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The Need-Adapted Approach in psychosis: the impact of psychosis on the treatment, the psychiatrists, and other professionals

Abstract

Psychosis is a challenging phenomenon for professionals. In the Need-Adapted Approach (NAA), therapy meetings constitute a deliberate effort to meet the challenges by bringing all the main parties together within a common discussion. The aims of this study are to analyze and evaluate psychiatrists' experiences of the treatment processes in psychosis. A qualitative multiple case study approach has been used. Between August 2007 and January 2009 co-research interviews (CR-Is) and stimulated-recall interviews (STR-Is) with ten psychiatrists from three different part of Finland were videoed and transcribed verbatim. The material was analyzed using qualitative content analysis. The difficult emotions of the professionals and the critical views expressed had a prominent role. It was almost impossible to proceed with the treatment until the memories of coercive acts had been addressed. There were fewer harmful effects in outpatient than in inpatient care. If the client-centered principles of NAA were not followed, the CR-Is functioned primarily as critical evaluations of the treatment processes. The STR-Is helped the psychiatrists to find words for difficult experiences. For the sake of both practice and research, the experiences of staff in the treatment of psychosis should be taken into account. For better prediction of failure, routine measures to obtain feedback could be included in NAA.

Keywords:

psychosis; need-adapted treatment; psychiatrists' experiences; qualitative study

Introduction

Psychotic crises are distressing to patients and to their social network. They also constitute a challenge to professionals, not least to psychiatrists. The Need-Adapted Approach (NAA) (Alanen, 2009) incorporates an effort to bring the patient, her/his social network, and all relevant professionals together to meet the challenges that occur. In NAA the psychiatrist

works as part of a team, and aspects of treatment are discussed and decided on together with patients, family members, and staff during therapy meetings (Rakkolainen, 1991). The meetings are guided by a psychotherapeutic attitude to find a common understanding of what has happened, and an evaluation of the real and changing needs of the patients and the family. 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 which could result in unnecessary treatments.

For several years, two of the writers have worked in psychosis teams as family-therapy professionals (the first author having trained as a psychiatrist, and the second author as a clinical psychologist). While following NAA procedures, we have observed many challenges associated with specific features of the psychosis phenomenon. Professionals find certain aspects of psychosis confusing and even threatening. They have to deal with the patient's loss of a sense of reality, incoherent psychological boundaries separating the self from others, gaps and shifts in associations, and the substitution of an organized and realistic logic by a more archaic logic of dreams – all this together with a weakening of impulse control because of delusions, hallucinations, and affective disorders (Alanen, 1997) This often leads to difficulties in treatment collaboration. Frequently, the professionals feel obliged to get the patients to admit their illness and to take medication to control their psychotic symptoms. The patients – who arrive upset, suspicious, and frightened in the first place – are left alone with their frightening experiences or even exposed to trauma, in the case of involuntary treatment.

Democratic societies deal with psychosis very differently from most other health problems. Though there are differences in Europe in both legislation and clinical practices regarding the compulsory treatment of psychotic patients (Jacobsen, 2012), psychiatrists and other professionals have exceptional power and responsibility in the

processes concerned. All in all, it can be difficult to integrate the humanistic stance of NAA – which is not based on interview manuals but on a more or less open dialogue between the participants at therapy meetings – with the institutional and scientific perspectives of medical psychiatry.

The ongoing research project – of which the present study forms part – is concerned with the inner dialogues of psychiatrists in the treatment process of psychosis, a process involving cooperation with the patient, her/his social network, and other professionals. The entire process of the research has been described in detail in two previous articles (*reference not mentioned because of the blind refereeing process*). The NAA tradition is founded not on the immediate control of psychotic symptoms, but rather on the emergence of a dialogue between the patients and other participants in therapy meetings. Many of the universal issues arising in all relational practices (for example, the toleration of uncertainty) are exceptionally visible and tangible in NAA, given that the aim is to avoid means of control that would hinder dialogue. With this as background, the present study sought to analyze the experiences of professionals as revealed in interviews, addressing the following research questions:

(1) What psychosis-related issues were dealt with in the interviews? (2) What was the impact of these issues on the professionals and on the treatment processes?

Need-Adapted approach, experiences of psychosis, and the therapeutic relationship

NAA has its roots mainly in Finland (Alanen, 1997), and partly in Sweden (Cullberg, Levander, Holmqvist, Mattsson, & Wieselgren, 2002; Piippo & Aaltonen, 2004; Piippo, 2008). However Gromer (2012) from United States have conducted a narrative review of seven studies of NAA concluding that outcomes were equivalent or superior to those

obtained in standard care. All in all, there is ample research indicating that NAA is a useful approach (Aaltonen, Seikkula, & Lehtinen, 2011; Haarakangas, 1997; Holma, 1999; Iso-Koivisto, 2004; Keränen, 1992; Lehtinen, 1993; Seikkula, 1991 &2011), but that it requires professionals to face the severe challenges mentioned above. The studies in question have addressed the impact of psychosis on the treatment provided; nevertheless, the experiences of professionals using NAA have been given more explicit attention only in a qualitative analysis linked to Acute Psychosis – Integrated Treatment Project (Aaltonen, Koffert, Ahonen, & Lehtinen, 2000), which is the most resent Finnish national research and development project involving NAA.

There is a mutual dependence between the impact of psychosis on treatment processes, the human experiences of clients and professionals, and institutional factors within psychiatry. Some studies have been carried out on patients' experiences and understanding of psychosis (Geekie & Read, 2009) and those of carers (Stern, Doolan, Staples, Szmukler, & Eisler, 1999), but the literature has mainly ignored the embodied human responses of professionals. With a few exceptions (Engqvist, 2009; Hardcastle, Kennard, Grandison, & Fagin, 2007), the professional perspective on psychosis has been presented via scientific theories of psychosis, or at most, the moral distress bound up with the psychiatrist's dual-role dilemma (Austin, 2008; Robertson, 2008). The therapeutic relationships between psychiatric staff and people with a diagnosis of psychosis appear to constitute a predictor of outcome (McCabe, 2004; Priebe, 2011). These relationships depend partially on personal features of the staff, for example, their attachment styles (Berry et al., 2008), and they have an impact on the work welfare of the staff members concerned (Dennis, 2007).

According to the phenomenological approach of Fuchs and de Jaegher (2009) – which is based largely on the evidence of the role of social interaction in the development of mirror neurons in early childhood – social understanding is a process in which the lived

bodies of the participants form a common incorporality. Because psychotic experiences are obscure and contradictory, and often even impossible to verbalize, the professionals as embodied agents are bound to be confused in their attempts to interact and align themselves with the patient. In NAA the aim from the very beginning is to constitute a boundary system in which the subjects and objects meshed with each other and to begin coevolution between the clients and the professionals (Seikkula, 1991).

Research process and methods

A qualitative multiple case study approach was chosen and the regional ethics committees gave the study positive statements. For therapeutic grounds the researcher mainly informed the different centers of the possibility to take part in the study and the staff, who themselves were willing to take part, chose the patients for the interviews. The first eight treatment process available was taken in the research. The interviews were conducted between August 2007 and January 2009. All interviewees were asked for their informed consent. The patients in the study had been treated for schizophrenic psychosis (diagnosis F20-29 according to the Finnish version of the International Statistical Classification of Diseases and Related Health Problems, ICD-10) for a maximum of two years. The ten psychiatrists from three different geographical locations of Finland included in the study were first interviewed together with the patient, family members, and coworkers, using the co-research interview method (CR-I) (Andersen, 1997). In CR-I, first the professionals and then the clients are asked to evaluate the treatment process, with the other parties listening in each case. The CR-I ends in an open discussion. Thereafter, the psychiatrists were interviewed about their thoughts, emotions, and experiences, using segments of videotapes from the earlier interviews, and applying a stimulated-recall method (STR-I) (Elliott, Slatick, & Urman, 2001). In the present study, the STR-I was conducted individually, or in pairs in the case of two interviews in which

psychiatrists from both in- and outpatient care were present. The interviewees and the interview process are described more detailed elsewhere (**reference not mentioned because of the blind refereeing process*).

Each STR-I was transcribed verbatim. The researcher then divided the transcriptions into topical episodes (Linell, 1998). Using qualitative content analysis (Graneheim, 2004), closer examination was made of thematic episodes exhibiting some of the special features of psychosis, or some kind of change in the interview process; this could involve, for example, the psychiatrists starting to see the patients as healthier than before, or the emergence of new ideas concerning the treatment.

As the interviews were, quite literally, *inter*-views, involving a dialogical conversation on themes of mutual interest (Kvale, 1996), the voice of the interviewer formed part of the material for analysis. A subsequent article will address the changes in the interview process, and also the voice of the interviewer.

All significant decisions made during the entire research process were discussed at least four times per year during group meetings supervised by the second author. For this particular part study ATLAS.ti 6 software was used. The conceptualization of Graneheim and Lundman (2004) was found appropriate for the analysis applied in the present study. Thus, the *manifest content* refers to what is visible and obvious (what is actually said), while the *latent content* refers to the relationship aspect, and involves an interpretation of what is said. The final categorization was based on these concepts. Adjustments involved segments of the "latent data" being omitted from the category of manifest content, or being replaced with a more suitable category of latent content. The final assessment of trustworthiness was conducted via a discussion between the first and third author (a person who came to the study from outside psychiatry and who had not previously been involved in the study). The paper was rewritten following discussion of three questions, namely: Are the analysis and the

results described plausibly? Would it be possible to construct a similar study following the steps outlined in the text? Is the narrative in the manuscript comprehensible?

Results

There were altogether 139 thematic episodes. Eighty-one of these involved psychosis, while in 85 it was possible to identify some kind of clinically meaningful change within the interviews. Seventy-one (84 %) of these changes concerned the discussion of the treatment of psychosis. We shall illustrate the results within partially overlapping categories, mainly following the conceptualization of Graneheim and Lundman (2004).

The first seven categories (*the beginning of the treatment; psychotic symptoms; neuroleptic medication; involuntary acts; the setting of the treatment; the diagnosis; the family*) are concerned with the *manifest content* of the interviews. Unless otherwise mentioned they embody what the psychiatrists in the interviews actually said. The last category (*ethical issues*) embodies the *latent content*. Unless otherwise stated, it refers to the researcher's interpretation of the meaning of the text. We shall address each of these categories by first setting out our understanding of the label used: thereafter we shall present our findings and provide a brief summing-up (in italics). We here use the word *client* to refer to the patients and also their family members, and the word *professional* to indicate all employees in psychiatry, whether interviewed or spoken about.

The beginning of the treatment

There are many challenges in the initial treatment of psychosis. The symptoms can make the therapeutic interaction difficult and arouse anxiety. In conjunction with the inflexibility of medical institutions and the attitudes and legal norms of society, emotional pressures often

lead to overly simplistic treatment strategies that take no account of the experiences of the clients.

In this study, too, the start of treatment was observed to be of the utmost importance. There were difficulties in all cases, and only one case in which these difficulties had no impact on the rest of the treatment process. In six cases the initial difficulties resulted in hospital care, making the success of the treatment more problematic – particularly so in the case of the three patients undergoing involuntary treatment. If the clients felt mistreated at the start, the professionals were thereafter obliged to make great efforts to help the patients overcome their resentments and frustrations. In two different STR-Is the psychiatrists mentioned the risk of the staff becoming too cautious. In trying not to hurt the clients' feelings the professionals avoided issues which were relevant to the disorder and to recovery from it, for example the possibility of grief concerning the disorder.

The difficulties at the beginning of the treatment were more connected to hospital care; they made it difficult to focus on issues which might form the background of the psychotic crisis in the first place. Some psychiatrists noticed the extent to which they had been too cautious.

Psychotic symptoms

The dominant biomedical approach in psychiatry concentrates on symptoms, and this is especially the case in psychosis. Since psychiatrists have a social role in the process of involuntary commitment, this actually compels them to focus on symptoms such as a lack of a sense of reality.

Especially the professionals in the hospitals were indeed especially likely to concentrate on symptoms. There was thus a risk of misinterpreting ironic remarks made by patients, viewing such speech as psychotic, and not noticing the resources the remarks might

illustrate. The patients had to exhibit exceptionally good mental health and competence if they were to convince the professionals of their capabilities. Some psychiatrists avoided questioning their patients' understanding as far as possible, feeling that the patients were, in any case, frequently being forced to face distressing confrontations. Psychotic speech and behavior aroused confusion among professionals, and feelings of threat. However, the professionals' experiences of threat showed wide variation with regard to a given patient's symptoms and behavior. Because of the legal responsibilities involved, it was extremely hard for inexperienced psychiatrists to tolerate uncertainty. The professionals tried to understand what had happened to the patient before the symptoms started, for example to think of possible stressors; however, discussion of the meaning of the psychotic symptoms, or of their basis in reality, occurred mainly with regard to two particularly acute cases, which were treated solely in an outpatient setting. The existence of negative symptoms, including a lack of initiative, was an important theme in one interview. In this instance the interview became a kind of meeting to formulate a treatment plan focusing on concrete behavioral ideas for future care. Because the patients in the CR-Is were present on a more equal footing and were able to talk about matters that were important to them, they were seen as healthier and as having more agency than during the actual treatment.

In the inpatient setting in particular, there was a risk of interpreting patients' speech and behavior as psychotic even when this was not the case. It appeared that some of the psychiatrists were attempting to protect patients from unpleasant confrontations.

Neuroleptic medication

According to the dominant biomedical approach of current psychiatry, antipsychotic medication constitutes a self-evident treatment for psychosis, and most often patients are either persuaded or forced to take drugs for the condition.

Antipsychotic medication was used in all the cases in our study. It emerged that there was often too little discussion of medication during the treatment: thus, not merely the patients but also family members would have wished to have more information more rapidly. Because the psychiatrists were so used to the common side effects of the neuroleptics administered, it seldom crossed their minds to broach the matter with the clients. Even among agents working on the same case, contradictory expectations were expressed – ranging from skepticism to excessive optimism – concerning the effects of antipsychotic medication. Mention was also made of the need for close attention on the part of psychiatrists regarding the appropriate medication and the dose.

Neuroleptic medication was most often seen as the self-evident treatment for psychotic symptoms, at least by someone who played an important role in the treatment process. The case-specific differences and experiences of clients were easily overlooked in everyday clinical work.

Involuntary acts

As mentioned above, psychosis is a very special case in health problems: psychotic symptoms can result in involuntary treatment, and may also have forensic consequences.

Three of the eight patients were treated on an involuntary basis. The experiences of different kinds of coercive measures were of major importance for the entire treatment process. In particular, the experiences of forensic psychiatry and of coercive measures in relation to child welfare were felt to be traumatic by the patients and family members. At the worst extreme, the incidents were so abnormal that neither the clients nor the professionals could integrate them within their previous life experiences: as one client described it, it was like living in a nightmare. There was an obvious tendency for the discussions to become locked in these bad experiences instead of addressing the underlying

disorder. When the professionals and the institutional environment reminded the patients of painful memories, it was somewhat easier and more useful to have the therapy meetings at the client's home. The psychiatrists had greatly differing perspectives on the coercive measures in force. At one end of the spectrum the principle was presented that the same professionals should continue to treat the clients and give them the possibility to talk about their experiences. At the other end of the spectrum it was felt that the situation was, in fact, so threatening and frightening that it was impossible to continue the treatment with a specific patient. A further point arising was that adherence to the legal principles was not as precise as the psychiatrists had expected. In fact, this could also have advantages: if a patient was treated on a voluntary basis (even if it should have been done involuntarily by law), the situation could be more comfortable for the patient.

The coercive measures were experienced as traumatic by the patients and families, and sometimes also by the professionals. It was almost impossible to proceed in a cooperative manner until the painful memories of coercion had somehow been addressed.

The setting of the treatment

In Finland, as in most countries, it is felt that outpatient care should be the primary care setting for psychosis. However, for a variety of reasons, inpatient treatment is often required.

More harmful phenomena occurred within inpatient than outpatient care. It was common for significant disagreements to arise between the patient and the staff in the ward, and this in turn hindered confidence and cooperation in the future. On the other hand, the hospital was regarded as a better setting if the patient was seen as requiring a structured environment, or if it was simply not possible to offer intensive outpatient care. The presence of fellow patients in the wards was thought to have various effects. The presence of chronic patients could increase a sense of hopelessness. On the other hand, the coping strategies of a

peer group (involving for example the naming of hallucinations as a strategy for coping with voices) occasionally provided concrete benefits. Though outpatient care was generally regarded as the primary setting, it often failed, despite serious attempts to make it work. The decision on inpatient treatment could result from many factors, including the mistakes of professionals, boundaries between organizations, the clients' lack of knowledge of treatment possibilities, the inability of outpatient clinics to offer immediate help, and family members' anxieties and beliefs. Regarding the outpatient setting, it was observed that the psychiatrists were occasionally too cautious in challenging patients' views, due to a fear that that the patients would abandon the treatment.

The generally recognized goal – that psychotic crises should be addressed in the outpatient setting – was found to be demanding for the professionals concerned, and also the institutions. However, even though the professionals experienced more problems in the inpatient setting, some patient did obtain benefit from being in the hospital. It also seemed that outpatient treatment could sometimes lead professionals in the direction of over-caution.

The diagnosis

The importance of having a descriptive diagnosis has been highlighted in psychiatry, even though a possibly stigmatizing diagnosis (as in, for example, schizophrenia) is by no means a neutral factor in recovery.

In fact, the diagnosis of schizophrenia was generally avoided; this was a deliberate policy, or resulted from a sense that the label was unhelpful. The psychiatrists tended rather to speak of psychosis. Even if family members might sometimes wish to use the term schizophrenia, the psychiatrists seemed to be uncomfortable about using the word. On the other hand, if the patient himself/herself spoke of the possibility of having schizophrenia, this was seen as forming an important and useful opening. Melancholy and sadness after an

episode of acute psychosis was labeled by some psychiatrists as postpsychotic depression, while others spoke about grief of becoming sick. The diagnoses were seen as approximations.

Regardless of different viewpoints on diagnostic categorization the psychiatrists tended to avoid the diagnosis of schizophrenia. This could be explained in terms of maintaining optimism.

The family

Psychosis is a crisis for the whole family. Thus, the well-being of the family, including communication between members, forms an important aspect in the patient's recovery.

The professionals tended to relate to family members as carers rather than as clients with their own personal needs. Nevertheless, most psychiatrists were very well aware of the difficulties and suffering of family members, and valued their attempts, accepting their limitations, and even defending them against a patient's disrespectful behavior. On the other hand some psychiatrists criticized family members, expecting them to be capable of giving more assistance in the treatment. Consideration was also given to the causal roles of family members in the patients' disorders. In their desire to ensure that a young patient would continue with outpatient care, professionals were too willing to accept the patient's reluctance to ask family members to take part in the treatment. If the patient had a child, this resulted in major challenges regarding cooperation with clients and between different authorities. The psychiatrists had to make considerable efforts if they were to convince the child welfare services that a psychotic parent, together with her/his social network, was capable of taking care of the child.

Family members were seen as resources for the treatment, rather than as clients with their own needs. Occasionally the psychiatrists felt that the family could and

should have done more for the patient. The concurrence of parenthood and psychosis constituted a particularly difficult and complicated dilemma.

Ethical dilemmas

Psychotic symptoms such as hallucinations and delusions challenge normality, overturn one's normal ways of sensing and thinking about one's environment, and give rise to a range of ethical dilemmas.

The need to engage in coercive measures constituted only one of the ethical dilemmas faced by interviewees. The psychiatrists had to struggle between the differing views of patients, family members, and other professionals and authorities (e.g. child welfare bodies). They also had to balance biomedical perspectives, institutional resources and responsibilities, attitudes in society, and their own human perspectives and needs. This resulted in a tendency to continue the treatment on a "just in case" basis, and not take sufficiently seriously the desire of a patient to end the treatment. There often appeared to be a gap between the structures or resources of the institutions and the needs of the clients. Some of the psychiatrists had negative and critical attitudes towards the clients. On the other hand, some of them had to find a stance which would allow them to confront the stigmatizing and manipulative attitudes of the treatment culture, or of co-workers. A small number of the professionals experienced elements of the psychosis treatment tradition as inhumane; indeed, one psychiatrist saw the treatment as belonging to another age entirely. Professionals who worked purely in the inpatient setting ran the risk of becoming accustomed to abnormal standards of interaction; this could lead them to emphasize control instead of listening and understanding. Some professionals found themselves battling between hope and cynicism.

The everyday treatment of psychosis is characterized by crucial ethical questions for psychiatrists and the psychiatric system.

Discussion

If, at the start of treatment, the clients had no feeling of being respected and listened to by the staff, significant problems for the psychiatrist were likely to ensue. This was especially the case when the patient had painful memories of coercive measures. These had to be talked over before proceeding with the treatment. Even though the psychiatrists concerned were not personally responsible for previous shortcomings, they had a tendency to be over-cautious, and to avoid difficult issues. They might not wish to go deeply into background of the patient, including the psychotic crisis for which the patient had been admitted in the first place. Piippo (2008) observed that when clients experience mistrust it concerns the treatment system. One can suggest that professionals should consider such difficulties more in terms of problems affecting the therapeutic relationship, and try to modify their own responses accordingly. Thus they should be ready to speak openly about their own feelings (Seikkula, 1991). From this point of view, the clients' criticisms, and their eagerness to speak of their disappointments (which was observed in seven out of our eight interviews), actually provide psychiatrists with valuable information concerning how to relate to patients and continue cooperation with them. According to Piippo (2008) the ability of patients to criticize the personnel, and the ability of the personnel to tolerate such criticism, can increase patients' feelings of autonomy.

The psychiatrists experienced far more problems when in-patient treatment was involved. However, it often seemed almost impossible to avoid hospitalization. There are different perspectives on this issue, but overall we would here agree with Keränen (1992) that the crucial factor influencing the choice between outpatient and inpatient treatment is the reciprocal interaction between the clients and the team. From our interviews, it appeared that the staff in the hospitals ran a major risk of becoming accustomed to abnormal and even

inhumane procedures. Occasionally the psychiatrists found it ethically very difficult to be part of the system. There seemed to be a tendency in psychiatric hospitals to see the patient as an illness, rather than as a multifaceted human being. This led to the hindering of learning through a wish to avoid risk. The ethical distress felt by the psychiatrists in our study was similar to professionals' first-person accounts of their experiences in the inpatient setting (Hardcastle et al., 2007). . If the clients and the staff were able to cope with the uncertainty connected to the treatment of acute psychosis on an outpatient basis, positive effects emerged: in addition to all parties being more satisfied, there was more discussion of what the psychosis actually signified. In the outpatient setting, it is easier to have conversations with symbolic meanings (Seikkula, 1991). This makes it possible for the clients to construct a meaningful understanding of the psychotic experiences, and it strengthens clients' feelings of agency (Holma, 1999). A comprehensible psychosis narrative has been found to be important for the recovery of patients (Geekie & Read, 2009). Psychosis exhibits a prenarrative quality of life (Holma, 1999), and in addition, it can be seen as a kind of catalyst. If the basis of the treatment is not to get rid of the acute symptoms by medication or to simply define them as sign of an illness, and if the patient is seen as a competent participant in the conversation, the experience of psychosis can oblige parties to try to find some common understanding of what has happened. According to Karatza and Avdi (2011), psychotic family members run the risk of being positioned purely in terms of the psychiatric discourse employed; by contrast, therapeutic change is associated with the personal and reflexive voices of participants.

One factor which tended to prompt the interviewees to continue the treatment on a "just in case" basis was the psychiatrists' dual role dilemma (Robertson, 2008), i.e. the moral distress of balancing between different expectations (Austin, 2008). Such a perspective is problematic from the point of view of patients' agency, bearing in mind that the patient's own decision to quit or adjust medication should be seen as an act of taking agency (Iso-

Koivisto, 2004); hence, suggestions to end or reduce the therapy meetings can be regarded as attempts to take more responsibility for the treatment relationship. Horizontal expertise and open dialogue for deritualization of the treatment is recommended (Aaltonen et al., 2000) if one is seeking to take all voices seriously and support the empowerment of clients. This does not require the total abandonment of the biomedical approach. According to Geekie and Read (2009), to the extent that they are active participants in the process, patients recovering from psychosis are able and willing to integrate multi-factorial contradictory accounts of psychotic experiences. Since the psychotic episode is an overwhelming phenomenon it is understandable that clients are eager – or even feel compelled - to use sophisticated thinking in order to make sense of the experience.

According to our study, strong emotions endangered the agency not just of the clients but also that of the professionals. Haarakangas (1997) found that NAA is challenging to inexperienced professionals in particular. Indeed, the emotions of professionals form both a challenge and an opportunity. One of the main aims of professionals working along NAA lines is to generate dialogue concerning themes that are difficult for the clients. The emotional responses of professionals are good starting-points for this purpose. Our results are in line with those obtained by Haarakangas (1997), indicating that the reflective discussions of professionals in the presence of the clients help the staff to discuss delicate issues respectfully and openly.

In NAA one of the main principles is often expressed as "minimal neuroleptics," referring to both the dose and the length of drug treatment. Antipsychotic medication is administered merely to support and assist psychosocial treatments and communication (Lehtinen, 1993). To guarantee that patient will only minimally lose her/his agency for iatrogenic reasons, the psychiatrist should be extremely active in discussing medication (Iso-Koivisto, 2004; Lehtinen, 1993). Nevertheless, our observations indicate that

this tends not to occur in the real-world setting. The psychiatrists experienced guilt at not taking more initiatives to discuss medication with clients, within their sometimes hectic everyday practice.

The psychiatrists avoided to use of the diagnosis of schizophrenia, sometimes as a means to maintain hope. This practice is supported by research (Read & Haslam, 2004; Read, 2004) which casts doubt on the usefulness and relevance of the concept of schizophrenia. Through interviews with patients, Iso-Koivisto (2004) found that there were major individual prognostic impacts for self-stigmatization when the diagnosis of schizophrenia was given, depending also on how the diagnosis was told.

Unlike some individually oriented psychotherapeutic approaches whose aim in the first place is to create dialogue with the patient (Lysaker, 2007), NAA takes a more a family-therapeutic approach, striving to generate dialogue between the patient, her/his social network, and the professionals concerned. With respect to patients' relatives, our findings are fairly similar to those of Piippo (2008). The family members tended to be seen as resources by the professionals. Nevertheless, the team occasionally paid more attention to the views of the relatives than those of the patient. According to our former study (***reference not mentioned because of the blind refereeing process*) this could develop into a situation in which the patients actually became excluded, due to the critical attitudes of family members. The relatives could act in such a way as to lead the professionals to unite in a kind of us-against-them manner, with the patient being left alone, between the parties.

In the study by Stern and his associates (1999) negative symptoms made it more difficult for the family members to construct a story that made sense. Our own results indicate that symptoms such as a lack of initiative led to a greater of indicative, concrete language (including efforts to try find concrete behavioral ideas for the treatment), in preference to conversations that would aim towards a more abstract understanding of the

problem. Stern et al. (1999) also found that women had the primary role as carers. This is line with our observation that no male family members attended our interviews. Here we can identify an important clinical challenge, namely to include more voices of male family members in the therapeutic processes, and relieve the burden on female relatives. Occasionally the professionals in our study experienced family members as critical and challenging. The issue is one of collaboration, and of not viewing family members merely as a number of discordant individuals. The overall need is to look for opportunities to integrate critical voices within a common understanding.

The difficult emotions of professionals and the critical voices of interviewees had a prominent role in our study. For a variety of reasons most of the treatment processes turned out to be unusually challenging. There was variation on the part of the professionals and the research center with regard to commitment to the principles of NAA. Often the client-centered principles of NAA were not followed successfully, and drugs, in-patient treatment, and coercive measures were used to take control of the crisis. On those occasions CR-Is largely constituted a common critical evaluation of the treatment process. For their part, the STR-Is could be said to have had a positive function, in so far as they assisted the psychiatrists, together with the interviewer, to find words for uncomfortable and sensitive thoughts and emotions.

Study limitations and strengths

Unsurprisingly, simple generalizations are not possible based on our findings, which are based on small number of selected interviewees. Nonetheless our observations, and also other studies, show the relevance of findings concerning the impact of psychosis on professionals and on the treatment. Some of the results may well apply also to other severe mental disorders. On the other hand, psychosis is a particular phenomenon from the perspective of

experience and communication – and also from the point of legal implications – and these aspects emerged strongly in our interviews. One of the strengths of the study is that exceptionally challenging cases were selected for our research. It should be noted that we did not set out to study the dialogues that occurred in the therapy meetings themselves. Nevertheless, the main issues concerning psychosis and the arousal of emotions did emerge within the discussions, when the participants (persons who had been involved from the beginning) met in the CR-Is. Given that the first two authors are committed to the tradition of NAA, one can see here a possible source of bias. However, the third writer came from totally outside psychiatry, and had a major role in evaluating the trustworthiness of the study. We were also able to find other studies with similar results from outside the tradition of NAA. As mentioned above, the voice of the researcher exerted a clear influence on the course of the interviews. In a subsequent paper we shall focus on the impact of the interviewer on clinical relevant changes, which happened in the research process.

Conclusions, implications for practice, and further research

Psychotic reactions should be seen as attempts to make sense of one's experiences and to cope with experiences that are so difficult that it has not been possible to construct a rational spoken narrative about them (Seikkula, 2002). If we are to help the patients and their families to find ways of dealing with the situations, we need to apply vertical knowledge, based on professional expertise, and also horizontal knowledge, based on interactive work, and drawing on the resources of the participants in therapy meetings (Laitila, 2009). To generate more valid horizontal knowledge, which has relevance in the real world clinical practice, we also need to take into account the treatment setting and the experiences of the staff (Aaltonen et al., 2000) in research as well as in clinical practice.

It has been found that positive effects can be obtained by modifying the perceptions of the staff concerning individual patients, and helping them to develop psychological formulations (Berry, 2009). In NAA the concept of a shared image guiding the treatment process (Aaltonen & Räkköläinen, 1994) is particularly valuable for hospital teams, since keeping this concept in view helps staff to make choices that are more oriented to the clients' stories. In the original study by Aaltonen and Räkköläinen the therapeutic understanding of the patient was based on a conversation between the staff and a supervisor. In contrast, we would prefer to include the clients in these discussions, for example by using the CR-I method. In fact, both interview methods used in our study turned out to be useful in the treatment processes (of psychosis). STR-I can be used as a means to find words for experiences which remain implicit with participatory observation.

Psychotherapy research has demonstrated fairly convincingly that the therapy outcome has a particularly strong dependence on the therapeutic relationship (Lambert & Barley, 2001; Lambert, 2005; Norcross, 2011). A variety of measures of both the alliance and the outcome have been developed to improve the success rate and predict failures (Lambert et al., 2002; Miller, 2005). In NAA the therapeutic relationship is emphasized. Concerning the treatment of psychosis, there is at least some evidence that the therapeutic relationship actually has a role as an independent predictor of treatment outcome (McCabe, 2004; Priebe et al., 2011). Promising efforts have been made to develop measures that would help professionals to meet the needs of individual patients diagnosed with psychosis (Priebe et al., 2007; van Os et al., 2004). In order to secure the ability of clients to give honest feedback, and to avoid treatment failures, it might be worth investigating measures that could be used routinely in therapy meetings. In so doing, it will also be possible to give a better evaluation of the therapeutic processes of NAA.

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