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The need-adapted approach – developing an integrated and individualized psychotherapeutically oriented treatment of schizophrenic patients

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Summary

The need-adapted approach means a broad-based, integrated psychotherapeutically oriented treatment model for schizophrenia, in which the therapeutic activities are planned and carried out flexibly and individually in each case, so that they meet the therapeutic needs of the patients as well as the people making up their personal interactional networks (mostly their families). The approach was developed in Turku, Finland, during the last decades, with the goal that it could be applied more generally to public psychiatric health care. Treatment practices following the basic line of this approach have since been developed and carried out in several centres in Finland and in other Scandinavian countries. In this paper, project results and later developments of this approach are described. According to them, the approach has proven to be successful both with regard to treatment as well as economically. It also increases the humanistic aspect of psychiatry.

Key words: schizophrenia, psychotherapy, need-adapted approach

As we know, the term schizophrenia refers to a rather heterogeneous group of psychotic conditions, with severe psychosis due to extensive and deep-rooted developmental disorders at one extreme and prognostically benign acutely psychotic states at the other. According to my opinion, such heterogeneity is relevant also to differently rated etiological factors and treatment needs among our patients [1, 2].

My presentation deals with *the need-adapted approach*, which is *an integrated treatment approach for new patients of the schizophrenia group in which different treating methods are combined with each other so as to meet the therapeutic needs of individual patients* as well as the people making their personal interactional networks, mostly their families. This approach was first developed gradually by me and my colleagues in Turku, Finland beginning in the 1970's [1, 3, 4, 5, 6, 7, 8]. The overall goal of our project was to *develop a treatment of schizophrenic psychoses that is predominantly psychotherapeutic and can also be applied more generally to the public psychiatric health care*. We had an access to study all first-admitted patients from the schizophrenia

group in the Turku Health District – even if all of them were not treated by us – and we decided to direct our strivings to cohorts composed of these patients.

Since then, different projects following the basic characteristics of the model and developing it further have been carried out in Finland in other Scandinavian countries, including its tentative application in a larger community psychiatric context connected with *the Finnish National Schizophrenia Project* during the 1980's [9, 10], the family-oriented *Western Lapland project* [11, 12, 13], and *the API- (Acute Psychosis Integrated treatment-) project* carried out in 6 psychiatric catchments areas in Finland [14] in the 1990's, and *the Parachute project* comprising 17 centres just now going on in Sweden [15, 16]. I have met an increasing interest in our approach also in many Central and Southern European countries, such as Germany, Austria, Spain and Italy. I am, of course, very glad and proud of the fact that my book has also been published as a Polish edition.

The treatment should be broadly-based

According to our comprehension, *the psychotherapeutic treatment of schizophrenic patients should have a broad basis*. This appears already from the list of the goals we specified in the beginning of our Turku project. They can be seen in Table 1.

Table 1. **The Turku schizophrenia project: goals**

- a psychotherapeutic basic attitude
- development of hospital wards into psychotherapeutic communities
- development of individual therapeutic relationships
- development of family therapies and other family-centred work
- pharmacotherapy regarded as a mode of treatment supporting psychosocial therapies
- establishment of comprehensive training and supervision activities to support active participation of all professional groups in the therapeutic work
- development of rehabilitative activities
- follow-up studies of cohorts including all first-admitted schizophrenia group patients from the catchments area

With regard to developmental goals, the ward communities and individual psychotherapeutic relationships were in the foreground during the first phase, even if family therapy was also put in practice when this seemed to be indicated [3]. Here, I will especially emphasize *the encouragement of all professional groups* to an active participation in the therapeutic work. This was necessary both for the increase of our therapeutic resources and for a comprehensive development of the wards to *psychotherapeutic communities*, serving as the basis of a common approach to understand and treat the individual patients and their problems (that is what I mean with *"psychotherapeutic basic attitude"* in my Table 1). The atmosphere of wards should be unauthoritarian, inspiring and appreciating the capacities of individual staff members. For the nursing staff, such an atmosphere is much more rewarding than the customary hierarchical way of working. Beginning with personal nurse-relationships and with the aid of on-

the-job training and personal supervision many of our nurses became gradually able to develop longer psychotherapeutic contacts with their patients, often with a very considerable help to their patients [3, 17].

Establishment of Therapy Meetings and Increase of Other Family-centred Activities

A very significant change of our activities was brought about in the beginning of the 1980's, stimulated by the establishment of an ordinary three-year family therapy training, multi-professional and systemically oriented. Some younger colleagues of mine began, as a team, *to begin the treatment* of *newly admitted patients arranging joint meetings with them and their family members* - or, in some cases, with other persons close to them, e.g. friends of adolescents moved to Turku because of their studies [18, 19].

In my book *Schizophrenia – Its Origins and Need-Adapted Treatment* [1] - published in Polish (2001), I summarized *the functions of these meetings*, soon called by us *therapy meetings*, dividing them into three main parts: *informative, diagnostic, and therapeutic*. When meeting the patient and his/her family members in vivo, we are able much better to get a good view and understanding of the interactional family dynamics than through separate contacts with family members. We are thus able to better diagnose the therapeutic needs relevant to individual cases; e.g., whether there is an urgent need of family centred treatment or should the emphasis be from the beginning placed in individual therapy of the patient. Besides our patients, we can support also their families and other significant others. Depending on case-specific circumstances we can also list other factors increasing the therapeutic significance of these meetings, among them a lessening of the experiences of rejection felt by the patient admitted to hospital and his/her stigmatisation as someone ill, as well as the possibility to observe directly and deal with the reactions of the patient and family members to the admission to hospital and the paranoid attitudes that may be involved.

The positive effects of these meetings were clearly noticeable in *the five-year follow-up investigation made by Klaus Lehtinen*, one of the initiators of therapy meetings, comparing the outcome of the cohort of new schizophrenia group patients from the Turku area treated in the new family-centred way with that of an earlier cohort treated predominantly with an individual psychotherapeutic orientation [7] (Table 2).

Patients with the diagnoses of schizophrenic disorder, schizophreniform disorder

Table 2. **Comparison of clinical and social follow-up findings of first-admission schizophrenic patients diagnosed according to DSM-IIIR, [6, 7]**

Cohort		Outcome variables		
Year of admission	Size of sample	Percent without psychotic symptoms	Percent able fully to work	Hospital days per person during 5 years
1976-77 (10 mos)	56	38	30	272
1983-84 (12 mos)	30	61	57	132

and schizoaffective disorder are included. The percentages are calculated for the patients who attended the follow-up examination (53 in the earlier, 28 in the later cohort). There were 2 suicides in the earlier, 1 on the later cohort.

The difference between the follow-up results is impressive. It was statistically significant (p= 0.03) also in the light of the four-dimensional Strauss-Carpenter Scale (in-patient care, social contacts, working, symptoms). Many patients – especially those with acute onset of their psychosis – recovered very quickly from their regressive state, the need for hospital treatment was greatly reduced, and, according to the follow-up study, less patients than earlier were left in a continuously psychotic state.

It is important to note that even if this comparison between two cohorts of first-admitted patients from the same catchment area reflects the effects of the development of our approach, it should *not* be interpreted as a comparison between family-oriented treatment and individual therapy. Psychodynamic individual therapies of longer duration were carried out with many patients in the new cohort, too, in cases in which it was regarded as indicated and possible to put in practice (even if the number of such patients was slightly decreased – from about 30% of the first cohort to about 20% of the latter). The difference arose from the establishment of therapy meetings and the impetus given by them also to other family- and system-centred activities. The treatment of patients in the new cohort was also notably more uniform than in the earlier because it was possible for us to extend the family-centred initial meetings to a great majority of new patients in the catchment area (among them were those treated outside of our hospital), which was not true with regard to the individual therapeutic relationships.

According to Lehtinen's study, especially the outcome of schizophreniform psychoses and paranoid schizophrenias was better in the later cohort than in the earlier, while there was no difference as regards the "disorganized" (mostly hebephrenic) patients – even if family therapy is very important also with them. The family-centred meetings appeared to facilitate the endeavours to get also paranoid patients with no insight to their illness into the sphere of psychotherapeutically oriented practices. One may add that also with regard to schizophrenic patients with a tendency to acting-out behaviour as well as to alcohol or drug addictions (more common nowadays) a family- and environment-centred line of treatment is usually better indicated than individual psychotherapy.

During *The Finnish National Schizophrenia Project*, led by myself during the 1980's, the family-centred therapy meetings became the most popular part of our recommendations for the treatment of new psychotic patients (about our treatment model, cf. [9]). It became also clear that the willingness – and need – of family members to participate in the initial common meetings is high – in Turku it was 87%, and also in a multi-centre project included in the National Schizophrenia project, 70%, despite the often long distances between home and the hospital. In a large part of the country, so-called *acute psychosis teams,* multi-professional and responsible for the planning and initiating the treatment of new and recurrent psychotic patients (often also other acute crisis situations), were established [10].

The Principles and Practice of the Need-adapted Treatment

In the following, I will first describe *the general principles characterizing the integrated need-adapted treatment* arrived at the later phase of the Turku project and, after that, innovative developments arrived at in some of later projects.

We defined the principles in terms of *five maxims* [1, 4, 6, 7]. (Table 3).

Table 3. **Principles of need-adapted treatment**

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 (most often, the family)
2. Examination and treatment are dominated by a psychotherapeutic attitude
3. The different therapeutic activities should supplement each other instead of an either/or approach
4. The treatment should attain and maintain the quality of a continuing process
5. Follow-up is important both at the level of individual patients and at a more global level, directed to the development of treating units and the treatment system as a whole.

1) 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 of the persons in their interactional networks (most often, the family). *The family-centred approach* is indicated in order to alleviate the strains that the outbreak of the psychosis and a continued psychotic behaviour are likely to arouse in the family members, and because the outcome of schizophrenic psychoses is especially dependent on the attitudes of family members and/or other people close to the patients. While beginning the treatment by means of intensive therapy meetings together with the therapeutic team, patients and their family members (sometimes other persons close to patients) we can get better acquainted with the psychodynamic family situation and, through this, also the individual therapeutic needs of patient.

2) Examination and treatment are dominated by a psychotherapeutic attitude. This refers to an attempt to understand what has happened and is happening to patients and the people in their interpersonal network and how we can use this understanding as a basis for approaching and helping them. An attitude of this kind essentially also involves observation of one's own emotional reactions.

3) The different therapeutic activities should complement each other rather than constitute an 'either/or approach'.

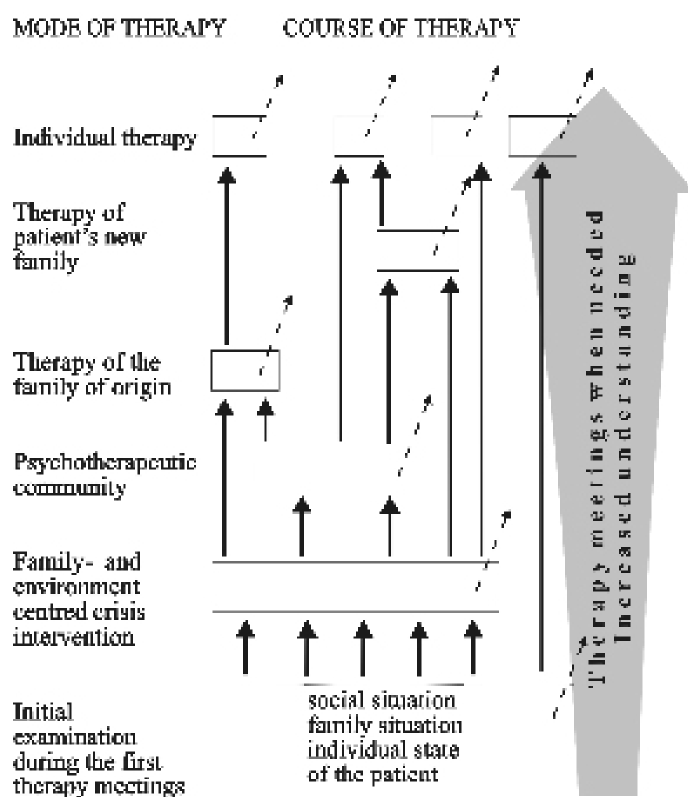
4) The treatment should attain and maintain the quality of a continuing process.

5) Follow-up is important with regard to both individual patients and the treating units and the treatment system as a whole.

We also produced the *enclosed diagram to represent the usual relative weighting of the psychotherapeutically oriented modes of treatment* applied during the course of integrated need-adapted treatment of schizophrenic psychoses, as well as other functional psychoses included in the schizophrenia spectrum (esp. paranoid psychoses and acute psychotic disorders). (Figure 1).

This figure should not be interpreted too literally: need adaptation may in many

Figure 1. **The treatment process and different modes of therapy [5]**



cases require therapeutic decisions differing from those in the diagram. I will also emphasize that while describing psychotherapeutic activities, a kind of ideal picture of our orientation may be presented in the figure, a goal rather than achieved reality. With many patients, we have to be content with mostly supportive family and/or individual therapeutic relationships combined with rehabilitative measures, important also for many more intensively treated schizophrenic patients.

The bottom of the diagram represents the starting-point, the first therapy meetings and establishment of the individual contact with the patient. At the same time, the social situation of the patient is separately studied and the indicated rehabilitative measures - such as social interaction practise, vocational guidance, and assistance in finding jobs-planned.

It should be emphasized that the therapy meetings are usually repeated frequently – often daily - in the first phase of the treatment and often also used later, especially during crisis periods or shifts of the treatment from one unit to another. If the family is not reached, the team often is working in this way with the patient alone.

The black vertical arrows in Figure 1 tell us how *the focus of treatment subse-*

quently shifts, differently for different patients, from one mode of the treatment to another, while the broken diagonal arrows indicate that the termination of treatment is possible at all stages. It is essential to note that the arrows always display the main emphasis of the prevailing activities, that is, *the primary therapeutic concern*, and that this does not exclude other treatment modes which may be used at the same time. It is quite common that a patient has an individual relationship along with attending family therapy – in the psychotherapeutic communities this is the rule – but the focus of the treatment process may first lie in family therapy and only move to individual therapy later on. As shown in the diagram, *it is usually expedient to proceed from less specific family- and environment-oriented modes to more specific individual-focused ones*, but the observation of the therapeutic needs may bring about changes of this rule.

A shift from family-centred meetings to *ordinary family therapy* happens in many cases, even if the use of this name is not always preferred. This is often indicated with severely ill young patients whose contacts outside of the home are quite limited, and whose differentiation from parents is inadequate. Another group with an urgent need of family-centred treatment are patients who have established a family or couple relationship. We had rather positive experiences of couple therapy with married patients, even if the results were usually much dependent on the attitudes of the spouses. If the patient has children, it is necessary to examine their mental development as well as family dynamic roles and to arrange the therapeutic support needed.

Individual therapy right from the beginning (cf. the right side of the Figure 1) is best suited to patients whose personality is more differentiated than that of the average schizophrenic. Most of these patients have also moved out of their primary families – although concrete separation as such cannot be considered an indicator of a successful psychological separation-individuation stage. I would like to emphasize especially that in many cases *a preceding family therapy may significantly increase the preconditions for the patient's successful individual therapy*, both by preparing ground for the growing individuation of the patient through loosening the mutual intra-familial symbiotic ties or simply because the confidence of the parents in the treatment system, including the individual psychotherapist, has increased following their initial participation. I still don't think that a systemic family therapy would provide to us a similar possibility for the development of the patient's personality structure as an intensive individual psychotherapy when successful; at least this should be regarded as exceptional. However, often there may, through family therapy, come into being a kind of "new beginning" [20], allowing for the patient a better chance for a continuation of his/her stagnated psychological development, sometimes crucial especially for the fate of young people fallen ill with acute psychoses.

Group therapy is not included in Figure 1, even if we know that it is a very important mode of therapy especially with regard to the treatment and rehabilitation of chronic patients. We have not practised ordinary group therapy in our psychotherapeutic community. Different kind of *group activities,* on the other hand, became more and more important in the course if time. We have daily morning meetings shared by the patients and the staff, various common activities and excursions, and I also changed my doctor's bed rounds to meetings in which groups of patients and staff members

are sitting together in a more informal discussion including some group process characteristics.

Continuity of therapeutic relationships is very important with schizophrenic patients whose dependency on the therapist may often grow to be exceptionally great. This often brings about problems because shifts of therapists cannot always be avoided. *A sectored community psychiatric system* has to be recommended as a significant prerequisite for a well functioning need-adapted treatment approach, because then the continuity of therapeutic relationships can more often be preserved when a patient is proceeding from hospital treatment to the open care, or the other way around. Another advantage of the sectored model - even more essential – is that the proximity of the services to the users makes it easier to arrange locally family- and milieu-oriented activities and may also improve the flexibility and mobility of the treatment system.

Later Developments of the Need-Adapted Treatment Model

I will here deal with successive matters and/or problems rather than proceed from one study or project to another.

With regard to the general development of our orientation, an increased flexibility of the activities was especially emphasized in connection with the Finnish API- (Acute Psychoses Integrated Treatment-) project. *Two further principles* were added by Aaltonen et al. [21] to the five earlier ones:

6) Emphasis on horizontal expertise, which seeks continuously to cross the professional boundaries and the barriers between different sectors of expertise.

7) Deritualization of the treatment and using the open dialogue: The expertise of all staff members is best utilized in a setting in which the rituals are at minimum and the patients have large freedom of choice concerning their treatment. This can sometimes be best achieved in a treatment process wholly conducted at the patient's home.

Endeavours to liberate oneself from the traditional barriers of psychiatric treatment were clearly increased during the later project work. Already in the first part of 1980's, a psychosis team was established in Turku with the purpose to meet patients recommended for hospital treatment and meet up with their family members, even before their registration to the ward. With continued therapy meetings, about 30% of these patients could be treated outside of the hospital, in their homes [22]. In many centres participating in Cullberg's Swedish "Parachute project" [15], *small crisis homes*, with 3-6 first episode patients, were established, with the result that, according to follow-up findings, the utilization of traditional in-patient care was diminished as well as a better functional outcome of the patients found in these centres. (As pointed out by Aderhold and Greve [23] in their excellent German review of the need-adapted model, the Soteria model [24, 25, 26] can be naturally integrated with this treatment orientation. In Finland our experiences with this model are rare until now; I hope that they will increase in the future.)

There are plenty of studies confirming *the significance of early beginning of the*

treatment to the outcome of schizophrenic patients [27, 28]. Psychotic symptoms have, according to psychoanalytic concepts confirmed by my experience, a defensive psychological goal in the meaning of finding psychodynamically "the best possible solution" [29] at the regressed level of ego functions. In the course of time they often become chronic and consolidate with the result that it becomes more and more difficult to give them up. Early intervention is very important with these patients. Viljo Räkköläinen [30], a close friend and co-worker of mine, has compared a young person's falling ill with schizophrenic psychosis to an acute leukaemia: both form an utmost threat to his or her course of life and should be encountered with equal intensity.

According to a follow-up study of the Finnish National Project [10] *acute psychosis teams,* recommended by us to carry out the initial examination of psychotic patients as well as the planning and integration of their family- and milieu-oriented treatment, were in 1992 working in about 50 per cent of the Finnish Mental Health Districts. Their "home base" is usually in open care centres but a good mobility should be provided for them, including a growing amount of home visits and a close contact with hospital wards. It was regularly reported that after their establishment, it was possible to obtain treatment more quickly than previously, the number of hospital admissions decreased, and cooperation with families increased. In connection with the heavy economic depression in the first half of the 1990's, this development was endangered because our community psychiatric resources were even unreasonably diminished. Still, psychosis teams continue functioning in various centres and there has been several studies confirming their clinical and also economic advantages [5, 11, 31, 32, 33, 34].

Continuity of treatment still forms a problem not removed with the establishment of the teams; because of the steady flow of new patients their resources for continued treatment of patients were insufficient. Because of this, in some districts a shift from one greater team to several working pairs or teams with a longer responsibility for treatment has been organized. A small Northern Finnish district had a pioneer position in this development. Here, a three-year family therapeutic training programme for practically all the staff members representing different professional categories was realized, followed with individual therapeutic training for about a third of them - *The Western Lapland project*; [5, 11, 12]. *In my opinion, these kinds of activities should have a key position in the community psychiatric treatment of new and recurrent psychoses included in the schizophrenia group.* However, they should not exclude the development of other, more long-term psychotherapeutic practices.

Especially interesting among the new developments is the *narrative approach* developed by Holma and Aaltonen [32, 33] and emphasizing that even in an acute psychotic state there exists an active search for the causes of this experience – a point of view, I think, which serves as a very welcome counterbalance to a one-sided emphasis of the patient's psychological regression. An important aim of early family-centred interventions is to construct narratives of what happened, in dialogue with the patient and his/her social surroundings. The narratives only attain a personal meaning when re-authored by the patient. This should be done before the patient's experience acquires meaning through "stories" where meanings are already determined, e.g., by reductive bio-psychiatric explanations of the illness. Then, the personal meanings remain un-

narrated and uninformed, leaving the individual in a kind of vicious circle.

There are now many projects aiming *at prevention of the onset of schizophrenic psychoses through early identification and intervention* among patients admitted to psychiatric treatment units. Positive results have been reported by several of them [35, 36, 37]. The experiences of the family-centred Western Lapland project pointed to a clear decrease of the annual incidence of schizophrenia group psychoses (DSM III-R) in the catchment area, corresponding to the establishment of the comprehensive family and social network-centred system of treatment.

However, it is important to point out that there are also dangers to be avoided in the preventive activities. Ethical discussions on these concern the so-called "false positive" risk assignments, stigmatisation, informed consent and acceptability of treatment procedures [38]. For my part, I would like to especially warn about early and inconsiderate use of neuroleptic drugs which may especially stigmatise youngsters and even – especially in higher doses - lead to harmful side-effects. An empathic approach is explicitly needed here.

Family and Individual Therapies: On their Integration and Indications

I have already talked about the indications of *family therapy*. This mode of treatment is very suitable to be carried out in community psychiatric units, compared with long-term individual therapies. In Finland, the most usual mode of doing family therapy is basically *systemic-strategic oriented and carried out as a team work*, which, besides its obvious advantage of enlarging the observation sphere also makes the therapy both safer and more pleasant than working alone. However, we also consider that it is very important to *maintain our psychodynamic viewpoint*, e.g., emphasizing the importance to clarify the influences of three-generation dynamics, i.e., the relationships of the parents with their parents and the transmission of the problems from one generation to other.

Especially in the U.S.A. the practice of family therapy in schizophrenia has suffered because of accusations that family therapists are blaming the parents of their offspring's disease. Such accusations have had their causes but are very unfortunate because the family therapy of schizophrenia was established to help both, the patients and the parents, the whole family. The newer systemic paradigm should remedy this matter by emphasizing that *all intra-familial interactions are two-way processes*: we now understand better than earlier on, that not only are the parents influencing the development of their children, but that also the children, with their innate inclinations, are influencing their parents. From the systemic point of view, *both* the innate qualities of the child *and* those of the parents are perpetually influencing the relationships and roles established amidst the family circles. As family therapists we have to follow Stierlin's et al. [39] excellent concept of *Allparteilichkeit* ("taking everybody's part"): we must be able to create an atmosphere in which everybody in the family has the basic experience to be understood.

I will also lay stress on the significance of *patients' as well as relatives' associations*, the activities of which have greatly strengthened in Finland and other Northern

European countries during the late decades. For family therapy and other family-centred work, good and collaborative relationships between the therapeutic organizations and relatives' associations form a necessary precondition.

According to my opinion, the principles of *psychoeducational family therapy* are best suited for long-term patients. With acute patients this approach has often the disadvantage to be connected with the one-sided neurobiological concept of schizophrenia. This is also declared to the patient and the family members, emphasizing the chronic nature of the illness and the need for a continuous medication. However, there are in Finland also centres trying to connect psychoeducational points of view with systemic-psychodynamic family therapy.

Working in the frames of community psychiatry, the intensity and depth of *individual psychotherapies* becomes necessarily varied, including both supportive relationships with rare frequency to more intensive, psychoanalytically oriented psychotherapies. Because of limited resources – even if strengthened by buying services of outside psychotherapists – there is a special need to deliberate on *the indications of intensive individual therapies.* Our experiences confirm that the preconditions for a successful psychodynamic individual therapy are best when 1) the patient's disorder does not belong in the most serious clinical category as regards both the depth and duration of the symptoms and the ability to relate, and 2) insightful motivation for long-term work is being or has been aroused in both the patient and the therapist. One should add that a necessary recondition for beginning an intensive individual therapy is also that the prerequisites for sufficient continuity of the therapeutic relationship exist.

However, certain flexibility with regard to indications should remain. It often happens, e.g., that the patient's insight into his state and his motivation for studying the reasons of his illness may only develop during the stay on the ward. Benedetti [40] and Volkan [41] have emphasized subjective factors, such as the mutual "fit" between the therapist and the patient. In our psychotherapeutic community we emphasized the importance of spontaneous contacts when selecting "personal nurses" for our patients. In psychosis psychotherapy, mutual contact and a positive transference-countertransference relationship have a very basic importance for the introjective processes essential for the growth of the patient's personality.

In community psychiatry, t*he frequency of visits* in psychoanalytically oriented psychotherapies with these patients is not as great as in the ordinary psychoanalysis. Except for the initial contact phase in the ward community, the amount of therapy hours is usually two visits weekly. According to my view, this frequency – which could be increased during crisis phases – is often better than a greater frequency. The therapy with a psychotic patient is often a strongly emotional experience both for the patient and for the therapist, through the feelings brought up by the transference and counterfransference processes. A heightened but still ambivalent transference as a result of very intensive relationship may be more difficult to control in both the patient and the therapist, and especially the patient's separation anxiety connected with the therapist's vacations heightened. I will here refer to the excellent book by Murray Jackson, *Weathering the Storms; Psychotherapy for Psychosis* [42], in which surpris-

ingly good results are described in therapies with this – and even lower - frequency, supported by proficient supervision.

Cullberg has laid emphasis on positive experiences of combining points derived from *cognitive psychotherapy* with a psychodynamic approach [43]. I myself have had positive experiences of considerate use of *interpretations upward* – translations of patient's psychotic expressions to more normal language in an atmosphere based on mutual understanding – which are related to cognitive methods.

Psychotherapy training programmes

In the Turku Clinic, we began stimulating psychotherapeutic activities of staff members by enlarging *on-the-job training and supervision programmes*. Later, ordinary *multi-professional psychotherapy training programme* were developed in our country. They are divided into two levels: a special level and an advanced special level, of which the former requires 2½ - 3 years and the latter in its entirety 5 - 6 years of training, along with regular work. Participation in training programmes is often economically supported by local health care officials, especially with regard to the three-year individual and family training programmes, often participated also by nurses. During the last two decades the training activities increased notably. They are provided by the Centres for Extension Studies of the universities, on the one hand, and private associations on the other.

Since 1988, we have an advanced special level training in family therapy, multi-professional (psychiatrists, psychologists, social workers, nurses specialised in psychiatry), systemically oriented and with psychotic disorders as one of its target areas. Initiated by the Centre for Extensive Studies of the University of Turku, we are now also organising advanced special training in psychodynamic individual therapy of severely ill patients (with borderline and psychotic level disorders), to close the gap in systematic training for the partial treatment of these patients. Even this training is open to professional groups mentioned earlier [44].

Comments on Neuroleptic Treatment. Results of the API-Study and the Parachute Project

What about the use of *neuroleptic drug treatment*, by far the dominant method in the treatment of schizophrenia? While summarizing our model, we specified our goal to be "to find the minimal dosage required to keep the patient's ability for contact and communication optimal in the situation" [9]. During the psychotherapeutic treatment, the need for drugs usually clearly diminishes (cf. the Inter-Scandinavian Nordic NIPS project; [45]).

The results of the Finnish API-project referred to earlier [14] were especially interesting. It was participated by six centres with long-term experience of the need-adapted approach. The subjects in this project consisted of consecutive first-admitted patients with non-affective psychoses in the years 1992-93. Following the pioneer project led by Viljo Räkköläinen in Kupittaa hospital in Turku [5, 31], three of the

centres (experimental) implemented *a scheme of minimal neuroleptic use*, including an initial three-week neuroleptic-free period and the control of patient's anxiety, when needed, with benzodiazepines (lorazepine) for shorter periods. The other three centres (control) used neuroleptics as usual (which, in the connection of the need-adapted approach, still means a considerable lower dosage than in the common practice nowadays). According to a two-year follow-up (Table 4) 43% of the experimental group patients had not received neuroleptics *at all* during the whole two-year period while the corresponding proportion in the control group was 6%. The clinical situation of the patients from the project (n = 135) was relatively good (52 % of the patients without psychotic symptoms) and the outcome was even somewhat better in the experimental group (58 %) than in the control group (41 %).

Table 4. **Two-year follow-up results of the API-project [14]**

(With maintenance of grip on life is meant that the patient has not lost his/her effort to attain life goals considered as normal for human beings).

As their conclusion, the leaders of this project state that the routine use of neuro-

Outcome criteria	Experim. group %	Control group %	In total %	X	P
Less than 2 weeks in hospital during 2 years	51	30	42	6.40	0.01
No psychotic symptoms during last year	58	41	52	2.92	0.09
Employed at the time of the follow-up	33	31	32	0.05	0.83
GAS score 7 or more	49	25	40	5.51	0.02
Maintenance of grip on life	66	55	62	1.11	0.29

leptics in the treatment of patients diagnosed with first episode of schizophrenia-type psychosis seems *not* to be as essential as has been usually considered. However, a necessary precondition of this is a vigorously developed and comprehensive psychotherapeutic approach. In the treatment of new patients, intensive efforts to build positive contacts with the patient and the people close to him should be more important than an immediate beginning of drug treatment

A continuing neuroleptic-free treatment is best suited to acute schizophreniform psychoses and may then prevent the danger of an unnecessary and perhaps stigmatising use of this medication. However, there is reason to remember that for long-term patients a maintenance medication with low or moderate neuroleptic doses is usually in order and that an abrupt end of a long-lasting medication may cause an accelera-

tion of psychotic symptoms. The most important matter to be emphasized here is that great doses of neuroleptics should be avoided and the dosage cautiously diminished corresponding to the recovering course of the patient. According to positrone emission tomographic (PET) investigations made in Sweden already during the 1980's even very moderate doses of neuroleptics were enough to achieve a 65-75% blocking of dopamine transmission in the brain [46]. It is good practice is to discuss medication with the patient and listen to his own opinions of it.

In Table 5, *preconditions for the establishment of a well functioning need-adapted orientation* within the community psychiatry are presented. (Table 5.)

Table 5. **Preconditions for the establishment of need-adapted orientation**

- Committed leadership, support from administrative officials
- Non-authoritative, inspiring and supportive working atmosphere
- Catchment area (sectored) model recommended
- Good cooperation with basic health system and social welfare activities
- Sufficient qualitative and qualitative resources
- Qualitative resources:
- Psychosis teams
- Rehabilitation teams
- Hospital wards developed to psychotherapeutic communities
- Development of on-the job training and supervision activities
- Stepwise rehabilitation system established
- Possibilities for psychotherapy training promoted
- Follow-up of the activities and their results (both with regard to individual patients, to different treatment and rehabilitation centres and to the organization as a whole)

Conclusions

I will end my presentation with a short summary of the experiences of the need adapted approach, as defined by our group (Alanen, Aaltonen, K. Lehtinen and Räkköläinen):

1) It is both possible and recommendable to integrate different treatment modes flexibly with each other in the treatment of the schizophrenia group psychoses. This is noteworthy especially with regard to individualized use of psychotherapeutic treatment modes based on systemic principles, on the one hand, and psychodynamically oriented on the other which have seen to be complementary to each other.
2) It can be carried out in different community psychiatric treatment environments.
3) It has proven to be successful with regard to treatment results as well as economically.
4) The approach enables the treatment of acute psychoses with small neuroleptic dosages and in some cases even without neuroleptics.

5) It diminishes the need for hospital treatment.
6) It diminishes chronicity.
7) It allows observing interactional and social networks of the patients, supports their members and aspires to enliven them.
8) It increases the humanistic aspect of psychiatry.

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