Interview Date:	November 10, 2010
Interviewer:	Carrie Streeter
Interviewee:	Kathy Williams
Location:	Training room on third floor of Broughton Hospital, Morganton, North Carolina
Transcript Key:	CS = Carrie Streeter KW=Kathy Williams

CS: So today is November 10 [2010], and if you would just state your name.

KW: Kathy Williams.

CS: And what year were you born?

KW: 1953.

CS: And where were you born?

KW: I was born in Cleveland County.

CS: And where did you grow up? Did you grow up in Cleveland County as well?

KW: I grew up in Cleveland County, and I still live in Cleveland County.

CS: Were your parents born there as well?

KW: They were.

CS: So the family has lived there for a long time?

KW: The family has been there for many many years, yes.

CS: What education did your parents achieve?

KW: Both of my parents were high school graduates. My mother had an associate degree in nursing.

CS: So she was in nursing as well. And your father? What did he do?

KW: He was a technician, a nurse aide, and a part time farmer.

CS: Did he work here? Did they both work here at Broughton?

KW: Yes, they did.

CS: Oh my goodness, ok. And did their parents work at Broughton?

KW: No. Both of their parents were farmers. We come from farming families. I kind of live in a rural area that predominately was farming up until probably the late 40s.

CS: So when they started working at Broughton was it the 40s or 50s?

KW: It was the early 50s, actually right after I was born.

CS: So you grew up with stories about what was happening, about their careers.

KW: Yes I did.

CS: Oh that is interesting, that's great. Some of this is life history things right now, so have you been married?

KW: Yes, I married my high school sweetheart and we were married 27 years when he passed away. And it will be twelve years this coming Saturday since his death.

CS: That will be a difficult day.

KW: Yeah, if you've ever had a soul mate, I had a soul mate. And I miss him a lot.

CS: That is really sweet. I bet he was proud of the work you did.

KW: He was proud of me and I was proud of him. We had a unique relationship. As close as we were, I don't think we smothered each other.

CS: Yeah. That is saying something. Isn't it?

KW: I didn't realize it I think until I grew older and could sit back and see other people and I could see that this was not how it always was. We did a lot together, and we did things separate. He liked to hunt, so I learned to hunt. Remember I grew up on a farm. So I rabbit hunted with daddy when I was a little thing. But we took trips out West and hunted out there. And he was a plumber, actually a utilities contractor and put in water lines. And if I had a day off and he needed help, I would go help him with that.

CS: Ahh. How fun. Those are good memories. We could talk for hours about that, couldn't we?

KW: We could. (laughing)

CS: That would be fun.

KW: And I am a lucky person to have had him. I didn't want to give him up that soon, but I was so lucky.

CS: Yeah, you enjoyed your years together.

KW: Yes, I am fortunate that we had such a relationship.

CS: Yeah, love makes a big difference. Hmm. Did anyone in your family suffer from mental illness?

KW: No.

CS: So when you thought about career, was it partly the example of your parents?

KW: No. You want the truth?

CS: Yeah the truth!

KW: I had always intended to go to college. That was always my intention. My parents both were very interested in reading and learning and they gave me every opportunity to do well in school, and I did pretty well actually. So, my intention was to go to college.

My senior year I had already been accepted at Western Carolina University. I already had a dorm room, everything ready to go. I was going to major in Math and or Biology and Physical Education. Because I liked sports. And I decided about Christmas that I could not leave Randy. And I told my mother and daddy, I just can't go away. I just can't . And we were already beginning to talk about getting married at that time.

So mother said, "Well there is a program at Western Piedmont Community College in nursing. An associate degree. You know, I'm afraid that you might not stick with it 4 years married, and you might think about that."

And I went, "Well, I don't know." You know, I had never thought about being a nurse. So, I think I'll try it. So I go straight out of high school to Western Piedmont, barely 18 years old. Married. And graduated in two years with an associate degree. I'm still 19 years old, three days when I came to work here at Broughton.

CS: Wow, you came here to work at 19 years old?

KW: I came to work on June 11. I was still 19, and my birthday was June 14.

CS: So, June 11, what year?

KW: 1973. Now to be honest with you, my thought was not psych nursing. Everybody that goes through nursing school has this vision of bedside nursing. Well I did. And you know I wanted to improve skills. And my intention was to go work in a general hospital. And hopefully learn all these skills, which technology has just really gone since then. So when I go to hospitals to apply for jobs, and I look at salaries versus salary here. There was an enormous difference at that time. Not now. But the state of North Carolina rate of pay was much better.

CS: Why do you think that was?

KW: We probably had politicians who were advocating for State Hospitals. I'm assuming, I don't know. But it was quite a bit. And of course, we were married and Randy had been the only person working. And I'm like "Well, I'll make more money. Let me just do that for a few years, till we kind of get ahead." The Lord puts you where you are supposed to be sometimes. And, like I said, I didn't do it because mother and daddy worked here, because it didn't really turn me on just from what they said. But when I came to work here, I realized this is my place. And psych nursing has been my specialty and my love since then.

CS: Do you remember, was there an experience that stands out in your memory? Or did it just gradually become something you realized fit for you? Was it the patients, or was it some of the aspects of the job?

KW: I really am an advocate for the psych patient. I have worked with all areas of psychiatry just about, not a lot in geriatrics. Very limited in adolescence. I have worked several years with substance abuse, that is actually where I first came. Now talk about a wide awakening. I had no contact with alcohol, or anybody who was intoxicated. You know, I came from a Baptist family. And so just the intoxicated state of patients was a new thing for me. But I found it was really, everything I encountered was interesting.

You know, everything was a challenge. I might have been just as taken if I had gone to a general hospital, I'll never know, but it was like every day was something new to learn. And I had an absolutely wonderful nurse manager who was a mentor from then until probably, she left the hospital, I had been here probably 26, 27 years. And I worked with her on and off the majority of that time.

CS: Had she been here for a very long time as well?

KW: She had been here probably 10 or 15 years at that point.

CS: Would you feel comfortable saying her name?

KW: I hesitate to. I don't think she would mind, because I can't say anything but good things about here. But I hesitate to do that, and I wish I could because she deserves the credit.

CS: That's ok. She was probably a mentor to a lot of other nurses.

KW: I never met anybody that didn't say they gained in their encounters with her.

CS: How important do you think that was in your education, or in your learning what it meant to be a nurse?

KW: I think it was foremost. I think her concern for her staff to do the best they could, to learn the most they could—she would arrange different experiences for us to go to seminars. And where a lot of times you'd think that when you had the money available, the manager would go. This didn't happen. She would send staff.

But it wasn't just that, anything she knew she passed on. Anything she learned, she shared. She had the most effective and the best supervision style I've ever seen. I just finished teaching a class in supervision, and I mentioned her and gave several examples. But I have to give her the reason for a lot.

CS: Do you remember something that was difficult that you were dealing with that you went to her for advice?

KW: Yes. When I first came to work here nurses were all expected to supervise.

CS: Supervise patients?

KW: Supervise staff.

CS: Supervise staff? Every nurse was expected to supervise staff.

KW: So, I'm 19 for three days. I'm basically 20 years old, supervising people that were my parent's age. They were technicians. You gotta remember when I first came to work here, nurses were few and far between.

CS: Yeah, psychiatric nursing was very young.

KW: Well technicians did what, now is totally RN nursing directed roles. But because of us being a state institution, their scope of practice was much broader, and legally so. They dispensed, administered medicine.

CS: This is the technicians?

KW: These were the technicians. They noted orders. You might, at one point, and this was further on then what I first started to tell you about. I was the only nurse for six wards all the time.

CS: How many patients would that have been?

KW: Well it was 21 employees. It would have been probably 100-110 patients.

CS: So the attendants that you managed were the ones responsible for giving medications?

KW: Yes, noting orders. And basically what I was, I was the night supervisor if you want to think about it. I was on 2nd shift at the time. They had an issue, they called me. There were certain medication situations that I had to assess, like PRN medicine

if they felt like a patient needed that. Or if I was on the ward and decided a patient needed, that decision had to be made by me. But just the routine orders, transcribing orders, that was technicians who did that.

CS: And so then your responsibilities were of course management of the technicians. What else was on your plate?

KW: Any medical issue, you know I was still the nurse. Any significant occurrence, like somebody cut their wrist, somebody swallowed batteries. Somebody eloped from the hospital.

CS: Were you more the intermediate then with the doctors or the psychiatrist?

KW: I worked closer with the psychiatrist. Now obviously you did have to have interaction with the interns or with the medical doctors, it could be whoever. At that time, we did surgery here. And we had three surgeons on staff.

CS: What kinds of surgeries?

KW: Hmm. Whatever. We did it. Appendectomies. Hips.

CS: So things you would find in a general hospital?

KW: Yeah. We had an anesthetist on staff. We had our surgeons. We had a medical surgical ward. Actually when I first came here, for the first couple of years, when I was on alcohol and drug abuse division, we had a neuroscience division that did neurological surgeries. They actually did something called a stereotactic surgery, where they, I didn't work there, but basically, with someway they would go with in with some leads—I think they actually went through the eye orbit. And, they lazorred a part of the brain to the patients, and it wasn't anything like a lobotomy. Don't get me wrong. It had nothing in the world to do with that. But it was like to try to help with seizures or erratic behavior.

CS: In the 70s that would have been kind of cutting edge?

KW: Yes it was, very much. Occasionally we would get a case in from the community, because we had a neurosurgeon on staff. We got a baby in one time that had been in a car accident. And you know even though I didn't work there, this was one of the things I think was so neat about this Hospital, and it was probably everywhere. The Hospital worked like a family. And when something happened, the whole family was concerned. And when the baby was there everybody was worried about the baby. We were all worried about the baby.

So, we've seen some unique stuff here. That (the neurosurgical ward) left us at a point, and I don't know if that was there funded by something special.

CS: Research or something?

KW: Yeah. I don't know. I can not tell you that. But at any rate, they kind of got a way from the surgery. The physician who was there left. And I won't say his name. And it wasn't long until that area closed down. It still stayed as a neuroscience kind of area, and they tried to take care of uncontrolled seizure patients, and that sort of thing, but there really was not a need for that specialty kind of. So it was treated in other areas after that.

CS: So you were talking before, before I started asking all these questions about these rolls, about a situation when you went to your mentor.

KW: Yes, when I first came to work, like I said, I was expected to supervise these staff like two days out of five that I worked. Because I did work with another nurse. And if she was there then she was the head nurse, which was great. However, she was an older nurse who had worked her for quite a while, and had been in nursing for quite a while. And it was fine as long as it was her idea. But when it wasn't, or if we had a difference of opinion, she wasn't always real nice. And I don't know how to say it exactly, but she could try to make me feel uncomfortable. And I was determined not to.

And Ms. England called me in and she asked for my opinion about an employee, and he was temporary—should we hire him? And I had seen some pretty negative behaviors that the other lady had seen also. So, she should never have, looking back I can't even believe, at that time I was still young enough to believe—well, maybe I'm assessing this wrong. And she was like, oh yeah he's great. We need to keep him on. And she asked me about it, and I said, "Well I'm gonna be honest with you, but I said, now so and so is not going to be happy with my response." And she's like "I figured this." And she said, "Let me know if you have any problems with your supervisor, and your staff, or repercussions." She said, "I expect you to do whatever you feel is right, and we'll figure it out."

CS: So she really validated your, she wanted you to feel like you could speak what you saw?

KW: Exactly. And just because I was new and young, she was not going to let that take away from my value.

CS: That is incredibly valuable.

KW: Oh, you can't imagine. One of the things that was, and looking back I know why she did it now but at the time it made me kind of uncomfortable, she insisted that everyone called me Ms. Williams. Now it just came natural for me to call her Ms. Whoever, but she always referred to me as Ms. Williams. And she knew me, she knew my name, and to the other staff. And looking back, that was her message: This is your supervisor, she is the person who is in charge of this ward, when she was in charge of this ward. And this kind of set the ground for that.

CS: Yeah, an identity. Did you wear a certain uniform.

KW: Oh, we all wore white. Everybody wore white. You gotta remember, this was in '73. I mean we even wore our hats sometimes. Can you imagine? Our dresses with our white hose. Our white, clinic shows and our hats. Our caps. Our caps.

CS: When did that change?

KW: We probably stopped here before other places did. But it was sort of optional. We had a few people that wore those caps up until actually the early 80s. But now, I gave mine up right off. It was aggravation to me. You know, it was like in my way and that sort of thing. But no, I still worked with some nurses up until, I'm sure it was the early 80s, I can think of a couple of ladies who wore their caps every day. And you really, it would have been odd to me if they hadn't. Because that was them!

CS: Right, part of that identity. So, I would imagine in Morganton, there were a lot of people that worked at this institution. So did you sense anything special, or was the community supportive, or was there anything that you felt as a stigma about your career choice?

KW: Well as the community goes, you gotta remember I live in Cleveland County. So I am 26 miles from here. But having worked here as long as I do, I shop here after work and that sort of thing. So I'm very familiar with Morganton. I think the town as a whole has always been receptive to the state institutions. But I'm also going to admit, that the state institutions, I'm saying institutions because there are three right here together and if you go further there are correctional centers here also. That is probably a big income and big economical input to this county, I would guess. So, you know as far as the town and the people I didn't really pick up a great deal of stigma in that. I think it was outside of this direct area, and you still do. You still do. And that's really the things that anybody who works in psychiatric, in the behavioral health area, need to be advocates for the fact that mentally ill are just ill. They have got an illness that requires treatment just like anybody else who requires treatment.

CS: Did you feel like you really learned that in your training? You know when you were 18 or 19? Or is that something that really sunk in as you worked here?

KW: It is from working here. As far as my nurses training, I don't think so. Now you gotta remember two years in nursing school, you know I was getting facts.

CS: Did you have any kind of clinical experience in those two years.

KW: Yes, yes, oh yes. But what can you get in two years? Here again. I even worked as a nurse aide the summer between those two years and took some classes too to try to get more experience. But, I'll have to be honest. I learned an enormous amount of what I know after I graduated. I had the tools to be able to learn it with though. I'll

have to say that I was as prepared as they could have made me in two years. I had a good base of knowledge and a good exposure to different situations and that sort of thing. Actually my first patient that I ever witnessed to have DT's.

CS: DTs?

KW: Delirium Tremors, withdrawals from alcohol. And it is actually called Delirium Tremors I think is what it is. The first patient was in the emergency room when I was a student nurse. And I got to actually start my first IV with this guy. So, you know you never forget that first IV. But that one was ohhhh. And I was like, "What's wrong?" And they said "He's in withdrawal, he's got DT's."

You know I'd go read about this, and I'd find out about this. And I found it interesting. That was another thing that I tried to do, and I just love the Internet. I hate that we didn't have it when I was younger. Because when I see something new, I want to know about it. And actually not only were my supervisor that I had then and others, were helpful. I found the physicians that I worked with to be wonderful teachers. I don't know if that happens everywhere, because I had this experience. But I feel like so much of what I know about psych treatment and medication have come from different physicians that I worked with.

CS: Right. So you felt like they were approachable? And wanted and would be willing to have those conversations? Did you see that they felt you were part of the team?

KW: Oh definitely. And I wonder if maybe more, I don't know, but I got the feeling that, especially years ago—listen when I graduated and you were in the nursing station and the doctor entered, you stood up. O.K. Everybody stood up. But here, our opinion was very valued. We were asked, we were expected to be able to assess and pass that assessment on. And always because probably we didn't have the presence of, especially physical physicians as much and maybe not even psych, but on 2nd and 3rd shift you had an on-call.

CS: A doctor or a psychiatrist on call?

KW: On call, yeah. And we are talking about 800 to 1,000 patients with just an on-call physician is trying to take care of. So you had to be prepared to give them a good assessment of what is going on, so they could cut to the quick of it and take care of it. They didn't have time to wonder if you knew what you were talking about. You know many times it was done over the phone.

CS: Were these things about mental issues or physical issues?

KW: Could be both, could be either. And now they always had a medical doctor back-up. You always had a psych on call, and because we admitted 24-7, and you also had a medical doctor who was on call, and if the psych couldn't take care of it, they would then confer with the medical doctor.

CS: Would they sometimes say, "Hey will you keep an eye on this patient, this patient, this patient?" Would there be a list maybe, or how did you know? Was there any communication there about particular acute patients?

KW: We got good shift reports. That was always a big issue. And here again, going back to that first supervisor I had. And I'm gonna go ahead and call her name. Miss. Bradley. That was one of her things that we started doing. We kept a log. And you entered basically what you had done for a long time on card-ex, now I think it is on a nursing communication electronic type thing now. But we kept that log book. And if she discovered about certain things that happened on your shift that should have been logged in and past on, cause that way somebody said something about that, now let me go back and see, she would mention it. And she was supervisor that could say, "Kathy I just don't believe you got all that down like you needed to, did you?" And you still didn't feel like you had lost her support, or it was just basically, "I'm your supervisor, this wasn't done just exactly like it should have been done, so I'm telling you."

CS: She just wanted you to learn?

KW: Exactly. But you still just had so much a feeling that she respected you, and she realized that everybody wouldn't always be perfect. But if it wasn't perfect, she was gonna try to make it as perfect as she could and help you make it as perfect as you could. And you wanted her to. I mean it almost got to the point where you appreciated it, and I did. But we did kept good shift reports. And we knew how to cover so many wards. Like when I covered the 6th. And just to be honest with you, when another nurse was off, which meant at least 2 days out of 5, I covered 10 wards.

CS: Wow. So that would be?

KW: Well each of those other 4 wards had 24 patients. So you are probably looking at close to 200 patients. Two of those wards were what we called high control then, high management. Aggressive patients. One of them was a theft ward of psychiatric mentally ill patients. Six were general psychiatric treatment wards that walked. Meaning they had to stay on the ward unless they were supervised off-ward. And they were being treated, usually less than 90 days. But they were expected to be discharged back to somewhere.

Then we had a special open ward that had some longer term patients. And the ward was actually left unlocked at certain times of the day, and patients came and went as they wanted to as long as they went to the activity they had been assigned, or their work assignment or whatever it was. So I had a real variety during that time. But what we would do during our shift change was you sat down, I took my little pad. And I knew who was physically sick, who had an elevated temp, who had a seizure that day. Who was on suicide watch. Who's aggressive. Who's been in seclusion. We actually never used restraints in that area. It just wasn't part of it. Who had been in altercation with who. You know who had had to had seutchers

because of it. You knew exactly. And to be honest, I knew the patients in both areas just as well.

CS: in the restricted and not restricted areas?

KW: Well, I was primarily assigned to my six wards, but I knew those other four just as well. I knew those staff just as well.

CS: Just a really quick question. Was there unique funding for your associates degree, was that federal funding or grants?

KW: No, however, because I had good grades and graduated pretty high in my class, I got a scholarship from Cleveland Memorial Hospital Women's Auxiliary for $500. Which was a pretty good amount at that time. The only requirement was that I work for at least one year at Cleveland Memorial Hospital. And that is really what I had intended to do. But when I started looking at those jobs, I can pay this $500 back in like two months working here. And Randy and I looked at it, and we were like—I really don't mind working at Broughton for a couple of years and then I'll go get some experience you know. And I said this is really going to help us. Because we were already thinking about buying a home.

And I couldn't wait to get of nursing school, you know the day I graduated I quit taking birth control. I was ready for a family. And so, I'm like, I'm just gonna do this. And he was like, "Whatever you want to do is fine with me." You know. Whichever. If you want to work at Shelby, that's fine. I'm saying Shelby that would have been Cleveland Memorial. Or if you want to go there. And I'm like, well let's just do that. And I paid it back in two years. And my parents helped me some.

We were close. My parents are deceased now, but we were very close. And my mamma and daddy were great. And like I said, they were always encouragers. Actually to be honest with you, my mother had worked here for 20 years before she went back to nursing school. She started at Piedmont maybe a couple of quarters before I did. But she actually graduated the year after I did because she actually worked the whole time. And her reason for not going sooner, first of all the program had not been there all that long. I graduated in '73, and I want to think the first class was maybe in '68 or '69, I could be wrong. But anyway, she had to work.

CS: And it wasn't required for her to have a certificate?

KW: Well no. But she was a smart lady, and she was doing a lot of the work.

CS: There was an increase in her salary?

KW: Oh, big increase in the money!

CS: Was she an attendant or a nurse?

KW: She was a nurse aide. Or technician. We called them technicians here, or did then. Yeah. Talk about coming out and being a good nurse, see she had all this background. To be honest she was very helpful to me.

CS: Was she working here, when you were working here?

KW: We both worked here. We actually took one class together. Yes, yes we did. But you know that was such an inspiration to me to see her go back to school. My dad was real supportive and he said, "I don't want it, but you know as long as your mom does." He didn't want to go back himself. He said, "If your momma wants to that is great with me." And so she actually worked the last 10 years as an RN and retired with 30 years of service.

But, the only reason she didn't go before then is because she had a family. And my sister is four years younger than me. So she wanted us to be old enough to be able to do whatever we needed to be able to do without her going to school and taking anything away from us. And she did. And I did the same thing. I waited until my children were grown. This was before Randy died though, I had actually started back to school. Because he knew I had always wanted to go on.

I could be a professional student if I had the money. And I talked about it and he said, "Now why don't you do that." And he said, "The kids are grown, they are doing their own thing. You know try it, if you don't like it quit." And I was already, I was into it that I was ready to start into the BSN program just right before he died. So, actually Phoebe had me for that. She's fantastic. It was kind of nice that I had that, because it gave me something to have to do. And of course I was still working here too. But it was hard to work for a while there.

But I did the same thing Mom did. I waited and now I'm going back to work on my Masters. I don't know why. See I'm retired from here. I'm just working part-time here. But I'd kind of like to maybe teach in the school of nursing area.

CS: Helping teaching psych nursing?

KW: Psych nursing, yeah. If you want me to do psych, great. Beyond that, I'm probably not going to be very good.

CS: You've got so many good stories, thank you. Let's see. So what kind of job titles have you had throughout your career? Have you always worked here?

KW: Always here. Except for two semesters that I worked at Cleveland Community College as an adjunct instructor in their CNA program.

CS: You've touched a little bit on how your mentor nurse would send you to some conferences and other events. Did you enjoy professional organizations? Did you find those to be valuable to you?

KW: Upon her encouragement, I did join the American Nursing Association and was a member for quite a few years. And I probably never would have done it if it hadn't

been for her. But she came one night when I was working 2nd shift and they were actually having a meeting. And she told me something about it, over at what was Western Carolina Center at the time. And she said, "I'm gonna come get you at this time, and we're going to go over there." And I thought, Ok maybe I do need to do this. I'm telling you this lady was just so inspirational and so beyond her time as far as, most of nursing we were still the hand maid, you know.

CS: Just the extension of the doctor?

KW: Yeah. And you know, do your role. I guess here there was a little more than just the hand maid, because we had more responsibilities simply because we did supervise so much. And we had to work with the direction from the physician, we had to work independently some. Now there was always that scope of practice, and we were very careful that we did maintain that. But, probably with more independence than we would have had anywhere else. And I think I liked that. I liked that being able to stretch. And to step out and to learn and then be able to use that, so that I didn't feel like I was just stuck. And I think that she was able to see that more so than most people at that point then.

CS: Did you see her giving that kind of same encouragement with all the other nurses? Did she want to play to their strengths?

KW: I think it was to everybody. To the technicians. You know when we went to training, if at all possible the technicians went also. If it was something that would focus to a need that they had or if it was something that was of an interest that they could gain something from. It wasn't just nurses that went.

The first thing I ever went to. I was pregnant, I got pregnant right off. Love it. Wanted it. And we went to a seminar about treating alcoholics. It was like a two-day seminar. And actually I think I may have been the only nurse that went. I think it was like two or three technicians and one of the psychologists went. But no, she sent, she showed respect and value for every staff member that she worked with.

CS: That would make a big difference.

KW: It did. It did.

CS: Did you join, there as like the American Psychiatric Nursing Association?

KW: I never did. And looking back I wish I had.

CS: But that was pretty new, I think it was like 1967?

KW: It was, but I still need to that and I may. Because I think I could keep up with stuff. When I was working in the clinical area when I was on the ward taking care of patients, you were almost so busy with that you didn't take time for a lot of other things. And see I had the family too. But I wish that we could have, in some way,

make it so that nurses had time available to them to actually explore some of the things that they are interested. If it wasn't anything more just to go into the computer lab and search the things that they want to know. I think they would pick up on some stuff like, hey I'm seeing this in the American Nursing Psychiatric Association.

CS: Right, finding what other nurses say about these kinds of things.

KW: Right, and I think you would be more inclined about it. Because since I have gone into education, working here in staff development, working here and going back to school, I'm seeing that surface a lot when I'm looking at psychiatric issues. And probably that would be something I would consider.

CS: So what do you teach now here?

KW: Well, part time right now and the primary thing they want me to focus on is supervision.

CS: O.K.

KW: So that is what I'm doing right now. I have done when I was here full time in staff development, continuing med-ed, because all nurses here have to have 5 hours each year, and I taught a CNA class here, policies—anytime we had an update in policy. So, some of my classes were focused directly to technicians only. Some were directly only to nursing. Some to multi-disciplinary approach like sometimes psychiatrists and doctors would be there.

Actually we did an overview of the concepts of psychiatric behaviors to some of the adjunct support staff that were just interested. They said they had to go on the ward sometime sand they really didn't know what we need to think about. Recreation. RT people were there. I think I had social workers that came. I did that same thing for the Broughton Police here. A lot of training for survey readiness, standards, national patient safety goals. Accrediting agencies, I've done a lot of education to meet those requirements.

CS: When did you start working in staff development then?

KW: 1997.

CS: You started working in this in a very interesting time in mental health treatment, 1963 is that Community Mental Health act that Kennedy passes and they start to try to deinstitutionalize a lot of things. Did you see that happening here? Was there an interest in having patients go to community centers?

KW: Yes, but you see, you gotta remember. '63, that was already kind of in place. When I came here we worked very closely with the local mental health clinics. I can give you some second-hand history if you want to hear it.

CS: Yes, please!

KW: Because my parents worked here. And actually my dad was the one that told me about this. And it would have been mid-50s I'm gonna guess. You gotta remember, there wasn't even much treatment for the mentally ill until the 1950s. So when they started working, they were just starting to beginning to have the Thorazine, that was the first anti-depressant. So they are just sort of beginning to have this. And they had been here working a few years, so it may have been '55 or '56. And they decided that the state institutions would have to be integrated. Which meant that if you were from the counties that Broughton Hospital served, it wouldn't matter, you are going to go to Broughton.

CS: Instead of Goldsboro?

KW: Right. Because to begin with, Broughton was all white, Dix was all white I understand. Goldsboro was black and I think Umstead was black. I'm not sure. Find that out.

CS: I will find that out.

KW: So, I'll never forget Daddy telling me about it. And he worked with, at that time, he worked on admissions before, but at that time he was working with chronic long term care, ambulatory patients. He said "His little old men." And he loved them and he loved that. He said it was so sad. They pulled up here in busses and they filed off of those busses with their little things in their hand, their belongings and they didn't have a clue where they were going. What they were going to face when they got there. It is always chaotic when you are moving that many people, you know?

CS: They were moving them to the community mental?

KW: They were moving them from Goldsboro to here. The black patients.

CS: O.K.

KW: Because they probably were from the western counties. And he said they would get off in that little line with their clothes and whatever. And here you would see them going across the campus. And he said we got our little line of patients. And he said some of them couldn't tell you what their name was enough that you could understand maybe, and they had trouble with having good records, and they were scared. And he said it was a sad orientation time. He said, you know, after a little bit everything settled and we knew them and they knew us. And they got to the point that they realized they were not going to be a harmed. But when you are moving people who are not maybe processing as well and as quickly, it can be frightening.

We found that when we moved patients from our admission wards to the long-term ward, they had a transition period there where a lot of times they would

digress a little and most of the time they didn't want to go. And how we did that sometimes really helped the patient. When we would walk out there with them and introduce them to the staff and other patients and that sort of thing, we found it really did help them not be as frightened of the new setting.

CS: Was there a time period here, or maybe even in your parent's experience, where a lot of patients were moved from here to local community centers or nursing homes or boarding houses?

KW: Ok. Yeah. And that has continued to happen some, because we have continued to decrease our beds. It did begin more I think later in the 60s and we were still seeing that some in the early 70s, that big movement. I had been here less than a year when they did a total reorganization of the hospital. And at that time, we went from like six special areas to 11 or 12 maybe more than that. We had what they called A unit, B unit, C unit. And those were all general psychiatric units where they were admitted. And certain counties went to A.

CS: Ok, so it was organized by county?

KW: It was at that time. E unit was more for surgery. That was our med surge unit. F unit was substance abuse, that is where I went to work. G was geriatric, that was it. That was what we had.

SO then they reorganized. And they kept going with the letter. H, I, J, K, L, M, N, O, and P. We had that many new units.

CS: Was there still county organization?

KW: The counties just stayed the four. But once they were in the county area and it was assessed that they were not going to be able to go back home, for whatever reason they were not stabilizing well enough to leave the hospital, then, I said the counties—now "G" admitted all geriatrics, anybody over the age of 65. So if they were in those geographic counties and it was obvious that they were not going be able to go right back home, it was going to take a little longer and maybe a long time, then the decision was made was what specialty do they need. And remember "F" is still admitting substance abusers. So they are unique. "E" gets transfers to them because they are sick for whatever reason. So if we go that route. "G" is still geriatric admissions, pretty much not keeping them too long. Probably sending them out to rest homes or nursing home. "H" became rehab.

CS: For substance abuse?

KW: No, behavioral rehab. And I mean it started out as a very assertive behavioral rehabilitation. To the point that <KW asked the next bit not be included in the transcript> There were very rigid training programs, gaining privileges based on things. Tokens big time. And really very individualized, personalized orders. Very

rigid but very individualized. It was really fascinating. I never worked there, but I liked to find what was going on because it really was fascinating, "H" Division that was behavior rehab. Primarily driven by psychology. Obviously.

CS: And research and experimentation and that sort of thing?

KW: Yes. Ok. "I" division was intermediate care. And those would have been those ICF patients that we have still. And they actually surveyed under different standards, they were surveyed under ICF standards. "

"J" was when we first started having a separate adolescent division. "K" was geriatric psych care. So if you came in on "G". No "K" was geriatric admission. You came in there. If it was going to be admission and quick care, you stayed there. If not you went to "G" division for a longer term. And actually in "G" division they worked with a skilled nursing facility that was totally under the umbrella of the hospital, but their survey was totally different as a skilled nursing facility. It was called Twin Pine. That would have been "K".

"L" was organic brain center. "M" was long-term chronic males. No "M" was mental retardation. A whole unit for that which was really valuable. When they closed that down we saw the repercussions of that in other areas of the hospital, definitely.

CS: Why?

KW: Because it really is to their benefit. You can have much more therapeutic environment and therapeutic interventions for those mentally or cognitively impaired are together, than if you've got them with other general population.

CS: Their needs are very different?

KW: Yes. Very different and it is hard to give needs both places if they are all in the same house so to speak. So "M" would have been mental retardation. "N" was the chronic male kind. And you are hoping those eventually got to go out to rest homes. "O" was high control. Let's see. No. "N" was high control. "O" was the deaf ward. And "P" was just long term care.

CS: Were you 20 or 21 when this happened. Do you remember your reaction to this reorganization?

KW: For what it's worth, I don't know.

CS: Yeah, you were a young new nurse.

KW: And it didn't affect me that much, because you see I was in the substance abuse. So all we did was actually expand into another ward, and when we moved that was a unique first experience. Since then I've moved hundreds of times it seems like. But I did see the rest of the hospital really struggle. And the reason is that staff were

reassigned also. Some were reassigned to areas that they hadn't worked in many many years, for instance my dad. He had always worked with his little old men on 36 and 37, that is where they were.

And when they reassigned, it was really a compliment to him because they reassigned him to an admission ward, which they tried to get staff. I mean admissions are pretty fast paced and you got to be able to keep moving and that sort of thing. But he just didn't want that. I don't want to leave my little men. And he actually went to, they had the opportunity to do this, he went to the director of the hospital and he said, "Dr. Gibson, I'll do whatever you want me to do, but, he said, I would really rather be with my little men." And that is where they let him be. Because you had other people who wanted to move around. They probably had other people who thought, "I don't want to be out here with these little men." Because they are incontinent sometimes, but you know Daddy loved to make them comfortable, and huh that was his thing.

It didn't affect mother's job. She stayed basically where she had started out. She was in, I guess it would have been three wards at that time. It was a non-ambulatory medical kind of situation. Many patients who were not responsive, they were bedridden. They needed total care. At that time some of them would come in with numerous bed sores. Ahh, just horrible. A lot of intense care. And medical care, but in a more chronic fashion. So that is where she was.

CS: I think it is interesting that patients were admitted into a county system. Why do you think that was? Was there any cultural reason for that?

KW: There was a reason behind it. Alright remember now, we are still in the move to community treatment, and for them to be able to return to the community, which is great. If they can get the services they need in the county in their community, it is much easier for the patient. It is much better for the patient.

CS: Is that because the family is near?

KW: Well it is probably cheaper in most situations. A lot of these folks they had to drive hours just to come visit their family. So, there is probably less expense, greater support if they had church and family and community. You know and friends, it was more conducive to them to get that support. So we are still trying to do that. We liaisoned very intensely with the communities. So in order for us to be able to do that, if you were, and mental health clinics and I think they still are kind of grouped, at that time they would be Blue Ridge. There would be some of the mountain counties, and then you had Smoky Mountain. And then you had Piedmont, that was Davie and some of those down there.

Foothills, I worked with foothills a lot. And I'll tell you about that. That was some interesting work. Foothills was Burke, Caldwell, McDowell, and Alexander. So, if you had all of their patients from Burke county in one place, they would come to the hospital once a week, twice a week maybe. And here we all are. We'd have our staff meeting. They would come sit in on the treatment team meeting. And we would talk with the patient, find out how they are doing, what do you think they need?

They could give us input on what went on before they got to us. A lot of times we knew before a patient ever came to the hospital. We would hear so and so hasn't been in for two visits, you know. They've missed their last two appointments. We know that they've probably run out of medicine two weeks ago, you know that kind of thing. So we would already, well they might say, we've already have calls about it, their family, you know would give us a heads up. Or we might say, "Now when they get home, you know they are going to have trouble with transportation. So they are probably not going to be able to get their medicine unless somebody is going to be able to help them."

CS: This is fascinating. This is a treatment team of the nurses, the community mental health people. Were psychiatrists there?

KW: Yes, psychiatrists. It actually now, and I don't know how long it has been there, but I know it has been, I was aware of this probably as early as '85 maybe, might have been a little later. In order to have a treatment team to be sanctioned by joint commission, you had to have an RN, a psychiatrist, a doctor, and a social worker. So those disciplines had to be there. Now hopefully we had a liaison person from the mental health center. We had a technician that worked with the patient day in and day out. We had the PA, who were taking care of their medical issues. We had recreation, who had probably done a lot of activities with them, they could give a lot of input. If they had any kind of referral that had been made to OT or PT, they would have a representative there. We had nutritional services, registered dieticians, if they had special diet needs they would try to be there.

CS: And this was like a weekly meeting?

KW: Weekly yes.

CS: By county?

KW: Well we usually did everything on one day. If they knew we were gonna do theirs before, or after lunch. Sometimes it was a time that we had treatment team most of the day on Tuesday and half the day on Wednesday. But it was so good! Because we were able to give the patient more what they needed because we understood more what they needed from both ends. When you are blinded to a certain part of what they are going to face and encounter, you can't help them with it.

We got a little lady in, and this was a very unique situation. She came in with some mental issues and untreated TB. And we found out, and we found out from a mental health clinic. She had been diagnosed. She knew she had TB. She had even been given medication. Her husband who also had some mental issues would not help her take the medicine. So we had to work with her and a husband that is not real stable himself and her going back home, to be treated for both this mental illness and the TB, and our solution was to get the health department very involved. And they did almost daily kind of thing, until we got her.

CS: But you knew this before she came and you were able to talk about it?

KW: We knew what she was going to need when she got on.

CS: So were those meetings in place when you started working here? OR when did you see that?

KW: Hmmm. Probably and I can't tell you for sure, because with substance abuse patients they didn't stay that long. Now, yes we had a social worker who did a good follow-up appointment. And we got them hooked up with all kinds of rehab stuff when they left the hospital. We actually did a little rehab ourselves, I didn't work that much in that area. But a lot of times if it was going to take much rehab we would transfer them to an alcohol rehab center. I would always try to get them an AA visit of some fashion, and we had AA meetings here and we tried to help them out with an AA group before they went home, but not as much this individual county wide support. Sometimes if we had a unique situation, we would actually call and say could the liaison person come by. But that was not usual.

CS: Are those kinds of meetings happening still?

KW: I don't know. It was as much as two or three years or ago, somewhat. Now you got to remember, that the communities have lost a lot of their resources. They are left with working with fewer staff, and with less money. And it's a shame. It's a shame. Because I've not seen as much as we probably have got.

Well let me tell you about the Foothills. I worked the second shift and I supervised all those wards that I told you about.

CS: Yep.

KW: Alright. I had my 2nd child and I wanted first shift. While I was out on maternity leave, they called in September. We are going to open up a new ward, would you be Interested in it. And I'm like, "Well, what do you mean?" They said, "Well, it would be a 1st shift position." I said, "Well sure, I want first shift this would be great." Well what I come to find it is a co-ed admission ward that provided services to all of Foothills patients.

CS: And Foothills is?

KW: Burke, Caldwell, McDowell, and Alexander.

Now within this same CU, there was still some other counties that were on other wards. But they wanted all of their patients, this is the thing, they wanted all of their patients on one ward. Great. To have them all on one ward, and Foothills were wonderful to work with, and probably I felt, the best about sending patients home and out of the hospital during that time. Because I was so aware of who they were

going to be seeing, when, and if they needed a case manager to get that set up. I mean it was just so, the strength of the discharge plan and focus was so great.

The downside of it was, have you ever had manic men and women on the same ward? You can not imagine. And we just had to be real creative, and real vigilant that everybody stayed where they were supposed to stay. Because when there was a common area that they could go sit down and watch TV, and they could mingle around in certain parts of the ward together. But the ladies did have their own restricted area that they could go chill and watch TV, they had their own sitting room. But, manic men and manic women are very disinhibited, that is part of their illness. And it was really unique. I loved it. But it took some good staff. I had good staff, I worked with good staff.

CS: Did you notice any significant cultural differences in patients or family from the mountains versus other areas?

KW: Absolutely.

CS: How would you describe that?

KW: Well, beliefs, as far as medical treatments, what is going to work. The patients themselves sometimes would have misconceptions, and most of them were from more secluded, rural areas.

CS: Are you saying they were maybe more hesitant?

KW: Well, hesitant and not sure that they were going to ever get out of here. That was one of the biggest things I think I saw. Especially with patients who were from the northwestern counties, the western counties. They thought we might keep them here for the rest of their life. Then years ago, I understand, of course I never heard mamma or daddy say anything about this, but my understanding was that a lot of people were placed at this hospital and forgotten. They basically went back home and had a memorial service and that was that. I can't prove that, but I've always heard of that.

You always have to take culture into consideration when you are caring for patients, well that is a big thing—cultural competency and that sort of thing. But there is a lot to consider everywhere, and I think in psychiatry especially because of the disturbed thought processes and the frequency and opportunity to get misconceptions and the confusion that just go with the fact that people have a thinking disorder, that their thoughts are disordered. And because of that you have to think not just from where they are from.

CS: So from what I'm hearing it sounds like maybe a lot of the staff and the nurses that worked here in your career were from this area?

KW: Yes.

CS: And they may have been more aware of some of the cultural needs. Do you see anyone new moving here that needs that training or has had a hard time adjusting or noticing cultural things?

KW: I didn't see it much before I left the ward. I have oriented more nurses and CNAs that I feel are not home-grown. They are not from this location, so I really don't know because I haven't been able to follow them. I don't know if they have any issue or not.

But one thing that I have seen, the biggest cultural difference I have seen have been more with our physicians and our internal population. Because we have always had quite a few physicians who were from other countries. Just like our three surgeons were from Korea, all three of them were Korean. I have been able to identify some things with some of our physicians that I know were cultural kind of issues. One of the physicians that I loved to work with, he was just so great, the most gentlemanly man you could ever meet, oriental, actually he was a hematologist, really good. But he had a little bit of a, and he didn't realize he had it, a little bit of hesitancy of accepting suggestions from women. So we learned to try to give him assessments without making suggestions so that it would be his idea. But they couldn't help that. They were from other cultures.

We used to get a lot of medical interns. Like was in the detox area, we had quite few Vietnamese. And they had a horrible time with the language. We had more times to be working with physicians than with other areas.

Now with the patient population, we had a few patients who didn't speak English that we helped occasionally that we treated. But not often. And now it is very common to get Spanish speaking patients obviously, Vietnamese, Laotian, Hmong. We've got a large group of Hmong in the McDowell area. Anyway, so the cultural differences relay more, I think as far as with patients go, and maybe more with our physicians. Now nurses I'm beginning to see, and technicians, a few more people moving here who are obviously not Burke or Cleveland County. And you can tell that from my accent, well you can from them too. I spoke with a really nice nurse yesterday, and I knew she was not from here, but she spoke quite well. And as we began to talk, she shared that she was originally from Germany. And I don't get the feeling that she is having any issues with cultural differences. But I think we are seeing that quite a bit more. Quite a bit more.

We've got a real variety of physicians who are from other countries. Middle Eastern . . .

CS: Medical doctors and psychiatrists?

KW: Yes.

CS: Interesting.

KW: I worked with a psychiatrist who was from Egypt. Great psychiatrist, great psychiatrist.

CS: Do you see anyone trying to identify maybe what is understood as a stereotypical Appalachian culture? Doe that figure into your conversations at all or to your way of operation?

KW: We probably handle it better than most because we are close enough. Some of it probably still trickles down to us. There is Appalachian culture. And yes, we have. An example is language. There are some words that we just learn. If you had a family telling you that somebody was having fits. What do you think that would mean?

CS: Not sure. Nervous things?

KW: They were having seizures, or their family had seizures.

CS: So you had to know that word "fits" meant seizures.

KW: And that is just one example that comes to mind. I'm sure there are other things.

CS: I've heard nerves.

KW: Yes. Nerves.

I had an African-American patient one day come up to me, and you could tell he was having side affects to their medicine because they start holding their tongue and feeling in their mouth. And he was doing that. And my first thought was, he was having side effects. And it was close to shift change, I had several African-American employees that I worked with but they didn't happen to be there that day. Or else they didn't tell me, I don't remember. And I was trying to figure out what was wrong with this man. Because I'm thinking it is side effects and I'm asking all these questions. And he kept saying, "No it is roots, it's roots." And I said, "What?" And he said, "Got roots. Got roots in my mouth." Well I just didn't know what in the world.

And one of the technicians on 2nd shift came around I said, "Can you help me figure out what is wrong? He looks distressed, and I can't figure it out." Well he said, "I've got roots in my mouth." And the technician said he feels like somebody has put a curse on him. That is what a root is, a curse. And I never had heard it. And I kept talking to him, and it was side effects. But I had thought he had something in his mouth. Has he swallowed a pencil or something? You know what I'm saying? Because I did not know that roots meant a curse.

CS: What a good example of how language and background take into account.

KW: Language can really make a difference. If you are not familiar with those Southern terms and Appalachian terms or African American terms, you know?

CS: That is very interesting. Well, we've covered so much. Thank you so much.

KW: Well, I've probably given you more than you wanted.

CS: Oh no, I'm fascinated by this, so I really enjoy it. I really enjoy everything you are sharing. I guess if you think about, in your 1973, and maybe in that first decade, is there anything that comes to mind as a very significant change, either in your roles and responsibility, or you just described this big reorganization in the hospital, is there anything else that comes to mind in those first 10 or 15 years?

KW: Ok. A couple of things happened. We began to function more with a treatment team approach. And that really began in the late 70s, but 77 we were already into that. And it was an interdisciplinary, not a multidisciplinary, but an actual interdisciplinary interaction.

CS: With all the people involved with patient care?

KW: Yes, and that eventually ended up into an interdisciplinary treatment plan. Now nursing was still making their own nursing care plans, but eventually that plan was actually incorporated into one, global plan. That was a big change. And we each had to kind of figure out, and I guess it was kind of nice, because we were able to help set the role of the nurse. What our role would be, our guidelines and kind of the input that we would have. So that was sort of fun.

CS: Who asked for that? Who asked for the input?

KW: Well, I don't know if anybody just asked. It was just the culture. And when we gathered into our group, and I guess it was under the overview of our supervisors or managers, they call them chief nurses back then, in that our input would be in this fashion, and it just sort of developed. We knew what our role was going to be.

CS: You were informing that?

KW: Yes, we were saying this is something that we can do. You know, we can be the scribe, and we were, which we never should have agreed to do, which we figured out later.

CS: Scribe for the doctors notes?

KW: No of the treatment plan. Remember now, we did one big treatment plan here. And even though the doctor signed, still everybody's name went there as being part of that treatment plan. So, you know. But there were different things, and your treatment teams were different. Each one had its own personality and that kind of thing. But that was unique, you know bringing everybody in, and I liked that. It gave me an opportunity and a good view on this is what the patient needs now how can I get it. If I know my patient, and I took that, I guess most nurses did, but I felt like my role was to advocate for that patient's needs, not just their nursing needs but their needs. If I knew that they didn't have a job, you know that is when I said, "You know they don't have a job, they want to work." I talked with the Doctor and he agrees

that they are able to work, can we get them into Vocational Rehabilitation. So we used to send a bus over there everyday. So we were able to get Vocational training for our patients, and a lot of times they had a job when they left out of here.

CS: And you were the advocate for that?

KW: That was the role I took, yeah. I could say, "I see them being poor money managers here. They will give their money away to other patients if we are not careful. I am afraid they won't understand where they need to go get their medicine. The liaison person from Burke County would refer it to a case manger. And then we all talked about it. But it let me feel like, and other people came in. They might say something to me like a nursing thing. Rarely. They didn't meddle in nursing, but if they wanted to they could. If they wanted to say, hey Kathy I just found out that he's been seeing a doctor for whatever, you might want to check. And then of course I would track it down. So, everybody was doing all that they could do to get the most and the best care for that patient. It was great. It was a good feeling. It was a GOOD feeling.

CS: I bet. And very validating, and empowering.

KW: Yeah. And I think that everybody else got the same feeling, you know. They felt like you know we've got so many resources here that we can plug into to get what this patient needs, and everybody was very cooperative and working together. It was a team effort. That was a change.

CS: That was a change. You saw that in your first 10 or 15 years.

KW: And the next thing that affected my role was, and I don't know where this came from, but probably the Board of Nursing, in fact I'm sure it came from the Raleigh offices through the Board of Nursing, but it was CNAs would not be allowed to administer medicine. So it was good because we were able and had to hire more nurses. There was a need to hire more nurses. And that took more of my time, which I kind of liked.

CS: Was that because you had more time with patients?

KW: Well, it was because I am OCD a little bit, and I like to know that my orders, I mean I would still go back and check a lot of times to make sure the orders were transcribed right. You know, I would observe medicine passed. Because I wanted to see how hesitant the patient was taking their medicine. If I knew they resist it here, I knew they wouldn't take it at home. If I they were saying. "Are you sure this is the right medicine? Are you sure I'm supposed to take this?" You know if you have to go through that every time you hand it to them, you know they are going to be just as guarded about it when they get home. And they probably wouldn't take it. And that gave me that information. So, it was just some part of my nursing role. I just felt like that was part of the role I should have been doing all along. Anyway, so I didn't mind

it, but it did take some of my time away from some other things. And it did require that we had more, and here again I'm on 1st shift and we had more nurses I thought, but it did mandate that we had more actual registered nurses and LPNS on 2nd shift. Yes, that was good.

And the next big change was when we went to what they called a nurse clinician. And I really didn't change a whole lot of what I did, but I was viewed as a greater source of information. My role was looked at with more seriousness as far as my part in the treatment plan. And during that time, there was even a brief time, and I really liked this role, I was a clinician with a specific psychiatrist. And all of our patients were not on one ward. And I went to each ward. And we had some nurses who were just on that ward, but we were the nurse clinician and we kind of helped with the development of the treatment and we acted as liaison between the nurses and the ward staff and the treatment team. And we insured that the plan was implemented and the patient was getting what was necessary. And you didn't have stuff falling through the cracks. It didn't last long. And I don't remember what happened. We started downsizing, I know that. And they started closing some wards and that sort of thing. And just staff-wise we would continue to do that. That was great, that was unique.

CS: I can imagine.

KW: We were even able to come back and say, especially if it was 2nd and 3rd issue that they had wanted help with, we could go back and say, is this working? Now what else do you think?

CS: You could really follow-up.

KW: And I could go back to the treatment team and be sure that we can try to get this implemented.

CS: And that was probably in the 80s?

KW: That would have been in the mid 80s.

CS: Is there anything else you want to add for now?

KW: No. (laughing)

CS: Believe me, there is so much I could still talk, I could still go. I really thank you very much for your perspective, for your work, for what you do, for these patients and for all the staff.

KW: Well thank you. I think I told you everything I've ever done. (laughing)

CS: Thank you for spending this time with me.

<NOTE from CS: After I turned off the recorder, Kathy Williams and I were casually talking. She discussed how everyone ate at the hospital cafeteria, even community members would come there because it was so good. She mentioned how good Broughton Brownies were. As Kathy kept talking, I realized I needed to turn the recorder back on, so I did.>

ok

CS: Say the little pig thing again.

KW: So when we would go on walks and take our patients on walks, we would go up to the farm area where the little pigs were. That's what the patients wanted to do. And like I said, they had some big hogs because that's what they raised them for was for the meat. But they always had some little baby pigs. And patients loved it, and they'd say, "Let's go see the baby pigs." And that was usually the way your walk went was at least by there. But you gotta go see the little pigs.

CS: And the dances, you were just describing those.

KW: Some other neat things that we did. One was the dances. On Wednesday night I always had the dances, and patients loved it. Staff would dance with them some if they had to and wanted to and needed to, but patients simply loved the dance. And you know you didn't have to be able to dance. They just liked to get out there. They liked the music, they liked the interaction. We would even take patients from high control and keep a close eye on them, you'd pretty much be one on one with them, but it gave them an opportunity to get out.

I'll never forget I had gone with that group one night to help keep up with everybody, and I had started out kind of in front of the patients and I was standing at the door. And we got to a point. And the patient stopped. And I'm looking like, Ok lets go. And he said, no you go. I'm like, no you need to go. And we are sort of there at a stale mate, and I'm like I can't go and leave him. What's he gonna do? Where's he gonna go? And I'm still standing there and finally one of the technicians came up with his patient and he said, Kathy you are going to have to go in front of him, because he is a gentleman and he will not walk out in front of a woman. I did not know that. I worked with the man for years, and I didn't know it. And that is what he was doing. I was thinking he was wanting to get me on out of the way so he can abscond, as Dr. Killbride used to say. But no, that is what he wanted. They loved that dance.

Wow!

We always had a movie on Friday afternoon. Everybody goes to the gym, had some neat movies. We took patients to Tweetsie. We took patients hiking up to the South Mountain and different outings. Usually once a year we would have what we called our big picnic where we tried to take patients where they spent the day just to have some hot dogs and playing ball and doing whatever they wanted to do.

CS: Were family members invited?

KW: Usually we didn't include family. It is not to say that occasionally family wouldn't go, but no you probably wouldn't.

CS: You wanted to be able to control the culture yourself?

KW: Yeah. The fairs. We always took patients to the local fairs around. Oh there's something else. The commissary. Have you ever heard of the commissary?

CS: No.

KW: Honey, that was the hub of socialization. It was a store, and we called it the commissary. And it actually started out years ago as more like a commissary that offered more services to staff than patients. I know that my first hula hoop came from the commissary. I don't why they got toys in, but mother and daddy bought me a hula hoop from the commissary. But till I came to work here, it was mostly food, candy, snacks, chips, drinks, personal items—although we had those on the ward for patients, cigarettes—you know that was a big thing. We had cigarette machines. Everybody here smoked, I don't know why I never picked up that bad habit but thank goodness I didn't.

But the commissary was the place to go socialize. And you had all these tables and chairs and they would go sit around and talk with each other and drink their cokes and eat their snacks. So when you got privileges, you could figure the first place they would go was the commissary. Oh yes.

CS: So could community members buy things there too or was it just for patients?

KW: Just for patients. And they probably wouldn't have thought to. One of the things that I remember about it, and you know we didn't have air conditioning way back, the Jones building was actually the only air conditioned building here for a while. And the commissary wasn't air conditioned. And they would open the door to let air in, and of course there would be some flies.

And everybody would spill drinks, and you would walk in and your feet would just stick to the floor. And they would clean it like twice a day, I mean it didn't matter you had all of the patients sitting down and talking and staff would go sometimes down. You always had some staff members there working. So, you know it was supervised. But it was just the social outlet, the social hub.

And you still got a few patients here that right now today, do you remember the commissary, they will say, "Oh yeah. I miss that!" And we would take orders up for patients who wanted things from the commissary. But as soon as they were able to go, you let them go. That was, sometimes kind of that first trial off the ward to the commissary. To see how they feel, see how they do.

I had one little guy who had served several tours in Vietnam. He was a ranger, which put him right out in front. He was very psychotic and very frightened of everything, and he was at a point where we felt like he would be fine to go off the ward. And we would ask him to go with us to the commissary. He would give us his order and we would say, "Now why don't you just walk with us today?" And he would say, "No I can't go out there, they are hiding in the bushes." And he would tell me, "Now you be careful they will shoot you." "You be careful, they will shoot you."

And this is hilarious, he always called me Rufus—I do not know why or where he got that from, but he always called me Rufus. And he would say, "Now Rufus you be careful, you pay attention, they are hiding in the bushes and they will shoot you." But he had to get a little better before he could walk outside.

CS: Did he ever go to the commissary?

KW: Oh yeah. But it took a while.

CS: That is a good story. A neat story. I feel like we could talk for hours.

KW: I've got all kinds of stories. Unfortunately I'm a story teller. And you know, if I thought it was helpful, I would write it down maybe sometime. I would just have to be so careful that nobody could identify someone. I would never want to cause any time of discomfort to patients to families.

And we were talking about the stigmatism. I can get right angry and irritated about a stigma that people place on mental illness. You know it is not fair. These people didn't ask for that. They did nothing to deserve that, in most situations it was totally placed upon them. Nobody asks for it. Sometimes it happened because of an injury. That's even sadder, you know. You are fine one day and you have an accident and from then on you've got mental limitations, but we are going to have to address mental illness if we expect to have a healthy population. The well-being of our nation and our population can not happen until we open our eyes and realize if you are not emotionally and mentally well and healthy, it is going to affect everything. And vice versa. Sometimes those physical issues blend into the emotional issues.

We can't separate that patient. We don't want to go into it about the behavioral health stuff, we don't want to start saying they are depressed or they are beginning to get paranoid, or their anxiety is causing them to have to stay at home, they've not ever done that, but now they can't get out because they are so anxious. I mean there are things that are limiting people's happiness and their ability to function, and we are sitting back looking at it as if it is their fault or it is a stigma. You know. It makes you bad if you have a mental illness. And I don't know anybody, even those folks that are well educated who would be as open if they had a mental illness as they would if they had diabetes. They wouldn't mind talking to you about the diabetes or high blood pressure. But they are careful about who they tell about their depression or their schizophrenia or their bipolar disorder. It is just not fair. It's not fair to those folks.

I think the new medicines are great. I'm so glad that we finally are trying to treat the symptoms. And I think if we had more research to prove to people, if we know it, we already know it is there, but if we could say because this happens here, this person has schizophrenia. I think people would be more accepting. But they don't know why the pancreas doesn't secrete insulin always. You know. What's the difference? If you can't rationalize it, when it's got to do with behaviors and thinking then it is just really hard, you know.

CS: So we don't ask the same questions of the pancreas? That is a really good point.

KW: No.

CS: We kind of accept that it may not function sometimes, and we just treat it but we don't accept that the brain may not function.

KW: Right. Where are those same—you know, why are the neurotransmitters and the serotonin and the dopamine, and this sort of thing, why is the screw up of that an different? We don't know why. We don't know why a lot of things. But because it causes physical issues, we are ok with it. But when you start having strange thoughts or strange behaviors, we will even accept depression before, I think personally this is my opinion, we will accept that and anxiety before we will those psychotic disorders like schizophrenia, schizoaffective, and you know. It is no different. But still the depression and the anxiety, it is still a negative disease that is looked at. It is just like, "Can you believe that?" You know. It is almost like, let me see I was going to say, a sin, but it much like a—

CS: A moral issue?

KW: Kind of yeah. It's like a black mark in their life when it is just an illness. And why would we think we can give somebody an antidepressant that allows them to have the availability of more serotonin to help their mood, and that helps their depression. Why would we ever think it is not a disorder? They didn't consciously have that happen. Medicine helps everything, that is why we take it and that is why it works. So, you know that in itself should be proof enough to me. If I can change these neurotransmitters make-up, however more or less, and I get a reduction of psychosis with the decreased dopamine or I can get more elevated mood with more serotonin, then right there is where the problem is.

CS: Yeah, we take ibuprofen for a headache, it is the same.

KW: Exactly, yes.

CS: Do you see nurses being advocates, or trying to play that role, maybe if not so publicly but maybe in their communities or families? Do you see that kind of concern there?

KW: I think some. In the psychiatric nursing yes I do. And I think that that is something that we try to promote here. And I think our nurses do, especially if they continue to work here. They find that this is their place. Part of the general population, medical hospital areas, I don't know that it is as great. Simply because they don't see the mental as much. But my oldest daughter is a nurse. And she works in an ICU, and she is very aware. I don't know if it is because of me, or not. But she is able to realize. So maybe it is happening some out there.

CS: The understanding of mental illness?

KW: Yeah, the fact that just because you get somebody in that has had a heart attack doesn't mean that they didn't also have a mental illness that you are going to need to continue to manage. Yes.

CS: Right. We are growing perhaps a little bit of awareness.

KW: But I doubt there is a lot of thought to it. And that is typical. You are concerned about what you see and what you deal with all the time.

To be honest with you, when I talk with my nurse staff here, I tell them, "If you are not careful you will get a distorted view, a distorted picture of mental illness from working here. Simply because the hardest to manage cases are admitted here." So it is going to be more intense, difficult to control, high management issues, aggressive issues, you know.

If you are committed you have either got to be dangerous to yourself or to others and have a mental illness. That's what has got to be there. So, we are seeing the most serious cases. It is just like diabetes. Most people with diabetes are going to end up in an ICU setting. Now if I talk to someone who works there, she would probably say we have certain people that we see pretty frequently because they have such a bad time controlling their diabetes or they are not compliant. Here it is the same way. We have those cases that just don't respond well to medicine, or they are non-compliant or they don't have a good support. Whatever the reason, they are the harder cases.

And I said I like to think of this as the ICU for the mentally ill. We are the end of the line. We can not say, we can not take care of this psychiatric patient let's transfer them on to a higher level. Because there is no higher level left. And you know I usually ask that when I was teaching CNAs. I would say, so where are we gonna move him? He is hard to manage, where can we send him? And they might say, Jail. And I'd go, well he don't have any charges against him why would you send him to jail? I mean they probably brought him from jail. I don't know, what are we gonna do? I said, we have to be able to manage those hard cases, that is what our job is. You know, I liked it. That is what I liked.

I think I would have liked the community setting also. Because I think it would have been nice to seen those people who are more functional.

The majority of the people who are mentally ill, have a mental diagnosis a psychiatric diagnosis, never come here. And if you don't really stop and think, your first thought is that everybody who is schizophrenic is dangerous. No. No. Just a little bit of them. Just a small little portion of them are aggressive. And you know with treatment we can usually take care of that. But now if they are aggressive, I guarantee you they are gonna tell you on the 6:00 news, so and so held officers at bay for 2 hours and he has a diagnosis of paranoid schizophrenia. I mean it is on the 6:00 news every night. Somebody has done something. But if he is paranoid schiz, I bet they don't say he is a diabetic. You know. Why do they feel the need to do that? But they will, they will do it every time. Bipolar disorder, borderline personality disorders.

And I really never stopped to think about it. My first thought if you tell me borderline is that they self-mutilate in some fashion. The cutters, the burners, they hurt themselves cause injury to themselves in some fashion at some point or have. No. And it never really occurred to me when I was talking to people who worked at the local mental health center talking about borderline personality disorder and how it is so discouraging because they hurt themselves. And you try to help them, and you know they are not hurting anybody but themselves most of the time actually, you know the cutting and the burning. She said, yeah, but you know all of them don't do that. And I said, "They don't?" She said, "Oh heavens no, but they do other things that can be very harmful and hurtful to themselves. They set themselves up to be abused in marriages, and they make impulsive decisions and it is still harmful but it is not to the degree that I am accustomed to. And that was not the case. I had a distorted opinion of that because that is all that I could see. But we need to be real careful when we are working in a place like this, that we understand that most of the folks are being treated and they are functional.

CS: Right. That this is the ICU for mental illness.

KW: This is the acute area. And to not always look at the chronic disorder that is going to result in nonfunctioning individuals. Most function well all their life. They may need a special medicine. They may need a support group in some function, but there are a lot of physical illnesses that need just the same.

CS: That is a really good point. Well worded observations from a career, from many years of being here and thinking about these things thoughtfully.

KW: I've seen many people that just give up on life because they were mentally ill.

CS: I'm glad I turned that recorder back on!

Great interview!