Chapter 26

Healing Through Relationships: The Impact of Collaborative Care on a Patient with Spina Bifida

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Trends indicate that hospital use in the primary care sector is significantly higher for persons with coexisting physical and mental health conditions than for those with no mental health needs.[1] The following case illustrates the utilization of a healthcare team as necessitated by a patient whose care was complicated by both her physical and her mental health needs. By recognizing these issues, the providers were able to address the concerns of the patient as well as the clinic and practitioners that were involved in her care. Meeting the needs of this patient meant an available healthcare team that collaborated with her about the best way to manage her care. Meeting the needs of the family physician meant the availability of a reliable referral source in the clinic to which she could refer, participate in, and get feedback from regarding mental health. The challenge to provide quality care with financial and time constraints is a huge issue in healthcare. Among the top priorities is cooperation among clinicians.[2] The answer, in this case, was in collaborative care that served to balance the patient's mental and physical needs as well as to decrease her multiple visits to the clinic. The format for care in this case was very much a "medical home," a clinic that was flexible enough to schedule clinic visits with the team approach in mind.

I was in my internship year of a 3-year program in marriage and family therapy when I met Kim. When I remember that year, I often think of my relationship with her. I remember the lessons she taught me about the therapeutic relationship, about my role of helper, and most importantly about the importance of collaboration. I worked as a mental health provider in a family practice clinic that serves a lower socioeconomic patient base. I was privileged to collaborate with physicians, residents, and nurses on a daily basis. Primarily the medical residents in the clinic, as in this case, referred patients for mental health care. Meetings involving the physician, the mental health provider, the patient, and the patient's family were possible and encouraged.

Kim felt comfortable asking her physician for a referral to mental health care to help her address some of the issues in her life that she felt were persistent. Of primary importance to her was the feeling of being alone, a feeling that complicated her life as she struggled to connect to others, many times unsuccessfully. Her physician asked me if I would join her in the examination room after Kim asked for help. Our initial meeting was between Kim, the medical resident, and me.

The physician and I entered the examination room together, and were met by a huge smiling face, attached to a body that was confined to a wheelchair. I remember how dirty she looked and the uneasiness I felt when she asked for a hug. I noted the way she tried to draw me in with her eyes and keep my focus, I felt, on her face. While her physician went over her medical concerns, Kim updated us both on her other priorities. These included her relationship with her mother and her seemingly never-ending quest to find a soul mate. She named both of these issues as contributing to her struggle with depression. Additionally, she had concerns about a good friend who also struggled with a physical disability. She feared the friend's demise and reflected that the same could possibly happen to her.

Kim was born with spina bifida and her struggle with medically related issues was lifelong. She was a regular at the clinic as she dealt with various health concerns related to her medical diagnosis. Along with physical concerns, she suffered with depression and her physician was particularly concerned that Kim was not caring for herself. She lived in an apartment complex for the handicapped and although she prided herself in independent living, her physician worried that this was not the best environment for her—self-care seemed so difficult. Finally, Kim admitted to not taking her medications, stating that she simply forgot.

Kim kept all of her medical appointments. In fact, she often showed up without an appointment, stating she felt she needed to "be checked." Kim was at the clinic at least every other week and each time requested to see "her doctor," appointment or not. The resident intuitively noted Kim's extra appointments were serving to connect Kim to other people. We scheduled a follow-up visit that included talk therapy, 1 month from the date of the referral.

My first meeting alone with Kim was pleasant but superficial. She dutifully answered the questions I asked and I remember my frustration at not getting to the heart of what I was sure would be some terrific outpouring of problems. After all, she had asked to see a mental health provider, so did that not mean there was some huge dilemma that I was going to be a part of solving? But no dilemma presented itself during that meeting, or the subsequent one. I was beginning to wonder about the purpose of her visits and my uncertainty was making me uncomfortable. I decided to present her to my supervision group, which included another master's level marriage and family therapy intern, my doctoral supervisor, who was the behavioral health specialist at the medical school, and the director of the urban family medicine department.

During supervision several things were discussed, including Kim's lack of compliance with medical recommendations and the way her physical health may have been influencing her mental health and vice versa. Then my supervisor asked me how it felt for me to be present with Kim. After I had described my frustration at her constant "visiting" and not getting to "anything significant," my supervisor commented that my reaction to Kim could be one that many people had when dealing with her. She also encouraged me to explore what purpose these visits may be serving for Kim and why I, as her therapist, was eager for Kim to present a problem that I could help "fix." We wondered together how it would be to connect with Kim on another level that may actually *not* focus on her physical self since so much of her life seemed to be about being handicapped.

The collaboration at lunch that day changed the way I approached Kim during our next meeting. The urban medicine department director encouraged me to use the conference room instead of a regular examination room where Kim and I struggled to turn her wheelchair around after every visit. As he pointed out, this wheelchair struggle was potentially highlighting what she already knew—that getting around was difficult. Instead of checking in to make sure she followed treatment recommendations, he thought listening to her story might give me a better idea of how her healthcare team could best serve her.

Kim did have a colorful story of hardship as she dealt with the state of her body but more than that she suffered tremendously at the loss of relationships, which she felt was in large part because of her body. She felt rejected by her father, who refused to allow her to stay in his home. She asked other family members to care for her, and all refused. She met multiple men and fell in love very easily. Consequently she was heartbroken frequently as her dreams of a wedding and moving into her own home were let down over and over again. She felt self-conscious about sex and self-conscious about asking her boyfriends to do things for her such as assist with a bath. She felt abandoned by her mother and now resented her mother's attempts to reconnect. She lost a best friend 2 months before I met her, a friend with spina bifida like herself, and she was scared to death to die. Another friend that lived in her apartment complex was struggling with complications related to a disability and Kim's conclusion was that this deterioration would also eventually happen to her. Lastly, she needed questions answered not only about the complications of her illness, but also about her future. She was scared of death, somewhat worried about pain, and wanted to know more about her prognosis. Her problems, contrary to my assumptions, were a result of fear and disconnections from people she cared about—not just about the state of her body. Her frequent medical visits served many purposes, not the least of which included providing a connection to people whom she felt cared for her. Despite her mounting medical bills, she felt the conversations with her physicians were worth her financial dilemma.

I visited with Kim's physician in the precepting room after that mental health appointment. We decided that weekly visits with a mental health care provider might decrease the frequency of her pop-in medical visits. We also agreed that the resident would participate in these visits for a few minutes, not to address additional health concerns, but just to let Kim know she was involved. Keeping the importance of connection in mind, both the physician and I presented the idea to Kim, and Kim thought it was a good plan. Kim also agreed that I would ask during every visit about her compliance with the citalopram (Celexa) prescription and other medical recommendations, and forward that information to her physician if compliance continued to be a problem. Her physician and I both learned that one of our concerns, Kim's ability to care for herself, was indeed a concern of Kim's as well and contributed to her depression since multiple family members rejected her attempts to ask them for assistance. Her physician was able to provide education about her prognosis and current state of health that we were able to incorporate into our weekly visits.

By the end of my internship year, Kim's visits to the clinic decreased to only the scheduled medical ones. The clinic accommodated the need to have her mental health appointments immediately following her medical visits, which allowed for both physician and mental health practitioner to visit her simultaneously when necessary. Kim still suffered through bouts of depression but her self-care improved. She regularly took all of her medications. She worked hard on finding the courage to seek meaningful connections that would eventually diminish her sense of isolation. This included joining a bingo group and making friends who were not handicapped. She still maintained close ties to the clinic and her treatment team but described a shift in perspective to one that allowed her to begin to trust people who were not directly involved in her healthcare. Eventually her care evolved into medical visits only.

According to Knudson-Martin,[3] emotions are a linking mechanism contributing to an individual's state of health. This case exemplifies a positive outcome of collaboration and the influence of a team approach to emotional issues. We learned that through sharing the complexity of her life, Kim's story of healing could include physical and mental health. Charon[4] speaks of the importance of a physician's ability to listen to the narratives of the patient, grasp and honor their meanings, and be moved to act on the patient's behalf. Taking into account the meanings of Kim's narratives, it was also important for the team to realize that Kim needed to connect to a world that did not focus solely on her physical self. As this case study exemplifies, the treatment team can enrich the patient's experience as well as their own by participating in collaborative care. By recognizing and addressing what *Kim* thought was important, Kim could begin to feel heard. According to Lyness,[5] we are who we are only when examined within our current contexts, the most important of which are our relationships with others. Those forces that keep the patient out of connection are the forces that keep her or him from growing and thriving in life.[6] In a safe context the person can begin to change them.[6] The treatment team in this case served to create this safe context so this patient's problems no longer seemed unmanageable.

When taking into account the Three Worlds model, this study emphasized the importance of clinical collaboration by expanding the patient's story of illness to include psychosocial factors that affected the patient. A team of providers not directly involved with her care was utilized via consultation meeting to brainstorm about her case and suggest alternative ways of thinking about Kim's situation. With this new knowledge the treatment team changed the way her healthcare was delivered by her physician and therapist. Specifically we increased the frequency of her visits with the focus intended to be on Kim as a person, not only on Kim the patient. The resident maintained her connection with her patient but expanded the patient's treatment network, which in turn allowed Kim to seek out, and trust in, healthy relationships in her private life. Secondly, the financial implication of the patient's repeated, and often-unscheduled visits to the clinic were compounding her desperation to find help. A few extra scheduled visits initially meant fewer visits in a matter of months. By taking a few simple steps with input from several practitioners, we hopefully allowed Kim to see that she did matter and that she was heard.

This patient's story required her physician listen from multiple perspectives. The essence of a narrative-based approach to information sharing involves the physician simultaneously attending to two narratives—one from the biomedical perspective and one from the patient's perspective.[7] Kim's physician utilized the resources that were available in the clinic to improve her patient's healthcare, reduce treatment costs, and ultimately help the patient heal.

Most healthcare providers, if they are lucky, remember stories of patients that had a profound impact on their education. I will always be grateful for the opportunity to know Kim as a patient and as a person.

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