# Orgonomic First Aid for Eating Disturbances In Medical Illness

**Howard J. Chavis, M.D.***

Reprinted from the *Journal of Orgonomy*, Vol. 22 No. 2
The American College of Orgonomy

A disturbance of eating is a frequent concomitant of illness. Sometimes the degree of dysfunction seriously impairs the capacity of the organism to recuperate from disease or the rigors of treatment, such as surgery. It can also, if severe enough, threaten the life of the patient through the effects of inanition including increased susceptibility to infection. Certainly nausea, physical obstruction, or the anorexia associated with illness-related depression can interfere with this basic biologic function. However, without a functional, energetic understanding of somatic armor, character structure, and health, it is impossible, other than in a superficial, mechanical fashion, to appreciate the etiology of, and hence the therapy for, particular varieties of eating disturbance. The following case presentations demonstrate the capacity of the functional approach to render comprehensible symptoms and simple observations and to provide a rationale for effective treatment in the form of orgonomic first aid.

## Case Presentation

Arthur is an unfortunate 42-year-old, single, Jewish, chemical engineer, hospitalized with a month-long history of stomach pain. Diagnostic evaluation and laparotomy revealed a gastric carcinoma with previously undetected metastases to the liver. Surgical resection of the malignancy was performed and a course of intensive chemotherapy was completed. The nausea usually associated with chemotherapy uncharacteristically persisted for weeks and was unrelieved by oral and intravenous medication. Eating was rendered impossible and further work-up of this distressing symptom was unremarkable except for the healed gastric pouch. A psychiatric consultation was requested. On initial examination, Arthur was cooperative but guarded and spoke in a somewhat subdued, very matter-of-fact voice. Gentle questioning about his circumstances gradually softened his reserve and quiet sobbing emerged with sad thoughts of his mother who died several years before and concerns for the welfare of his elderly father. As more open crying ensued, fears for his survival surfaced. With emotional yielding, Arthur's persistent nausea was relieved. He began to eat, gained some weight and strength, and was shortly discharged home.

## Case Presentation

Selma is an 80-year-old, black, retired office manager, admitted to the hospital five months previous with fever and lower abdominal pain symptoms of diverticulitis, a disorder of the large intestine. In the course of her diagnostic evaluation and treatment, she had major abdominal surgery and suffered multiple complications and setbacks, including infection, heart attack, and a mild stroke. She spent countless weeks in intensive care and was finally transferred to a regular medical service where a new problem arose; "failure to thrive." Because of great difficulty swallowing, she was unable to eat and saliva pooled in her mouth. Over a six-week period, she lost more than 25 pounds and was increasingly withdrawn and lethargic.

The medical staff, after an exhaustive (and for Selma, exhausting) evaluation including cine-radiographic studies of the pharynx and esophagus, still could not explain her disordered swallowing, and a psychiatric consultation was requested. Immediately apparent was the "cowed" expression in Selma's eyes ("What are you going to do to me now… And the saliva drooling from her mouth as she spoke through jaws that barely opened. She could only separate her teeth the width of a small finger and literally could not swallow. After a brief explanation and with her cooperation, I elicited gagging with a tongue blade and then began gently but firmly pushing her mandible forward by pressing on the angle of the jaw. This was painful and tolerated only for seconds at a time but elicited misery and crying. In subsequent brief sessions, gagging was repeated as much as tolerated and work on the mandible was expanded to include massaging the masseters and having Selma bite on a cloth. These efforts, produced greater expressions of misery about the experiences she endured during the endless months of hospitalization and her hopelessness about ever being discharged alive. In subsequent sessions, as she allowed more vigorous and sustained physical work, her misery, gave way to anger and resentment. She told me, "I could kill you," as she punched at my arms. This deepened into rage for everything that had gone wrong and for all the indignities suffered during her hospital stay. After only a few sessions, Selma was again able to swallow. She began to eat and saliva no longer pooled in her mouth. She became more sociable and lively with the hospital staff and with her boyfriend. She was discharged home two weeks after initial consultation.

**Case Presentation**

Donna is a 27-year old waitress and part-time model with known epilepsy secondary to head trauma in childhood. She was admitted to the neurology service because of an increase in seizure frequency. Laboratory testing determined blood levels of anti-seizure medication to be below therapeutic range, and over a week's time adjustments in dosage were made. Donna, however, reported continued seizures preceded by her familiar aura, a "feeling" in her

stomach, and the type of medication itself was also changed. Persistent, distressing nausea with occasional enervating vomiting and diarrhea started about five days after admission and was variously thought to be "flu" or drug side effect. Eating exacerbated the problem; she was treated with intravenous fluids to maintain hydration, and an anti-emetic was given without consistent effect.

These developments were followed firsthand; a psychiatric consultation was requested within the first several days of admission once the medical staff learned of a history of physical and emotional abuse in childhood and adolescence. On initial contact, Donna was a thin, attractive, anxious young woman with a look of misery on her face. Her eyes occasionally showed fear and her voice was flat with a grinding, whining quality. Accounts of abuse by her mother and foster family, as well as details of more recent unhappy incidents, were presented almost as a litany. Her anxiety she related to her intention of ending a live-in relationship with a man 25 years her senior. Little apparent headway was made beyond recounting the above history as subsequent dally sessions were soon focused on, and limited by, her nausea, weakness, and physical distress. Her neurologic evaluation, meanwhile, confirmed the pres-ence of an irritable focus in the right hemisphere but also determined some of her "seizures" to be motor activity without concomitant electrical discharge in the central nervous system (so-called "pseudo-" or psychogenic seizures). She anticipated this finding by asking if some of her seizures could be "emotional." Although she still suffered nausea, I began to work with her biophysically. Having her breathe while opening her eyes wide produced a lump in her throat which was relieved by vigorous gagging. The next session she complained of pains in her stomach. I palpated, firmly massaged, and "dissolved" a small, painful, firm mass in the right upper abdominal quadrant which produced an outpouring of crying misery and angry memories of her mother making her eat from a bowl on the floor with the family dog. She looked and felt enormously relieved with complete resolution of her nausea. The following day she complained of pains in her legs which had plagued her intermittently for years. I worked on her calves and thighs with similar results - memories of abuse and a painful outpouring of misery and anger, the emotions that had been absent from her litany. She was discharged shortly there-after, eating well and seizure-free.

**Case Presentation**

Hilde is an independent 80-year-old, retired, German bookkeeper admitted to the hospital confused and disoriented after failing and striking her head. A subdural hematoma was diagnosed after a CT scan found a localized collection of blood just under the dura, the covering of the brain. She was effectively treated over several weeks with steroids, and although no longer confused, she refused to eat or drink. A psychiatric consultation was requested. During the initial visit, this frail,

elderly, seemingly hearing-impaired, apathetic, depressed-looking woman said she "wanted to die" but also, on questioning, reported feeling a lump in her throat. Prominent biophysically was the limited mobility of her jaw, depressed respirations, a "lost" expression in her eyes. Treatment began with gagging induced by a cotton-tipped applicator followed by pushing her mandible forward. This last therapeutic maneuver elicited sobbing cries of "momma, momma." After this brief session, she asked for a drink of water and later that evening ate her first meal in weeks. Daily, brief sessions using gagging, breathing while stretching the jaw, and pushing the mandible forward elicited misery, despair, and small but significant amounts of anger. Her eyes soon appeared more focused, and her hearing, surprisingly, returned to normal. She became more vocal in her complaints about life in the hospital and more interactive with the nursing staff. Her appetite continued to improve but she also told her doctors she was "too heavy" on admission, felt more comfortable having lost 15 pounds, and would eat only enough to maintain her current weight. She thanked me at the end of each session, obviously looked forward to seeing me again but was also able to tell me she didn't like the physical work I did with her. She was soon transferred to a rehabilitation program in a nursing home, hopefully an interim step preparing her for return to her own apartment.

**Discussion**

For the classically trained physician, illness causes problems with eating because patients "don't feel well," are "depressed," or have some mechanical or physiologic dysfunction created by the disease process itself. While these "reasons" may have validity, they often fail to provide more than a superficial, mechanistic explanation of symptoms derived from the acute local and systemic effects of, and reactions to, illness on armoring and the energetic state of the organism. The clinical histories presented demonstrate how a functional, orgonomic approach allows not only for a comprehensive understanding of the disturbance of a basic biologic function but also for its treatment in the form of orgonomic first aid.

* Medical Orgonomist, New York City. Diplomate in Psychiatry, American Board of Psychiatry and Neurology.