BRIEF COMMENTARIES ABOUT DESIRES AND AVERSIONS

JOSE GILBERTO GARCIA, M.D.

In the chapter that refers to the stomach in Kent's repertory there are pages that the doctor consults daily. I refer to the paragraphs that mention desires and aversions for food. It seems useless to say that there ought to be outlined in a repertorization only those paragraphs that refer to desires and aversions very accentuated in our patient, as when not being so, if we include them in the list of symptoms, they only contribute to confuse us. Desires and aversions are of great help to individualize and, as they are the expression of the whole system, they reach the category of general symptoms.

The daily consultation of those paragraphs gives material for several brief considerations.

Aversion to eggs. This is a very frequent symptom, particularly among children. Often the mothers tell us that the child hates eggs. It is strange that the repertory gives us so few remedies. *Ferr.*, Kali sul., Nit.ac., Sul., of which the only one that reaches the privilege of italics is the first. The desire for eggs appears also in a very short paragraph of four remedies, and with only *Calc.* in italics; but the mentioning of this remedy as the only one, and with the highest degree, for the desire for boiled eggs, and the prominent desire for soft eggs, turns this symptom into a valuable one, conducting us often to *Calcarea carbonica.*

Aversion for fats and rich food. A very common symptom in digestive troubles of gastric, hepatic or pancreatic origin, accompanied by insufficiency of one of the three mentioned organs. Very numerous are the nosologic entities that show that symptom; we must recall stomach cancer. It includes 34 remedies and is of great value in repertorizing.

Let us consider the opposite symptom: *Desire for fat.* This is a paragraph of only five remedies that it is useful to memorize: Arsenicum, Hepar, NITRICUM AC., *Nux V.*, and *Sulphur.* Desire for salted food and fat food, reduces our investigation to only two remedies:—*Nitricum ac.*, and *Sulphur.* If we add the paragraph desire for sweets, we must consider *Sulphur,* as it is the only remedy that has the three of them.

Among children it is a rule to find a well-marked *desire for sweets.* On account of its frequency, I believe that it loses its importance as a key-note; but, if we find a child with aversion to, or at least indifference for, sweets, we must then give it a superior place in the rank of the symptoms. The same happens with the symptom of aversion to sour things, as when it exists in a child, it must be placed as important, as it is common among children to crave for acids and sour things. Children are in great need of calories; the physical restlessness, so natural in them, putting their muscles in almost continuous movement, means a great consumption of glucose. The need of restoration of the loss of carbohydrates is manifested with that great passion of childhood for sweets. When that symptom exists among adults it becomes of great importance. Allen mentions it as a psoric one.

These considerations about combustion and the production of heat in the child's organism, reminds me of two very familiar symptoms to the homœopath: "desire to uncover" and "frequent thirst for small drinks." Mothers tell us: '"I cover him carefully, but as soon as he falls asleep, he throws the covers off." We all know that it is necessary to use our parental severity to make a child dress with heavy clothes even if the weather is cold. The frequency of this symptom shall reduce its value when trying to determine the remedy. Whichever may be the origin of a feverish condition in a child, very often we find that prominent indication for *Arsenicum:* frequent thirst for small drinks. Must we consider that as a guiding symptom

of the same value in the child as in the adult? *Arsenicum*, *Thuja* and *Natrum sulphuricum* are the three medicaments that have a complementary relation among them. Thinking of the prominent antisycotic nature of the last two, there comes to my mind the idea whether such a symptom, so prominent in *Arsenicum* and so frequent among children, wouldn't derive from a very accentuated sycotic taint. I believe it to be prudent to investigate sycotic antecedents of such children, and to give to these little patients, when the acuteness of their illness has vanished, a very high dose of *Thuja*, or *Natrum sulphuricum*, as *Arsenicum* does not appear in the paragraph regarding sycosis.

There is a disconcerting paragraph in the repertory, that Allen quotes when there is a tuberculous taint: *Desire for meat*. It covers twenty remedies, the majority of very little value, as only five reach the honour of italics, but that rarely appear to fulfill a repertorization. *Aversion for meat* appears in a paragraph that we could call ideal: eighty-eight medicaments of which many are in bold type and italics. According to Allen, this corresponds to a syphilitic taint.

The paragraph that refers to the desire for highly seasoned food, mentions, among other remedies, three in bold type: *China, Phosphorus, Sulphur.* Allen states that this symptom is due to psora. I remember that Dr. Carlos Montfort, my professor, used to say that among the yellow race the syphilitic taint predominates; among the Saxons, sycosis; and among the inhabitants of Spanish America psora is the most accentuated. I would appreciate very highly your comments about this. This comes to my mind on considering that the desire for very highly seasoned food is very common in my country, and that *Sulphur*, our best antipsoric par excellence, appears in such a small paragraph in a capital place.

Who can say something about the *desire for beans?* There is no mention in the repertory, and I have observed it very frequently through the history of several patients,

mostly among children, that have developed serious rheumatic conditions. Such legumins appear daily in 90% of our homes, tho' in a different way than is sometimes used in the States, and constitute an appreciable source of vegetable protein.

The marked desire for salt or salted things is very common when there are malarial antecedents and quinine. Allen mentions it as a tuberculous taint. Malaria is very frequent in my country and it is for us a very hard, serious and stubborn problem. Quite often the great remedy is *Natrum muriaticum*, but during the years of 1941 to 1943 there were many cases in which that failed us in a terrible manner. It is useless to assure you that we are profusely lectured about the best homœopathic literature referring to intermittent fever. I know that the Indian Homœopaths face the same troubles; and you are surely very happy in not having to handle malarial cases. I believe that all those cases of protozoa have that clinical character of such stubbornness.

Desire for alcoholic drinks. Sulphur appears in all the paragraphs and very highly. Medicaments very important, as they only fail in the *desire for ale* and *desire for claret*, are NUX, Lach., Puls., Spig., and Staphisagria. *Nux* and *Sulphur* that are accentuated for the desire for beer, have also prominent aversion for beer. These remedies that have both opposite symptoms are very interesting, says Dr. Margaret L. Tyler, of London.

To what extent should it be convenient to allow satisfaction of the desire for an accentuated craving during an acute illness? Of course, we all remember that story by Nash about the typhoid fever patient that desired ardently a lemon which he was denied, until they called an older and more experienced doctor, who, noticing the desire, satisfied his wish, and the patient devoured it with the peel also, the concession resulting well.

In the same book Nash tells of that longing typhoidic whose restoration did not begin until he was given the

oysters for which he had clamoured for days without succeeding. I believe that it is not wise to accede always to the desires of patients, due to the abnormal manner of life that we lead; some of the desires might not be the true expression of an effort to orient toward cure. Pediatrics state that the best guide to follow about the quantity that should be given to a lactant is the appetite that he manifestates. His desire orders. The baby of a few months presents these reactions more purely; perhaps he has not lived long enough in order to mislead his inclinations with the artificial modes of the following years. I believe it to be dangerous to accede to the numerous desires of the grown child and of the adult when they become ill in acute form. Homœopathic physicians are often more willing to please due to their special ideas in reference to desires and aversions and I believe that their attitude results in a practice very convenient.

I believe that homœopaths were the first in considering the matter of aversions that are perhaps a more genuine expression of reaction. The child that refuses to drink milk, what he needs is not a coaxing or much less the naming of a spanking, but to be taken to an understanding homœopathic physician who will correct that disaccordance with the environment. All of those deficiencies that make us suffer when we come into them, and turn us sick when attempting to adapt to them, reveal deep and chronic disease full of menace for the future.

DISCUSSION

DR. ALLAN D. SUTHERLAND: I have read every number of *The Recorder* since 1927 and have attended, roughly, five conventions of this body, and this is the first time there has ever been an intelligent presentation of desires and aversions with an evaluation of their worth. I appreciate this paper very much. This is to me the highlight of the presentations that have been put before this body.

I have a sort of hazy feeling in the back of my mind along the lines of Dr. Garcia's paper that at certain ages, for instance, a

desire can be disregarded because it is natural to the individual at that age, and we should certainly take that into consideration.

DR. A. H. GRIMMER: Dr. Kent used to say that we should realize in the well people the desires are normal whatever they may be, and those foods they desire are best for them, but it is in the sick that we get the perverted desires, and those are the ones that are to be followed, strictly.

DR. CHARLES A. DIXON: I take a great deal of pride in this paper, which shows good understanding of homœopathic philosophy and case-taking, and repertory study; and, while I can't take all the credit for that, because he had excellent homœopathic instruction, I am sure, before he came to our Foundation, yet I want to say that that paper shows that he took a lot away from our post-graduate school.

DR. J. W. WAFFENSMITH: I don't want to miss the opportunity of thanking the good doctor for this excellent paper.

When he was speaking about beans, that reminded me, when I first went out to practice, on horseback, at the turn of the century, in the Southwest, and the population was 99.9 per cent native Spanish or Mexican, I had beans three times a day. The beanpot, like the coffee pot in some places, was everywhere on the stove; and in that country, with the outdoor exercise, one naturally can eat a great deal of protein and you get a remarkable per cent of protein in the native brown Mexican bean of old. They don't raise it any more. They raise what they call now a Pinto, but it isn't nearly as good as the old original brown Mexican bean, as it was called.

Now, in reference to malaria, we were up five, six, seven thousand feet altitude, and I have seen the most violent series of congestive chills and rapid deaths that I have seen anywhere else where malaria was prevalent, and the strange thing about these epidemics was that they were local. One year it would attack a certain limited section, and it would kill in twenty-four to thirty-six hours if you didn't get in there in good time, and then in another year it would travel probably ten or fifteen miles away to another limited section. I have never heard an explanation for that and I cannot now give one.

I remember there was one old school man who came in there and just in the spring, about the beginning of the annual epidemic of malaria, he was there, and he was a student of the Abbott preparation and after he had put his shingle out, the first few patients he cured. Well, he had everyone in that section and cured them of their malaria. The next year, and thereafter, he

had practically a 95 per cent failure, and the remedy that he gave was *Chininum arsenicosum.* It was the epidemic remedy for that season and he had phenomenal success with it, again coming back to our simple homœopathic teaching of the epidemic similar remedy for a particular time or period.

DR. P. C. PAUL [Calcutta, India]: I thank Dr. Garcia for his excellent paper. I also have had the same difficulty in cases of malaria in India, and these cases are so stubborn, and our homœopaths are afraid to take the actual case in hand. Acute cases die within twenty-four or thirty-six hours, in some cases where the temperature rises to 107° and 108°, and suddenly comes down to 94°, and the patient is in a state of collapse, and in that case our homœopathy doesn't act well, probably. I have not known where we can prescribe the similimum. Our best prescribers of homœopathy fail to do so, and we see this very stubborn thing in our country, very obstinate cases in our practice, our everyday practice, and I do not know whether you can help us in this subject, in a case of malaria, saying something so that we can gain something from it.

DR. THOMAS K. MOORE: We have had so many and such good papers from Dr. Garcia that we could hardly expect that from one man. I wonder if he wouldn't tell us the other men who have been writing these papers. We wouldn't expect one man to put out all of this!

DR. ALLAN D. SUTHERLAND: One point Dr. Garcia brought out referred to the frequency with which young children become uncovered at night. That might be considered an aversion to being covered, or desire to be uncovered. I think the point he made in that respect was that young children many times sleep restlessly, and automatically get uncovered. It is not to be considered a desire to be uncovered; it just happens. I have two sons, one of whom, when a baby, never had any difficulty about being uncovered. The second son, now a baby, from his infancy has always been uncovered. He never will keep the covers on—and he still doesn't—and he is two years old. This is a point to consider.

I also recall when I was an intern under Dr. Griggs, at the Children's Homœopathic, he made this statement: "Babies who continually kick off the covers need *Sulphur.*" I know that has been borne out. It has been confirmed in my practice. I think he referred to babies in infancy. A little baby tends to sleep quietly because he is not strong enough, as a rule, to turn himself about; he hasn't reached the stage of muscular development where

he can move himself about, and get himself out from under the covers; but you see little babies even three weeks or one month old, who will be nicely covered and tucked in by the doting mother or father, as the case may be, and within an hour or so you go back to see how he is doing and he is uncovered, has kicked the covers off. I think that can be considered an aversion to being covered.

DR. HARVEY FARRINGTON: Just a few words: The value of desires and aversions in the way of food, rests upon the fact that they are natural or that they belong to the voluntary sphere; but their value also is determined by two things, by their intensity and by the unusual or peculiar nature of the desire.

When the *Aluminum* baby wants to eat slate pencils, and the *Aconitum* patient wants to eat coal, and other outlandish things not considered natural, or at least which are not considered natural nourishment, then it becomes an unusual or peculiar symptom, and we know from the *Organon* that the symptoms should be strange, rare, and peculiar. This is all governed by the law of averages and you can estimate, then, whether in your case the cravings or the aversions are of importance, if you use this method. It depends upon your experience and upon your judgment; and also there is another point: The desire, as I said, if it is inordinate, becomes a valuable implication, but if this desire is one that seems to belong to the patient, the old Latin phrase, "De gustibus non est disputandum" applies—tastes are natural and you cannot dispute them, as a rule; but when this desire or this aversion appears as an accompaniment of the ailment, and is contrary to the usual appetites and desires or aversions of the patient, it is even more valuable than before.

I have thought of that question many times and it appears to me that the first symptoms that appear in the disease to be treated are more valuable than those that are natural for the patient, perhaps, through life; but, nevertheless, if the constitution of that patient is modified or has one characteristic that may be useful in determining constitutional remedies, that is valuable.

DR. JAMES M. HEIMBACH: I don't know whether Dr. Garcia remembers me or not, but I had some correspondence with him some years back and I want to thank him for the paper; but this is what I would like to have an answer to, and I am thinking of Dr. Nash, whom you all know—I understand he was called to a very serious case of typhoid fever in a girl of twelve or thirteen years of age, in consultation, and as soon as he came

to the bedside, the girl spoke up to him and said, "Can I have a pickle?"

Dr. Nash said, "You want a pickle that bad?"

"Oh, doctor, if I could only have a pickle."

He said, "Give that girl a pickle."

Now the point that I want to bring out is when a system craves something so intensely, isn't it wise to give it? I think it is. I never ignore those intense desires, if they have any sense to them at all.

DR. MOORE: Would you include alcohol?

DR. HEIMBACH: Alcohol!

DR. JOSE GILBERTO GARCIA [*closing discussion*]: Thank you very much for your kind discussion. It has been so extensive that I have not anything more to add, but, in reference to malaria I would like to say something. Perhaps you say: "That doesn't interest us," but we are facing that problem and I have to tell you that we have a very bad feeling with a patient that day after day has a chill and he has full confidence in us. The homœopathic physician has been of great value to that family for several years, and then comes a case of malaria. Generally, the homœopathic physician is able to cure it, but, sometimes, we are facing a really stubborn case.

Well, perhaps you will tell me: "You are in need of a good homœopath at the bedside." My experience is that I have frequently tried with all my forces to handle several special cases of malaria and I have failed. If you fail to find the exact remedy in the first days, you are in a real trouble. Well, of course, very frequently I can cure it,—and the most commonly indicated remedy is *Natrum muriaticum*, 10m., single dose, immediately after the paroxysm—but, for instance, I was graduated in '37 and up to '41 I have had no problem with malaria, all cases cured very soon; but in '41 my troubles began, and I don't know why. I know that my colleagues in Monterrey are facing more or less the same problem. Fortunately, after those bad few years, '41, '42 and '43, the trouble stopped, and I cannot tell you why, but since '43 I have resolved every case of malaria that has come to my hands with pure homœopathy, even sometimes after an exhaustive work.

I remember and I know your literature about the intermittent fever in this country, and you have splendid books. Allen has a splendid book, but I don't know if it is the kind of malaria, or whether it is different from the kind of malaria, that we have in my country.

DR. SUTHERLAND: It probably is.

DR. HUBBARD: *Certainly!*

DR. GARCIA: That is my experience. I know an Italian physician wrote recently a book, and the tale, the story, was funny. He said that the mosquito has nothing to do with malaria. I know there are very good experiences about that problem and I don't believe him, but he says that the occurrence of malaria depends more on the conditions of the soil, and of the weather, temperature and altitude, and he puts the mosquito aside.

Well, when you have a case of malaria,—I suppose many of you have not in many years had to face a case of malaria—perhaps you are in front of another type of disease which in tropical countries is different.

I know that *Hering*—and, of course, every homœopath knows it—lived for years in Brazil, and Brazil is a very malarial country. I wanted to know the experience of Hering. When the feverish accesses are very intense and the remedies have failed he does not hesitate to give quinine "but there must be in mind the fear for the future in the development of secondary sickness" he adds judiciously; and for the pernicious form he advises: "One gram of quinine sulphate and 9 grams of lactose. Triturate for an hour. Give in doses of 0·50 ctgrs., one each two hours."

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SIMPLE BLADDER TROUBLES

BY W. KARO, M.D. (WURZBURG).

I. *Bed wetting* (*incontinence of Urine*) is a frequent and troublesome disorder of children, characterised by partial or complete loss of power to retain the urine. It is not a naughtiness, as many parents believe, but a real disease. In some patients it is nothing but a symptom of a general neurasthenia, running in families, as the parents, brothers or sisters of the child have been suffering from the same disease. In other cases, again, the incontinence is only a symptom of epilepsy; in these cases the incontinence occurs only in long intervals during night. In other cases