Very often, a person whose foot begins to heal may notice that other injuries in the body also begin to stand up and demand to be noticed – or even start to heal on their own, with no healing techniques being administered. This means that whether or not an auxiliary injury can prevent rapid addiction is still a crapshoot – one with dangerous, mind-altering risks.

Injury on a non-Stomach channel

As an example of how an unhealed injury on a non-Stomach channel might affect the Du, consider Olli's shoulder injury. It traversed the area where the Triple Burner channel and the Small Intestine channels cross the shoulder. The scar tissue in that area could block the Qi of those channels. These channels are supposed to flow into Du 14, on the back of the neck. If they were blocked, the resulting decrease in channel Qi would subsequently decrease the Qi that flows into the Du channel at Du 14. However, it would not disrupt the signal in the same way that the Stomach channel diversion does. This decrease in Qi would merely alter the *amount* of Du channel Qi, not its distribution pattern. To return to the waterfall analogy, the Triple Burner injury would decrease the *amount* of water in the Du stream, and the amount of water (or Qi) in its eventual waterfall drop from Yin Tang to the mouth, but *not* the distance of the drop. From an electrical analogy, the amperage would be decreased, but the voltage would remain the same. The shape of the Du channel would be the same – the Du Qi could still flow down to the lip – but the quantity of Du channel Qi would be less than usual.

Therefore, the existence of non-Stomach channel unhealed injuries might cause a decrease in Du channel flow, but not deflect it. (Deflection of current is the most likely mechanism for the Gall Bladder channel's influence on the Du.) These injuries could not trigger or sustain Parkinson's disease if there was no longer a foot injury – but they might decrease the parasympathetic system, and hence the addiction system, just enough to account for the difference in addictability between patients like Olli and Viktor.

Olli was starting to recover from PD, still had remaining injuries in his arm, and because he had not stopped his medication in time, was lured to slowly increase it. Viktor, with no other injuries that I am aware of, experienced the full bliss and addiction of dopamine saturation almost simultaneously with the unblocking of the injury in his foot.

Summary

Possibly the variations in Qi flow due to individuals' various Qi blockages contribute to the variations of addictiveness in people who are recovering from Parkinson's disease. This would provide a simple, logical reason for the range of addiction responses that we have seen in our clinic. It would also match the patterns that we have seen: rapid, violent addiction response in patients with no secondary injuries and slower, more gradual reversion to addictability in patients whose Qi has other, non-Stomach channel blocks.

In this year, 2003, thinking of addiction in terms of deflected electrical fields may not seem logical to many westerners, but that is because they are not used to considering the electrical and magnetic influences of the body in their study of biology. Radio did not seem logical to people who first tuned in to the airwaves. In the late twentieth century, many an old-timer was heard to whine, "But where *is* the Internet?" Qi flow, to many westerners, is still regarded as a pagan myth. But in this new century, when Qi flow – the vibratory energy and microelectrical circuitry of the body – is given its rightful place in the study of western physiology, these systems will be seen to be the drivers, and not the side effects, of metabolic processes. However, the focus of this book is medication issues, and not Asian medical theory; full development of this idea is, you guessed it, beyond the scope of this book. And yet, if the ideas presented in this book can in any way further the understanding of the scourge of addiction, it is not a moment too soon to be considering this ancient/new way of understanding brain chemistry.

