Family Process and Legal Guardianship for the Psychiatric Patient: A Clinical Study

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Introduction

In grappling with the problem of the incompetent psychiatric in-patient who needs but refuses treatment, legal authorities have often turned to legal guardianship—a special case of substituted judgment—as a solution. A number of contemporary legal cases[1-3] have turned upon the issue of substituted judgment, while a number of articles in the professional literature[4-8] have addressed the problems—legal, clinical, ethical and logistical—inherent in the guardianship process.

To our knowledge, however, there exists no clinical study of the impact on family functioning created by the clinical need for appointment of a guardian for an incompetent family member who is a psychiatric in-patient. This study attempts to address this void in clinical data by surveying the effects of the guardianship procedure on family process.

The Context

In Massachusetts in 1975, the so-called "Boston State Case" (formally Rogers vs. Okin[2]) was filed, addressing **inter alia** the rights of psychiatric in-patients to refuse involuntary medication. In the threatening adversary climate created by the filing of this suit, the Massachusetts Department of Mental Health instituted a number of policies regarding refusal of medication, including use of court-appointed legal guardians to consent to use of medication against the incompetent patient's will. As a result, for the first time, a wave of guardianship petitions had to be filed—a procedure almost unheard-of in previous decades. Also for the first time, family members had to be recruited when possible to serve this function, although they were often unavailable or unsuitable, as noted elsewhere.[4]

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The Setting

The study took place on Service Two, an inpatient ward at the Massachusetts Mental Health Center (MMHC), site of a previous study on drug refusal.[9] Social workers assigned to the ward work with the families of in-patients in a number of ways as delineated elsewhere.[10] Thus, when the decision is made to petition for guardianship, the social worker spearheads the recruitment of family members for this role, the interpretation of the procedure to families and the management of anxieties, concerns and family stresses resulting. The present study draws upon observations made during these events.

We have organized the material under headings speaking to the clinical tasks and problems involved. To protect the confidentiality of our patients and to preclude recognition, all identifying data are altered, disguised or composite in all but the essential clinico-legal details.

Clinical Study of Family Process

A) Family Process in Uncomplicated Guardianship

While the recommendation for a family member to become guardian for an adult patient frequently reawakens old conflicts and creates new tensions or undermines family work toward separation/individuation, there were a few instances in which the guardianship was achieved without undue stress and complications for the family member involved.

Mr. A. was told by the social worker of the hospital's recommendations that he become guardian for his middleaged son with schizophrenia. The patient was agitated and was refusing all forms of medication and other treatment for his psychiatric and physical illnesses; his condition was deteriorating rapidly. Mr. A. welcomed the suggestion for guardianship for his son and had the legalities accomplished in a few days. He then carried out his role as guardian in a matter-of-fact, sensible manner.

Mr. A. had for many years angrily refused to allow the patient to live with him, although he would look after practical affairs for his son; he had maintained a distance, both emotionally and physicially, from the patient. In addition, he was uncomfortable when visiting the patient and only did so when the social worker accompanied him. He persistently denied the existence of his son's illness, regarding guardianship as "another practical affair."

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A second uncomplicated parental guardianship was that of Ms. B. and her father. The patient was in her twenties when hospitalized for the first time, had been ill for several years, but had recently been

walking the streets and acting out sexually. After admission, she refused all medication and involvement in any of the milieu therapies. When her condition worsened, the hospital recommended that the father become temporary guardian. Of significance was the fact that the patient's mother had a long history of untreated psychotic illness. The father only sought treatment for his wife when her behavior became dangerous and uncontrollable on one occasion. The father was as unable as he had been with his wife to set any limits on the patient's behavior himself. He welcomed the recommendation for his application to the court to become temporary guardian for his daughter and carried out the necessary steps expeditiously; she returned home and refused to cooperate or accept treatment after leaving the hospital.

It would seem that the father welcomed becoming guardian for his daughter because his role as paternal authority in the family had been of no use with his sick wife and daughter. Further, he felt alarmed enough to seek treatment for them only when their behavior was uncontrollable or dangerous. Apparently in fantasy he saw the role of guardian as implying that the court by appointment was reinvesting him with the authority he lacked in his family.

In both these situations, where family members (parents) welcomed the hospital's recommendation for guardianship in order for the patient to receive treatment temporarily, the parents involved had distant relationships in which the parents accepted responsibility for practical matters pertaining to their offspring, but expressed no feelings in the relationship other than anger or disapproval. Both parents saw the patients as willful and their behavior as purposeful; both denied the presence of a serious illness. Despite the objective legal significance of temporary guardianship, both parents' fantasies led them to see the procedure as a means of maintaining control of the patient rather than as a means of dealing with a crisis.

B) The Inappropriate Guardian

Sometimes in a crisis situation, it is difficult to recommend that a close family member become temporary guardian for the purpose of treating a patient because the person closest (or the **only** person close) to the patient may be inappropriate for this role.

Ms. C. was a middleaged woman who was admitted following an unsuccessful, but serious, attempt at suicide. For two weeks following admission, she refused all food and liquid as well as all medications. When ECT was recommended, she refused this form of treatment as well. She was living with a man who had lived with her parents prior to their death. They had taken in this man after his discharge from a psychiatric hospital, and he had stayed as a

roomer. He was dependent upon the patient who had, essentially, taken over her parents' role as caretakers. He carried a diagnosis of chronic schizophrenia, and was perceived by the social worker and psychiatrist to be thought disordered and helpless at the loss of Ms. C., the nurturing, indeed the only, figure in his life. He was very cooperative and willing when guardianship was recommended, but in view of his own disability and difficulty in managing his life, it was decided that he would not be an appropriate person to become guardian for the patient, despite the absence of alternative family members. An attorney eventually served this purpose, to the friend's relief.

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Another case in which the closest family member was thought to be inappropriate as guardian was that of Ms. D., a teenage girl, admitted after several months of withdrawn, isolative behavior at home, with refusal to eat, leave the house or talk. Mr. D., the patient's father, was her nearest family member; he had obtained custody of his daughter many years before after a court battle which centered mostly on his eccentric ideas about diet—his own and his daughter's. The patient's mother had lost custody due to her inability to care for the patient; moreover, she lived at a great distance. The father's life centered on his relationship to the daughter, whom he said resembled his own mother, who had died in his fifth year. The father and patient had never been separated prior to admission and father insisted that the patient's illness was a result of poor diet rather than a serious emotional or psychiatric disorder. Mr. D. also viewed psychotropic medications with disapproval and felt the patient should be given his medications every third day. While the patient's refusal to take in food or liquid as well as medication created an emergency, the treatment staff believed that the father should not be encouraged to apply to the court for guardianship. The father agreed. The issues of control, autonomy and symboisis were central both to the psychopathology and to the guardianship process itself.[4] Instead, the father's casework was directed toward his grief at experiencing the patient's withdrawal, which recapitulated his own mother's death.

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In this situation, the family member's pathology was so intertwined with that of the patient that the father could not gain the perspective necessary for the role of guardian. In addition, this appointment would have had a marked countertherapeutic effect. As described elsewhere,[4] the patient's further deterioration permitted emergency treatment, obviating the need for guardianship in this case.

C) Competition for the Role of Guardian

In one instance where the hospital recommended temporary guardianship for an assaultive and suicidal woman who refused treatment, two family members disagreed over which of them should petition for the guardianship.

> Ms. E's parents had divorced many years prior to admission. Her father was described as a bright but unstable man, who had taken the patient to live with him after her previous hospitalization, and had ordered her to leave one day later, even though he had been advised that Ms. E. needed a structured living situation. The patient's mother lived a great distance away and kept in touch with both patient and social worker by telephone. She was frightened of the patient's violence, and was prone to tell her when she did visit what pain and difficulty she had caused her. In addition, she was afflicted with serious health problems requiring major surgery in the near future. Each parent felt the other was unsuitable for the task of guardianship. After careful evaluation of the situation, Ms. E.'s father was not encouraged to petition for guardianship as he was unreliably available, unable to view the illness as serious and life-threatening and unable to maintain a serious committment to any treatment plan. Although the patient's mother lived at a distance, and was physically seriously ill, her understanding that the patient had a serious mental illness made her a more appropriate guardian.

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This example illustrates how family struggles are as likely to be acted out in relation to guardianship as with other reality issues. In addition, the case underscores the importance of careful assessment of family members by the social worker to determine on clinical grounds their suitability for this legal role.

D) Family Conflicts in Guardianship

Recommendations that guardianship be sought are made in life-threatening crises, when a patient's refusal of treatment results in dangerous physical deterioration or uncontrollable self-destructiveness. The goal of these recommendations frequently varies sharply from the goals of the social worker's casework with the relative, and may encourage maladaptations in the relationship between the patient and his family. In the following examples, all involving a parent and an adult child, the major issues involved were the parents' need for control, their intrusiveness into the lives of the patient and their inability to allow the patient to separate.

Ms. D.'s father (described earlier) clearly had a symbiotic rela-

tionship with his daughter, controlled her life almost completely (until she rebelled by becoming ill) and kept her closely bound to him.

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The case of Mrs. F. illustrates less dramatic but equally conflictual tensions between the necessity of the family member becoming temporary guardian, and the longer term goals of lessening or shifting pathological and counterproductive modes of relating.

Mrs. F., a woman with manic-depressive illness, had been hospitalized sporadically for the previous 10 years. Her parents, a sophisticated professional couple, had been actively engaged in her treatment throughout her illness. Nevertheless, their overwhelming guilt, their constant and intense efforts at controlling their daughter's life, (and, in particular, her treatment) were still the major focus of their lives and served to perpetuate their daughter's need to struggle with them. Because of their guilt, both parents hung on every word or demand the patient would utter and would comply, each time hoping they were "undoing" her illness. When Mrs. F's depression deepened and she refused medications, a recommendation that they seek temporary guardianship was made. The social worker and parents discussed the fact that while legal control of the patient through guardianship was necessary for the limited purpose of consenting to treatment, the parents needed to continue to explore their feelings and conflicts driving them to overcontrol and intrude in their daughter's life, keeping them in a constant state of anxiety and desperation.

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In one case, a family member welcomed the recommendation for temporary guardianship. Ms. G.'s father had a need to control and dominate his children; his relationship with Ms. G. had been one of hostile dependence. In addition, he had been bitterly disappointed with Ms. G.'s limited achievements, despite her early promise. Family history revealed that patient's father had been unhappy in his marriage and divorced the patient's mother, who died soon after. The patient had left home physically, travelled extensively, leaving the father frustrated in his need to plan her life.

Although the guardianship was essential to save the patient's life, we felt it was welcomed insofar as it supported the most destructive elements in the father-daughter relationship. During the father's intermittent contacts with the social worker, he would focus entirely on trivial legalities, using this as a resistance to exploration of his troubled feelings and relationship to the patient.

E) Siblings as Guardian

In three situations where a guardian was recommended because of the patient's refusal to accept medication, the patient's siblings were the only close relatives appropriate to assume that role. Although these cases were varied in terms of the patient's diagnosis and relationship to the sibling involved, all were similar in that the relative was emotionally distant from the patient, rarely (or never) visited and had established an independent life, essentially alienated from the family of origin.

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Ms. H. was a single woman with a history of assaultive behavior, causing serious injuries. Her older sister was the only one of her three estranged siblings to agree to become temporary guardian when the patient refused treatment. While planning for the guardianship, this sister was elusive and difficult to reach, carrying out some procedures, forgetting others and resisting contact with the hospital after becoming guardian. She allowed the patient to visit her infrequently, but never initiated any contact and remained essentially unavailable to Ms. H.

Ms. I. was in her twenties, single and diagnosed manic-depressive. Her sister was her closest relative, although she lived in an adjacent state, had a full life with her children and husband and basically disapproved of the patient. She had avoided contact with the patient and excluded her from family functions altogether. She agreed to become guardian for purposes of treating Ms. I. when crises arose; however, for practical purposes, she delegated most responsibility to the patient's cousin, a conscientious and concerned woman, while the patient's sister remained distant and angry.

Mr. J., a middleaged single man, was hospitalized since his teens. Our staff had little information about Mr. J. and there was no knowledge of any involvement with him by family members. Shortly after his admission, a crisis arose necessitating informed consent to allow him to receive a special type of treatment. The social worker noted that Mr. J. had an unusual surname and consulted an array of telephone directories, discovering that his brother's name was listed with a slight difference in spelling. Mr. J.'s brother stated he had not seen him for 17 years, that the patient's parents had died then, and only one other sibling still lived, a widow, terminally ill. The patient's brother stated that currently he was himself seriously ill and could not assume the role of guardian, even though the legalities could be carried out without his leaving home. In further conversations, he remained firm in his decision to remain uninvolved and divorced from his brother.

In all three of these cases in which siblings were asked to assume the role of guardian, the siblings remained distant from and, in two cases, angry at the patient. Despite the staff's hopes to enlist uninvolved family members through the guardianship procedure, in none of these three was there any change in the pattern of avoidance existing prior to the crisis.

F) Family Refusal of Guardianship Role

Of interest was the group of family members who refused to assume the role of guardian despite the compelling and life-endangering crisis that had prompted this recommendation. Dynamic issues in the family member's relationship to the patient were the determinants of their refusal. Of these family members, three were parents, one was a spouse, two were siblings and one was the patient's daughter.

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Mrs. K. was an elderly female concentration camp survivor married for the second time in 1948 and suffering from Alzheimer's disease. Her husband, a non-Jewish, previously-married Austrian soldier, was devoted to the patient and later converted to Judaism. He was always concerned about Mrs. K.'s well being, coddling and protecting her. As Mrs. K.'s dementing illness progressed, her husband became distraught. Guilt and reaction formation were prominent features of the husband's relationship to Mrs. K., and he was insistent on making needless sacrifices; however, when a badly needed guardianship was recommended, Mr. K. adamantly refused. He was able to share his fear that guardianship would result in "the authorities" taking from him everything: food, shelter and clothing.

Mr. L. was a middleaged widower, severely depressed, who required a guardian when he refused medication and nourishment. His only daughter lived in the south with her children, but had plans to move to this area. She agreed readily to apply for guardianship and arranged to move earlier in order to facilitate this, not wishing to start proceedings until after her arrival. Upon moving to Boston, however, she became indecisive, denied the severity of her father's condition and expressed guilt at the prospect of authorizing the treatment her father had refused. As she visited the patient, her denial and indecisiveness solidified, resulting in her refusal to become guardian.

Mr. M., a single paranoid schizophrenic, had been raised by his father, an ambitious businessman in another state, to be independent at an early age. Achievements and success were discussed; failures or problems were not. When the patient became ill, the father tried in vain to participate and to talk to hospital staff and patient, but the patient refused all contact. On many occasions, the father was called to bail the patient out of difficulty, only to be shut

out once again. These trips cost the father his job and he decompensated as his world collapsed, viewing himself a failure as a parent and as a man. He began to write letters demanding small, inconsequential details about his son's condition and going over the past in a self-blaming manner. When the patient refused medication, food and liquid, the father was contacted and told of the recommendation that he become temporary guardian for his son. He reacted with anger and suspiciousness, revealing that he himself was in therapy in order to effect separation from his son. He refused to become guardian and continued to berate the hospital, projecting his guilt and dwelling on irrelevant legalities.

Another parent who refused the guardianship role was Mrs. N., mother of Mr. O., a middleaged paranoid schizophrenic man. Mrs. N. had shared with the social worker her anger and frustration at the patient as well as her guilt related to her fantasies about the patient's illness. The patient was often angry at the mother and they fought frequently. The mother refused to become guardian, stating repeatedly her fear of the patient's anger, should she authorize treatment which the patient had refused.

The last example of a family's refusal of the guardianship role that we shall describe is that of Ms. P., a single woman, diagnosed as "borderline" and chronically suicidal. Ms. P.'s parents had only glowing and positive memories of Ms. P. up to the time of young adulthood; however, for the past 15 years, the parents had experienced the agony of the patient's several near-fatal suicide attempts and had cared for her as she failed in every aspect of her life. The patient lived with the parents and was often regressed.

The parents were unable to set limits and felt increasingly angry, guilty, fatigued and trapped in this no-win situation. At the same time, they could not separate from the patient. When the patient became so self-destructive that her life was continuously endangered on the service, the parents were asked to become temporary guardians for the purpose of administering ECT. In spite of the emergency situation that existed, both parents refused. They felt such a step would be "mean" to the patient, would cause her to be angry at them and would adversely alter their relationship with her. Ironically, their anger and guilt could not permit their taking this step which might, in fact, have preserved the possibility of relating to them in any fashion.

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The group of relatives who needed to refuse the role of guardian all shared long-standing anger at the patient and immobilizing guilt in relation to the patient. All but one experienced fear of the patient's anger, a result of their own projected anger. One husband did not fear his wife's anger, but rather feared displaced retaliation by the "authorities."

G) Guardianship as Transference and Resistance

The recommendation to a family member that he or she become guardian for the patient evoked various transference reactions, some common to several families. All of the refusers (and several other families) felt such a step was cruel and unkind to the patient. In the "uncomplicated" cases (as in that of Ms. G.), family members looked to the court unrealistically to provide the authority and control they lacked. One family repeated its original custody battle in its struggle as to which parent should be guardian, a situation implying that the role had for them personal significance beyond the legal facts. In several cases, family members felt unfairly burdened by the recommendation and regressed to a helpless, incompetent position; these families expressed anger at the social worker, whom they felt imposed a task too difficult to bear. This is not surprising in view of the fact that often the hospitalization of a patient represents for the family a crisis[10] which, for these particular families, was then intensified by the clinical emergency necessitating temporary guardianship. Some of the families saw the guardianship role as a panacea and used it as resistance to casework focused on their internal conflicts and feelings.

Clinical Countertransference and Guardianship

Like other clinical phenomena related to confrontation, guardianship can evoke in the clinician feelings that may be subsumed under the rubric of countertransference.

The central issue here is the oppositional position in which the clinician is placed. The guardianship proceedings have, as their goal, the sanctioned overruling of the patient's stated (albeit delusional) wish. Thus, any conflicts in the clinician around coercion and sadism may be intensified by participation in guardianship, since the hoped-for posture of mutual collaborative work must be temporarily replaced by that of unilateral judicially-sanctioned force.

In addition to these difficulties, the legalities themselves may provide a distraction from the often stressful engagement with troubled patients and families in crisis, as has been suggested elsewhere.[11] A regrettable consequence may be that needed treatment is placed "on hold" while the legal process transpires.

For the social worker working with the family, recommendations that a family member become guardian almost always posed a dilemma and evoked subjective responses. Most common was anger at the intrusion into the casework process of legal thinking and procedures. The workers were concerned that, at the very time family members required support, the recommendation for guardianship and its ramifications (including the patient's responses) tended to overload the ego in this crisis.

Social workers also were in conflict about other countertherapeutic effects on their clients. Frequently, to the social worker, guardianship

represented a regressive step, towards intrusiveness and overcontrol, undermining any struggle towards separation, which the family member may have been making. Often the social worker felt trapped in the middle between the physician pressing for guardianship and the relative resisting it. This readily resulted in the workers' anger, either at the doctor or at the family, or at both. They were also often torn between the pressure for speed in effecting the guardianship and the need for working through the issue it represented at the family's pace in casework. On the other end of the scale, in some situations, the social worker herself viewed the guardianship as a panacea, and allowed herself to become needlessly distracted from longer term goals, more painstakingly arrived at; at times workers were drawn into using legalities as a form of avoidance of interpersonal involvement and thereby misallying themselves with the client's resistance.

Conclusions and Recommendations

Legal authorities who turn to guardianship as a panacea in areas of conflict about competence appear to see it as an objective substitution of an "average, prudent" guardian for the incompetent ward. Our clinical study of the realities of family participation in guardianship reveals that this "objective" procedure undergoes ready contamination by family illness, problems in relation to the defined patient and pathologic modes of relating among family members—difficulties that may make guardianship countertherapeutic even when uncomplicated.

If guardianship must be used with psychiatric patients in certain jurisdictions, however, certain conclusions about its use may be drawn from our data.

1) Guardianship **can** be sought and granted without overwhelming stress on family functioning; factors which seemed to predispose to good outcome included: absence of excessive family conflict centered on patient; sufficient distance and objectivity in the potential guardian and a positive attitude toward psychiatric treatment.

2) Guardianship may, however, go smoothly for the family for "the wrong reasons," i.e., the appointment of a guardianship may recapitulate, reawaken, reinforce or reenact syntonic but pathological or destructive family relations and old conflicts.

3) Guardianship may also be difficult to accomplish **because** of preexisting pathologic relations in the family, especially insofar as the family is essentially placed in charge of the patient's treatment—a situation that may be problematic for patient and clinician.

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Based on the foregoing data, we offer certain recommendations to the treatment team in managing these matters:

1) Social workers dealing with the family of the patient should remain in touch with the clinical issues and resist being distracted by details of

legalities from the therapeutic task at hand.

2) The worker should be attuned to the pathogenic resonances between family process and legal process as described in our study and, based on such understanding, should employ clinical grounds to determine the choice of family member for the role of guardian as described.

3) The worker must attempt to extract from the procedure as much clinical leverage as possible both in understanding family function and modes of relating and in choosing suitable interventions.

4) The workers must convey with great precision and clarity the limited and specific purposes of the guardianship procedures in order to counter and reality-test fantasy elaborations of its meaning that may be empirically observed in the family material.

5) The workers should attempt to speak to and recruit the family members' most adult ego functioning for the task and should stand ready to deal with anticipated anger, fear or guilt that may be mobilized by both the crisis and the procedure to deal with it.

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While we believe that guardianship is a most unsatisfactory approach to problems of treatment refusal, we suggest that the approach outlined above may yield the most therapeutic effect for both patients and families as the clinical team aids them to cope with a crisis affecting them all.

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