Self-Help for Emotionally-Related Abdominal Pain
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Background

We all experience emotional overloads, and fairly regularly. What constitutes an overload will vary and depends largely on how we are feeling at the time and what else we are dealing with. When we are busy or focused on a particular problem or task, what might otherwise be a minor disturbance can in fact be an overload.

The body is intelligent. It has a strategy for emotional overloads: dump the excess emotion into one or more of the sphincters (one-way valves) in the gastro-intestinal tract. It does this so that we can continue to function, survive, what have you. But this is a temporary rather than a permanent solution. We're supposed to go back and process the overload very soon—say in the next 12 to 24 hours. Unfortunately, given the press of obligations in modern times, we often don't get around to it.

When this occurs, these sphincters go into spasm. We may experience nausea, headaches, and flu-like symptoms. Sometimes these symptoms can persist for days. Onset may be immediate or delayed. The triggering mechanism may be obvious or not. The trigger may seem insignificant, and might otherwise be, but for some pre-existing issue, sensitivity, or tendency. The following approaches are **only** for emotionally-triggered spasms and symptoms. They are not for conditions that are potentially life-threatening (see **Contraindications**).

Triggers

Common triggers include things people say or do to us, events we witness, hear of, or read about, and things that remind us--often on a subconscious level--of something that traumatized us in the past. These sphincters are essentially emotional circuit breakers or fuses that from time to time trip or blow when the body/mind/spirit is overloaded. Often, pain is the only clue that a sphincter is in spasm.

How to check for spasms

Place the heel of your hand on the skin directly over the sphincter, using the weight of a fly. If you feel counter-clockwise rotation immediately, within the first three seconds of palpation, the sphincter is in spasm. If there is no immediate counter-clockwise rotation,

the sphincter is not in spasm. If you are uncertain about what you feel, check again. Before trying to treat a given sphincter, check the other four for spasms.

Multiple Involvement

More than one sphincter can be in spasm. However, one sphincter will be in control. If you find more than one sphincter in spasm, there's a simple way to determine which one is in control or dominant. While inhibiting on of the spasming sphincters with hand or finger pressure, test another. If the one you test has stopped spasming (doesn't rotate counter-clockwise in the first there're seconds), the one you are inhibiting is controlling or producing the spasm in the one you tested. If the one you tested rotated counter-clockwise in the first three-seconds, its spasm is not controlled by the sphincter you inhibited.

Even if all five sphincters could be in spasm. This system of inhibiting one while testing another will allow you to quickly determine the dominant one. When you release/reset the controlling one, generally all the others will reset on their own. You should test each to make sure that this is the case. If one or more are still in spasm, repeat the testing, inhibition, and release procedures until all are no longer in spasm.

Releasing Spasmed Sphincters

Releasing is an extension of listening (the testing described above), with slightly more pressure. Follow the rotations and pulls in the underlying tissue until a softening is perceived or chaotic rotation stops. If having done this and no change seems to have occurred, try a recoil. Recoil consists of snapping or popping your hand off the skin as quickly as possible, starting just as inhalation begins. The recoil shocks or surprises the underlying tissue into letting go of it's spasm. After recoiling, check to ensure that the spasm(s) are over. Sometimes, several recoils are required. In really severe emotional trauma, you may have to repeat the recoils several times for several days.

This entire approach assumes that the spasm reflects a mind-body problem which can be addressed or corrected mechanically. Typically, that suffices. If not, try addressing the emotional component simultaneously. While continuing the mechanical release, ask your client to direct his or her attention into the area beneath your hand and ask your body if it has any information that you need to know at this time. Breathe deeply and exhale. Remain quiet and receptive. This may take a few minutes.

If something pops into the therapist or client's consciousness, don't dismiss it--no matter how absurd it may seem at first. Typically, once the mind grasps the content behind the symptom, the symptom is no longer needed and quickly departs.

Sphincter Names and Locations

The sphincters function as one-way valves to ensure the one-way movement of food, fluids, wastes, and other materials from mouth down through the gastro-intestinal tract. Locations are also shown on the last page.

Cardiac plexus: Midline, just off the tip off the xyphoid process at the base of the sternum. This is where the esophagus meets the stomach. The cardiac plexus is designed to prevent gastric reflux, where stomach contents enter and burn the esophagus.

Pylorus: Midline (except when the stomach is full then about an inch right of midline) halfway between the navel and the tip of the xyphoid process. This valve is designed to prevent back-flow from the duodenum into the stomach.

Sphincter of Oddi: Half an inch up and half an inch right of the navel. This is where the bile duct empties bile from the liver and gall bladder for the digestion of fats into the duodenum. It's also the avenue of escape for gall and liver stones, which are bundled toxins from those organs.

D-J Junction: Half an inch up and an inch left of the navel. The duodenal-jejunal junction separates the first and second part of the small intestine.

Ileo-cecal valve: One-third of the way between the navel (umbilicus) and the superior anterior corner of the iliac crest (hip bone). This is where the small intestine meets the colon. The valve prevents fecal material from the cecum of the colon from entering and poisoning the ileum of the small intestine.

Contraindications/Cautions:

Severe abdominal or thoracic pain might indicate a life-threatening condition such as appendicitis, aneurism, embolism, ulcers, hernia, heart attack, ruptured spleen, gallstones, kidney stones, peritonitis or other infection. **In the event of severe pain, consult a physician immediately.**

(Unless you've had your appendix removed), fever, intense pain, and/or rigidity in the abdomen, could be a sign of **appendicitis**, a life threatening situation requiring immediate surgery. **In a case of appendicitis, consult a physician immediately. Do not recoil!**

Similarly, if the **abdomen is drum-tight**, this could be a sign of an **embolism, another life-threatening situation requiring immediate surgery.** Consult a physician immediately**. Do not recoil.**

Ulcers and **hernias** are also serious medical conditions that can be life-threatening and should be ruled out by a physician before any recoiling is attempted. Intense abdominal, chest, or arm pain, fever, sweating, clamminess, and shortness of breath may indicate a life-threatening condition. If any of those symptoms are present consult a physician immediately.

If a recoil or palpation intensifies the pain, consult a physician immediately. When in doubt, always check with a physician first.