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Background: In the Need-Adapted approach (NAA) therapy meetings are a deliberate effort to bring all meaningful parties and views to a common discussion prior to decisions; this constitutes a challenge for psychiatrists' agency.

Aims: To describe how psychiatrists see their agency in NAA.

Methods: Using videos of co-research interviews, stimulated-recall interviews of ten interviewees were conducted and transcribed verbatim. The material was analyzed via an adapted dialogical-narrative analytical method.

Results: Institutional forces were experienced as having an enormous impact on psychiatrists' agency, especially in the inpatient setting, reducing professional creativity. In the outpatient setting, psychiatrists who attended also hospital care were the most able to follow the principles of NAA and those who took part only in outpatient treatment had a tendency to adopt the position of medical consultants.

Conclusions: The ability of psychiatrists to have agency in the language used with the clients is an underrated issue. The interview methods used in the research could be utilized in practice.

Keywords: psychosis; need adapted treatment; inner dialogue; psychiatrists' agency

Introduction

The ongoing research project aims to shed light on challenges linked to the inner dialogues of psychiatrists whose clinical practice is based on the Need-Adapted approach (NAA) to the treatment of psychosis (Alanen, 2009). In NAA the psychiatrist works as part of a team, and treatment aspects are discussed and decided on together with the patients, family members, and staff during therapy meetings (Rakkolainen, 1991). They are guided by psychotherapeutic attitude to find a common understanding of what has happened, and to evaluate the real and changing needs of the patients and the family. In addition, concrete treatment plans are drawn up and continuously revised within therapy meetings. The purpose is to work with the experiences of the clients, and to avoid the dominance of a medical perspective that might involve unnecessary treatments. In NAA the psychiatrist should be able to hear and consider all the voices present in the therapy meeting, including the scientific and institutional voices of the profession. The fictitious case story below illustrates these challenges.

In a jungle of voices

The patient has experienced voices and delusions. However, he has maintained his working capacity. From time to time he shows understanding of his condition. The patients and his parents, the psychiatrist, a nurse from the ward, and a psychologist from the outpatient clinic

take part in the therapy meeting. The mother is wondering what could possibly have happened. The father is requesting medication. The nurse is suggesting hospital treatment, but the psychologist would prefer an outpatient setting. The managers have emphasized that psychiatrist should base their decisions on the current guidelines for evidence-based treatment (Finnish Medical Society Duodecim / Current Care, 2008) and try to get patients to take neuroleptics. However, many researchers have expressed criticism of the predominant view in biological psychiatry (Read, Mosher, & Bentall, 2004). Starting medication might mean involuntarily treatment in the hospital. The patient doesn't even wish to take a brief period of sick leave. If the professionals cannot succeed in creating a working alliance with the patient now, the situation may become even harder in the future. The psychiatrist would prefer to apply a need-adapted treatment model. Some international early-psychosis studies have come close to the need-adapted treatment tradition, though they place an emphasis on cognitive therapy and family psychoeducation (Gleeson & McGorry, 2004). The open dialogue approach (Seikkula, 2011) would make it possible to have a constructive conversation in order to gain some understanding of the psychotic crisis. Should the psychiatrist ask the patient to say more about his strange experiences, or about the moments when he acknowledges his symptoms? Or should he focus on the resources of the patient, emphasizing health as the results from research on recovery indicate (Topor, 2004). The psychiatrist is not convinced that the other participants within the therapy meeting are paying attention to the strengths of the patient. He has legal responsibility. Hospitalization could relieve the insecure situation, but this would mean starting the patient on medication. Inpatient treatment often leads to difficulties in co-operation, even to traumatic experiences, and the patient and his natural network lose their agency. In outpatient care there isn't enough resources to meet the family every day, though that might be the best procedure. Can the patient and family tolerate the uncertainty and take the responsibility? The father is starting to become nervous, as the psychiatrist is not making any decisions.

Agency, the dual-role dilemma, shared decision making, and NAA

In social constructionist literature the concept of agency is defined as the capacity to make choices and to act upon them (Burr, 2004). There has been a substantial body of research in this tradition, including a study on patients' agency in acute psychosis and NAA (Holma, 1999). Unfortunately we have been unable to find studies with direct relevance to the present paper. The concept of double agency, as used in psychiatric literature, has a slightly different

nuance. It refers to psychiatrists' conflicting obligations to their patients and to a powerful third party. Nevertheless, although the moral tensions implicit in a dual role (Austin, 2008; Robertson, 2008) form one important aspect of the present study, in contrast to the more traditional psychiatry within NAA such tensions are not seen as phenomena to be avoided. Therapy meetings constitute a deliberate effort to bring all meaningful parties and views together within a common discussion.

Some papers concerning shared decision making (Patel, 2008; Quirk, 2012; Seale, 2006) have highlighted psychiatrists' agency with regard to psychosis, focusing on patients' and psychiatrists' negotiations on treatment plans. Although the therapy meetings of NAA described here are indeed forums for shared decision making, they differ from the more traditional approaches as their main aim is psychotherapeutic and they are multiprofessional family discussions.

Participants and methods

Research process and methods

The eight psychiatrists in this study – two of whom attended two different interviews – were first interviewed together with the patient, family members, and coworkers, following the co-research interview method (CR-I) (Andersen, 1997). Thereafter they were interviewed using segments of the videotapes of the first interviews applying a stimulated-recall method (STR-I) (Elliott, Slatick, & Urman, 2001). The interviewees were asked to describe thoughts, emotions and experiences they had in the specific section of the CR-I they saw from the video. The STR-I's were conducted individually, or as a twosome in the case of two interviews in which psychiatrists from both in- and outpatient care were present. Out of the ten interviewees, three were responsible solely for inpatient care. Three out of the seven who were responsible for outpatient care also participated in inpatient treatment. The entire study process is described in more detail in a separate article (Borchers, Seikkula, & Lehtinen, 2012).

The transcripts of the STR-I´s were studied via an adapted form of dialogical-narrative analysis (Rober, Seikkula, & Laitila, 2010; Wortham, 2001), focusing on *voices, addressees*, and *positioning*. *Voice* refers to the speaker or actor, the *addressee* to the person to whom one is speaking, or the person who is being acted upon, and *positioning* to the position from which one is speaking or acting. In this analysis only those addressees who were referred to

in a context indicated by reported speech (some other situation than the ongoing STR-I) were included and positioning refers to the perspective from which the psychiatrists look at their own agency. Altogether the analytic concepts (voice, addressee and positioning) were used as tools to get detailed descriptions how the psychiatrists in their own narratives see their agency and also what does their manners of using words tell about their positioning towards agency.

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 two doctoral students. After the primary researcher (P.B.) had clarified the concepts, each of the three went through two different thematic episodes in order to identify the voices, addressees, and forms of positioning. Altogether 90 identifications were made. Only one identification regarding positioning differed from the researcher's own analysis.

Results

We present our material that appeared to have clinical relevance. We shall first describe what the three different analytic concepts indicate, with regard to how the psychiatrists saw their agency. Thereafter we shall present the more or less common findings, and finally consider the effects produced by different settings. The interview extracts have been translated from Finnish to English, and simplified. Names, and details have been altered. The word client is used to refer to the patients, and their family members.

What the analytic concepts indicate

Voices

The voices of the professionals had a tendency to fuse with institutional voices. Thus, hospitals or outpatient clinics became agents who, rather than functioning as the professionals within them, became entities that took care of the treatment. It could be said that the inpatient unit *per se* actually had emotions.

1. *I suppose it was a challenging incident for the ward also, quite exceptional for a single parent father to be committed to a psychiatric hospital.*

The institutional tone "contaminated" the voices: the speech about normality, health and trust referred to the opposites – pathology, disability, and suspicion. The institutional forces of psychiatry had silenced the personal voices of the patient: the voices of health and

normality were used referring mainly to the time before the patient entered psychiatry. Moreover, although family members, and especially siblings and friends brought with them the voices of everyday life, the people concerned were drawn into the category of close relatives of the patient rather than that of persons with their own interests. On the other hand using institutional phrases such as therapy meeting the psychiatrists, their coworkers, and the clients were put together within a kind of "us," seen as having a common interest.

Addressees

Addressees were used of all but one interviewee as verbal resources e.g. to express emotionally difficult parts of their internal dialogue. In the following extract, the interviewee quotes the managers, who have accused her team of inadequacy.

> 2. *There is need for a proper psychosis team for the area. But we hear constantly: "Why don't you do anything? How come you have fewer appointments than the other units?" They don't understand the differences between having a therapy meeting in a psychotic crisis and consulting a group of patients in order to write prescriptions.*

When describing e.g. their disappointments about treatment failures the psychiatrists quoted occasionally to a hypothetical interaction which never happened.

Positionings

The interviewees positioned themselves towards their agency on three different levels, the first two of which are relevant to the clinical perspective of this article: 1) the *storytelling* event, this being the interactional context (i.e. the interview) within which the speaker utters something; 2) the *narrated* event described by the utterance (Wortham, 2001), and 3) the *present moment*, meaning that in articulating their thoughts, the interviewees simultaneously positioned themselves in relation to their own words, within the same utterance.

In the storytelling event the interviewees searched for words describing their emotions, shared their confusing experiences, and co-constructed a coherent narrative in such a way as to strengthen their feeling of agency. They also evaluated the treatment.

> 3. *As I heard* [in CR-I] *he was medicated involuntarily so often I became even more irritated. When we had a quarrel with the hospital ward, I was thinking: let them handle it, I won't come here another time. That wasn't constructive. I should have attended the therapy meetings more often.*

The narrated events most often dealt with the treatment of the patient or the CR-I, but also e.g. personal issues.

4. *The patient being openly racist is exceptionally difficult for me. I have lived in South Africa and I became familiar with apartheid. It's incomprehensible. Right from the start of assembling the case-specific team, I wondered if I could skip this background. The patient is entitled to proper treatment.*

Common features

The most important choices were present in the interviewees' inner dialogues. At best they were grounded on the aim of increasing hope and empowering the clients. Active listening made it possible to hear clients' therapeutic proposals, resources, and processes of recovery, but also frightening issues. All the interviewees had experiences of losing their agency – mostly as a response to a strong emotion such as fear. .

5. *After he threatened me, I said to him: "There is the door, get out! Do you know what zero tolerance is? We follow it." Situations like this provoke affects. Though it was partly done on purpose, it wasn't reasonable behavior on my side either.*

Taking account of clients' feelings or intentional therapeutic purposes, the interviewees considered what parts of their inner dialogue it was safe and meaningful to utter aloud, and what words and therapeutic orientations were appropriate.

6. *We could have told them more about schizophrenia spectrum disorders. But I wanted to give a more optimistic and comprehensible story. We should avoid using these diagnoses that can have negative effects on the prognosis. I myself have pushed some patients close to suicide by talking about schizophrenia.*

Though serious effort was more important than success, all the psychiatrists reevaluated their past views and actions, or planned new measures.

7. *Leena* [patient] *is verbally extremely talented. Her responses are occasionally insulting. Staying quiet to preserve at least some kind of relationship has become an automatic reaction. Maybe it's time to start to discuss difficult issues and put one's own emotions into words.*

Achieving a coherent narrative to calm down disturbing thoughts and emotions was so important that there was a risk of creating a pathological story or moralistic assessments of the clients - at times ignore the actual facts.

Though facing critical views was difficult, the patient's siblings managed to phrase their criticism in a useful manner. Often the interviewees ended up in a position of ambivalence, located between defending themselves and self-criticism.

Discussion with colleagues and trustworthy coworkers and previous experience with psychosis emerged as resources contributing to agency. It was seen as important to adjust the treatment approach to the resources. Though some psychiatrists were confused about their dual role the participation of family members in the treatment was considered to be important. Positive feedback from clients was felt to be important. The feeling of responsibility was experienced as burdensome, but was a basis of agency.

The positioning taken by the psychiatrists was influenced also by personal features.

8. *For my generation this way of blaming parents is quite disturbing. I was even more annoyed when the father didn't respond. That's why I started to defend the father.*

Effects of different settings

The inpatient setting

The psychiatrists responsible for inpatient treatment seldom used addressees as resources, and never hypothetical situations. They often gave thought to their agency with regard to involuntary commitment and compared to other settings had a stronger tendency to focus on pathology and symptoms. In spite of the big differences between the interviewees there was a clear risk of the "total institutions" phenomenon (Goffman, 1961), i.e. of institutional forces capturing human agency.

9. *I f the patient behaves in the way ordered, uses permissions as decided, doesn't cause any disturbances ,and takes medication, patients are considered fit to be in society and are released to outpatient care.*

The spirit in a psychiatric hospital made the staff to fantasize risks that might threaten their patients; avoidance of essential uncertainty was a hindrance to the process of recovery. The inpatient setting reduced hope, and it increased the frustration and cynicism of the interviewees. The team was seen as essential, but at the same time, it muddled the psychiatrists' experiences of their responsibility.

The outpatient setting

The possibility that the patient would leave outpatient care led the psychiatrists to avoid important delicate matters.

The psychiatrists taking part in both outpatient and inpatient treatment

These interviewees were able to use voices connected with many emotionally significant memories from specific treatment situations.

> *10.* *The mother told us that the police had arrested Matti* [the patient] *for something he knew nothing about. It was unbelievable. I was shocked. We sat with the family for over two hours and were almost as upset as they were.*

Shared experiences with the clients reinforced feelings of empathy and understanding and facilitated reflective thinking. This setting forced the psychiatrists to try to find a way to collaborate with the clients.

> *11.* *If involuntary commitment is needed, I prefer to make the referral myself. Then we can discuss it openly in therapy meetings. In my experience it doesn't break trust.*

Given local treatment principles, including a family orientation, were felt in the same time as challenging and as a basis of agency. The psychiatrists in this group tended to analyze in detail the reasons for the possible failures, to emphasize their limited expertise, and to see the need for continuous learning from the clients. Becoming too closely connected with the clients was seen as a threat to the professionals' agency. This group was the only one to give consideration to efforts to keep the dose of neuroleptics minimal.

Psychiatrists taking part only in outpatient care

The psychiatrists in this group positioned themselves as medical consultants for the team. Their agency was focused on supporting nurses, who were the main professional agents, and organizing a treatment system – taking account of resources – that would be optimal for the treatment of psychosis. The stance of medical specialty sometimes collided with clients' holistic expectations.

> *12.* *The mother had said to my coworker, "You must arrange an apartment for Heidi* [the patient]. *We are all fed up, she must move out straight away." Quite peculiar expectations. After all we are a psychiatric institution, not a housing agency.*

Because they did not have so much face-to-face contact with the clients, they used impersonal clinical voices, and psychiatric discourse. They constructed typical narratives of themselves within the psychosis treatment process.

13. *With psychotic patients I have automatic patterns of thinking .Whenever possible I don't question their experiences or thoughts - you have to do it so often anyhow. In long run there is a risk that we don't dare to bring up vital matters.*

Discussion

The aim of this study was to characterize psychiatrists' inner dialogues concerning their agency in Need-Adapted teamwork. All the interviewees felt that they had made and acted upon relevant choices, but reported also instances they could have handled better. The interviewees utilized the interviews as a form of clinical supervision, and those who had an ongoing therapeutic relationship with the clients planned changes to the treatments. The diverse barriers to agency resulted partly from the dual-role dilemma (Robertson, 2008), with psychiatrists finding themselves to be servants of several masters. The strength of institutional forces seen in the study was also found in a study by Austin (2008): actions became agent-less, which was experienced as morally disturbing by the psychiatrists. According to Galeazzi, Mackinnon, and Curzi (2007), psychiatrists perceived conflicting demands of their social control function and the collaborative model they wished to follow. This was seen in the present study, in particular with regard to the inpatient setting. Vuokila-Oikkonen's (2002) study on acute inpatient care showed how difficult and important it was for authoritarian participants to give space for the expressions of clients and coworkers within common meetings.

Psychiatric discourse was used when speaking of clients: they were patients or relatives rather than human characters. This tendency was strengthened by the suppression of creativity in psychiatric hospitals. Psychiatrists with family therapeutic training – a proper training to meet the practical challenges of therapy meetings of NAA - had critical reflections on the tendency to focus on pathology or on a diagnosis such as schizophrenia. The involvement of patients' natural networks – particularly siblings and friends – increased the number of voices outside psychiatry.

The NAA tradition has features in common with the concept of shared decision making (SDM). A review of papers concerning SDM (Patel, 2008) found that patients' motivation to

participate was often explained by their past negative experiences of, i.e. involuntary treatment, and that they generally have preferred greater participation than was offered. Patients emphasized the importance of trust in their service providers, which they avoided to offend viewing them as family members. The therapy meetings conducted within NAA, which are broader, psychotherapeutically-oriented multiprofessional family discussions, could provide an opportunity to respond to patients' needs for greater participation and, to process involuntary acts in such a way as to bring about better confidence in the professionals. Seale et al. (2006) reported findings that are consistent with the present study, e.g. emphasizing the benefits of knowing clients for a long time, expressing a human response, and facing up to the limitations of one's knowledge. However in our study though the psychiatrists working solely in an outpatient setting had a consultant role which emphasized the stance of medical psychiatry, as members of the case spesific team – one of the main principles of NAA - they had indirect agency concerning alternative treatment methods. The tradition of NAA can be seen also in the attitude towards medication: none of our interviewees concentrated particularly on strategies to enforce compliance with medication. Conversation analytic research (Quirk, 2012) has demonstrated the risk of losing the benefits of SDM through implementing the approach in such a way that the patient feels that he/she has little real influence. Our interviewees recognized clients' difficulties in expressing critical comments, and of professionals in responding to them; however, the reflective type of discussion used in CR-I was seen as opening up space for all parties to say and hear more.

Psychotic symptoms have been found to be a source of noticeable interactional tension and difficulty (McCabe, 2002). The anxiety associated with psychosis, the difficulties in tolerating uncertainty, and the formal responsibility laid upon psychiatrists impelled the interviewees – especially those with less experience – to choose actions that would calm the symptoms via medication and inpatient treatment. The opportunity of seeing psychosis as a form of agency and as an attempt to make sense of one's own experiences (Holma, 1999) was missed.

Psychiatrists who attended both in- and outpatient treatments were committed to the principles of NAA. Because they had diverse personal contacts with the clients, they were able – or as individuals, compelled – to have an emotionally rich inner dialogue concerning the whole context of the case. This extremely challenging arrangement required experience and psychotherapeutic training, and also personal conviction, including a readiness to be

exposed to strong emotions. When these features were present the psychiatrist was able to experience the challenges of psychosis in a holistic manner, and to develop as a professional and as a person to adjust to the needs of the therapeutic relationship with the clients. It would appear that adherence to the principles of the open-dialogue approach (Seikkula, 2011) can contribute to the task. However, the risk of falling into a reductionist approach should be avoided: one needs to take into account local factors such as resources and professionals' personal realities. For good reasons, attention has been paid to the problem of unrealistic expectations for individual psychiatrists, and for psychiatric expertise as a whole (Austin, 2008; Rosen 2006). It appears that the concept of responsibility needs to be reframed in a more relational way (McNamee, 1999).

Study limitations

The psychiatrists' commitment to NAA varied. Nevertheless, because the composition of the CR-I resembled that of a therapy meeting – with the exception of the role of the interviewer – we would argue that the challenges bound up with psychiatrists' inner dialogue in NAA are clearly visible in the study. The main researcher in the study was by no means a neutral observer and the future analysis will focus on the impact of the interviewer. The writers' commitment to NAA is also an eventual source of bias. Though some of the findings e.g. the tendency of inpatient setting to focus on symptoms, is obvious, we argue that the present study shows in a novel way the importance of the actual practice of choosing words which support recovery from psychosis.

Conclusions

According to the study psychiatrists have meaningful difficulties to follow the humanistic principles of NAA. Their opportunities e.g. to maintain psychotherapeutic attitude and to avoid the dominance of medical perspective could be improved by (family) therapeutic training. This would also support their abilities to meet the challenges to take part both in the inpatient and outpatient care of the same patient, which should me favored by the administration. The central challenge for psychiatrists is how to adapt their dialogical potentials to different contexts in which they meet clients (Quirk, 2012). Psychiatrists' creativity and their abilities to have agency in the language used with clients constitute underrated issues. It could be recommended that psychiatrists, as authoritarian participants, base their own speech not just to the words clients but also their coworkers in practice use – and in the same time give words to their own experiences. Given this situation, the interview methods used in the present research could be utilized in practice. Using reflective positions

in therapy meetings – which would include separating the turns of speaking and listening in the manner described by Andersen (1991) – could promote the openness of professionals, in such a way that they would not lose the respect of the clients, and open space for the clients to hear the professionals. The co-research interview method (CR-I) (Andersen, 1997) appears to be a suitable method for the purposes of clinical supervision: in every interview the presence of an experienced outsider brought new perspectives to the discussion, and helped the clients to evaluate the treatment process more openly. Overall, the clients' participation in the treatments, and also in the training and education of professionals, should be strengthened. The stimulated-recall interview method (STR-I) (Elliott, Slatick, & Urman, 2001) can be used in professional training. It can substantially contribute to professionals' opportunities to have agency in their listening and in their use of language. It can help them to focus on patients' resources, and in this way open up a space in which patients can find words for their symptoms and for other frightening mute experiences (Seikkula, 2002).

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