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The Shared Image Guiding the Treatment Process
A Precondition for Integration of the Treatment of Schizophrenia

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The aim of the study reported here was to develop psychotherapeutic in-patient treatment for acute schizophrenia, following the principles of a need-adapted approach. To improve the integration of experiences which hospital staff have with acutely psychotic patients and their families, systematic supervision sessions were organised. In these sessions, it was possible to achieve shared psychological images through which the whole staff could integrate patients' behaviour and symptoms, both symbolic and non-symbolic. Such an image was called 'the shared image guiding the treatment process' (SIGTP). The process of achieving the SIGTP was interpreted through Peircean semiotics, especially the concepts of indexical, iconic, and symbolical signs. An SIGTP was considered to have been achieved in the early phase of the supervision process in 32 of the 54 cases. For the patients, SIGTP and the need-adaptation connected with it meant achieving a more realistic and more functional ordering of their experiences.

The integrated approach to the hospital treatment of schizophrenic patients and their families presented here is based on developments that have been pursued for over two decades in Turku, Finland (Alanen *et al*, 1986, 1991; Räkköläinen *et al*, 1991). The goal has been to develop comprehensive, psychotherapeutically orientated, family-centred treatment specifically for acute schizophrenia. It has been concluded that the treatment of schizophrenia must always be planned individually and on case-specific premises. These studies have indicated that because of the heterogeneous nature of the schizophrenic psychoses, not all schizophrenic patients need to be treated with the same psychotherapeutic method. This approach has been called 'need-adapted treatment' of schizophrenia (Alanen *et al*, 1991).

The main principles of the need-adapted approach are (a) therapeutic activities are planned and carried out flexibly and individually in each case, so that they meet the real and changing needs of patients and their family members; (b) examination and treatment are characterised by a psychotherapeutic attitude; (c) the different therapeutic activities support and do not impair each other; and (d) the process quality of therapy is clearly perceived. For both diagnostic and therapeutic reasons, family-centred initiation of the treatment is particularly emphasised.

Our project, for its part, is a continuation of the innovative approach established by the national developmental programme for the study, treatment, and rehabilitation of schizophrenic patients (National Finnish Schizophrenia Project) that was carried out in Finland in the years 1981–1987. The goal of this project was to reduce the number of institutionalised schizophrenic patients, and it resulted in several recommendations for the development of a model for the treatment of new schizophrenic patients and their families. One of these recommendations was that special psychosis teams should be established in mental health districts. In their introduction to the treatment model, Alanen *et al* (1990) stated:

> "It is difficult to transcend the image of reality created by one's observation. The more fully we are committed to what we are doing, the more difficult it is to think differently. Even so, our own reality is only a partial one. Observations made from different points of view are necessary to ensure the success of the work. . . . The central goal of this model of treatment is to try to combine, in the best possible way, the different orientations and their therapeutic methods in the treatment of an individual patient."

Emerging from this community-psychiatric background, the main theme of our project has been a multi-level effort towards integration of therapeutic efforts in the hospital treatment of schizophrenic patients. This has happened through the development of psychotherapeutically orientated in-patient treatment for acute schizophrenia, using the kind of systematic supervision that fulfils the principles of need-adapted treatment.

Under the title "The image guiding the family-centred treatment process", this study was carried out at Kupittaa Hospital (the municipal psychiatric hospital of the City of Turku) during 1986–1991. It was based on records of conjoint supervision sessions with the members of the ward staff, and on the

records of a sample of 54 acutely psychotic patients treated in the closed ward for acute psychotics. The ward has 35 beds and about 25 patients in intensive out-patient care. The staffing ratio is 1.3 : 1 for the in-patients, but only 0.8 : 1 if the out-patients are included. The supervisor is the first author of this paper, the second author being the medical director of the hospital. The selection of patients for supervision was made by the staff as a whole, the criterion for selection being that the treatment of each case was considered to have reached a situation of deadlock.

Rationale for a shared image in the hospital ward

The shared image guiding the treatment process (SIGTP; Aaltonen, 1991; Aaltonen & Räkköläinen, 1989, 1993) is created in the conjoint supervision sessions with the ward staff, who are multi-professional. It has been emphasised that all staff who have psychotherapeutic or other contacts with the patient (including nursing aides) can participate in the sessions. The rationale for this arrangement has been the following.

First, hospital life contains many different modes of lived experiences that the staff have with the acutely schizophrenic patients and their families.

Secondly, psychotherapeutic methods based only on the symbolic understanding and interpretation of patients' symptoms are too narrow to reach most of these lived experiences, especially the most concrete ones.

Thirdly, acute psychosis may be seen as a regressive collapse of different modes in generating psychological meaning. Therefore, the emphasis of an integrated approach must achieve a shared psychological image through which the whole staff can integrate both the symbolic and non-symbolic behaviour and symptoms of each patient.

In the hospital treatment of schizophrenic patients, there cannot be any integration of different treatment interventions without shared images of the patient. Much of the difficulty in the treatment of acute schizophrenia often lies in the fact that there is a collapse of the generation of psychological meaning in everyday activities. The shared image guides the psychotherapeutic activities not only in a restricted sense but also – and especially – in the seemingly trivial everyday routines of treatment.

Thus, the shared image is a triadic relationship between the patient's symptoms, their referents (or objects), and the staff's interpreting thoughts. The unity of the integrated treatment is created in a process where the SIGTP, the needs of the patient and his family, and the adaptation to therapeutic needs form the following circle of gradually deepening psychological understanding.

First, the treatment system – the ward staff, with the help of the supervisor – finds a case-specific shared image (SIGTP).

Secondly, within this image, the aims of treatment become need-adapted (i.e. connected with the therapeutic needs arising from the patient's present situation).

Thirdly, the treatment system adapts itself to this image, and resolves both far-reaching goals (e.g. a rehabilitation plan) and partial and immediate ones (e.g. indications for medication) through this adaptation. In this way, the treatment system changes its own structure, in order to remain optimally adapted to the patient's needs.

Supervision process for achieving the shared image

In the hospital treatment of schizophrenia, the professional supervising the staff is important as a collector of knowledge of the direct everyday experiences that different members have had with the patient and his relatives. These experiences can generally be defined as the ways in which the patient's actions have compelled the staff members to think and act. The supervisor waits for the description of these experiences to evolve in his/her mind, or in the staff members' minds, into a shared core image. The experiences are different from each other, but because they are experienced in the same daily activities, with the same patient's basic conscious, pre-conscious, and unconscious dynamics, they must also have some shared basis. In the supervision sessions, the emphasis is on trying to see whether the different images that emerged from the experiences with the patient have similar qualities, both to each other and to the patient's dynamics (i.e. they are 'iconic signs'; see later). The images can therefore be brought together with each other.

As a first step the supervisor asks the staff to report anything about the patient that they have brought to the session. Invariably someone starts reciting the patient's medical history from the records. But regularly, almost inconspicuously, small everyday incidents – especially those where new feelings about the patient have emerged – are related, drawn from the flow of the patient's actual life in the ward. Little by little, in the supervisor's mind, a dynamic picture of some basic configuration is emerging. He/she describes this image to the staff; if this touches on their pre-conscious experiences of the patient, it triggers a feeling of familiarity or

similarity in several members. From then on, they are able to contribute both minor and major incidents which give support to the basic observation: "It just did not occur to me before."

The image is not an abstract description of the patient's psychodynamics, in psychological or theoretical language; at best, it is a new shared experience expressed in everyday language. The supervisor encourages the group in this kind of discussion about their experiences, and elaborates these into more psychologically orientated observations and hypotheses.

The shared image which the ward staff discover is an inseparable element of attempts to integrate the patient's collapsed levels and modes of experience. The shared image is also felt as providing relief, because the patient's psychosis often provokes (as e.g. Stanton & Schwartz (1954) and Kernberg (1976) have described) powerful and confusing anxiety or primitive defensive operations, especially splitting, within the ward staff.

The supervision sessions last 1½ hours, with only one patient under discussion in each, but the staff can bring up the same case for supervision several times.

The method for assessing that the SIGTP was achieved was *saturation of the psychological material*, a method used in qualitative psychological and social research (Strauss, 1988); the final SIGTP was achieved when additional data in the supervision session no longer changed the consensus. The achieved SIGTP was written down in a special SIGTP record in two or three condensed sentences. It was emphasised that the record should be seen and read by the whole staff during the patient's treatment process. During the first supervision session, the SIGTP was achieved in 60% of 54 cases.

The shared image and integration of treatment

The two clinical examples presented in this paper are from the year 1991. The psychotherapeutic model was then being applied openly, and the ward personnel had primary-level training in a psychotherapeutic orientation to the treatment of acute psychosis – both family- and individual-centred. One goal of the treatment process is that the members of the same therapeutic team that starts the treatment with the patient and the family will continue even in outpatient care.

The role and usefulness of the SIGTP becomes even more important if the patient is staying in the ward for a considerable time; several psychotherapeutic interventions of different kinds may then be attempted, so that integration often becomes the vital issue. In the need-adapted approach, this refers to the integration of treatment given in different places, the different modes of treatment, and the psychological content of these treatment interventions.

In our approach, psychotherapeutic and other methods (e.g. pharmacotherapy) are not polarised. Family therapy, for example, may be associated with simultaneous individual-centred treatment: the patient's therapeutic team may have individual therapy meetings with the patient – perhaps weekly. The approach can be seen as a modification or combination of individual therapy, group therapy, and family therapy. All the time, there is both actual and potential overlapping between different therapies offered for the patient and family, and there is even overlapping between the definitions of different therapies. The SIGTP is an 'uncontaminated' tool, owned by none and by all of the overlapping and sometimes competing psychotherapeutic approaches.

Case reports

The following clinical material comes from two cases discussed in the supervisory sessions. The examples are highly condensed, and designed to show (a) the concrete nature of the original observations made in the ward; (b) some typical forms of the SIGPT found in the sessions; and (c) the actual application of the SIGPT in clinical practice.

Case 1

It was noticed that a catatonic young man became symptomless when visited by his mother, but was quite the contrary during visits by his father. The parents were divorced and lived apart, but were highly involved through their only child, the patient, who shuttled between them.

The SIGTP was that: "The mother is a neuroleptic to the patient." It was decided in the session that if the patient became severely psychotic and excited and the mother was not available, one of the nurses on duty – one who really was a biological mother – should go to the patient and say: "I am a mother". It worked, and the patient's psychotic confusion disappeared. But there was not always a staff member present who was a mother. When the patient once again turned grossly psychotic, kneeling on the floor and crying in despair, one of the unmarried female nurses (who at that time was already involved in the case in several ways) went to the patient and, feeling helpless but experiencing genuine empathy, explained: "I am *not* a mother, but I am here because no mother is here at the moment." The patient then calmed down. Later, a genuine and clearly important, long-term therapeutic relationship developed between them.

Case 2

A boy of 17, living with his mother and sharing a bedroom with her, was admitted in an acute and typically

pre-psychotic state with grave disturbances of identity and openly incestuous wishes towards his mother. The boy had lived most of his life with his maternal grandmother, who had died six months before; after her death, he moved to live with his mother. His unmarried parents had lived together until the mother's pregnancy, when the father had moved to live with his own grandmother, near the mother's house.

It soon became apparent to everybody involved that the death of the mother's mother was an important trigger of the patient's psychosis. In this case, the experience of the psychological certainty of the trigger became the shared image, but the therapeutic problem was how could this shared image be used? The patient regressed deeply within the next few days. He urinated and fainted in a family session, and was sinking into a catatonic state; he ceased even eating and drinking, and had both suicidal thoughts and hallucinations about his dead relatives.

In the course of the supervision, it was concluded – based on the patient's life history – that the main psychodynamic issue was the real lack of an object as an alternative in the patient's Oedipal–incestuous dilemma. The supervisor asked if there were any grandmothers in the staff; there was one, who was a warm and spontaneous nursing aide. It was decided that she should go to the patient, and say: "I am a grandmother." In her casual way, she did as agreed; while offering some food (which was her principal duty in the ward, from the patient's point of view) she spoke about her grandchildren, and the patient tasted the food. He recovered rapidly. Later, in the family sessions, the theme of 'the grandmother's importance to the men of this family' (with a reference to the father's flight to his grandmother) was discussed among others.

Semiotic approach to the shared image

Because acute schizophrenia is seen in this conceptualisation as a collapse of different levels of experiencing, the focus is how to integrate the symbolic, pre-symbolic, and non-symbolic ingredients of the patient's behaviour without neglecting any of the ingredients. This is the rationale for the introduction below to the semiotic interpretation of SIGTP. Semiotics is defined as a scientific study of signs or symptoms. According to Fiske (1982), semiotics has three main areas of study.

> "*1. The sign itself.* This consists of the study of different varieties of signs, of the different ways they have of conveying meaning and the way they relate to the people who use them. For signs are human constructs and can only be understood in terms of the uses people put them to.
>
> *2. The codes or systems into which signs are organized.* This study covers the ways that a variety of codes have developed in order to meet the needs of a society or culture, or to exploit the channels of communication available for their transmission.
>
> *3. The culture within which these codes and signs operate.* This in turn is dependent upon the use of these codes and signs for its own existence and form."

Based on our experience, we suggest that understanding the process of integrating the concrete and symbolic levels of meaning in acute schizophrenia can be described with the help of the concepts developed by C. S. Peirce (1839–1914), the American pioneer of semiotics, and the first main pragmatist. He also developed a theory of the triangular relationship between sign, its user, and the external reality as a necessary means of studying meaning. A psychotic symptom can be seen as a many-faceted sign. In the field of philosophy, his theory has had increasing importance during recent decades, especially in the philosophical analysis of meaning (see e.g. Hookway, 1985).

Peirce's theory of signs also yields a theory of the self as both the object and the subject of semiotic systems. From this viewpoint, as Singer (1980) describes it, the locus, unity, and continuity of the self will be found in the systems of signs that constitute the dialogues between utterers and interpreters of the signs. Peirce (1960) writes:

> "Every sign is determined by its object, either first, by partaking in the character of the object, when I call the sign *Icon*; secondly, by being really and in its individual existence connected with the individual object, when I call the sign *Index*; thirdly, by more or less approximate certainty that it will be interpreted as denoting the object in consequence of a habit . . . when I call the sign a *Symbol*."

An iconic sign resembles its object in some respect; an indexical sign is contiguous with its object or physically related to it; and a symbolic sign stands for its object because it is so interpreted by convention, agreement, or rule. These categories are not separate or distinct. One sign – or psychotic symptom – may be composed of various types. Symbols come into being, Peirce states, by development out of other categories of signs, particularly from icons, or from mixed signs partaking of the nature of both icons and symbols.

Peirce holds that man has an "out-reaching identity". Here Peirce's theory – as Percy (1972) and Lincourt & Olczak (1974) have shown – has similarities with Sullivan's interpersonal theory of schizophrenia, and his three modes of experience: (a) the prototaxic experience occurring before symbols; (b) parataxic experience characterised by private symbols; and (c) syntaxic experience conceptualised in symbols which are defined alike by the communicating persons. Following Singer (1980), we can state that the out-reaching identity

implies that there is a social consciousness, through which man's self is embodied in others. The entire mechanism is dependent on the unique way in which the integrated – or disintegrated, as we see in acute schizophrenia – feelings, thoughts, and actions of the patient are connected with those of the ward staff through the processes of semiotic communication.

Peirce's concepts seem to be particularly well suited to the examination of an acute psychosis in a supervision process, since they enable us to examine an outside reality more concretely than is the case with approaches focusing only on symbolic processes. In the psychological regression typical of acute schizophrenia, the three categories of sign still exist, but have become confused with each other and/or mixed in an unconventional and strange way; communication (understanding what is going on) is therefore difficult or impossible.

In the two clinical examples above, there was a temptation to interpret the whole situation as a symbolic one. But if it had been the only starting point for different treatment efforts, the ward staff would not have had any concrete possibility of integrating the non-symbolic dimensions of the situation. The situation had to be encountered at the same level of sign that prevailed in the patients' and their families' life, i.e. at the indexical and iconic levels, as they emerged in the ward. That is why it was important to emphasise that the first patient's mother was a 'neuroleptic' (i.e. an indexical sign) and to use her as a neuroleptic, with artificially trying to interpret her symbolic meaning as the mother for the patient before the ward staff had enough experiences to understand the mother's symbolic role in the patient's life, and before the patient had become organised enough to use this new understanding.

In the second patient's case, from the theoretical point of view, the goal was to create an indexical and iconic situation both for the patient and for the ward staff. The SIGTP was the ward staff's certainty of the importance of the grandmother's death as the trigger of the patient's psychosis. There was a real grandmother in the ward, but this was neither the patient's grandmother, nor any symbolic representation of his grandmother, nor any general representation of grandmotherhood. The staff had to adapt themselves to that experienced fact – that they had no way of communicating their certainty, other than this indexical one. This new scene was, however, semiotically a more integrated SIGTP; for the ward staff, the new SIGTP was primarily an indexical one. In Peircean terms, it meant for the patient the beginning of organisation of this element of his out-reaching identity, through the processes of semiotic communication.

For the patient, the new SIGTP was relieving iconic experience of grandmotherhood; it made it possible for him to experience some resemblance with his own grandmother, but without the anxiety-provoking dimensions that his own, indexical, grandmother had contained. Later, the treatment also included family sessions, and at that phase, symbolic interpretations became possible. One consequence of the family therapy was that the patient's father started spending more time with his wife. One could say that he was then, for the first time, establishing a family.

Discussion

This paper is based on approaches for the treatment of schizophrenic patients pursued for over two decades in Finland. The goal of these projects has been to develop a comprehensive, psychotherapeutically orientated treatment system that is especially suitable for acute schizophrenic patients and their families. One of the results and recommendations of these projects has been that the treatment of acute schizophrenia must always be planned individually and on case-specific premises. The treatment process must take into account the different and changing therapeutic needs of both the patient and the people close to him. This approach has been called need-adapted treatment of schizophrenic psychoses.

A common situation in Finland today is that difficult cases of schizophrenia are treated in a psychiatric ward, by using a variety of psychotherapeutically orientated interventions, facilitated by drug treatment. In this hospital treatment, the field of collaboration includes qualified individual and family therapists, together with less psychotherapeutically trained personnel; different kinds of intervention are taking place all the time, both psychotherapeutically and as everyday interactions.

The need-adapted approach, especially in the hospital treatment of acute schizophrenia, calls for a detailed integration of different levels of experience with the patient and his family. This requires the development of both theoretical and practical tools for integrating psychotherapeutic efforts with the actual experiences that ward staff have with their schizophrenic patient. Theory based only on the symbolic interpretation of a schizophrenic patient's symptoms has proved to be too narrow. We consider schizophrenia as both an intrapsychic and interpersonal collapse, where an important dimension is the patient's regressive incapacity to make a difference between the concrete and symbolic elements of creating meaning.

In our study, which is a continuation of the Finnish Schizophrenia Project, we have found it especially useful to apply Peircean semiotics in the hospital treatment of acute schizophrenia. By that means it has been possible to combine – in a concrete way – a psychotherapeutic orientation, different psychotherapeutic practices, and even the everyday experiences of the staff in the psychiatric hospital ward.

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