Hannah Godfrey, LICSW
Clinician Narrative
Social Work
Advanced Clinician

Recently, I was working with Anna, a 29 year old female with a very complex medical and psychiatric history. At this young age, her diagnoses included: Lupus, Functional Neurological Disorder, Psychogenic Nonepileptic Seizure Disorder, Fibromyalgia, Migraines, Major Depression Disorder, Anxiety, Post Traumatic Stress Disorder, Panic Disorder, Conversion Disorder, Borderline Personality Disorder and Attention Deficit Hyperactivity Disorder. She presented as a transfer from a rehab, where she had been admitted for the last several months including two readmissions to another Partners Hospital, the hospital that originally transferred her for acute rehab. During this lengthy period of multiple hospitalizations and transfers to the rehab facility, Anna had deteriorated significantly; she lost weight, became unable to care for herself and was reliant on a wheelchair for mobility. The rehab became concerned that she was regressing both physically and psychiatrically due to her psychological condition and felt that Anna had become disorganized, delusional and paranoid, thus needing a psychiatric admission. They hoped that with our structured setting and expertise with psychiatric medications, she could greatly benefit and begin the process of physical rehabilitation, which she had not been able to do for the past several months.

It is critical to note that Anna had a very complex trauma history. Trauma, by most definitions, is the emotional response a person has to an extremely negative event and can greatly impact someone's life. Unfortunately, in the healthcare industry, we don't always know when patients have a trauma history. Healthcare services themselves can be re-traumatizing, thus undermining the effectiveness of treatment. Even physical touch or removal of clothing needed to complete a physical exam can re-traumatize a patient without the provider knowing. As a clinician, it is important to keep this in mind and provide trauma informed care, which creates space where a patient can feel safe, is transparent and trustworthy, provides a patient with choices that honors dignity, recognizes mutuality and collaboration and empowers the patient's strengths. Social work on Blake 11 is a strong member of the multidisciplinary team. We participate in diagnostic discussions and formulations, provide expertise in community resources, assess for safety and have a large role in after-care planning. Further, because of my education and training, I can identify trauma, provide trauma informed care and educate our colleagues so that we may provide the most effective treatment for our patients.

Anna was bullied in high school and sexually assaulted in college. Thereafter she was in an abusive relationship with her ex-fiancé. Due to what she described as embarrassment, she shared that she minimally informed her family about the abuse and never filed charges against her ex-fiancé.

Her current social situation was equally complicated and significant. She had been a very productive adolescent and young adult, completing a bachelor's degree at a prestigious university and a master's degree in Journalism. She had one sister and her parents were still married. During the six-month period of hospitalization and transfer to rehab, the relationship with her parents and sister deteriorated completely. They stopped talking with her altogether and wrote private letters to the medical team at the rehab stating that they would no longer be involved in her care. Thankfully, Anna's maternal grandparents were very involved and supportive. Anna's grandfather was her Health Care Proxy and her grandmother was her alternate. They lived in Vermont and visited only once during her admission at MGH. However, they were extremely involved over the phone with Anna, Nursing and me. I spoke with them almost daily during her 21-day admission.

When she arrived at our inpatient psychiatric unit, Anna required use of a wheelchair, needed a two person assist for most ADLs, wore sunglasses most of the time to protect her eyes, and had difficulty with her speech and word formulation. Because she was a transfer within the Partners System, we were adequately prepped with all of the rehab's concerns and were prepared with a very strong multidisciplinary team. Our first meeting with her included the Attending Psychiatrist, two Resident Psychiatrists, RN, Psychologist and me, Social Work. Anna was very focused on two things: treatment for her ADHD and talking with Social Work to discuss protective services. She struggled to communicate effectively, making the first meeting somewhat challenging. Despite this, Anna was very strong in her request for Adderall. Stimulant medication for ADHD is not a preferred treatment while on an inpatient psychiatric unit for many reasons. For Anna, the team felt that there were many other things that needed treatment before the ADHD. Further, there was concern that Anna was abusing the stimulant medications. As such, very firm limit setting was critical immediately upon her arrival. As an inpatient Psychiatry unit, setting limits allows patients and the team to immediately understand boundaries. When limit setting is used well, it reduces conflict between the team and patient. In Anna's case, the team communicated in the first meeting that she would not receive stimulant medications and she would be expected to adhere to a behavioral plan. Conversely, when it came time to develop the behavioral plan, the team listened to Anna's goals and incorporated them into daily expectations. This is congruent with trauma informed care; in particular, collaborating with Anna to form the goals. This process gave her choices, offering her dignity, which is a critical component of the trauma informed care. The behavioral plan included expectations to participate with Physical Therapy, Occupational Therapy, direct and increase her participation of self-care, compliance with medications and participation with daily groups offered on the unit. Of note, group therapy is a critical treatment offered on Blake 11. These groups are offered by Occupational Therapy, Psychology, Physicians, Musical Therapy, Pet Therapy and Chaplaincy. They offer wonderful education and activities to help patients increase their coping strategies. Three or four groups are offered per day and range in topic allowing for a diverse experience. Patients can pick and choose which groups they would like to attend as they are not mandatory.

Despite this wonderful collaboration with Anna, some of these limits were understandably upsetting and she struggled in her relationship with the team. Especially since she struggled to communicate effectively, I think she felt that she wasn't being heard or her concerns taken seriously.

Regarding her desire to discuss protective services with me, I offered to meet with Anna separately. In my role on Blake 11, I participate in multidisciplinary rounds which include Psychiatrists, RNs and Social Workers. However, I also take additional time to meet with patients separately. For Anna, allowing separate time adds to the trauma informed approach as discussing traumatic events in front of a large group can be re-traumatizing. Since I knew this would be likely a lengthy admission, I took things slowly. I gave her ample opportunity to talk, which she did not have during multidisciplinary rounds. By taking things slowly, it allowed me to create a space where Anna could feel safe and control the pace of discussing traumatic events, another crucial aspect of trauma informed care. I wanted her to feel empowered in the work we would do together and have a strong voice to express her concerns. Most of all, I wanted her to feel that I would always listen to her concerns and take them seriously. As the greater multidisciplinary team needed to set some firm limits with medications and other treatments, I wanted her to have a safe space with me where she felt in control of our discussions.

During our meetings separate from the multidisciplinary team Anna quickly started talking about a relationship that recently ended. She described what I was concerned were abusive and controlling behaviors by her previous partner. I immediately considered the MGH program, HAVEN (Hospitals Helping Abuse and Violence End Now). HAVEN is a free service which provides welcoming and affirming advocacy services to all survivors, in the early dating years through later life. With a patient's consent, I can consult HAVEN. Depending on the advocate's availability, they can meet with a patient while admitted and continue working with them after discharge. When I offered HAVEN services to Anna, she immediately latched onto this opportunity as she shared that she had worked with them in the past after a previous unhealthy relationship. By taking her concerns seriously, I began to create a transparent and trusting relationship with Anna, another important feature of trauma informed care.

When I consulted HAVEN, the advocate I spoke with immediately remembered Anna from their previous work together. She was sad to hear about Anna's current physical and psychological condition. She offered to meet with Anna several times during this admission and would continue to work with her over the phone even after her transfer to the rehab facility. Anna was thrilled to hear that she would be working with the same advocate she had worked with in the past and was very thankful for this connection. I was able to continue to collaborate with HAVEN during Anna's admission. I provided clinical updates, including the plan to return to rehab. I was so pleased to hear that the HAVEN advocate would continue to work with Anna while at the rehab and could be a resource for the rehab staff if they needed guidance.

Slowly but surely, Anna started to improve. Her thoughts became more organized, her speech became louder and her sentence structure improved. Even though she was still at odds with the Psychiatrists due to disagreements about medication, it was evident that she was working hard with Physical Therapy and Nursing to meet her goals each day. This dynamic, called splitting, is not uncommon with people that suffer from Borderline Personality Disorder, which is a mental health disorder that affects the way a person thinks and feels about themselves and others, causing problems with interpersonal relationships, distorted self-image, extreme emotions and impulsiveness. As you can imagine, the team on Blake 11 is very skilled and understand well this defense mechanism of splitting. As a multidisciplinary team in conjunction with Anna, we took time to create a good treatment plan that met all of Anna's goals while on our Inpatient Psychiatric Unit and we held steadfast to the plan. In fact, I kept a copy of the plan and every time I met separately with Anna, I would reference it anytime she expressed discord with a member of the team. These strong limits helped Anna stay on track and focus on the goals she identified.

Anna and I continued to meet separately, and she eventually shared more details of her recent relationship. Sitting with her, listening and watching her share a horrific event that she had carried by herself for a long time, my first reaction was shock. I knew that I had created an environment where she felt safe enough to tell me all these details. And as I listened further, I had to think quickly. Clinically, I needed to remain open and listen because sharing this was very valuable to her. From a trauma informed perspective, I needed to allow her to have choices in what she shared so that she maintained her dignity and I knew it was not the time to ask for any more details, but to use the information she had shared to empower her moving forward.

I shifted immediately to a strength's perspective. I shared how much I was in awe of her strength. She was strong in sharing the details of this abusive relationship with me, she was strong in her ability to restrict further contact with this person and she continued being strong as she fought for her recovery in spite of all the trauma she had experienced in her lifetime. I validated her experiences and shared all these strengths with her, emphasizing the beauty of her words as she described one of the worst events of her life. Knowing that she was once a Journalism major, I encouraged her to write as a coping mechanism, even though her physical ability to write was extremely limited due to her neurological disorder and weakness. She would not have been able to share this with me had I not created a trusting therapeutic relationship with her. By validating her previous concerns and coordinating helpful interventions, she trusted me with more intimate information.

Anna continued to improve and continued to get stronger. With encouragement from the multidisciplinary team, she began wheeling herself in her wheelchair around the unit and began taking the lead with her ADLs. As the Psychiatrist completed the medication changes, her mental status improved, and she was much more organized in her thought process and her speech. With her trauma work with

HAVEN and me, she became psychologically stronger and able to address some of the previous traumatic events.

During my time working with Anna, I was also working with her grandparents. Anna's grandparents were absolutely incredible. They were not the most psychologically minded and didn't understand Borderline Personality Disorder, Conversion Disorder, Functional Neurological Disorder or Anna's defense mechanisms of attempting to split her family or the medical team. However, they offered something that Anna had in no area of her life: unconditional love and support. They were steadfast in their support of her. They challenged some of her delusional and distorted thoughts, they supported the medical team and their decisions, and they were strong in their support for her. They continually made it clear to Anna that they would not abandon her as her parents and sister had. In fact, there were consequences to their decision to remain in Anna's life; her parents and sister cut off communication with them as well. Despite this great loss for them, they never regretted supporting their granddaughter.

I spoke with them almost daily and provided clinical updates. Eventually, they came to MGH for a family meeting. They were so impressed with how Anna had improved and were so thankful for the team's interventions. I facilitated the family meeting that included Anna, her grandparents and the Attending Psychiatrist. We reviewed the hospitalization, all of the medication changes and the plan for Anna to return to physical rehabilitation.

Per Anna's wishes, I met separately with her grandparents. They detailed how difficult the past six months had been for them. Despite being tearful when they shared that Anna's parents and sister no longer speak with them, they never regretted their decision to support Anna. I thanked them as I had so many times previously for their unconditional support of Anna and emphasized how helpful it was to her knowing that they were there.

Toward the end of Anna's hospitalization, the multidisciplinary team was very careful in planning the return transfer to the rehab facility. I first participated in a conference call with the rehab team, updating them on the comprehensive approach we took with Anna. We detailed Anna's hospitalization and progress. Anna greatly enhanced her coping skills through a multidiscipline approach: trauma work with Social Work and HAVEN, strong medication changes, physical therapy, occupational therapy and psychology. I also had several, very productive phone conversations with the Social Worker at the rehab. I was impressed with her knowledge of trauma informed care and believed that she would be an unbelievable asset to Anna's continued recovery. The rehab Social Worker and I coordinated the completion of an application with the Department of Mental Health (DMH) with Anna for continued services when she eventually entered the community. We were both aware of the very long road of recovery Anna had ahead of her and were hopeful that DMH could offer good community-based support services for her.

Finally, my work with Anna came to an end. The day of her discharge, she was quite anxious. We met several times, in the multidisciplinary team and separately. In her anxiety, she was pulling for more attention and requested to meet with several other providers. In an effort to reduce her anxiety, I again reminded her of the treatment plan, validated her emotions and acknowledged all the progress she had made during this hospitalization. She responded well knowing that she would continue to work with HAVEN while at the rehab facility, that she would work with a Social Worker there that would always listen to her and that her grandparents would never abandon her. Leaving MGH would be a difficult task as she felt so safe here and she made so many positive strides in her care, but by the time the ambulance arrived to bring her over, she presented with smiles and joked appropriately. It was clear that she was ready for the next step.

Working with Anna was one of the most rewarding experiences in my professional career. I felt that my interventions with her were a strong contributor to her improvement on our unit. During her hospitalization, I coordinated with the Blake 11 multidisciplinary team, many other MGH Departments, the rehab facility and Anna's grandparents. Despite all of her complexities: medical, psychiatric, psychological, family dynamics and traumatic experiences, she is a very strong person that has so many wonderful skills which will continue to contribute to her recovery. Just a few weeks ago, I spoke with a representative of the rehab facility and I was pleased to learn that Anna continues to improve.

SAMPLE QUESTIONS:

Clinician/Patient Relationship:

1. In your cover letter you describe your work on behalf of a young transgender man. How did you develop a relationship with him? What were the patient's goals?

Clinical Knowledge & Decision Making:

1. Please tell us about what theories guided your treatment with Anna, the patient in your narrative. Did you have short-term vs. long-term goals in mind?

Teamwork & Collaboration:

1. A letter of support describes a situation in which you identified your counter-transference in response to a patient who had homicidal ideation toward her young children. How did you support your team regarding their counter-transference?