Need-adapted treatment of new schizophrenic patients: experiences and results of the Turku Project

Alanen YO, Lehtinen K, Räkköläinen V, Aaltonen J. Need-adapted treatment of new schizophrenic patients: experiences and results of the Turku Project.
Acta Psychiatr Scand 1991: 83: 363–372.

This article describes a psychotherapeutically oriented approach to schizophrenia developed especially to meet the needs of the community psychiatric field. Because of the heterogeneous nature of the schizophrenic psychoses, the authors emphasize that these patients should always be treated based on case-specific premises. The main principles of the need-adapted 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 of their family members. 2. Examination and treatment are dominated by a psychotherapeutic attitude. 3. The different therapeutic activities should support and not impair each other. 4. The process quality of therapy is clearly perceived. A family-centred initiation of the treatment is especially emphasized for both diagnostic and therapeutic reasons. The positive experiences of this led the Finnish national programme for the treatment and rehabilitation of schizophrenic patients to recommend the establishment of family- and environment-oriented acute psychosis teams (APT) in the mental health districts. In later phases of treatment, the significance of individual psychotherapy is increased. The preliminary results of the approach are presented and compared with an earlier sample of patients.

Y. O. Alanen, K. Lehtinen, V. Räkköläinen, J. Aaltonen

Department of Psychiatry, University of Turku, Finland

Key words: schizophrenia; psychotherapy; family therapy; community psychiatry

Y. Alanen, Department of Psychiatry, University of Turku, Kunnallissairaalantie 20, SF-20700 Turku, Finland

Accepted for publication December 22, 1990

The therapeutic approach for schizophrenia patients presented here is based on local developmental efforts that have been pursued for 2 decades and have included follow-up studies assessing the outcome (1–3). Our goal is to develop a comprehensive, psychotherapeutically oriented treatment suitable for new and recurrent schizophrenic patients. Our clinic is a university hospital and is part of the community psychiatric organization of the City of Turku (population 160,000), Finland, and our approach has been developed to meet the needs of this field.

The Finnish national programme for the treatment and rehabilitation of schizophrenic patients carried out in 1981–1987 (4, 5) enabled us to collect experiences from the implementation of this approach, even in other parts of the country. We believe that the principles presented here may serve as a good model for the treatment of schizophrenic patients elsewhere in ways optimally suited to each therapeutic system.

One of the important points that we have realized is that the treatment of schizophrenia must always be planned individually and on case-specific premises, taking into account the therapeutic needs of both the patients and the people closest to them. It is not indicated to try to treat all patients with the same psychotherapeutic method, nor are the best possible results achieved in this way.

The approach described here has earlier been called need-specific treatment of schizophrenic psychoses (3). We are not fully content with this English term, however, as it does not correspond well enough to the original Finnish word *tarpeenmukainen*, which means "in accordance with the needs", and may suggest undue exactness, which does not do justice to the idea of flexibility we are aiming at. We therefore decided to use the term need-adapted treatment.

Development of the need-adapted approach

Starting-points

The reason why the therapeutic task should be defined individually in each case is because schizophrenic disorders are heterogeneous. This heterogeneity already appeared obvious to Bleuler (6), as the very name of his classical work referred to the schizophrenia group, as opposed to a single uniform illness called schizophrenia. Of the researchers with a psychotherapeutic orientation, especially Pao (7)

referred to the differences in the patients' developmental histories and clinical situation, which should also be taken into account when planning the treatment.

The question of the extent to which the manifestation of schizophrenia is directly associated with causal factors pertaining to biologic functions still remains to be answered. For example, the findings of Wong et al. (8) in their positron emission tomographic studies, which suggested that there are primary dopaminergic dysfunctions in schizophrenia, were not confirmed by other teams (9, 10), whose methods were probably more reliable. The computer tomographic findings of mild cerebral atrophy (11, 12) in a small portion of schizophrenics are not specific to this disorder but are also seen in manic-depressive and schizoaffective psychoses (13). They may suggest a heterogeneous aetiology of these psychoses or, more probably, heterogeneity in the differently weighted aetiopathogenetic factors. We do not believe that findings of this kind will diminish the need for psychotherapeutic and, more widely, psychosocial therapeutic measures, although their significance in defining the psychotherapeutic goals should be studied in the future.

A very obvious relation to the selective processes leading to different therapeutic procedures is observable in the factors involved in the psychologic relations between the patients and family members, especially the degree of their mutual interdependence. Several authors have described the disorders observable in the atmosphere of the primary families of schizophrenic patients, including communication deviances as well as binding parent-child constellations that prevent individual differentiation (14–18). According to Alanen (19), a notable portion of the parents of schizophrenic patients display defence mechanisms typical of the borderline personality organization defined by Kernberg (20), such as splitting, primitive idealization and devaluation as well as early forms of projection, especially projective identification.

Defence mechanisms of this kind, which we have also called transactional defence mechanisms (21, 22), are not restricted to the intrapsychic level, but are also of interactional nature and thus only accomplished successfully in concrete externalizations, i.e. in actual relationships with other people. They often result in reciprocal symbiotic bonds and introjective-projective processes in which an adequate therapeutic approach requires that both of the parties be taken into account. The family-therapeutic approach is urgently needed in these cases. In some other instances, this kind of family psychology may be absent or more benign, at least at the contemporary level, and the individual-therapeutic approach is therefore more easy to apply ever since the beginning. The other factors involved in the patient's actual life situation and interactional relationships must also be considered when analysing the therapeutic indications.

The starting-points of our studies on need-adapted treatment are contrary to the controlled therapeutic trials (23, 24), in which the schizophrenic patients comprising the study series are randomly allocated into different groups, of which each is given a different kind of treatment. In these studies, the idea of case-adaptability of treatment has been ignored for methodologic reasons. The modes of therapy are predefined in detail and very little flexibility or inclusion of new modes of action in the therapeutic regimen is permitted, regardless of how unmotivated the patients may feel towards the therapies that are implemented. Method-oriented works of this kind can hardly provide a fully adequate idea of the possibilities of treating schizophrenia psychotherapeutically. And despite the ostensible objectivity of the method, the assessment of the results is often also liable to weaknesses: if the mode of therapy under study is well suited to part of the random sample and less well suited to another part, the favourable and unfavourable results may cancel each other out in the statistical analysis.

Despite the methodologic problems arising, innovative investigations of a different kind are clearly needed.

Interactionality in treatment

While studying the patients of the schizophrenia group first-admitted to treatment in the catchment area of Turku in 1976–1977 (3), we obtained promising results from many psychodynamically oriented long-term individual therapies based on an empathetic and confidential therapeutic relationship as well as from treatment initiated in a psychotherapeutic ward community. Although our orientation at that time already was family-centred, it lacked genuine interactionality. At the initial examination stage, we met the patients and their relatives separately and the conjoint family therapies that were implemented were relatively few in number and meagre in outcome. An exception to this rule was the couple therapies of the patients who were married at the onset of their illness and their spouses, which were implemented in about 50% of the cases of this kind and demonstrated undeniably the expedience of this mode of treatment.

In 1979 we started 3-year family therapy training programmes in Turku. They acquired a notably system-oriented quality ever since the beginning, stimulated by the visiting instructors from London and Heidelberg. The effect of the system-oriented training was decisive for not only the development of

family therapy, but also the practice of working within the scope of community psychiatry in general (25). The results of the renewed therapeutic approach could be studied in a sample of schizophrenic patients first admitted in Turku in 1983–1984 (26), which simultaneously served as part of a more extensive project covering 6 catchment areas in Finland (the NSP project included in the national programme (27, 28)).

The new systemic starting-point required that therapeutic teams be formed that made an effort to meet jointly each patient and the family members as soon as possible after admission. It did not turn out to be difficult to arrange the initial joint meeting at this phase: in our new series this was successfully arranged in 87% of the cases and, in the more comprehensive Finnish study, covering 6 different catchment areas, in 70% of the cases on average.

The goal in this conjoint meeting is to acquire a shared understanding of what has happened. At the most concrete level, this means explaining how and why the patient was referred for treatment: at a more advanced level, a system-oriented evaluation of the psychological situation of both the patients and the family network they belong to, aiming at an assessment of the case-specific therapeutic needs. More than one session may be necessary to attain these purposes.

Another goal of the conjoint session(s) is to help the participants to conceive of the situation rather as a consequence of the difficulties the patients and those close to them have encountered in their lives than as a mysterious illness the patient has developed as an individual. This is an important difference compared with the psycho-educational family therapy approaches (29–31), which usually regard schizophrenia as an organically determined illness.

A joint session of this kind nearly always serves to alleviate the patient's regression. Being labeled as ill is not so conspicuous. The family members and the other individuals close to the patient are thus invited to commit to the exploration of the situation and the treatment while, at the same time, they are themselves given therapeutic support from the beginning, which alleviates their own confusion and anxiety. The session often also helps those present towards a preliminary working-through of the traumatic and often paranoid experiences associated with psychiatric hospitalization.

We call these sessions therapy meetings to differentiate them from the treatment planning meetings, where mostly only the therapeutic team is present. The name was selected because of the great therapeutic significance of these sessions.

We often continue the therapy meetings at the later stages of treatment; especially during inpatient periods they are part of our regular practice. They are then attended by the patients, either alone or with the people close to them, as well as by members of the therapeutic team.

In our opinion, the therapy meetings constitute the best way to follow up the course of the treatment and to reassess the therapeutic plans. These meetings are of especially great importance during changes in the therapy, when, for instance, the therapist, the mode of treatment or the therapeutic unit is changed.

Mutual weighting between the modes of psychotherapeutic treatment

Fig. 1 shows the most common mutual sequence of the central modes of psychotherapeutic treatment during the course of need-adapted treatment. The arrows in the diagram indicate the shift of focus from one mode of treatment to another, and the broken arrows indicate discontinuation of treatment, which, as can be seen, is possible at all stages.

The diagram always indicates the primary mode of treatment in particular. Family therapy, for example, may be associated with a simultaneous dyadic therapeutic relationship – for as long as patient is in hospital, this is the rule – but the primary focus lies on one of these modes of treatment.

Single cases may naturally require exceptions to the order presented in the diagram. It is also justifiable to caution against the hazards involved in very hastily sketched treatment plans proclaimed as case-adapted. The emergence of mutual understanding is

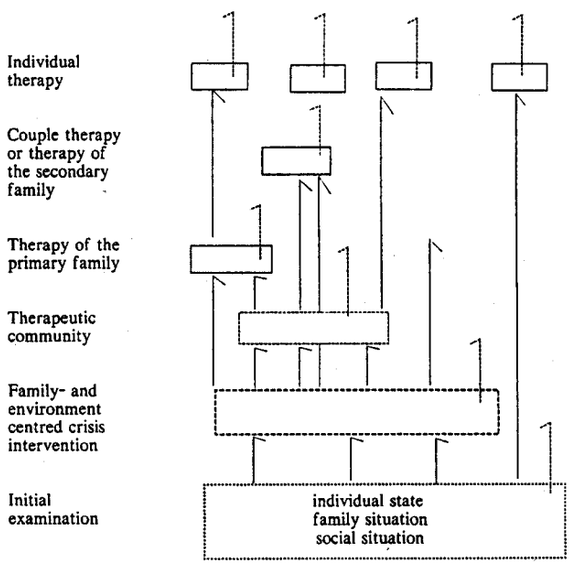

Fig. 1. Mutual weighting of the psychotherapeutic treatments of schizophrenic patients in the course of therapy

a process that may require time. In therapeutic units with a long psychotherapeutic tradition the modes of treatment are occasionally selected less quickly and ostensibly less rationally than in units with either a lacking or a short or ambiguous psychotherapeutic tradition (32).

The bottom of Fig. 1 shows the stage of examination, which also signifies the initiation of treatment. Its most essential goal is to clarify the situation of the interactional network of the patient's family and other important people, a point already discussed above. This clarifying analysis is inseparably associated with a family- and environment-oriented intervention in crisis, which may take place with the patient either in outpatient therapy or in a therapeutic community.

At the same time, the patient's individual clinical and psychologic status is assessed and, through a separated contact, the patient's need for and motivation to begin an individual therapeutic relationship is evaluated. A further assessment is made of the patient's social situation and associated needs for rehabilitation. The significance of this procedure becomes evident when we point out that 47% of our patients had needs of this kind upon admission; the corresponding figure was as high as 72% in the more extensive Finnish NSP project (28). The needs most commonly pertained to vocational guidance, assistance in getting a job and support for the development of social interaction and social skills.

When several modes of treatment are needed, it is usually expedient to proceed from the less specific family- and environment-oriented modes to the more specific and individual-centred ones. This major trend in the shifting of the focus of treatment is clearly visible in Fig. 1.

According to our clinical experiences, individual therapy beginning at the early stage of treatment is best suited to patients who show relatively better differentiation than the others belonging to the schizophrenic group. These patients usually also show some initial insight into the connection between their symptoms and their life situation. This is in accordance with our earlier investigation of the selective processes, whereby the patients were entered in the various categories of psychotherapy (2, 3).

Both insight and motivation to therapy often clearly increased during the family-oriented stage of examination. In our 1976–1977 series, some insight into one's own role in the development of one's problems and/or symptoms was shown by 51% of the patients, and in the 1983–1984 series by 66% (32). At some phase, many of the patients may themselves bring up the question of starting individual therapy, which is better from the motivational viewpoint than any prescription of therapy.

Another extreme category consists of the patients whose individual development is clearly delayed and less differentiated. They usually have strong bonds to their primary families and weak extrafamilial contacts. It is also in these cases that the intrafamilial problems are generally greatest. The patient is therefore not well suited to individual therapy, and the primary mode of treatment is conjoint family therapy. Its central goal is to promote the mutual process of psychologic differentiation between the patient and his parents. If this is sufficiently successful, family therapy should be followed by long-term individual therapy of the patient in a therapeutic relationship that allows personality growth through transmuting internalization (33). The practical facilities for such a course of treatment have so far been inadequate in our circumstances.

It is also in this most seriously disturbed group of patients that the significance of psychotherapeutic communities – i.e. psychotherapeutically oriented hospital or day-hospital wards (3, 34) – is greatest. They are not only important because of the notable regression of these patients but also because hospitalization is often the only way to achieve the prerequisites and motivation for family or individual therapy to be carried out on an outpatient basis.

Most of the schizophrenic patients who are married, or live in a long-term couple relation, benefit from couple therapy or family therapy of secondary family clearly better than from individual therapy. Interactional psychodynamics is equally important in the illness of these patients, as in those of those tied to their primary families, but it is more differentiated level than in the former cases, quicker to reach within a therapeutic process. cially the acute psychotic disorders of these p can often be described as a regressive deco sation, which, if prolonged, tends to be esta as part of the regressed family homeostasis couple or family intervention may help to and fortify the supportive elements associa interactional relations, which, in turn, may a rapid improvement of the situation.

We may guess that even for the judge Da Schreber (35) the best mode of treatment, present-day point of view, would have be therapy, which might have prevented hi regression. Mrs Schreber had stayed with band in Professor Flechsig's clinic for a time, and Schreber's condition deteriorate only after her four-day absence.

In some of the cases of this category therapy may be nearly contraindicated the consequences it may have for the i field of the family by placing one of the f bers in a long-term patients's role. C hand, individual therapy is needed in t

of any patient whose separation is taking or has taken place, or whose pathology of individual development turns out to be the central causal factor in his illness. The relative number of such patients is clearly smaller than the number of those in need of individual therapy after primary family therapy.

Only a few of our patients have regular group therapy, but various group activities within our therapeutic communities are having an ever-increasing importance in our treatment programme. The day in a ward community is begun with a group meeting of the staff and the patients, and the senior doctor's rounds also take the form of 6–8 patients and the same number of staff members meeting in a room, where they discuss the individual situation of each patient in turn. Different activity groups play a significant role in the daily programme.

Pharmacotherapy as part of need-adapted treatment

Pharmacotherapy must also be integrated as part of the therapeutic functions on the basis of the understanding that has been achieved. This means that when medication is being prescribed, the reasons for it must be made clear to the therapist, the patient and often others in a language they understand. The therapist must be ready to alter the dosage along with the changing therapeutic situation. A good goal in this respect is to find the minimum neuroleptic dose that is needed to bring the patient's contact and communication abilities to a level that is optimal for the situation. In practice, this means notably lower doses and shorter periods of medication than is currently customary in treating schizophrenic patients. Long-time neuroleptic medication with heavy dosage had adverse effects on the psychosocial prognosis of these patients (3).

Principles of need-adapted treatment

We can summarize the general principles of the need-adapted treatment of new schizophrenic patients as follows.

1. The therapeutic activities are planned and carried out flexibly and individually in each case so that they meet the real, changing needs of the patients as well as the people making up their personal interactional networks.

It is necessary to find out both the patients' subjective condition and the psychological situation of the families or the other essential interpersonal networks to which they belong. This is best achieved by conjoint meetings (therapy meetings) beginning at the initial stage of treatment, in which a team of staff members meets jointly each patient and family and/or significant others. To a particularly notable degree, the treatment of schizophrenic patients depends on the quality of the interpersonal relations prevailing in their closest environment. This includes the psychodynamic significance of the symbiotic ties and the mutual introjective-projective processes prevalent in these family networks, the patient's secondary dependence because of illness, and the family's need for support in a difficult life situation.

This principle also implies that unnecessary treatment should be avoided.

2. Examination and treatment are dominated by a psychotherapeutic attitude.

We define the psychotherapeutic attitude as an effort to understand what has happened and is happening to the patients and their significant others. This is best achieved by the participant-observer attitude originally described by Sullivan (36). This attitude also includes observation of one's own emotional reactions.

This principle should be an underlying motive in the implementation of all modes of treatment.

3. The different therapeutic activities should support and not impair each other.

The integration of treatment pertains equally well to the balance between psychotherapy and pharmacotherapy as to the combination of different modes of psychotherapy, such as family and individual therapies. Cooperation between members of the different staff categories and workers of the different units is especially important.

4. The process quality of therapy is clearly perceived.

This means that treatment must be conceived of as a developmental event, an ongoing process that should not degenerate into a routine of given actions. For this purpose, it is helpful to assess continuously the course and outcome of the treatment, which involves the possibility of modifying the therapeutic plans.

These principles are closely associated. They are all parts of the same whole. If one part of the whole is overlooked, need-adapted treatment is not implemented fully.

Preliminary results

Material and methods

Our series included 31 patients entering treatment for the first time for a schizophrenic disorder at an inpatient or outpatient unit operating in the Turku community psychiatric district during 12 months in 1983–1984. The patients were diagnosed in accordance with the DSM-III classification (37), using the following diagnostic categories: schizophrenic disorder (22 patients) and schizophreniform psychosis (9 patients). Twenty-four of the patients were first admitted into a hospital or a day-hospital ward and 7 into an outpatient unit.

The treatments that were implemented are shown in Table 1. Of the actual psychotherapeutic treatments (family, group and individual therapies), about 70% were conducted by psychiatrists and other physicians, psychologists, psychiatric nurses and social workers working in community psychiatry, and the remaining 30% by private psychiatrists and psychologists. The role of the latter was most conspicuous in intensive individual psychotherapies. Therapists with at least 2 years' psychotherapeutic training were in charge of slightly less than half of the therapies (this was most often the case in family therapies), and the other therapists worked with on-the-job training and associated therapy supervision.

There is an emphasis on family therapies during the first year, whereas individual therapies have also been implemented to a greater extent in the second year of treatment (Table 1). This is in accordance with the principles described earlier.

Few patients received neuroleptic drugs during the second year of treatment. This is largely because 12 of our 25 patients were already outside the treatment system at the end of our second follow-up year. This also corresponds to one of our principles: to avoid unnecessary binding of the patients to the treatment organization without a specific indication.

Case report

The individual therapies were oriented psychodynamically and a systemic orientation dominated in the family interventions and family therapy. We illustrate our approach with a case report from our series. This patient does not typically represent any of the groups referred to earlier, but she may illustrate especially well the individualized integration of different modes of psychotherapy as well as the benefits of the family-oriented treatment mode both for the patient and for the larger family group.

Table 1. Implementation of treatment according to the follow-up investigations

Treatment	Number of patients	
	1st year ($n = 31$)	2nd year ($n = 25$)
Initial family-centred intervention	27	–
Individual psychotherapy (intensive)*	6	4
Individual psychotherapy (low-frequency)**	5	6
Other individual contacts	14	9
Conjoint family therapy (primary family)***	13	0
Conjoint family therapy (secondary family)***	9	2
Other contacts with relatives	5	4
Home visits	2	–
Group therapy	2	–
Neuroleptic drugs	27	13

* 1 visit per week for at least 6 months.
** 1 visit per month for at least 6 months.
*** Minimum 3 sessions.

Marjorie, aged 33, began to hear voices upon her return from Sweden to her home town Turku with her 3 children. The voices had started from fits of fear, being partly accusing, and Marjorie had lately begun to talk to them and got compulsive laughing fits. She thought this to be caused by hypnosis, saying that she occasionally heard a whipping sound near her ear, as if she were being hit.

Marjorie had moved to Sweden at the age of 16. There she had been married twice and had had several partners living with her for short periods. Her second marriage ended in a divorce a year before she moved back to Finland. Out of her marriages she had 3 children, who lived with her, the eldest being 13 years old. She told us that both the marriages had been wrecked for the same reason: the husbands were aggressive and addicted to alcohol (as Marjorie's father had been, too).

In Turku, Marjorie had a few short, unsuccessful jobs. She tended to resort to her mother, although their relationship was liable to conflicts.

Having heard voices for more than 6 months, Marjorie consulted a doctor on her own initiative and thereby became included in our series. At the early stage of the treatment she was hospitalized for 5 weeks.

An analysis of the family situation, which was also attended by Marjorie's mother and the children, indicated that Marjorie had notable problems with her children. Especially the eldest daughter tyrannized her, and she was quite helpless when faced by her anger. The older children had also begun to play a parental role in relation to their mother.

Joint sessions were thereafter arranged by the same therapeutic team 4 times at intervals of about a month. Through their messages, the family therapy team made efforts to support Marjorie in her maternal role and to liberate the children from parentification. One transactional defence that appeared central from the family-dynamic point of view was the patient's pathologic projective identification with her children. She seemed to project on to them her own suppressed aggressions and then, identifying with them, to "maintain" in them this intrapsychi emotion that was originally her own.

After the family sessions, the focus of Marjorie therapy shifted to individual therapy. It had bee formally started as soon as she was admitted, b only acquired a real significance when the inte actional defences were broken down through t family sessions.

Marjorie's medication consisted of 8 mg of p phenazine and 50 mg of thioridazine a day. The d was later cut down by half.

The family was invited to a new joint session at

time of our 2-year follow-up. Marjorie had been continuing her individual therapy. She clearly held the mother's role in relation to her children now. The children's psychologic individuation had advanced and they no longer displayed the kind of transactionally based problems of aggression that coloured the initial situation in the therapeutic process. Both Marjorie and the children increasingly directed their attention to new fields of interest and relationships outside the home. A similar developmental process had taken place in Marjorie's relationship with her mother, who had become more distant, but thereby also less conflicting. Marjorie's attitude towards life and her mental world were, however, still characterized by timidity and wariness, and she still heard voices from time to time, though she understood them to be her own internal experiences. Socially, she had been supported through vocational counselling. . . .

Family therapy and individual therapy here make up a continuum, which shows the implementation of need-adapted therapeutic procedures from the point of view of the patient and the whole family. The most essential outcome of the family intervention, which was important to all the family members, was the preliminary break-down of the pathogenic transactional defence mechanisms as unnecessary, which simultaneously created both the necessary and sufficient intrapsychic prerequisites for the patients's individual therapy.

Results

The results of our treatment are presented preliminarily in Table 2. We compare the prognosis of our patients, as evaluated in a follow-up survey conducted 2 years after admission, with a series of patients of the schizophrenia group first admitted from the same Turku catchment area in 1976–1977 (2). The prognostic factors consist of disappearance of manifest psychotic symptoms (both "positive" and "negative"), avoidance of disability pension, and the number of inpatient days per patient during the first and second follow-up year.

Table 2. Comparison of the outcome of 2 series of schizophrenic patients

	Two-year follow-up	
Prognostic factor	1976–1977[1] 19 months ($n = 54$)	1983–1984[2] 12 months ($n = 25$)
No psychotic symptoms (%)	41	68
No need of disability pension (%)	62	77
Hospital days per patient		
first year	83	46
second year	36	9

[1] Typical schizophrenia according to Langfeldt et al. (3); yearly incidence 22 per 100,000.
[2] Intensified family-centred approach. DSM-III criteria for schizophrenic psychosis and schizphreniform psychosis; yearly incidence 19 per 100,000.

Two reservations should be made concerning the validity of the comparison. First, the diagnostic criteria of the 2 series are not exactly the same. The 1976–1977 series was originally larger, consisting of 100 patients, who were divided into 4 diagnostic categories: typical schizophrenias, schizophreniform psychoses, schizoaffective psychosis and borderline schizophrenias. The classification was in accordance with the Scandinavian tradition initiated by Langfeldt (38) as applied in Finland (39). The patients with typical schizophrenia were differentiated from the others in that they (3):

> besides a schizophrenic-type thought disorder (in practice, the criterion for inclusion in the whole series), had some other characteristic and distinct schizophrenic symptoms which had set about without any toxic or organic precipitating factors and indicated a tendency to persistence. We paid particular attention to the presence of eight nuclear symptoms of schizophrenia: autism, schizophrenic thought disorder, hebephrenic affective disorder ("blunting" of affect), schizophrenic auditory hallucinosis, physical delusions of being influenced, massive psychologic delusions of being influenced, typical catatonic symptoms (stupor or excitement), and sensations of depersonalization and/or derealization when the patient's consciousness is clear.

We considered that only the category of typical schizophrenics in the previous series corresponded in the severity of the disorder to the more recent series with the DSM-III diagnoses. The schizophreniform psychoses in the earlier series corresponded to brief reactive psychoses in the DSM-III classification, and the borderline schizophrenias did not meet the criteria of schizophrenia and schizophreniform psychosis in the new diagnostic classification either.

However, it seems to us that the series still correspond well for diagnostic borderlines. Both are composed of the new patients showing typical schizophrenic symptoms and admitted for treatment in the same catchment area within 2 specified time limits, the admission criteria being the same. The correspondence is substantiated by the admission incidences per year (22 and 19 per 100,000 population, respectively).

Another reservation has to do with the greater drop-out rate noted in the later follow-up investigation: in the new series we were only able to reach personally 25 patients of the original sample of 31. The corresponding figure in the previous series was 54 of 56. However, according to other information obtained, none of the drop-out patients had been hospitalized again. Two patients of the 1976–1977 series and 1 patient of the 1983–1984 series had committed suicide.

Bearing these reservations in mind, we can see that the difference in the prognosis in favour of the latter series is quite obvious. With regard to both the psychotic symptoms and the disability pensions, the

number of patients with a poor prognosis was 20% lower in the latter group. The difference is even more distinct with regard to the need of hospital care. Only 5 of our 1983–1984 patients had inpatient days during the second follow-up year, and only one of them was hospitalized at the end of this follow-up period.

As regards the therapeutic procedures carried out, the latter series is particularly characterized by an emphasis on interactional modes of treatment as a consequence of the system-oriented family therapy training that had been started in the mean time. The initial family-centred interventions were implemented in 27 of the 31 cases in the latter series, but only sporadically and not in a system-oriented way in the former series. Conjoint family therapies of at least 3 sessions were given to 22% of the typical schizophrenic patients of the former series during the follow-up period and 70% of the latter series. The number of "intensive" individual psychotherapies, however, was somewhat more lower in the latter series; about 20% of the patients being given intensive individual therapy as compared with 30% in the former.

The opinions of the therapists and therapeutic teams implementing the treatments on the effects of the new therapeutic approach are in accordance with what has been presented above. They observed that the intensive family-centred approach applied immediately after the patient's admission seemed to result in a more rapid alleviation of the symptoms than previously and, especially, a diminishing need for hospital care. On the other hand, the number of patients with a relatively short time between the onset of symptoms and the admission for treatment was somewhat greater in the latter series than in the former.

We consider our good prognostic results preliminary, because the series is relatively small and a follow-up period of 2 years short to justify any far-going conclusions at this stage. The treatment period of many patients was relatively limited and the permanence of the good outcome cannot be demonstrated yet.

Discussion

This report should be taken as a description of a pilot project of a type of action research aiming at an improvement of the treatment of schizophrenic psychoses in the community psychiatric field following an integrative approach emphasizing psychotherapeutic and system-centred treatment modes. A more qualified estimation of the prognostic results achieved by the need-adapted approach should be postponed to a time when the results of the investigations comparing a district-wide implementation of this approach with the prognosis of patients in other districts carrying out more conventional therapeutic orientation are available. Within the Finnish NSP project, covering 6 catchment areas, psychotherapeutic treatment approaching the need-adapted orientation was associated with a good hold on life (40) and with gainful employment during the second follow-up year according to a multivariable analysis (28). The results of the Turku series, in which the recommended need-adapted approach was developed most fully, compared well with those of the other districts, but the question of real prognostic differences between the districts was left unanswered because of the possible influence of other background factors.

Any assessment of the results at this stage is also hampered by a lack of sufficient resources for a more satisfactory accomplishment of the treatment practices. Especially the quantity of intensive long-term individual psychotherapies implemented in our series failed to correspond to the estimated need. However, we agree with Ugelstad (41), who postulated some 10 years ago that the establishment of a psychotherapeutic approach to schizophrenia within the framework of community psychiatry is not unrealistic, even given the relatively low annual incidence of this disorder. The conditions necessary for this kind of work are primarily a matter of qualitative rather than quantitative resources.

The arrangements and presuppositions of our approach in the treatment of new and recurrent psychoses of the schizophrenic group were dealt with more extensively in the treatment model report of the Finnish state-wide schizophrenia project, published in English in 1990 (5). The project group was led by Alanen and the developmental work related to the innovation of the treatment of new schizophrenic patients by Räkköläinen & Lehtinen.

A 5-year follow-up of the earlier series indicated that the prognosis of the patients had slightly improved compared with the 2-year follow-up. We do not know yet whether we can expect a similar development in our new series or not. A greater number of patients than in the older series discontinued the treatment at a relatively early stage. We can estimate the long-term results of our approach more conclusively as soon as the results of the 5-year follow-up in our newer series have been analysed.

In our opinion, the most significant qualitative resource is formed by acute psychosis teams (APT) which are able to make family- and environment-oriented (i.e. systemic) situational analyses of psychotic patients admitted for treatment. The establishment of such teams in districts was included in the recommendations of the state-wide project. Apart from the initial clarifying analysis, usually leading to a family-centred crisis intervention, the

teams should be responsible for the integration of treatments and their follow-up as well as serve as consultants in critical situations. The APT should be formed of 4 persons, including a psychiatrist and a social worker, 1–2 of the members having family therapeutic training.

The experiences elsewhere in Finland (42, 43) have indicated that the establishment of APTs resulted in a marked reduction of the need for hospital care of new psychotic patients. This is in accordance with our own experiences.

Another important qualitative resource is formed by adequate therapeutic and supervisory staff for the implementation of individual, group and family therapies. In Finland, multiprofessional psychotherapy training programmes (2.5–5 years) are now arranged by both university centres for complementary training and various private training centres and associations.

With regard to the organizational functions, our approach presupposes abandoning rigidly hierarchical power relations, at least at the basic clinical level of the treatment. Sufficiently versatile care and contribution of the workers' individual talents are thereby guaranteed. Supervisory activities should become an inseparable part of the therapeutic work. Promotion of cooperation and a division of tasks between the different working units of a given catchment area (including the APT) are of central importance.

References

1. Räkköläinen V, Salokangas R, Lehtinen P. Protective constructions in the course of psychosis: a follow-up study. In: Müller C, ed. Psychotherapy of schizophrenia. Amsterdam; Excerpta Medica, 1979.
2. Alanen YO, Räkköläinen V, Rasimus R, Laakso J, Järvi R. Psychotherapy of schizophrenia in community psychiatry. In: Stierlin H, Wynne LC, Wirsching M, ed. Psychosocial intervention in schizophrenia. Berlin: Springer, 1983.
3. Alanen YO, Räkköläinen V, Laakso J, Rasimus R, Kaljonen A. Towards need-specific treatment of schizophrenic psychoses. Berlin: Springer, 1986.
4. The State Medical Board in Finland. The schizophrenia project 1981–1987. Final report of the national programme for the study, treatment and rehabilitation of schizophrenic patients in Finland. Helsinki: State Medical Board, in press.
5. Alanen YO, Anttinen EE, Kokkola A et al. Treatment and rehabilitation of schizophrenic psychoses. The Finnish treatment model. Nord J Psychiatry 1990: 44: Suppl. 22.
6. Bleuler E. Dementia Praecox oder die Gruppe der Schizophrenien. Leipzig: Deuticke, 1911.
7. Pao PN. Schizophrenic disorders. New York: International University Press, 1979.
8. Wong DF, Wagner HN, Tune LE et al. Positron emission tomography reveals elevated D_2 dopamine receptors in drug-naive schizophrenics. Science 1986: 234: 1558–1563.
9. Farde L, Wiesel F-A, Hall H et al. No D_2 receptor increase in PET study of schizophrenia. Arch Gen Psychiatry 1987: 44: 671–672.
10. Martinot J-L, Peron-Magnan P, Huret J-D et al. Striatal D_2 dopaminergic receptory assessed with positron emission tomography and (^{76}Br) bromospiperone in untreated schizophrenic patients. Am J Psychiatry 1990: 147: 44–50.
11. Weinberger DR, Torrey EE et al. Lateral cerebral ventricular enlargement in chronic schizophrenia. Arch Gen Psychiatry 1979: 735–739.
12. Nasrallah MA, Weinberger DR, ed. The neurology of schizophrenia. Amsterdam: Elsevier, 1986.
13. Rieder RO, Mann LS, Weinberger DR, van Kammen DP, Post RM. Computed tomographic scans in patients with schizophrenia, schizoaffective and bipolar affective disorder. Arch Gen Psychiatry 1983: 40: 735–739.
14. Lidz T, Fleck S, Cornelison AR. Schizophrenia and the family. New York: International University Press, 1965.
15. Wynne LC, Singer MT. Thought disorder and family relations in schizophrenia. I-II. Arch Gen Psychiatry 1963: 9: 191–206.
16. Singer MT, Wynne LC. Thought disorders and family relations of schizophrenics. III-IV. Arch Gen Psychiatry 1965: 12: 187–212.
17. Alanen YO, Rekola J, Stewen A, Takala K, Tuovinen M. The family in the pathogenesis of schizophrenic and neurotic disorders. Acta Psychiatr Scand 1966: Vol 42: Suppl 189.
18. Stierlin H. The dynamics of owning and disowning. Fam Process 1976: 15: 277–288.
19. Alanen YO. In search of the interactional origin of schizophrenia. In: Hofling CK, Lewis JM, ed. The family: evaluation and treatment. New York: Brunner/Mazel, 1980.
20. Kernberg O. Borderline conditions and pathological narcissism. New York: Jason Aronson, 1975.
21. Alanen YO. Schizophrenia and the family. Psychiatr Fenn 1978: 15–28.
22. Räkköläinen V, Alanen YO. On the transactionality of defensive processes. Int Rev Psychoanal 1982: 9: 263–271.
23. May PRA. Treatment of schizophrenia. New York: Science House, 1968.
24. Gunderson JG, Frank AF, Katz HM, Vannicelli ML, Frosch JP, Knapp PH. Effects of psychotherapy in schizophrenia: comparative outcome of two forms of treatment. Schizophr Bull 1984: 10: 564–598.
25. Lehtinen K, Räkköläinen V. Community psychiatry as a psychotherapeutic device. IX International Symposium on the Psychotherapy of Schizophrenia, Torino, 1988.
26. Alanen YO, Lehtinen K, Räkköläinen V. Utvecklandet av vården av nya schizofrenipatienter i Finland (Swedish, with English summary). Nord Psykiatr Tidskr 1989: 43: 39–49.
27. Salokangas RKR, Stengård E, Räkköläinen V et al. New schizophrenic patients and their families (Finnish, with English summary). Rep Psychiatr Fenn 1987: 78.
28. Salokangas RKR, Räkköläinen V, Stengård E, Kaljonen A. Treatment and outcome of new schizophrenic patients, a two-year follow-up (Finnish, with English summary). Rep Psychiatr Fenn 1988: 81.
29. Leff J, Kuipers L, Berkowitz R, Eberlein-Vries R, Sturgeon D. A controlled trial of social intervention in the families of schizophrenic patients. Br J Psychiatry 1982: 141: 121–134.
30. Falloon IRH, Boyd JL, Mc Gill CW, Razani J, Moss HB, Gilderman AM. Family management in the prevention of exacerbations of schizophrenia. N Engl J Med 1982: 306: 1437–1440.
31. Anderson CM, Reiss, DJ, Hogarty SE. Schizophrenia and the family. New York: Guilford Press, 1986.
32. Aaltonen J, Alanen YO, Lehtinen K, Räkköläinen V et al. Experiences of family-centred treatment of new schi-

zophrenic patients in Turku (in Finnish). Helsinki: Sairaalaliitto, 1988.
33. KOHUT H. The restoration of the self. New York: International Universities Press, 1977.
34. ALANEN YO. The psychotherapeutic care of schizophrenic patients in a community psychiatric setting. In: LADER MH, ed. Studies of schizophrenia. Br J Psychiatry 1975: Spec Publ No 10.
35. FREUD S. Psycho-analytic notes on an autobiographical account of a case of paranoia (1911). The standard edition, Vol. XII. London: Hogarth Press, 1961.
36. SULLIVAN HS. The psychiatric interview. New York: Norton, 1954.
37. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 3rd edn. Washington, DC: APA, 1980.
38. LANGFELDT G. The prognosis of schizophrenia. Acta Psychiatr Neurol Scand 1956: Suppl 110.
39. ACHTÉ K. On prognosis and rehabilitation in schizophrenic and paranoid psychosis. Acta Psychiatr Scand 1967: Suppl 196.
40. SALOKANGAS RKR, RÄKKÖLÄINEN V, ALANEN YO. Maintenance of grip on life and goals of life: a valuable criterion for evaluating outcome in schizophrenia. Acta Psychiatr Scand 1989: 80: 187–193.
41. UGELSTAD E. Possibilities of organizing psychotherapeutically oriented treatment programs for schizophrenia within sectorized psychiatric service. In: MULLER C, ed. Psychotherapy of schizophrenia. Amsterdam: Excerpta Medica, 1979.
42. TUORI T. Family mapping in acute psychosis (in Finnish). Suomen Lääkäril 1988: 43: 3391–3396.
43. VARTIAINEN A, KALLIOKOSKI M-L, RIIKONEN T, JÄÄSKELÄINEN J. Open care of acute psychosis in a group in cooperation with the family (in Finnish). Suomen Lääkäril 1989: 510–516.