DIFFERENTIATION BEFORE DEATH: MEDICAL FAMILY THERAPY FOR A WOMAN WITH END-STAGE CROHN'S DISEASE AND HER SON

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Medical family therapy grew out of the experiences of family therapists working with other professionals to provide comprehensive, integrated health care for patients (McDaniel, Hepworth, & Doherty, 1995). This is the story of one such patient, her son, and those of us who were the three primary participants on her treatment team. To provide an account that comes closest to the experience itself, we have taken quotes from videotaped sessions and electronic mail communications that occurred throughout the course of therapy. Each provider tells part of the story in his or her own voice. The general commentary is provided by Susan McDaniel.

THE DEVELOPMENT OF BIOPSYCHOSOCIAL MEDICINE AND MEDICAL FAMILY THERAPY

Family Psychologist Dr. McDaniel

Every theory evolves in a particular context that is a fertile, determining environment for its development. Biopsychosocial medicine, an alternative to the reductionistic biomedical model, was developed at the University of Rochester School of Medicine out of the inspiration of one internist, George Engel (1977), working among a cluster of talented physicians interested in disease and the social aspects of the human condition (Epstein et al., in press). In 1980, I brought my family systems training to the psychosocially sensitive Department of Family Medicine. Family physician Thomas Campbell, having just completed a fellowship with George Engel, joined me to develop a behavioral science curriculum for primary care physicians. This curriculum integrated family systems and biopsychosocial approaches, which evolved from a common root in general systems theory.

Once we had developed a curriculum (McDaniel, Campbell, & Seaburn, 1990), we realized that most mental health professionals did not communicate, much less collaborate, with the physicians we were teaching to provide family-oriented, biopsychosocial care. When lesser interventions (such as pleading with community therapists) did not rectify the situation, we decided to experiment with on-site family-oriented mental health services. The experiment succeeded beyond our expectations. Problems with communication decreased sharply and, even more important, the setting provided routine opportunities for innovation and collaboration with other health professionals. Of course, barriers to collaboration occurred daily, but my tolerance for working through them was high because I grew up in a medical family (my father was an obstetrician) and live in one now (my husband is a pediatrician and internist). This is a context that I understand.

We had brought family systems theory to the medical context, but what had we ourselves learned about family therapy in the process? With family therapists Jeri Hepworth in Connecticut and William Doherty in Minnesota also working in primary care...
settings, the development of medical family therapy seemed a natural next step in terms of developing a biopsychosocial approach for family therapy that recognizes the effect of physical issues on emotional processes (McDaniel, Hepworth, & Doherty, 1992, 1997). The treatment described in this chapter illustrates the importance of the overarching goals of medical family therapy: agency (or self-efficacy) and communion (or significant connection). As in every case, these goals were important for the patient, the family, and the health care team itself.

My first contact with this case was at a colloquium organized to bring together family therapists from Psychiatry and Family Medicine with biopsychosocially oriented physicians, including George Engel, Thomas Campbell, and Ronald Epstein, to watch a Public Broadcasting System video of the Arthur Miller play "Broken Glass." The father of psychoneuroimmunology, Robert Ader, also works at the University of Rochester Department of Psychiatry and had recommended the play to me as one that illustrates the interplay among sociocultural factors (World War II), interpersonal interaction (a married Jewish couple in Brooklyn), and symptomatology (conversion paralysis of the wife). We were all moved by the play and its importance to our work. In the discussion period Dr. Epstein mentioned that he had to leave early to see a patient who had many of the same issues represented in the play—sociocultural issues (she had immigrated from Czechoslovakia), interpersonal issues (she and her son struggled over her dependency on him), and symptomatology (hallucinations; depression; secrecy; and a diagnosis of severe inflammatory bowel disease, also called Crohn's Disease). In "Broken Glass" the family physician treated the couple without help from any other professionals. Dr. Epstein left the gathering saying that he realized he did not want to do the same, and he asked me if I would work with him to provide care for his patient. Still stimulated by the play and the discussion, I agreed.

I quickly recognized the complexity of the case and the likelihood that the systems work would include a mixture of individual and family sessions, in addition to close collaboration with the health care team. I was also convinced that there was an educational opportunity for all of us in the story Dr. Epstein told, so I asked our Medical Family Therapy Fellow, Jennifer Harkness, PhD, if she would like to work with me on the case. In the beginning, Dr. Harkness observed and assisted in the therapy. By the end, she functioned as a cotherapist with me for the family sessions and as an individual therapist for the identified patient while I took primary responsibility for the individual sessions with the patient's son. This example of medical family therapy occurred over a 10-month period and involved a total of 31 individual and family sessions (6 family sessions, 3 network sessions with the family and professional network, 10 individual sessions with the patient, and 12 individual sessions with her son) as well as multiple interactions with her primary care physician, Dr. Epstein, and various other members of the health care team.

Family Physician Dr. Epstein
In October 1996, I was asked by Vaclav Havlicek if I would take care of his mother, Lola. I had known the 53-year-old Vaclav as a patient for 3 years. His mother, age 82, was hospitalized with severe inflammatory bowel disease (Crohn's Disease), characterized by abdominal pain, diarrhea, and rectal bleeding, and was refusing surgery that might eradicate the disease. Mrs. Havlicek was on high doses of steroids, which made her legs swell and had long-term risks of osteoporosis and diabetes. Her care was further complicated by the fact that she was admitted to two different psychiatric wards at hospitals where I did not ordinarily admit. Trials of two antidepressants, an antipsychotic agent, and an anxiolytic appeared to reduce her emotional lability somewhat but clearly had not solved the problem. Communication with medical specialists and psychiatric staff was difficult, and neither time was there appropriate follow-up.

Mrs. Havlicek initially struck me as a bright, engaging woman who had endured much hardship; the death of her husband at age 30 of colon cancer, raising a 3-year-old in a repressive political environment in Czechoslovakia, a difficult emigration to the United States, and now this illness. Her son described her as "difficult," and this was initially manifested in the unrealistic hopes that she expressed in
having me as her physician: “My son says that you are the best doctor in the world.”

During this time, Vaclav was clearly struggling with his role as his mother’s only living relative. Through prior psychotherapy he had come to the realization that he could not spend his entire life caring for his mother and that whatever was given would never be enough. As Mrs. Havlicek’s medical situation worsened, she became more demanding of hospital nurses and her son. Vaclav had taken to occasionally contacting me by means of electronic mail; these communiqués increased, as did pages to me from the hospital nursing staff. The gastroenterologist, nutritionist, and colorectal surgeon involved in Mrs. Havlicek’s care had few useful suggestions. The situation was beginning to seem hopeless.

Soon the risks of overinvolvement and my need to fix this situation crystallized. There were several elements of the case that were particularly cogent for me: First, the sense that no other physician had been successful in Mrs. Havlicek’s care and that she did not like her previous doctor were warnings to watch out for unrealistic expectations—but they were also lures: Could I be the one to fix the unfixable patient? Second, I realized that I needed to place boundaries around my involvement with this patient for the treatment to be useful for her and manageable for me. I knew unrealistic expectations would be harmful to both of us. The request from her son, a patient of mine, to care for his mother, made the task even more onerous and inviting—could I not only fix the unfixable patient but also satisfy the needs and desires of her son to get his mother off his back? These mythical, heroic themes were balanced by the warning I took from “Broken Glass”: Get help; you cannot do it all! Although I recognized that the need to accomplish the impossible was commonly part of physicians’ own family expectations, asking for help was still difficult for me because of my interest in psychological aspects of illness and my training in family therapy. Fortunately, Mrs. Havlicek did consent to surgery, but she still harbored significant ambivalence and fear. Shouldn’t I know how to manage this situation unassisted? My role was unclear—I am not an expert in management of severe Crohn’s Disease, and I routinely refer patients who are suicidal to therapists. The recognition that help might be available brought me a sense of repose and relief. The question was, whom should I ask for help?

Because I felt the obligation to fix the unfixable, I also felt an obligation to find an excellent therapist. Experienced therapists willing to work with medically complex patients, and see patients outside their office settings, are rare. Also, I had fears of being criticized, as I had been by one psychiatrist, for having made the clinical “error” of caring for more than one person in the family. I chose a colleague, Susan McDaniel, PhD, with whom I had studied family therapy, who would recognize that the consultation might be as much to provide support for me as to provide direct assistance to the patient. Dr. McDaniel also involved a Medical Family Therapy Fellow, Jennifer Harkness, as a cotherapist. I explained my (not very modest) goals for the consultation:

1. to support Mrs. Havlicek during a difficult time before and after surgery and help her adjust to changes in her living situation, her physical functioning, and her self-image in order to live as independently as possible
2. to evaluate Mrs. Havlicek’s mental state, which appeared to be labile
3. to share the care of a complex patient and thus relieve me of what seemed to be an overwhelming responsibility (or sense of responsibility)
4. to help Vaclav individuate—to be able to balance his needs with those of his mother and to help him prepare for a life without her.

Dr. McDaniel
A referral from Dr. Epstein is synonymous with the referral of a difficult (and usually fascinating) patient. Dr. Epstein is a very skilled family physician with training in both biopsychosocial medicine and family therapy. Once I read the reports from the patient’s most recent psychiatric hospitalization, I could see why Dr. Epstein was worried. This patient had severe medical illness; the need for major surgery in the near future; and a history of suicidality, anxiety, and being difficult to manage medically and psychiatrically. I could sense from Dr. Epstein a feel-
ing of being pulled into the case; it was a mixture of familiar connection, compassion, and feeling overwhelmed.

**PRESURGERY SESSIONS: CRISIS INTERVENTION**

**The Initial Collaborative Session**

The first session was attended by the patient, Mrs. Havlicek (Mrs. H); her son, Vaclav (V); Dr. McDaniel (Dr. M); Dr. Harkness (Dr. H); and Dr. Epstein (Dr. E). In medical family therapy we strive to conduct the first session with the referring physician, if possible, in order to hear the medical history and the physician's concerns and to gain his or her blessing for therapy with the family. Often this initial experience of collaboration by the treatment team is a powerful way to join and initiate treatment with the patient and family. For patients who define their problems as medical and not psychosocial, this beginning may be essential to making the referral "stick." Our first session took place in a hospital room established for family meetings. At that time, Mrs. Havlicek had been hospitalized for a week, receiving intravenous nutrition to regain enough strength and stability to withstand surgery on her colon. The patient quickly laid her cards on the table.

**Mrs. H:** I am an outspoken person. I don't know what this [meeting] has to do with my illness, and altogether I just don't know if it means some improvement for me. . . . I just don't know why [we're meeting].

**Dr. M:** Why are we here? Let's talk to Dr. Epstein about that and then we can each share our opinions.

**Dr. E:** I guess my concern . . . like we talked about before . . . is that your health is very fragile and you are going to be going through some pretty major surgery. You have had some problems with depression and also not wanting to live. And between the two of you, you have had some problems about how you can best help each other. So this is a time that I thought we could get together to help you and Vaclav optimize your health the best we can.

This is a high-risk time. I want you to get through the surgery not only alive, but living the way that you want to live. And without driving yourself crazy and driving Vaclav crazy.

Clearly this patient was not going to easily accept our services, although she had no reluctance to continue taking her psychotropic medications. Without Dr. Epstein at this session it is doubtful that this referral would have been successful. It was also clear at the outset that cultural issues were prominent. Fortunately, and coincidentally, Dr. Harkness's grandparents had emigrated to this country from Czechoslovakia. Searching for commonality, we silently agreed to use this as much as possible to put Mrs. Havlicek at ease so we could begin our initial assessment. It was also clear from the beginning that Vaclav was embarrassed by his mother's criticism of the United States and its health care system and by her attachment to the Old Country. Because of this, I worked to be especially respectful and understanding of the patient's history and values.

**Mrs. H:** [I] suffer so much, not for one person but for five persons.

**Dr. M:** Is your heart still back in Czechoslovakia?

**Mrs. H:** Yes. It wasn't [when I first came to this country] because I was healthy, I was happy. I had lots of friends here. Now in 2 years, five Czech people died: one a year. . . . Half of me is here and half is there, but I have to be reasonable. It is impossible to go there.

**Dr. M:** Yes, right. So even though there is part of you that knows that your heart is there you have to accept that your life is here, and that is what is realistic.

**Mrs. H:** In Czechoslovakia they have everything. They make it easier. Here it seems to me [that you] scratch your ear this way [touching ears with arms crossed], when you can do it that way [touching ears with arms uncrossed].

**Dr. E:** She means that we do things here the hard way.

**V:** The wrong way.
Mrs. H: Yeah.

V: Mom, don't forget that every friend of yours from the Czech Republic writes to you and tells you how terrible medicine is there because everything is changing dramatically. Somebody told you that you should be glad to be in a hospital here and not in Prague.

Mrs. H: Yeah, that is true. Like I said, it means a lot of change.

V: The point is that we are not here trying to change America but [to see] what can be done for you and me.

Next I turned to evaluate her feelings regarding the upcoming surgery.

Mrs. H: [I'm] nervous like an old cat. Everyone is scared.

Dr. M: Are you scared?

Mrs. H: Yeah.

Dr. M: You are. Do you want to live?

Mrs. H: Yeah, of course I would like to, if it like [is a] little normal life. . . . I was never scared when I had another surgery, but this time I do.

Dr. M: And the difference is . . .

Mrs. H: You know, maybe because it will be close to the end. My husband had colon cancer so that is . . . (tearing up).

Dr. M: The similarity is upsetting . . .

Mrs. H: Yeah, when you are waiting, that is the worst time. Like when you go to the dentist and you know that he will pull out your tooth. That is similar. My friend's husband died a few years ago. I think that the older you are, you are more scared. . . . I don't have the discipline that I had before. Not any more: I changed.

Many patients' peculiar responses to medical interventions are rooted in past experiences. For Mrs. Havlicek, this hospitalization for bowel disease reminded her of the tragic experience over 50 years before when her young husband, Vaclav's father, died at age 30 of colon cancer.

In addition to a life of loss and stress, Mrs. Havlicek also worried about mental illness. In an electronic mail note to Dr. Epstein, just before the referral, Vaclav said of his mother:

She called yesterday and said that she is not sleeping anymore. That she has to go to urinate many times every night and she is certain it is nervous in origin. She also told me that she is very (or extremely) depressed, that she is very scared that she will end her life in a psychiatric ward, as her father did.

We learned that Mrs. Havlicek was critical and unhappy about almost everything, as well as paranoid about the hospital staff, the professionals on her health care team, her friends, and sometimes her son. She denied any history of psychiatric treatment in Czechoslovakia, although she had been hospitalized twice in this country for suicidality and once in the distant past for unknown reasons. Her father's experience in an old-fashioned asylum haunted her. She did take solace in the fact that medications currently used in psychiatry were a significant advance over anything available when her father was ill.

Trying to understand more about her recent psychiatric experience, we asked Mrs. Havlicek about the hospitalization that occurred several months before this session.

Mrs. H: This injury [pointing to her shoulder] happened at the end of January. I don't know why Dr. Epstein was so stubborn that I have to go on psychiatric [ward]. . . . I spend there 10 days. I could not eat the meal. They did not do absolutely anything. What will they do with my arm on psychiatry? I suffered and suffered, 10 days I was in hell for nothing.

Dr. M: It seems like over and over again you have the experience of wanting to be helped and somehow it is frustrating because you feel your needs aren't really being met. And it seems like it happens over and over again throughout life.
I began to understand that Mrs. Havlicek pulled for people to argue with her about the facts of her life, but what she really needed was for people to listen and respond to her emotional experience. Vaclav had a very hard time doing this; he fell into arguing with his mother again and again. I knew changing the way he listened and responded to his mother would be an important part of this therapy.

V: I feel that my mother sees many problems with America, with the world, with everybody. [To his mother] Sometimes I feel like you think everybody is against you, everybody is your enemy almost. I don't think it is true. [To providers] If something could be done about that in a sense, I think that would do a lot about her attitude toward surgery.

Given her history, I had my doubts that Mrs. Havlicek's negative, depressive attitude was situational; my guess was it was a long-standing, perhaps lifelong, pattern of coping, punctuated by periods of major depression. I suspected that Vaclav had an equally long-standing longing for his mother to be more positive and nurturing (toward him) but that this wish was unrealistic. If these theories proved to be true, we would need to treat Mrs. Havlicek's agitated depression, help her become more comfortable with the need for surgery, and help both mother and son support and differentiate from each other.

At the conclusion of the first session, Dr. Epstein expressed his own goals for the therapy.

Dr. E: Is there a time that you could tell me about when she was actually feeling better, when she was the mom that you would like her to be now?

V: Actually, that would be difficult because I do not have much memories of that. I am concerned about how she feels, and does she want to live? Is she feeling well or not? I am concerned about this colostomy because, what sort of life will she have with it? I am concerned about her going to a nursing home too soon because she does not like people. The other thing I am concerned about is how she can accept help or not accept help. The fact is that I cannot be there every day.

It is evident from this exchange that Dr. Epstein is functioning as a cotherapist in this session. Also, Vaclav supported my hypothesis about his unrealistic expectations and demonstrated that he has insight into his own dynamics. It is interesting that Vaclav brought Dr. Harkness and me several articles during the course of treatment. The first was on mind–body integration, and the second was on attachment theory. An engineer, he clearly was well read on the psychological theories that might help explain his experience. Theories notwithstanding, he alternated between being worried about his mother and being furious about her demands on him.

Preparing for Surgery

At the end of the first session Dr. Harkness and I spoke about the case and realized that we would need to mix individual and family sessions to meet the goals established in this first session. Given Dr. Harkness's cultural connection, we agreed that she would conduct the individual sessions with Mrs. Havlicek and that I would take primary responsibility for the sessions with Vaclav. We would both attend the family sessions and attend to the collaborative relationship with Dr. Epstein. Because we frequently used electronic mail to communicate with Dr. Epstein, it was easy for both of us to be copied in on all contacts. Vaclav also initiated electronic mail contact with us, sent all messages to both Dr. Harkness and me, and often copied them to Dr. Epstein as well. He quickly caught on to the collabora-
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The nature of our treatment and used the computer to facilitate communication.1

As it turned out, both Mrs. Havlicek and Dr. Epstein were skeptical after the first session; they both later acknowledged that they were unsure we could help. I was too busy trying to formulate a treatment plan that covered the many aspects of the case to think too much about whether it would work. Although the relational issues between Mrs. Havlicek and Vaclav were intriguing, the first priority in our biopsychosocial assessment was to clarify Mrs. Havlicek's mental status, lower the anxiety in the system, and help the patient prepare for surgery. Mrs. Havlicek denied any current suicidal ideation or plan and passed the mental status exam embedded in her first session, but some of her behavior reported by the staff outside this session seemed delusional or even hallucinatory. Dr. Harkness visited Mrs. Havlicek several times in the next week, and we discussed her mental functioning with Vaclav and the nurses, but the most helpful information came from her Dr. Epstein, who expressed in an electronic mail note his belief that the "hallucinoid" experiences were secondary to the hospitalization and the steroid medications needed to control her Crohn's Disease and would clear with time.

Dr. E: I've talked to her about some of those events, mostly last week. I think that she is not truly hallucinating, but having hallucinoid experiences at times, mostly relating to actual events in Czechoslovakia. She knows that they are not real. One such event was that a friend told her that the doctors knew that she really had cancer, and that the diagnosis was being kept from her. This actually did happen to her husband. . . . I would not entirely rule out some subtle cognitive impairment, but she does very well on a mental status exam. No sundowning noted by nurses. Most of her changes of topic are probably not because of distractibility or psychosis; it is avoidant and controlling, a coping mechanism when anxious.

We came to agree with this assessment, borne of Dr. Epstein's longer term relationship with Mrs. Havlicek. Also, there were discussions about whether to change the dose or the medications she was taking. We decided to maintain the current regimen, wanting to keep from making a complex situation more complex. Fortunately, that was the right choice. Indeed, her hallucinoid experiences were transitory. We were all aware of the meaning of these symptoms to the patient.

V: The other thing that she is terrified of is that she will become crazy like her father. A couple of times I thought, well . . . it is coming . . . and now I am wondering if it is.

Dr. M: Definitely with older people who have been in the hospital for a long time, they can become delusional. It must be very upsetting to look at your mother and to see her so out of it. It sounds like, between the two of you, she has been difficult all along. She is so attached to you and has expectations of you that you do not share.

As we were gathering information to confirm a diagnosis about the delusional episodes we also held several family therapy sessions in the hospital with Vaclav and Mrs. Havlicek. These sessions followed the pattern established in the first session: treating Mrs. Havlicek with respect, encouraging her to become stronger as she moved closer to surgery, making sense out of her concerns given her history, talking about the differences between this country and Czechoslovakia, and helping Vaclav to hear the emotional realities embedded in what he experienced as provocative comments by his mother.

These themes were reinforced during individual sessions with Vaclav. Here is an exchange during one of the sessions in which we tried to connect Mrs. Havlicek's negativity with the anxiety that was understandable given her history.

Dr. H: I am curious. In a conversation with your mother, she mentioned having a friend who died of

1With regard to electronic mail communication among the providers and with Vaclav, care was taken to avoid identifying features of the case so that confidentiality was preserved.
cancer, and they did not tell the friend his diagnosis. Do you know about this?

V: She has a friend who did die of cancer about a year ago. That is something about this country: They do tell you if you are dying of cancer.

Dr. M: Yeah . . . but in a lot of other countries, they don't.

V: In Czechoslovakia, she probably did have some people . . .

Dr. M: Which is a horrible bind for her now because she does not trust our system. So when people tell her she doesn't have cancer, where does that leave her?

V: That is interesting! I was afraid that constant fear could not necessarily cause [cancer] to happen but . . . it may help it in some way.

Dr. M: Well, it could certainly cause anxiety, you know, if nothing else.

Vaclav took his mother's behavior at face value: To him, she was just a negative person. Over time, we appealed to Vaclav's considerable intellect to encourage him to look underneath the obvious to what emotions might be fueling her behavior. Later in therapy, we applied this same exercise to his own behavior. Vaclav was very invested in his spiritual development (especially Buddhism), but he maintained an engineer's exclusively cognitive view when it came to understanding the connection between emotions and behavior. It was this linear worldview that we slowly challenged in individual therapy.

It was unclear whether Mrs. Havlicek would survive this challenge to her health. Her mental health status also remained fragile. We knew that if she died before her relationship with her son improved Vaclav's attempts at differentiation would be extremely challenging. His mother's blessing for him to move on was very desirable. Their relationship had become very fused over the years, punctuated by Mrs. Havlicek's difficult emigration to the United States and Vaclav's series of failed relationships with women, including a marriage and a divorce. Together Vaclav and his mother spoke of wanting the other to be free and independent, but somewhere inside each wondered about being able to survive on his or her own.

After several family sessions, Dr. Epstein sent us an electronic mail note: “Mrs. Havlicek really appreciated yesterday's family therapy session. She indicated that she was very suspicious of the whole process in the beginning, but now sees that it might be helpful.” Meanwhile, after a slow start, Dr. Harkness was developing a strong relationship in individual therapy with Mrs. Havlicek, helping to lower her anxiety in the face of surgery.

**Family Therapist Dr. Harkness**

When we decided that I would meet with Mrs. Havlicek on an individual basis, I struggled with what therapy I could offer her. She had already been in the hospital for 3 weeks and made it perfectly clear to Dr. McDaniel, Dr. Epstein, and me that she did not want to work with us. At first I thought this attitude was strictly related to mental health services. I later learned it was generalizable to all health professionals.

The hospital staff described Mrs. Havlicek as unpleasant to care for, mostly because of her irritable mood and demanding demeanor. She complained about everything and everyone who entered her room. She was convinced that everyone around her either wanted her admitted to a psychiatric facility or secretly knew that she was dying. At that time, her mental health status was declining with her physical status; however, we constantly reassured her that we did not plan to admit her to a psychiatric facility. This gave her little comfort, and the medications she had to take for her Crohn's Disease complicated the situation with her mental status.

Mrs. Havlicek was on steroid medication to prevent her from bleeding profusely during her operation. Steroids often cause emotional lability and, sometimes, hallucinations and delusions. Also, she was on blood pressure medications, antidepressants, and anxiolytics, all of which can cause mental status changes. Part of her mental status changes included forgetting having met people the preceding day. This cognitive deficit made joining and building an established relationship with the hospital staff and me challenging. My hope was that she would survive the surgery, taper the numerous medications, and re-
gain a functional mental status. Meanwhile, I provided empathy and reassurance as much as possible, trying to cut through her cantankerous presentation.

**Dr. McDaniel**

Individual sessions with Vaclav during this period were mostly focused on him expressing his anger about the ways in which his mother had been disappointing and difficult through the years. Letting out these negative emotions seemed to allow him to tend to her in this period of crisis. At the time of the referral, Vaclav vacillated between frequent, intense contact with his mother around crisis times and angry distance at others. We talked about more balance in the future, if she made it through the surgery, when he might be able to schedule regular visits with her several times a week, at times she knew she could count on. He then could count on having the rest of the time to himself. This plan operationalized an appropriate emotional distance for this pair who had had to pull together to survive in their early days in Czechoslovakia.

We were also aware that this issue of closeness and distance was important in the dynamics of the treatment team. Dr. Epstein initially felt overwhelmed with responsibility, much like Vaclav. By involving us with him and sharing the responsibility, we were all able to play our respective roles with enough—but not too much—involvement.

Through the family and individual sessions, we were seeing gradual improvement with the Havliceks in a psychosocial sense. (At this point, Vaclav brought us the article on mind-body integration, showing that we shared a similar outlook on the treatment.) However, Mrs. Havlicek’s nutritional status was not improving, despite maximal intravenous therapy, and she remained physically weak. She alternated between being mildly optimistic, expressing a determination to live, and decidedly depressed, questioning her ability to survive all these biopsychosocial assaults. In an electronic-mail note to Dr. Epstein, Vaclav expressed his fear and concern:

> Today my mother told me that she has no appetite and that she did not eat anything. Wonder if that is related to the increased IV nutrition. Also, she said that she was depressed and crying and does not know why. She is talking about slipping away painlessly, sounded a little bit like a wish she died when having the surgery.

Worries about suicidality floated around during this period, but none were validated to us by Mrs. Havlicek. Finally, after weeks of delaying the surgery for fear that she would be too weak to recover from the operation, and recognizing that things were not going to improve any further, Dr. Epstein suggested to the colorectal surgeon to take Mrs. Havlicek to surgery despite the risks posed by her poor nutritional status. Fortunately, the surgery was technically successful, but it was impossible to reconnect her bowel, leaving her with a colostomy. When I ran into the surgeon soon thereafter, his comment was, “Now she needs you more than she needs me.”

**POSTSURGERY SESSIONS: ADAPTATION AND DIFFERENTIATION**

For several days pre- and postoperatively Mrs. Havlicek was intermittently delusional, but her mood remained pleasant. This was a brief period that Vaclav much appreciated, saying that his mother was loving and positive (even if not totally competent) in a way that he had never experienced before.

V: One of the things that I was concerned about was that she would die and I would not have been able to remember a pleasant time with her. However, these past 2 days I have really enjoyed being around her. Obviously, I don’t want her to be crazy, but I was glad it happened. Now she is back to complaining and saying her hallucinations and delusions.

Several days after the operation, Mrs. Havlicek’s pain medication was discontinued, and her mood began to return to its more negative baseline. However, she never returned to the dark periods that were part of the months before the operation.

**Dr. Harkness**

The usefulness of my visits with Mrs. Havlicek was clear after her surgery. Postoperatively Mrs. Havlicek
became less fragmented and delusional, especially after her morphine was discontinued and the steroids were tapered. She was able to recognize and trust me. I grew very fond of her, in spite of her occasional peevish presentation. Mrs. Havlicek reminded me of many things past and present. She reminded me of the work that I did as a volunteer in a nursing home facility. She reminded me of my 88-year-old great aunt, who struggles on a daily basis with chronic pain and depression. Mainly, she reminded me of my Czech heritage. This was a part of my own story about which I knew little, and I used this commonality to join with her and educate myself.

For Mrs. Havlicek, the cultural difference was the dominant story that organized her hospital and illness experience. Discussions about her homeland shed light on why she seemed so mistrustful of the American medical system. Complaining about and to the hospital staff was her only defense against the unknown. She was going to die fighting, if indeed she was going to die at all.

Mrs. Havlicek showed me pictures of her family, complete with stories of survival and loss. When her husband died of colon cancer at the age of 30, leaving her a single mother of their 3-year-old son, Mrs. Havlicek seemed to react to her loss by becoming enmeshed with her son and taking a job in a medical setting. Her son became her primary companion, her job an inoculation against illness. After her husband's death other family members and friends died, some more significant than others, but all carrying the same story of not knowing the truth about their illnesses. Her ability to connect past experiences of friends' and family members' deaths to present fears about her own condition was both impressive and oppressive. During this phase of therapy we also focused extensively on her considerable fears of institutionalization (related to her father), cancer (related to her husband), and perceived abandonment (related to her son).

**Dr. McDaniel**

Several weeks postsurgery, Mrs. Havlicek was discharged to rehabilitation at a nearby nursing home facility, where she slowly began to improve. During this time there were a few minicrises, like those before surgery, in which Mrs. Havlicek communicated panic to her son. In an electronic mail note to Dr. Epstein, Vaclav described his ongoing struggle regarding his mother's negativity and his desire to differentiate:

*I just had a call from her. It started very upbeat, but then she said that the next time I come in I can teach her how to "walk again," how to get up from the chair and get to the toilet. It was difficult for me. I told her I do not think that she needs to learn to walk, but that she needs to talk to you about it. She bitterly complained about some rehabilitation people, that they are not dependable, that they refused to work with her any more. I kept telling her to talk to you about it, and I think she was getting angry with me, telling me yes but meaning no. . . . Maybe she did not mean it, but what I heard was that she was giving me responsibility for her well-being in the hospital, and for her health, and I have a hard time accepting that. I do not think I can, I do not think I should.*

During this period of treatment we had weekly individual sessions punctuated with occasional family sessions. Dr. Harkness's conversations with Mrs. Havlicek focused on healing, gaining trust in the American medical system, and regaining her strength, as well as asking her about how she felt Vaclav was doing. Mrs. Havlicek clearly understood that her son was struggling, but she characterized her own behavior as out of her control: "[Vaclav] must be tired to have such problems with me, but what can I do? It is my destiny."

The sessions with Vaclav focused on helping him to accept his mother as she is, and had been, while grieving the mother he wanted but never had. We discussed her illness, its likely course, and its effect on her and on him. Vaclav continued to struggle with his mother's victimized stance. He particularly winced when his mother tried to show him her colostomy bag or talk to him about the details of her physical reality. During this period we also raised the issue that neither of them had discussed (although it had been a frequent topic of discussion by
Differentiation Before Death

the treatment team): her eventual death, and whether it would be sooner or later. Mrs. Havlicek spoke about her death in a fatalistic (external-locus-of-control) way, whereas Vaclav struggled with his desire for her to take charge of her illness and her life (in an internal-locus-of-control way). I worked in individual sessions to introduce doubt and complexity into the stereotyped way in which he understood his mother's behavior.

V: When I say something to her like, "I am happy that the surgery helped and that you will have some sort of a decent life,” or, “Maybe this will clear up?” she will say, “I do not know, maybe not.” Not that she was ever a positive person.

Dr. M: Do you think your mother is dying?

V: No, because I believe that if she really wanted to die, she probably would have. I think that she is getting weaker and weaker, and it is getting more difficult for her to be on her own. Is she dying? My sense is that she could be like this for many years.

Dr. M: I am trying to understand what you make out of her saying ["I do not know, maybe not"]. Is it her accepting that perhaps she is dying, or is it something else?

V: I don't know. I think it could be that she really thinks that she is getting weaker and may be dying.

Dr. M: And is more accepting of that than she used to be?

We also asked about any business that Vaclav felt was unfinished with his mother. Vaclav reported that, after tending to her through this latest and most serious physical crisis, he did not feel that anything important was left unsaid or undone. This labor of love seemed to have fulfilled some debt.

In a family session they both were able to discuss Mrs. Havlicek's inevitable death. In a touching exchange, Vaclav agreed to take his mother's ashes back to Czechoslovakia. In individual sessions with Vaclav we continued to work on his understanding of his mother.

V: Right. The other thing that I just can't get out of my mind is the martyr, the victim.

Dr. M: Do you think she is just posturing for you to feel sorry for her?

V: It is for me more than for anybody else. We all have a focus for our life, and I think the focus of my mother's life is this martyrdom. This is "me against the world." It is like this colostomy thing. Some people can make it the center of their life, and others just keep going on living. My theory is that she almost needs this [approach] for living.

Dr. M: It organizes her life. So it is real hard to tell [whether she's saying] something meaningful about her coming to accept that perhaps she is in the waning months or years of her life, or whether she is in her victim/martyr stance?

V: Of course. Whenever she [complains about] something, I think, well maybe I should check into it. [The hospital nurse] says "Don't worry about it. In my opinion, you do more for your mother than most people that I have come across."

We discussed Vaclav's need to know that he was doing enough for his mother and asked what relatives and friends from Czechoslovakia would expect. Fairly quickly, Vaclav came to believe that he was doing a good job as a son caring for his ill and elderly mother.

During this time, discussion about whether Mrs. Havlicek would go home or to a nursing home were frequent. It was finally decided to give it a try at home.

The first victory was that Mrs. Havlicek accepted the aides who came to her house to help her. She did not like them but, unlike previous times, she accepted them. She tapered her anxiolytic medication on her own and continued to feel less anxious but remained on the antidepressant to help with insomnia. Vaclav was attentive, in person and by phone, but it soon became clear that his mother should not live alone. Mrs. Havlicek suffered several falls at home. One fall in particular landed her back in the hospital for observation. She was also experiencing rectal bleeding and was having trouble changing and maintaining her colostomy bag. Vaclav complained about not understanding the details of his mother's medical condition. When I reported Vaclav's ques-
tions to Dr. Epstein, he replied to me via electronic mail:

I spent a while talking with [Vaclav] on the phone. I have explained the medical stuff to him repeatedly. It is not complex. She has residual disease, and he has trouble hearing this information.

She is now requesting to go to a nursing home. She feels too frightened at home, with reason. She is really too frail to live alone safely. I take this as a good development for her. She will do well, I think—it is him that I worry about now. Keep me posted.

This kind of collaboration is invaluable when a patient like Mrs. Havlicek is in transition from independent to assisted living and when family members like Vaclav are anxious because of it. (Anxiety frequently prevents patients and family members from hearing the details of the illness the first, second, or even third time.) Although we on the treatment team work in the same facility and probably discussed this case in person at least briefly once every week or two, electronic mail afforded us new opportunities for timely communication. This convenience factor also occurred to Vaclav. He wrote the following to Dr. Epstein, and copied it to me and Dr. Harkness, about the possibility of his mother’s referral to a nursing home facility:

I just had a call from my mother, saying that she feels very poorly, that she shakes [because of her] nerves, that she is afraid of falling... She is complaining all the time about the aides, even though I asked her to look at it from my point of view—that I feel much better when someone checks on her. When you listen to her, you would think the aides are definitely making the situation worse. I am realizing every day, more and more, that her stay in a nursing home is as much important for me as it is for her. I feel right now, a pronounced heartburn (pressure in the middle of my chest). I did have somewhat spicy breakfast, but wonder whether it is not more related to the phone call.

Dr. Epstein responded via electronic mail:

Perhaps when you get phone calls like that, take a deep breath and think about prior emergencies that were able to be resolved with the passing of time. Your instincts are right, but both you and she suffer the consequences of overreacting.

Vaclav responded: “My message earlier may have sounded urgent. She is better now, there were no accidents, and she was just complaining about things as she has been for many years. My heartburn is gone too.”

Soon after these electronic-mail exchanges, Mrs. Havlicek moved to a nursing home, where she made a surprisingly quick adjustment. The treatment team there agreed that Mrs. Havlicek was probably relieved (as was Vaclav) to be in a place that was safe and where she could interact with more people. Several weeks after her move to a nursing home, Dr. Epstein left town for a year’s sabbatical. Mrs. Havlicek was able to make the transition easily to an internist on the nursing home staff. Dr. Harkness attended her first case conference at the nursing home, with Vaclav. She continued to visit Mrs. Havlicek for the first few months of her transfer, writing in her chart and communicating with the nursing home staff.

Dr. Harkness

Working with Mrs. Havlicek was logistically challenging at times but ultimately rewarding. Several staff members, including a nurse practitioner and a psychiatrist, kept me fully informed about any changes in her mental status, helping to keep me up to date during the time of her initial adjustment. Even though these collaborators were not on site with me, we were able to form a team whose members relied on each other to help construct a more complete story and a comprehensive treatment plan.

When Mrs. Havlicek initially established residence in the nursing home, my job moved toward helping her to adjust to her room, the staff, and the idea that she was beginning to lose more and more
independence. The closed system that she tried to maintain with Vaclav was no longer possible. In fact, the more she tried to withdraw and reject providers, the more they were concerned and paid attention to her. Her depressive symptoms waxed and waned, but each succeeding episode lessened in severity. I attribute much of this to the collaborative efforts of the nursing home staff, her son, and our psychotherapy.

Through our work together, Mrs. Havlicek was able to write a different story about growing old: a story where she was not scripted to die in a mental institution, a story different from what she had observed with her father. Our sessions also involved discussions about her relationship with Vaclav and how they could improve their relationship. In the beginning, she did not trust that what she taught him would be enough to protect him. I think she felt if she stopped being protective and watching over him closely, he would make bad decisions and ruin his life.

Over time, Mrs. Havlicek was able to accept the supportive services from the nursing home providers, leaving Vaclav to feel less responsible for her caregiving needs. Mrs. Havlicek and I continued to work individually together with the idea that someday my services, too, would be transferred to a nursing home staff member.

About 7 months after we first met, I attended a second case conference for Mrs. Havlicek at which we planned for her mental health needs (like her physical health needs) to be met by a nursing home staff social worker. At that meeting, staff members shared their observations of Mrs. Havlicek’s overall positive adjustment. She had become an advocate for many residents in the home, voicing complaints about food preparation and reporting any disrespectful treatment. The staff concurred that she was doing well but were concerned that her mental health status still remained fragile. The decision was made to supervise her medications and to continue her bi-weekly therapy sessions with the newly appointed staff social worker. Toward the end of the meeting, a chair opened up at the end of the conference table, and I moved down for a better view. I had been sitting next to Mrs. Havlicek up until that point.

When she realized I was no longer next to her, she looked nervously around to find me but relaxed when I caught her eye and smiled. She spontaneously told the staff that she enjoyed our sessions because they helped relieve her frustrations—this, coming from the person who refused mental health involvement in the beginning. I knew at that point that she would be fine. She understood how and why mental health services could help her. I negotiated to visit her once more before turning her care over entirely. I was comfortable that she had successfully made the transition through surgery to the nursing home, improving her relationship with her son and even widening her social network.

Dr. McDaniel

Individual sessions with Vaclav took a new turn during this period. Each session began with an update on his mother and their relationship, about which he had increasing insight. In an electronic-mail note from this period, he wrote us about her complaints about nursing home staff:

I try to listen and acknowledge the difficulties and encourage her to ask/tell people there. I know this whole thing sounds like a call for attention, something that happened many times in the past. I will call the social worker today and tell her this. I thought you should know too. It is interesting to realize that some characteristics of my writing to you are similar to my mother calling me.

And, like his mother, a little support and reassurance went a long way in these exchanges.

The balance of the sessions during this time did not focus on managing Vaclav’s relationship with his mother; rather, we spent most of the time discussing the ways in which his relationship with his mother affected his relationships with other women. We learned that Vaclav was either attracted to a woman physically or emotionally and spiritually, but not both. As his view of his mother came into more realistic focus, he began to believe that perhaps he could find a female partner who more fully met his needs. As Dr. Harkness terminated her relationship with Mrs. Havlicek, we agreed that our work with Vaclav was also coming to an end. A family therapist
functions like the mental health version of a family physician; Vaclav and his mother both know that we would remain available should the need arise.

TEAMWORK IN POSTMODERN HEALTH CARE

Returning to the goals of the consultation, we all feel satisfied about the work we did. The three of us provided support and information to each other in what was a very complex, multiproblem case. As a team we were able to support Mrs. Havlicek through her difficult surgery (which she initially vowed not to have), her adjustment to a nursing home (which she consistently stated she would refuse), her improved physical functioning (although her survival was in serious doubt prior to surgery), her improved mental status (although her paranoia and depression are never entirely absent), and her improved social functioning (which also seemed in serious doubt prior to surgery).

An important part of every medical consultation is providing information that will shape or change the referring physician’s view of the patient, especially when that patient is viewed as problematic. In this case, Dr. Epstein progressed in his view of Mrs. Havlicek from describing her as “difficult and non-compliant” to “a person traumatized and confused by cultural transition” to “someone with an inadequate support system” to, finally, “an intelligent person faced with difficult choices.”

In addition, the relationship between Vaclav and his mother matured. He no longer seems resentful of the care he provides for his mother; he sees her twice a week at regular times, and he calls her in the interim. For her part, Mrs. Havlicek expresses confidence in her son’s ability to have a successful life, although of course she reserves the right to evaluate any major decisions. Perhaps one of the most telling signs of differentiation at this point is Vaclav’s increasing desire to have a serious, committed relationship with a woman (“I want a life partner.”). It is as if his mother has assumed her rightful place in his life, and now there is room for a full relationship with a peer.

We now have terminated family therapy with both Vaclav and Mrs. Havlicek, with the understanding that they (or their health care team) are welcome to consult again. Two points in time may make this likely: when Vaclav does become serious with a woman and wants to work on intimacy directly, and perhaps when Mrs. Havlicek dies. Although the former seems likely, the latter may be unnecessary as both Vaclav and Mrs. Havlicek have confronted this issue, which was so threatening when we began our work together.

So many patients, like Mrs. Havlicek and Vaclav, have complex biopsychosocial problems that demand a team approach. Medical family therapy requires flexibility and collaboration with the patient, the family, and the other providers, whether they be a primary-care physician, a surgeon, or the head nurse at a nursing home. A fully systemic approach conforms to a particular patient’s and family’s needs. More time and energy early in treatment often mean briefer and more comprehensive therapy in the long term. It also means increased agency and communication for the patient, the family and, not incidentally for us, the health care team itself.

References