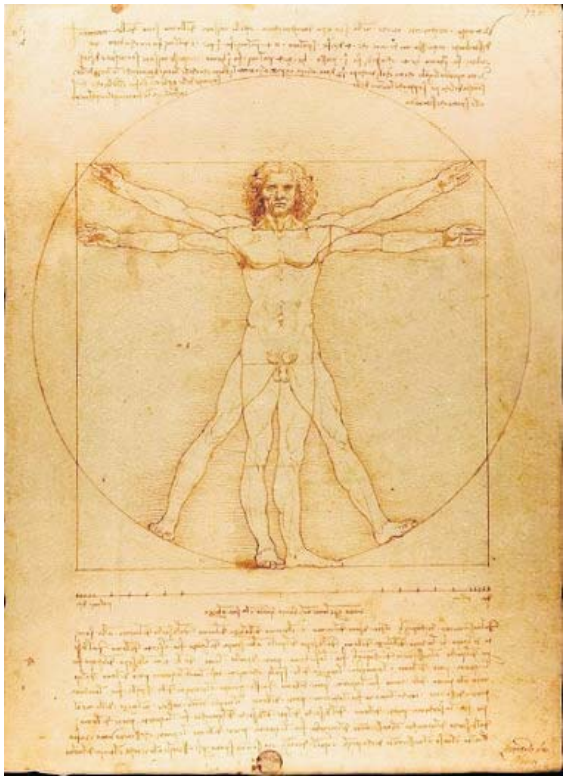
JYVÄSKYLÄ STUDIES IN EDUCATION, PSYCHOLOGY AND SOCIAL RESEARCH
347

Jukka Piippo

Trust, Autonomy and Safety at Integrated Network- and Family-Oriented Model for Co-operation

A Qualitative Study



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Editors
Jukka Kaartinen
Department of Psychology, University of Jyväskylä
Pekka Olsbo, Marja-Leena Tynkkynen
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ABSTRACT

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This research is based on three Studies which were aimed to explore 1. psychiatric patients' experiences concerning Network- and Family oriented treatment model, 2. development of trust in two different treatment contexts, 3. significance of relatives' participation in treatment process for patients, relatives and members of the patients' multiprofessional treatment team. General starting points of the research are 1. reform concerning psychiatry realized in Sweden during 1990 2. development of Need-Adapted Approach in Finland. This research is connected to still ongoing research and development concerning psychiatric treatment and care in the Nordic countries.

The theoretical frame of this research is the theory of Need-Adapted Approach including the theory of therapeutic system. According to theory of the therapeutic system, all sides participating in treatment process are reciprocally influencing each others actions and thoughts. The philosophical frame of this research is the idea of relations between people either as subject-object relation or subject-subject relation as described by Buber. Material for this research was collected in Västerås, Sweden (Study I and II) and at Jorvi hospital Out-patient clinic and out-patient clinic at Keropudas hospital in Western-Lapland (Study III). The analysis of the tape recorded and video recorded material is done according to Grounded Theory. The first Study was aimed to explore the patients' experiences concerning Network- and Family oriented treatment model. The model was based on co-operation between the patient, relatives and staff members in psychiatry and social services. According to the findings in Study I the experiences were divided to positive, negative and ambivalent categories. The core categories of Study I were trust, mistrust and honesty. The second Study was a specified study concerning development of trust in two different treatment contexts, Network- and Family oriented context and traditional context. Material used was the same as in Study I. According to the findings, both contexts make development of trust, as well as mistrust, possible between the patient and personnel. Study III was aimed to explore signification of relatives' active participation in treatment process for the patients, the relatives them selves and members of the patients' multiprofessional treatment team. The core category of Study III was safety. The findings show that shared discussions in which relations are treated created experience and feeling of safety for all sides.

Keywords: psychiatry, co-operation, network, family therapy, treatment, care

Author's address Jukka Piippo
email: jukka.piippo@pp.inet.fi

Supervisor Professor Jukka Aaltonen, M.D., Ph.D.
Department of Psychology
University of Jyväskylä, Jyväskylä, Finland
email: aaltonen.jyu.fi

Professor Jaakko Seikkula, Ph.D.
Department of Psychology
University of Jyväskylä, Jyväskylä, Finland
email: jaakko.seikkula@psyka.jyu.fi

Docent Juha Holma, Ph.D.
Department of Psychology
University of Jyväskylä, Jyväskylä, Finland
email: juha.holma@psyka.jyu.fi

Reviewers Professor Pekka Larivaara, M.D.
Department of Public Health Science and General Practice
University of Oulu, Oulu, Finland

Associated Professor Håkan Sandberg, Ph. D.
School of Health, Care and Social Welfare
Mälardalen University, Västerås, Sweden

Opponent Professor Pekka Larivaara, M.D.
Department of Public Health Science and General Practice
University of Oulu, Oulu, Finland

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CONTENTS

LIST OF ORIGINAL PUBLICATIONS

I Piippo, J & Aaltonen, J. 2004 Mental health: integrated network and family-oriented model for co-operation between mental health patients, adult mental health services and social services. Journal of Clinical Nursing. Blackwell Publishing Ltd. 13, 876-885

II Piippo, J & Aaltonen J, 2008 Mental health care: trust and mistrust in different caring contexts. Journal of Clinical Nursing. Blackwell Publishing Ltd. 17, 2867-2874

III Piippo, J & Aaltonen J, 2008 Mental health and creating safety: the participation of relatives in psychiatric treatment and its significance. Journal of Clinical Nursing. Blackwell Publishing Ltd. In press.

1 INTRODUCTION

This thesis summarizes a research project whose findings have been presented in three articles. The initial aim of the project was to investigate the importance of co-operation between patients in adult psychiatry, personnel in adult psychiatry and personnel in communal social services. The term 'personnel' in this research means all professionals involved in the treatment or care of persons suffering from psychiatric and social problems: medical doctors, nurses, mental health nurses, psychologist, social workers etc. The first article explored the importance of co-operation as experienced by the patients, and the main findings and core categories in that study were trust, mistrust and honesty. The project continued with a deeper study of the phenomena of trust and mistrust and how they develop. The objects of this study were two different treatment contexts, the Integrated Network- and Family-Oriented Model for co-operation (INFM) and the Traditional treatment model. : Traditional treatment, in this research, means individually oriented treatment in which the patient, his/her relatives or other significant others in the patient's social network are not active participators in planning of the treatment or in the treatment process. The findings of the second study showed that trust and mistrust are possible in both contexts but in different ways, although there were also similarities between the contexts. Material for the first and second study was collected via interviews with patients in Västerås, Sweden. The third study investigated the importance of the participation of relatives in the treatment process and the phenomena of the therapeutic system. The participants in that study were the patient, his/her relatives and members of the multiprofessional treatment team. The third study investigated the Need-Adapted Approach, of which the INFM model is an application. Material for the third article was collected in two out-patient clinics in Finland. The core category of the third study was safety.

Caring generally in health care and especially in psychiatry should be based on humaneness, and the patient's understanding and knowing concerning his/her situation should be taken into consideration when planning treatment and care (Eriksson, 1997; Söderlund, 1998; Hummelvoll, 1996).

However, psychiatric patients and clients in social services often say that they are treated badly in the treatment system: patients often experience themselves as objectives for the professionals' actions not only in psychiatric treatment but also in social services (Steinholz-Ekecrantz, 1995; Topor, 2001; Whitaker, 2002). The importance of co-operation has been studied by e.g. Vuokila-Oikkonen (2002), according to whom co-operative care in psychiatry increases the active participation of patients and their significant others in treatment process. According to Webb, Pfeiffer, Mueser, Gladis, Mensch and Degirolamo (1998), patients and relatives wish to participate in joint discussions with caregivers. However, in traditional psychiatric treatment and care they are not always invited to discuss openly with the professionals concerning their own situation, or the patients' illness and suffering. Paterson and Zderad (1988) consider caring to be a mutual co-operative process between patients and professionals, and they found that the two central aspects in caring relations were "being-with" and "doing-with". These aspects can be understood differently. Firstly, they can be understood concretely, in that professionals should actually be together with the patient and this makes caring possible. Secondly, the aspects can be understood as symbolic, in that professionals should be able to create a relationship with the patient so that they as well as the patient experience themselves as being for and doing for each other. In fact, Paterson and Zderad consider nursing and caring to be an inter-subjective process between the patient and the care-giver; caring and nursing involve a lived dialogue. The care-givers role is to take care of the "between" relationship: the between is the basic relation in which and through which caring and nursing occur.

Wright, Watson and Bell (1996) emphasize the importance of family-focused caring concerning serious illnesses. The results of their research show that when all family members are given the opportunity to express how the illness influences them and how they can influence the illness, they become confident and their experience gets a voice. Kleinman (1988) argues that exploring given meanings also implies a journey into relations. By inviting family members to tell about their narratives concerning illness, family members are also helped to take back their right to describe their own experiences.

Trust as a phenomenon has been studied from several points of view, e.g. Erikson (1968) from a psychological viewpoint, Giddens (1990, 1991) from a sociological viewpoint, Eriksson (1994) from a caring viewpoint and Lögstrup (1994) from a philosophical viewpoint. All these viewpoints have similarities: all consider that trust is a basic human need and that the development of trust depends on interaction with the social environment. If the development of basic trust is disturbed, mistrust appears. According to Eriksson (1994), it is not only a question of the patient's basic trust. Only if personnel have basic trust in themselves can the caring become adequate. According to Erikson and Giddens, experience and development of safety depends on the persons' basic trust: trust and safety are interdependent. However, Eräsaari (2002) argues that safety as a phenomenon is difficult to define. He considers safety to be a state that does not

express itself when a human being feels safe. When a person feels unsafe, the need to experience safety appears.

Psychiatric caring or treatment systems cannot be compared with society generally. On the basis of my clinical experience and understanding, I think that the same phenomena exist in psychiatric society as in normal society, but differently. Power, autonomy, relations, hierarchy, traditions, rituals and expertise are some of the phenomena that influence all human beings in different societies (Giddens, 1990, 1991; Helkama, 2004; Gadamer, 2003). These phenomena however, vary more in psychiatric society than in normal society as a result of the fact that professionals and patients, together with their family members and members of their social network, are in different dependent relationships and positions than are most people in society. However, according to Eräsaari (2002) society is difficult to define and a society can only exist on a conceptual level. Societies are produced by symbolization (Eräsaari, 2002) and societies and communities contain traditions and routines.

According to Giddens (1991), traditions consist of four factors. Firstly, traditions are built on rituals and ritualized behaviour. When psychiatric treatment and care, for example, are based on the personnel's ritualized behaviour; it allows the personnel few possibilities to adjust their behaviour to the patient and the patient's needs. The personnel's behaviour can then be understood as ruled by theories and usual ways of acting. Secondly, traditions are collective. In a psychiatric treatment unit some specific ways of acting dominate even though all personnel are expected to act according to, for example, one theory of human development. Thirdly, traditions have their guardians who are the experts in interpreting and understanding how one can or should act in a traditional way so that the actions are in line with a specific theory, for example. Fourthly, individuals are emotionally engaged with the traditions, which have a special importance for people. Traditions can function as guidelines for understanding phenomena and how to act. However, Giddens (1991) also argues that traditions are needed. When one wants to understand a traditional behaviour, one must go behind the tradition, though according to Giddens all traditions are invented. Traditions incorporate power, which can be seen as useful for legitimating behaviour, strengthening beliefs and defining truths.

The third study of this research project aimed to study the therapeutic system thorough relatives' participation and its consequences. Andolfi (1979) considers a family-oriented system to be a therapeutic system in which all participants are in mutual interaction and influence each other. This kind of system cannot, according to Andolfi, be studied as separate units but must be studied as a whole. The interaction between participants is considered to be of importance in the therapeutic system. Psychotherapy, as well as all treatment and care in psychiatry, are based on scientific research and clinical experience, and they can also be seen as carrying traditions. According to Gadamer (2003), therapy is a question of attitude, a restrained attitude of knowing or knowledge and can then be regarded as being in line with the principle of

psychotherapeutic attitude (Alanen, Lehtinen K, Räikköläinen & Aaltonen 1991, Alanen, 1997). Holma and Aaltonen (1997) conclude in their study that modern psychotherapy is based on narrative activity more than on prepositional features of knowledge as psychotherapy traditionally has been: the central core in narrative psychotherapy is the patient's story, which the therapist listens to and takes seriously. Stern (2004) is of the opinion that the most important issue in psychotherapy is the present moment, the intersubjective lived experiences between patient and therapist. According to Stern, people are psychologically and consciously alive only in the present, and the past is not of such importance as is historically claimed. Stern (2004) discusses nonconsciousness, which is different from unconsciousness. Nonconsciousness can be understood as unreflected, actually experienced issues. In fact, Stern is of the opinion that unconsciousness is not what psychotherapy should be interested in; consciousness is what should guide the interest.

In psychiatry there has been a lot of debate concerning authoritative and ritualised psychiatry: one can say that the whole history of psychiatry has been a struggle between different ways of understanding, caring and treating persons who have been interpreted as being "different" because of their behaviour (Foucault, 1969, 2006; Whitaker, 2002). The anti-psychiatric movement has made perhaps the most powerful critique to the dominance of the unbalanced, biological explanation of mental illness. In anti-psychiatry, the critique was directed towards the specific definitions and criteria of psychiatric diagnoses or disorders. They are considered to be vague and leave too much room for opinions and interpretations to meet basic scientific standards. For example, Laing & Esterson (1964) and Laing (1985) criticized the psychiatric caring and treatment system, and its use of power and explanation of mental illness as primarily a biological phenomenon. These questions raised by the anti-psychiatric movement are perhaps more relevant these days than during the 1960s and 1970s when biological research concerning psychiatric illnesses was increasing. My intention in this research project is not to be linked to the anti-psychiatric movement but only to point out that some elements of the critique that the movement directed against psychiatry are still valid and influence the treatment and care of psychiatric patients, and aspects of this are shown in the results.

The three articles that this research is based on are to be seen as a continuum and an entity, and they are dependent on each other. However, each of them can also be seen as articles with their specific content and message, but as a continuum they build a systematic theory of trust, mistrust, autonomy and safety and what makes these phenomena possible in psychiatric care. The aim of our research was not to try to explain trust, mistrust, autonomy and safety as general phenomena, since this research was made in special circumstances. The final core categories of the articles were the phenomena trust, mistrust, autonomy, honesty and safety in psychiatric treatment and care, and these phenomena can be seen as interdependent. This study can be considered as part of the qualitative research realized in the Finnish multicenter project The

Integrated Approach of the Treatment of Acute Psychosis (API) led by Aaltonen, Lehtinen and Räkköläinen (Lehtinen V., Aaltonen, Koffert, Räkköläinen, Syvälahti & Vuorio, 1996; Holma 1999; Aaltonen, Ahonen, Koffert & Lehtinen, 2000; Iso-Koivisto, 2004; Seikkula, 1995) The API project was a broadly based research and development project which sought first and foremost to improve the practices for treating acute psychosis in six different psychiatric catchment areas, to gather information on the integration of different forms of treatment in the care of psychosis patients. The project was initiated and motivated by earlier successful projects on the care of schizophrenia patients, above all the long-term Turku Schizophrenia Project and the National Schizophrenia Project 1981-1987.

2 THE NEED-ADAPTED APPROACH AND THE INTEGRATED NETWORK- AND FAMILY-ORIENTED MODEL

The Need-Adapted Approach is a development of psychiatric treatment and care where the patients' family members and members of the patients' social network participate in the treatment process, and has been developed in Finland over several decades for psychiatric public health settings (Alanen, et al., 1991; Keränen, 1992; Aaltonen & Räkköläinen, 1994; Alanen, 1997; Haarakangas, 1997; Alanen, Lehtinen V, Lehtinen K, Aaltonen & Räikköläinen, 2000). The Need-Adapted Approach emphasises early family-centred intervention, the planning of treatment to meet the changing and case-specific needs of each patient and family, the adoption of a therapeutic attitude in both examination and treatment, and horizontal expertise, which emphasises the expertise of all participants in the treatment process. The Integrated Network - and Family-Oriented Model for co-operation (INFM) is an application of the Need-Adapted Approach.

2.1 The Need-Adapted Approach

Development of the Need-Adapted Approach started in the Turku Clinic of Psychiatry in 1968, led by professor Alanen. The first development project aiming to develop family-centred psychiatric treatment was the "Turku Schizophrenia Project". The project's first sub-goal, which had a clinical aim, was to develop treatment for patients with schizophrenia especially in a community psychiatric setting. The second sub-goal, with a research focus, was firstly to find out how psychotherapeutic activities for this group of patients can be used, secondly to investigate the need for treatment activities among the patients, and thirdly to discover how the therapeutic activities affect the outcome. This research was realized in the form of five cohort studies in which

therapeutic communities, individual therapy and family therapy were the main areas of research. The findings showed that a family orientation in the treatment of schizophrenic patients was beneficial. Even individual psychotherapy was found to be effective for a number of patients. According to Alanen (1997), the researchers' clinical experiences showed that practicing the principle of early intervention was effective, and it was included as one of the principles of the Need-Adapted Approach. The cohort studies also showed that the need for medication among the patients could be reduced when the principles of the Need-Adapted Approach were practiced.

The Finnish National Schizophrenia Project for the further development of the Need-Adapted Approach was carried out during 1981-1987 (Alanen, 1990;Alanen et al., 1991; Tuori, Lehtinen, V., Hakkarainen, Jääskeläinen, Kokkola, Ojanen, Pylkkänen, Salokangas, Solantaus & Alanen, 1998). Six districts in Finland participated in this project. The main aim of this project was to minimize hospital use by reducing the number of schizophrenia patients in institutions, and the goals of the project were defined on the basis of experiences in Turku. In summary, the project's goals were integrated, case-specific and need-adapted treatment based on psychotherapeutic and family-oriented principles according to interactional analysis of the needs in therapy meetings with the patient and significant others, so that the treatment could be done as out-patient care, with a small role for medication and with active rehabilitation. The results of the project showed that need-adapted and case-specific treatment reduces the number of days in hospital for schizophrenia group of patients.

According to Alanen (1997) and Aaltonen et al. (2000), the principles of the Need-Adapted Treatment approach are as follows.

The therapeutic activities are planned and carried out flexibly and individually so that they meet the real and changing needs of the patients as well as of people in the family or social network. According to Alanen et al. (1991) and Alanen (1992), the patients' treatment and care must be carefully considered so all the treatment activities carried out really are helpful for the patient, the patient's family members and the patient's social network. In planning the treatment and care, the patients' psychological, social and clinical needs must be considered and evaluated.

Examination and treatment are dominated by a psychotherapeutic attitude. By a psychotherapeutic attitude Alanen et al. (1991) and Alanen (1992) mean an attempt to really try to understand what has happened and is happening to the patient and persons in their interpersonal network. This kind of attitude also includes observations of one's own reactions and emotions.

Different therapeutic approaches should supplement each other rather than constituting an "either / or" approach. The Need-Adapted Approach is not based on one particular treatment: it consists of several need-adapted treatment activities, and special attention should be given to planning and following up, so these activities do not constitute an "either-or" choice but are integrated.

The treatment should attain and maintain the quality of a continuous process. This means, according to Alanen (1997), that treatment should be considered to be a developmental, continuous interactional process. Such a process does not allow participants to fall into routine sequences of sessions or meetings.

Immediate family-centred intervention independent of how long the symptoms have been manifested by the patient.

Guarantee of the psychological continuity of the treatment and care, and integration of different treatment and caring activities.

Case-specific, multiprofessional treatment teams are the basis for treatment and caring activities. This does not rule out one-to-one relations, but is used as a complement according to the patient's real and changing needs.
Treatment meetings are the forum where all treatment and caring activities are planned together with the patient, his/her relatives and significant others and the multiprofessional treatment team. These treatment meetings also function as integration meetings where continuous follow-up concerning treatment and caring activities can take place.

Open discussions between all participants in the treatment process. (See also De-ritualization of the treatment).

Emphasis on horizontal expertise, which seeks consciously to cross the professional boundaries and the barriers between different sectors of expertise. Horizontal expertise (Laitila, 2004), developed as a new principle for the Need-Adapted Approach by Aaltonen et al. (2000), is a specific kind of expertise that differs from vertical expertise. Vertical expertise can be seen as a hierarchic way of regarding knowledge, where there is always somebody who has more highly valued knowledge concerning a specific issue than others, so the focus then is not on co-operation with other professionals. In psychiatric organizations, vertical knowledge is often practiced in a way which places the patient below all others and can lead to a narrow view of the patients' life situation. Horizontal expertise is the opposite of vertical expertise, where the hierarchic order is abandoned and all knowledge, no matter whose it is, is considered to be of equal value. When horizontal expertise is practiced, an attempt is made to consciously break up domains of knowledge and cross boundaries between different expertises. According to Aaltonen et al. (2000), horizontal expertise creates more possibilities for co-operational or collaborative work among and between personnel in a treatment unit and between different treatment units. But to be able to act according to horizontal expertise may require a change of attitude. When people feel that their ideas and knowledge are taken seriously and not ignored, they are likely to be more able to have the same attitude towards others. Launis (1997) argues that research concerning horizontal expertise has exploded the myth that new and innovative solutions are creations of single experts. Instead, innovations are the results of interactions in a multi-level network. However, horizontal expertise should not be considered to be always possible or suitable. According to the Mental Healthcare law (1990), professionals are always responsible for making decisions concerning

the patients' conditions and functions. In cases where the patient is considered to be a risk to him/her self or others, professionals can make decisions without the patient's agreement and without paying attention to the patient's wishes.

De-ritualization of the treatment and using open dialogue. In a post-traditional society, treatment and care cannot be based on traditions and routines such as rigidly defined places or times for treatment. The professionals should adjust their activities so that routine power is minimized and the patient's freedom of choice is recognized. Open dialogue has its theoretical background in social constructionism, according to which "truth" is considered to be a social construction between participants. In creating such a construction, everyone involved in the problem discusses it together and all have to accept the existence of different truths.

When the Need-Adapted Approach is applied, treatment and care can be planned in treatment meetings in which the patient, his or her family members and members of the patient's social network participate together with a case-specific, multi professional treatment team, as developed during the Finish Schizophrenia Project (Alanen et al., 1986) and the Finnish multicenter project The Integrated Approach to the Treatment of Acute Psychosis (Aaltonen et al. ,2000). The main feature is a case-specific, multiprofessional treatment team of different professionals which is responsible for planning treatment activities and for their results. It is recommended that at least one of the members of the multiprofessional treatment team has had family therapy training. This is important so that the interaction in the interactive treatment system can be observed and treatment measures changed according to the needs of the patient and relatives. Treatment meetings are the basis for the team's work and are realized according to the specific needs of the patient and his/her relatives. According to Alanen (1997), treatment meetings have different functions: 1. informative, 2. diagnostic, and 3. therapeutic. The treatment meetings can also be seen as an opportunity for the caregivers to create open dialogue between themselves, the patient and his/her relatives concerning the situation. Holma (1999) and Iso-Koivisto (2004) have studied the Need-Adapted Approach using a qualitative method, and they found that narrative and dialogical psychotherapy is suitable in the treatment of psychotic and schizophrenic patients. Their studies also show the importance of treatment teams, and of the team members' behaviour and ability to listen to the patients and their relatives, and to take the stories seriously.

2.2 Integrated Network- and Family-Oriented Model

In the 1990s the Swedish government decided to carry out a reform in psychiatry which was aimed to improve the situation of psychiatric patients who were also clients of the community social services. This reform was carried out by implementing local development projects with economic support from

the government. In the city of Västerås, adult psychiatric organizations and community social services decided to carry out a joint development project which aimed to improve the co-operation between personnel in both organizations and the patients/clients. This project was called the Västerproject, and the Integrated Network- and Family-oriented Model (INFM) was developed specially to improve co-operation between adult psychiatry and social services in Västerås (Piippo & Aaltonen, 2004, 2008a). This Integrated Network- and Family-oriented Model has its basic background in the Need Adapted Approach. An other background has been the Western Lapland project, led by professor Aaltonen, carried out since 1980s in co-operation with the Departement of Psychology at the University of Jyväskylä, Finland, in close interaction with the principles of the Need Adapted Approach. In this project all the municipal psychiatric staff (outpatient and inpatient members) were given a three years on the-job-training in systemic- and network-oriented family therapy or two years psychodynamically oriented individual therapy training. The treatment process was carried out in every case with a multidisciplinary team, in so called treatment meetings. This modification of the Need Adapted Approach was called an Open-Dialogue Approach (e.g. Seikkula et al., 1995). As mentioned, Västerproject was a development project concerning co-operation between psychiatric patients, their family members and personnel in psychiatry and social services. However, that kind of development could not have been possible to carry out without training efforts; and the training was organized in two levels during the project. Firstly, training on network-oriented way of working in basic level. This training, led by Seikkula, was realized by staff members of Western-Lapland psychiatric organization. Secondly, training in family therapy was organized in co-operation between Jyväskylä University, Department of Psychology, and Psychiatric Education centre at Västerås psychiatry. This training program was led by Aaltonen and Seikkula. Even in this education, staff members of the psychiatric organization in Western-Lapland participated as trainers. The principles of Need-Adapted Approach and Open Dialogue were central in the training activities and can be regarded as main sources for the projects results. The INFM model was a locally suitable application of the Need-Adapted Approach.

The principles of the INFM were as follows:

Patients should always participate in planning their treatment/care and in the treatment process. This meant in practice that psychiatric patients, who also were clients at community social services, should continuously participate in planning their treatment and the treatment process. The patients/clients had earlier had treatment in adult psychiatry and social services but there had been no co-operation between employees in the organizations.

Multidisciplinary treatment meetings should be arranged. In these meetings, all decisions concerning care or treatment should be discussed with the persons involved in the treatment or caring process - the patient's family members and other members of his/her social network and professionals. In

practice this meant that treatment meetings and network meetings were organized and members from the patient's social environment were invited to participate in joint discussions.

The task in the treatment meetings is to create open dialogue between the participants. The main aim in such dialogue is to create space for the opinions of all participants so they are accepted and taken seriously. The main point of this principle was to create discussions in which the voice of all participants, especially the patients/clients, could be heard and to make space for open discussions between professionals from the organizations.

It is recommended that discussions about family members or others involved in treatment meetings be avoided if the person concerned is not present. This principle is connected to Bachtin's (1991) view about dialogue, where all opinions should be directly directed to the person in question. The theory of social construction, according to which truth is always a result of social interaction between persons, was also of great importance.

Some of the principles of the Need-Adapted Approach were not included in the INFM due to the fact that the project was planned in co-operation between adult psychiatry and social services and the character of these two organizations is different. Not all the principles of the Need-Adapted Approach were regarded as suitable, and the last two principles had not been developed when the Västerproject was realized. However, even though all the principles were not included in theory, they were practically realized in the concrete work in the Västerproject. As shown in Study I, horizontal expertise was practiced even though this was not clearly pointed out in the principles of the INFM.

During the planning and implementing of the project, units in adult psychiatry and social services were informed about the project principles. Information sessions were arranged with a lot of discussion concerning the principles. In the units involved in the project, especially in adult psychiatry, staff members raised the question whether it is ethically acceptable to place a patient in a situation where he/she must speak with several persons at same time. This doubt had its background in traditions which saturated the psychiatric organization. Network- and Family-oriented practices were rare at that time in Västerås adult psychiatry, and a patient's treatment and care were most often individually oriented, that is, a patient individually met only one staff member. If staff needed to talk together about the patient's conditions and treatment, the patients did not participate in such discussions. There was doubt concerning the project even in communal social services, even though their way of working was more influenced by working with networks and families. However, the project was realized, and Articles I and II are about the patients' experiences concerning that project. Four persons were recruited for the Västerproject. Two of them had been trained as family therapists and two were on family therapy training during the project. Their main duty was to be involved with the patients/clients who participated in the Västerproject, and in the treatment and caring process, and to continuously participate in the

treatment meetings. It is considered important that at least one of the members of the multiprofessional treatment team is a trained family therapist.

2.3 Knowing and understanding as social construction

The Need-Adapted Approach and the INFM model are based on the idea that knowledge can be looked at from several points of view, that is, there is no unambiguous explanation or truth concerning psychiatric illness or of the problems of psychiatric patients. According to caring science (e.g. Eriksson, 1994) a human being can be regarded as having social, psychological, biological and spiritual dimensions, all of which should be taken into consideration when planning treatment and caring activities. Eriksson´s theory is close to Engel ´s (1977, 1980)theory of biopsychosocial model. In this research, the theory of Need-Adapted Approach functions as a frame of reference on how knowledge and understanding concerning the patient's problems and illness can be influenced by different factors especially among the staff members in a psychiatric treatment unit. The Approach can be regarded as including the idea of social construction.

According to Berger and Luckmann (1966), the social construction of reality can be understood as a person's way of understanding reality, which is always a creation between people. In this way reality as well as knowledge are always results of social activities between people. According to Gergen (1985), knowledge can be seen as the result of a social process of creating understanding, not a product of testing hypotheses. Gergen agrees with Berger and Luckmann that social activities are important in creating understanding, knowledge and reality. Shotter's (1997) view is that the nature of social constructionism is about spontaneously occurring dialogical activities between people. Shotter's idea is in line with the views of Berger and Luckmann (1966) and Gergen (1985), though social activities are also regarded of having great importance. But is it possible to regard social construction only as a conversation-based activity, and if so, what does the conversation "contain"? According to Gergen and Gergen (1988), cultural, historical and social contexts form the basis for knowledge and understanding. Individuals live in their cultures and are surrounded by the traditions of those cultures, and these influence how individuals value knowledge and understanding (Giddens, 1991). Giddens (1993) refers to Gadamer's work in hermeneutics when pointing out that understanding is entering into a different tradition in which the past and present influence each other. It is a question of how different individuals' 'being-in-the-world', including their lived experiences, history, culture and societies, interact with each other. Linell (1998) considers social constructions to be not only based on verbal activities but also to have a socio-cultural dimension. Memory and cognitions cannot, according to Linell, depend only on discourse. According to Giddens (1993), understanding is situated in history,

that is, understanding is influenced by tradition and culture and becomes possible thorough them. Fonagy (1999) has developed a theory concerning memory, and his concept of implicit memory is in line with the ideas of Giddens and Linell. According to Aaltonen (2008), these implicit memories become awake and actual when several persons are in active interaction with each other, though different stimuluses activate several different ways of experiencing oneself with others and different implicit memories. Social construction, then, is seen not only as verbal activity between persons but also as including the whole history of a person, which influences the process of making sense of things. The Need-Adapted Approach and the INFM model are based on discussions between all participants all of whom have their own specific way of making things understandable, that is, creating social constructions in themselves. In psychiatric treatment, the personnel have their own specific way of knowing and understanding, which differs from that of the patients and relatives. This is why it is important to understand what kinds of factors influence social construction and creating knowing and understanding.

The traditional viewpoint of human psychology assumes an interpersonal world with a specific psychological structure including defence mechanisms, and according to Pinker (2002) these psychological structures might also be seen as social constructions. Pinker argues that some things really are social constructions: they exist only because people tacitly agree to act as if they existed. Hacking (2006) argues that science generally, but especially the human sciences, has the tendency to "making up people". Social constructions, as creations of understanding of the patient's difficulties and illness, guide psychiatric personnel in their work. The process of making up people can be understood as being based on the personnel's interpretation of the patient's situation and reality, mostly according to theoretical considerations. Hacking states the specific steps of the process of making up people: 1. classifications are invented; 2. a need for people who feel bad is created; 3. institutions and clinics for the cure of bad feeling are created; 4. knowledge of how behaviour should be interpreted is created; 5. experts who generate the knowledge are created. Hacking does not use the concept of social construction but the process he describes is very similar to the process of creating social constructions, as can be seen in the light of Giddens ideas about traditions and routines. However, the process of 'making up people' involves only the professional's interpretation of the patient's situation. The professionals' understanding and knowledge influence the treatment and care of psychiatric patients. If the professionals' way of understanding is based only on their own interpretations, the image concerning the patients' problems that guides them in their work can be false, in which case the professionals are working according to the "wrong truth".

The process of making things understandable is found not only in psychiatric treatment systems but also in families, where there are several ways of making sense of things or make things understandable, even though members of the family have at least partly the same history. All family members cannot have the same perspective on or the same kind of

understanding of, for example, psychiatric illness. In family therapy, Goolishian and Anderson (1992) argue that human beings construct their understanding according to the social activities they are in with other people: they become influenced by others. Andersen (1990) argues that one of the most important things in treatment is a reflective conversation during which a person's inner thoughts can be expressed. In such a reflective process, different ways of understanding or different social constructions interact with each other. The professionals can make their thoughts and ways of understanding known so the patient and family members can find out what they think and also comment on it. Laitila (2004) and Aaltonen et al. (2000) approach social construction from a specific point of view when thinking of horizontal expertise, according to which all ways of understanding or structuring existence are equally important in a psychiatric treatment and caring process. Aaltonen's theory is similar to Gadamer's (1997) theory of the fusion of horizons and to Gidden's (1993) theory of the influence of history and cultures on the process of understanding. However, the theory of implicit memory should also be included in this process. Laitila (2004) has shown that reflective practices in the process of horizontal expertise improve the possibilities to activate the resources of all the participants in the treatment process.

3 AIMS OF THE STUDIES

The basic aim of this study was to examine the experiences of psychiatric patients, who also were clients of community social services, of the Integrated Network- and Family-Oriented Model for co-operation.

The main questions for Article 1 were the following: (i) what do the patients think of the treatment meetings? (ii) how has the INFM influenced the patient's life situation? (iii) what do the patients' relatives think of the INFM? (iv) how do the patients experience being listened to by the professionals? (v) how have the patients been able to influence the planning of their treatment? (vi) how do the patients feel about continuing the treatment meetings? and (vii) how has the INFM influenced the patients' mental health? During the interviews, the patients told not only about their current experiences but also about their experiences of their treatment and care earlier when their treatment was based on a traditional treatment context.

Article II was based on the same material but is more focused on specific issues and can be regarded as a continuation of Article I, delving more deeply into how trust is created in different treatment and caring contexts. Article I and II are based on interviews with patients who had also experienced the traditional psychiatric model of treatment and care before the INFM model. Traditional treatment and care diverge from the INFM model in crucial ways. In traditional treatment and care, the patient does not participate in planning the treatment and care, or in the treatment process, as an active partner. The patient's relatives or members of his/her social network are seldom invited to joint meetings together with the patient and professionals.

Article III is more specific and is mainly a study of the importance of the relatives' participation in the treatment meetings and treatment process. Concerning the interviews, there were no specific research questions in Study III. However, the analysis of the material was based on questions concerning the relative's participation in the treatment process and its significance to themselves and to other participants in the treatment process. The process of analysis for Article III resulted in important categories and the core category of safety.

In the course of the analysis, the main aim of this study came to include investigating trust and safety in the Need-Adapted Approach.

4 METHOD AND PARTICIPANTS

The method used to analyze the material in this dissertation was an adaptation of Grounded Theory. Grounded Theory and its application have been developed during several decades (Glaser & Strauss, 1967; Strauss, 1987; Corbin & Strauss, 1990; Glaser, 1992; Pandit, 1996; Strauss & Corbin, 1998). According to Strauss & Corbin (1998), Grounded Theory provides the researcher with tools to deal with large amounts of material and helps the researcher to notice the various meanings of a phenomenon. Grounded Theory was suitable for this research project since the aim was to investigate the patients' experiences. According to Glaser and Strauss (1967), Grounded Theory is suitable for research areas where there has been little recent theory development, and no relevant theory development was found in the literature while carrying out this research. No hypothesis was made concerning the phenomena studied, the intention being to openly hear the patients' narratives concerning their experiences.

The process of applying Grounded Theory is described differently by different researchers. According to Tesch (1990), the main interest in Grounded Theory is to seek regularities, to identify and categorise elements, and to study the relations between them. Chenitz and Swanson (1986) consider Grounded Theory to be especially suitable and important for research areas in which there are serious gaps in knowledge or in which there is need for new points of view. The main principles of Grounded Theory are open coding, axial coding, selective coding and continuous comparison between codes, memos and categories. Open coding incorporates free analysis mostly of written material, for example transcripts of interviews. During this process the researcher identifies utterances which are interpreted to mean something. When this process continues, it is possible and indeed unavoidable that different utterances can be gathered into the same category because the have the same or similar meaning. Axial coding involves comparison between the categories and analysis of how they are related to each other. If and when connections are found, it becomes possible for the researcher to identify the core category (selective coding) among the categories initially identified. Selective coding is

the process of choosing one category to be the core category, and relating all other categories to that category. During the whole process of analysis, continuous comparison is carried out.

Material for the first two articles was collected from psychiatric patients with different psychiatric diagnoses living in Västerås, Sweden between 1 March 1998 and 31 May 1998. The persons interviewed had been both patients in adult psychiatry and clients in community social services. All the patients/clients, 22 persons, had been participating in a development project which used the Integrated Network and Family-Oriented Model (INFM) for co-operation between psychiatric patients, personnel from adult psychiatric care and social services. There were 57 patients who could be interviewed, 22 of whom fulfilled the inclusion criteria and were interviewed (see Article I). The patients were orally asked to participate in the interviews. The interviews lasted between 30 and 90 minutes and were realized either at the patient's home, an outpatient clinic or the hospital or other institution. All the interviews were done in a three month period. The interviews were realized as free-floating discussions between the interviewer and the patients concerning themes for the interview.

Firstly, the researcher collected the material for Study I by interviewing all the 22 patients. All interviews were audio taped and transcribed before analysis. The transcribed texts were analysed using the table program of Windows Microsoft Word 4.0 (Carney, Joiner & Tragou, 1997). The researcher made notes during the interviews and these notes were used during the process of analysis. In Study I, the analysis was focused on the patients'/clients' experiences of INFM according to questions which functioned as the basis for free-floating discussions.

The first step in the analysis took place during the interviews. The researcher asked follow-up questions during the discussion, in order to check his preliminary understanding of the patient's utterances. During this phase the researcher read and re-read the transcribed text several times and compared the text with the notes made, and coded the themes identified as important. This corresponds to open coding. The second step, which corresponds to axial coding, was to identify aspects among the themes. The term aspect is used to emphasize the process character of the findings. The themes were clustered and compared with each other and in this way the aspects could be identified.

TABLE 1 Participants in Study I and Study II

Patient	Sex	Age	Diagnosis	Social problem
1	Female	45	No psychiatric diagnosis	One-parent family, unemployment
2	Female	40	Specific personality disorder	One-parent family, unemployment
3	Male	32	Schizophrenia	Unemployment
4	Male	55	Recurrent depressive disorder	No expressed or assessed social problem
5	Female	35	Schizoaffective disorder	Unemployment, homeless
6	Female	58	Schizoaffective disorder	Unemployment, homeless
7	Female	60	Unspecific non-organic psychosis	Alcohol abuse, single parent with grown-up children
8	Female	35	Other anxiety disorder	Unemployment
9	Female	37	Other neurotic disorder	Unemployment
10	Female	48	Bipolar affective disorder	No expressed or assessed social problem
11	Male	32	Recurrent depressive disorder	No expressed or assessed social problem
12	Female	35	Recurrent depressive disorder	Unemployment, problems of one-parent family
13	Male	29	Schizoaffective disorder	Unemployment, problems of one-parent family
14	Female	26	Bipolar affective disorder	Unemployment, problems of one-parent family
15	Female	50	Mental disorder, not otherwise specified	Unemployment, problems of one-parent family
16	Female	20	Dependence syndrome	Unemployment, homeless, problems of one-parent family
17	Female	35	Schizoaffective disorder	Unemployment, problems of one-parent family
18	Male	35	Other anxiety disorder	Unemployment
19	Female	60	Phobic anxiety disorder	Unemployment, problems in municipal dormitory
20	Female	30	No psychiatric diagnosis	Unemployment, problems of one-parent family
21	Male	27	No psychiatric diagnosis	Unemployment, problems of one-parent family, homeless
22	Female	30	Persistent delusional disorder	Problems of one-parent family, constant unemployment

The third step was to identify the core categories among the aspects. In this process, continuous comparison of themes, aspects, notes and tapes and their relation to each other was realized which corresponds to selective coding. The fourth step was to confirm the credibility of the findings. The first phase in confirming credibility was to return to the patients to confirm the findings (Streubert, 1995). The participants confirmed the findings during joint discussions. The second phase was to use the supervisor as outsider evaluator. The supervisor was not involved in the interview process. It is important to clarify the role of the supervisor at this point. The supervisor (the second author of the three articles) has functioned as a trainer for the researcher during his training in family therapy. He has also played a significant role as a developer concerning the Need-Adapted Approach and he has been used as an external evaluator of the initial analysis made by the researcher. The supervisor's background is connected to network- and family oriented treatment and care. However, the supervisor also has been trained as a psychoanalyst. These facts,

and their possible influence on the results, have been borne in mind by the researcher and the supervisor. The researcher is a nurse specialized in psychiatry and has basic training in individually oriented psychotherapy, and training as a family therapist.

The same material was used in Study II. The aim was to make a deeper study of the phenomenon of trust, and of what makes the development of trust possible in the INFM context and the traditional context. The fact that during the interviews the patients told about their experiences of treatment in both contexts made it possible to explore the factors that influence the development of trust and mistrust in the patient's treatment and care before the use of the INFM and when using the INFM.

For analysis of the material for Study II, the transcribed interviews were transferred to the Atlas ti. 4.2 computer program (Thomas, 2006). The first step of the analysis, which corresponds to open coding, was a preliminary reading of the text and note taking. As in Study I, the texts were read several times to find a balance between the two contexts to avoid too polarized a composition between the contexts. The second step was to identify meaning units that create either trust or mistrust. A meaning unit could be a word, sentence or several sentences, and these were labelled with single words or concepts, and finally clustered into categories. This step corresponds to axial coding according to Grounded Theory. The third step was to confirm the credibility of the clusters. As in Study I, the supervisor was used as an outsider evaluator since he had not been involved in the process of analysis. The fourth step was to identify the categories from the concepts, and this corresponds to selective coding. In this way the whole process is in line with the process of open coding, axial coding and selective coding and continuous comparison between categories, concepts, meaning units and notes and their relation to each other (Corbin & Strauss 1990). To confirm the credibility of the findings, they were discussed with the supervisor until a shared view was arrived at. The supervisor was not involved in the interviews or interpretation of the material and this made it possible to use him as external evaluator of the credibility of the findings.

Material for the third article was collected in outpatient clinics at Jorvi (in the city of Espoo in the south of Finland, 235 000 inhabitants) and Keropudas (in the city of Tornio in northern Finland, 72 000 inhabitants) in Finland. After the completion of Study I and Study II, it was consistent to study the whole treatment system, and new material was collected in order to study the phenomena of therapeutic systems (Andolfi, 1979) and the Need-Adapted Approach. The ten patients involved had been diagnosed as having schizophrenia or psychosis. The patients for this study were recruited by the local staff at Jorvi psychiatric hospital, at the Espoo city outpatient clinic and at Keropudas psychiatric hospital, in the Tornio city outpatient clinic. The inclusion criteria for the study were as follows:

The patients should have been in a treatment process for at least 2 years.
The patients should have a diagnosis of schizophrenia or psychosis.

The patients' relatives or members of their social network should have participated in the treatment process.
The patients had a scheduled visit to the outpatient clinic on the dates when the interviews were to be held.

Ten patients, 5 from each clinic, with relatives participated in joint interviews with members of the patient's multiprofessional treatment team. Five of the patients participating in the interviews were female and five male, aged between 21 and 45 years. The mean age was 33.

Interviews were held on 3-4 June at Keropudas and on 1-3 July 2003 at Jorvi outpatient clinic outpatient clinic. All patients visiting the outpatient clinics were potential informant. The drop-out rate is shown in Article III.

TABLE 2 Participants, Study III

Gender	Age	Marital status	Occupation	Diagnosis	GAS	Age of onset	Relatives in treatment process
Female	22	Unmarried	Student	Un-differentiated schizophrenia	6	17	Mother/ Father/Sister
Female	24	Married	Nursing student	Unspecified nonorganic psychosis	7	20	Mother/ Father/Sister/ Husband
Female	30	Married	Unemployed	Schizoaffective disorder, mixed type	5	27	Mother/ Husband
Female	39	Divorced	Employed	Un-differentiated schizophrenia	6	35	Former husband
Female	45	Divorced	Retired	Post-schizophrenic depression	5	38	Mother/Father/ Cousin/Child/ Former husband
Male	21	Unmarried	Student	Catatonic schizophrenia	3	18	Father/Brother
Male	31	Unmarried	Unemployed	Schizotypal disorder	3	29	Mother/Sister
Male	31	Unmarried	Unemployed	Schizotypal disorder	6	27	Mother/Father/ Girlfriend
Male	40	Divorced	Employed	Unspecified nonorganic psychosis	8	32	Former wife
Male	44	Married	Unemployed	Paranoid schizophrenia	5	39	Wife

Participating patients were informed about the research project and its aims orally and in writing by the local staff members. Before the interviews the patients and their relatives were again informed about the research purposes and written consent was obtained from the patients. Participating relatives or members of the patient's social network were orally informed. The participants in the interviews were the patient, his/her relatives and members of the multiprofessional, case-specific treatment team which was responsible for the

treatment process. The interviews were conducted at the out-patient clinic and lasted between 1.5 and 2 hours. The interviews were divided into three phases. Firstly, the patient and relatives were asked to tell about their experiences concerning caring and treatment from the beginning of the treatment process at the outpatient clinic. Secondly, the professionals were asked to discuss what they had heard and what they thought about what they had just heard. The third phase was a joint discussion between all participants.

The process of analysis is similar to that in the first two studies. All the interviews were video-recorded, transcribed and analyzed using the Atlas Ti. 5.0 computer program for qualitative material analysis (Callahan, Maldonado & Efinger, 2003). The first step in the analysis was reading the transcripts and taking notes. During this process, the researcher made memos and marked quotations while asking questions about the text - "what is being talked about?", "what is the person saying here?" and "what are the persons experiencing here?" This process was carried out several times. The second step was to identify concepts in the quotations. A quotation in this study could be a sentence, several sentences or part of a longer discussion. All the quotations were compared with others and in this way the concepts were identified. The first and second steps together correspond to open coding. The third step was to identify the categories in the quotations and the concepts initially identified. This was carried out using the principle of the continuous comparison of the categories, concepts, quotations and memos and their relation to each other, and corresponds to axial coding (Corbin & Strauss, 1990). The fourth step was to identify the core category among the categories. During this process, the continuous comparison of categories, concepts and quotations was carried out. This step corresponds to selective coding according to Grounded Theory. The fifth step was to confirm the credibility of the categories and the core category. The concepts identified were discussed with the supervisor to arrive at a shared view. The fact that the supervisor was not involved in the interviews or in the interpretation of the material made it possible to use him as an external evaluator of the credibility of the findings.

5 RESULTS

In the course of writing this summary article, the process of continuous comparison has continued, that is, the three articles and their contents are compared with each other, and connections and similarities have been identified. This means that a new kind of understanding concerning trust, mistrust, autonomy and safety and their interdependence has developed as the three articles are analyzed in relation to each other.

The findings of the three articles are not presented separately but as a continuum, as a process in which safety can be created. The four core categories, three of them (trust, mistrust and honesty) from Article I together with the new core category, autonomy, are essential in creating safety. Safety should be seen as the final finding in my research. The core categories are interdependent and depend on the categories initially identified during the process of analysis of all material in my research.

5.1 Trust

In the first article (Piippo & Aaltonen, 2004), the main aim was to investigate the experiences the patients had had concerning the Integrated Network and Family-oriented Model (INFM). The main findings showed that the patients had mostly experienced the INFM model as positive; the model brought a different kind of content to the patients' treatment than they had experienced earlier in psychiatric treatment and care. During the interviews the patients spoke about how they had experienced the INFM and their earlier treatment and care, which can be seen as an individually oriented model.

The phenomenon of trust was identified in the first article among the categories initially identified (Figure 1). The positive categories created a sense of trust among the patients. Positive categories here are categories which, according to the patients' experiences, was good for them and which developed their treatment and caring process positively. When the patients were able to

have all the important persons from their social network gathered together in an atmosphere which allowed understanding of the patient's difficulties from several points of view, and the patients could speak about issues that were important to them, they experienced co-operation instead of objectification. This can be seen as a conclusion of the categories in Article I, which are as follows: 1. Having all important persons in the patient's social network gathered together. 2. Atmosphere where one feels free to say what one wants and needs to say. 3. Seeing their problems from several points of view. 4. Patients experience co-operation instead of objectification.

These categories became identified as positively influencing development of trust in the IFNM model. The issues that make the categories possible are often connected to the personnel's behaviour, their attitude to the patients and their way of making psychiatric illness understandable. When the personnel were practicing the principles of the IFNM model, they were open in their way of thinking and were also open to other people's thoughts concerning the patient's illness or problems. As Giddens (1990, 1991) has argued, the development of trust is a mutual process between two or more persons, a process which includes disclosure and honesty. When one side discloses something personal about him/herself, he/she invites the other side to also disclose something personal. This kind of process continues, according to Giddens (1990, 1991), and gets stronger when the trust developed is not betrayed. In such a process, honesty is important, since all participants are vulnerable and if the disclosed personal issues are misused, the process stagnates. The categories can also be understood in terms of the idea of Aaltonen et al. (2000) of horizontal expertise. When the treatment team acts according to horizontal expertise, they want to let the patient really feel that his/her opinion is of great importance, this is, horizontal expertise is not a therapeutic method or technique but a matter of attitude. Horizontal expertise includes knowing, all participants knowing from their own point of view. This is not necessarily the same as not-knowing possession (Anderson, 1997), which can be used as technique.

In Article II (Piippo & Aaltonen, 2008a) the phenomenon of trust is studied in more detail. In the second article, the term knowledge was used in the first category. Now I prefer to use the term knowing as used by Stern (2004), because knowing corresponds better to the Finnish word "tietäminen" than does knowledge, since it is not a question of knowledge as hardware of facts or some kind of truth. It is more a question of a process between different persons in which knowing is created in a shared process between participating persons. This phenomenon is described by Stern (2004) as what he calls intersubjective knowing. It was shown in Article II that the way knowing was created affected whether trust was created or not in the INFM context. When knowing, and through that understanding, was created in a mutual process, the patients experienced themselves as whole persons and their experience of autonomy increased. The reciprocal character of the process also affected the creation of trust. The categories of trust creation are interdependent and are needed for the

creation of trust (Figure 1). Autonomy is the central issue for the experience of trust. Both the first category, "versatile interchange of knowledge and understanding leads to the experience of wholeness and autonomy" and the third category, "being able to accept help from others leads to the experience of autonomy", include autonomy and the second category, "a reciprocal process involving honesty and openness", connects all these three categories together. The autonomy that the patients experience gives them power, meaning that the patients experience themselves as more able to cope with their lives even if they feel that they need help from others. Here again, the personnel's behaviour is important since a reciprocal and open process between the patient and personnel is a necessity for the development of trust. The openness can be regarded as being open to different ways of understanding the patient's situation, and non thought or social construction becomes an unspoken issue that influences the process.

The categories which create trust identified in Article I and Article II are very similar to each other, nearly the same, which is understandable since the findings in the articles are based on interviews with the same persons. The categories are interdependent and create a wholeness of how trust can be created in the IFNM context. When important persons in the patient's social network are gathered together, an atmosphere is created in which there is freedom to speak freely, which enables the creation of versatile knowing and understanding. This makes it possible to examine the patients' problems and difficulties from several points of view in a reciprocal process involving honesty and openness which leads to the experience of co-operation instead of objectification for the patient, and this makes it possible for the patient to accept help from others while remaining autonomous.

It is interesting that even when several persons were gathered together, the patients experience the freedom to speak, whereas common sense might say that the presence of several persons would make it difficult for the patients to speak freely. According to Aaltonen (2008), this might become possible thorough the activation of several different ways of experiencing oneself together with others. Aaltonen's view is connected to Fonagy's (1999) theory of implicit memories. According to Fonagy, implicit memories are the area in which psychotherapeutic changes happen: they are nonconscious activities which influence interaction with others and the way of experiencing the other. When several persons interact with the patient, he/she experiences him/herself as being more than before, this is, experiences him/herself in several ways with others. This can encourage the patient to speak freely, since no way of knowing and understanding is forbidden. In a traditional treatment context, trust was created when the patients experienced themselves as individual persons, were treated with respect, and experienced themselves as autonomous persons with one specific member of staff (Figure 1). The categories in a traditional context are also interdependent. When patients feel that they are treated as individuals, in a respectful way, they feel that they are autonomous. As in the INFM context, the creation of trust in a traditional context was dependent on the personnel's

behaviour. When the patients experienced that they were participating in their own treatment process as autonomous individuals, trust could be created. A traditional treatment context includes routines and rituals, and traditions as viewed by Giddens (1991) influence the personnel's behaviour, especially if one member of the staff depends on others when it comes to how the patient should be treated. However, when individual staff members adjusted their behaviour to match the situation where they met the patient and to the patient's needs, the development of trust was possible even in the traditional context. Indeed, the traditional context does not prevent the development of trust when staff members find ways to act that are suitable for the patient's need and for the context itself. Trust in the INFM context is not limited to trust in personnel, it is also a question of trust in the whole treatment system. As shown in the articles, patients began to experience the whole treatment system as honest as the system became more open concerning opinions about the patients problems, and we can conclude that horizontal expertise was being practiced. This did not happen in the traditional context, where trust was created concerning merely one staff member.

Giddens' (1990, 1991) views concerning trust are quite similar to those of Erikson (1968), Lögstrup (1994) and Luhmann (1979), in that according to Giddens, trust is created in a relationship between two or several people, and in this relationship all sides are vulnerable. When two or more people disclose something personal, they invite the other/others to do the same. This process, according to Giddens, gets deeper and deeper and trust develops between participants. However, participant in such conversations also become more vulnerable during the process. When one side acts against another in a way that ends the process of trust creation, trust turns, in Giddens term, to mistrust. Giddens (1990) also thinks that trust is not bound up with risk so much as with contingency. A contingency is something that can happen, but that generally is not anticipated. Planning for contingencies often requires a more innovative approach, because contingencies are not obvious. In an human beings life, the social environment is of great importance especially concerning development of trust. The positive development of basic trust helps people to manage their lives and problematic situations without help from the treatment and caring system. However, some people are dependent on these systems but this does not necessarily mean that their basic trust is undeveloped. It may be that they have been living in difficult circumstances and their trust in themselves is not strong enough and they need help from others. Even if childhood has not enabled the positive development of basic trust and trust in oneself in later years, this development can be activated during adulthood. As shown in the studies, the personnel's different ways of acting and functioning in treatment and care, especially concerning traditional treatment context, treatment measures can increase development of trust and autonomy. The Need-Adapted Approach seems to favour such development more than does traditional psychiatric treatment. Why is this? Perhaps it has to do with the influence of the case-specific multiprofessional treatment team. It is not bound to one single staff

member's actions and behaviour and in that way the treatment team's work also activates the implicit memories every psychiatric patient has and enables the new development of basic trust as well as trust in others.

The findings have important implications for psychiatric treatment systems and for social services. It should be noted that the personnel's behaviour is important for the relation between the patient and personnel, regardless of whether it is a single staff member or the whole multiprofessional treatment team, and the development of trust is possible in both situations. However, in a multiprofessional treatment team the patient is not bound to a relationship with only one specific staff member, and this fact increases the possibilities for the patients to relate to several persons and also makes the development of trust different than it is in individual contacts. As the results also show, the staff's abilities to knowing and understanding the patients' difficulties and situation depend on the images that the staff have. When several points of view concerning the patient's situation could be presented, it enlarged the view of the patient's situation and made shared discussions possible, in which the patient was an active participator and an autonomous person. The routines and rituals that influence the personnel's actions are based on the interpretation of theories, and trust development depends on how strong the traditions are and how dependent the personnel are on the theories. Theories are not static; they are under constant development, as is a human being's life. The routines and rituals which influence a treatment system, whether it is traditional or not, should therefore follow the constant development of existing and new theories. The question whether personnel see and understand the patient's difficulties from several points of view is justified; a multiprofessional treatment team does not suffer from that limitation.

If the psychiatric treatment system and community social services want to develop treatment and care for patients and clients, co-operation is of great importance. Leiman (2007) proposes that even though official organizations must have structures and descriptions of the organization, they still can give freedom to personnel to plan interventions according to the patient's needs. This makes it possible to carry out treatment and caring activities in the way that the Need-Adapted Approach suggests.

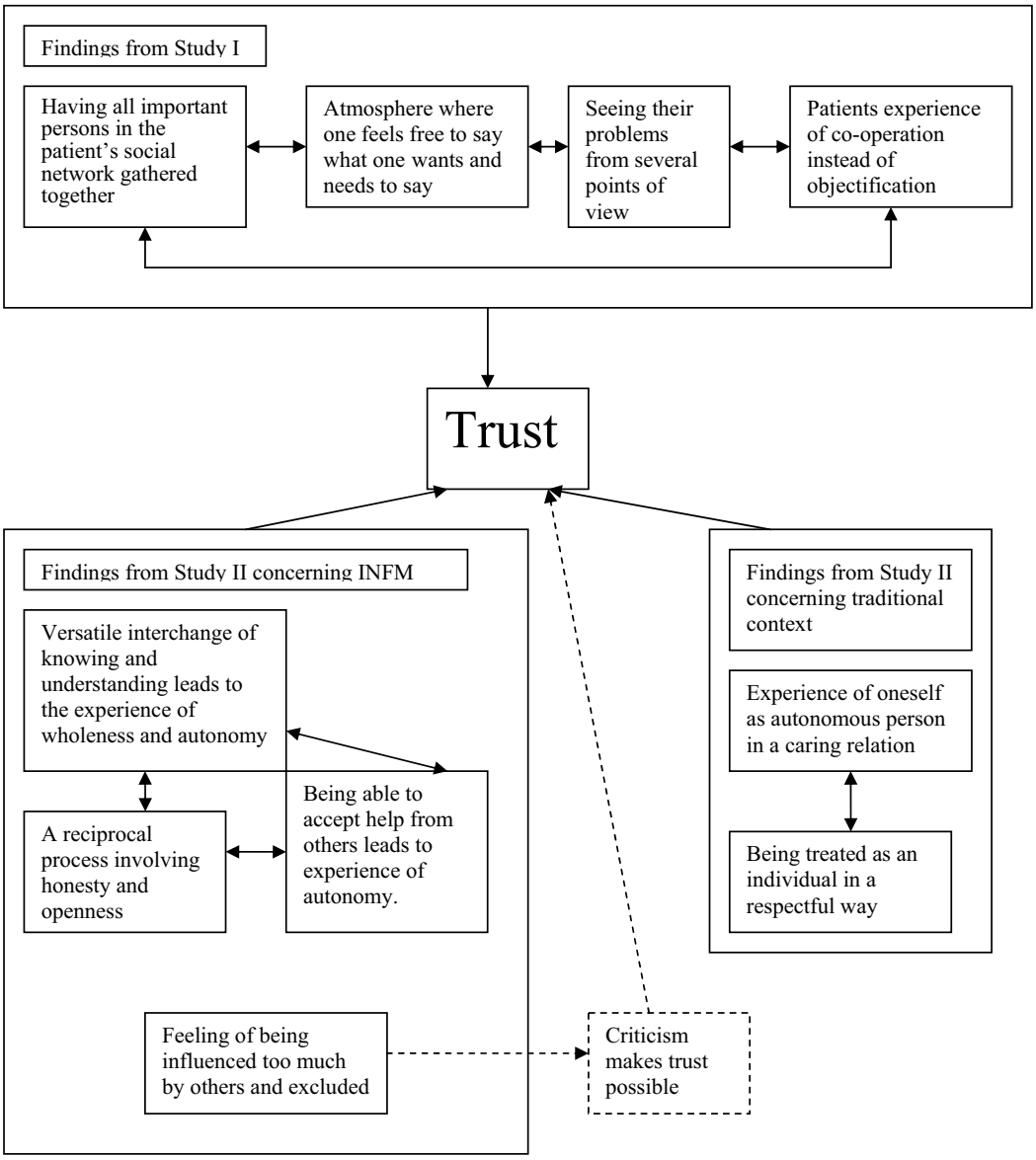

FIGURE 1 Categories increasing trust

5.2 Mistrust

Mistrust was experienced by the patients in both the IFNM context and the traditional treatment context. Both contexts include categories that increase the development of mistrust (Figure 2). The negative categories in Article I were categories that created mistrust. These categories can be summarised as 1. the personnel's overwhelming enthusiasm for a new treatment model; 2. too abstract treatment and caring model. When personnel became too interested in the INFM model they forgot the patients' needs. This happened also when the model became too abstract for the patients; the model seemed to diverge too much from the patients' daily life. The personnel's behaviour was also such that they forgot or did not notice the patients' situation; they just realized the model without being sensitive to the patients' needs.

In Article II, the categories which led to mistrust were more specific in both models. In Article II, comparison between the models was also done more consciously and the categories that led to mistrust in the INFM model were 1. experience of being influenced too much by others, 2. exclusion and confusion decreases autonomy (Figure 2). However, in the INFM model criticism from the patients was possible and the category "experience of being influenced" can turn to trust through criticism as shown in Article II. However, when the patients experience exclusion and confusion it seems that development of trust never becomes possible. In the traditional model mistrust was created through three categories which can be summarised as follows: 1. the patients experience that the personnel's rigid thinking makes their own understanding underrated, 2. the patients as individuals experience depersonalization, and 3. feeling of being left alone in an incomprehensible situation (Figure 2). These categories differ from the categories concerning the INFM model: none of them can in any way lead to the development of trust. In this way, when mistrust is created in the traditional context there were no possibilities for further development of trust in that context. Indeed, as the results show, a change of the treatment context can be a way of creating new possibilities for trust development even if the patients had been in traditional treatment and care before treatment and care according to the INFM. Mistrust cannot be seen as separate between personnel and treatment system: when mistrust exists, it is about both personnel and the treatment system. This makes mistrust different from trust since trust can be about personnel but not the whole treatment system, as shown in the results concerning the traditional context.

Mistrust categories cannot be seen as interdependent, each category led to mistrust as a single category. However, if several categories are in interplay, mistrust might be strengthened. Mistrust categories in Article I were not interdependent but connected to each other through the INFM model because analysis of the material did not result in findings that connected the categories to each other in other ways. It seems to be the same concerning mistrust categories both in the INFM and traditional context according to findings in

Article II. The categories functioned as single categories which increased mistrust but they were not necessarily interdependent. Even here the assumption that mistrust is strengthened if the categories are in interplay can be seen to be justified.

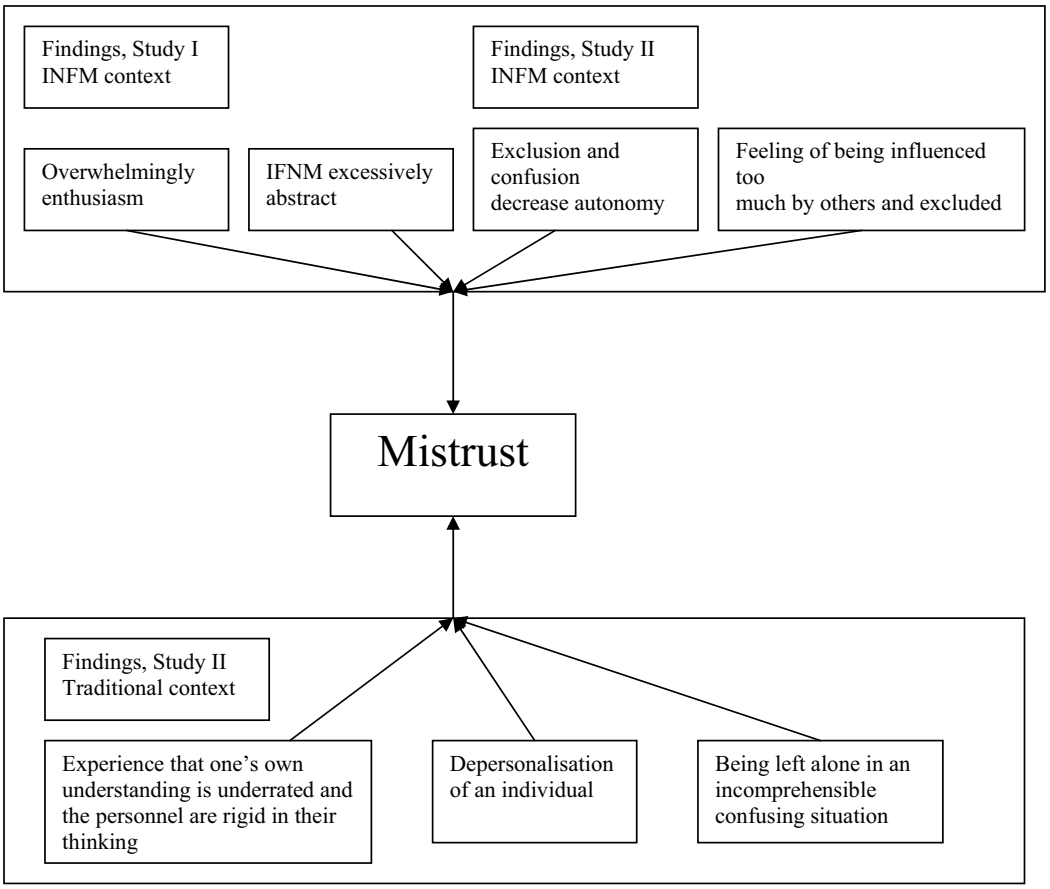

FIGURE 2 Categories increasing mistrust

5.3 Honesty

Honesty was also identified as a core category in the first article. The patients interviewed for the study said that they experienced the INFM model as being honest. Honesty was connected to the personnel's behaviour when they were able to talk more freely concerning their own thoughts about the patients' situation and when the patients asked questions they had not asked before. It seems as if the IFNM model made it possible for the personnel to be open with

their social constructions. In the INFM model, the patients experienced their participation as happening in a mutual process with the personnel, a process which included honesty through openness. Honesty was expressed by the professionals when they were able to open up their thoughts concerning the patients' situation and problems and were not ruled by routines and traditional ways of understanding the patients' illness. Traditionally, not only the patients but also the professionals were used to meetings with only one professional present. When several professionals from different psychiatric professions gathered together it became possible even for the professionals to talk differently about the patients' problems and life situation. This was surprising for the patients, in a positive way. Honesty as a core category can be seen thorough all the categories that increase trust. Helkamas's (2004) ideas concerning honesty are interesting since he connects honesty with trust and even power. According to Helkama, trust is possible when there is equal distribution of power, when people act honestly; there is no need for hierarchic and controlling power structures. In psychiatry the question of power is always present, depending on the hierarchy (Foucault, 2006; Thomas & Bracken, 2004). The influence of these power structures can, however, be reduced by practicing horizontal expertise or, as Thomas and Bracken propose, critical psychiatry. The phenomenon of dishonesty is not examined in our articles. However, honesty can be examined through its opposite, dishonesty. An example of dishonesty would be hiding some significant issues from another person or persons. There are many reasons for dishonesty and sometimes people omit mentioning something significant in their stories if the consequences might be difficult for them. The results in Articles I and II show that the professionals often left something significant unspoken in the traditional context. This research does not provide answers to the question why the professionals do not speak out concerning their thoughts and opinions, but perhaps it has something to do with traditions and routines and a vertical view of expertise.
Concerning the third Article and the Need-Adapted Approach, it was shown that relatives sometimes deny or do not reveal significant important issues when there is a risk of being criticised or unmasked. This becomes a difficulty especially for members of the treatment team if they are forced to try to balance between two different descriptions of reality or truth.

5.4 Autonomy

Gadamer (2003) illustrates two different kinds of authority, authoritarian and authoritative authority. According to Gadamer (2003), there is a crucial difference between these two. Authoritarian authority strives for authority and to have power. Authoritative authority does not strive for authority or to own power and has a different attitude to the human environment than authoritarian authority. Gadamer argues that only a person who does not have

to refer to his/her authority can bee seen as authoritative. The word authoritative does not refer to the power a person has but to the signification the person has, not the one he/she claims he/she wants to have. The opposite, an authoritarian person, consciously undertakes certain measures, makes utterances and carries out actions to attain authority, and is in fact only acting for power. However, according to Gadamer that kind of authority never has any authority over the human environment. Authoritarian attitude seems, according to this research, to be connected to experience of decreasing autonomy among the patients. The attitude of professionals in psychiatry can be considered in the light of Gadamer's views concerning the two different ways of viewing authority, and this can be seen as connected to autonomy. The traditional context and the INFM model gave different experiences of autonomy among the patients interviewed.

The theory of Aaltonen et al. (2000) concerning vertical versus horizontal expertise is in line with Gadamer's (2003) views of authoritarian and authoritative authority, where vertical equates to authoritarian and horizontal to authoritative. Authority can be regarded as being connected to power. Horizontal expertise can be considered as authoritative, since when horizontal expertise is practiced, power is not owned by somebody specific. Vertical expertise, on the other hand, can be understood as including authoritarian authority since power is not shared in such circumstances. Vertical expertise can also be seen as including elements of Giddens' (1991) views of traditions. In the articles that are basis for my dissertation we can see that different kinds of expertise can be understood as different kinds of authority. On the basis of my own experiences as a professional in psychiatry, and as a researcher, it seems to me that traditional psychiatry includes more authoritarian authority than does the INFM and the Need-Adapted Approach. In Articles I and II the patient's experience of autonomy is central in these two caring contexts. If the caring system and psychiatric treatment are such that makes it possible for the patients to experience autonomy, it is shown in my articles that the INFM model, which is an application of the Need-Adapted Approach, gives at least several more possibilities for the patients to experience autonomy than the traditional treatment context. The first category in the first Article is an example of this, when the patients/clients were able to discuss with several members of staff, the personnel become able to talk more freely. Their usual way of discussing changed and the patient's narratives become larger, according to the patients.

Gadamer (2003) argues that professionals in psychiatry are eager to help the patient, but the help is not always of the kind the patient needs. The professionals want to make the patient believe what they think about the patient's problems. In this way the professionals try to influence the patient to believe in what they believe, in fact they try to impose their social constructions on the patient. When the Need-Adapted Approach and INFM model is practiced, this happens less often than in traditional psychiatry, as shown in the articles. When several persons gather together and openly discuss the issues, the social constructions of all are present more or less in spoken form. However,

two of the categories concerning the IFNM model in Article II are categories that decrease the experience of autonomy, *Exclusion and confusion decrease autonomy* and *Feeling of being influenced too much by others and excluded* are not the same as the mistrust categories concerning the traditional context. Mistrust categories concerning the IFNM context are connected to the categories in the first Article since they are connected to the personnel's striving to act differently The personnel did not have total responsibility concerning the patients' treatment and care since they were depending of external opinions concerning the patients condition, neither the personnel nor the patient had power. The patients and their relatives are often forced to place their lives in the hands of the professionals. The power of the professionals must be handled with care so that it does not become a negative aspect in the relation between patients, relatives and professionals.

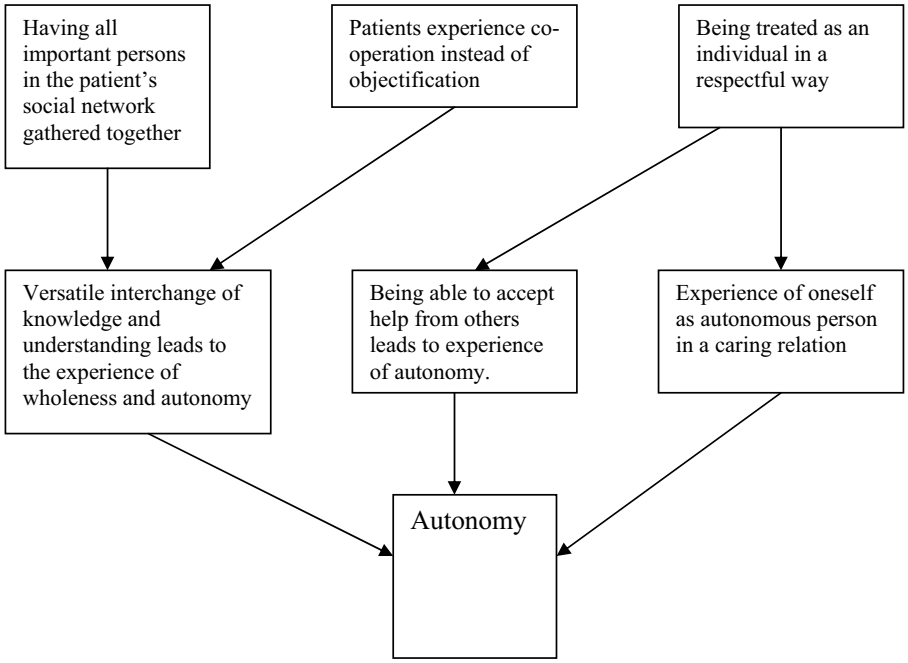

FIGURE 3 Categories increasing experience of autonomy.

5.5 Safety

In the third article (Piippo & Aaltonen, 2008b), safety was identified as the core category. Among seven initially identified categories, three - shared understanding, new kind of relationship and being able to cope with life - were connected to the development of safety, while the sixth category, whom or what can one believe, was connected to safety thorough shared discussion. Category four, exclusion, category five, need for a one-to-one relationship, and category seven, keeping the illness secret, did not increase safety but according to our analysis they did not decrease safety either, the experience of safety remained unchanged. The three first categories increased the experience of safety as single categories but also thorough interplay between them. Shared discussions were not about the patient's illness or problems but about relations between all those involved in the discussions. However, the experience of safety was not the same for all involved. For the patients and relatives, shared discussions made it possible to redefine relations, which made it possible to cope with life. The patients' and family members' experience of safety is to be seen as interdependent. Their relation changed thorough and during the treatment process in which relatives could participate. Previously the patient and relatives had not been able to discuss issues that had worried them, and they had different explanations as to why things were as they were. The personnel's experience of safety is to be understood as confidence in their own work when they, thorough shared discussions, could ensure that their understanding of the patient's situation was not only of their own construction. The personnel's experience of safety was not without complications. Honesty, which is one of the core categories in Article I, was needed in the relatives, so the personnel were able to trust that their actions and understanding were adequate.

A consequence of the continuing process of analysis was that the creation of safety depended on several of the categories and core categories initially identified in the three articles. All the categories which, in the two first articles, increase the experience of the core categories trust, honesty and autonomy are needed for the development of safety. In the two first articles the categories and core categories were about the patient's experiences concerning the INFM model and in the third Article the creation of categories and the core category have different grounds since it is about patients, family members and members of the multiprofessional treatment team's experiences of the Need-Adapted Approach. Indeed, we can see that safety in these circumstances is a shared creation which depends on several factors. The categories which are connected to the phenomenon of trust are connected with the three first-mentioned categories which increase the experience of safety and these categories are not such that safety can be developed only thorough them.

Safety, as Eräsaari (2002) illustrates, is difficult to define. Its expression becomes substantial when there is a lack of safety. Perhaps safety is most easily definable in terms of its opposite, un-safety. When people experience that they

are unsafe, they feel fear and cannot tolerate uncertainty. When the future is unknown or uncertain and people do not know how they are going to live their lives, they feel unsafe. For the development of safety, trust, honesty and autonomy are needed. In addition to these core categories, other factors as revealed in the findings in Article III are needed to ensure that the development of safety is adequate. The kind of shared discussions that were held during the patients' treatment process were not controlled by one person but by all those participating in the discussions. When the principles of the Need-Adapted Approach, which is the object of the third article, are practiced, Andolfi's (1976) theory of a therapeutic system can be realized. In the therapeutic system, all participants are in mutual relation with each other and no one person can control what is going on in the system. This is because when relations are discussed in a system, everything one says has an influence on others and on oneself as well. Of course, there are issues that vary in their importance to different participants, but none of these dominate the discussion. As shown in the third article, it was not the patient's illness not his/her symptoms that were treated but the relations between patients, relatives and members of the treatment team. When relations are "treated", nobody needs to own the power to decide how to discuss or how the relation should be treated since all participants are dependent on others and influence each other. The power to decide must be shared, as well as the discussion. As shown in Article III, the power can also be regarded as being shared since the patients and relatives experience increasing autonomy. As Gadamer (2003) argues, autonomy and power are dependent on each other, and in my research autonomy was one of the core categories for safety.

Two of the categories in the third study, exclusion and need for a one-to-one relationship, neither increased nor decreased the experience of safety. Study III does not give any explanation of why these categories do not have any effect on the experience of safety among patients and relatives. However, if the patients' need for a one-to-one relation had been noticed and responded to, it might be that they do not experience exclusion. In this way these two categories can be seen as interdependent. The seventh category in Study III, keeping the illness secret, is independent of other categories and it does not have any effect on the experience of safety, according to our analysis. However, this category can be seen as one that keeps the situation in the family stable even though it has two contradictory dimensions. On one hand there is nothing to be ashamed of, and on the other hand it is impossible to speak about the family's situation and the patient's illness with other persons, only with professionals.

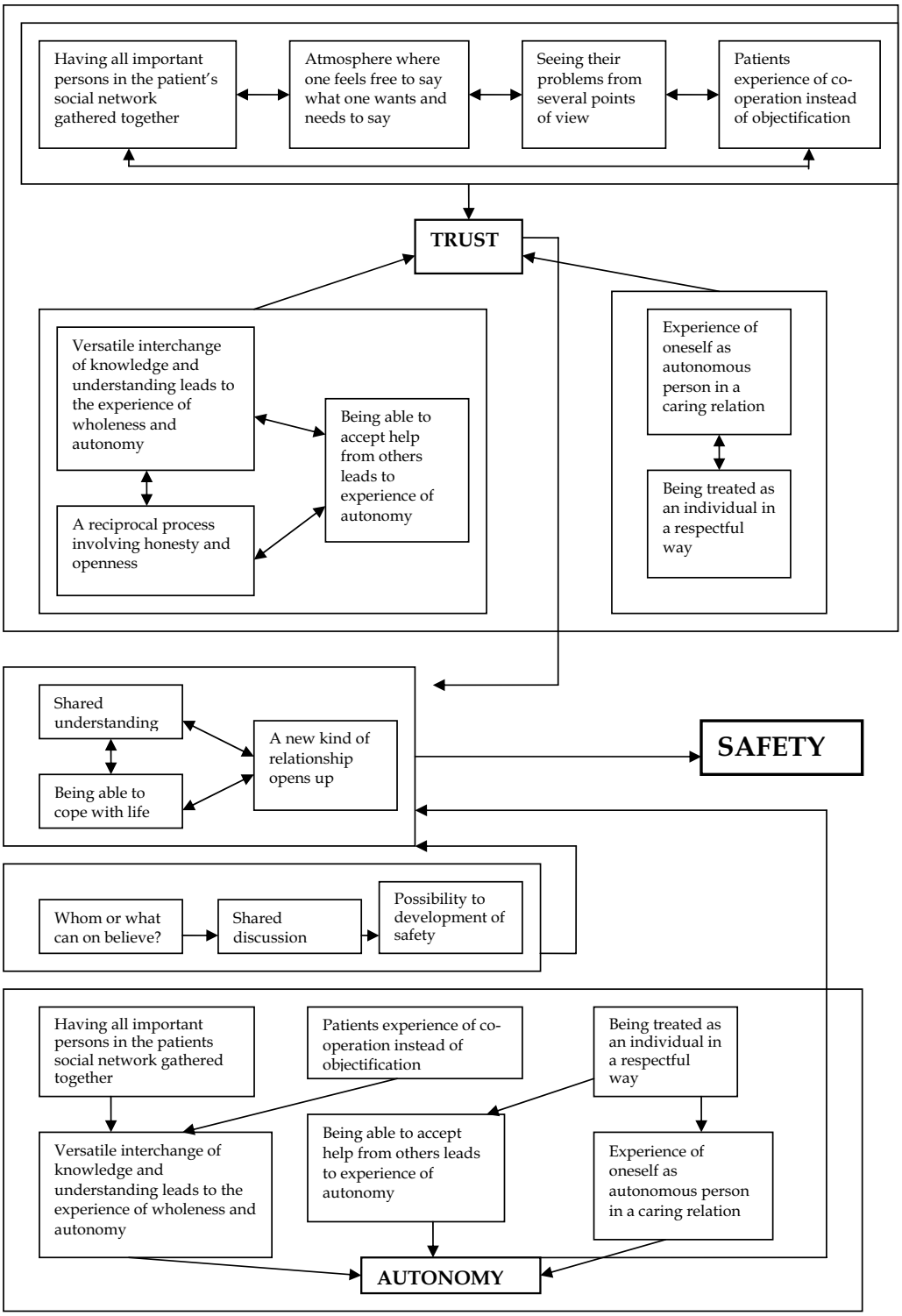

FIGURE 4 Categories increasing safety.

6 CONCLUSIONS

I will now attempt to create a theory of trust, autonomy and safety in psychiatric treatment and care. As shown in the articles, trust is possible, necessary and dependent on several factors. Autonomy is also dependent on several factors and is connected to trust thorough these factors. Two categories from Article I concerning the INFM model, two categories from Study II concerning the INFM model and two categories from Study II concerning the traditional treatment context are of importance concerning both trust and autonomy. Honesty, which is one of the core categories in the research, can be seen as included in the categories on which trust and autonomy are dependent. All categories and core categories are interdependent, but in different ways, and through them safety can be created.

There are psychological (Erikson, 1968), sociological (Giddens, 1990, 1991) and philosophical (Lögstrup, 1994) theories of trust as a phenomenon. According to Erikson, trust is built mainly in the relationship between an infant and the mother. Erikson argues that during the beginning of his/her psychological development an infant experiences an existential crisis which can lead to either trust or distrust. The mother mediates trust especially because she cares about the infant by satisfying his/her basic needs, and the infant develops basic trust which functions as a base for trust developed later in the infant's life. According to Erikson (1968), if the infant's interaction with his/her social environment is positive the infant develops an experience of basic trust in him/her self and the environment. In this way, the relation to the mother should not be seen as the only relation that makes the development of basic trust possible. If the early interaction with the environment does not develop well, the infant can experience mistrust in the environment and this can lead to isolation and anxiety. However, Erikson does not see the first phases in the infants' development as definitive. An infant's later development, if it progresses favourably, can compensate for earlier crises and the person experiences basic trust. Lögstrup (1994) agrees with Eriksson. According to Lögstrup, an infant entertains trust without reservation. When an infant expresses trust he/she opens up him/herself and becomes vulnerable. If the

infant is not met with love, trust is turned into distrust because if trust is met by some other attitude than trust, it creates distrust. Luhmann (1979) considers trust not to be based in an individual's actions but as actions of communicative actors. His argues that communication is fundamental for the creation of trust. As shown in Figure 1, trust became possible when the patients were able to be critical in the IFNM context. It may be that criticism activated the personnel's thoughts, and their influence on the patient decreased. This made possible a versatile interchange of knowing and even the whole process of trust creation in the interplay of all the trust-increasing categories.

Trust is based on honesty and an attitude of striving to be and act honestly with patients who are in need of psychiatric treatment creates possibilities to trustful relation. As shown in the second Article, trust is created when versatile knowing is possible. This in turn becomes possible when horizontal expertise is practiced and the personnel show that their knowing need not be valued more than the patients' or relatives', as shown in the third article. When this kind of knowing is combined with open discussion concerning all the participants' ways of making things understandable for themselves, the patients are able to accept help from the professionals and also experience autonomy. My assumption here is that when the patients experience autonomy, they also experience themselves as responsible for their situation and its further development. This gives them power to control their lives with appropriate help and without too much influence from professionals. Furthermore, when patients also experience that they are treated with respect as individuals, their experience of autonomy increases; they trust the personnel, they experience that the personnel trust them, and they can also come to trust the treatment system. The psychological basic trust that can be assumed to exist in every human being can be hidden or may be of varying strength. During the infant stage, it is dependent on the relationship with the mother and other persons and factors in the infant's environment. However, it is perhaps not necessary to view basic trust as static. A person's psychological inner world is in constant movement (Vygotsky, 1995; Stern, 2004): it is expressed in the present, the specific moment the person is in. A person's trust can be developed and increased in power when a person is met by trust and his/her expressions are received with trust and care. It may be that patients who are not able to trust personnel have no real contact with their basic trust or it may be hidden, but that is dependent not only on themselves but also on the social environment they are living in and on how they have been treated earlier. In my own clinical experience I have seen that when patients have been treated badly and their wishes and thoughts have been ignored, they direct their mistrust to the treatment system and the personnel who represent the system. This research shows that the patients have not totally lost their basic trust in themselves, since they were able to begin trusting both the personnel and the treatment system when the INFM model and the Need-Adapted Approach were realized, regardless of their earlier treatment.

The relatives' involvement in the treatment and caring process has also been shown to increase trust, not only between patients and relatives but between all sides. In conditions where no one is excluded, and all sides can express their inner thoughts, and can experience that they are accepted, trust becomes possible, autonomy is experienced, and a feeling of safety is created.

In this study trust was found to be necessary for the development of safety. Several categories that increase trust are in interdependent relation to each other and are needed for the development of safety. In psychiatric treatment and care, priority has often been given to the treatment of symptoms or illness. In social services, priority is often given to problem solution. However, as the results show, the issue is not which treatment created the experience of safety among patients, their relatives and members of the multiprofessional treatment team. The "issue" that was treated was the relations between all the participants, perhaps mostly between patients and relatives. However, the treatment of relations is also dependent on several factors. Shared discussions, being able to cope with life and new kind of relationship are in interplay with each other. According to the results in this research, shared discussions are needed for the development of coping skills, coping skills are needed so that new kinds of relations can develop, and new kinds of relations create possibilities for new kinds of shared discussions. Indeed, when viewed this way the development of safety can be compared with Giddens' (1991) theory of trust development, which Giddens describes as a process between two or several persons and is dependent on disclosure and honesty. The development of safety is also dependent on several factors, not only one. In fact, as e.g. Paterson and Zderad (1988) have shown, treatment and care is realized "in the between" in a social process between human beings. As shown in Figure 4, trust and autonomy are partly dependent on the same categories. These phenomena influence each other and are needed for the experience of safety. As shown in Figure 4, three categories were identified in the third Article which creates the experience of safety. However, the categories that are needed for the development of trust and autonomy influence the development of safety through these three categories (Figure 4). I conclude that these three categories alone are not enough for the development of safety. The Need-Adapted Approach, which was studied in the third study, is the basis for the INFM context. The INFM context has aspects that increase the development of trust, and as mentioned earlier safety cannot exist without trust. Because the INFM context is based on principles that are similar to those of the Need-Adapted Approach, we can assume that when the principles are realized the Need-Adapted Approach also increases the development of trust.

7 DISCUSSION

7.1 General starting points of the project

Co-operation between different actors in psychiatric treatment is important if the treatment is to match the real needs of the patients, and those of their relatives and significant others. Psychiatric patients often have social as well as psychiatric problems, which is why such co-operation is essential. Hjern (2001) points out that the treatment and care of persons with multiple needs requires co-operation between those who are responsible for these persons' welfare.

However, psychiatric treatment systems are ruled by theories which are more or less rigid or flexible depending on how the contents of the theory are interpreted. Several theoretical trends also influence psychiatric treatment systems, and depending on how the theories are understood, the culture of the treatment systems is created differently. In a culture there are often traditions, routines and rituals which guide or compel the members of the culture, to think and act in particular ways (Giddens, 1990; 1991). According to Giddens (1991), traditions and rituals have guardians who ensure that the "rules" are followed collectively. People in a culture or society are often also emotionally engaged with the collective routines and rituals. According to Giddens (1991), people also need routines and rituals in order to know how to behave and act also concerning their will to co-operate with others. However, the routines and rituals sometimes no longer serve their purposes, and do not serve people in the way they perhaps were thought to do.

Topor (2001) has studied the factors that help psychiatric patients in their recovery process and concludes that there is a discrepancy in how professionalism is understood. According to Topor, Parsons (1951) holds that a professional should not talk about him/herself nor enter into reciprocal relation with patients. If they break these principles, the professionals reveal a lack of knowledge and personal development which is not acceptable in psychiatric treatment. However, Topor shows that it is precisely when personnel break existing rules, created by theory and practice, and become more human, that

they contribute most to the patients' recovery process. The results of this research project, especially Article II, support Topor's claims. When personnel acted differently in the traditional psychiatric context, the patients experienced a development which can be compared with Topor's concept of recovery.

In this research, the theory of the Need-Adapted Approach (Alanen, 1997; Aaltonen et al., 2000) has functioned as a frame of reference on how knowledge and understanding concerning psychiatric patients' problems and illnesses can be influenced by different aspects. The Need-Adapted Approach contains the idea of social construction, according to which there is no simple or unambiguous explanation of truth or phenomena. Hummelvoll and da Silva (1994) and Alanen (1997) consider a human being as consisting of biological, social, psychological and spiritual dimensions, and in accordance with that view, psychiatric illness or suffering should be considered as a multifarious condition. Traditionally, psychiatry is dominated by biological knowledge of the patients' symptoms and suffering, which determines how these disorders should be treated. Such a way of approaching psychiatric illness can be considered to be vertical expertise. Aaltonen et al. (2000) argue that horizontal expertise is the opposite of vertical expertise. Horizontal expertise includes an interplay of a variety of social constructions which are in interaction when understanding and knowing concerning psychiatric illness are created.

7.2 Questions and aims

The main aim of this study was to investigate the experiences of psychiatric patients, who also were clients of community social services, concerning the Network- and Family-oriented Model for co-operation (INFM). The first study resulted in the core categories of trust and honesty, and Study II was aimed to further explore the phenomenon of trust. The next stage of the research project was to investigate the Need-Adapted Approach and its significance for psychiatric patients, their relatives and members of the multiprofessional treatment team, in Study III. The INFM is an application of the Need-Adapted Approach, so this was a logical continuation of the study, since the INFM and especially the Need-Adapted Approach are based on co-operation in a treatment system (Andolfi, 1979). In this research, a therapeutic system includes the patients, relatives and the treatment team working together with the family.

7.3 Material and method

The material for this study was collected firstly in Västerås, Sweden, and secondly at psychiatric outpatient clinics at Jorvi and in Western Lapland, in Finland. The material consist of individual interviews with 22 patients who also

were clients of community-based social services in Västerås, and 10 joint interviews with 10 patients, five from Jorvi and five from Western-Lappland, their relatives and members of the patients' multiprofessional treatment team. For Articles I and II, all interviews were tape-recorded; for Article III, the interviews were video-recorded. All recorded material was later transcribed for analysis. In this research, neither the tape-recorded nor video-recorded material was used other than via the transcripts made. None of the studies aimed to do more than analyzing the interviews and what was said during interviews.

The method used in all the studies is an application of Grounded Theory. Grounded Theory was used because it allows the researcher to adjust the method according to the available material. Grounded Theory is recommended for use in research when there is little knowledge concerning a phenomenon and further research is needed. Analysis of the transcribed interviews according to the principles of Grounded Theory made it possible to investigate the patients' experiences of what was for them a new kind of treatment model in Articles I and II. It was considered appropriate to continue using the same method in the analysis of the interviews for Article III.

The way the interviews for Article III were realized has special relevance to the trustworthiness of the research. Did the fact that members of the multiprofessional treatment team were listening to their stories concerning the treatment process during the interviews have any effects on the patients and relatives? On the basis of my own experience, this had no negative effect; it did not prevent the patients and relatives speaking about their past. The Need-Adapted Approach is based on mutual work and process between patients, relatives and professionals. This approach is based on shared discussions between all participants, and a psychotherapeutic attitude, horizontal expertise and open dialogue make possible a new kind of relation between personnel, patients and relatives. This kind of relation is not based on traditional ways of thinking about relations between professionals and people with psychiatric problems. The interview method is also in line with Andolfi's (1979) view of the therapeutic system. The patient, relatives and members of the multiprofessional treatment team can be regarded as a therapeutic system that cannot be examined as single parts. I do not think that relations would have been a possible "object" for treatment if all the elements of the whole therapeutic system had not been interviewed together.

In the course of writing this dissertation my interest in methodology and Vygotsky's (1982) theory of development of thinking increased. In Vygotsky's theory combinational thinking forms the base of creating combinations and relations, the beginning of creating concepts. However, this is not all: in a developed form, the creation of concepts demands not only the connection and generalization of separate experiment-based element. It also demands separation, distinguishing, isolation and expertise to examine these separate abstract elements out of the real context. A real concept is created in a process of analysis and synthesis. Separation and combination are equally important in the creation of concepts. A concept is born when distinguished qualities are

synthesised again. This process is, in my view, very close to the Grounded Theory method used in my research. Vygotsky did not practice Grounded Theory but his idea that thinking and combining things is the way that people create something new is close to the principles of Grounded Theory. According to e.g. Glaser and Strauss (1967) grounded theory is especially suitable for the development of new theory. Reading the text, selecting quotations, making memos and combining these lead to the creation of categories, i.e. concepts in Vygotsky's terms. In the light of Vygotsky's theory, it may be argued that if a researcher functions only on the level of combinational thinking, he/she may not be able to process the material adequately, and not be able to evaluate the methodology rightly. I hold the view that my way of practicing Grounded Theory is in line with Vygotsky's theory, and that the categories, including the core categories, in my research are the results of distinguished and synthesised elements.

7.4 Central findings and their general sense

Study I in this research project resulted in the core categories of trust and honesty and the project continued with a more detailed study of trust and mistrust in the INFM context and traditional treatment context in Study II. The next step in this research project was to study the Need-Adapted Approach, and Study III resulted in the core category of safety. According to the results, the development of trust and safety in psychiatric treatment and care is possible but it requires that discussions be shared, and not owned or ruled by somebody specific. Results of this research are similar to those in Latvala's (1998) research concerning patient-oriented psychiatric care, where she concludes that patient-oriented caring in psychiatry is co-operative caring. One necessity for this is that psychiatric personnel are able to work in a co-operative way. Vuokila-Oikkonen (2002) has shown that when there are discussions and question from the experts after the story telling by the patients and significant others, the patient and others experience their own participation as active. According to Latvala (1998), trust, safety and mutual sharing are emphasized in co-operative psychiatric treatment and care. However, Latvala's research does not reveal how trust and safety can be developed. Latvala also concludes that psychiatric treatment and care are still bound by traditions and are realized in the form of authoritative caring, that is, the patient is a passive care receiver and nursing personnel depend on authorities, most often medical expertise. In circumstances where traditions and routines have a strong influence, it can be difficult for personnel to adjust their behaviour according to the patient's situation and real needs. If the culture in a treatment unit is guarded by experts who own the knowledge of how treatment should be realized, personnel might have few possibilities to act differently from the ways prescribed by the traditions. As shown in the first two articles, in psychiatric treatment and care

routines can be an obstacle to the development of trust, and if safety depends on trust, then the development of safety is also hindered. It was shown in Article II that even new treatment models can very soon become influenced by routines: the INFM model was such when personnel were too eager to practice the principles and the patients' needs were forgotten. However, routines and rituals need not be only negative: humans need traditions, routines and rituals. But when it seems that they are not keeping up with the times, they are not adequate if one as professional caregiver needs to go behind the traditions, routines and rituals, meaning that professionals are not able to act otherwise than according to their usual way. When doing this, one should investigate the core of the traditions. This also allows modification of the traditions so they serve their purposes better.

In the light of the results of this research, I want to reflect on trust and basic trust and their relation to safety. The patient's basic trust strengthens when the Need-Adapted Approach or the INFM model is practiced; that is, when the patients, their relatives and members of the treatment team share issues together in a mutual process, the patients and their relatives experience safety. If we assume that safety is connected to trust, and trust to basic trust, a secondary effect of the Need-Adapted Approach and the INFM model is to strengthen the patient's basic trust. This, as the results show, can be possible through shared discussions in which the relations are treated, not the illness or symptoms. This secondary effect may be related to the theory of implicit memory (Fonagy, 1999) and its activation. When a person acts and discusses with others, several different implicit memories and several ways of experiencing oneself among others are activated (Aaltonen, 2008).

The Need-Adapted Approach as well as the INFM model are based on shared discussions between patients, relatives, members of the patients' social network and members of a multiprofessional treatment team. These discussions can be considered as happening on two different levels. Firstly, when people are discussing with each other they are doing something in common. Secondly, when the discussion reaches another level, people are also able to create something together, a shared construction of an issue. According to Bahtin (1991), Seikkula et al., (1995) and Linell (1998), dialogue is a special kind of discussion and is most often understood as verbal activity. The question whether dialogue is only verbal activity is justified. Buber (1993, 1997) argues that dialogue is more than verbal activity between humans. He considers dialogue to be a phenomenon of relation. Buber uses two word pairs when he describes his philosophy of dialogue. The first one, which Buber considers to be a relation including dialogue, is "I-Thou". The second one, which Buber considers to include monologue, is "I-It". I-Thou is about a genuine meeting between two subject who really meet each others, subjects without any assumptions or previously constructed understanding. This kind of relation is not ruled by one side; it is an equal relation. In such a relation I do not exist without Thou, they create each other in a mutual process. The I-It relation can be seen as the opposite. It is a relation but it is not equal; it is typically a meeting

between one subject and one object, and the subject has more power or knowledge to control the meeting. The I in an I-Thou relation is not the same as the I in an I-It relation. Buber himself thought that an I-Thou relation is not possible in treatment and care due to the fact that personnel and patients can never meet each other equally, because their positions are so different. Buber also argues that in a relation of I-It, the subject never becomes anything other than an object for the other but the subject may not be aware of it. In the Need-Adapted Approach and the INFM model, the kind of relation which Buber terms dialogical can be possible. One of the main ideas of both models is that professionals are not the ones who decide how and why changes happen in the lives of patients and relatives. When the Need-Adapted Approach and the INFM model are practiced, horizontal expertise is also practiced, that is, everybody's knowing and expertise are needed. If the meetings between personnel and patients are real meetings between subjects, and the subjects are really interested in each other and each other's otherness, then dialogue becomes possible. Buber's idea that a relation is dialogical can also be considered in the light of the theory of Paterson and Zderad (1988) theory of "the between", where dialog exists and becomes realized in the between. Communication then can be considered as dialogical activity and is based on different ways of thinking. Individuals are not seen as independent actors but as interdependent, and communication between them should be considered as social interaction, the one who talks and the one who listens construct meanings together. Understanding then can be considered as an event in which two separate interpretations of reality meet and create together new meanings which are not directly connected to any of initial meanings of the participants but are created in the between.

Safety is a phenomenon that is mentioned in the literature concerning care and treatment but there is little research concerning what safety is or what influences the development of safety for patients and/or their family members in psychiatric care and treatment. Some researchers mention safety or security but they do not clarify what they mean by these terms (Koivisto, 2003; Waddell, Ross, Ladd & Seeman, 2006). According to Berg (2006), one important condition for the experience of safety is a personal caring relation. This supports the finding in this research since one of the categories in Article III, the need for a one-to-one relation, did not increase the experience of safety among patients. In light of Berg's research we can assume that if this need had been met it might have led to more experience of safety among patients.

Eräsaari (2002) argues that safety is nothing in itself; it cannot have an independent content, but is the opposite of insecurity. When people are living a safe life, they do not experience unsafety but they do not know what safety actually is either. One phenomenon, according to Eräsaari (2002) that makes unsafety tolerable is belonging to a community. Structures in a society are problematic but in a community, which can be defined as a family or a group of people doing something together, people can experience safety. When the Need-Adapted Approach as well as the INFM model is practiced, a kind of

community is created, a therapeutic system in which all parts are in mutual interaction with each other.

In psychiatric care or treatment as well as in social services, something new and innovative can be created by recognizing the patients' or clients' right to self-determination and their wishes. This in fact can mean that personnel lay themselves open to criticism, since they are departing from prescriptive rituals and routines. As the results show, the personnel' ability to adjust their work, especially in the traditional treatment context, according to the patients' needs resulted in the development of trust and autonomy. They did depart from existing routines concerning how the patients' illness should be treated, and treated the relation between themselves and the patient. Eräsaari (2002) asks which is more important; one's own wishes or duty, independent success or prearranged safety. The results in this study suggest that one's own wishes and independent success were more important to the development of trust, autonomy and safety than duty and prearranged safety. According to Erikson (1968), safety is one of the elementary human needs. A human being strives to satisfy his/her feeling of personal safety. Un-safety is connected to uncertainty or an unpredictable future. A person can feel un-safety when, for example, risks in the future are difficult to predict or understand. However, even an unpredictable future can be tolerable if a person is not left alone but experiences him/her self as being responsible and autonomous with others, and experiences co-operation with possibilities to influence his/her own future. The experience of safety becomes possible thorough several factors. Trust, autonomy and honesty are needed. But these phenomena do not appear by themselves: something else is needed before they appear. All the categories identified in the three articles are needed, some of them for only one phenomenon, some of them for several phenomena. It is the interplay between the categories identified and human behaviour that creates the core categories in this dissertation and makes safety possible.

Perhaps one of the most important findings is the fact that safety was created when shared discussions were realized. These discussions were not about the treatment of illness or symptoms, but about the relations between patients, relatives and members of the multiprofessional treatment team. It is important for patients and relatives to get knowledge about the diagnosis and treatment, but this study shows that knowledge about the diagnosis seems not to be the main factor that creates a sense of safety among patients and relatives.

As Vuokila-Oikkonen (2002) have shown, when discussions and questions from the experts follow the story telling by patients and significant others, the patient and others experience their participation as active and co-operative. The importance of shared discussions can also be understood when we look at caring and treatment from the point of view of Paterson and Zderad (1988). When they argue that caring and treatment are realized in the between, they are not referring to safety, but according to my view they are pointing at precisely on the phenomenon of safety which is created between persons in shared discussions. Safety was created in shared discussions, and shared discussion

happen between persons. Of course, such a discussion cannot be controlled by any one person, and horizontal expertise, including a therapeutic attitude, is necessary: that is, the principles of the Need-Adapted Approach must be carried out.

Vuokila-Oikkonen (2002) studied co-operative team meetings in which the patients and their significant others participate together with at least two professionals, most often a doctor and a nurse. This is similar to the INFM context and the Need-Adapted Approach, though the patient did not have individually oriented contacts. According to Vuokila-Oikkonen co-operative team meetings are active or passive, depending on the patients' and relatives' abilities to participate in the discussions. One goal of co-operative nursing and team meetings is to improve the participation of patients and significant others in the treatment process. When experts asked open-ended questions, the patient and significant others were able to express their views and the experts followed their stories. Meetings were passive when questions were based on the experts' viewpoint; the patient and significant others were silent and their participation was in jeopardy. The main interest of the professionals should be the way the patient and his/her family members or members of the patient's social network make their situation understandable. As shown in the third article, the fact that when discussions in treatment meetings were about relations between the patient and relatives, the experience of safety increased. Vuokila-Oikkonen et al. (2002) did not study safety but their findings support the findings in my research. Active participation by the patient and relatives makes it possible to experience the categories identified in my research. When active participation is possible, the patients can also experience horizontal expertise if their narratives or stories are taken seriously.

Psychiatric treatment and care are not the same regardless of where or by whom they are practiced. In the two first articles, psychiatric treatment and care are distinguished in terms of two different contexts, the Integrated Network- and Family-oriented context (INFM) and the traditional context. The main difference between them is that the INFM involves a different philosophy of how the patient should be treated. The Need-Adapted Approach, of which the INFM context is an application, is based on different principles than traditional treatment and care. There are more categories that increase the experience of trust in the INFM context than in the traditional context. Giddens (1990, 1991) and Erikson (1968) are of the opinion that trust is a necessity for safety. The findings in Article II, especially, show that the Need-Adapted Approach gives more possibilities for the development of safety than does the traditional treatment context.

On the basis of my own lived experience, I conclude that the theoretical understanding in the Västerås circumstances was too rigid at the time for the Västerproject. The culture was satiated with prepositional knowledge of how psychiatric illness should be interpreted and understood. This prepositional knowledge also determined the way patients should be treated. Giddens' (1991) ideas of traditions are manifested in such circumstances. One of the main

arguments against the INFM model was that it is unethical to expose the patients to a situation where they are forced to talk with several persons together. In the Västerås circumstances, it was rare that the patient met several professionals together; the patient's relatives or members of the patient's social network were not invited to gather together for joint discussions. At that time in Västerås, working with multiprofessional treatment teams was out of the question. A treatment team was defined as the whole outpatient clinic, which could have about 15 members. Discussions concerning the patient's treatment and care were realized at meetings between members of the whole outpatient clinic. Only about 2 hours a week were allocated for this, and some patients' situations were never even discussed. However, as the results show, especially in Articles I and II, the doubts concerning the INFM were unjustified. The patients experienced participation in treatment meetings as good for them, and as responding more to their needs than their earlier treatment. One can wonder, what were the doubts and the accusations of an unethical way of working based on? The INFM model was based on joint discussions, and that is one thing that the patients appreciated since they had experienced that discussions with individual members of the staff were more directed by the personnel, and most often only one way of understanding their problems was presented. Such discussions cannot generally be regarded as the kind of discussions which increase the development of trust. However, as the results show, particular staff members were able to act and work with patients in a way where the patients experienced themselves as individuals and autonomous. The traditional treatment system differs from the Need-Adapted Approach in that it involves fewer theoretical disciplines when it is question of direct discussions with the patients. The traditional treatment system is based on individual contacts and different disciplines are not in joint interaction with the patient at the same time. As the results show, such discussions are of great importance if the goal is that no one specific discipline controls the patient's treatment.

My decision to discuss traditions, routines and rituals has its roots in the situation I was in when material for the first and second Articles was collected, and the development project was going on in Västerås, Sweden. In the project, a new kind of treatment should have been applied in a context that perhaps was not ready for it. This research started with an investigation of the importance, from the patient's point of view, of co-operation between patients, adult psychiatry and community social services. All the patients who participated in interviews for Article I and II had multiple needs for psychiatric treatment and care and help from social services. The results in Articles I and II can be seen as general, concerning personnel in both adult psychiatry and social services, and no attempt was made to distinguish the two groups of personnel. Even though the actions of the social services were more influenced by networking and working with families, the patients could still experience the social services as individually oriented. Community social services differ from healthcare and should be more amenable to influence by the client and the involvement of networks and family, but in practice it seems it is not always so. The results of

this research project can be useful for the social services as organizations and for the personnel, as well as for psychiatric organizations, if the social services want to create services that are need-adapted for their clients. According to e.g. Hjern (2001), the municipal healthcare and social services are becoming more and more specialized, and more and more spearhead knowledge is created in these organizations. However, Hjern points out that this creates new problems when it comes to meeting the multiple needs of patients and clients. The personnel's actions are strictly controlled by their specific tasks, and the possibilities of diverging from the rules and routines are minimal if there is no flexibility in the organization. Hjern argues that specialization guides the work in psychiatry and social services more than the needs of the patients and clients, and points out another way by proposing that professionals in organisations must be able to step outside their inflexible organisations, gather together with other professionals and create networks of professionals when they meet persons with multiple problems, such as psychiatric and social problems. In such cases the problematic situation of the patients/clients can be confronted by all the different professionals at the same time, and this, makes it possible to make use of everybody's expertise and also makes it possible for the patient/client to experience him/her self with others in several different ways. This has been shown especially in Article I.

7.5 Trustworthiness of the study

Qualitative research is often based on interviews and interpretation of the tape- or video-recorded material. The researcher is responsible for the interpretations made and for ensuring that the interpretations reflect what the persons interviewed actually have said. However, the purpose of research is to generate something new, not merely repeat what the persons interviewed said. The researcher's ability to follow the narrative of the person interviewed, to ask follow up questions and to ensure that he/she has understood the narrative is of great importance. If the researcher is experienced and can monitor his/her pre-understanding, he/she can make correct observations and interpret and analyse the material correctly. It is possible that during the interviews, the patients revealed their social constructions concerning their experiences through their narratives. In this way the patients truly expressed what they had experienced, expressing not only what had happened but also what those things meant to them. I want to emphasize that the way the interviews were conducted allowed the patients to speak freely about their experiences of treatment and care, regardless of the context.

According to Lincoln and Guba (1985), trustworthiness of qualitative research is composed of four factors: credibility, meaning that the interpretation made during the analysis corresponds to the narrative told by the persons interviewed; transferability, meaning in this study that the categories and core

categories can be applied to other situations and circumstances; dependability, meaning that the way the analysis is done is applicable to the cases regardless of differences within the cases; and confirmability, meaning that it is possible to reach similar results with the material used by using different methods.

In this research, concerning Study I, credibility of the interpretations was possible to confirm by returning to the patients interviewed in Sweden (Streubert, 1995). During these occasions the researcher was able to listen to the discussion between the patients interviewed and their comments, through which they confirmed the findings. This was not done with the material gathered in Finland, since the interviews there were realized at two units which are far apart, which made it difficult to gather all the persons interviewed together. However, all analyses made in this study were firstly analyzed by the researcher. Thereafter, the findings were discussed with the supervisor who was not involved in the interviews but had access to the transcribed texts. This made it possible to use the supervisor as an outsider evaluator. Transferability of the findings can be hard to point out since the material was derived mainly from patients with psychosis or schizophrenia, the findings may not be directly applicable to all psychiatric conditions. However, the findings can also regarded as applicable to other groups of psychiatric diagnosis since the categories and core categories found were about issues that happen between human beings. In my experience, psychiatric patients do not differ from persons who are not suffering from psychiatric illness in any way that would make the findings applicable only to them. Regardless of the heterogeneity of the patients interviewed, especially in Study I and II, there were no specific problems of using the Grounded Theory method and this fact should correspond to dependability required. In this research I have examined patients' experiences and differences in their background or problems did not cause any difficulties when analysing the material. Concerning confirmability, I find it hard to think what kind of other method could be used for analysis of the material used in this research. The material used in this research is qualitative so quantitative methods are out of question. Other qualitative methods might be possible to use, I just come not to think what method it could be.

The supervisor of this research, who is also the second author of the three articles, has been used as an external evaluator of the findings in the three Studies. He has also functioned as the researcher's trainer in family therapy and as a principal developer of the Need-Adapted Approach. These facts could compromise the trustworthiness of this research, given the supervisor's knowledge of and interest in family therapy and network- and family-oriented psychiatric treatment and care. However, the supervisor's background is not only in family therapy but also in psychoanalysis. It cannot be denied that my supervisor has influenced my research but this influence was not one-sidedly in favour of the INFM context and the Need-Adapted Approach. The supervisor has continuously reminded me of the danger of idealization, and has not unduly influenced my research in any particular direction.

Like all research, this study also has its limitations. When doing qualitative research, one cannot measure extensive material in the same way one can in quantitative research. For Study I and Study II, the interviews were made by the researcher. All the patients interviewed were informed about the fact that he was employed by the psychiatric treatment system, and this may have influenced the patients so that they did not want to express their inner thoughts freely. The interviews were also based on previously planned themes, which may have prevented the patients from speaking about important issues, if the interviewer was not flexible and followed the patients' narrative.

Interviews for Study III were realized as group interviews, where the patient, his/her significant others and members of the patients multiprofessional treatment team were all present. The presence of members of the treatment team could lead to patients and their relatives not speaking freely. However, the patients' treatment and care had been organized in co-operation between all those present in the interviews. Such groups interviews in psychiatric treatment are a form of the therapeutic system according to Andolfi (1979), and this kind of system cannot be studied as separate parts. It may be that the central finding in this research, the importance of treating relations between all those involved at the treatment process, would not have been found if the interviews had not been realized as group interviews.

7.6 Ethical aspects

Research should be based on ethical principles which guide the researcher's work. According to Pietarinen (1999), there are eight ethical requirements for all researchers; interest, honesty, conscientiousness, eliminating danger, respect for human values, social responsibility, development of the profession, and collegial respect.

This research project was inspired by interest in psychiatric treatment and care. A desire to discover what treatment and care actually mean for the patients, and what they experience, guided my work. The interest I have for especially network and family-oriented psychiatric treatment and care can also be regarded as creating bias. However, honesty, which is also one of categories among the findings, has been of importance to me during my work. During whole research project I have tried to avoid idealization of network- and family-oriented treatment. As mentioned, the supervisor has continuously reminded me of the danger with idealization. When results of my analysis have been too prejudiced in favour of the INFM model, I have continued analysing the material which resulted in more balanced composition between INFM model and traditional treatment. A researcher should be conscientiousness during the whole research project and not keep back any information found in the material used for research. In my research, I have strived to analyze the material conscientiously. I have read the transcribed texts several times and tried to

notice all important aspects, examined the material in such a way that no relevant information became omitted, no matter what they were about. If the results of the analysis do not correspond to what the persons interviewed have said, and they are misrepresented, then the recommendations made in the research can lead to inadequate development of psychiatric treatment and care, presupposed that results of my research is used for such purposes. Eliminating danger, in this research project, can be partly understood as giving trustworthy recommendations to personnel in psychiatric treatment systems. But that is not all! When Västerproject was started discussion concerning ethics of exposing patients in situations where they must meet and talk with several persons at the same time. These fears showed to be groundless since none of the patients expressed that they were put in an unethical situation. In fact, all of the patients interviewed in Sweden expressed satisfaction with the INFM model even if there were aspects that some of them they experienced negatively. Social responsibility in this research is combined with the two earlier factors, meaning that the persons interviewed must be treated respectfully and that the consequences of the research do not harm them. Treatment according to principles of Need Adapted Approach and the INFM model is based on co-operative work in which multiprofessional treatment team is responsible for the treatment and care. This can be regarded as responding to social responsibility since, as concluded in the findings, the patient and his/her family members are given possibilities to have control of their situation. Concerning the development of the profession and collegial respect, Pietarinen concludes that research should not be such that it serves some specific interests. The multiprofessional treatment team consists of personnel from several disciplines. In that way none specific profession is privileged. It is unethical to serve only the interests of a specific profession in psychiatry. This research is about multiprofessionel psychiatric treatment and care, and the findings are not limited to some specific profession but are for all psychiatric personnel. A researcher must also always show respect for other researchers' work. Even if I have been critical to traditional psychiatric treatment and care I do no underestimate such treatment and care or research which shows that even traditional treatment and care responds to the patients needs. At the beginning my attitude to traditional context was more critical than it is now since during this research project, my own attitude concerning traditional treatment and care has changed to be more positive. As shown in this research, traditional treatment context has its benefits. Traditions and post-traditions perhaps can exist together and influence each others positively. Indeed, as shown in Study II, the INFM context and traditional context have similarities.

All the research plans for this study were approved by the ethical commissions of Uppsala University in Sweden, concerning interviews with the 22 patients, and by the Western Lapland ethical committee, concerning the interviews with patients and their relatives and members of the patients' multiprofessional treatment team in Finland. During this research project I have consciously striven to meet these ethical demands. All data gathered have been

stored so that only both authors have had access to the material. The use of the supervisor as an outsider evaluator ensured that the findings were in line with the original material and the interpretations were done honestly and with respect for the persons interviewed.

Concerning especially Study I and Study II, it is necessary to consider the ethical question whether the patients interviewed really were able to freely speak concerning their experiences of treatment and care. The interviewer and researcher had been employed by the psychiatric organization before the Västerproject in which the INFM was realized, and the researchers' position may have influenced the patients. However, the interviews were conducted more as discussions than questions which the patients answered. During the interviews the researcher could ask follow up questions and also reflect concerning the patients' utterances. My sense as a researcher is that the patients really were able to speak freely concerning their experiences of treatment and care before and during the Västerproject.

The interviews resulted not only in positive utterances by the persons interviewed. The question, how did the negative experiences concerning treatment and care which the persons interviewed told about influence them is justified. Remembering and re-living difficult situations can affect a person negatively. However, the effect can also be the opposite if the conditions during the interview are right. Earlier negative experiences can became more tolerable if the person interviewed is allowed to express him/herself and listened to.

7.7 Need for further research

There is need for further research especially concerning the development of trust and safety within psychiatric treatment and care. As concluded in this study, trust and safety are connected to each other. Trust and safety are also generally considered as being important in psychiatric treatment and care. As the results show, the personnel's behaviour is of great importance for how treatment and care respond to the needs of patients and their significant others, and also for the development of trust and safety. Psychiatric treatment and care should not cause mistrust to develop between personnel and patients, which is why further research concerning trust and safety in other diagnosis groups is needed.

The education of personnel in psychiatric treatment and care is based on science, and education also presents an opportunity to influence students and to give them the skills to act and behave in such way that lead to the development of trust between personnel and patients, and also trust in the whole treatment system, so that patients and their significant others can experience safety. When trust develops between patients and personnel, trust for the treatment system can also be developed since personnel are always representatives of the treatment system.

7.8 Recommendations

The findings of this research allow several recommendations to be made.

1. Personnel in psychiatric treatment and care should always have an orientation that makes the patients' human environment a natural part for co-operation. When psychiatric treatment and care is organized so that the patients' family members and the social network are included in the treatment process, it becomes possible for the personnel to use their expertise appropriately.

2. Psychiatric personnel should be aware of their own thoughts during the treatment process, and be willing to change them. When the personnel can openly reflect together concerning their thoughts, it becomes possible for the patient and their significant others to also verbally reflect about the personnel's thoughts. In this way, all possible social constructions created by all sides become open material for consideration.

3. The personnel should pay attention to the routines and rituals in their work. If routines and rituals begin to guide them in their work, innovative and creative treatment and care become difficult.

4. The personnel should be sensitive and open to criticism from the patients. When the patients can openly express criticism and the personnel pay attention to it and do not ignore it, trust can be developed.

5. It is recommended that in the treatment and care of patients with psychosis or schizophrenia the relations between patients and their relatives should be considered as forming the base for further treatment and care of the.

As concluded especially in Study III, treatment of the relations between patient and family-members is of great importance, not only relations between patients and family-members but also between them and the professionals. The Need-Adapted Approach is based on several principles which form the Approach content. According to the findings of this study, when relations between patients, their significant others and personnel are treated, safety can be experienced by all sides. Information concerning the patients' illness and treatment of the symptoms is in general considered to be the main aspect in psychiatric treatment and care. However, as the findings show, this conception can be questioned.

YHTEENVETO

Kolmesta osatutkimuksesta koostuvan tutkimuksen tarkoituksen oli selvittää 1. psykiatristen potilaiden kokemuksia verkosto- ja perhekeskeisestä psykiatrisesta hoitomallista 2. omaisten hoitoprosessissa olemisen merkitys potilaille, omaisille itselleen sekä moniammatilliselle hoitavalle työryhmälle. Tutkimuksen taustana oli 1. Ruotsissa 1990-luvulla toteutettu psykiatrian uudistus reformi 2. Tarpeenmukaisen hoidon Suomessa tapahtunut kehitys. Tämä tutkimus liittyy täten Pohjoismaissa tapahtuneeseen ja yhä jatkuvaan psykiatrisen hoidon kehitykseen ja tutkimukseen.

Tutkimuksen teoreettisena kehyksenä toimivat Tarpeenmukaisen hoidon teoria, teoria terapeuttisesta systeemistä. Tarpeenmukaisen hoidon voidaan katsoa sisältävän ajatuksen sosiaalisesta konstruktionismista jonka mukaan ihmisten tarinat ja kertomukset tapahtuvat sosiaalisessa vuorovaikutuksessa aktiivisina ja vuorovaikutuksellisina kertojina. Terapeuttisen systeemin mukaan hoidollisessa tapahtumassa kaikki osapuolet vaikuttavat vastavuoroisesti toisiinsa, toistensa toimintaan ja ajatuksiin. Tutkimuksen filosofisena taustana voidaan pitää ajatusta ihmissuhteista joko objekti-subjekti suhteena tahi subjekti-subjekti suhteena (Buber 1993, 1997).

Tutkimusaineisto on kerätty Ruotsin Västeråsissa (osatutkimukset I ja II) ja Jorvin sairaalan sekä Keroputaan sairaalan psykiatrian poliklinikoilla (osatutkimus III). Ruotsalainen aineisto koostui psykiatrian pitkäaikaispotilaista jotka olivat myös asiakkaita kunnallisessa sosiaalitoimessa. Pääosiltaan potilailla oli psykoosi diagnoosi. Suomessa kerätty aineisto koostui psykoosi ja skitsofrenia diagnoosiryhmistä. Tutkija haastatteli Ruotsissa 22 potilasta kahdenkeskeisissä haastatteluissa ja Suomessa 5 potilasta, heidän omaisiaan sekä hoitavan työryhmän jäseniä yhteisissä haastatteluissa sekä Jorvin sairaalassa että Keroputaan sairaalassa. Tutkimusaineiston analyysissa on toteutettu Grounded Theoryn periaatteita.

Ensimmäisen osatutkimuksen tarkoituksena oli tutkia potilaiden kokemuksia verkosto- ja perhekeskeisestä hoitomallista, joka perustui yhteistyöhön potilaan, omaisten sekä psykiatrian ja sosiaalitoimen henkilökunnan välillä. Tutkimuksen mukaan potilaiden kokemukset yhteistyöhön perustuvasta, verkosto- ja perhekeskeisestä hoitomallista voitiin jaotella positiivisiin, negatiivisiin ja ambivalentteihin kategorioihin. Keskeiset löydökset osatutkimuksesta olivat luottamus, epäluottamus sekä rehellisyys.

Toisen osatutkimuksen tarkoitus oli syventää tutkimusta luottamuksen kehittymisestä psykiatrisessa hoidossa. Tutkimuksen kohteena tässä osatutkimuksessa olivat verkosto- ja perhekeskeinen hoitomalli sekä traditionaalinen hoitomalli. Tutkimukseen osallistuneet potilaat olivat pitkäaikaispotilaita ja haastatteluissa he kertoivat kokemuksistaan molemmista hoitomalleista. Tutkimuksen mukaan molemmat hoitomallit mahdollistavat niin luottamuksen kuin myös epäluottamuksen kehityksen potilaan ja hoitavan henkilökunnan välille. Hoitomalleilla on myös yhteisiä piirteitä. Verkosto- ja perhekeskeinen

hoitomalli mahdollistaa myös luottamuksen kehityksen potilaan ja hoitosysteemin välille. Tällaista ilmiötä ei tämän tutkimuksen mukaan löytynyt koskien traditionaalista hoitomallia.

Kolmannen osatutkimuksen tarkoitus oli tutkia omaisten hoitoprosessissa aktiivisen mukana olemisen merkitystä potilaille, omaisille sekä hoitavalle työryhmälle. Tämän osatutkimuksen tulokset voitiin jaotella ensisijaisiin, toissijaisiin ja ambivalentteihin kategorioihin. Mitkään kategorioista eivät olleet osanottajien mukaan sellaisia että turvallisuuden tunne olisi heikentynyt. Tulosten mukaan, yhteiset keskustelut, jotka suuntautuvat ”hoitamaan” ihmissuhteita, hoitokokouksissa luovat turvallisuuden tunnetta ja kokemusta kaikille osapuolille omalla tavallaan. Hoidollisesti sairauden tahi oireiden hoitamisen tärkeys ei tullut esille tässä tutkimuksessa.

Tutkimuksen tulosten mukaan voidaan todeta että verkosto- ja perhekeskeinen hoitomalli, joka perustuu tarpeenmukaisen hoidon periaatteisiin luo enemmän mahdollisuuksia luottamuksen kehitykseen ja turvallisuuden kokemiseen potilaissa ja omaisissa kuin traditionaalinen hoitomalli. Myös hoitavan, moniammatillisen työryhmän kokemus luottamuksesta turvallisuudesta kasvaa.

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