

DELUSIONS— A TALE OF TWO SOCIAL WORKERS: A HOSPITAL NARRATIVE

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The following is a personal narrative depicting encounters between a staff social worker and an elderly female patient on a psychiatric ward. The genre of personal narrative is suggested as a means of describing the social work role in various settings.

Delusions – A Tale of Two Social Workers¹

Once upon a time, everything was understood through stories. Stories were called upon to make things understandable.

Parry & Doan (1994)



Introduction

I began writing hospital narratives as a response to the stress of working in a dramatically changed hospital system (Globerman, 1999; Globerman, White, & McDonald, 2002). The downsizing and restructuring that began in the 1990's in Canada had pushed many of us to work at a frenetic pace that allowed little time for emotional processing. I found the writing helpful both in facilitating this processing and in bringing into sharper focus the extent to which these structural changes had impacted our working lives.²

It was only after I presented the narratives at public readings, however, that it became clear they could be helpful in other ways. While feedback from social workers expressed feelings of validation and connection to the stories, non social workers

reflected surprise at the challenging nature and complexity of our work. It was these latter comments that led to my using narratives as a means to convey a more realistic view of our role in this setting.

"Delusions" was written after I moved from medicine to inpatient mental health.

A Tale of Two Social Workers

The story of Elizabeth Stewart (one of my patients) started when she was brought to the hospital after being observed "pacing outside a supermarket and talking to herself for over six hours." She was to tell me later that this (chart) description was not accurate. She had been both "inside and outside" of the supermarket and had on occasions "sat down for a couple of hours".

The apprehending officer recounted that Elizabeth had told him he was very rude to interrupt her, as "couldn't you see I am speaking to someone." When the officer replied "No, I couldn't," he quickly discovered that Elizabeth didn't take kindly to her sense of reality being questioned. Hospital staff were also quick to find out that such an approach, followed closely by any inquiries regarding possible next of kin, was met with swift disengagement.

Elizabeth was an 80-year-old, white-haired, attractive, articulate, and well-educated woman. Her posture was upright and her demeanor regal. She informed us all just after admission that she was actually

“Lady Stewart” and that we could use this title if we wished. In general, when professional staff were summoned by her, they left feeling that they were being brought to the principal’s office for some yet unknown misdemeanor.

When I first handed Elizabeth my card, she looked at it carefully. She then informed me that she too had been a social worker. Although I was skeptical at first, when she said she “specialized in group work rather than case work,” I felt this must be true. Who else but a social worker would use the now rather dated term “case worker”? She asked me where I went to school and then told me that she had attended the same university. “Although they did not have MSWs then— just certificates,” she stated.

Elizabeth told stories about past clients and also about some of the famous people who had taught her. In many of the stories about clients, her strong sense of social justice was clear.

Elizabeth also told me about her many personal and professional accomplishments. These were so impressive that when she told me she had won The Nobel Prize but had not yet had a chance to pick it up, I could almost believe it.

Elizabeth’s social work stories were interspersed with others which she would recount in our daily meetings. These stories had two main themes. The first was that the man she had been married to was not her real husband nor was he the father of her children. I later learned that the person she claimed as her real husband was a onetime physician acquaintance of her brother. This belief was so fixed that she had obtained I.D. with his name, had named him as her joint power of attorney, and had on occasions sent letters to her children using his last name. Elizabeth had held this belief for the majority of her married life, much to the distress of her family.

On one occasion, when her psychiatrist referred to her by her “official” name, Mrs. Stewart, Elizabeth asked him why she had to suffer for the hospital’s sense of history.” I tried to stay out of trouble by always calling her “Elizabeth,” fighting my English upbringing that told me this was impolite.

The second theme that surfaced more recently was that this “other” husband could communicate with her over radio waves using the principles of particle physics. When Elizabeth was first admitted, she would adjust a radio, which was situated in the air just above her head, to tune in better while she was talking to me.

On one occasion she told me that the message was actually for me. Her “husband” was working at the “Hospital for the Criminally Insane in Penetang” (a hospital in Ontario— now, not surprisingly, renamed). She said he wanted *me* to visit him there. I hardly knew what to say, but eventually I told Elizabeth that it was not possible for me to take such a trip. “Nonsense,” she responded. “Give me your card. I will speak to your supervisor and get permission for you to go and be paid for it.” I was so taken with her concern that I get paid for the trip that I gave her my card and told her the name of my manager.

At this point many days had passed with no one showing up to visit her. “What else can you do to find her relatives?” the team asked me in rounds. I recounted my considerable but so far unsuccessful efforts. Elizabeth’s purse had disappeared in the ER and she would only give us her name.

Apart from the next-of-kin issue, the team wanted “collateral information.” They wanted to know the truth about Elizabeth. I thought a lot in the following days about the “truth.” Why should Elizabeth accept our truth, the psychiatric “DSM” truth? “Her truth” had won her a Nobel Prize. From her point of view what did the grand narratives of psychiatry have to offer, other than a diagnosis? Elizabeth never gave in to that truth. She hung on to the

end, insisting she was in hospital for “medical reasons only.” Perhaps, apart from anything else, it was this spirit of not giving in that drew me to her.

The next time I visited Elizabeth, I asked her how she “as a social worker” would assess her present situation. She looked at me. “It’s the ultimate in reality and absurdity,” she stated. This sounded quite reasonable to me so I asked her to explain further. “Well,” she replied, I was married to a man for six years that no one else was able to see.” This wasn’t quite what I expected. However, I tried to stay with her and asked if this was something like “The Invisible Man.” She looked at me as though I were a rather dim student. “That’s trite rubbish compared to what I’m talking about,” she replied, and then proceeded to explain at length her theory of particle physics.

At the end of this she looked at me and asked, “Do you think I’m hallucinating?” I thought carefully before responding. There are a number of ways in which one could address such a question. I slowly answered, “I’m not sure.” “Good,” she said, “One should never be too sure about such things.”

As days went by I made subtle attempts at getting information on possible next of kin, but I also returned because Elizabeth was so interesting. I asked her to tell me what it was like being a social worker all those years ago. I longed for her thinking to clear so that she could really focus on this. It was at those times that I wondered what it must have been like for her family. Did they also yearn for her thinking to clear?

Elizabeth told me she once ran a mental health facility in England. “I saw the people the psychiatrists gave up on,” she stated. She also spoke about being a published author and a social activist there. All true, I was later to learn.

Elizabeth did not hesitate to chastise me for not acting as she felt proper for a social worker. When on one occasion I made a note

in her presence, she informed me that when she was a social worker, she always waited until she left the room before making clinical notes. I made sure never to make notes in her presence again.

One day Elizabeth told me she needed more clothing and, amazingly, gave me a telephone number that she assured me belonged to her son. She also told me she had another child, a daughter, that she did not speak to.

Elizabeth’s son Andrew was distressed to hear that she had been found outside a supermarket. “I usually get calls from ritzy retirement residences,” he stated. Andrew told me he would come to the hospital with his sister, Claire. He added that their father had died many years before in England. He believed her “other” husband had also since died.

Andrew and Claire told me with some amusement of an incident that took place during one of their mother’s many past admissions to hospital. Elizabeth had organized all the patients being detained under the Mental Health Act. She urged them to call in the Rights Advisors and demand hearings to free themselves. This created havoc on the ward and after a couple of weeks they decertified her and sent her home. “They had had enough,” Andrew stated. I tell this story to my colleagues. “I guess old social workers never die,” one comments.

Despite hanging out on occasions at retirement residences, Elizabeth would tolerate no suggestion that she might actually live in one of these establishments. She told me many times of her intention to return home, noting that she had always “managed well.”

But when Andrew visited his mother’s apartment, he had been shocked to find cigarette burns on the furniture and bed, and soot covering cupboards and walls. Even more troubling were the charred remains of plastic supermarket bags that Elizabeth had been using to dispose of her cigarette butts.

The superintendent told him that there had been fires in her apartment and that the fire department was called several times.

Dr. Hunter and I decided to speak to Elizabeth together. He explained that he could not let her return home at present because of safety concerns, and that she would continue to be held under the Mental Health Act.

When Elizabeth demanded details, Dr. Hunter told her that he had received information that she had not been safe with respect to smoking and that the fire department had been called a number of times. "No," she corrected him. "They were called only once. The other times I put the fires out myself."

After this meeting Elizabeth refused to speak to either of us for several days. Although we had little choice, for the first time we had actively questioned her version of events, namely that she had "managed well." We were later surprised to hear that when the Rights Advisor visited, she declined the chance of an official hearing.

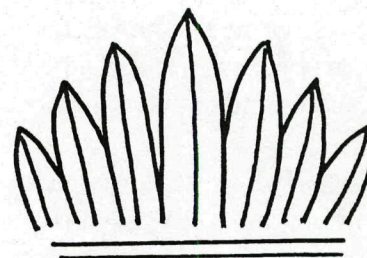
By this time Elizabeth had been in the hospital for several weeks and her "length of stay" was becoming problematic. "Nursing home" was being suggested in rounds if Elizabeth was not yet safe to go home. I tried to imagine what life might be like for her in such a place. Would she be kept in a locked unit "for her own safety?" Although our unit was locked, Elizabeth was able to go outside to smoke and to the cafeteria more or less whenever she wanted. But things weren't quite the same in nursing homes.

Eventually, I approached Elizabeth and suggested that in order to give her more time to recover, we should make an application to an inpatient psychiatric assessment unit at a well known geriatric facility in Toronto. Not that I believed Elizabeth needed further "assessment," but I once worked at that facility and knew that they would be more likely to keep her long enough for a fuller recovery. Although Elizabeth objected to this

initially, she eventually agreed to the move, but only because she "knew the director personally."

When I went to say goodbye to Elizabeth, she told me that I had been a disappointment to her as a social worker as I had not assisted her in her wish to return home immediately.

When I called the facility a week later, the social worker told me that Elizabeth had been given a private room and that staff were careful to always knock and wait for her to answer before entering. She confirmed that Elizabeth did know the director personally and that he had already been to visit her. Although Elizabeth was still telling anyone who cared to ask that she was there for "medical reasons only," she continued to take her psychiatric medication, as she had in my own hospital. Months later I met the social worker at a conference. She told me that Elizabeth continued to improve. Her apartment was refurbished and she had returned to her former life in the community.



Post Script

In my encounters with Elizabeth, I would often think back to an author who wrote on the topic of oral history. Portelli (1981) suggested that the significance of oral sources frequently rested not in their adherence to the facts but in their divergence from them, in which case imagination, symbolism and desire entered. He noted that even though the facts may lack credibility, "psychological truth remains." As social workers especially in the field of mental health, we are often faced with the psychological truths of our clients that may

or may not coincide with the truth that “collateral sources” provide. This is what makes social work such an interesting and challenging profession, especially during those times when we are involved in discharge planning and the patient is felt to be at personal risk.

Conclusion

The personal narrative has been described as being both as old as time itself and a new and exciting innovation. It is often seen as part of a postmodern trend that seeks to give voice to “ordinary people whose lives and selves would otherwise be rendered invisible” (Rainer, 1997). It is however, not the kind of writing generally done by social workers (Swenson, 2004).³

Narratives act to humanize patients by allowing a thicker description of their lives and situations than could ever be captured in a medical chart (Davis 1991). They also allow for a deeper appreciation of the value and uniqueness of the social work role. Therefore, by taking some of the stories we hear and using them in our own narratives, this form of writing can be seen as a tool of advocacy for both ourselves and our clients (Chambon, 2004).

For social workers, this seems especially important now, not only for those of us in hospitals whose positions are being threatened (Nelson, 2004), but for those of us in the general community who are engaging in “image campaigns” in order to bring forward a more realistic view of our work (Jackson, 2004).

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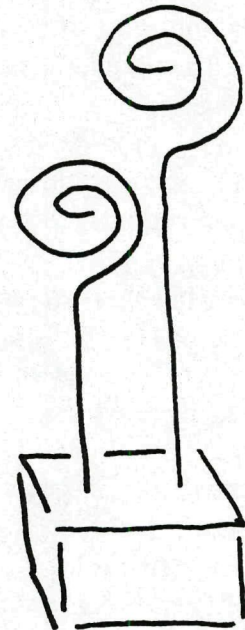
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(Endnotes)

¹ An earlier version of “Delusions...” was presented at the National Social Work Conference in Saskatoon in June 2004.

² “A Day in the Life of A Social Worker” was the first narrative to be publicly presented. It was presented recently at the 4th International conference on Social Work in Health and Mental Health in Quebec City in May, 2004, with the subtitle “Presenting our role Through the Personal Narrative.”

³ For other recently published personal narratives, see the author’s “I Remember You’ –A Brief Encounter in Palliative Care” in the *Journal of Palliative Care*, and Carol Swenson’s “Dementia Diary” in *Social Work*.



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