therapy is terminated and the patient is ready for discharge. In such instances the completion of the questionnaire will have to wait long periods of time. Obviously, such rather uncooperative family attitudes do harm the accuracy and the reliability of the data.

VII. CONCLUSION

It is evident that an integrated patient recording system using electronic data-processing on a nation-wide scale is possible and has certain advantages. However, the availability of electronic data-processing hard-ware as well as soft-ware, or agencies which can provide processing services on a computer-time basis is an essential requirement. Since the amount of data-processing of such a project will only take a few hours weekly, the installation of an electronic data-processing unit is impractical and relatively too expensive. It is also clear that such a recording system greatly enhances more systematic communication between the Directorate of Mental Health as central directive agency and peripheral psychiatric facilities. In this manner, a more integrated and balanced approach to mental health problems will develop and their possible solutions will be found.

It is also gratifying to know that the Indonesian government has realized the importance of this project and has given full support for its continuation.

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BIBLIOGRAPHY

1. KRAMER, Morton; *"Application of Mental Health Statistics."* Geneva: World Health Organization, 1969.
2. McLACHLAN, G. and SHEGOG, R.A. (Ed), *Computers in the Service of Medicine Vol. I & II."* Oxford: University Press, 1969.
3. SALAN, R. and SADONO, Budi; *"General Purpose Psychiatric Questionnaire."* Direktorat Kesehatan Djiwa, 1971.
4. TAINTOR, Zebulon; SALAN, R. and SADONO, Budi; "Some Developments on the Computerized Recording System Project of Mental Patients in Indonesia." *Proceedings of the 2nd Annual Meeting of the Indonesian Society for Neurology, Psychiatry and Neurosurgery, 1972.*
5. TENNEY, Ashton Monroe; "Activities of the International Committee Against Mental Illness." *Trans-cultural Psychiatric Research Review* 8: 201, 1971.

THE NURSE AND PSYCHOTROPIC MEDICATION

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INTRODUCTION

This paper examines the psychological aspects of the nurses' interpersonal relationships from the standpoint of her role in serving medication. The psychodynamics of interpersonal relationships between medical nursing and paramedical staff with the patients are of tremendous interest and its study can be rewarding for all concerned in the therapeutic community. The author puts together some of the experiences and opinions of assistant, staff and student nurses and sisters in a psychiatric unit. The points mentioned in this paper arises from group and individual discussion in the ward and perhaps a well constructed research could be formulated to study this area of human interaction to promote greater efficacy in "modern milieu therapy" (Abroms, 1969).

Patient-Nurses Relationship

The presence of psychiatric units in a general hospital and the use of effective psychotropic medications in recent years have changed the nurse-patient relationship from one of dominance-submission to one of understanding, emotional

involvement and therapy. Where previously external controls on psychiatric patients were necessary and they were given custodial care, the introduction of phenothiazine drugs gave a form of internalised control to the patient. The act of giving medication very often establishes or maintains relationship between a nurse and a patient. So much emphasis is given nowadays to gain a patient's rapport". In a busy psychiatric unit the positive and negative aspects of this rapport and the transference and counter-transference between nurses and patient can be centred on the deliverance and acceptance of medication.

Responsibility in Serving Medication

To begin with the nurse has to understand the patient's problem and the nature of the medication he receives For example, the nurse would be helped considerably if she reserved the serving of medication to paranoid patients towards the end so that she is not frustrated in the beginning of her rounds serving medication and also the paranoid patient has the opportunity to see other patients taking medication from her. In the case of suicidal patients the nurse have to learn the art of ensuring that the patient swallows the tablet without showing the patient that she does not trust him to do so. The nurse has to be aware of the symptoms and signs of the possible side effects of the drugs and report them to the doctor promptly when detected.

Special problems in the Psychiatric Ward

Unlike other wards where patients are usually physically ill and incapacitated in bed, sometimes with the bed number and names of the patient beside the bed, the patients in a psychiatric ward are ambulant. The nurse has to make an effort to remember the names of the patients. In the case of several new cases in one day she has to counter-check that the patient is actually answering to his own name when called for medication. Similar names and similar faces can result in a patient receiving another patient's medication. Again, during the time of serving medication the patient may be in one of many places, thus the nurse has to look for the patient and those who are not present in the ward, their medication has to be kept aside in a safe place till they return to the ward.

When the patient's identification of the nurse as a significant personality in his own life can lead to his taking medication from one nurse but not from another. The nurse has to be aware of the patient's tendency to project (Teoh, 1972) and she should feel less threatened when a patient refuses her medication. Nurses need also to learn about their own tendency to identify with the part which the patient tries to force them to play. Failure to realise this will unnecessarily foster faulty patterns of behaviour, nurses acting unconsciously as if they were the strict parents, jealous siblings, overpossessive wives, etc.

Sometimes patients have valid reasons for refusing medication – they complain of the side effects – giddiness being the commonest, dryness of mouth, constipation, etc. The nurse is understandably in a difficult position when the patient says, "I will not take this tablet because it will make me feel giddy and when I want to sleep you all will not allow me to have my bed!", or patients begin to question the efficacy of the drug because "I am still the same after taking this medicine". In short, it is not easy to give a satisfactory answer to the patient; the attitude of the nurse in giving medication becomes all important.

Sometimes the seniority or attractiveness of the nurse also counts. Very often a nurse from a general medical ward transfered to work in the psychiatric unit is very much taken aback by patients disobeying her instructions and labels the patient as 'uncooperative' and difficult. Again the suspicious patient will question the nurse as to the change in the number of tablets, the change in colour of tablets and even the difference in time the medication is served.

Frequently, the nurse who has difficulty medicating patients, tends to be ineffective, vague and uncertain in her proposition. If the nurse acts as a central focal point in the ward for patients, confidence in her is likely to be engendered and patients more likely will trust her. The reciprocal response to an uncertain nurse serving medication is devastating to a paranoid patient.

The nurse has to have the patience and confidence to explain and impress on the patient that he is receiving the right medication in the right dosage and at the right time, that the same drug can be in different colours and two small tablets could add up to the strength of one big tablet. More difficult still is the situation when the patient states categorically that "the doctor gave me a different medicine yesterday" – this almost challenges the whole position of the nurse and can provoke anger in the nurse.

The personal handing out of medication by the doctor to the patient is most effective in patient-doctor contact. It is the intermediary relationship that can be disruptive. If most psychiatrist could

personally serve medication, the cultural impact on therapeutic acceptance is tremendous. However, this is not possible and the nurse has been entrusted to perform this duty with presumably less impact. Hence, when a doctor is asked to serve medication because the patient refuses to take it from the nurse, it is best that he coaxes the patient to take the medication from the nurse, since this would reinforce the therapeutic role of the nurse.

Emotional Feedback on the Doctor

The majority of our nurses have undergone an educational system in which the teacher is always right. The teacher–centred teaching leads them to feel that the doctor is always right and that they work under doctors. The whole question of whether nurses feel comfortable in questioning the medication prescribed by doctors is rather interesting. Where the doctor-nurse relationship is left much to be desired, the nurse adopts the attitude that the doctor will not listen to her. The patient may have shown no improvement to one phenothiazine drug in the last 10 days and in frustration the nurse writes in the progress notes "Patient remains the same. Dieted well. Slept without sedation." When she would have actually preferred to say "Please try another phenothiazine".

In the agitated patient the nurse can be very upset during her night duties if she hears the afternoon nurse reporting that "the patient has been so terrible the whole day but his medication has not been increased. I think you better give him i.m. before he gives you trouble". Nurses should be encouraged to suggest to doctors any change of medication they feel necessary and the doctor in turn has to discuss with the nurse the pros and cons for a change.

It is a paradox that the nurse who spends most time with the psychiatric patient has least therapeutic responsibility, while the physician who spends a few minutes with the patient makes all the major decisions for the patient. Furthermore, we have to take cognisance of the fact that nurses are expected to have initiative and be responsible for making significant recommendations, while doctors accepting advice from non-medical staff is highly threatening to their feeling of omnipotence. Hence the way out of this bind, as is frequently seen, is that the nurse must communicate her recommendations without appearing to be making a recommendation statement and the physician in requesting a recommendation from a nurse must do so without appearing to be asking for it. This "doctor-nurse game" (Stein, 1967) has an inhibiting effect on open dialogue and is stifling and anti-intellectual and obviously is contrary to the concept of psychiatric personnel being counsellors in helping patients communicate effectively in their daily lives.

We have to also take into account the fact that the nurse may hesitate to speak openly of her feelings about the patient's medication, fearing consciously or unconsciously that her prejudice or tendency to have favourites may become obvious to all (Jones, 1968).

Intramuscular Paraldehyde

Where the patient is clearly violent the doctor has no compunction in ordering paraldehyde and the nurse has no hesitation in its administration. However, in the case of personality disorders with hysterical acting out behaviour or behaviour that disturbs the peace of the ward the nurse has to decide whether she should give i.m. paraldehyde which had been prescribed on a prn. basis. A conflict exists in the mind of the nurse as to whether to be punitive in her actions or try a less painful corrective measure. Soon she may lose patience due to pressure of work and she wonders whether her senses have been so dulled that she has become even sadistic in her liberal use of paraldehyde. This can be very disturbing to the emotional stability required of the nurse. She begins to worry about her relationship with other patients as they watch her use physical force to administer the injection.

Where previously the dominance-submission role of the nurse-patient relationship existed prior to phenothiazine therapy, vestiges of such an authoritative control still exists in most large institutionalized hospitals. Chronic psychiatric patients tend to be given a much larger dose of chlorpromazine than is required. It is a sad fact that the Victorian attitudes to mental illness still exists, and nursing staff can utilize a new therapeutic agent – psychotropic medication – not as a means of cure, but as a means of control of psychiatric patients.

The Pharmacy's Role

Doctor's prescriptions having to be sent to pharmacy department for supply poses problems to the nurse. There is the question of whether the drug would arrive in time or even after a long wait to be informed through the phone that the medication is not in stock. Where a new drug is being used, information on the drug should be circulated amongst nursing staff. The success or

failure of a drug trial depends much on whether the nurses are aware of what difficulties the patient may present when placed on this new drug and if so, what special measures are available to handle these difficulties.

Other problems

Apparently minor problems like illegible handwriting on the part of doctors, failure of doctors to obliterate drugs when discontinued and the haphazard use of chemical or proprietary names of drugs can add to the discomfort of the nurse (Martin, 1967). The drugs prescribed for the last admission when the patient was manic could by mistake be continued on his readmission for a depressive episode if the old medication card is used again before the doctor prescribes for the second admission. Constant interruptions during a nurse's medication round can be extremely irritating for her. Night sedation is a thought provoking subject; the over-anxious nurse gives the sedative at 9.00 p.m. and as a result the patient is awake at 3.00 a.m. while at the other extreme the giving of sedation at 1.00 a.m. results in confusion at breakfast time.

The Value of Medication

Nurses in their general training may have the value of medication over-emphasised in their performance of duties. Although psychotropic medication plays an effective role in management of patients it is not the only treatment nor always the best treatment available in psychiatry. The patients should have some idea of the possibilities and limitations of different forms of treatment. If the staff relies too exclusively on physical treatment patients are liable to expect far too much from them. If on the other hand the nurses communicate their awareness of the importance of environmental and psychological factors, many patients will soon realise how many different avenues of help are open to them and make fewer demands for magical cures through medication alone (Martin, 1962). If the nurse understands the patient, the drug involved and the other therapeutic requirements of the patient then she is in a much better position to play her role when administering drugs to their fullest therapeutic value.

SUMMARY

This paper examines some aspects of the role of the psychiatric nurse in administration of psychotropic medication.

The patient-nurse relationship is very much affected by the serving of medication and with emphasis of the therapeutic role of a nurse in a psychiatric unit several factors are worthy of discussion. To begin with, the nurse has her responsibility in understanding the patient and the drug he is served. She has to face the special problems involved with psychiatric patients in the unit – the patient's drug refusal, his identification of the nurse and his preferences between nurses.

Arising from the nurse's difficulty in administration of psychotropic drugs her relationship with the doctor is affected. Whether a nurse is able to disagree with a doctor's prescription or even voice her opinion regarding the efficacy of the drug already prescribed is of importance in the management of the patient.

Problems of another nature arise in the question of giving i.m. paraldehyde night sedation and drug trials. Sometimes doctors presume that what is prescribed will be served by the nurse and accepted by the patient. Many more factors are involved and it is hoped that this paper will add some food for thought into this largely unexplored area in psychiatry.

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BIBLIOGRAPHY

1. ABROMS, Gene M.; "Defining Milieu Therapy." *Arch. Gen. Psychiat.*, 21:553–60, 1969.
2. TEOH, J.I.; "The Role of the Psychiatric Nurse in the Therapeutic Community." *Nursing J. of Singapore*, 12:2, 1972.
3. STEIN, Leonard; "The Doctor-Nursing Game." *Arch. Gen. Psychiat.*, 16:699–703, 1967.
4. JONES, Maxwell; *"Social Psychiatry in Practice,"* Penguin Books, (1968).
5. MARTIN, Denis, *"Adventure in Psychiatry – Social Change in a Mental Hospital."* London: Bruno Cassirer Publishers Ltd., 1972.
6. MARTIN, Ruth; "Administering Drugs in the Ward: the Problems." *Nursing Times:* 63–47, 1967.