An Attempt at Indianisation of Psychiatric Nursing

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THE socio-economic, cultural, educational and political status of the country and the problems associated with these conditions determine the contributions of different disciplines and professions. This is very much true in the field of health in general and mental health in particular. Considering the problems and prospects of developing countries from the mental health angle, specific recommendations and appropriate suggestions were formulated in organising mental health services. (W.H.O. 1975 & 1984). Likewise, the mental health experts in collaboration with personnel from social welfare and education have formulated the National Mental Health Programme for India (N.M.H.P., 1982). All these documents emphasize a common theme that each of the Mental Health professions—Psychiatry, Psychology, Psychiatric Social Work, Psychiatric Nursing and Occupational Therapy—have to rise to the occasion and suitably modify their approaches and formulate innovative programmes, specially in view of the conditions prevailing in the respective countries.

Psychiatric Nursing which had its origin in USA has its knowledge and practice base resulting mainly from the western literature. It is imperative on the part of trained psychiatric nurses in developing countries to suitably adapt theoretical formulation to the realities.

India, being mainly an agrarian society, the professional methods should take cognisance of the multifarious activities related to agriculture and its implications. Applying this general framework, we can arrive at the conclusion that the psychiatric nurses in their professional responsibilities, need to incorporate the values, nuances and other aspects of agriculture-related work.

It is in this regard that an attempt has been made to make use of the horticultural activities in the course of Psychiatric Rehabilitation Nursing in the National Institute of Mental Health and Neuro Sciences, Bangalore.

Horticulture as Therapeutic Measure

Horticulture is the science and technology involved in the production, processing and marketing of fruits, vegetables, flowers, ornamentals, etc.

Structured and planned involvement of psychiatric patients in a variety of activities connected with the above aspects of gardening, as part of comprehensive psychiatric treatment programme can be termed as horticulture therapy.

Aim and Objectives of the Programme

Horticulture therapy programme was started with the main aim of assessing the feasibility of such efforts in our setting. It was also the concern of psychiatric nurse to systematically observe patients' reactions to these activities.

In addition, the Nurse-Therapist wanted to know the utility of the programmes as perceived by the patients, and the problem faced in such programmes.

Brief Description about the Programme

For this purpose, it was planned to involve 10 male chronic schizophrenic patients with ages of 20 to 45 years, attending the Day Care programme of NIMHANS, in activities related to cultivation of maize in a specified area of the campus. This, being the maiden attempt as far as 'structured participant observation' of the nurse-therapist is concerned, attempts were made to carefully plan different stages of cultivation and different modes of involvement of patients. To enhance the activities the ten patients were given brief orientation and elaborate guidelines in regard to their continuous and consistent involvement. All the patients agreed to these plans and conditions. They were made to realize that involvement in these activities would help them therapeutically. They were also told that they would be given financial incentives depending on the work and the yield.

Usually, the patients spent 2-3 hours in the field every day. In the remaining time, they were sent to the other units of occupational therapy centre. They continued their work for four months. As far as the work was concerned each patient was allotted a specific area of the land and was assigned particular tasks in their respective lands.

Observation of the Nurse-Therapist

Initially, the patients did not show much interest

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TABLE 1
Details of Patients and Benefits Perceived

No. Patient	*Age in yrs.*	*Duration of schizophrenic illness*	*Marital status*	*Benefits perceived by the patients*
1. Mr. KR	28	6 years	Unmarried	1. Found work satisfactory 2. It was a change 3. It was interesting 4. Able to get more friends 5. Learned 'watering and removing weeds'.
2. Mr. SK	32	12 years	Married	1. Change from routine work 2. Friendship developed 3. Medicines decreased 4. Improved knowledge 5. Gained confidence in doing independent work
3. Mr. NBR	30	8 years	Unmarried	1. Felt 'Energetic' 2. Good experience 3. Mind became 'fresh' 4. Learned to plough, sowing etc.
4. Mr. DN	47	14 years	Unmarried	1. It was nice going out 2. More people to talk to me
5. Mr. NS	32	6 years	Unmarried	1. Was happy 2. Movements freed and relaxed 3. Got friends 4. Good exercise 5. Learned 'digging and watering'
6. Mr. NM	25	5 years	Unmarried	1. It was nice 2. Would get money 3. Gave satisfaction
7. Mr. MT	26	11 years	Unmarried	1. It was nice 2. Learned many activities 3. Started gardening at home
8. Mr. RN	53	13 years	Married	1. Reduced 'boredom' 2. Interesting 3. Lessened my tremors 4. Good in health 5. Had two friends
9. Mr. PV	28	5 years	Unmarried	1. Interesting 2. Boredom reduced 3. Had close friendship with three members 4. Would get money
10. Mr. SR.	30	8 years	Married	1. Could enjoy the work 2. Learned new activities

in this kind of work. They required much explanation and persuasion to get involved in the programme.

When they started doing the work, they found it difficult to cope with the tasks. This was genuine because of the fact that it was the first time cultivation was started in this land.

In such moments of dejection and disappointments, they were given extra doses of support and encouragement. These reinforcements of Nurse-Therapist made them continue the work.

Sowing the seeds, followed by appearance of seedlings, gradual growth of young plants, formation of buds and their blossoming and fruit development had tremendous potentials for self-reinforcement and motivation.

It was observed that the interactions, both frequency and intensity, improved as they continued to work together. In their interactions, they spontaneously shared their personal problems with each other. They began to learn new ways of relating to others, maintaining themselves and helping each other in the course of their work.

They were regular in their work and treatment programmes. However, they preferred to work in group rather than individually in the allotted sites. In fact, the relationship was so much strengthened that they continued their friendship outside the field also. Other details regarding the patients are given in Table 1.

Implications for Psychiatric Nursing in India

These observations and findings are relevant and significant in the context of changing trends in psychiatric nursing profession in India. Such efforts, if undertaken in other centres, will yield fruitful results as far as professional growth and development is concerned. The uniqueness of horticultural activity is that it literally brings forth the fruits of one's action. When the disturbed minds witness 'the things of beauty they become the subjects of joy for ever'.

In developing countries like India, horticultural activities serving as the therapeutic and rehabilitative programmes remain, yet unexplored and hence underutilised by the professionals. In many simple tasks which are repetitive in nature, even the mentally retarded individuals can be involved.

The psychiatric nurses should be prepared to take up such innovative programmes in order to face the realistic challenges posed by the conditions prevailing in our country. These programmes, no doubt, would make psychiatric nursing sensitive and responsive to the growing demands of our country. If such activities are replicated in other centres, Indianisation of psychiatric nursing practice becomes a reality.

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