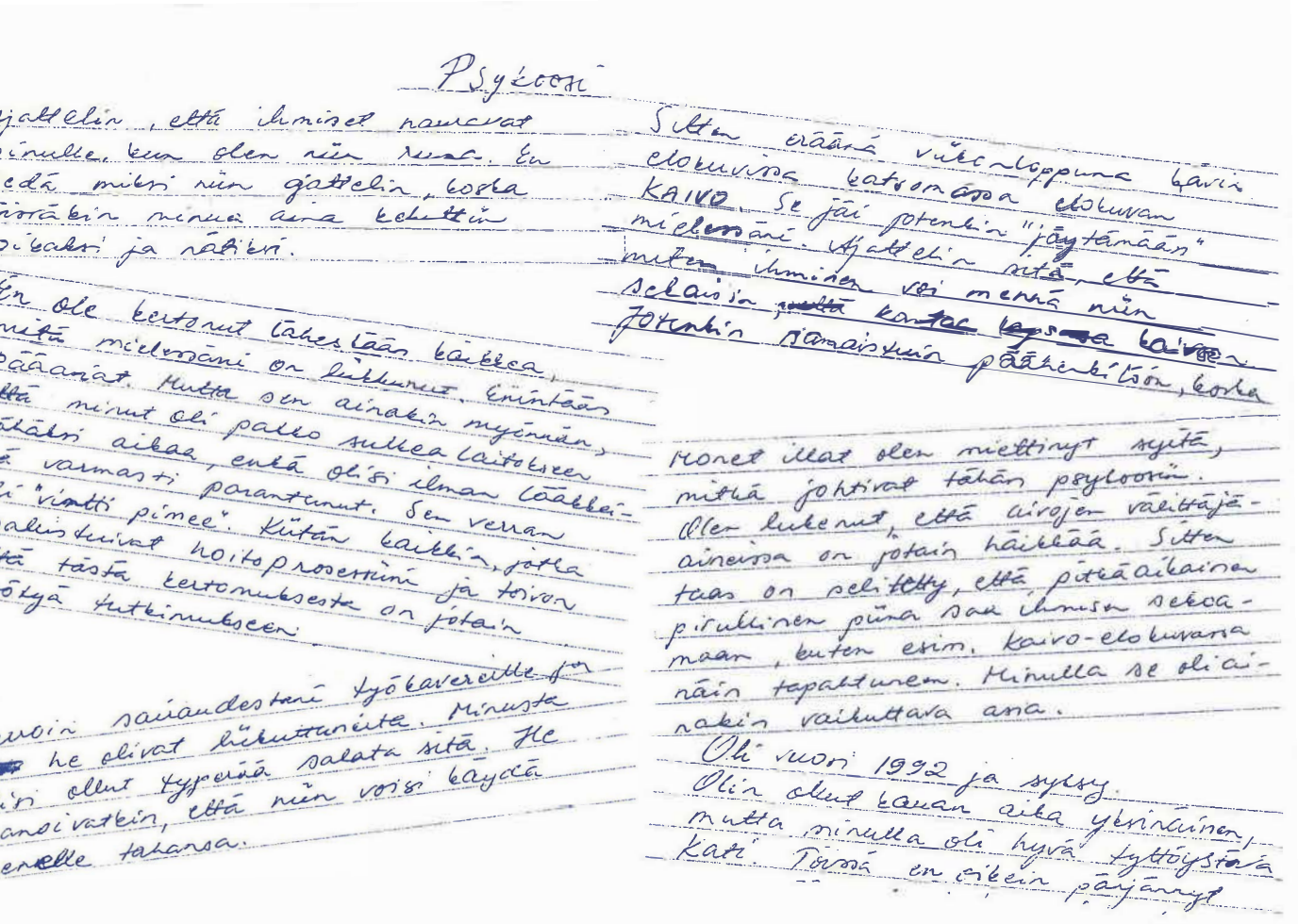

Psykoosi

Juha M. Holma

THE SEARCH FOR A NARRATIVE

Investigating Acute Psychosis and the Need-Adapted Treatment Model from the Narrative Viewpoint

JYVÄSKYLÄ STUDIES IN EDUCATION, PSYCHOLOGY AND SOCIAL RESEARCH 150

Juha M. Holma

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ABSTRACT

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This study is a subproject of the Finnish multicenter project The Integrated Approach to the Treatment of Acute Psychosis (API project). The basis of this project is the need-adapted treatment model developed in Finland over the last three decades. The aim of the studies presented here was to investigate from a social constructionist narrative viewpoint psychosis and schizophrenia as well as the psychology of the recommendations of the need-adapted treatment model. In recent family therapy, social constructionism and the narrative viewpoint have been the main theoretical approaches. This study integrates the Finnish tradition of treating acute psychosis and schizophrenia with recent developments in the field of family therapy. The material was gathered during the treatment of 21 first-episode psychotic patients. The method used was participant-observer qualitative narrative analysis. The author participated altogether in 140 therapy meetings during the hospitalization stage and in 34 follow-up meetings. The results indicate that constructing a self-narrative is essential in acute psychosis, since it may be either collapsed or not coherent enough (Study I). The search for a narrative in acute psychosis exists but the result of this search can be insufficient because the stories available in the social context do not sufficiently capture the pre-narrative quality of personal experience (Study II). Psychosis can also be an escape in order to maintain a sense of agency. When experiences remain unnarrated, the experience of being-in-time is also missing (Study III). When the patient has trouble in creating narrative form for experiences, the aim of therapy and treatment is to open a channel through which the pre-narrative quality of life can become narrated. Once experiences are given narrative form, they can be left behind as a part of the individual's personal history, enabling present experiences to be narrated and preventing unnarrated experiences from accumulating (Study III). Hence, early, family- and network-centred intervention is of special value in cases of acute psychosis. It is important that the narratives conform to the pre-understanding of the interpreter as well as adequately capture the intentions of its originator, that is, the patient (Study IV). Thus team work utilizing therapeutic principles and involving patient, family and social network alike is specially indicated

Keywords: acute psychosis, schizophrenia, treatment, narrative, hermeneutic

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I Holma, J & Aaltonen, J. 1995. The self-narrative and acute psychosis. *Contemporary Family Therapy, 17(3),* 307-316.

II Holma, J. & Aaltonen, J. 1997. The sense of agency and the search for a narrative in acute psychosis. *Contemporary Family Therapy, 19(4),* 463-477.

III Holma, J. & Aaltonen, J. 1998a. The experience of time in acute psychosis and schizophrenia. *Contemporary Family Therapy, 20 (3),* (265-276).

IV Holma, J. & Aaltonen, J. 1998b. Narrative understanding in acute psychosis. *Contemporary Family Therapy, 20 (3),* (253-263).

1 INTRODUCTION

The purpose of this thesis is to describe four studies which apply a social constructionist, hermeneutic narrative viewpoint in the study of acute psychosis and schizophrenia. In recent family therapy social constructionism has been one of the main theoretical approaches. From the mid 1980's in the family therapy context has been discussed therapy as a linguistic system (Anderson & Goolishian, 1988), as stories and narratives (White & Epston, 1990) and in the light of postmodernism (Anderson 1997; Hoffman, 1990, 1991). This is argued to be a new phase following the strategic and information-based phase (Real, 1990) or a new paradigm moving away from the cybernetic paradigm and machine metaphor (Goolishian & Anderson, 1992). In this new approach language and semantics have an essential role. The focus of therapy is on human life as storied and on the social construction of meaning. This new social constructionist approach is seen as a part of postmodern psychology (Gergen, 1992; Kvale, 1992; Polkinghorne, 1992). It is postmodernist in challenging objective position of the therapist in therapy, in emphasizing language in constructing reality, and in viewing knowledge as a social product.

The interest concerning narrative is not, however, new nor is it found in the area of family therapy only. Spence (1982) and Schafer (1992) have analysed psychoanalysis from narrative point of view and emphasize the narrative features of psychoanalysis. In psychology and the social sciences interest in the narrative features of knowledge arose in the 1970s and 1980s (e.g. Bruner, 1986; Sarbin, 1986; Shotter, 1993). This interest has its foundation in different areas of investigation: anthropology (Geertz, 1973), feminism, social constructionism (Berger & Luckmann, 1966; Gergen, 1985), system theory (Bateson, 1972), deconstructionism (Derrida, 1972). In philosophy the interest concerning narrative is connected to the tradition of hermeneutics and to the work of Paul Ricoeur (1983, 1991a). This shift towards narrative is part of the criticism levelled against modern science and the dominance of propositional knowledge in the field of social sciences and psychology.

Psychotherapy has traditionally attempted to ground itself on psychology or psychiatry founded on propositional knowledge. According to Ellenberger (1970), in the prehistory of psychotherapy Freud and other pioneers discovered that a patient could be cured by someone listening to them, if they were given an opportunity to tell their story; but this essential feature was suppressed when these scientifically trained doctors sought to fit their work into a scientific framework. Psychotherapy research, like most psychological research, has largely adopted the methods of the natural sciences. Therapy is regarded as equivalent to a drug that is administered and the task of the researcher is to discover what kinds of therapy are suitable for what problem and what are the most economically viable (McLeod, 1997). The practice of psychotherapy is, however, grounded on narrative activity, that is, on the patient telling his story to the therapist with the therapist in turn willing to listen the story and take it seriously. This kind of activity has a poor fit with the propositional features of knowledge. For this reason there have been many attempts to develop research methods (e.g. conversational analysis, discourse analysis) that would show an improved fit with this special activity. The narrative method is one of them.

The narrative method is an appropriate tool with which to investigate psychotherapy because, firstly, it allows access to the story-making practices that are the special province of psychotherapy. Secondly, it allows events to acquire a narrative construction through the active cooperation and collaboration of therapist and patient. Smith (1997) terms these kinds of narrative approach where therapist and client together move from monologue to dialogue hermeneutic or dialogic narrative approaches to separate them from what he terms re-authoring approaches to narrative therapy. Thirdly, it conveys the intentions of the agents in the story. This address to the intentional dimension of human life is what makes psychotherapy a separate discipline, according to van Deutzen-Smith and Smith (1996) This is in contrast to a psychology which analyzes the human system's competencies by breaking the behavior of the system down into relatively simple interacting units, and to a psychiatry, which examines the system as a purely physical system.

In the case of acute psychosis and schizophrenia interesting problems emerge from the social constructionist narrative point of view. According to DSM-III-R (American Psychiatric Association, 1987), psychosis features disturbances in several of the following areas: content and form of thought, perception, affect, sense of self, volition, relationship to the external world, and psychomotor behaviour. The psychotic person may have delusions, loosening of associations, hallucinations etc. From the social constructionist viewpoint the psychotic person as defined above no longer takes part in socially shared communicative practices when having the psychotic symptoms. In the psychotic story a psychotic person connects events, persons and sensations differently from other people in same place at the same moment. If the psychotic person does not adopt the dominant, culturally dependent, socially constructed way of using language he is easily discounted, marginalized and pathologized. Psychotic persons may be able, however, according to the extensive literature on the psychotherapy of schizophrenia (e.g. Alanen, 1997; Lidz, 1964; Räkköläinen, 1977; Searles, 1965; Selvini Palazzoli, Boscolo, Cecchin & Prata, 1978; Volkan, 1995), to

construct a narrative that contains all the criteria for a intelligible narrative. Such a narrative has an understandable plot and it connect events and people in a meaningful way. It can be hypothesized that these narratives do not construct enough meaning for the psychotic person's experiences, that is, important parts of the individual's experience remain unnarrated.

This study is a subproject of the Finnish multicenter project *The Integrated Approach to the Treatment of Acute Psychosis* (API project) which follows the tradition established over the last three decades in Finland (Alanen, 1997; Alanen, Lehtinen, K., Räkköläinen & Aaltonen, 1991; Alanen, Räkköläinen, Laakso, Rasimus & Kaljonen, 1986; National Board of Health in Finland, 1988; Räkköläinen, Lehtinen, K. & Alanen, 1991) of conducting research into schizophrenic patients, their families and their treatment in municipal hospitals, and public mental health services. It was out of this research that the the need-adapted treatment model emerged. The need-adapted model is psychotherapeutically and family-centredly oriented and stresses that treatment should be adapted to each patient's individual and changing needs.

2 THE NARRATIVE APPROACH

2.1 Social constructionism and hermeneutics

During the study the theoretical viewpoint of the author shifted from the social constructionist towards the hermeneutic viewpoint. In the beginning the theoretical starting point was the language of speech. During the study the material indicated that other aspects of communication also needed to be taken into account in the theory. To understand psychosis involved borrowing some theoretical concepts from hermeneutics, for example concerning the pre-narrative quality of human experience and mutual understanding. In psychosis the referential function of narrative is also essential because it is the basis for definition of psychosis. This also meant adopting a critical stance towards certain postmodern assumptions.

According to e.g. Gergen (1985) the social constructionist orientation presumes that what can be taken as knowledge of the world is not a product of induction or testing hypotheses but a process of understanding. The degree to which a given form of understanding prevails is not dependent on empirical validity alone, but on the vicissitudes of social processes. Words gain their meaning not through their capacity to picture reality, but through their use in social interchange. Accordingly, what Shotter (1993) terms dialogical or conversational social constructionism, i.e. people's responsive understanding of each other, is primary. Whether or not a given description of an event is valid depends primarily on the historically situated conventions of a given culture or subculture rather than on an absolute match between word and thing. Knowledge and understandings have bases in their cultural, historical and social contexts (Gergen & Gergen, 1988).

According to Giddens (1993) one version of hermeneutics, based on Gadamer's work, emphasizes that understanding is not a subjective matter, but rather an entering into another tradition, such that past and present constantly mediate each other. Understanding is situated in history and is understanding

from within a particular frame of reference, tradition or culture. Understanding demands thus some measure of knowledge of frame of reference, tradition and culture whereby further understanding is possible. The hermeneutic problem is not a problem of the accurate mastery of language, but a correct understanding of the things that are accomplished through the medium of language (Giddens, 1993).

Wittgenstein's later philosophy (especially *Philosophical Investigations*, 1953) is viewed as seminal to social constructionism (Gergen, 1985). In this work Wittgenstein argues that the basic link between language and reality is found in so-called language-games. Language-games do not replace the naming relationship but constitute them. The role of language-games as a semantic link between language and reality is ineffable. The teaching of these games is more like training the learner in a new skill than conveying to him definitions of words and expressions (Hintikka & Hintikka, 1986). The affinities between some of the main themes taken up by Gadamer and the later Wittgenstein are striking: for Gadamer, as for the later Wittgenstein, language is not first and foremost a system of signs or representations which in some way 'stands for' objects but an expressions of the human mode of 'being-in-the-world' (Gadamer, 1965/1984).

Gergen (Gergen & Kaye, 1992) refers to Wittgenstein and language-games, too. For him words gain their meaning through social interchange, which is not limited to the linguistic realm alone, but include all our actions, along with various objects in our surroundings. A language-game for him is an ongoing social way of making meaning, limited to the ways of talking inherited from the past. This is a much narrower viewpoint than that which sees language-games as expressions of the human mode of 'being-in-the-world'. Gergen prefers a multiplicity of truths and non-commitment to any particular language-game. For example, to be committed to a story of the self is vastly to limit one's possibilities of relating. This may pose problems in relation to psychosis, as will be discussed later.

In the field of family therapy Goolishian and Anderson (1992) have proposed that from a social constructionist orientation language does not have a representative relation alone to the world, i.e. it is not an interpretation or verbalization of lived experiences, but it constitutes the world in which we are living. Descriptive language and the theoretical narratives are not different lenses giving different perspectives on the same world, but are different worlds of action and existence. Humans construct the world they do because they participate in language, social practices, institutions and other forms of symbolic action.

If language is not defined first as a system of signs but as an expression of the human mode of ´being-in-the-world´, then understanding concerns not the system of signs but the whole mode of being. Understanding is based on what Shotter (1993) calls a third kind of knowledge that is concerned with how to be a person of this or that particular kind according to the culture into which one develops as a child.

This process of understanding is the result of the active, cooperative enterprise of persons in relationships, where words acquire communicative capacity by virtue of shared usage (Gergen & Gergen, 1988). Also in hermeneutics the emphasis is on the 'available' character of meaning through shared linguistic

expressions (Giddens, 1993). Semantic units, or 'meanings' are not merely abstract features of the linguistic equipment of individual persons, but are intersubjectively produced in interaction or dialogue. To generate meanings via interaction speakers must not only be competent linguistically, but also have command of the social settings which turn the mastery of language into understanding of the other (Giddens, 1993).

2.2 Narrative and story

The starting point of the narrative approach is that human experience is always narrated. It is the narratives in which we situate our experience that determine the meaning we give to that experience. Narrative gives form to what is unformed. The plot of the narrative is the way the events are situated in it. It makes the story understandable. The plot serves to make *one* story out of multiple incidents. The story is unified and complete in that sense. It also organizes together heterogeneous components. The plot is a totality which is at the same time concordant and discordant (Ricoeur, 1991b).

Our familiarity with the conceptual network of human acting is of the same order as the familiarity we have with the plots of stories that are known to us. We understand what action and passion are through our competence to use in a meaningful way the entire network of expressions and concepts that are offered to us by a natural language (Ricoeur, 1991b). He terms this the semantics of action. The second feature lies in the symbolic resources of the practical field. If action can be recounted, this is because it is already rearticulated in signs, rules and norms; it has already been symbolically mediated. In this way symbolism gives an initial readability to action. It makes action into a quasi-text for which symbols provide the rules of signification in terms of which a given features of conduct can be interpreted. The third feature is what Ricoeur terms the pre-narrative quality of human experience. Life is a constant search for a narrative.

The textual analogy for human systems takes on much greater complexity than it does in the field of literature. People are not passively inscribed in texts or stories, but actively make choices between different narrative alternatives offered by their social surroundings. These narrative choices determine the meaning of experiences. My view is that the new narrative emerges in a continuous dialogue between the existing narrative construction of the experience and the new narratives offered now. Thus it can be said that the unfolding text is always something that occurs between people (Lax, 1992) or more accurately between narratives. The meanings of experiences are generated in the act of story-telling, where a person is describing his experiences to someone and making choices between different narrative alternatives.

Telling one's story is a re-presentation of experience; it is constructing history in the present (Anderson & Goolishian, 1992). Dialogue and conversation (for example therapeutic conversation), provide the arena for the performance of stories. In therapy understanding is always dialogue between client and therapist. A therapeutic conversation is a slowly evolving and individual life story,

stimulated by the therapist's curiosity to learn, which increases the potential for narrative development.

According to Ricoeur (1991a), in speech the ideal sense of what is said turns towards real reference. The referential function is important in that it compensates for the separation of signs from things. A text is not without reference but it is the act of reading that fulfills the reference. A text is free to enter into relations with all the other texts that come to take the place of the circumstantial reality referred to by living speech. Another feature is that in text there no longer is a speaker, at least in the sense of immediate and direct self-designation (Ricoeur, 1991a).

There are rules or elements for proper story telling which concern both the grammar and structure of the story and its social settings. Gergen and Gergen (1988) see the following points as important in the construction of an intelligible narrative: the establishment of a valued end point, the selection of events relevant to the goal state, the ordering of events, and the establishing of causal links and demarcation signs. Bruner (1990) points out that there are no sharp grammatical distinctions between true stories and imaginary ones, but they are signalled by indicators of genre within which they can be categorized. Marking a story as belonging to a particular genre conveys meaning over and above the claimed truth status of the narrative that is being delivered.

It is argued (Aaltonen, Vartiainen, Kalliokoski & Riikonen, 1994) that in a case of acute psychosis, the patient's and the family's story may be so incoherent or collapsed that no more than fragments of the dominant story that preceded the situation can be seen. If the past is characterized by the fragmentation of the story, the future presents itself, and is realized, in a chaotic form. Aaltonen et al (1994) also assume that in case of acute psychosis the patient and the family have difficulties in composing a new story, because it may be impossible for the family members compose either a story or its plot. They may not have the competence to structure their experiences in a narrative form. On the other hand the story of the psychotic person may be grammatically or structurally well ordered but lack social and institutional relations or mutually shared knowledge.

2.3 Self as narrative

The narrative view holds that it is the process of developing a story about one's life which forms the basis of all identity. The development of a story or narrative is the process of defining who we are in interaction with other people's perceived understandings of us (Lax, 1992). Gergen and Gergen (1988) employ the term self-narrative to refer to individuals' accounts of the relationship between self-relevant events across time. In developing a self-narrative the individual attempts to establish coherent connections among the life events that have taken place. It is a natural outcome of the life story. It is by means of a narrative developed in relation to others over time that we come to identify who we are (Lax, 1992).

However, as the individual moves through the processes of social interaction the self-narrative is always subject to constant shift according to the discursive practices and stories through which that individual makes sense of his

own and others' lives (Davies & Harré, 1990). What we imagine ourselves to be is not an object-like thing as such, but a mobile region of continually reproducing activity (Shotter, 1992). Lax (1992) argues that a permanent self is merely an illusion. According to Gergen and Gergen (1988), there is no *one* story to tell but people are capable of adopting multiple perspectives, and the culture will offer the individual exposure to a wide variety of narratives. Gergen & Kaye (1992) prefer a multiplicity of truths so that to be committed to a story of the self is vastly to limit one's possibilities of relating. This point of view is problematic in connection with psychosis because, as noted by Aaltonen et al (1994), in acute psychosis it can argued that the identity narrated may be collapsed or not coherent enough.

Ricoeur solves the problem of constant shift, multiplicity of identity and coherence by applying the notion of the play of sedimentation and innovation. If identity is constructed through narrative action, there is no self-understanding that is not mediated by signs, symbols and text (Ricoeur, 1991b). We can apply to ourselves the concept of narrative voices borrowed from literature etc. This is the way that we learn to become the narrator of our own story, without actually becoming the author of our own life. However there is a difference between life that is lived and stories that are told. This difference is partially abolished by our power of applying to ourselves the plots that we receive from our culture and of trying on the different roles of characters in these stories. It is by the imaginative variations of our own narrative activity that we escape the apparent choice between constant change and absolute identity. Subjectivity is neither an incoherent series of events nor an immutable substantiality, impervious to evolution.

According to Ricoeur (1991c), what he calls narrative identity can be used in two different ways: identity as sameness and identity as selfhood. Identity as sameness contains:

(1) Uniqueness in contrast to plurality. This term corresponds to identification understood as reidentification of the same.
(2) Resemblance in contrast to difference.
(3) Uninterrupted continuity in the development of a being.
(4) Permanence in time.

The self constitutes a response to the question of who, as distinct from the question of what. It is the question we tend to ask in the field of action, when looking for an agent. Narrative enables the construction of the durable properties of the character, which by constructing the dynamic identity found in the plot creates the character's identity. The capacity of people to identify themselves as stable units has great utility within the culture.

In acute psychosis narrated identity may be collapsed or not coherent enough. When identity is lost the question *who* remains unanswered; the aspects of identity as sameness (uniqueness, resemblance, continuity and permanence) may also be lost (Study III: Holma & Aaltonen, 1998a). A psychotic person may have lost his sense of being only one person. He may also have lost resemblance, and believes that he is not the same as the other people around him. Continuity, meaning the experience of being somehow the same throughout the flow of life, may also be lost by the psychotic person. The psychotic person may also

experience lack of permanence in time; i.e. the sense that he shall also exist tomorrow. The loss of identity causes threat and anxiety, which are usually clearly observed by others, and the psychotic person makes much use of metaphorical language in an attempt to invest his pre-narrative experiences with meaning (Study III: Holma & Aaltonen, 1998a). Metaphorical language, however, does not enable the construction of a strong enough reflexive stance to experience, and hence the individual is unable to maintain a coherent enough identity.

Metaphorical language, which can also be labelled as regressive (Alanen, 1997), is usually difficult or almost impossible to understand. Thus the psychotic person is easily left out of a dialogue and conversation. Although it has been argued above that it is the psychotic person who no longer takes part in socially shared communicative practices, he is also very easily left out of any possibilities of taking part in these communicative practices. The patient's activity in the search for a narrative is easily disregarded and regressive features of his communication begin to dominate and form what has been termed the problem-saturated story.

2.4 The problem-saturated story

People seek psychotherapy or a similar kind of help when faced by the kind of problem that is described and understood as a psychiatric/psychological problem (Anderson & Goolishian, 1988). Describing the influence of the problem in the lives and in the relationships of family members is a story that White (1989) calls the problem-saturated description or problem-saturated story. The problem-saturated story connects events, people and relationships such that those who are participants at that moment in the construction of the story see that event as problematic. What is seen as problematic depends on both the participants and the context. A therapeutic system is a problem-organized system, that is, the therapeutic system has coalesced around a problem that has specific meaning for the people in that specific system. By engaging in the therapeutic conversation, the therapist becomes a member of the problem system (Anderson & Goolishian, 1988, 1992). Then the problem also begins to saturate the therapists' and therapeutic system's story and makes it rigid and unfluid. The whole system, family members, team members and so on, lives according to the story that is saturated by the problem. Acute psychosis seems to saturate the storytelling of the therapeutic system so that the problem-saturated story becomes extremely dominant (Holma, 1994).

White and Epston (1990) assume that a person's problematic experience is experienced as problematic because it is situated in stories that others have about him and his relationships and that these stories are the dominant ones to the extent that they allow insufficient space for the performance of person's preferred stories. Or these stories do not sufficiently encapsulate the person's lived experience or are very significantly contradicted by other important aspects of the person's lived experience.

From the social constructionist point of view the therapist is not merely a

listener to these stories. The therapy system can be seen as a system connecting certain events and relationships that have specific meanings for those involved in that specific system, including the therapist. The story that the patient and family members and hospital staff evolve about the events, people and relationships circulating around the problem is formed during that very conversation in which they are taking part.

2.5 Sense of agency

Problems acquire their problematic meaning in the narrative context when they diminish our sense of agency and personal liberation (Anderson & Goolishian, 1992). Problems block us off from defining competent action for ourselves. A change in therapy can open up an opportunity for new agency as the result of the creation of a new narrative that re-relates the events of our lives in the context of a new and different meaning. Narratives permit (or inhibit) a personal perception of freedom or competency to make sense and to act, which is our sense of agency (Anderson & Goolishian, 1992).

According to White and Epston (1990), as individuals change the performance of their old stories, they experience a new capacity to intervene in their own lives and relationships. This is what White and Epston term the re-authoring of lives and relationships. Re-authoring also generates a context of reflexivity, an awareness of the process in which individuals are simultaneously performers in and audience to their own performance. Thus with every performance of a story an individual is making a choice from the multiplicity of stories that are currently available through the contemporary culture. In these performances of stories lies the sense of an individual's agency and re-authoring (Epston, White & Murray, 1992).

Ricoeur's (1991b) narrative interpretation of psychotherapy implies that the story of a new life grows out of stories that have not been recounted, not yet told. Our familiarity with the conceptual network of human action is through stories that are known to us. Accordingly, we are justified in speaking of life as a story in its nascent state and so of life as activity and passion in search of a narrative. Ricoeur terms this activity the pre-narrative quality of human experience. Life appears to us as constructive activity, borrowed from narrative understanding, by which we attempt to discover our subjectivity. The individual can become his own narrator, imitating the narrative voices and applying the plots that he has received from his culture, without actually becoming the author of his own life.

In psychosis it can be assumed, firstly, that the subject has the pre-narrative quality of human experience but experiences difficulty in the search for a narrative (Study II: Holma & Aaltonen, 1997). This activity in the search for a narrative is diminished when a subjugating story blocks off an alternative story. The alternative story that would better encapsulate that individual's pre-narrative quality of experience remains unstoried, thus reducing the sense of agency.

Secondly, the context of reflexivity is lost when the subjugating story blocks off the making of a choice from the multiplicity of stories. The individual is no

longer a performer, but more like member of an audience at his performance of a story. An individual is unable to take charge in his search for narrative identity when the subjugating story blocks off possible alternative stories. It is as if identity is being copied or borrowed, lacking any personal impact (Study II: Holma & Aaltonen, 1997).

The psychosis can function as an escape, leading to the construction of an alternative story, identity and sense of agency to replace the unbearable situation, caused by the subjugating story, in which the individual is immersed. Narrated reality and identity in this situation are different from the story shared by most of us. The story emerges from the subject's inner conversations, and conversations with others remain unnarrated. Psychotic symptoms can, however, prevent narrative identity from collapsing totally (Study I: Holma & Aaltonen, 1995). The symptoms may be the ultimate means of maintaining a sense of agency, since they constitute part of the interaction which creates narrative identity.

2.6 Time

The plot of the story has two functions: it configurates different events in a meaningful way and it configurates time. Time becomes human to the extent that it is articulated through a narrative mode, and a narrative attains its full meaning when it becomes a condition of temporal existence (Ricoeur, 1983).

The composition of the plot of a narrative is grounded, firstly, in a pre-understanding of the world of action, its meaningful structures, its symbolic resources and its temporal character. It is upon this pre-understanding, common to both narrator and readers, that the emplotment is constructed (Ricoeur, 1983). Time acquires, through the narrative, a social basis.

Secondly, the plot mediates between the pre-understanding and postunderstanding of the order of events and its temporal features. The configurational arrangement of the plot transforms a succession of heterogeneous events into a meaningful whole and makes the story followable. The configuration of the plot also imposes the "sense of an ending": the events of the story lead to an end. The repetition of the story also constitutes an alternative to the representation of time as flowing from the past towards the future (Ricoeur, 1983).

Thirdly, in narration a vicious circle is formed by the violence of interpretation and narrative redundancy. Firstly, the construction of a narrative creates consonance where before there was only dissonance. Emplotment is however never the simple triumph of "order", but also includes discordance. Temporality lies in a story ending up in some kind of order. Without leaving everyday experience we are not inclined to see the episodes of our lives as stories that demand to be told in given sequences (Ricoeur, 1983). Narration thus satisfies both the need to end something up and leave it behind in some kind of order and at the same time it constitutes an invitation to restoring the experience later. This leaving behind opens up the possibility for other experiences to be narrated.

In acute psychosis activity in the search for a narrative exists (Study II:

Holma & Aaltonen, 1997). The stories constructed, however, fail sufficiently to capture the quality of the personal experience. The context has not offered the possibilities for the emplotment of the experiences that, for example, personal development brings. Some areas of a psychotic individual's pre-narrative experience remains unstoried. These areas can be expressed only in metaphorical language or they remain in the pre-narrative position. Metaphorical language offers no distance on experience; it does not contain and carry the sense or the experience of time and space as narrated language. Understanding experiences expressed in metaphorical language allows the listener to share in the experience of fullness of an individual's situation as a being-in-time (Meitinger, 1989). The time peculiar to a metaphor is only successfully filled in and through re-figuration activated in and through the consciousness of one who understands. Time emerges first of all as linked to the abilities of one who understands, not the abilities of the narrator.

In acute psychosis narrated identity may be lost and the question *who* remains unanswered (Study III: Holma, J. & Aaltonen, J. 1998a); the aspects of identity as sameness (uniqueness, resemblance, continuity and permanence) (Ricoeur, 1991c) may be also lost. The question of time is implicit in the last two aspects of sameness: continuity and permanence in time. It can also be hypothesized that during the psychotic state the individual experiences the lack of a socially constructed being-in-time (Study III: Holma, J. & Aaltonen, J. 1998a). The act of creating one's narratives is diminished, and without narratives history, the present and, especially, the future remain unstructured. Without the order created by narrative, experiences can not be left behind and new experiences remain unstoried. They remain in the active search for a narrative. This may explain Alanen's (1990) notion that the disturbances in the transactions between the patient and the patient's closest interpersonal network are not only something that can be traced far back in the patient's past developmental psychology, but are also something that is still active and actual.

3 THE FINNISH INTEGRATED APPROACH TO THE TREATMENT OF ACUTE PSYCHOSIS PROJECT (API PROJECT)

This study is a subproject of the *Finnish multicenter project The Integrated Approach to the Treatment of Acute Psychosis* (API project). The social constructionist, hermeneutic narrative viewpoint described above can be seen to be implicitly included in the treatment recommendations of this project. This can be seen especially in the principles that 1) the patient is regularly included in all situations concerning him, especially when treatment is being planned; 2) the family and other people significant for the patient are also included; 3) the team uses a transactional level of approach in which the focus is shifted from the level of the individual to an analysis of the whole transactional system, including the treatment team itself. These principles can be seen as attempts to take into account the socially constructed bases of the problem-saturated story and strengthen the patient's of sense of agency in the treatment process.

The background to the API project is the Finnish national programme for the treatment and rehabilitation of schizophrenic patients carried out in 1981-1987 jointly with the Turku Project. The Turku Project is a research project of over 30 years standing with the aim of developing the treatment of psychoses of schizophrenia group patients in a community psychiatric setting. It focused on efforts to develop a family-centered approach to the treatment of new schizophrenic patients. The results of this project have been brought together in an approach called the need-adapted treatment of schizophrenic psychosis (Alanen et al., 1991; Alanen et al., 1986; Alanen, Anttinen, Kokkola, Lehtinen, K, Ojanen, Pylkkänen, Räkköläinen, 1990; Lehtinen, K, 1993; Räkköläinen et al., 1991). The main principles of this approach are:

1) The therapeutic activities are planned and carried out flexibly and individually in each case so that they meet the real and changing needs of the patients as well as those of their family members. This is best achieved by conjoint meetings

(therapy meetings) from the initial stage of treatment onwards.
2) Examination and treatment are dominated by a psychotherapeutic attitude. A psychotherapeutic attitude is defined as an effort to understand what has happened and is happening to the patient and to the patient's significant others.
3) The different therapeutic activities should support and not impair each other. The integration of treatment applies equally to the balance between psychotherapy and pharmacotherapy as to the combination of different modes of psychotherapy, such as family and individual therapies. This means co-operation between the different professionals (doctors, nurses, psychologists, social workers etc.) Who are members of the different units is especially important.
4) There is a clear perception of the nature of the therapy as a process. Treatment must be conceived of as a developmental event, an ongoing process that should not degenerate into a routine. For this purpose, it is helpful to assess continuously the course and outcome of the treatment, which involves the possibility of modifying the existing therapeutic plans. These principles are closely linked. If one part of the whole is overlooked, need-adapted treatment will not be fully implemented.

One task of the national programme was to make recommendations for the treatment of new schizophrenia patients and their families (National Board of Health in Finland, 1988). The recommendations for the treatment of new schizophrenic patients can be summarised as follows:
1) Early, family-centered intervention as soon as possible after the patient's admission, on the same day if possible
2) Team work with patient, family and social network from the beginning in conjoint therapy meetings with the patient and the family members.
3) A guarantee of the psychological continuity of the treatment process through the different treatment modalities and continuous follow-up of the ongoing treatment process.
Specific psychosis teams (termed therapy teams in this study) should be established to plan and carry out these recommendations.

The scientific results together with the recommendations for the treatment of new schizophrenic patients gained from the projects described above form the basis of the new nationwide *Integrated Approach to the Treatment of Acute Psychosis Project* (API project). The combination of these recommendations is termed the integrated approach to the treatment of acute psychosis (later, simply, the integrated approach). Thus the API project follows the tradition established over the last three decades in Finland of conducting research into schizophrenic patients, their families and their treatment in municipal hospitals and public mental health services.

The API project was run jointly by the National Research and Development Centre for Welfare and Health in Finland and the Universities of Jyväskylä and Turku. This multicenter research project involved six municipal psychiatric catchment areas from different parts of Finland, including psychiatric hospitals and open-care and half-way facilities. Some of these centres had been active for a longer period in developing the treatment of psychosis in Finland. The populations of these individual catchment areas varied from 75,000 to 200,000; and combined, the total catchment area was over 600 000 inhabitants.

The main aims of the API project can be formulated as follows (Lehtinen, V., Aaltonen, Koffert, Räkköläinen, Syvälahti & Vuorio, 1996, pp 282-283):

1. To develop treatment activities for patients with acute schizophrenia-type psychosis in accordance with the model of the National Schizophrenia Project and examine how the model can be set up in different treatment settings.
2. To study the need for and the meaning of neuroleptics when new patients with acute psychosis are treated with an intensive psychotherapeutically oriented and family-centered intervention from the start.
3. To study by follow-up the outcome of patients and, especially, to compare the short-term and long-term outcome of those patients who have received neuroleptics with those who have not.

The interest in neuroleptic treatment had arisen out of earlier clinical experience in the Turku project that gave support to the hypothesis that the role of neuroleptics is not as central or self evident as has traditionally been assumed (Lehtinen, V. et al., 1996; Vuorio, Räkköläinen, Syvälahti, Hietala, Aaltonen, Katajamäki & Lehtinen, V, 1993).

Thus this study combines the tradition established over the last three decades in Finland of carrying out research on schizophrenic patients, their families and their treatment with the recent theoretical developments in the field of family therapy.

4 AIMS OF THE STUDIES

One of the initial aims of the API project was to study the psychology of the need-adapted model of treatment. The present studies concern that task. The general aim was to investigate psychosis and schizophrenia from the social constructionist narrative viewpoint.

The narrative view holds that it is the process of developing a story about one's life which forms the basis of all identity. This self-narrative is essential in acute psychosis and schizophrenia since it may have either collapsed or not be coherent enough. The aim of Study I was to find out what differences exist between patients with a collapsed and patients with a non-collapsed self-narrative in creating a new narrative during the therapy meetings.

The sense of agency is diminished in acute psychosis and schizophrenia. A change in therapy can open up an opportunity for a new sense of agency as the result of the creation of a new narrative that re-relates the events of one's life in the context of a new and different meaning. The aim of Study II was to describe how it is possible in psychosis to find a new narrative and a sense of agency.

From the narrative point of view the plot of a story configurates time. In psychosis and schizophrenia experiences remain unnarrated and thus no distance on experience is offered; there is nothing to contain and carry the sense nor the experience of time. The aim of Study III was to apply the narrative approach to investigate how time appears in the narrating activities of psychotic patients and their family members.

In the principles of hermeneutics it is stressed that an object has to be understood as a subject, as a full and equal partner (Giddens, 1993). Understanding demands some measure of pre-understanding whereby further understanding becomes possible. Understanding has to conform to this pre-understanding. In Study IV the aim was to investigate (i) how personal experiences in cases of acute psychosis and schizophrenia can be formed so as to be shared as a story; (ii) how to bring the psychotic patient in as an equal partner in the process; (iii) how the context can be taken into account in this process; (iv)

whether the ideas regarding pre-understanding of the interpreter and the intentions of the patient give us practical tools by which to understand the process.

5 PARTICIPANTS AND METHOD

The material was gathered in one of the hospitals included in the API project (Kangasvuori hospital in the city of Jyväskylä, Central Finland; catchment area 117 000 inhabitants). The patients eligible for participation in this study had to fulfil the criteria laid down by the API project: they had to be first-episode psychotics, aged between 15 and 44 years, and have diagnosed schizophrenia or a delusional or other non-affective psychotic disorder according to DSM-III-R (American Psychiatric Association, 1987). Patients should not have had intensive psychotherapy or neuroleptic drug treatment before hospitalization. Exclusions were also made for pregnancy and serious somatic illness. These exclusion criteria were necessary because the research purposes of the project as a whole also concerned neuroleptic treatment.

During the API project (1.4.1992-31.12.1993) 21 patients who matched the above criteria were hospitalized in Kangasvuori hospital. Also included in this study were patients from the local continuation project (inclusion criteria same as API project). This continuation project had been carried out since the end of the API project to strengthen the development of the treatment that had taken place during the API project. During the continuation project (1.1.1994-31.5.1995) 26 patients matched the criteria. The local mental health crisis team took part in this continuation project and one psychotic patient was treated in open care only. One patient began open care treatment, but was hospitalised later. During the continuation project nearly all staff were given two years systematic training in family-centered integrated treatment. This training included both a theoretical and a supervised component. Since the continuation project no further systematic research project has been initiated, although the author participated in the treatment of new 7 patients in the hospital.

Finally patients were only included in this study if the author had participated in the therapy meetings during the initial stage of treatment. Thus 21 patients (8 from the API project, 6 from the continuation project and 7 after that) formed the participants in this study. Nine of the patients were male and 12

female. Follow-up meetings were held half a year, one year, two years and five years from the beginning of the treatment process. The author participated altogether in 140 therapy meetings during the hospitalization stage and in 34 follow-up meetings. One of the patients was treated in open care only. A more detailed description of the patients is presented in table 1 (page 28).

The therapy meetings were arranged with family members and significant others as soon as possible after the patient's admission to hospital. Two or more persons representing different professionals (psychiatric nurse, social worker, physician, psychologist) comprised the therapy team. A person from an open care or referred facility was also usually invited to this meeting. No one-way screen or other such equipment was used during the meetings. Also, no break was taken during the meeting and no special interventions administered, but occasionally the team members reflected during the meeting according to the principles of the reflecting team (Andersen, 1990), but in the same room, as described by Aaltonen, Vartiainen, Kalliokoski, and Riikonen (1994) and Seikkula, Aaltonen, Alakare, Haarakangas, Keränen, and Sutela (1995). The aim was to find out (1) why help was being sought at this particular time, (2) who had made the first contact with the request for help, (3) what was going on in the life of the family when the problems appeared and (4) what affect problems were having on family life. The author participated as one of the team members in these meetings, but also openly informed all present about his extra role as a researcher. Permission for his participation had to be granted by patient and family members[1].

The therapy meeting came to play a major role in treatment during the API project and its continuation project. First of all, the primary task was to arrange the first therapy meeting during the first 24 hours after the patient's admission. During both projects teams developed in which all staff members could participate. Teams were termed case-specific teams. Around a new patient a case-specific team was assembled that consisted of a psychiatrist, one to three nurses and perhaps a special worker (psychologist, social worker, occupational therapist etc). The composition of this case-specific team was defined according to the needs of the patient and the family members. Therapy meetings were arranged regularly and persons from out-patient or other facilities were invited to these meetings when hospitalization came to an end. Therapy meetings were arranged not only for the first episode psychotic but they became the regular treatment modality for all patients.

The follow-ups were conducted half-a-year, one year, two years and five years after the patient's first admission to hospital. The objectives of these follow-ups were to find out what the situation was like at those points, what changes may have occurred within the family and what seemed to have been important during the course of treatment.

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[1] The API project had the permission of the ethical committee of the National Research and Development Centre for Welfare and Health in Finland and of the local hospital. The continuation project had the permission of the ethical committee of the local hospital.

TABLE 1

Nr Sex	Diagnosis according to DSM-III-R or ICD-10 (initial/last)	Hospital-isations (number/days)	Therapy meetings attended by author	Follow up (time/number/ mutual checking)
1 F*	Psychotic disorder NOS/ same	2/66	6	2 years Moved/2/yes
2 F	Delusional disord./same	3/134	3	Moved
3 M	Psychotic disorder NOS/ Hebephrenic sch.	3/160	9	5 years/2/no
4 M*	Sch.form disorder/ Psychotic disord. NOS	6/649	7	5 years/2/ref.
5 F*	Brief reactive psych./ Psychotic disorder NOS	3/37	11	5 years/4/yes
6 F*	Sch.form disorder/same	1/76	4	5 years/3/yes
7 M*	Sch.form disorder/ Atypical schizophrenia	2/86	10	5 years/4/yes
8 F	Sch.form psychosis	3/118	2	refused
9 F	Psychotic disorder NOS/ same	2/26	1	2 years/2/no
10 M	Psychotic disorder NOS/ Schizophrenia NOS	4/265	3	2 years/3/no Died 1998
11 F	Brief reactive psych./same	3/47	7	2 years/3/no
12 F	Sch.form disorder	0	5	refused
13 M*	Psychotic disorder NOS/ Schizoaffective disorder	5/215	19	2 years/3/ref.
14 F	Psychotic disorder NOS/ Psychotic depression	4/129	7	½ year/1/ref. Suicide 1996
15 M*	Hebephrenic sch./same	6/304	17	2 years/1/ref.
16 M	Delusional disorder/same	1/20	5	1 year/2/no
17 F*	Paranoid disorder/ Paranoid schizophrenia	2/46	7	1 year/2/yes
18 M*	Brief reactive psych./same	1/14	5	½ year/0
19 M	Psychotic disorder NOS/ same	3/56	4	1 year/0
20 F *	Sch.form disorder	2/46	4	0
21 F	Psychotic disorder NOS	1/14	4	0

* Case presented in studies I, II, III or IV

The author of this study firstly (1) (see fig. 1) gathered the material in the therapy meetings as a participant-observer making "thick" descriptions (Geertz, 1973) about the meetings and the issues discussed. Immediately after every meeting he made a note of the oral accounts given of personal experience and the explanations of that experience and how the meetings had gone. This was usually done first by dictaphone and then written down. The purpose was to capture the meaning of speech events (Ricoeur, 1991a), i.e. what was said, rather than a verbatim transcription. The act of speech was interpreted in that particular social context, i.e. the meeting, and written down as thick description (Geertz, 1973) in story form. In the qualitative methodology "thick" description includes information about the context of an action, the intentions and meanings that organize the action, and the process in which the action is embedded (Denzin, 1978). This allowed for access to all the knowledge for interpretation which the participants themselves had. The narrative theory described earlier offered the interpretational framework. It directed what was searched for and selected as material. The interpretational framework allows the observer to go from text level to meaning level. Thus analysis began during the data collection phase, when the observations were placed within an intelligible frame, a theoretical story, and recorded as thick description.

Due to the change in the interpretational framework the descriptions got longer and more detailed during the course of the study. When the interpretational framework changed, the method allowed for change in the way the material was gathered. For example the pre-narrative quality of experience was discovered when questions from the team remained unanswered, unstoried during the therapy meeting, but were answered afterwards. Hence it was only possible afterwards to find out what had been missing earlier but was now narrated. It was also possible to refer to other material gathered as a part of the normal case record by other team members.

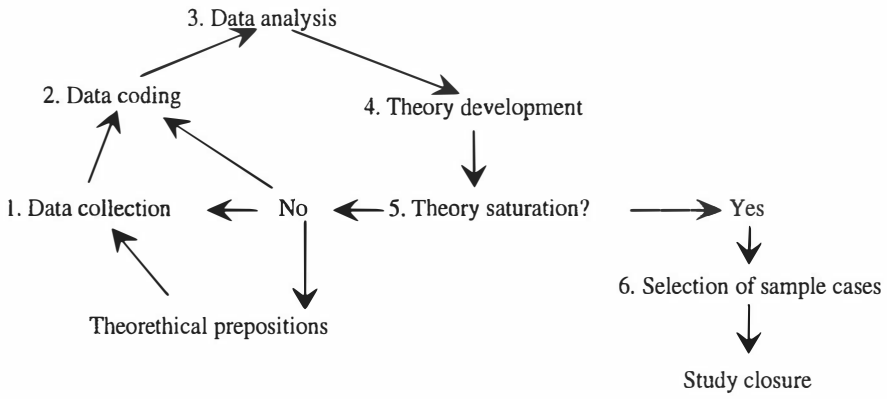
In the first follow-up meeting the author asked the patient and the family to read these texts. The patient and the family members were asked to make corrections to the descriptions if there was anything to change or insert. In this way the author checked his recordings of the socially constructed story against that of the other participants. Mutual checking was one strategy for accomplishing the credibility of the study (Erlandson, Harris, Skipper & Allen, 1993). In five cases the patient or family members agreed to do the mutual checking. No major corrections came up at this stage, only a few minor corrections of detail, for example names and dates. Four patients refused to read the descriptions. In six cases the author decided not to ask for the descriptions to be read because of the situation in the follow-up or the patients psychological state. In three cases follow-ups have not yet been arranged. Thus these corrected recordings constituted the final material of the study.

The second step (2) in the analysis was to code this material into categories according to the aims of the study (self-narrative, sense of agency, time and understanding). In the coding, the data that had already been written according to the narrative interpretation framework was categorized into incidents, experiences, happenings etc. concerning the item and then put back together in a story according to the interpretation framework. The unit of analysis was a story,

the plot of which connected incidents, experiences and persons in a meaningful way. These units could vary from one sentence to several lines.

The third step (3) was to analyse how these stories changed during the treatment process and to construct a new story taking such changes into account. The aim was to construct a story (or metastory about the stories) that was simply a descriptive narrative related to the central phenomenon of the study in question. These stories were then compared to the theory underlying the study and the findings described. Where there were findings that did not match the theory, the theory was developed further (4) affecting theoretical prepositions, data collection and data coding alike. This was done until a certain level of saturation (5) of the new findings was achieved. The final step was to exemplify the categories by selecting sample cases (6) . The criteria for selecting the cases in the four articles included in this study were (i) many therapy meetings, (ii) many follow-ups, (iii) allow to present and describe the features, and (iv) mutual checking, if possible. The process of data collection, data coding and data analysis is described in figure 1. An example of the analysis is presented in example 1.

FIGURE 1 Data collection, data coding and data analysis



EXAMPLE 1 How the problem-saturated story is coded and analysed.
The material is in the left column and the result of the analysis in the right column. The problem-saturated stories were coded by [1], the category concerning the self-narrative was coded by [2] and the findings when compared to the theory by [3]. (Case C in Study I: Holma & Aaltonen, 1995)

A 27-year-old woman was brought to the hospital because of **sleeplessness and fears**[1]. She had visited a general practitioner and been given sick-leave. She was diagnosed as suffering from **exhaustion**[1]. She had gone for the night to her parents because of her fears and they had taken her once

The first problem-saturated story was about sleepness and fears. The general practitioner saw the problem as exhaustion. The problem-saturated story constructed in the first family meeting was that she didn't know who she was. She imitated the self-narratives of others.

again to a general practitioner and to the hospital. In the ward **she didn't know who she was**[1,2]. During the first family meeting she **didn't recognize her family members**[1] (mother, father and 23-year-old sister) or the hospital staff. **She thought that she was a doctor or an ambulance driver**[2]. She called the others actors.

It was impossible to her to construct a coherent story about who she was[3]. She couldn't remember her past history in a coherent way.

The method used here, in which the researcher is both a participant in the investigated phenomenon and undertakes the major part of the data collection is known as naturalistic inquiry (Tesch, 1990). This method allows the data to be collected and analysed as part of an interactive process (Erlandson et al, 1993). The aim is to understand the meaning the people under study give to their experience. The way the data was collected enabled the researcher to have both an immediate, experiential knowledge of the material and a more distanced knowledge acquired during the subsequent process of analysis. Naturalistic inquiry is also a label for the entire post-positivistic knowledge-producing paradigm. The method of generating the material described above shares aspects of discourse analysis if discourse analysis is seen not as a method in the traditional way, but as a broad theoretical framework concerning the nature of discourse and its role in social life (Potter & Wetherell, 1987). Language is seen as instrumental in constructing versions of the social world, which can be demonstrated by the variations that occur in it (in this case stories). The method can also simply be labelled narrative analysis when it takes the stories themselves as its object of investigation. "Analysis of narrative studies opens up the forms of telling about experience, not simply the content to which language refers" (Riessmann, 1993, pp. 2). However, narrative analysis is not a specific method as such, but is dependent on the theoretical framework used. The method refers to Finnish narrative studies concerning health and illness (Hänninen, 1996, Valkonen, 1994, 1997)

The method of analysis is the same as in case studies: objects of study are found and described, understood and explained according to the underlying theory. And this way the transformation from local to global is achieved (Hamel, Duford & Fortin, 1993). When the objects of study are interpreted through the abstract level of theory the results can be generalized beyond the specific cases studied. Overall generalization is not, however, the aim of the present study, which is to understand acute psychosis and schizophrenia and develop ways of treating these conditions.

6 RESULTS

The results are presented here through the principles of the need-adapted treatment model presented in chapter 3 (pages 21-22). The case material is not presented here, as it is given in the original articles. Many of these principles as well as the arguments governing the narrative approach are overlapping.

6.1 Early, family-centered interventions

One of the recommendations in the Finnish national programme for the treatment and rehabilitation of schizophrenic patients was early, family-centered intervention as soon as possible after the patient's admission, ideally on the same day (National Board of Health in Finland, 1988). The results indicated that in areas where early, family-centered interventions were part of treatment the prognosis was better. In particular, the first hospitalization time was shorter. The patients were usually in a more acute stage. In that project psychosis was seen as a crisis for all the people around the patient. It was important to see all the people that the crisis situation concerned in order to support them. The patients were seen as dependent and undifferentiated and in need of more support from those nearest to them.

One observation in the Turku Project was that early, family-centered therapy meetings often quickly alleviated the patient's regression, appealing to his adult self and helping him to communicate (Lehtinen, K., 1993). In the Turku Project the point of view was system-oriented: family-centered meetings also make it possible to support and influence the patient's interactional network directly and attempt to make changes in it. The therapeutic task should not apply to the patient alone, but also his interactional milieu, mostly his family. This was seen as important because schizophrenic disorder has both an individual and an interactional dimension which should be taken into account in treatment (Alanen,

1990). Family-centered therapy meetings offer a possibility to see in vivo the interactional situation of the family and make a systemic diagnosis, which helps to decide whether the treatment should focus on family or individual therapy (Räkköläinen et al., 1991).

6.1.1 The narrative viewpoint and early, family-centered interventions

According to the narrative approach, the crisis situation at the onset of the psychosis is seen as an active search for narrative interpretation of the experiences that are the cause of the situation (Study II: Holma & Aaltonen, 1997). It is important to hold early family-centered interventions, where the aim is to construct narratives in dialogue with patient's social surroundings, before the patient's experiences acquire meaning through stories where meanings are already determined and personal meanings remain unnarrated. This is especially important in cases of acute psychosis, because the patient frequently uses language that contains metaphorical and other expressions that are not easily understood (Study IV: Holma & Aaltonen, 1998b). Thus the psychotic person is easily left out of the dialogue in which the meanings are negotiated with reference to the immediate context. If the patient and family members are not taken as equal partners in dialogues aiming at defining the needs for treatment, the real need of the patient and family members will remain unsatisfied. The first reason, from the narrative viewpoint, why early, family-centered interventions in the case of acute psychosis and schizophrenia are important is that they offer the patient and family members the possibility to participate as an equal partner in a process where the meanings of the patient's personal experiences can be determined.

Although the psychotic patient uses language that is difficult or impossible to understand during these family-meetings, it is possible to gain some understanding of the patient's situation through the patient's life course and developmental history. Narrative understanding emerges from the life events and earlier actions of the patient. This kind of narrative understanding needs to take into account not only communication and spoken language at present moment but also actions and events in the past.

The second reason, from the narrative viewpoint, why early interventions are useful, and often successful, is that if an experience does not acquire form by means of a narrative, that experience will remain the focus of narrative activity and other experiences now happening will remain unnarrated and unformed, leaving the individual in a vicious circle (Study III: Holma & Aaltonen, 1998a). Both the individual and the people around him find themselves stuck in this unnarrated experience, trying to narrate it without success, at the same time as other subsequent experiences remain unnarrated. When this situation lasts for a long time the unnarrated experiences accumulate, and it becomes more and more difficult to resolve all these unnarrated situations. Early, family-centered interventions can prevent this cumulative process.

Psychotic patients were not, in the present study, seen as dependent or undifferentiated but as active in the search of a narrative interpretation for their experiences. The result of this search, however, is that the stories available do not sufficiently capture the pre-narrative quality of personal experience (Study II:

Holma & Aaltonen, 1997). This happens where narrative activity in the cultural context around the individual has come to dominate the preferred narrative, i.e. narrative activity that would better construct that individual's experience. This activity is, however, present and the patient and his closest network are trying to construct their experiences narratively. Thus the family members and significant others around the patient are not seen as a system of defence mechanisms, but as a group of people who are trying to construct narratively shared or private experiences. From the narrative point of view it is the patient's social context that has not offered a narrative possibility for these experiences. When the patient and his family have difficulty in constructing meaning in acute psychosis through narrative action, the aim of the therapy and treatment is to bring about the narrating of the repressed stories, to lend narrative construction to experience. This means that private experiences are discussed and narratively constructed in interpersonal conversations, which are then internalized as inner conversations (Study II: Holma & Aaltonen, 1997). The outcome of interaction as meaningful depends upon the existence of mutual knowledge which can be drawn upon by the participants. Thus the question is not one of narrative activity of the individual but of the narratives of the whole social context. This is the third reason why it is important to bring family members into the process of constructing new narratives for experiences.

6.2 Team work with patient, family and social network

Team work with the patient and the patient's family and social network was the second recommendation in the Finnish national programme for the treatment and rehabilitation of schizophrenic patients. Team work was seen important because it guaranteed multiplicity in the ways of seeing the situation and meant that the team would better be able to keep a distance from the family and remain participant observers. It was also recommended that the team continuously observe and study its own interaction as well as the interaction of the therapeutic system. The treatment itself could also be seen as co-evolving out of the treatment system and the family system (National Board of Health in Finland, 1988). According to Lehtinen, K. (1994) team work helps to tolerate and contain the anxiety present in psychotic crises.

6.2.1 The narrative viewpoint and team work with patient, family and social network

In the narrative point of view therapists are not seen as separate from the problem-saturated system, and they are thus unable to keep a distance from the family. A therapeutic system is a problem-organized system and by engaging in the therapeutic conversation the therapist becomes a member of the problem system. Hence the problem also begins to saturate the therapists' and therapeutic system's story so that the whole system, family members, team members and so on, lives according to the dominant story that is saturated by the problem (Study

I: Holma & Aaltonen, 1995).

In earlier projects team work was recommended as a way of offering multiplicity in ways of seeing the situation. This is in accordance with the narrative viewpoint, whereby the aim of therapy is to create stories that are not yet told or are held in subjugation. With every performance of a story an individual is making a choice from the multiplicity of stories that are currently available through the surrounding culture. These new stories offer possibilities for the construction of a new kind of meaning and thus enable personal experiences to become storied (Study II: Holma & Aaltonen, 1997). Multiplicity of stories alone, however, does not guarantee the construction of a new story. All the stories may be just as subjugating as before or they may fail to construct the pre-narrative experience the patient and/or the family members are experiencing. The construction of a new story must happen in a dialogical process between the patient, family members and team members. This involves the active cooperation and collaboration of therapist and patient. Smith (1997) calls such narrative approaches, where therapist and client together move from monologue to dialogue, hermeneutic or dialogic narrative approaches, to separate them from what he terms re-authoring approaches to narrative therapy. Thus team work involving patient, family and social network is important in the narrative approach; it does not guarantee success but it can offer an opportunity to create a new story that offers a new sense of agency and identity.

In the hermeneutic-dialogic approach the individual's personal experiences become shared with others in the process of dialogue (Giddens, 1993). This sharing of experiences and the construction of a narrative for them can happen when the team reflectively tries to narrate what has happened and is happening to the patient and the people in the patient's close network (Study II: Holma & Aaltonen, 1997). The pre-narrative quality is experienced both during the meetings and throughout hospitalization and becomes part of the team's experiences. Moreover, because it has been experienced by the team, it also has the potential to be narrated. Thus it is important that the team members allow themselves to experience the family's narrative activity and what remains unnarrated, and then try to narrate their own experiences which have been evoked during the meetings. This opens up for the patient and family members a channel through which the pre-narrative quality of life is capable of narration. By determining the meaning of our experience, by alienating us from direct experience and enabling learning from experience, narration also enables the taking of a reflective stance to oneself, to be both the performer and audience of stories. A second reason for recommending team work with patient, family and social network from the narrative viewpoint is because it can create a possibility to experience the pre-narrative quality of life, and reflectively share and narrate experiences.

To construct a new narrative in a dialogical process during the treatment of acute psychosis is important because the stories currently available do not offer enough narrative multiplicity to allow the individual to construct a narrative identity and/or that identity does not allow enough sense of agency. The self-narrative in cases of acute psychosis is essential because either it is collapsed or not coherent enough. When the self-narrative is collapsed, it is important to create

concrete practices that produce stories concerning the patient in relation to others. This forms the content of the process of socially constructing the self-narrative (Study I: Holma & Aaltonen, 1995). The patient, however, has to feel that the self-narratives are his own. They must be re-authored by the patient even though they are socially constructed, which means the self-narratives must be created in a dialogical process with the patient. It becomes important to find other possible practices of storytelling, of constructing a self-narrative that can be re-authored. It means concrete practices that differ from the dominant problem-saturated story. These practices create a multiplicity of stories; they create multiple perspectives of self-narratives. At the same time as the construction of multiple perspectives of self-narratives, each self-narrative must, however, be coherent enough to allow the patient to see himself as separate from others. The sense of agency is enhanced by creating multiple narratives that differ from those hitherto dominant and so demonstrate other possibilities to create meanings, to narrate experiences (Study II: Holma & Aaltonen, 1997). During this process it is important that the identity and sense of agency of everybody who takes part in it is retained. Thus to offer a possibility to construct a new and coherent enough self-narrative that carries a sense of agency is a third reason for team work with the patient and family members.

A fourth reason for network-oriented work is to strengthen the psychotic patient's sense of agency by involving him in all the treatment situations in which decisions about him are made. This also means that the patient must be taken as an equal partner in a dialogue in which the meanings of the events around him/her are constructed (Study IV: Holma & Aaltonen, 1998b).

6.3 Psychotherapeutic attitude

A psychotherapeutic attitude was defined in the Finnish national programme for the treatment and rehabilitation of schizophrenic patients as an effort to understand what has happened and is happening to the patient and to the patient's significant others (National Board of Health in Finland, 1988). This means a shared understanding of what has happened; from the concrete level of how and why the patient was referred for treatment to a system-oriented evaluation of the psychological situation of both the patient and the family network. Another goal is to help the participants conceive of the situation rather as a consequence of the difficulties patients and those close to them have encountered in their lives than as a mysterious illness which only concerns the patient (Alanen et al., 1991). The family members are thus invited to commit themselves to an exploration of the situation and the treatment while at the same time themselves receiving support, which alleviates their own sense of confusion and anxiety. It also helps them towards a preliminary working-through of the traumatic and often paranoid experiences associated with psychiatric hospitalization.

6.3.1 The narrative point of view and the psychotherapeutic attitude

The psychotic patient's experiences are open for narrative construction either through stories where the meanings are already determined, for example diagnostic and theoretical stories about the etiology of a disease, or the patient's experiences can be storied through stories where unique and personal meanings are shared and genuine dialogue is created. If the aim is to construct meanings for private and individual experiences, the psychotherapeutic attitude defined as an effort to understand what has happened and is happening to the patient and to the patient's significant others is appropriate. Understanding is dependent on the unique way in which the feelings, thoughts and actions of the patient are connected with those of the ward staff, i.e. mutual knowledge (Study IV: Holma & Aaltonen, 1998b). In this way understanding conforms to the pre-understanding of the interpreter as well as adequately captures the intentions of its originator. Sharing feelings and experiences and being in close relationship are indispensable in the search for a narrative for our pre-narrative experiences. During this process it is important that the identity and sense of agency of everybody who takes part in it is retained (Study II: Holma & Aaltonen, 1997).

6.4 Real and changing needs

Due to the heterogeneity of schizophrenic disorders the Turku project begun by recommending that the therapeutic activities should be planned and implemented individually in each case, and integratively, combining the different therapeutic activities to in a manner meeting the needs of each patient as well as the people making up his personal interactional network (Alanen, 1990). Differences in the patients' developmental histories and clinical situation should be taken into account when planning treatment. Another reason that fundamentally contributed to this recommendation was that the treatment model was developed in the field of community psychiatry. The therapeutic approach has to meet all the needs of the psychiatric field.

6.4.1 The narrative viewpoint and identifying the needs of the treatment

From the narrative point of view, in psychosis parts of experiences do not acquire a narrated structure and thus the aim is to construct narratives socially for these pre-narrative experiences (Study II: Holma & Aaltonen, 1997). The needs of the treatment as well the treatment modalities can be determined through the mutual knowledge constructed via dialogue with the patient and the patient's family members as equal partners. Since the treatment aims at attributing meaning to experiences via narrative construction, whether they are private or shared will determine the modalities of that treatment (Study IV: Holma & Aaltonen, 1998b). When the need is one of attributing meaning to private experience the treatment modality should be primarily individual. The meanings can and perhaps should be shared afterwards with significant others. If the lack of narrative concerns the

whole family or other subgroup, there will be a need for family- or network-oriented treatment.

When the pre-narrative experience acquires a narrative construction, that is, the events in the story lead to an end, it is possible to leave the experience as a part of one's personal history (Study III: Holma & Aaltonen, 1998a). Psychotic experiences and periods themselves can then be constructed as stories with an end. This allows the patient and significant others, for example, to miss the psychosis as a part of their mourning work. They now have a reflexive stance to the past. When the pre-narrative experience acquires a narrative construction and it is possible to leave the experience as a part of one's personal history, there may be a change in needs as well as treatment modality. Thus, treatment must be conceived of as a developmental event, an ongoing process that should not degenerate into a routine. For this purpose, it is helpful to assess continuously the course and outcome of the treatment, a process which involves the possibility of modifying existing therapeutic plans.

6.5 Continuity of the treatment process

The results of the Finnish national programme for the treatment and rehabilitation of schizophrenic patients indicated that in many areas active interventions remained too short and there was a lack of continuity of treatment. Most of the patients would have needed longer intensive treatment or the treatment ended when place of treatment changed. Thus guaranteeing the psychological continuity of the treatment process through the different treatment modalities and continuous follow-up of the ongoing treatment was recommended (National Board of Health in Finland, 1988). According to Lehtinen, K. and Räkköläinen (1993) there is a built-in risk of the discontinuity of relationships in the treatment of schizophrenic patients especially in community psychiatry, because of its complexity. The number of people involved in such treatment are large, and there are complex structures which are difficult to observe. The responsibility for treatment is easily lost, resulting in loss of understanding and contact. Families and patients are in danger of dropping out of treatment or their treatment becomes discontinuous because of changes in the it. Changes are inevitable in long-term treatments, but some continuity should be guaranteed, e.g. through team work.

6.5.1 The narrative point of view and continuity of the treatment process

From the narrative point of view continuity is not only related to the narrated history but also to the experiences and events that have happened during the treatment process. Thus it is the interaction between the patient, family members and significant others and team members as a whole that constitutes the process of treatment. The interaction itself is where the text exists and where a new narrative emerges. The outcome of interaction as meaningful depends upon the existence of mutual knowledge (Giddens, 1993) which can be drawn upon by the

participants. This knowledge is based not only on language and conversation but also on the relationships and actions taking place during the treatment. It refers to what is outside language, to the so called pre-narrative quality of experience (Study II: Holma & Aaltonen, 1997) . Everything that is shared during the treatment process can not be shared through language afterwards. This is why, from the narrative point view, the continuity of treatment can happen only through the continuity of real persons during the treatment, that is, through team work so that at least one person is involved in the treatment over the long term.

There is also a second reason to try to guarantee the continuity of the treatment process: The continuity of real persons in the treatment also guarantees that different experiences are told as narrative. Heterogeneous components are then constructed as whole that is at once concordant and discordant. This offers the possibility that the experiences are under a continuous process of story-telling and meaning-making and do not form propositional knowledge (Study IV: Holma & Aaltonen, 1998b). Giving narrative form to experience offers a possibility to repeat the story. In this way, within-time-ness or being-in-time exhibits features which are irreducible to the representation of the linear time of separate narratives (Study III: Holma & Aaltonen, 1998). Within-time-ness is above all a reckoning with time, and we give it an existential description before the measuring it calls for. Narrative configurations and the forms of temporality corresponding to them share the same foundation of within-time-ness. It is these which enable the experience of being-in-time or within-time-ness.

7 DISCUSSION

In this study the general aim was to investigate from the socially constructed narrative point of view acute psychosis and schizophrenia as well as the psychology of the need-adapted treatment model. The narrative approach seems to be an appropriate framework to investigate psychotherapy because it allows access to the story-making practices that constitute a special activity in psychotherapy and allow events to acquire a narrative construction through the active cooperation and collaboration of therapist and patient. From the socially constructionist framework acute psychosis and schizophrenia form an interesting diagnostic category in which the diagnostic features are based on differences in experience and a shared socially constructed reality. From the social constructionist viewpoint the psychotic person has ceased to take part in socially shared communicative practices in that domain that is psychotic. In psychotic narrative a psychotic person connects events, persons and sensations differently from the other people in the same place at the same moment.

The multiplicity favoured by postmodern therapy would imply that psychosis is somehow a positive state. This is the first difference between the postmodern view of therapy and the narrative approach in this study. From the narrative point of view the psychotic subject experiences difficulty in the search for a narrative, but nonetheless has the pre-narrative quality of human experience. The alternative story that would better encapsulate that individual's pre-narrative quality of experience remains unstoried. Thus some narratives are better than others, not from the general point of view, but from the individual point of view in accounting for personal experiences. This does not, however, mean that people's narratives are inaccurate and unreliable and that in therapy the client's narrative is replaced by a professional, scientifically approved narrative, as Gergen and Kaye (1992) argue, in distinguishing between modern and postmodern therapy. The core difference from the narrative point of view is between stories that contain already determined meanings and stories where the meanings emerge in a case-specific context. In therapy the client and the therapist

are cooperatively engaged in constructing a narrative. That is, a mutual search for understanding and exploration through dialogue around ever-changing problems (Goolishian & Anderson, 1992). The goal of the therapist is to facilitate or promote such a change in specific stories or in the relationships between stories. The therapist is not seen as an objective observer who has privileged access to what can be called as true feelings, health communication, appropriate systemic change etc.

This shift towards respecting the patient's and family members' ability to construct meanings and be equal partners in the dialogue from seeing them as an objects of treatment is also included in the principles of hermeneutics. Another premise of hermeneutics according to Giddens (1993) is that the interpretation of a human product or action must be adequate in relation to the intentions of its originator, that is, usually in this context, the patient. This interpretation or understanding has to conform to the actuality of the experience of the interpreter, so-called pre-understanding. All understanding demands some measure of pre-understanding whereby further understanding is generated. Hermeneutics brings to the process of treatment the idea of mutual knowledge and mutual understanding, a socially constructed frame for interpretation. The outcome of interaction as meaningful depends upon the existence of mutual knowledge which can be drawn upon by the participants. An observer cannot make observations independently of her or his knowledge as a member of society, of mutual knowledge. Understanding is dependent on the unique way in which the feelings, thoughts and actions of the patient are connected with those of the ward staff through the process of semiotic communication (Aaltonen & Räkköläinen, 1994). The goal is to create a safe environment where a free flow of previously unsaid stories can occur.

The other narrative approach, compared to the hermeneutic approach, is a re-authoring approach where therapist uses externalization, unique outcomes and other techniques to free the client from socially and culturally constructed disempowering ways of thinking and being (Smith, 1997). The hermeneutic approach stresses the social construction of a narrative as a consequence of family- and network-oriented treatment. An individual constructs his identity and being-in-the-world through socially shared narratives. An individual is connected to his social surroundings by narratives. To change these narratives concerns not only the patient but also his significant others.

There is also another difference between the postmodern view and the narrative approach: the question about the permanence and multiplicity of identity. According to postmodernism, the idea of the permanent self is merely an illusion; postmodern thinking prefers a multiplicity of self-accounts and non-commitment to any of them. According to the narrative approach, one feature of psychosis is that the person is unable to form a coherent enough identity. When identity is lost, the question *who* remains unanswered; aspects of identity as sameness (uniqueness, resemblance, continuity and permanence) may also be lost. The loss of identity causes threat and anxiety, which are usually clearly observed by others. From the therapeutic point of view this can not be preferred.

During the course of this study the theoretical viewpoint of the author shifted from the social constructionist towards the hermeneutic viewpoint. Given

to the definition of psychosis, the referential function between narrative and reality must be taken into account. This means that the spoken language is not seen as primary as in some social constructionism, but that actions, intentions and events are also important. All these are a continuous process where different things, actions and events gain their meanings. No single process can be separated out. These unverbalized, unsymbolized elements seem to play an essential role in understanding psychosis and schizophrenia, as the results showed. The implications of the narrative for social relationships are not the main focus as in some social constructionist views, but the narrative, experience and lived life are narratively formed, constructing a fabric in which the lived and narrated, life and fiction, past and future, and other's and one's own narratives imitate and form each other. Narrative and reality can neither be separated nor identified as identical. The theoretical shift did not concern social constructionism as a whole but some postmodern ideas in it, as discussed above.

The material for this study was collected during the Integrated Approach to the Treatment of Acute Psychosis project (API project). Thus this study follows a tradition established over the last three decades in Finland, of carrying out research into schizophrenic patients, their families and their treatment in municipal hospitals and public mental health services. The social constructionist, hermeneutic narrative viewpoint can be seen as implicit in the API project's recommendations for treatment in attempts to take into account the socially constructed bases of the problem-saturated story and strengthen the patient's of sense of agency in the treatment process.

The method of data collection used in this study allows access to material that would otherwise remain outside research. The material consists not only of the themes of conversations during the therapy meetings, but also descriptions of actions and the atmosphere of meetings. This type of recording has its weak points in that it is possible to miss some information as well as the fact that it does not yield exact transcripts of the conversations as would be the case e.g. using audiotape. On the other hand it includes auditory features and non-verbal information that direct transcriptions very easily neglect (Riessmann, 1993). This way of taking notes also disturbs the situation less than using recording equipment, and is more like the usual hospital practice, at least in this particular hospital. On only two occasions did the patient refuse to allow the author to take part in the team. The author's impression is that there would have been more refusals by the patient or family members if the therapy meetings had been videotaped or audio taped.

Methodologically, the narrative approach is an appropriate way to construct what happens in the process of psychotherapy and treatment of acute psychosis and schizophrenia. The plot of a narrative constructs events and people in an intelligible manner, thus giving access to an understanding of actions that imply goals, motives and intentions. Through narrative, actions take on agents, who do and can do things which are taken as their work and as a result, these agents can be held responsible for certain consequences of their actions. To identify an agent and to recognize this agent's motives are complementary operations (Ricoeur, 1983). This intentional dimension of human life is what, according to Deurzen-Smith and Smith (1997), the discipline of psychotherapy should be dealing with.

Acute psychosis and schizophrenia have very special features: Firstly acute psychosis seems to saturate the storytelling of the therapeutic system so that the problem-saturated story becomes extremely dominant: interest is focused only on present events, and much effort is made to eliminate the symptoms according to the medical narrative (Holma, 1994). The search for a narrative in acute psychosis exists, but the result of this search may be insufficient because the stories available do not sufficiently capture the pre-narrative quality of personal experience (Study II: Holma & Aaltonen, 1997). In psychosis the patient frequently uses language that contains metaphorical and other expressions that are not easily understood. Thus the psychotic person is left out of a dialogue in which meanings are negotiated with the reference to the immediate context. As professionals, we must recognize the particular danger of understanding utterances and actions through stories in which the meanings of experiences are already determined, for example diagnostic and theoretical stories about the etiology of a disease. Unique and personal meanings are consequently not shared and a genuine dialogue is not created (Study IV: Holma & Aaltonen, 1998b). Thus the psychotic person is easily marginalised and left without psychotherapeutic help.

From the hermeneutic and dialogical narrative point of view it is important that experiences, however strange, chaotic or frightening they may be in the case of psychosis, are faced and experienced. Only through this experiencing can these experiences be narrated and shared. The core of the narrative approach is that these experiences do not acquire any higher level of generalizations, law-like propositions or general hypotheses. The experiences are individual, case-specific. Any other way of constructing the experience will not satisfy both the need to end something and leave it behind in some kind of order and at the same time allow it to constitute an invitation to restoring the experience later. To live one's life differently means constructing a narrative for one's life differently. To construct a new narrative requires a place where a person can imagine with his significant others possibilities of constructing what has previously been left without construction. This place can termed a potential space (Aaltonen et al., 1994) and it contains the possibility for both family members and team members safely to experience being and not-being the other. Without distinguishing what belongs to the team and what does not, the capacity for empathy is lost as well as the possibility for a new narrative. Without a new narrative the individual is stuck in the previous narrative way of constructing the experience, that is, in the previous way of life.

What are in need of narration are not only events and things but relationships and interactions between people and things. Through narration that is by constructing self-narrative the individual can differ from other individuals and perceive similarities and differences between things, and more importantly between himself and others. Without dialogue this narration as well as self-narrative is in danger of remaining without social reference.

This possibility of constructing an experience differently later is essential for the sense of agency. One is not determined by his history; only determined to narrate it over and over again. Another way of retaining and reestablishing the sense of agency is the reflective way of working. Reflective working respects the autonomy of the patient and family members by letting them decide whether they

want to listen or not, and respects all parties as equal partners in dialogue. The transformational process is affected not only by the speech act of the therapist but also by additional anchoring experiences that may take place in the session, reconfirming the new story (Sluzki, 1992). A crucial component of this process may inhere not only in the alternative ways of understanding generated by the discourse but also in the different order of meaning which concurrently emerges when our eyes are opened to seeing our blindness. It is a progression from learning new meanings to developing new categories of meaning, to transforming one's premises about the nature of meaning itself (Gergen & Kaye, 1992).

The psychotherapy of acute psychosis and schizophrenia contains the same elements that are mentioned in descriptions of narrative therapy used to treat other mental disorders. The exceptions mentioned above are characteristic of schizophrenia and psychosis and their treatment. This means that psychotherapeutic efforts are also very important in the treatment of psychosis and schizophrenia. From the narrative point of view the question in schizophrenia and psychosis is that experiences remain without narrative construction. This means that the relation between reality and the sign has to be constructed or reconstructed through the process of psychotherapy.

This can be achieved through integrated treatment, where the treatment modalities are adapted to the specific needs of the patient when the patient's needs are defined as a need for the narration of pre-narrative experiences. The patient's needs are defined at an early stage in family-centered meetings where the patient is involved in the process of narrating his own story and thus guaranteeing his sense of agency. The continuity of the treatment and the process of actively searching for a narrative is ensured through team work. The patient's needs are defined and treatment is planned through a dialogical, hermeneutical process where pre-narrative, unverbalized experiences acquire a narrative construction and can be left behind. The narrative construction contains, however, a discordant concordance that offers the possibility to narrate the experiences in a new way and thus obtain new meanings. Integration is not a mixture of different kinds of treatment modes, but, when successful, offers a tailor-made treatment for each patient. Because this case-specific treatment contains the pre-narrative dimension that has been narrated through the dialogical process, integration is a new way of constructing the patient's experiences and the understanding achieved cannot be fully generalized to other cases.

YHTEENVETO

Neljästä osatutkimuksesta koostuvan tutkimuksen tavoitteena oli selvittää Suomessa akuutin psykoosin ja skitsofrenian hoitoon kehitetyn tarpeenmukaisen hoitomallin psykologiaa narratiivisesta näkökulmasta. Tutkimuksen taustana oli akuutin psykoosin integroitu hoito-projekti (API -projekti) sekä Keski-Suomen sairaanhoitopiirissä toteutunut API -projektin jatkoprojekti. API -projekti oli jatkoa Turussa 1960 -luvulla alkaneelle skitsofrenian perhekeskeisen hoidon kehittämis- ja tutkimusprojektille ja v. 1981-87 toteutuneelle valtakunnallisen skitsofreniaprojektin osana toteutetulle uusien skitsofreniapotilaiden hoidon kehittämisprojektille (USP-projekti), joiden tuloksena muodostui tarpeenmukaisen hoidon malli. API -projektin tarkoituksena oli tutkia tarpeenmukaista hoitomallia ja sen soveltuvuutta uusiin hoitoyksiköihin. API -projekti oli Sosiaali- ja terveysalan tutkimus- ja kehittämiskeskuksen (STAKES), Jyväskylän ja Turun yliopistojen yhteishanke. Täten tutkimus liittyy yli kolme vuosikymmentä kestäneeseen psykoosin ja skitsofrenian julkisessa terveydenhoidossa tapahtuvan perhekeskeisen hoidon tutkimisen ja kehittämisen perinteeseen.

Tutkimuksen teoreettisena lähtökohtana on narratiivinen lähestymistapa ja sosiaalinen kontruktionismi. Narratiivisen lähestymistavan mukaan muodostamme jatkuvasti kertomuksia itsessämme ja ympäristössämme tapahtuvista asioista. Erilaiset tapahtumat, asiat ja henkilöt yhdistyvät kertomuksen juonen avulla ymmärrettäväksi kokonaisuudeksi. Näin kertomuksen kautta tapahtumat saavat merkitykset. Sosiaalisen konstruktionismin mukaan kertominen tapahtuu sosiaalisessa vuorovaikutuksessa kullakin hetkellä. Ihmiset eivät ole passiivisia suhteessa kertomuksiin vaan aktiivisia kertojia, jotka tekevät valintoja sosiaalisessa ympäristössä tarjolla olevien erilaisten kertomuksellisten jäsentämistapojen välillä. Ihmisten välinen ymmärtäminen pohjautuu näihin sosiaalisesti jaettuihin kertomuksiin. Elämäntapahtumilleen valitun kertomuksellisen jäsennyksen kautta ihminen vaikuttaa senhetkiseen elämäänsä ja suuntaa tulevaa elämäänsä.

Tutkimusaineisto kerättiin Kangasvuoren sairaalan (Jyväskylä) toimialueelta API -projektin (1.4.1992-31.12.1993) ja sitä seuranneen paikallisen jatkoprojektin

(1.1.1994-31.5.1995) aikana. Tutkimuksen kohderyhmänä oli ensi kertaa akuuttiin non-affektiiviseen psykoosiin, lähinnä skitsofreniaan sairastuneet potilaat, heidän perheenjäsenensä ja hoitonsa. Tutkimukseen osallistui 21 potilasta perheenjäseneineen. Tutkimusaineisto kerättiin osallistuvaan havainnointiin perustuvalla laadullisella menetelmällä. Tutkimuksen tekijä osallistui tarpeenmukaisen hoitomallin mukaisesti järjestettyihin moniammatillisiin hoitokokouksiin, joissa oli mukana potilas ja hänen perheensä. Näistä hoitokokouksista tehtyjä muistiinpanoja analysoitiin narratiivisen lähestymistavan luoman teoreettisen tulkintakehyksen kautta.

Ensimmäisen osatutkimuksen kohteena oli potilaan identiteettikertomus. Narratiivisen näkemyksen mukaisesti identiteetin perustana ovat kertomukset, jotka henkilö on muodostanut elämästään. Tutkimuksen perusteella akuutissa psykoosissa potilaan identiteettikertomus voi olla joko romahtanut tai se ei ole tarpeeksi yhtenäinen (koherentti). Psykoottinen henkilö ei pysty luomaan riittävän koherenttia identiteettikertomusta sosiaalisesti tarjolla olevista kertomuksista. Tällaisessa tilanteessa tulee moniammatillisissa hoitokokouksissa pyrkiä luomaan potilaan, lähiomaisten ja henkilökunnan kesken potilaasta monipuolisia, uudenlaisia kertomuksia. Näistä uusista kertomuksista potilas pystyy luomaan itselleen identiteettikertomuksen romahtaneen tilalle. Kokemuksen jäsentyessä kertomuksellisesti poistuu uhka, joka kohdistuu erillisenä subjektina olemiseen. Samalla reflektoiva suhde identiteettikertomuksen ja subjektin välillä palautuu. Toisinaan psykoosi voi myös ehkäistä identiteettikertomuksen romahtamista.

Toisessa osatutkimuksessa kohteena oli potilaan ja perheenjäsenten toimijuus. Tulokset osoittivat, että akuutissa psykoosissa henkilö pyrkii luomaan kokemuksilleen kertomuksellisen jäsennyksen, mutta saatavilla olevat kertomukselliset jäsentämistavat eivät tarjoa siihen riittävää mahdollisuutta. Osa henkilön kokemuksista jää jäsentymättä, esi-narratiivisiksi kokemuksiksi. Hoitokokousten tavoitteena tulee olla näiden esi-narratiivisten kokemusten kertomuksellistaminen. Tämä voi tapahtua, kun moniammatillinen työryhmä reflektiivisesti keskustelee kuulemastaan ja kokemastaan. Kokemuksen saadessa narratiivisen muodon potilas kykenee paremmin hahmottamaan omaa elämäänsä ja samalla lisääntyy hänen toimijuutensa eli tunne, että hän voi myös vaikuttaa elämäänsä. Toisaalta psykoosi voi toimia joskus pakona toimijuuden säilyttämiseksi.

Tutkimuksen kolmannessa osassa tarkasteltiin ajan kokemista psykoosissa ja narratiivin liittymistä siihen. Narratiivisesta näkökulmasta kertomuksen juoni jäsentää tapahtumia ajan suhteen. Tulosten mukaan jos psykoosissa osa kokemuksista jää esi-narratiiviseen muotoon, tietyt kokemukset ajallisuudesta saattavat puuttua psykoottiselta. Varhaiset perhekeskeiset interventiot, joissa potilaan kokemuksille pyritään saamaan kertomuksellinen muoto, ovat perusteltuja psykoosien hoidossa. Ne estävät esi-narratiivisten kokemusten kasautuminen. Narratiivin kautta kokemus saa jäsennyksen ja henkilö voi keskittyä tämänhetkisten kokemusten jäsentämiseen. Narratiivisen jäsennyksen erityispiirteenä on, että samalla kun sen myötä kokemuksen voi jättää osaksi menneisyyttä, siihen voi myös palata uudelleen siten, että uuden kertomuksellisen jäsennyksen kautta kokemus saa uuden merkityksen.

Tutkimuksen neljännessä osassa tarkasteltiin hermeneuttisesta näkökulmasta kertomuksen muodostumista psykoottisen henkilön kokemuksille. Tutkimuk-

sen tuloksena oli, että hoitokokouksissa psykoottisen henkilön ja hänen perheenjäsentensä mukanaolo tasavertaisina kumppaneina kertomuksen muodostamisessa, on erityisen tärkeää. Ilman heidän mukanaoloaan työntekijöiden kertomukset eivät liittyneet psykoottisen henkilön tai hänen perheenjäsentensä kokemuksiin vaan pelkästään työryhmän jäsenten kokemuksiin tai tapoihin hahmottaa tilanne diagnostisten tai teoreettisten kertomusten kautta. Varhainen perhe- ja verkostokeskeinen interventio on perusteltua, jotta muodostuisi parhaimmillaan kaikkien osapuolien jakama käsitys hoidon tarpeesta. Narratiivisesta näkökulmasta esinarratiivisten kokemusten kertomuksellistaminen määrittää hoidon tarpeen. Se koskevatko nämä kokemukset yksilöä vai perhettä, vaikuttaa hoitomuotoon. Hoidon edetessä hoidon tarvetta ja hoitomuotoa tulisi jatkuvasti tarkistaa ottaen huomioon, että tietyt kokemukset ovat saattaneet saada narratiiviseen muodon ja uudet tarpeet tulleet esiin.

Tutkimuksen tulosten mukaan narratiivinen lähestymistapa tuo psykoosin ymmärtämiseen ja hoitoon tiettyjä erityispiirteitä. Edellä kuvattujen periaatteiden mukaisesti toteutetut hoitokokoukset tarjoavat mahdollisuuden erilaisten esinarratiivisten kokemusten muuttumiseen yhteisesti jaetuiksi kertomuksiksi, joiden avulla potilaan koherentti identiteettikertomus, toimijuus ja kokemus ajassa pysymisestä voidaan palauttaa.

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I

The self-narrative and acute psychosis

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II

The sense of agency and the search for a narrative in acute psychosis

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IV

Narrative understanding in acute psychosis

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