Reprinted from PSYCHOSOMATIC MEDICINE
Vol. XXI, No. 5, September-October 1959
Published by PAUL B. HOEBER, INC.
MEDICAL BOOK DEPARTMENT OF HARPER & BROTHERS

Printed in the U. S. A.

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A Case Presentation

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THIS BRIEF COMMUNICATION describes a series of occurrences in the life of a former patient that, because of their interesting and somewhat dramatic nature, are worth reporting.

For one year I saw in psychotherapy a man in his late thirties, who came to me with vague complaints. He felt lost and depressed. He did not know where he was going as far as his occupation was concerned, and his relationships with people were not satisfying. He appeared suspicious and distrustful, and, during the entire period of therapy, he remained quite guarded. He was an overt homosexual; his relationships with men were brief, often passionate, and often ended in a quarrel. If he attempted a more prolonged relationship with a man, he usually became bored with him. I felt from the beginning that since he had a potentiality for being very depressed, perhaps suicidal, and since he had paranoid tendencies, I would keep the therapy superficial and supportive.

He was helped by the therapy considerably, in several ways. His friendships with men became somewhat more stable so that he could continue a relationship with one man for a longer time, and his work situation improved so that he progressed from a poor job situation to being a well-paid, junior executive in a large sewer-pipe manufacturing company. This was an interesting choice of work, because the patient was preoccupied with his bowels. During the therapy he had occasional periods of constipation, which were connected with feelings of stubbornness toward me. He would relieve his constipation by giving himself enemas and laxatives.

I knew how important I was to this patient, so that I was reluctant to discharge him, but after considerable preparation for the separation I did discharge him. Several months after the discharge I received a call from an internist to whom I had sent the patient during the treatment. He told me that the patient was in the hospital and that he had been operated on ten days before for bowel obstruction.* The patient was not doing well. He had had no bowel movements since the operation and a new operation was being considered. The internist asked me to see the patient. During my hour with the patient that evening, I said little. The patient was panicky. He feared he would die. He wept, saying he knew what was important now; his silly, everyday concerns were nothing. Life itself was all that really mattered. I promised to see him again in several days. When I returned he looked much better. He reported that he had a large bowel movement

Received for publication May 20, 1959.

*The surgeon had found old adhesions, probably the aftermath of an appendectomy that the patient had had at two years of age. The significance of these adhesions was equivocal.

15 minutes after I had left. He was eating well and was having bowel movements regularly. He asked me then why I had not shaken hands with him after the last time I had seen him in therapy.

I saw the patient a few days after this and he told me that the Harris tube was to come out that night. Several days passed before I saw him again. In the meantime I had heard from his internist that new problems had arisen. Any attempt to take out the tube made the patient panicky and brought back symptoms of obstruction, and this was true even though the tube had been turned off for several days. I was aware of how suspicious and eager for control the patient was, so I suggested that the patient be permitted to pull the tube out himself so as to give him a sense of control. This was tried and it did not work.

During the next week several more attempts were made to get the patient to pull out the tube and all were failures. The patient again was becoming panicky and his bowel obstruction symptoms recurred again. Disagreement arose at this time between the surgeon and the internist as to what to do. The surgeon of course wanted to operate and the internist wished to delay. The psychiatrist tended to side with the internist, but no one was very sure of himself. I mention this because the patient became aware of these disagreements and they added to his panic. He was constantly asking each doctor detailed questions about his treatment, about the prognosis, and whether a second operation would be necessary. He was observing himself very carefully, trying, as he put it, to learn all he could about the problem so that he too could help. At the same time he was often very frightened and crying in a rather childish way. I decided that my suggestion to give him some responsibility for the tube coming out had backfired. It encouraged him to feel that he was responsible for what happened in his bowel. He had interpreted the good effect of my first visit as proof that his problem was psychosomatic, and this meant to him that if he had the right thoughts he would get well. The doctors' confusion added to his sense of responsibility. The responsibility that he was shouldering was very frightening and he was retreating from it by becoming more and more of a baby. Having lost faith in the doctors, he developed faith only in the tube.

I suggested to his internist that he develop a more authoritarian and masterful attitude toward the patient. We agreed that the internist, after establishing this relationship with the patient, would come in and rather abruptly take the tube out in five minutes; and if the patient complained or looked panicky, he was to be told gently but firmly to be quiet. This was carried out as planned and the results were very effective. When I saw the patient the next day, he complained a little about the authoritarian attitude of the internist, but in a somewhat teasing, friendly way. He told me that he had almost forgotten by now that he had ever had a tube; the experience of having the tube seemed like a dream which had passed. The patient improved rapidly and was discharged about a week later.

I have described the developments of this situation as I experienced them and realize that I have left many questions unanswered. No definite answers are possible, but one can speculate on the following: The bowel obstruction, itself, may have been precipitated by the patient's discharge from therapy. A lonely and suspicious person was separated from someone of importance to him. The re-establishing of a relationship with me, on my first visit, permitted his first bowel movement after the operation. At that time the patient, half out of desperation, developed some sense of trust in the psychiatrist, but this did not last. The patient now believed that his problem was psychosomatic and he resolved to cure himself by having the right thoughts and attitudes. We were aware of his suspiciousness and need for control and mistakenly played along with it by giving him responsibility for the removal of the

tube. The patient's sense of responsibility was further strengthened by the confusion he was able to detect among the doctors. He lost faith in the doctors and retained it in the tube. Only after the internist behaved in what the patient considered a masterful way was he able to trust the doctor and give up the tube.

I saw the patient six weeks after his discharge from the hospital. He could scarcely remember how he had felt in the hospital. He was intensely grateful to me and out of gratitude asked to re-enter therapy. I told him this was not necessary but I would always be available to him when he wanted an appointment. The patient called me several times during the next year and has continued to feel well.

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