Interview Date: November 12, 2010
Interviewer: Carrie Streeter
Informant: Betty Parker
Location: Broughton Hospital Staff Library, Morganton, North Carolina
Transcript Key: CS = Carrie Streeter BP=Betty Parker

CS: It is November 12, 2010. I'm Carrie Streeter and I'm here with Betty Parker. Betty what year were you born?

BP: 1944

CS: And in what city, county, and state?

BP: Statesville, Iredell County, North Carolina.

CS: And where did you grow up?

BP: In Rowan County.

CS: Were your parents from Rowan County too?

BP: My father was from Rowan County, my mother was from Alexander County.

CS: And had they grown up there for most of their lives?

BP: Yeah. My mother actually graduated from Appalachian when it was a 2 year Normal School. That was actually the name of it.

CS: Was that when it was a teacher's college?

BP: Yeah. That was in 1927.

CS: So did she teach?

BP: Yes.

CS: How about your father? What did he do?

BP: He was a farmer.

CS: So did your mother teach during your childhood?

BP: She taught for years before I was born. My parents were married later in life. My Mother was actually almost 38 when I was born, and I have a younger sister believe it or not. Anyway, after she graduated from Appalachian, the two years that's all the school had. Then they made it a four year college, and she completed her four year degree working on

it in summer school. Public school was eight months at that time, so she could go to two sessions of summer school and still have a little bit of vacation. And she was teaching in Cleveland, North Carolina and she was living in a boarding home that was the home of my husband's aunt. And that's how they connected, someway or another.

CS: Ahh, that's fun. So when did you decide to go into nursing?

BP: I can't remember when I didn't want to be a nurse. All the women in my mother's family who worked outside the home were school teachers. All the women in my father's family who worked outside the home were nurses.

And I've always loved anatomy, and I wanted to know what made things happen and I didn't like it when the doctor would say something I didn't understand. I wanted to know why. And I liked working with anatomy. Hog killin' days is when I got my anatomy lesson. Hogs are essentially the same as humans on the inside, and so when I took anatomy and physiology in nursing school why I already knew what all that stuff looked like and where it was, I just didn't know what the names of everything were. So I've always been interested in that sort of thing.

CS: You mentioned there were nurses in your family. Were any of them mentors to you? Or did they encourage you?

BP: My father's sister was a nurse at Grace Hospital for years, and she didn't deliberately mentor me exactly but I visited her frequently and I just found what she did interesting.

CS: Did she go through her nursing education at Grace Hospital?

BP: No.

CS: And where did you go for your training?

BP: I went to Lenoir-Rhyne for undergraduate. And at that time, it was basically two years on the Lenoir-Rhyne campus and two years in the nurses home, which we called the nunnery.

CS: What years were these? Do you remember?

BP: Oh yes, I'm afraid I do. And we lived in the nurse's residence next to Grace Hospital. So we'd get called for deliveries and for autopsies and for all kinds of interesting things. I graduated in 1967.

CS: So that was four years? The two years in your classes and then two years of clinical?

BP: Yes. It was a Baccalaureate Nursing Program. I was in the fourth graduating class from Lenoir-Rhyne.

CS: Were most of the nurses whom you worked with at that time gone through that

program? Or was there a difference? Because in decades before that nurses trained in diploma programs. Did you see a change there?

BP: Well, diploma programs were created by hospitals to staff their hospitals. And then later on they found a need for expanding education to college campuses and that's when Baccalaureate programs were formed. I have taught all the levels of nursing. LPN, BSN and Diploma students.

CS: And why did you choose to enter psychiatric nursing?

BP: I had a clinical, when it was a semester long clinical at Broughton. And I was in undergraduate school. And I liked it okay. There wasn't anything that just thrilled me, but I liked it okay. And I worked at Grace Hospital when I first graduated. And then I got a chance to come to here and work at Broughton teaching diploma student nurses on affiliation. At that time the state paid for nursing students in diploma programs to come to State Hospitals for their psych experience.

The first students I had stayed here twelve weeks. So, although I was a Hospital employee, I was out on the wards with the students hours at a time. So, in addition to teaching the lectures I was out with the students with the patients for hours at a time.

CS: And this is in the late sixties?

BP: This was '68 to '73.

CS: What kept you in psychiatric nursing?

BP: I loved it. I loved it. I loved getting to know the people, and the relationship. Well one of the reasons I left Grace was because I was working with surgeons and although I certainly knew what was expected of me, I didn't like the fact, particularly on surgical units that as soon as you got done doing whatever procedure you had to do, it was on to the next patient. Well, I wanted to pull up a chair and talk for a while. Well, you can't do that. You could even get fired for sitting in a chair at that time.

So when I got to Broughton and I had a chance to get to know people and talk with them, you know, over a period of time, I really enjoyed it. And I liked the teaching too. So, I'd say that I was really combining my two parents: teaching nursing.

CS: What were some of the things you might say to students, say on their first day, giving them an impression of what they were about to do?

BP: That's been way too long to remember.

CS: Yeah. If you were to describe maybe the top five or ten things for a psychiatric nurse to know about their job, what would you say?

BP: You definitely have to have good assessment skills, because you have to be able to understand patient's behavior, know when what's going with them—and it is a great safety

factor to be able to read your patients. Because I've never been hurt, although I've been in every ward on this hospital in some fashion or another. I've been grabbed and I've been pushed. I've been cursed, but I've never had anyone really hurt me. And the main reason for that is because I learned to read patients. And when you sense that they are getting out of control, you have to be prepared. So assessment of that sort of thing is the main thing.

Another thing is being comfortable with your self. Because they will know how to push your buttons. And if you are insecure or easily bothered by out-of-control psych patients, then you are not going to survive very well. You have to remember that they are the patient and you are the healthy one. And I've been called all kinds of names and told I was awful and this and that and the other, and you can't take that to heart.

Another thing, you have to be able to compartmentalize. You have to be able to, for the most part, go home and leave it. And there's been a few times I couldn't totally do that. But most the time, I could go home and leave it and come back the next day and pick it up again. So if you take the work home with you mentally too much you won't survive.

You have to have realistic expectations. Chronic mental illness is not quickly fixed or treated. In fact it may be a lifetime. And if you are the kind of person who needs to see results, like now, which you might in critical care, you are not going get in psychiatry. That just doesn't happen with most people.

CS: Would you say that is one of the larger differences between general practice nursing and psychiatric nursing?

BP: Definitely. There are chronic illnesses in physical health of course, like diabetes or cardiovascular problems and all, but it is just different partly because, particularly chronically mentally ill people are usually not in a position to really stroke your ego. You know nurses, usually, maybe all of us, like to be appreciated. Well, psych patients are not necessarily going to appreciate you. And so that is one of the reasons you need a strong self-image and ego because you are not going to necessarily get what you need from your patients. You have to be able to find it somewhere else.

CS: Did you kind of know that instinctually as you entered this field, or is that something you had to learn?

BP: No, I learned it. The director of nursing education when I first started working was a wonderful mentor. Susan Kappell is her name. She was the first nurse in this hospital to have a master's degree. She was wonderful. My psychiatric nurse teacher in undergraduate was very good, Gernell Dale. And she had worked at Broughton, I'm not sure in what capacity, but she had worked here. And then she started teaching at Lenoir-Rhyne. And then when Miss Cappel needed somebody in that position, Gernell recommended me. That's how I got contacted in the first place.

CS: Was your family supportive about your choice to become a psychiatric nurse? Did you talk about this with all the nurses in your family?

BP: No, that was an individual decision. My mother never did understand what I did. She was a school teacher who taught from the 4th grade to the 8th grade and she had no idea

what I did. I would explain some things to her and she would look at me like, huh? So, I learned a lot from my mother, but not about psychiatric nursing.

CS: How would they describe their feelings about what you were doing?

BP: Well they were proud I was a nurse, but, and particularly that I went to a Baccalaureate program, but no one ever really ever said anything to me one way or the other about working here.

CS: So, did your job titles change throughout your career?

BP: Yes.

CS: What have been some of the job titles you have had?

BP: Well I started out as a staff nurse, and then I was an instructor when I was here teaching diploma student nurses. After I went back and got my master' degree, I was teaching at Lenoir-Rhyne at that point. And then I became Assistant Professor, and of course I got my certification as a clinical specialist. So that is the thing I'm proudest of, Psych Clinical Specialist, Board Certified.

CS: What year was that?

BP: I graduated from USC-Columbia in 1981, and I was certified January 1, 1986.

CS: And how did that change what you were able to do or how you felt about your abilities?

BP: Well, to teach at Lenoir-Rhyne, I needed at least a Master's Degree. But one of the best jobs I ever had was when I was working as a Clinical Specialist, because that entails all of the aspects that I really like. I like teaching, but I like patient care. And I didn't like not having a lot of patient contact. But when I was working as a Clinical Specialist, I had a lot of patient contact. But I also did a lot of teaching: staff development, design forms, wrote policies, that kind of thing. And I did a little bit of research, so I dabbled in a lot of different things. And I liked that. I liked variety. I didn't want to do the same thing everyday.

CS: When you started working here, what was the process of patient admission? In 1967, is that right?

BP: I first started working here in '68.

CS: Were patients admitted into counties, or were the wards organized by counties, or did that come later?

BP: Yes, they were organized by counties at that time, and there was a mental health center in each area. And previously to that before my time, they had been on wards based on their diagnosis. I can't imagine anything worse than a whole ward of people with schizophrenia,

or a whole ward of bi-polar manic. But, when I first worked here, they were divided according counties.

CS: And how did that help? What were the purposes for that?

BP: The purpose of that was so that the mental health center could come to the hospital and go to a certain and see patients from their area. Because if they were all over the hospital, it wouldn't work. So that was the purpose to have a seamless treatment, of course it didn't work that way all the time, but they would hopefully have the same staff looking after them in the hospital and those staff members would work with the mental health center staff.

CS: How would you describe your relationship, your student nurses' relationships with other staff members? Who did you work with most? Who did you report to? In those first years.

BP: Well the first 5 ½ years I worked here teaching diploma students, I answered to the Director of Nursing Education Miss Cappel. There was another instructor, so there were three of us who taught the students.

CS: And did work closely with the doctors and the psychiatrists at that time?

BP: Not really. Ahh, I attended treatment team meetings, but since I did not officially work on the ward with the patients, I could throw my two bits in, but it wasn't the same as if I was a staff nurse on one of the wards.

CS: How did your nursing students seem to relate to the psychiatrists and the doctors?

BP: Hmmm. Okay I guess. I don't remember any particular problems. One of the things I've liked about psychiatrists ever since they have been in the business is that psychiatrists, as a breed, have more respect for nurses opinions than a lot of other professions do. Psychiatry is not an exact science, and psychiatrists need to ask the nursing staff what's going on on a 24 hour basis, not just the 15 or 30 minutes that they see a patient. So psychiatry actually had the treatment team approach way before any other specialty did. And I liked that.

CS: And was the treatment team a weekly meeting? Or how often were those meetings?

BP: Depended on how long the patient had been in the hospital. They would have to have a treatment team meeting shortly after they were admitted and then at increasing intervals depending on how long they stayed. And you have to remember that some of these people stayed 30 or 40 years. So, you weren't going to have a treatment team meeting every week for those patients. I think the farthest apart, I think, was every 3 months. I believe.

CS: And who would be involved with those meetings?

BP: Psychiatrists, social worker, nurse, pharmacist, CNAs, techs.

CS: Would there be a nutritionist there?

BP: Probably.

<The phone rang, and we paused the interview>

CS: What were your experiences with relating with patients and their families? Did you have a lot of interaction with patient's families?

BP: No not really. They would be there maybe to visit sometimes and I would see them. Or they might be at treatment team meeting, but generally I didn't interact with families a whole lot. Partly because I might not be on the ward when the patient families were there. And the other thing is there were a lot of patients who had very little family contact. Part of the issue was that some of these people were miles away, and it was hard for the families to come. And some of them had burned their bridges with the families and they didn't have much family support. And money was an issue too, because they couldn't miss work to come visit. And if they drove after they got off work it might be too late for visiting hours. So there were all kinds of reasons.

CS: Did a lot of the patients whom you worked with come from the mountain counties of western North Carolina?

BP: I can't tell you numbers, but it was probably proportionate to the county population. Of course Mecklenburg County had the most patients, but that was also where the population was, so it was to be expected. I can't tell you numbers.

CS: No, that's ok. Did you notice any cultural differences with patients that came from Appalachia?

BP: Oh sure.

CS: What were some of those differences?

BP: This is not specific to working at Broughton, I worked at other places too. But Mountain people are very private. And getting them to really reveal their feelings was not necessarily very easy. They tended to come from an environment where they didn't see a lot of people they didn't know pretty well. They were a very closed society in a lot of cases. And sometimes they just wouldn't talk about their feelings very much because they were not accustomed to doing that. It wasn't particularly directed at us, it was that they didn't talk to anybody that they didn't know.

CS: What were some of the things you learned to do to help treat people from that area?

BP: Well I grew up in an agrarian society, and consider myself still a farm girl. And you have to talk to patients differently depending on what they are expecting. And one thing I did with one patient, this was not at Broughton but was the same idea applies, he had paranoid

schizophrenia. And the reason he had survived as long as he had outside the hospital was that he had worked as a surveyor's assistant. And of course it was just the two of them and a dog out in the bushes and brambles surveying. And so he could be pretty weird if he wanted to be and as long as he carried the equipment and did what the surveyor told him, nobody cared. So, I realized that he wasn't going to connect with anybody who he thought was a city girl. So I started talking to him about my cows and my horses and hoeing cotton and doin this and that and the other, which of course I was all very truthful abut, and he started looking at me like "Ohhh, you do know about the country." And then he would talk to me.

And then one time, same hospital around here, I had an ASU professor who was very depressed. And she refused to go to group because she wasn't going to reveal her innermost feelings to these people that she, I don't know that she exactly thought they were beneath her, except in education—which of course they were. And so I didn't insist on her going to group. But I did one on one counseling for her a lot. And one of the assignments I made for her was, I had to do in-service to keep up my license. Anyway, I was reading professional articles. And in order to get credit for it, we had to 70 or 80 percent right on the questions that accompanied the articles. So, I would give her those articles although she wasn't a nurse, I'd give her those articles and say, "Tell me what you think. And we'll see if we agree." She loved it!

You have to learn to meet the patients on their level. You're country if they need country, you are more sophisticated if they need that. And you have to figure out what it is that will work for therapy, and will make them feel comfortable talking with you.

CS: Did you see that most nurses understood that? Were a lot of the nurses from this area when you started working here?

BP: Yes, a vast majority of the nurses lived in this area. Miss Kappell was originally from this area but she went to school in New York state and had worked in several states. But the majority of the staff were not from out of state at that time.

CS: Has that changed?

BP: I can't give you numbers, but people are more mobile now than they used to be. And you'll see fewer people planning on working their 30 years in one place and that kind of thing. Many percentage of the staff years ago came to work here and expected to work here for 30 years. But that was more or the less the way it was in most jobs. People worked in textiles for 30 years or they worked in furniture for 30 years or whatever. So that was more the way it was, the expectation. Now, you know it is more accepted for you to change jobs fairly frequently.

CS: So, in the 1960s psychotropic ~~jobs~~ drugs had come on the scene for care, right?

BP: Thorzine came out in '53 and was widely used until '55, so I don't know anything about that. Typical antipsychotics were about the only drugs that were used when I first began, and they were terribly over used. Partly because nurses did not give the medications. Techs gave the medications after only a few hours of in-service. When I first worked here there

were like 2,500 patients and 77 RNs. Three of us worked in teaching the students, so we didn't even count. So, you could see that was no way that nurses could give the meds. So, part of the trouble was lack of alternative treatment and nurses not giving the meds. And just desperation sometime to help the patient. I have personally seen people walking around the grounds while they were taking 2-3,000 grams of Thorzine, which seems astronomical. But, I saw that. I mean it was just unreal really the amount of psychotropic medications.

CS: When did you see that change?

BP: It would be hard for me to say exactly, but it was not during the time that I was here originally. Not before '73, it was after that. I wasn't an employee back here again until '87. So, it was probably late 70s more than likely when it really changed. There were more medications to choose from, nurses began giving medications, there were a lot more standards for what you could use. There were a lot more pharmacists to consult with, so the staff was much more educated about medications. And of course if you know more about medications, naturally you are going to be better prepared to give it to them.

CS: What are some other kinds of treatments that were in place when you first started working in psychiatric nursing?

BP: ECT was a big thing.

CS: Electronic shock therapy?

BP: Yes. And I remember seeing at least 15 to 20 patients sitting along a wall in a long hall waiting their turn for ECT. And they were not put to sleep, and that is what was so bad about it—all that time sitting there waiting for their turn. And then the <medicine> that they gave to them to put decrease the muscle contractions, decreased their chance of fractures, it made it so they couldn't breathe for a while. And so here they are wide awake but they can't breathe. That was only a very short period of time, 30 seconds or something. But it wouldn't take long of that to terrorize me. So, that's the time when it got such a bad name. You know. I've heard, none of the professional staff, say things like "If you don't do so and so, I'll get the doctor to shock you." Which probably didn't happen, but it was used as a threat sometimes. So, it's those days when ECT gets a bad name.

CS: Yes, there is a lot that is happening in the country at that time . 1963 is the Community Mental Health Act, which called for deinstitutionalization, were you aware of what was going on with those public policies. Was that talked about here? And did you see that start happening, the deinstitutionalization?

BP: Sure. Well, it had already begun a little when I was a student here in 1966. And by the time I was here in 1968, the population was down from 3,000 to 2,500. That was about the time it was really getting going. Because after the mental health center act, regional health centers took a little while to get started. They had to get the building, the staff, you know get organized. So that didn't help instantly after the information came out in 1963, it took a

little while. So about the time I started working here in '68 is when they were really working on getting people out.

CS: Did you see more involvement with community mental health centers?

BP: Sure.

CS: Was that viewed as positive?

BP: Of course. Because one of the main reasons patients stayed here for years was for lack of family and/or community involvement. They needed a support system, and if they didn't have it it was highly unlikely that they would be discharged. Because we didn't have all the assisted living and group homes that we do now.

CS: Did you see anything that didn't work smoothly with these transitions?

BP: Well it was such an improvement over what we had before, that I don't remember anything. One thing that I was amazed at was the autonomy that nurses had in the mental health centers. They were really, the ones I saw, the nurses really ran it. Doctors came through and signed the orders.

CS: What kinds of things were they doing?

BP: They were regulating patient's medications. Now they didn't usually start a patient on a particular medicine, but they would adjust the dosage up and down. Or they would call the doctor and say, "So and so doesn't seem to be working, can we put them on whatever." And I had never seen that before.

CS: And this was largely in the community mental health centers?

BP: Yes. And it was out of necessity because there weren't many doctors. The one where I was assigned as a student, the doctor came through on a Friday morning. So, the rest of the time, the other 36 hours of the week, the nurse was in charge. Now she had a phone line to the doctor if she needed to call, I don't mean she just did everything without a doctor, but the nurse was the one who ran the place.

CS: And would the nurse be leading other kinds of therapy as well? What were some of those therapies?

BP: Sure. Well, psychiatric nursing was the first to really view the nurse-patient relationship as part of the treatment. And I really liked that part. As I told you it was very frustrating to me to finish up a treatment with a patient and then it was on to the next patient. I wanted to sit and talk with them a while. And that is a lot of what you do in psychiatry.

CS: Right. Like milieu therapy?

BP: Yes, that is the whole environment. Milieu. Nurse-patient relationship was first viewed as therapeutic through the writing of Peplau in the middle 50s. We still do have students do process reportings that she initiated over 50 years ago. And we still don't know a better way to do it, to teach it.

CS: So, do you remember reading her in your schooling?

BP: Oh yes, she was the patron saint of psychiatric nursing. I met her one time at the hundredth anniversary of psychiatric anniversary. I thought, "My. I'm meeting this legend. Ahh. I'm meeting this legend!" Actually I have the book that they gave out at that meeting signed by about 10 of the big names of psychiatric nursing, several who wrote textbooks. And she [Peplau] was so amazing, because here was this woman that was the finest in the world and she just talked to you like anybody else. And that's part of what made me believe that she was really real. She was really what she wrote about.

CS: So you were quite involved in leadership, and in attending conferences. Did you seek that out?

BP: Sure.

CS: What year would that 100th anniversary been?

BP: I would have to look a the book. I honestly don't remember right now. It was before I graduated from USC, so it would have been the late 70s maybe.

CS: Were you working back here [Broughton] at that point?

BP: No.

CS: When you left Broughton, where did you go to work then?

BP: I went to Western Piedmont and taught students for one year, when I got pregnant and stayed out for a while. Then I went to Lenoir-Rhyne and was assistant to Gernell Dale, my old psych professor. And then I went back to graduate school, and then I became the person in charge of the course. And then I went to, after I finished graduate school, I wanted to get certified but you had to do a lot of clinical. And I really didn't have time to look after my family, and teach full time at Lenoir-Rhyne and do clinical hours. So that was one of my motivators for leaving Lenoir-Rhyne. I went to Frye as a staff nurse and then after I had my clinical hours, I took the exam and I passed the Board Certified. And so after that I taught at Lenoir-Rhyne three more years and then I went to Catawba Hospital and worked there 10 years as a Psychiatric CNS. Then I came back here and worked nearly three years as Psychiatric CNS. I was one of the first two Psychiatric CNS's who worked here.

CS: CNS? Tell me what that means?

BP: Psychiatric Clinical Nurse Specialist. As opposed to manager or, yeah, or opposed to manager. Because there are two tracks you can go, more clinical or more administrative. And I wanted to go to the clinical. I wanted the patient contact.

CS: So were you in charge of nurses at that point as well? Were you supervising?

BP: There were two of us and we divided the hospital. I mean, that was our job description. The two of us worked together on things like writing standardized nursing care plans. Teaching new nurses here. I think it was a 30-hour course we taught for new nurses on interpersonal relationships and all the things that might be new to someone with a med-surge background. So we worked together on a lot of things. But we also worked with individual staff in their areas in the hospital. Or problem behavioral patients, we discussed with our staff ways that they might work with them. I sat in on treatment teams and had a lot to do with planning care. I wasn't really giving direct care much of the time, but I was planning care. And being support.

CS: What are some of the problems that nurses came to you with consistently?

BP: Hmmm. Well. Particular behavior that they didn't know how to manage. Or how they should encourage the patient to be more independent. Because sometimes the staff would do things with the patient that they really shouldn't. Because you make them dependent on you.

CS: And when you were at Catawba, was that the psych ward of the hospital?

BP: Well, my office was on the psychiatric floor. But my job description was that I would see patients all in the hospital. And so they would call me anywhere from emergency room to birthing center. I would see psych patients at the birthing center, that you know, really got out control because they were off their medicines because they were pregnant and all the hormonal changes with them. So I've seen some really wild things there. And I frequently went to critical care because they would get overdoses or self-afflicted gunshot or one of the, I can't say strangest, but [cases that] surprised me, was one patient who was a type-1 diabetic who had quit taking his insulin. Well they just couldn't understand why in the world he would do a thing like that cause you know what you are doing to yourself. Well, he was suicidal! I mean, you know. So, I would see patients in critical care even. Or maybe on the medical floor. Patient would eat things they weren't supposed to. And the non-psych staff, more or less, would expect people to do things that were logical. And psychiatry you don't exactly expect it to be logical. You find out what the reason is, which is logical to them, but not necessarily what a rational person would think so much.

I like variety and I don't want to do the same thing all day.

CS: Did Catawba have a psych nurse before or was that a new position?

BP: No. Hmm. I think there had been somebody before me there for a few months. But there wasn't anybody in the position when I went there. But I think there had been somebody there for a bit before me. But I found I had to make my own way. And they

looked at me like "What are we gonna do with you?" (laughs).

CS: Was there a general unknown about what psych nursing was at that time?

BP: No, they just didn't understand. If you weren't gonna do staff nursing what were you gonna do? And when I started teaching classes on nurse-patient relationship and communication skills and how to chart and help them with writing care plans and help them with problematic patients, they thought "Oh, she comes in kinda handy." (laughs)

One of the worst things on the medical floor was the non-compliance with patients. And as I said, most non-psych people tend to think people should make rational decisions. Well, rational according to whom? And psych nurses are usually, well I have some OCD tendencies, but not like critical care nurses—which is appropriate there, but you can't do that in psychiatry. You gotta kind of go with the flow and see where it works, as long as it's within reasonable boundaries. And, you know, I don't have to see instant change. And so, you know, that sort of thing is my cup of tea.

CS: Do you remember anything in your early days of your career that stands out as an experience where you felt you had really learned something or that it was particularly challenging?

BP: Ahh. This is when I was working here, I can't tell you the exact year, but I had been here a while. And I had learned my way around and there was this, I think he was 16 at the time, big African-American teenager who would come around my office. And there two of there in the office, and that time the other nurse was about the same age as I was. And he would come by and talk to us. And he was big, I mean he was big!

And it didn't take me long to figure out that he deliberately ate to much, I mean he was tall, but he was big, and he deli early ate too much because he learned that size was power. And he had come here as a little kid, I think he was no more than 14 and I think he might have been younger than that, and they had no youth unit, so he was put on the same ward with adults. We don't have to talk about what probably went on. Fascinating

Anyway, he said his mother accused him of sexual abuse with his sister. And she got him admitted here. And I always believed that he was admitted because he got big and hungry and she didn't have money to feed him. And that was at a time that you didn't have to have really accurate assessment and justification for admitting somebody.

Anyway. That is the background. Point being. He'd come by my office and sometimes he'd talk to the other nurses, sometimes he'd talk to me and sometimes he'd talk to both of us and one day he came in and he had a stick about, I know your recorder don't show distance, but it was a stick about 15 inches long. And then on the end of it he had a long, I don't know whether it was, a needle or what, but it was several inches long and it was big. And he was just kind of waving it around. And a lot of people on the 3rd floor in Avery who were in staff development was also up there, and we were nursing education, allot of them were afraid of him. And he came in with that [stick], and I was in the office by myself. And I started talking with him and I had been in the business kind of long enough to read people, and I knew he wasn't going to hurt me. Although he was just kind of waving it around, not at me specifically, but he was just kind of waving it around.

And so long story short, he had found a needle that had been disposed of

inappropriately and he had found it somewhere and put it on this stick and he was just going around seeing what people would do. And after we talked a while, I said, "Now what do you think you should do with that?" And he finally said, "I should give it to you." So he gave it to me. I knew I learned the business from then on. Because most people would have been scared to death by that. He was big, black and carrying a weapon, in a mental hospital. He wanted somebody to care about him and to trust him.

And the saddest thing I think I have ever heard in all my years is he told me one time that I treated him better than his mother. It brought tears to my eyes. So that's the kind of thing that makes it worthwhile. I've often wondered what became of him. That was 40ish years ago. I'll never forget that.

CS: Wow. Hmmm. I can tell that you've probably been a really important mentor to a lot of nursing students too.

BP: I hope so. I did my best to indoctrinate them. (laughs) And I tell them that's what I'm doing! The most effective too for teaching when I was doing lectures at Lenoir-Rhyne, I worked there full time for 6 years when I went back the 2nd time, was actual examples. Here's a diagnosis, here's the symptoms, and here is what happened. Here's the diagnosis, here's the symptoms, and this is what I saw. And I didn't use much PowerPoint because I wanted them to listen to me. I didn't want them to focus on a bunch of words on a PowerPoint.

CS: How would you describe the changes that you've seen, and I'm sure you've seen a lot, from that first decade in working in mental health nursing and now?

BP: It is hard to even know where to start there. Some changes have been good and some have been bad.

When I first came here in the late 60s so many of these patients had been here for years. And because of the mental health center movement, and the community involvement, they were beginning to get a lot of them out. They really didn't need to be here. But of course that also coincided with a period of time when they were using more medications appropriately and there were more medications to choose from. So it wasn't just one single thing, it was several things. So, that part got better.

And although ECT was very therapeutic and very useful for a lot of patients, the procedure itself was so inhumane there is not comparison to what it used to be and what it is now. Just no comparison at all. And it bothers me that people still have, in so many cases, still have the same impression of it as in "One flew over the cuckoo's nest" or something. And I don't know why when all these other things have changed so much in health care, I don't know why they think it is still like that. It is pure ignorance. Anyway, that is one of the biggest changes.

We've gone backward now in the last few years because mental health care in North Carolina deteriorated when we went away from the mental health centers in the same fashion that they had before. There is less money for mental health care all the time, more and more population, more and more stress, more and more PTSD for one reason or another, particularly from coming back from wars. And more break up with families and there is more stress about any way you can figure, certainly with the last few year's

economics added to it. So, there is worse and worse care. It is so bad now that you can hardly get anybody admitted for psychiatric care unless they say they are suicidal. And I know for sure some patients say they are suicidal when they aren't because they know that's maybe the only way they will get in the hospital. And I don't really blame them. And you can print that! (laughs)

Anyway, care was actually better 10 years ago or something that it is now. The patient population here is so chronic now that you can hardly get anyone admitted in the hospital, and there is no place for patients. The care is really terrible now. Just today I was reading a chart of a patient who had been admitted for psychiatric care, I'm not sure where, but 40 admissions, and the patient was 48 49, 50 years of age. [This patient] had had 40 psychiatric admissions, and all of that is because of lousy after care. Patients who don't recognize that they need medications, don't have support that they need to look after them.

We need places, not assisted living and not group homes the way we have them now, but some type of, for lack of a better word assisted living facility that is specifically for chronically mentally ill patients with staff that are trained to deal with patients like that. Who can make sure that they take their medicines and have good follow-up care. Until that happens, it is going to be terrible. It is just getting worse and worse. There are more mentally ill people in prisons than in the hospitals. You don't want me to go on about that.

Absolutely right!

CS: You know, Dorothea Dix saw that in the 1840s.

BP: Hmmmmh. This hospital was built because they didn't know anything else to do with them. And then there was way to many people here and they couldn't get them out. And then the community mental health movement came, and they started getting them out appropriately and had good follow-up care and more medications to use. And then that got too expensive or somebody's lack of understanding of mental illness they decided to go a different way and it is not working. A lot of different mental health units were closed for lack of money.

And part of the issue is that the powers that be, and I don't care if you print this either, don't understand that uncontrolled mental illness cost society. You can't get away from paying for mental illness. And until we put money at the front and at the long-term then everything won't get any better. And it's awful that patients may be back here for an emergency for 3-7 days because they can't get admitted anywhere, and then they keep them here just long enough to get them stabilized and discharge them. Just today I was reading a chart of a different patient who had been in the hospital 2 weeks and back, and she was manic, one of the worst patients I'd seen in a long time. She had only been out of the hospital 2 weeks, probably didn't take a single pill that she was supposed to take while she was gone. She's never going to be able to manage her own life, ever. And until there is some type of long-term facility to deal with people like that we're gonna keep on having this broken system. So, it has got better from the 60s and then it has digressed.

CS: Do you think part of that was that was funding issues?

BP: I know it was. That and lack of understanding of what works and what doesn't. I mean so few people really understand mental illness. Part of it is just theory. Part of it's if your family member is gone then you don't have to worry about him. It is a lot of different

things. Funding is the biggest single issue from the state legislature.

CS: Do you think a lot of the nursing students that you work with now understand these issues?

BP: When I get through with them, they do.

CS: Do you think they understand that before they come in, or is it not something that they've really given thought to.

BP: A few of them will, but the majority of them won't.

CS: Do they run into their own stigmas about mental illness? Do you see that happening?

BP: Sure. And they write a self-evaluation of what they feel from the first day to the end. And it is not graded. They can put down anything they want, it is not graded. And almost without exception from the beginning to the end, from the time that I have them here which is only a few days, their eyes will open wide and they say, "My gosh, I didn't know, and I feel so differently about it now." And it is, like I said there is no grade to it, they can put down whatever they want to. It's not being held against them. So I know that they are telling the truth about what they have learned. Well they see it though, it is not just that I tell them. They see it. I'm just a slightly passionate teacher, wouldn't you say?

CS: Yes. That's totally good. We've covered so many of my questions. So when you first started working here, the number or nurse and the number of patients?

BP: When I first worked here in 68, there were around 2,500 patients and I think there were 77 nurses. 3 of them were considered the ones teaching, so they didn't work with the patients.

CS: So how many patients would maybe one nurse be responsible for on a shift?

BP: Well, considering that there were probably 30 wards at that time, and people had days off and vacations and all, I'm sure there were a lot of times when there were 2-3 RNs here on 1st shift and on 3rd shift there might not be but one. So, you know what little supervision the techs had.

CS: That changed in the 70s? Wasn't there a law that passed that said techs couldn't give meds?

BP: Yes, and that was one of the big improvements.

CS: Did nurses respond to that favorably or what did you see?

BP: Yes. I know nurses were upset with what was going on, but what could you do? There weren't enough of us. And I know nurses looked on that as a favorable change.

CS: Did you ever lobby or get active in an organization for nursing associations?

BP: I've been a member of NCNA since '68. I went in there when I was in graduate school. And that's when the registered care technologist's issue came up. Do you know what I'm talking about?

CS: No, tell me about it.

BP: That came up when I was working here between 87 and 90. I can't tell you the exact year, but it was in that timeframe. This was, I'm not sure who initiated it, but it possibly administrators, but I'm not positive. Anyway, it was initiated to have someone kind of like a CNA but who had a lot more autonomy and a lot more patient care. All of them would be under one or two RN. And what it amounted to was ways of getting cheaper patient care.

So, nurses were up in arms about it. And we lobbied everybody we could and carried our banners and did everything we could. Because it was going to decrease patient quality care and it was going to put more responsibility on RNs. And if you are gonna give me the responsibility, then I want to be doing it, or close enough to it to see how it is done. So, that was one time that we really got together. And it was a real fight. And see, the nursing standards are pretty much developed by state board of nursing. But, you have to do it within the realm of possibly. You can't make regulations that can not be implemented. So the state board of Nursing at NCNA fought the registered care technologist issue like crazy.

CS: I want to go back to that conference where you met Peplau.

BP: Hildegard Peplau.

CS: Where did you travel to go to that?

BP: I think it was Washington, DC. I think. It was either Washington or Philadelphia. I think it was Washington. I should have brought that book, with the signatures.

CS: Did you travel with other nurses that you worked with.

BP: I went with one other nurse that I worked with. Of course, when we got there there were some other people that I knew. I brought a different book. <BP got out a program for the September 14-17, 1988 10th Southeastern Conference of Clinical Specialists in Psychiatric Mental Health Nursing > This is the group that I was telling you about, but see I thought you might want to read it.

CS: Oh yes, this is great.

BP: I went to their conferences for years. And then it disbanded in 96 or something.

CS: This is great.

BP: Now that is the first one that I went to. But once I went to that, in fact, I'm almost sure that this where I met Kathy Gaines.

CS: Hmm. Yeah. I like the title of this one, "Ho-Ho-listic Nursing: Intentional Use of Humor in the Health Care Setting." That is great!

BP: Really, I'd be glad to let you borrow it. And then just bring it back to Karen sometime.

CS: Thank you very much, this will be very helpful. Incredibly helpful.

BP: I kept all of the books like that there from those conferences. And the three ways I networked, one was that group. And you'd go back, depending on which state it was in, you'd have more people from North Carolina if it was in North Carolina, you'd have more people from Georgia if it was in Georgia, but you see they were often the same people. And I found how important it was to network and I would have done continuing if they didn't pay me. I wanted to know what was going on. So that was one group.

NCNA has a psych nursing advanced practice council. They also used to have a CNS council. SO NCNA has been very helpful, and I've networked with that Advanced Practice Council. And the third way, Kathy and I are involved in this together, is Peer Supervision Group.

CS: Yeah, you mentioned that on the phone.

BP: She and I are the only ones from the original group, over the years people have come and left if they moved out of the area or they changed jobs or whatever. But she and I were in there since about 20 years. And we meet about once a month unless it is Christmas or something. You see a lot of places I've been I was the only one or the only one with my educational level. And you need peer support, you need someone you can say, "Okay I've seen this work what have you done and what have you seen in this kind of situation?" or you have a difficult patient, what would you recommend. And these are nurses with years and years of experience. So, you need your networking group.

CS: I can imagine how important that will be. This book you brought is like gold, thank you for bringing this for me. I'm looking over these questions, and you've covered so much of what I have on here. Is there anything else you wanted to share?

BP: Yes. I thought you'd never ask. I have collected over the years, and you can make copies of this if you want, writings of patients and here is a poem written by a manic person. If you copy it you can't have the name on it of course.

(BP pulled out a box full of patient poetry and art and showed it to CS.)

CS: Oh my goodness. Patient poetry.

BP: This is one of the nicest things a patient has ever said to me. (Betty handed CS a poem written by a patient about her)

CS: Would you read this poem out loud?

BP:
"I'm very poor in the world of goods
The things I own are few
I count among my treasures
My friendship dear with you

You shared my every sorrow
And the dreams that I have sought
What you've given me my friend
With money can't be bought

There are few I've met along life's way
Who cared about me only
Who came with outstretched helping hands
When I was broke and lonely

I wish I could repay you
But I've nothing good enough to send
Except these simple words I've written
I'm proud to call you friend."

That's why you stay in it.

CS: Hmm. Yeah.

BP: Now this was not an original. Those others were given to me personally. So if you want to make copies of this, you can as long as you take off the patient's name.

CS: I'd love to, and that is important to protect the patient's identity.

CS: Do you remember the cafeteria here? I've heard people talk about the Broughton Brownie. I've heard there was a time period when community members would eat at the cafeteria. They had a really good bakery.

BP: Oh yes.

CS: What are some of the things you enjoyed eating there?

BP: Broughton Brownies are the most famous thing, but we could just get all kinds of good food. Now the quality of the food has gone down somewhat because they don't serve as many people as they used to and I'm sure the cost factor is involved. But when I first started working here, and actually for a while, my husband and I would come over here and eat supper. It was that good. See for a while there were 3,000 patients here, three meals a

day, plus staff and then when what's now a mental center was built, the kitchen here served meals for them there. So you are talking about thousands of meals per day. Thousands. The cafeteria, the kitchen was a big deal.

CS: Were the dairy farm still operating and the hog farm?

BP: The hog farm was still operating, some of the vegetables they were still growing. I'm not sure if the dairy was still in operation.

CS: Did patients help with that work at that point?

BP: The patients did the majority of the work. They had a farm colony.

CS: When did that change?

BP: You'll have to ask Karen about that. There was a farm colony that was started about the turn of the century.

CS: Yes, with Patrick Murphy, the first superintendent.

BP: Anyway, they found, "My goodness, put these people out working on the farm, hoeing vegetables or milking cows or whatever, strange thing, they got better. Sure beats sitting on a ward wishing you had something to do. And that was one of the changes that I thought was detrimental when somebody's ill-guided wisdom they decided that patients shouldn't work. Well, then they had the problem of what to do with them on the ward because they weren't working like they used to.

So, I think that's a terrible mistake. Because a lot of our feeling of self worth comes from whatever job you are doing. And actually the patients that I know that are going to work therapy, of course they get paid for that, they love it. And it is not just the money they love. So people need therapeutic work. Growing vegetables is one of the best things that patients can do. So people who lived on the farm colony had pretty much a normal life, by comparison to the rest of the hospital.

CS: That was still going when you started working here?

BP: Yes.

CS: When you came back in the 70s was it still going?

BP: It probably was ending about the time that I started working here when I came back in the 70s. I was over there while it was still in operation, and I worked here until '73, so it had to have been going during that period of time. But, they used to have the patients do the majority of the work. Because this was a whole city. They made their own clothes, they made their own sheets, washed all their clothes, did the majority of the work on the farm. Worked in the kitchen. And of course you have to remember that at that time there were so many people here in the hospital who really were functional. Now you are down to such a

[situation] that there is probably hardly anybody who can do that. But years ago they didn't get out of the hospital, you brought them and left them there and that was the end of that. So, when they weren't in an acute episode, they're very functional. So, you know, some of them worked just like anybody else does.

CS: These are beautiful poems. I'm glad that you kept these.

BP: I got to show you something else too. I also have artwork done by patients.

CS: Did you do art therapy with patients? Is that what you called it?

BP: I didn't initially mean to, but it worked out that way.

CS: It kind of just grew into that. When you went to those conferences did you start seeing people talking about things like this? Where did you get your ideas?

BP: I'd probably been here about a year, and a student was assigned to a basically non-verbal patient. And she, out of desperation, gave the patient paper and pencil to write.

<there is a pause here as we flip through some different art>

BP: Art therapy, from what I've seen, is appropriate for people who can't verbalize their issues or too little to understand what has happened to them. Or something like that. The people who do verbalize probably don't need art therapy so much. But so many people can't really talk about their issues.

CS: So these are from some of your student's patients. And this is 1969?

BP: Yes. Notice the abnormality of the hand. The student put her hand there and the patient traced it. And then the patient traced her own hand. Notice how it is disconnected from anything. It was around Christmas. So, this is fantasy about Christmas tree and presents, but notice the abnormality of the hand. That is the way she viewed herself.

<showing another picture by the same patient> This is one of the best examples of depersonalization you've ever seen.

CS: Two personalities?

BP: No. This person parts of herself duplicated. She was having hallucinations like that. But this is the way she viewed herself when she looked in the mirror.

CS: It is like Picasso.

BP: One of the most interesting things about the way she drew trees is that the ways she draws trees will change as she gets better. So the art is not necessarily relative to her capability, the art is directly connected to her psychosis.

BP: On this one she just colored it. The nursing student would draw this and the patient would color it. Notice the abnormality of the colors.

BP: <another image> Notice the window, the open part and the chair in-between the legs are all colored in. Even a child won't do that. That is related to schizophrenia. Strange, strange perception of things.

BP: <another image> Now notice how she is drawing trees at this point.

CS: They've got a top now.

BP: This is the same person. The only reason it changes is because she is getting better.

CS: And there is even flowers. There were not flowers before. And the sun doesn't look so angry.

BP: Notice the abnormality of the colors though. <another image>

BP: this is a picture of me (by the same patient)

CS: You look like you've got a coon skin cat or something, Betty?

BP: (laughing) and I don't think my eyes are quite that far apart.

CS: But you get the feeling that she's not scared by you.

BP: Yes. I did have a dress on.

CS: Did you wear a uniform when you first started working as a nurse?

BP: Yes, it didn't last that long.

CS: Did you have to wear a hat?

BP: I did at Grace, but not here.

CS: That is such a treasure that you've held on to those [patient poems and drawings]. It looks like you've shared some of that when you are teaching.

BS: I've shared some of this in art therapy class. The group I showed you at the very last was all by one patient. These others were done by different patients over a period of time.

CS: When we first started looking at these you started talking about how one of your students started this and I asked if you had come up with the idea of art therapy by going to conferences?

BP: No the student that talked with that patient where I had a group of pictures done by the same patient, she was desperate for something to do because the patient was essentially non-verbal. So she gave her a piece of paper and pencil and said, do whatever. And that is what started it. And apparently she said to the patient, ok put your hand down, and she traced it. And then she used here hand."

CS: Did you come up with that idea to do this when she came to you for help?

BP: Well, the student just gave the patient the paper and something to write with. And when the student showed it to me I went "Oh YES! More of this please!" So you know it got to really be a project. It was the student's idea to use the paper to begin with.

CS: Was that one of the first times you'd seen that show up as a way of communicating with patients.

BP: Sure. Because there was no art therapy here at that time. There was nothing like that. And you know I was new to the business, I hadn't been here very long. So the first picture I saw I knew we were on to something.

CS: Did you ever present that at a conference or share that with your colleagues?

BP: No. I've presented it at school to various groups, particularly to the art therapy class.

CS: I imagine there was probably not a lot of discussion of that kind of therapy in formal setting yet, but there you guys had stumbled on it and were seeing positive things. That's really cool.

BP: You have to be able to be open to whatever works for patients. And although I have no personal artistic ability you don't have to be very versed in the subject to go, "Oh, here we're seeing something." So, you just have to be open with what works for the patients as long as it is in reasonable parameters.

CS: Do you remember the doctors seeing what was going on there and how they responded to this?

BP: No, I don't remember. At that time doctors had so many patients, they didn't do much individual care. I don't remember. We're going back to '68. (laughs)

CS: Well thank you so much for everything you've shared, and your career, and what you have done for patients and what you are doing to teach nurses. I really appreciate hearing your stories.

BP: I think it is obvious I enjoy what I do. It's a little frustrating at times, particularly the system, but you work with what you can.