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Understanding a complex intervention: Person-centred ethnography in early psychosis

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Abstract

Background: Mental health interventions are increasingly "complex" as it is recognized that a holistic, integrated or "biopsychosocial" approach is required to provide adequate treatment and support. While randomized controlled trial (RCT) studies are applied to assess clinical outcome, the actual workings and experiential effectiveness of this type of intervention are poorly understood and documented.

Aims: To discuss the value of a social science perspective of interpretive understanding (verstehen) and existential phenomenology to study sociocultural processes in a complex intervention, in particular when taking an ethnographic approach.

Methods: A person-centred ethnographic study of a Danish early intervention in psychosis service involved two years participant observation and repeated interviews with 15 clients.

Results: The study detailed therapeutic encounters in the intervention, supplemented by clients' reflections and insights generated through dialogue. Following first episode psychosis clients experienced an existential crisis, and the intervention offered therapeutic engagement, support and systems of explanation that provided meaning and life direction through the recovery models of "episodic psychosis" and "chronic schizophrenia".

Conclusions: The person-centred ethnographic approach provides rich insights into the sociocultural and personally experienced workings of a complex mental health intervention, which allow a critical understanding of therapeutic processes and how they may be improved.

Keywords: *Complex intervention, ethnography, existential phenomenology, interpretive sociology, psychosis, understanding*

Introduction

In this paper I argue that although mental health services in general are subject to comprehensive research, evaluation and audit, there is a need for social sciences to contribute to this empirical knowledge-base with a critical investigation based in the tradition of interpretive understanding. In particular, the person-centred ethnographic approach has much to offer to our understanding of complex therapeutic processes that currently remain largely unexamined, or are merely theoretically and instrumentally presupposed.

Current research on mental health services is predominantly designed according to the medical research "gold standard" of randomized controlled trials (RCTs), paying exclusive attention to quantifiable measures for outcome. Consideration of the actual service content and delivery are in these studies traditionally reduced to compliance with protocol that can be monitored according to quantitative standards. This situation reflects a more general

problem, as health managers and policy makers seem to naïvely rely on RCT outcome studies to provide research evidence, without a thorough examination of how the clinical effectiveness is achieved in practice and on the experiential level of the client. There is in this type of research a tendency to treat the intervention as a ''black box'' that delivers certain outcomes, but exactly *how* these outcomes are achieved is not critically examined (cf. Burns, Catty & Wright, 2006, p. 34). Particularly in the evaluation of complex interventions the application of a RCT design has recently been subject to critical discussions emphasizing the requirement to develop a phased approach combining it with qualitative methods (Campbell et al., 2000; Donovan et al., 2002; Medical Research Council, 2000). This highlights the need for qualitative research and multi-sector collaboration when designing a complex intervention (Byng & Jones, 2004) and suggests that the need to standardize the intervention should pay less attention to individual components of the intervention and be more concerned with its actual process and function (Hawe, Shiell & Riley, 2004). Equally, it has been shown how combining a RCT with a qualitative study of service user perspectives can enrich the theoretical understanding of benefits of the intervention (Rogers et al., 2003). In this paper I propose to further develop this line of inquiry by pointing out that while valuable in their own right, RCT studies are blind to the ''on the ground'' interpersonal dynamics of service delivery. This is a significant omission since therapeutic effectiveness of mental health intervention in many, if not all, cases is crucially dependent on such intersubjective, social and cultural aspects.

Social sciences[1] – and here I think of sociology and anthropology in particular – allow a comprehensive, in-depth empirical examination of the sociocultural and experiential reality of mental health services, and offer an interpretive methodology that draws on theoretical models of interpersonal and cultural dynamics to provide a critical analytic exploration and understanding of how these services work. Of particular relevance are theories on the dynamic way in which identity and self-perception are constructed and negotiated within specific social and cultural contexts (e.g., Csordas, 1994; Jenkins, 2004). The entry of social sciences into this field of research is not least pertinent as mental health services increasingly are ''complex interventions'' that, apart from biomedical drug treatment, integrate a combination of various psychotherapeutic and social support mechanisms. A case in point is the specialised service for early intervention in psychosis, which has recently been introduced nation-wide in the UK (Department of Health, 2000). Drawing on experiences and findings from my study of a similar Danish service I will in the following present the interpretive and existential phenomenological approach as applied in person-centred ethnography. Although significant contextual and policy differences must be assumed to exist between this Danish early intervention in psychosis service and the similar services established across the UK and elsewhere, and I therefore do not intend to make any claims on the study's direct generalizability, I present these findings in the expectation to illuminate key functions in the process of this type of intervention (cf., Hawe, Shiell & Riley, 2004). Before describing the Danish mental health intervention and outlining key findings from the research I will, however, first discuss in more detail the epistemological and methodological rationale for the social science approach of interpretive understanding as applied in person-centred ethnography.

Understanding and person-centred ethnography

While the human world is undeniably material, and in this sense bound up in physical and biological mechanisms, it is also fundamentally a social world, as it involves engagement with other people and the institutions which are made up of formalized relations and

practices between the social roles we assume in everyday life (Berger & Luckmann, 1966; Jenkins, 2002). From the perspective of the individual, the world is also social in the sense of being *culturally embodied*, as we perceive and act in our lives according to the values and meanings that we have become familiar with and largely have learned to take for granted through our upbringing (Csordas, 2002; Merleau-Ponty, 2002). This means that the human world is socially and culturally meaningful: it is not just a neutral field for individual actors to interact, but a place where meanings are played out and negotiated. This existential phenomenological insight concerning the *ontological* status of the human world has profound *epistemological* implications as we determine the kind of knowledge that is relevant to research. When studying a mental health service it means that we have to examine how it is experienced and what different actions and social roles means as they are presented and challenged in meetings between individuals.

In the philosophy of science a distinction is drawn between causal explanation (*erklären*) and interpretive understanding (*verstehen*), representing the difference between the natural sciences' search for universal laws and the social and human sciences' attempt to make sense of the human world as it is lived and experienced in time and space. While it is possible that this categorical distinction can be overemphasized (Jenkins, 2002, pp. 35–36), it does, however, signify an important difference in the overall approach to making analytic sense of the subject of investigation. The former seeks underlying universal laws that govern the material world, while the latter seeks insight into the lived and experienced reality of human existence. In sociology the concepts of interpretive understanding and *verstehen* are often associated with Max Weber and his work to develop conceptual and methodological tools for sociologists to explain social action (Tucker, 1965). However, Weber was not alone in developing these ideas as a basis for qualitative methodology in sociology (Platt, 1985). The interpretive approach in human and social sciences relates to the philosophical traditions of hermeneutics and existential phenomenology, which are both concerned with the problem of understanding. Hermeneutics has its origin in studies of religious texts, and problematises how to understand their meaning through recognition of the historical and cultural context at the time the text was written and the knowledge and perspective of the reader at the time of reading the text (Gadamer, 1990). Existential phenomenology directs attention more broadly to acknowledge that our perception and understanding of the world and phenomena will inevitably be experienced and lived in the particular human context of "being in the world" (Butt, 2004; Merleau-Ponty, 2002).

The interpretive approach to study mental health services allows us to empirically explore and theorize how social aspects of the intervention work at the level of intersubjective dynamics. Currently, such theoretical models are either non-existent or largely invisible to clinical practice and political decision-making in the health field. The theoretical models directly addressing therapeutic effectiveness which are widely accepted in the clinical field are typically of a biomedical or psychological nature, and therefore reductionistic and insufficient when it comes to explain processes of a sociocultural character. Before exemplifying what I mean by the type of analysis and theorizing I propose, I will discuss how person-centred ethnography may present a useful methodological tool to obtain the kind of empirical data needed for the endeavour.

Ethnography is a social science research method that places emphasis on the researcher's engagement in seeking insight and data through active participation and reflexive observation in naturally occurring social situations (Atkinson et al., 2001). It is in this sense that the approach is *naturalistic*, in contrast to research methods which are explicitly arranged and controlled by the researcher, such as formal interviews or controlled experiments. During an ethnographic study the researcher seeks to "blend in" and "hang out" with people on their

own terms and in everyday situations that take place over time (Sharkey & Larsen, 2005). The purpose is to be able to describe and understand the spoken as well as the unspoken social roles, rules, structures and meanings that govern the day-to-day life and events in specific social and cultural settings. The notion of *participant observation* underlines the double-sided approach of taking part and observing, seeking to be an insider and an outsider at the same time. This ambivalent position allows the ethnographer a critically questioning and reflexive perspective to provide detailed observations and recordings, which are not usually available for people in their ''natural condition'' (Schutz, 1967), where they take their sociocultural conditions and experiences for granted, and therefore tend to be blind to them. Analytically, the insider-outsider perspective allows the ethnographer to be ''destabilising habitual patterns of thinking by thinking his own thoughts in the place of somebody else'' (Jackson, 2005, p. 49), thereby transgressing and expanding the ''emic'' or local knowledge through a different theoretical perspective.

The ethnographic approach I advocate here stresses intersubjectivity and dialogue. This is in contrast to some other ethnographers who advocate the use of ''non-participant observation'' or ''mini'' or ''focused'' ethnography to research the health field, and who tend to emphasize the observational part of the approach, aiming for an objective and personally disengaged position to record people's behaviour (e.g., Muecke, 1994). By adopting this methodological stance and ambition such studies fail to grasp the lived and experienced reality of the subjects of investigation, thus hugely reducing the possibility for interpretive understanding. Other ethnographers emphasize the subjective experience of the researcher, and this approach is perhaps most strongly represented in recent years' growing interest in *autoethnography* (e.g., Ellis, 2002; Reed-Danahay, 1997). This approach is a hybrid between autobiography and ethnography where ethnographers use their personal experiences as socially positioned individuals to generate an in-depth description of the particular sociocultural world, as it is lived and experienced. The approach, or genre, is characterized by detailed and intimate description of private concerns, personal relations and social situations, combined with an ''outside'' critical and reflexive analysis of their biographical and sociocultural circumstances. The value of autoethnography as a source of insight into the life world of a specific group of people is, however, conditioned by the ethnographer's status as an insider or *existentially authentic* member of that particular group. Another problem is that the approach tends to present a partial view and empirical representation, as seen and experienced from one particular person: the researcher him- or herself.

Person-centred ethnography presents an alternative to the researcher who is not already an existentially authentic member of the field being studied and who seeks insight into the conditions and perspectives of specific groups of people in the field. The term was introduced by Robert LeVine (1982) to refer to the attempt by anthropologists to achieve an ''experience near'' description of human behaviour, subjective experience and psychological aspects, and their incorporation within cultural and social processes. Person-centred ethnography is inherently existential phenomenological by recognising that ''finely tuned theories must begin with the careful specification and description of human subjectivity'' (Hollan, 2001, p. 49). In contrast to autoethnography, the approach is, however, not directed towards the personal experiences of the ethnographer, but based on active, dialogical engagement with the subjects or informants of the research. As Hollan pointed out, examining the personal perspectives is in this approach integrated with close attention to observational data:

[W]hile I agree that good person-centered ethnography must begin with close observations of ongoing behaviour in different social contexts and cultural domains,

I would argue that it must eventually end with some more active engagement with our subjects in which we take advantage of their human capacity to reflect upon themselves and their experiences. (Hollan, 2001, p. 56)

The engagement in a dialogue places the other's viewpoint at a similar footing as one's own; and Jackson suggested that: ''[t]his demands that one find something in one's own experience that is analogous to, or approximates, the experience of the other, and may therefore bridge the gap between the two'' (2005, p. 31). Methodologically, the researcher utilizes the shared human condition as an intersubjective starting point for understanding the other person's particular situation, suggesting a ''psychic unity of humankind'' (Jackson, 1998, p. 15). The dialogue represents the social and shared meaning-frame that is at the centre of interpretive understanding: ''Human sociality is thus no longer simply the object of our understanding, but the very method whereby we achieve it'' (Jackson, 2005, p. 32).

The methodology of interpretive understanding thus goes hand in hand with existential phenomenology and person-centred ethnography to define the personally experienced and intersubjective field of investigation. I will now go on to describe the relevance of this approach to the study of the specific empirical field of a mental health service for early intervention in psychosis.

The early intervention in psychosis service

In 1998 the health and social service providers in the Danish capital Copenhagen jointly established a new intervention, called OPUS, aimed at people aged 18 – 45 years who first time were diagnosed with a serious mental illness within the ''schizophrenic spectrum'' (World Health Organization, 1993, pp. 64 – 76). This type of intervention is currently promoted in Australia, Europe and North America and supported by clinical outcome research (Birchwood, Todd, & Jackson, 1998; McGorry & Yung, 2003), although the evidence is not definitive (Warner, 2005). It is proposed that intensive and integrated biopsychosocial treatment and support in the period following first episode psychosis will significantly improve recovery rates.

In the Danish service clients[2] were offered a comprehensive 2-year ''biopsychosocial'' intervention before being referred to standard mental health services. This included closely monitored medication with lowest effective dosage atypical antipsychotic drugs and psychosocial interventions based on personal case managers operating in small multi-professional teams (Stein & Santos, 1998). The two teams in Copenhagen jointly serviced about 100 clients at any given time. Each case manager was seeing clients on a weekly basis and was personally responsible for no more than twelve clients at a time. The service was provided in the community, which meant that the meetings took place both in situations when they were inpatients and when they were discharged from hospital. Often the case manager visited the clients in their homes, but meetings could also take place in a staff office or in a café.

Clients and their relatives were invited to take part in multi-family groups (McFarlane, 2003), which met once a fortnight for one and a half hours over 18 months. Further, the clients were screened to take part in a social skills training program (Bellack et al., 1997), with weekly meetings for one year. In the periods when the clients were active in all the available therapeutic groups they, on average, were in contact with OPUS staff three and a half hours per week (Larsen, 2001, p. 68). Apart from these therapeutic interventions the service provided clients with social and financial support in terms of applying for social benefits, housing, education, jobs, and social activities.

OPUS was initially established on a temporary basis, but as the special project funding ran out after five years it was integrated universally as the standard service by the health service provider (*Hovedstadens Sygehusvæsen*) in the Danish capital (see https://www.opus-kbh.dk). During the experimental period outcome data from the intervention were documented by a RCT study which was initiated and carried out by the health service provider, arguing the need for this ''gold standard'' research design to provide a solid evidence base documenting the intervention's benefits or shortcomings compared to standard mental health services. The social service provider (*Familie- og Arbejdsmarkedsforvaltningen*) reluctantly agreed to the political need for the RCT design for the medically led research, but arranged for a complementary formative evaluation of the social aspects of the experimental intervention.

The study: Design, role and methods

I was employed to carry out this social evaluation research from April 1998 to December 2000 and, during this period, spent 23 months working on-site in the project. Combining the evaluation work with a PhD scholarship (Larsen, 2002a) I returned in August 2001 to revisit staff in OPUS and complete follow-up interviews with key informants. Hence, the study stretched over three and a half years and I did altogether two years of fieldwork.

My approach to the study was to provide rich empirical documentation and examination of the service provision and its experiential effects on the clients, in order to ethnographically illuminate what went on within the complex intervention. In respect to the early intervention in psychosis service this seemed particularly pertinent because although an increasing literature provided clinical protocols and manuals with normative guidelines for how to deliver this service (Birchwood, Fowler, & Jackson, 2000; Department of Health 2001; International Early Psychosis Association Writing Group, 2005) there was an apparent lack of critical empirical examination of how the service is actually delivered.

In my active membership role (Adler & Adler, 1987) as project evaluator I sought to describe and enable an understanding of the sociocultural workings of the intervention through taking part in the various project activities and meetings, whether therapeutic or exclusively for staff, and I made fieldnotes on my observations and reflections. To supplement participant observation and generate data for ongoing evaluation reports for the intervention steering group (e.g., Larsen, 2001), I employed a multi-method approach (Patton, 2002), which included activities such as documentary analysis, individual interviews, focus group interviews, surveys, time registration forms, and written narratives. In order to illuminate how the intervention was experienced by and affected the clients I approached 15 clients shortly after they had been included in the service. They were selected as key informants considering variation in terms of gender, age, the professional background of their case managers and inclusion in both OPUS teams. Informed consent was obtained prior to interviewing. Our principal contact was through repeated interviews, every half year. I conducted the last series of interviews after they had completed their two-year involvement with the service. The design meant that it was possible for our conversations to address themes at the time they were relevant for the clients in respect to their progression in the intervention. For example, at our first meeting we talked about their situation being included in the service and what they thought about it; and during the interview preceding their discharge we addressed their hopes, fears and plans in relation to ending the intensive support. The design provided a biographical connection between the interviews, allowing me to follow up on themes from previous interviews. Also, the repeated meetings allowed us to get to know each other on a personal level.

In accordance with the existential phenomenological perspective my approach to the interview situation was to engage in a *dialogical investigation* in order not just to "collect" information from my informants, but together to reflect on events and individual life circumstances (Larsen, 2003; see also Butt, 2004; Foddy, 1994). The interviews were audio-recorded, transcribed verbatim, coded using broad empirical themes, and analysed using within-case and across-case analytic strategies (Ayres, Kavanaugh & Knafl, 2003). The computer software *QSR NVivo* (Richards, 1999) facilitated data management. Apart from the interviews, eight of my informants took part in a book project, initiated and facilitated by me. This involved regular meetings of the editorial board where we discussed their individual narratives about experiences with mental illness and mental health treatment. This collaborative and creative-expressive methodology was valuable by providing a forum for clients to develop narratives on their own term. The final book (Larsen, 2002b) was targeted for the broader public and aimed to reduce ignorance about psychosis and schizophrenia, and to allow other people with psychosis and their relatives to read about similar experiences.

In the following I will present some findings from the research while emphasizing how the participant observation and dialogical reflection supplemented each other in creating insight into the workings of the intervention.

Intervention, social negotiation and self-transformation

The social, interactional aspects of the service involved meetings between staff and clients either in one-to-one case manager meetings or in therapeutic groups. The principal aim of the multi-family groups was to increase the supportive value of the close family network and reduce levels of expressed emotion (EE) between family members, which has been proven to reduce chances of recovery (Bebbington & Kuipers, 1994). In the groups clients and relatives were educated about mental illness, and through concrete problem-solving exercises relatives, mainly parents, but occasionally also siblings, grandparents or partners, were advised how they could support the client. In the social skills training (SST) groups staff were identified as "trainers" (*trænere*) and the aim was, aside from educating clients about medical notions of mental illness, to train them in using cognitive and behavioural coping techniques. The intention was that clients would use this knowledge and skill in their everyday lives to better identify and control their symptoms to prevent psychotic relapse and improve their quality of life.

In order to identify how these principles were applied in practice I took part in staff training sessions and I participated in meetings of two different groups of each type. In the multi-family groups clients were referred to as "the young people" (*de unge*) and service staff assumed roles as "therapists", controlling the structure of the meeting and facilitating group discussions. Although the groups paid prime attention to family relationships and the needs and concerns of relatives in respect to the clients' situations, the therapists in the two groups interpreted this overall therapeutic goal differently. In one group, therapists assumed a confrontational attitude to challenge the perceptions and behaviour of the relatives in order to morally educate them, for example to "be more caring towards each other". In the other group, the therapists took a quite different and unconfrontational approach to express emotional sympathy with the difficulties of living in a family with a mentally ill "young person". While the first group sought active change of family dynamics, the other expressed and encouraged empathy and emotional support. In both situations, however, the clients took a generally passive role, and the discursively dominating medical model of mental illness made them "problem holders" (*problembærere*) – as a member of staff remarked.

In the two SST groups I took part in clients assumed relatively more active roles: talking about their symptoms, sharing views on medication and taking active parts in problem-solving exercises. Their role did, however, resemble that of a "pupil", reflecting the staffs' role as trainers. For example, clients were asked to read teaching material out loud for each other and they were generously praised when having completed tasks successfully. Some clients complained during meetings that they were treated as children and that there was not given enough attention to their own views and opinions. Again, differences in staff attitudes led to variation in therapeutic emphasis and practice between the two groups. In one group there was a strong emphasis on teaching the medical model of mental illness and clients were encouraged to find medical solutions to their problems. In the other group, clients were encouraged by trainers to engage extensively in finding behavioural or social solutions to their difficulties, and the biomedical perspective was presented as negotiable rather than definite. The most obvious explanation of this difference was the professional backgrounds of the lead trainers in the groups, as psychiatrist and psychologist, respectively.[3]

During conversations with my key informants they reflected on the differences I observed in the groups. For example, several informants told me that personally they did not find it very rewarding to take part in the multi-family group. Nonetheless, they found the group useful for their relatives, as the exchange of experiences and discussions in the group allowed their relatives to better understand the difficulties they suffered. Also, they said that their relatives appreciated to meet other relatives who were in a similar situation as they were in, finding ways to support a mentally ill son, daughter or sibling and developing new hopes for their future lives. Informants described how the groups had helped them to develop a better and more supportive relationship with their parents, and that the fortnightly late afternoon meetings had provided a recurrent social occasion afterwards to have a family supper together.

Some informants described how the group's meaning and importance changed throughout the course of the intervention. Martin[4] explained how he initially refused the staffs' persistent attempts to convince him to take part in a multi-family group, as he feared that it would make public the intimate sexual problems that particularly tormented him. Eventually, he agreed for his older sister to take part, as he found it easier to accept that she, rather than his parents, could hear about his private concerns. However, he soon found out that the approach in the group was more "superficial" than he had expected, dealing with subjects as sleep problems and difficulties in attending social activities, so he agreed that his parents could also take part. Martin appreciated that he and his parents through the group meetings had developed a more open and supportive relationship. However, he felt that personally he had gained most from the weekly meetings with his case manager and the meetings in the SST group, as these interventions allowed him to talk about his personal problems and learn how better to cope with and approach them. In contrast, Eva, another of my key informants, found the approach in the multi-family group to solve concrete everyday problems very helpful, and she thought that the SST group paid too much attention to therapeutic role-plays, which she found difficult to relate to her real life experiences. In this way, clients expressed different views and preferences depending on their current situations and how they understood their problems. And, interestingly, the conversations provided an exploration of how the perceived "superficial" character of the multi-family group could be a positive quality as it allowed inclusion of the parents in the therapeutic work to build a close socially supportive relation for the client.

The repeated interviews also allowed me to examine in-depth how the clients perceived their relationships with staff. For example, Claus described how he initially found the meetings with his case manager pointless, and that he only kept the appointments because he felt morally obliged to, as he had agreed to take part in the intervention and the research.

However, as their relationship developed, he experienced that the case manager could help him in many ways, not only by planning and arranging his education, but also by acting as a confidant with whom he could share his worries and concerns. When I spoke to him shortly before his two years were up in the intervention he described what it had meant to him:

> I think that I have been guided in the right direction. Like if you imagine that I was in a black tunnel, and I then got a light to follow . . . then I have come out again. That sounds very grand [*flot*]! [Laughter]
>
> *JAL: Yes, it does sound grand. What is that light you got to follow, what do you think, what was that?*
>
> This . . . this about having healthy thoughts and . . . well, and . . . also this about that there is a life after the psychosis, and things like that. Because when I was discharged [from the psychiatric ward] everything was just black for me, you see. And I was suffering from delusions and racing thoughts [*tankemylder*] and things like that. And OPUS has helped me to . . . to see that there was a way out. It is like OPUS has been the light to guide me towards wellness [*raskheden*], you see.
>
> *JAL: Can you say something about what it is in OPUS that has done this?*
>
> I think it is both SST and the case manager, and then medication, of course. But, you see . . . the medication did not do it all, because I was also medicated when I was discharged, and then I was completely flat [*flad*]. I could not even, I mean . . . I just felt that my life was lost [*tabt på gulvet*], and couldn't manage anything . . . and, and things like that.
>
> *JAL: What is it then you have got through SST and the case manager, which . . . what has made the difference?*
>
> I have regained the belief that . . . or not 'regained', but, you see, there is also another life than the normal, what you call 'normal', you see, this about having a permanent job, and things like that. There is a little group of Danes, who live a bit differently and, in fact, feel all right about that . . .[5]

During the same meeting Claus told me that he was very concerned whether he would receive sufficient support from the community mental health service (*distriktspsykiatrisk center*) that he was soon going to be referred to. He knew that he was no longer likely to benefit from the weekly meetings he had had with his case manager in OPUS. In our following meeting, half a year after he had been discharged from OPUS, we discussed if there had been advantages by leaving the intervention. Claus for a while thought about this question and then told me that it had meant that he now felt more independent, competent and self-confident. He was himself surprised about this insight, which had been provoked by our critically reflective conversation. Claus stressed that his two years as client in OPUS had supported his recovery, so that he later was able to "stand on his own feet" (*stå på egne ben*).

Analytic interpretation and conclusion

The rich ethnographic data and the dialogical engagement with my key informants allowed an exploration of the sociocultural dynamics of the intervention and its experiential effectiveness for the clients. The explorative quality of the approach allowed the opportunity for the research to illuminate unexpected problem fields (Sharkey & Larsen, 2005), and it is in this respect that *ethnography is less about finding the right answers to questions, than finding the right questions to ask.* Through the conversations it became clear to me that a very significant

issue for my informants was how the intervention helped them to understand themselves and their difficulties, and what to expect for their future lives. The biomedical and cognitive behavioural explanation of mental illness in this way came to play a very important part in the therapeutic effect of the service, as did also the different ways in which members of staff applied these understandings to the clients. As illustrated above, it was apparent that although the service operated with a clearly defined and ''evidence-based'' approach to treatment, there was broad scope for individual members of staff to interpret these in different ways – and that these differences significantly influenced clients' experiences of them. As the summaries of my conversations with Martin and Claus illustrated, it was equally clear that clients' preferences (and perhaps needs) for being treated in different ways also differed over the period of their engagement.

The interpretive approach is not confined to the data gathering stage of the research, but is equally important to the way data analysis is conducted. The findings threw up questions that demanded a theoretical framework for interpretation. Informants described how they following the psychosis felt bewildered, confused and uncertain about themselves and the direction their lives were taking. This *ontological insecurity* has previously been seen as a defining characteristic of people with the diagnosis of schizophrenia (Laing, 1969). However, applying a sociological perspective on the dynamic way in which identity and self-perception are socially constructed involving the individual in an active process of negotiation and discovery (Csordas, 1994; Jenkins, 2004) my data suggested that it might be more appropriate to understand the sensation of ontological insecurity as related to the *existential crisis* on becoming mentally ill (Larsen, 2005). They were profoundly affected by the extreme and often frightening psychotic experiences which had destabilized their sense of self and thereby introduced a radical social renegotiation of identity. In this situation, the individual engaged in essential meaning-making activity to try to make sense of what had happened to them, and they drew on a range of available cultural resources to help them in this endeavour. As Claus described in the quote above, the biomedical and cognitive behavioural explanations provided in the Danish intervention service were highly influential in offering clients an understanding of what had happened to them and how they could learn to deal with their situation and plan their future lives. But these were not the only systems of explanation available to the clients as members of the wider Danish society, and they described how for example psychodynamic and religious understandings could also be helpful for them and could be creatively combined in work of *bricolage* to provide individually satisfying explanatory models (Larsen, 2004).

The sociocultural therapeutic work of the mental health intervention service could be understood as a form of *symbolic healing* (Larsen, in press), which anthropological studies of healing rituals in different societies have suggested provides a ''deep structure'' for their therapeutic effectiveness (Dow, 1986). Drawing on a culturally shared authoritative explanation (a ''mythic world'') the healer engages with the client and brings about a transformation of the illness experience that makes it understandable and allows a social renegotiation of the person's notion of self. In the Danish service members of staff engaged in such work in various ways through individual case manager meetings, multi-family groups and SST groups. Clients were offered biomedical and cognitive behavioural explanations that provided ''insight in illness'', helped them to make sense of their disturbing experiences and guided them in how to plan their future lives. However, the analysis indicated that there was not just one single ''therapeutic resolution'' offered, but that two different recovery models were applied in the intervention. One suggested *episodic psychosis* and described that clients were supported through ''full recovery'' from the episodic psychosis and, while acknowledging their vulnerability to psychosis, encouraged their return to previous life

projects. The other suggested *chronic schizophrenia* and the necessity of comprehensive life adjustments to the mental illness and accepting a self-identity as ''a schizophrenic''. During the healing process, different staff encouraged either one or the other of these models and this appeared to significantly influence clients' recovery experiences.

The person-centred ethnographic study provided rich insights into the sociocultural and personally experienced workings of the complex mental health intervention. The interpretive approach to data gathering and analysis allowed the research to follow the findings as they emerged and to explore their meanings in dialogue with the research informants themselves and with the existing body of empirical research and social science theory. The research methodology is in this sense theory-generating. And it threw up new research hypotheses that require future investigation using a comparative design. The study of the Danish early intervention in psychosis service suggests a need to carefully examine the ways in which staff interact with clients to negotiate meaning in respect to the psychotic experiences and how these may be influenced by the overall therapeutic theoretical framework in the individual services, as well as staff training and management support structures. But equally important, the study points to the importance of the type and quality of the personal relationship between staff and clients, and whether the staff adopts an authoritative or an equalitarian attitude to negotiate meanings and life directions. By critically examining sociocultural and interpersonal aspects of the therapeutic processes the interpretive approach of the person-centred ethnographic study is well suited to inform practice development work to improve service delivery and client outcome.

Notes

1 When referring to the broad notion of ''social sciences'' I agree with the arguments put forward by Richard Jenkins (2002, pp. 22 – 27) that, rather than seeking to narrowly identify – and thus limiting – discrete academic disciplines, it is theoretically and methodologically more fruitful to operate with a ''generic sociology'' that naturally embraces the intertwined intellectual resources of disciplines like sociology, cultural and social anthropology, cultural studies, social history, social policy and social psychology. In Britain there is a strong academic tradition for such a generic approach to sociology, for example at the University of Sheffield and Keele University.

2 In this paper the term ''client'' is used to refer to the mental health service users. In fact, this issue was frequently debated in the multi-professional OPUS teams and at different times and in different social circumstances various terms were used: ''patient'', ''participant'', ''client'', ''user'' and ''the young people'' (*de unge*).

3 I have provided a fuller description and examination of the sociocultural aspects of the therapeutic work in OPUS elsewhere (Larsen, in press).

4 The names of informants are pseudonyms.

5 The quote is translated by the author from Danish to the nearest equivalent English. Where words are used that have a special meaning in Danish these are provided in square brackets and italics.

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