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Background: In the Need-Adapted approach (NAA) decisions are made in therapy meetings together with all relevant parties; this poses a professional challenge to psychiatrists.
Aims: To describe psychiatrists' inner dialogues concerning their workmates in treatment meetings.
Methods: Using videos of co-research interviews, stimulated-recall interviews with eight psychiatrists were conducted and transcribed verbatim. The material was analyzed using an adapted form of dialogical analysis, focusing on voices and positioning.
Results: The psychiatrists took actions in the treatment situation not only as professionals, but also as individuals who had their own characteristics, and individual relationships with their co-workers.
Conclusions: Professionals as individuals and the quality of clinician-clinician relationships have an impact on treatment, and these aspects should be taken into account in practice, in education, and in future research.
Keywords: psychosis; psychiatrists; inner dialogue; teamwork

Introduction

As well as being painful to the patients and their social network, psychotic crises constitute a challenge to professionals. For several years we have been working as family-therapy professionals (the first and the third author having trained as psychiatrists, and the second author as a clinical psychologist), working in psychosis teams and following the Need-Adapted approach (NAA) (Alanen, 2009). Within our practice we have observed the difficulties of integrating all the aspects that need to be taken into account. In NAA the psychiatrist always works as part of the team, and treatment aspects are discussed and decided in therapy meetings together with the patients, family members, and staff. Psychiatrists – most of whom have no specialized relationship-focused training – have to be able to co-operate with the patient, the families, and workmates, while at the same time taking on social and medical responsibilities. In 2005, at the time when the first author began to study psychiatrists' inner dialogues in therapy meetings within the NAA treatment of first-episode psychosis, it appeared that (at least in Finland) there were confusing differences in the guidelines for the treatment of psychosis (Finnish Medical Society Duodecim / Current Care, 2001; Gleeson & McGorry, 2004; Read, Mosher, & Bentall, 2004; Seikkula, Alakare, Holma, Rasinkangas, & Lehtinen, 2003; Topor, 2004). The aim of the research was to describe the inner dialogues psychiatrists have. The study described in this paper aimed to characterize psychiatrists' inner dialogues concerning their workmates; the focus was on the personal aspects of the professionals in question.

Inner dialogues

The inner guiding images of staff members have been studied in NAA, with the aim of describing how the treatment process of schizophrenia is conducted in a multiprofessional team (Aaltonen & Räkköläinen, 1994) The shared image evolves as each member of the staff brings her/his own inner dialogue concerning the treatment into a team discussion. Each participant in the meeting participates in the discussion – the outer dialogue – and at the same time has many thoughts about what is discussed – the inner dialogue. In understanding notions of dialogue we have found the ideas of Mikhail Bakhtin (1984) and his co-workers to be particularly useful. Rober (2005) describes inner conversation as a negotiation between the experiencing self and the professional self of the therapist. In therapy meetings, professionals have to consider whether their emotions and associations are in any way connected to the treatment, and whether they should be said aloud. In a dialogue, as it continues, our thoughts and emotions are transformed: we begin to compare and evaluate our different responses. *Voice* and *positioning* are concepts which are used to catch the complexity of dialogical phenomena. Voice refers to the speaker or actor, and positioning to the position from which she/he is speaking or acting. Every participant in a dialogue – even in a single utterance – speaks in different voices and positions her/him self in different ways, according to the context.

Professionals' inner dialogues and relationships

Within the literature, the concept of relationship-centered care (RCC) – which is associated mainly with somatic and general medicine – comes close to the focus of this study. RCC highlights the importance of all relationships and their impact on health outcomes; it further focuses on the personhood of all the participants, their affects and emotions, the context of reciprocal influence, and the moral value of genuine relationships (Beach, 2006; Safran, 2006; Suchman, 2006). The only study we have found regarding teamwork in psychosis (Engqvist, 2010) concluded that collaboration between nurses and psychiatrists in postpartum psychosis is based on confidence in the nurses' competence.

Participants and methods

The research process

A qualitative multiple case study approach was chosen, and the regional ethics committees gave the study positive statements. The interviews were conducted between August 2007 and

January 2009. Eight psychiatrists from three different geographical locations were asked for their informed consent. For research purposes, the *inner dialogue* is a theoretical concept: in fact, we are forced to rely on the *outer dialogue*, meaning what is said aloud about the inner dialogue. To create a context in which the inner dialogue could be studied, the psychiatrists were interviewed together with the patient, family members, and the fellow workers within the team, following the co-research interview method (CR-I) (Andersen, 1997). The CR-I is a method which allows the professionals and the clients to evaluate the treatment process conjointly, with the help of a third party. The research process continued with a stimulated-recall interview procedure (STR-I) (Elliott, Slatick, & Urman, 2001): segments of the videotapes of the first interviews were used to help the psychiatrists to recall their thoughts and feelings during that first interview.

The interviewees and the interview process

Out of the eight psychiatrists (seven females, one male, aged 36–61 years) six had lengthy experience in psychiatry. Two were undergoing their psychiatric training, and four were family therapists. The participants' experience of psychotic patients ranged from one to 26 years. Three of the psychiatrists were in charge only of patients' inpatient care; two were responsible for outpatient care, but also contributed to inpatient care. The remaining psychiatrists worked in outpatient care. In two interviews the psychiatrists from both the inpatient and outpatient care centers were present. Two psychiatrists were interviewed twice.

In seven CR-I´s only one co-worker was present, in the eighth there were three. Eight of the participating co-workers were nurses and two were psychologists.

The patients consisted of four females and four males (age range 19–56 years). Their diagnosis (of psychosis) had been operational for a maximum of two years. On four occasions the patient's mother took part in the interview, on two occasions the mother took part together with a sister, and on one occasion a sister took part. One patient did not want his family to contribute to the treatment, and this patient's family was not interviewed.

Both interviews lasted approximately 1.5 hours. The STR-I took place one to five days after the CR-I. The researcher selected from the CR-I, choosing the parts to be viewed in the STR-I.

Material

Each STR-I was transcribed verbatim. The researcher then viewed the videotapes several times, and at the same time read the transcriptions. Thereafter, the researcher divided the transcriptions into topical episodes (Linell, 1998). In total, 139 topical episodes were formed.

To categorize the material, summaries of the topical episodes were made. Five themes emerged; thus the interviewees were observed to speak about 1) persons who were involved in the treatment process; 2) the psychiatric syndromes and the symptoms; 3) the treatment and opinions or stances concerning the therapies; 4) institutional factors; and 5) the research situation.

Method of analysis

Topical episodes in which the interviewees referred to their workmates were examined more closely with an adaptation of dialogical analysis.(Markova, Linell, Grossen, & Salazar Orvig, 2007; Rober, Seikkula, & Laitila, 2010). The voices and positioning were divided into categories, and these were used to write the results as a story containing various personal aspects of the professionals' inner dialogue, as it related to their workmates' impact on the psychosis treatment process. All meaningful decisions concerning the interviews and analysis during the entire research process were discussed at least four times per year during group meetings supervised by the second author.

A credibility assessment of the final analysis was conducted by the second author, in collaboration with three doctoral students. Each of the four went through two different thematic episodes to name all the voices and ways of positioning observable in the interviewee's talk about her/his workmates. Altogether 134 remarks were made relating to 33 speech lines. Only two remarks differed from the researcher's own analysis. Following the researcher's clarification, the four credibility assessors were able to understand the differences, which were seen to stem from the researcher's greater familiarity with the material.

Results

The interviewees spoke about their workmates in 60 of the 139 thematic episodes. Four main voice categories and eight main positioning categories were created. The voice categories were 1) voices of professionals, 2) voices of patients and family members, 3) institutional voices, and 4) voices outside psychiatry. The positioning categories were: 1) ourselves as members of staff or professionals, 2) the interviewee as an individual in relation to the professionals involved, 3) a conventional occupational relationship, 4) the psychiatrist as leader, 5) respect as a position, 6) critical evaluation as a position, 7) ambivalence as a position, and 8) miscellaneous positioning. The categories are presented below with extracts; here one can see different personal aspects of the psychiatrists' inner dialogue related their

workmates as having a possible impact on the treatment. There are a number of different voices and ways of positioning in every extract, but (with the exception of the category of institutional voices) each extract is chosen to exemplify one category. The interview extracts have been translated from Finnish to English, shortened, and simplified. Names, occupations and details have been altered.

"If this conversation was individual psychotherapy"

There were various kinds of tensions between the professional and personal aspects of the interviewees, and these were manifested in speech about workmates. The first extract shows how the problematic features of the psychiatrist hers/himself can have an impact.

1. *If this conversation was individual psychotherapy, I might talk about this at length. I have to struggle to control my behavior when I feel anger towards my workmates. With this psychologist, I feel a bit at a loss. Generally I just interrupt her abruptly. But these interruptions are a bad idea if we think of the good of the patient.*

The second extract shows how a patient's comment can challenge externality. A middle-aged female psychiatrist was astonished at a young male patient's view that the staff could serve as a role model for him concerning his drinking habits. Even though the interviewee tries to emphasize the gap between the professionals and the patients, the personal lives of professionals are strongly present in her speech.

2. *If we had a man in his thirties working here, I could see him as an example to the patient. But we are all women. We are in no way a temperance association, but that's not our patients' business. Then again, if he only knew the truth about the drinking habits of the nursing staff. I'm not speaking about myself – though in my youth I used to go to bars quite a bit. If he ever ran into a member of staff in one of those bars, what would happen then? He might think, what's the big deal, if they drink, why should I be sober?*

Because of the emotions of workmates, there seemed to be a risk of exaggerated caution and consideration, even concerning obvious shortcomings.

3. *Helena* [a psychologist] *was almost crying when she said that the mother* [of a patient] *was extremely worried. I was forced to make a referral to the hospital. Helena had allied with the mother. Helena is very conscientious, but she also carries anxieties with her, and strong emotions.*

The interviewees found it difficult to believe co-workers' – or clients' – critical comments concerning professionals whom they themselves felt to be trustworthy. As we can see in the next extract, this dilemma can elicit even suspicions.

4. *I asked the psychiatrist in the outpatient clinic if the public-health nurse had been in contact with them. I didn´t get any proper answer. I have my doubts that the nurse made the phone call to the young social worker, who didn´t recall it. There is nothing mentioned in the documents either. In spite of that, I believe that the nurse did make a phone call to the outpatient clinic.*

"He used racist talk about killing niggers"

A patient's young age or some special features, for example a threat of violence, amplified the emotions of the professionals, and this made it harder to reach reasonable decisions about treatment. The emotional challenges in the treatment had a tendency to turn out arguing between professionals.

5. *The staff on the ward said to me, why haven't you done anything in outpatient care. They were angry. It´s quite unusual that the young mother of a small child is committed to hospital. I was very irritated when I asked them about the heavy medication. The conversation we had, it was unconventional and uncomfortable.*

6. *Our team was conflicted. I felt like a total traitor, as I had been talking to my senior psychiatrist. The patient had planned to get a gun, and had used racist talk about killing niggers; there was heavy drinking and some fist fights with total strangers in a bar. The police arrested him.*

The criticisms and demands from family members were painful to hear. Comments of this kind could lead to increased criticism of workmates. In the next extract the interviewee, a member of the outpatient team, comments family member's astonishment concerning patient's sleepiness in the hospital ward.

7. *I thought he* [the patient] *had such a heavy medication only for the first night. It sounds that it was actually several days. We had disagreements with the staff in the ward, but hearing this, made me feel anger.*

However, as in the extract below, demands from family members could lead to a kind of unification of the professionals. There was then a danger that the patient could be left alone between two groups – the professional as "us," and the family members as "them."

8. *We had unreasonable demands from the family members' side. Somehow we were supposed to find her* [the patient] *a job. Of course the nurse confronted*

the realities of the situation. Of course we try to help. But she herself is responsible for her life, we are treating her psychiatric illness.

"Why haven't you done anything in the outpatient care"

Institutional voices are seen in most of the extracts, for example regarding the boundaries between professionals and clients (extract 2), inpatient and outpatient care (5, 7), medical documents (4), the leadership, hierarchy, and medical responsibility (6, 8, 11, 12, 16), and ethical dilemmas and rules in institutions (10, 13,17).

"There was a downpour and a very strong wind"

The voices observed mostly came from the professional setting. The following extract demonstrates how the voice of the environment is used as a means to describe intense frustration, caused partly by a co-worker.

9. *When we left the patient's house and opened the door, there was downpour and a very strong wind (laughter). We tried to walk forward. It felt like it was actually impossible to get out of there.*

"It's difficult to apologize for someone else"

One important detail concerned the interviewees' relationship to shared institutional responsibility. In the next extract the interviewee tries to find a way to respond as a person in an institutional setting where someone else has failed.

10. *She refused to discuss it further, because nobody had had a conversation with her when she arrived at the hospital. Should we somehow have made an apology as the family did? As this is a system with many different people in it, it's difficult to apologize for someone else.*

"I was so alone"

Medical responsibility was associated with feelings of loneliness. In the following excerpt the interviewee describes his feelings concerning team discussions about ordering medicine.

11. *Basically it's a decision you have to do yourself alone. Occasionally you can get some support from the senior psychiatrists, which is extremely pleasant. If there are major problems in the treatment (laughter), you are not able to find proper medication (laughter) and a team member speaks out of turn – yes, you can say it´s stressful now and then.*

An experienced workmate's lack of support had been exceptionally difficult for an inexperienced psychiatrist.

12. *I felt deep relief, maybe even malicious pleasure. I was so alone during the treatment process. Leena* [a nurse] *was a powerful person in the team. I was surprised that* [in the CR-I] *she said things I had been thinking about all the*

time – things she had played down before. So I hadn't overreacted, nor am I stupid. Actually things could have ended badly.

"How one can make better use of them"

The next extract indicates the dilemma between professionals as persons and as part of the institution. Respect towards nurses had in some measure an instrumental value for maximizing effectiveness, and this can involve an ethical challenge for the interviewee.

13. *This is a delicate matter. I have noticed that you can´t ever be too careful about treating the nurses respectfully. One has to admit the thought isn´t so fine. It isn't an absolute value that they are to be treated with respect and appreciation. The truth is that this is how one can make better use of them, to put it in an unpleasant way.*

"I don't want to be disrespectful"

Almost without exception the interviewees at least tried to speak about their workmates as persons who deserved understanding, empathy and esteem, or politeness. If there were disagreements, the interviewees tried to understand their workmates.

14. *The communication with him is quite difficult. I don´t want to be disrespectful. He has very many good features, but it´s very hard to give him feedback. Like all of us, he is sometimes tense, because of too much work or some other reason.*

"I feel ashamed"

A different kind of critical evaluation was accompanied by strong emotion on the part of the interviewee. In the next extract, a patient's interruption (during the psychologist's account of recent confusing and frightening incidents involving the patient) is reported as having affected the interviewee's feelings towards a co-worker.

15. *When the patient says that he has started to suspect his mental health, in a way he is giving you a starting point. Many kinds of meaningful conversations are possible. But the psychologist is bewitched by his own voice and continues with his account, which is going nowhere. I feel ashamed.*

Respect and critical evaluation were interconnected: when the workmates were involved in a challenging task, it was difficult to utter critical thoughts aloud.

16. *I demand a lot from the nurses. Still, if it doesn´t go the way I 've planned, I´ll get irritated. I understand one can't ask for more, they really do an excellent job. The nurses are obliged to bear so much responsibility, so whenever possible, I try not to say anything critical.*

"It just stuck in my mind"

The interviews – and also the conversations between professionals during the treatment – were to a considerable extent emotionally loaded situations for the interviewees. In the following extract, when the interviewee is commenting on a patient's view concerning manipulation, he seems to respond as a person to his own words. The interviewee's admiration for his workmate's straightforwardness and boldness changed – probably because he was saying it aloud in front someone – to a sort of shame. This is observable in the paralinguistic communication and in the last sentence.

17. *It was sort of manipulation, when we confronted her with the terms, how to get out of the hospital. When she refused to sign the form dealing with her property, which was kept in a locked closet, her personal nurse just said, okay, next time I'm on the shift is a week from now , we'll return to this question then* [uneasy laughter]. *After that she did sign all of a sudden* [uneasy laughter]. *It just stuck in my mind* [uneasy laughter].

"He has enough worries and sorrows himself"

If the workmates had problems in their personal lives, the interviewees were not merely extremely careful not to say anything critical; by taking a therapeutic attitude they to some extent positioned their workmates as patients.

18. *Sometimes we made our way to work together in the same train. He has enough worries and sorrows himself. I even recommended him to make an appointment with a colleague. You just want so spare him. Inevitably these kinds of things have an effect.*

Discussion

The aim of this study was to characterize psychiatrists' inner dialogues concerning their workmates during Need-Adapted teamwork. Undoubtedly, teamwork in the treatment of psychosis was seen as beneficial, or even self-evident; for example, case-specific teams and psychiatrists' discussion with experienced workmates were recognized as important ways to share and delimit responsibility. Nevertheless, the interviewees' speech concerning their workmates was related to challenges and problems. The interview protocol had a tendency to develop into a critical evaluation of the treatment. In line with the literature concerning relationship-centered care (Beach, 2006; Suchman, 2006), this study shows how the psychiatrists took actions in the treatment situation not only as professionals, but also as

persons – individuals who had their own characteristics and emotional reactions, and genuine relationships with their co-workers.

Though we were unable to trace methodologically similar qualitative studies, parallel findings have been discovered in various fields of medicine: the physician's role in the welfare of their workmates is prominent (Jimmieson, 2010), interprofessional collaboration is crucially important for novices, and challenges in professional collaboration are associated with crises in patient care and affects (McGrail, 2009), and with the boundaries in health care organizations (Braithwaite, 2010).

The majority of the few papers concerning workmate relationships in psychiatry do not focus on the personal characteristics of professionals; however, the following are relevant to the findings of this study. Psychiatrists' respect for and trust in workmates' competence is essential (Engqvist, 2010). There can be a contradiction between the views of psychiatrists and others concerning the power of the psychiatrist (Peck, 1999). It can be harmful for recovery if there is excessive focus on avoiding failure and blame (Peck, 1999) and if the individual responsibility of professionals remains vague (Herrman, 2002). Norman (1999) saw a strong adherence to an uni-professional culture. Nevertheless, our interviewees had hopes of mutual responsibility with experienced workmates from other professions, and such an attitude will tend to place an emphasis on the quality of NAA teamwork. The central clinical guidelines of NAA include a psychotherapeutic attitude – referring to the intention of achieving an understanding going beyond mere diagnostic categorization – and genuine multiprofessional discussion.

In NAA the main forum for discussing and deciding about the treatment is the therapy meeting. Here, group conversation between the patient, the family and the multiprofessional team shows significant differences compared to a more structured conversation based on different treatment orientations. We believe that for example psycho-education involves a risk of underestimating human experience. Therapy meetings are professional scenes full of human thoughts, experiences, and emotions (Haarakangas, 1997; Seikkula, 2002). Psychotic reactions should be seen as attempts to make sense of one's experience and to cope with experiences that are so difficult that it has not been possible to construct a rational spoken narrative. Therapy meetings are thus a forum for constructing and negotiating a positive sense of identity (Seikkula, 2002). According to Haarakangas it is essential to have a reflective attitude towards both the outer and inner dialogue in treatment meetings. The members of the team should ask themselves whether their thoughts are based on what has appeared in the discussion, or whether they are irrelevant in the context. In his

study, the reflecting that occurred between team members – or self-reflection on bodily feelings – was a working method by which the personal voices of team members could become material for the inner reflection of the clients (Haarakangas, 1997). In this process of helping service users, the experiences and emotions of psychiatrists and other staff can be resource – or a barrier. NAA constitutes a humanistic and democratic approach, one that is based on horizontal knowledge, dialogue, and polyphony. At the same time, NAA is an opportunity for professionals to achieve greater understanding and respect, both in relation to each other and to their clients. However, as this study demonstrates, the challenges are substantial. In the Finnish NAA tradition, multiprofessional (family) therapy training programs have been implemented to help staff to be able to meet these challenges (Aaltonen, Seikkula, & Lehtinen, 2011).

Study limitations

The proportion of family therapists in the sample was high as compared to that among psychiatrists in general. The interviewees described their inner dialogue within CR-I, and not during an actual therapy meeting. Furthermore, the researcher in the study was by no means a neutral observer; indeed, it is intended that future analysis will focus on the impact of the researcher.

Conclusions

Professionals as individuals and also clinician-clinician relationships have an impact on the quality of dialogue, and this may well be influential in the outcome of psychosis (Seikkula, 2002); hence these aspects should be taken into account in practice, in education, and in future research. The current evidence-based tradition, which emphasizes firmly-structured approaches (for example psycho-education), cannot take into account the phenomena which exist in a real-life situation, and which were seen in this study. The training and supervising of psychiatrists should enhance their self knowledge, their dialogical skills, and their ability to tolerate uncertainty in the kinds of complicated relationships that exist within the multiprofessional processes that occur during the treatment of psychosis.

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