NARRATIVE UNDERSTANDING IN ACUTE PSYCHOSIS

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ABSTRACT: Hermeneutical premises are adequate in understanding the psychotic patient. It is more important to hear and try to understand the patient's story told by the latter as an equal partner in conversation than understand events through stories in which the meanings are already determined. 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. In this way understanding conforms to the preunderstanding of the interpreter as well as adequately captures the intentions of its originator. These are the preconditions for the integration of the need-adapted approach to the treatment of schizophrenia.

KEY WORDS: schizophrenia; psychosis; narrative; understanding.

Story-making is the basic principle in the construction of meanings according to the narrative approach. A narrative through which meanings are constructed is always socially created and maintained in dialogue with others. An individual's identity and agency are also constructed and maintained dialogically by his or her relationships. Accordingly, what Shotter (1993) terms dialogical or conversational social constructionism, i.e., people's responsive understanding of each other, is primary.

In our professional world we attempt to understand utterances

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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 genuine dialogue is not created (Seikkula, Aaltonen, Alakare, Haarakangas, Keränen, & Sutela, 1995). Shotter (1993) argues that we maintain such systematic texts to fulfill our responsibilities as competent and professional academics.

In psychosis one frequently uses language that contains metaphorical and other expressions that are not easily understood. Thus the psychotic person is left out of dialogue in which the meanings are negotiated with the reference to the immediate context. The attempt to engage in dialogue does not succeed, thereby diminishing the individual's sense of agency and leaving his or her identity unconstructed (Holma & Aaltonen, 1995, 1997).

From a narrative point of view the aim of therapy is to create stories that are not yet told or are held in subjugation. These new stories offer possibilities for a new kind of meaning construction and thus enable personal experiences to become storied (Holma & Aaltonen, 1997). This means that the individual's personal experiences become shared with others in process of dialogue. Sharing is difficult, especially in psychosis and schizophrenia, which are characterized by exceptional experiences (like hallucinations) or actions (like aggressive behaviour) and difficulties in sharing socially constructed reality (like impairment in reality testing). In psychosis and schizophrenia the even greater danger exists that the situation will be explained on the basis of theoretical or diagnostic stories rather than understood through dialogue.

According to Giddens (1993) hermeneutics is predicated on four premises:

1) An object has to be understood in its own terms, that is, as a subject. The other has the authentic right to take his or her role in a dialogue as a full and equal partner. This is the premise of hermeneutic autonomy.
2) An object has to be understood in context and it is through this that meaningful coherence is generated.
3) Understanding has to conform to the actuality of the experience of the interpreter, so-called preunderstanding. All understanding demands some measure of preunderstanding whereby further understanding becomes possible.
4) The interpretation of a human product or action must be adequate in relation to the intentions of its originator.

The aim of this paper is to study acute psychosis and schizophrenia from the above-mentioned conversational constructionistic, narrative, and hermeneutic points of view. Questions arising from the theoretical frame are:

1) How can experiences in cases of acute psychosis and schizophrenia be shared so that personal experiences can be storied?
2) How do we bring the psychotic patient in as an equal partner in a dialogical process?
3) How can we take the context into account in this dialogical process?
4) Do the ideas regarding preunderstanding of the interpreter and the intentions of the patient give us practical tools by which to understand the process?

PARTICIPANTS AND METHOD

This study is a sub-project of the Finnish Integrated Approach to the Treatment of Acute Psychosis (API) Project (Lehtinen, Aaltonen, Koffert, Räkköläinen, Syvälahti, & Vuorio, 1996) and its local continuation project. A more detailed description of the project, including material and methods, has been presented in our earlier papers (Holma & Aaltonen 1995, Holma & Aaltonen, 1997).

RESULTS

The results are presented here through three example cases selected to show how the understanding of psychosis occurs in different treatment modalities.

How to Use a Reflective Team in Attempts to Understand a Patient's Experiences

Case A. A 34-year-old single woman was brought to the hospital because she was in a confused state. She had just got a new job, but one week later telephoned her brother telling him that she had quit. As neither her brother nor her parents managed to contact her by telephone, they went to visit her. She was watching television, although the set was not switched on, and said that everything that

was said in the apartment could be heard outside. She then stopped talking. In the hospital the only thing she said was that they had confused the weekdays at work.

At the first family meeting with her parents and two brothers she did not come to the room where the meeting was being held. Consequently her relatives and the team went to her room. At the beginning of the meeting she was in the bathroom, but she came out soon and lay down on her bed, keeping her eyes shut and not answering questions.

The team and the patient's relatives spoke about the events that had caused the hospitalization and about what had happened during the past year. Her parents had not been worried about anything and the situation itself came as a surprise to them. They said that they had not known much about her recent life. She had lived alone for many years and had little contact with her family. Her younger brother said that this situation did not surprise him. He himself had caused his sister to worry when over a year ago he had fallen and fractured his hip which had still not mended. The other thing that may have had some effect on his sister was her new job and the stress brought with it, he said. It was the first time she had worked in nursing and she took very seriously being bound to secrecy. She did not share any of her worries concerning the job even with him who was closest to her in the family. This story about a stressful work situation was the first attempt to understand her situation and was constructed in this dialogue with her brother.

Her mother told a very tragic story about how one of their children had died in a car accident and how another of their children, a son, committed suicide 10 years afterwards. Just before committing suicide he had telephoned his father and told him how he had felt guilt about the accident all these years. He had never mentioned this to anyone before. This story about the tragic past of the family helped the team members to understand the family's anxiety in this situation. This was a story about family who did not talk and share their feelings with each other. It did not, however, help in understanding the patient's situation now.

During the next family meeting three days later the main issue concerned whether it was better to speak about these things or not. The mother saw these meetings as necessary but the father and brothers did not. They were afraid that the patient would get angry if they spoke any further about her affairs without her taking part in the conversation. They would prefer the patient herself to speak. The younger brother said that she would be silent for another two weeks

yet, but would speak in the future. We just have to wait, he said. At that particular meeting the family members respected the patient as an equal partner in dialogue.

The story that it was better to be silent than share your feelings and thoughts was reinforced. This story was shared by all the male participants in the family. This story persisted despite their experiences (the case of the brother who committed suicide) of how it can cause problems and end badly.

The team and the family members decided to take a longer break before the next meeting. They respected the family members as equal partners in determining treatment needs. The team discussed the situation and decided, however, to continue in order to gain a storied frame for the patient's experiences but without the family. It was decided to continue conversations where the team members reflectively (Andersen, 1990) talked about her situation whether or nor not she herself joined in. Reflective working of this kind respects the patient's autonomy by letting her decide whether she wants to listen or not. These meetings were held every day. A new dimension discussed in the first two meetings was the possible experience of fear in the ward during the night. This concern was based on the observation that she had occasionally left her room to sleep in the corridor of the ward. After the second meeting she suddenly started to talk and asked for some new clothes. Soon after that she asked the name of one of the team members.

Her actions and intentions were interpreted during this discussion as they were understood in the specific context of the ward. This interpretation conformed to the experience of the interpreters, that is the ward staff, and it was adequate in relation to the intentions of its originator, the patient. This helped the patient to construct a meaning for her experience and she was manifestly less anxious.

During the third family meeting the next day the parents and brothers said that they had visited her, but she had not talked to them. The patient led the team members one after another from the room by hand. She indicated with her hand that the team member whom she had contacted before and the family members could stay in the room. After that she began to talk. Everyone talked about the events that had lead to her hospitalization. The patient did not remember those events. Something had happened at work before her hospitalization that she could not talk to the others about because of the bond of secrecy. She was now willing for the rest of the team to participate in the next meeting.

The patient was taken as an equal partner in the dialogue whether she was psychotic or not, and her actions were interpreted as indicating the intentions of a full partner.

After the meeting she remained confused and anxious in the ward, but talked more and more. She wrote down everything that happened or was discussed in the ward. Three days later she telephoned her younger brother and asked him to bring her some clothes. Four days later she described her state as frightened and insecure. The next day she described her stressful situation at work. She wondered about her state when she did not talk. She could remember feeling anger.

One week later during the last meeting on the same day she left the hospital, she spoke about the stress she experienced in her work and about a secret that she was unable to talk about. The events and the causes remained somewhat mysterious. She had stayed overnight at her own apartment and everything seemed to be well and normal.

Half a year later she was hospitalized for the second time. On this occasion she herself had telephoned her younger brother and told him that she felt confused and wanted help. He took her to the hospital. After being discharged from the hospital she had managed well until she received a new offer of a job. One week after the job interview her symptoms began again, she subsequently said.

When she was admitted to the hospital, she did not talk and was restless. The team composed of staff members who had taken part in her first period of hospitalization began a reflective discussion as before about the events that had occurred subsequently. Her younger brother had informed the team about these events. The team held discussions and on the second occasion consisted of only two persons. After the second session she left the room and searched for the staff member she had earlier first talked to and began to talk to her. She talked about the same things that the team had just discussed, that is, her stress and anxiety concerning the possible new job. She also began to talk to other people when there was only one at time present.

Discussion with many people was "hurly-burly" for her. Next day at the family meeting she spoke little and was anxious. This case shows how the same use of a reflective team that constructed concrete dialogue around the patient also worked for her a second time. Now the general understanding about her situation was also more precise in relation to the size of the team. It could now be understood why she had led the team members by hand from the room during the pre-

vious hospitalization. This was also a good example of how important it is to guarantee the psychological continuity of the treatment process through hospitalizations as recommended according to the need-adapted model of treatment (Alanen, Lehtinen, Räkköläinen, & Aaltonen, 1991).

Understanding Is Constructed in Individual Conversation and Shared Afterwards with the Family

Case B. A 33-year-old woman was brought to the hospital for a second time because of psychotic thoughts and inability to take care of herself (Same case as Case C in Holma & Aaltonen, 1998). As previously reported (Holma & Aaltonen, 1998), during the two first therapy meetings the theme concerned oppression and the sense of agency. At the first meeting the story concerned the oppression of her mother as the patient saw it. The patient's experience of oppression, however, was very different. The patient's oppression was understood when she met the team alone, without her parents. The process of understanding began from the attempt to understand why she read always the Bible before answering a question. It helped her to find her unbroken self, she said. It did not matter whether it was the Bible or any other book. When this had been understood, that is, the role of the Bible was not as much loaded with for example religious meanings as the team was eager to understand, she began to talk about her experiences with her ex-boyfriend. She narrated this story without looking in the Bible. After the meeting she wanted to remain in the room alone and said that she had an unbroken feeling.

Firstly, in this session the patient was first taken as an equal partner in conversation. Secondly, the effort was made to understand her motive in using a Bible, despite the highly psychotic nature of this activity in the context. This was less difficult than might appear, as it helped the patient to tell her story through dialogue and acquire a narrative construction for her experiences. The story was about lost love and how she felt oppressed by the events surrounding it. This narrative had not been storied in the previous family meetings, where the parents' and team members' stories dominated. When she constructed the present narrative which included experiences that also involved her feelings, she felt less unbroken, and this feeling later continued in the ward.

During the next therapy meeting the story was told to the patient's parents as well. They now heard these events for the first time;

the story and meanings connected to the story now being shared with meaningful others. The patient's voice as an equal partner and story-maker was raised in a public act. She was no longer seen as a psychotic patient but as an equal partner in conversation. The possibilities for creating meanings and narratives had been widened. This does not mean that there was now less conflict between the stories and thus between the family members, on the contrary. The patient's story was, however, on an equal level with the other stories.

The Whole Family Needed for the Narrative Construction of a Shared Experience

Case C. A 22-year-old man (same as Case A in Holma & Aaltonen, 1997) was hospitalized after a suicide attempt. At the two first family meetings during the patient's hospitalization one of the main topics for his parents was how to cope with his fears and aggression. During hospitalization he made several attempts to injure himself and was placed under special control. During the third family meeting his mother said that the week had gone fine, although the patient had been in the ward and they had not met. The patient agreed. The mother termed this period "separation" and the patient termed it "differentiation". The period was valued positively by all the participants. The patient, however, asked for a home visit, but it was decided in the context of the separation/differentiation distinction that a home visit was not appropriate at that time.

At this meeting the actions taken by the hospital staff to ensure that the patient would not take his life stimulated a search for a narrative interpretation. The hospitalization was labeled by the family members in their own terms. The patient's suicide attempts were not interpreted in terms of separation/differentiation but as the causes of his hospitalization.

During the next family meeting the topic of separation/differentiation continued. The mother recognized some anxiety in herself concerning the separation, especially when the patient had telephoned her and asked her not to visit him. The patient said that he had thought back when he was 15–16 years old when he was more differentiated. The mother and the patient talked about the quarrels they were having at that time and how at first two people had had different opinions but soon all the family members were taking part so that at the end of the quarrel nobody knew who was against who. Everyone was part of the same mass, the patient said. The father did not

agree with this story. The team decided to see parents separately and the patient would have a meeting of his own in the ward. The aim was to reinforce the separation/differentiation. Soon, however, the family meetings started again.

This period brought relief but also anxiety at the same time and led to attempts to find narrative expression for these experiences in dialogue during the family meetings. The experiences were also connected with the past history of the family. Here the need for narrative construction concerned not only the patient but more or less the whole family, and so it was decided to continue family meetings.

Four months later during a family meeting the father expressed concern about the patient's silence and withdrawn state. He had also been worried previously about what the patient was doing in the ward. Now he was more worried about the change that had come over in the patient: he was no longer the same boy, the father said. He was concerned because he did not know what was in the patient's head, he said. The team, however, interpreted this as a good sign in the context of separation/differentiation. The team left the family to decide about the question of home visits, but notified them to make sure that the patient was given enough time to be silent. The question of separation/differentiation seemed to continue to be highly important in the family; but this time between the patient and his father. The family meetings continued.

During the follow-up meeting two years after the patient's hospitalization his mother said that she had noticed that the patient and father were getting along fine with each other. For example, they had found a new mutual hobby. The question of separation/differentiation seemed to have been dissolved. The patient continued to have individual therapy with one of the team members

DISCUSSION

From a narrative point of view it is important that the patient is brought into a dialogue where the meanings of events are socially created. Thus, it is more important to hear and try to understand the patient's story as told by himself than to understand events through stories where the meanings are already determined. This means that diagnosis in the traditional way seems to be less essential in the treatment process than understanding the patient's situation through the story that he or she is telling through his or her action and

speech. When the patient is brought into a dialogue his identity and sense of agency are also constructed and maintained. He should be taken as a valuable participant in social relationships and not marginalized as a psychotic, sick person, but as an equal partner in the relationship. Narrative construction also contains enough redundancy to invite a person to restory his or her past in a new way if necessary (Holma & Aaltonen, 1998).

From a hermeneutical point of view interpretations of a patient's utterances and actions have to conform the preunderstanding of the interpreter as well as to exist in an adequate relation to the intentions of its originator. This is referred to as what has been termed mutual knowledge (Giddens, 1993), a socially constructed frame for interpretation. The outcome of interaction as meaningful depends upon the existence of mutual knowledge which is 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 & Rakkolainen, 1994). The situations in psychosis had to be encountered at the same level of sign as prevailed in the patients' and their families' lives as they emerged in the ward.

To generate meanings via interaction speakers must not only be competent linguistically, but have to have command of the social settings which turn the mastery of language into the understanding of the other (Giddens, 1993). When this seems to be missing from the psychotic patient or family, the team members' task is to create just such a social setting. This is where professional skill comes in this field. The appropriate social setting might, for example, involve working as a reflective team ensuring the patient as an equal partner of the dialogue.

Any action, speech, or other action, is always in search of a narrative interpretation. This narrative interpretation has to be constructed socially and maintained in dialogue in relationships with others. If we try to understand utterances and actions through stories where the meanings of experiences are already determined, unique and personal meanings will not be shared and real dialogical conversation will not be created. 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.

Without understanding and mutually created narrative construction the individual and those around him or her will be stuck in this unnarrated experience and will attempt to narrate it without success, while simultaneously other subsequent experiences remain unnarrated. Where this situation is of long duration, the unnarrated experiences accumulate, and it becomes more and more difficult to resolve them (Holma & Aaltonen, 1998).

Through the mutual knowledge constructed via dialogue with the patient and family members as equal partners the needs of the treatment as well the treatment modalities can be determined. 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. These are the preconditions for the integration of the need-adapted treatment of schizophrenia from the narrative perspective.

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