TREATMENT AT SOTERIA HOUSE:

A MANUAL FOR THE PRACTICE OF INTERPERSONAL PHENOMENOLOGY

Final National Institutes of Mental Health Report: Grants Number R12MH 20123 and R12MH 25570. Prepared by Loren R. Mosher, M.D., Project Research Director; Robert Vallone, Ph.D., Research Co-Director; and Alma Zito Menn, A.S.C.W., Principal Investigator. This report includes material from *Soteria: A Manual: The Care and Feeding of A Soteria* (1972), which was compiled and edited by Mosher and Menn and included contributions from most members of Soteria's staff. Voyce Hendrix, Jr., M.S.W., made extensive contributions to this report, which was edited by Deborah C. Fort, Ph.D.

INTRODUCTION

To put this document into context, readers need to grasp a few key facts about its background. It attempts to organize and synthesize some of the events and therapeutic responses at two separate California facilities for community-based, experimental residential treatment. *Soteria* and *Emanon* housed people in severe psychological crisis in the 1970s and early 1980s.* Soteria, the original facility and the focus of this report, lasted 12 years (1971-1983), Emanon, 7.

Being There

During this span, only three figures were consistently on the scene:

1. **Psychiatrist Loren R. Mosher,** the project's designer, chief theoretician, analyst, spokesperson, and writer, including the crafting of this introduction.* Between 1976 and the project's end in 1983, my formal role was that of collaborating investigator.

Prior to 1976, when I was, in effect, research director, a post I later assumed formally, my role was much more "hands on." I helped select the original staff, worked directly in San Jose and San Mateo with clients and staff, directed setting up the research, and sent my Washington, D.C.-based research assistant to California to help with the process.

Also important was the fact that my National Institutes of Mental Health (NIMH) Parklawn Building office received and analyzed all data collected in the project. After 1976, my role became more peripheral when a review committee's recommended that the project recruit a research director located at the Medical Research Institute, the Palo Alto-based grantee institution, and all data analysis be transferred there. Since the project closed in 1983, and the research staff left because of lack of sufficient funding, I again became research co-director with Robert Vallone, Ph.D. In addition, I have remained in close contact with many members of the Soteria community and have worked extensively on this final document.

2. **Social Worker Alma Zito Menn** was the first full-time employee of the project. Hired by part-time Principal Investigator Leonard Goveia, she fulfilled the responsibilities necessary to start the project, when he became gravely ill prior to the opening of Soteria. She selected the initial staff and together with them discovered and evolved the procedures and social techniques needed to implement the theoretical design. When it became clear in 1972 that Leonard would be unable to carry out his responsibilities, she was officially designated principal investigator and has remained in this role--sometimes alone, sometimes with collaboration--throughout the life of the project. With the opening of Emanon House, she turned over clinical responsibility for Soteria to Voyce Hendrix, Jr. She continues as principal investigator.

3. **Soteria Mainstay Voyce R. Hendrix, Jr.,** has been actively involved with project since its inception in 1971. Starting as a staff member, he became the senior staff person, then house director, then director of both Soteria and Emanon. When the project closed he worked to write its history and then left to earn his M.S.W. When he returned to work in the San Jose area, he continued to provide information, review, and comment on this summary.

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*Soteria means *deliverance* in Greek; Emanon, which was chosen as no name spelled backwards to clearly separate itself from its older sibling, has some serendipitous relationships with *emanant* (Latin *emanans* to flow out, arise).

Changing Patterns

The project lived in an atmosphere of perpetual uncertainty about continuation of its funding. It was site-visited and reviewed by NIMH committees more than half a dozen times during its 12 years of research support. Although the project acquired subjects slowly and followed their progress for 2 years, its longest research grant support was only for 3 years. In this context, keeping a core staff intact was difficult. Hence, from the research perspective, my involvement and that of Alma were the only constants.

The staffs of the houses also turned over a number of times over the project's life. Alma, Voyce, and I estimate that several hundred people had important clinical involvement with Soteria or Emanon. The core staff, usually about seven full-time equivalent per facility, were typically imbued with counter-culture values. Although they loved the work and the *residents* (or sometimes *clients)* not *patients*, a label Soteria staff resisted as both too medical and too passive, such staff members resented the intrusion of the logical positivist research into their phenomenological-existential interpersonal world at the facility. Note writing, tracking particular behaviors over time, goal setting, treatment planning, case management, psychotherapy, etc., were usually anathema. Hence, much of the project's contribution to the field is unwritten; it lives in the experience of the myriad persons involved. It was for them a time, a place, a context to be experienced; to be lived; to be loved; to be frightened by; to be "bummed out about."

Soteria and Emanon were not observational experiments with controls. Staff were not Audubons sketching schizophrenic birds in protected parts of the forest. They were Janes or Joes trying to relate to, *be with,** and understand persons whose means of communication and behaviors were often unlike anything the staff had encountered before. Staff came in most cases to have an experience that would leave an indelible imprint, an experience that would be reciprocally formative, on which they would have an impact. Staff were explorers in an uncharted frontier; they were in a place where few people without preconceived notions had ventured before, and they were there without the usual trappings of power to control madness. Staff did not carry the highly symbolic keys to freedom: There were no locks on the doors; there were no syringes and few medications; there were no wet packs, restraints, or seclusion rooms.

Besides Alma, Voyce, and I, along with psychiatrists Stan Redd, Ken Woodrow, Richard Poe, Bob Spitzer, and Howard Siegel, all M.D.s who consulted regularly at Soteria, administrators are the only members of the Soteria community whose identities have not been disguised. On occasion, persons playing administrative, temporary, and/or theoretical roles also appear under their own names. Those of all other staff and, of course, residents have been protected.

A Few Constants

And there was no one to whom to turn to obtain "the answer". Staff and residents alike found themselves in an environment that eschewed the existence of "the answer" to madness.

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*For more on *being with*, see *Treatment Techniques*, pages 41-60.

Although based to some extent on R. D. Laing's ruleless (at least explicitly) Kingsley Hall in London, my experiences there led to Soteria's opening with three prohibitions. (For further discussion, see *Structure*, pages 77-80.) Soteria's original rules follow.

1. In so far as we were able to prevent it, violence to self or others was forbidden. From the outset, Soteria planners believed it important to make this expectation explicit. Providing the safe, quiet, protective, containing, predictable environment we found essential to natural recovery from psychosis demanded freedom from violence.

2. Tourists were not allowed without prearrangement and agreement of the current residents of the house. (Family members and friends of residents were of course, welcome, although the community preferred to know in advance that they would be visiting.) Just as no one can invite a stranger into my house without asking me, the community exercised a similar veto. In addition, clinical experience taught me that persons disorganized enough to be labeled psychotic frequently reacted poorly (for example, they withdrew, ran away, or became angry and assaultive) when confronted by strangers.

3. No illegal drugs were allowed or were to be consumed in the house. When Soteria and Emanon were in operation, much of the nation was involved in drug use and abuse. Both to continue to be in good standing with the NIMH, however, and, more importantly, to coexist peacefully with the local community, the facilities could not afford to be seen as drug scenes. Furthermore, we were attempting to conduct a drug-free experiment. We had no clear guidelines as to what effect illegal drugs would have had on the course of recovery from acute psychosis. We did not wish to muddy further the already opaque waters of madness. In practice, the project's participants rarely used illegal drugs.

Note that sexual activity, very commonly proscribed in community residential programs, went unmentioned when Soteria opened. Eventually, the community would have to add a fourth rule in that regard. Part of the project's uniqueness grew from our freedom to find and furnish a facility, to hire staff, and basically to turn them loose in it with only the three original rules. Otherwise they were free to operate entirely as they saw fit, except that two staff members were to be on duty at all times. About the same time that their burnout dictated devising a regular ongoing staffing pattern (basically 24-48 hour shifts), events also conspired to bring about a fourth rule.

One of the project's early admissions was an excited, overactive, incoherent young woman. One of the expressions of her psychosis was to disrobe, climb into a male staff member's lap in front of others, and invite him to have intercourse with her. Although potentially attractive, when admitted to Soteria, she was not bathing or brushing her teeth; had lost 25 pounds, dropping to a skeletal 85 pounds; and obviously lacked ordinary judgment based on an assessment of what was appropriate.

Staff had been trained to *be with* the residents, to try to put themselves in the situation of the disturbed person rather than interrupt or disrupt his/her experience. This young woman's behavior, therefore, created a situation with conflicting injunctions: The project's clinical gurus encouraged staff to go along with what the clients wanted so long as it was not dangerous. On the other hand, in this case, they felt they would be exploiting her by doing what she asked. In this situation, staff chose to apply a normalizing rule: If I met a woman looking and acting like this in an ordinary social context, would I want to have intercourse with her?

To a man, the staff answered (to themselves), "No."

Because she continued this behavior for several weeks, staff decided to consider a general rule prohibiting sexual relations between staff and residents. Such a policy would relieve them of dealing with these contradictory dictates. A house meeting was convened and in the end the community affirmed an incest taboo on sex between staff and residents--not between staff members or between clients. In 12 years of operation, this taboo was violated only once, and by someone who was neither a staff nor a resident but a guest.

(Soteria solved this single violation by redefining the guest's role. The next day, after open discussion by the house membership, he was officially defined as a live-in volunteer, an acknowledged staff-like role. The problem did not reoccur.)

Other rules came and went at Soteria, most commonly a ban on alcohol when it was being abused by someone living in the house. However, these four--*not more*--endured, a remarkable accomplishment in an open residential setting dealing with unmedicated acutely psychotic clients.

Impact

From the perspective of public mental health in 1992, the two-decade old Soteria project is a ground-breaking original prototype of a means of providing humane, effective, normalizing residential care to disturbed and disturbing people whose levels of psychological distress would ordinarily have been dealt with in psychiatric hospitals. Variations on the original Soteria theme appear widely in today's public mental health system; such facilities are generally called crisis houses.

Despite the controversy Soteria frequently generated--usually because of its stance against neuroleptics--the project is widely known. A number of the techniques it elaborated (for example, *being with)* have been incorporated into usual mental health practice. So, despite the occasional lacunas in this document, the project as an entity has had a substantial impact on the field.

A number of specific interactions and techniques designed to deal with particular situations are not recorded here because no one took them down at the time they happened. Hence, a number of Soteria (and Emanon's) real contributions may be lost to the NIMH and logical positivist science forever. However, the Soteria experiment changed the lives of many people. Voyce, the members of the staff, and I, who have tried to collect and write down the experience of this unique place in mental health history, are humble about how little we've succeeded in transmitting, for all our best efforts.

The material below comes from a variety of sources: audiotapes from staff debriefings, notes in clinical records, psychiatric admission work-ups, write-ups of particularly significant incidents by Voyce and me, and, very importantly, retrospective discussions and reconstructions among the individuals involved, particularly those consistently present during the 20 years that preceded the writing of this document.

Who Lived at Soteria?*

The approximately 100 residents at Soteria have been distilled into the 36 individuals (names changed) below.

Female Residents

Bonnie, Charlotte, Christine, Ida, Iris, Kate, Katherine, Kelly, Naomi, Nora, Tammy, Tamara, Toni, Tracy

14 female residents

Male Residents

Alfred, Brett, Chuck Starr, Conrad, Chip, Ethan, Evan, Henry, Howard, Hugh, Ike, Kevin, Kris, Leo, Mel, Michael, Nicholas, Orville, Sam, Spence, Stephen, Todd, Tom

22 male residents

Who Worked at Soteria?

The approximately 100 staff members at Soteria have been distilled into the 34 people below. All names have been changed except those of the three primary administrators and theoreticians and other miscellaneous professional staff.

Women Staff

Della, Francie, Ophelia, Katy, Kay, Natalie, Nelly, Tabitha, Tara O'Neill, Susannah

Alma Zito Menn

11 female staff (2 volunteers, 1 real person)

Men Staff

Adam, Bart, Daniel, Ed, Elmer, Geoff, Hal, Keith, Len, Lewis, Luke, Ned, Saul, Stuart

Bob Spitzer, Howard Siegel, Ken Woodrow, Leonard Goveia, Loren R. Mosher, Richard Poe, Stanley Mayerson, Stan Redd, Voyce Hendrix, Jr.

23 male staff named, (4 volunteers, 9 real people)

*Lists in all cases are alphabetical by first name. Because of the changing nature of roles at Soteria, individuals originally admitted as residents sometimes later reappear as friends, as volunteers, occasionally as staff.

Their contributions aim to convey a sense of what happened in a special place and to describe some of the kinds of approaches used to deal with the kinds of problems encountered there. We offer *at best* guidelines, not a cookbook, and *certainly* not a prescription. Each social context and the individuals interacting in it must be regarded as unique to remain consistent with the tenets of interpersonal phenomenology.

This report we dedicate not only to the staff--physicians, students, groupies, gurus, therapists of every stripe, researchers, psychics, mental health professionals, and volunteers who came into these unique social contexts--but most importantly to the residents whom they may have changed and who certainly changed them.

Loren R. Mosher, M.D.
Research Director
January, 1992

CHANGE SOTERIA STYLE

Once residents' needs for warmth, food, and shelter were met, and once clients understood that those needs would continue to be met, the community encouraged changing roles in terms of function and power at Soteria.

Complementary and Symmetrical Relationships

Relationships were central to Soteria's therapeutic environment. Said one staff member: "When I was first hired for the job at Soteria, I felt as if I had been adopted into a family." Her experience resulted from the community's style of interpersonal relationships. Its aim was not only to provide tangible examples of and personal participation in honest, affectionate, caring, and trusting interactions, but also to instill the skills necessary to initiate such contact with others. Soteria created the opportunity for such relationships for both the staff and the residents. If this base did not develop, a resident's progress could be greatly inhibited, and much of what was unique to the Soteria experience, which rests on interconnections and a sense of community, would be lost.

Soteria stressed the necessity of developing symmetrical as well as complementary relationships. In the former, two people exchange similar types of behavior--for example, mutual criticism, support, or advice. Symmetrical relationships can become competitive. Symmetry, or balance, is the focus. In complementary relationships, on the other hand, the behaviors exchanged reinforce each other: One gives and one receives; one teaches and the other learns, and so forth. The tendency here is to develop roles of power and dependency, roles that are by definition imbalanced. Soteria fostered neither symmetrical nor complementary interactions exclusively. Constructive, balanced relationships are made up of constantly shifting elements of both kinds. Hence, interactions at Soteria, which was meant to offer a corrective interpersonal environment, provided new relational experiences for residents.

It would be simplistic to describe the activities at Soteria only in terms of these two dimensions. Interrelationships among members of the community were far too complex to describe only in terms of complementarity and symmetry. Still, these concepts usefully describe certain community practices. For instance, symmetrical interactions among staff and clients were encouraged at the time of separation. Because of the crises that many residents were experiencing when they moved into the house, symmetrical interactions usually weren't immediately feasible, and complementary relationships emerged at first.

Compared to more causally-based models of treatment, Soteria's focus on interpersonal phenomenology neither assumed nor focused extensively on and explored what preconditions caused behavior patterns to emerge. This approach distinguished Soteria's methods from most--if not all--other major approaches to treatment. At Soteria, no preconceived notions about the causes of madness separated what individual members of the community saw as "what is" from what the program defined as "what is," as "reality." Everyone was entitled to his or her view.

Because this condition was essential, staff members were selected because of their strength of character, compatibility with the others, tolerance, and flexibility. Identification and emulation were major components of change at Soteria; therefore, staff members were chosen for their abilities to serve as good role models as well as to be comfortable with the maelstrom that often characterizes acute psychosis. Although everyone was allowed an individual view of the nature of reality, the staff and program director were

the purveyors of Soteria's culture. Thus the *program* conformed in many ways to conventional realities while it at the same time recognized the *individual's* right to harbor an idiosyncratic one. Soteria's process, thus, allowed its members to establish a community that had the support and protection of a group identity to guide it through the broader social context.

How Patients Change--"Dispatching" on the Wards

For six months in 1975, Holly Wilson, a medical sociologist, went into the two local 30-bed wards, where the Project's control subjects were admitted and treated to describe them. "As a former nurse," wrote Loren, "she [was] uniquely qualified to describe hospital ward processes. Her report is based on 120 hours of participant observation on the ward, which included time spent on all shifts, attendance at all meetings, review of all the ward's written documents (e.g., guidelines for medical coverage, nursing notes), and informal interviews with all types of staff." Wilson described the wards' primary overall functioning as a "dispatching process" with a variety of subprocesses as follows.

> 1. *Patching.* Staff's initial contact with patients often revolves around the imposition of a variety of behavioral controls such as the use of seclusion rooms, mechanical restraints, verbal instructions, and particularly heavy doses of psychotropic medications such as Haldol™, Prolixin™, or Thorazine™. In essence, violent, out-of-control, or inappropriately bizarre patients are *patched together* by subduing their socially unacceptable symptoms as quickly as possible.
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> 2. *Medical screening.* Because the psychiatric dispatching process (a term used to encompass the multiple, complex operations employed for "processing patients through" a clearinghouse model of care) takes place in a "medical" setting under the direction of physicians for the most part, a standardized routine of physical testing and diagnostic procedures is immediately initiated for all new admissions. These procedures include a physical exam, blood work, urinalysis, E.E.G., and a selected variety of others. Such screening also serves as an information-gathering strategy in that on occasion a patient's psychiatric problem is discovered to be a consequence of a medical or physiological disorder. Properties of this process of screening are that it is extremely time consuming for staff, that it requires accurate and proper completion of a multitude of requisitions and forms, and that it is rigidly imposed, even though a patient who is readmitted may have undergone the same screening process within the same week.
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> 3. *Piecing together a story.* Proportionately speaking, the most staff time and energy is devoted to this dimension of the dispatching process. In order to make subsequent decisions about distributing a patient to the appropriate aftercare placement, as well as the more immediate decision of which course of medications to begin, a diagnosis must be made. Thus, information-gathering and intelligence operations consume staff's focus during the first 72 hours of a patient's confinement. The interaction of staff attempting to sleuth out and uncover information about a patient in order to engage in fate-making decisions, with patients who are attempting to cover up what they believe is damaging data about themselves, constitutes another key focus for staff/patient contact. The major modalities for this contact are the "Group Intake Interview" wherein a newly admitted patient is confronted by a group of staff in an interview room and questioned, and the "Second-hand Report" where bits and pieces of data are passed along from shift to shift verbally and on the patient's chart and then used

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‡Societal barriers to learning: The community psychiatry example. In G. Serban (Ed.), *A critical appraisal of community psychiatry* (pp. 145-161). New York: John Wiley.

to make generalizations about the patient. Properties of this process are its preconceived tendency, a reliance on speculations which easily become "truth," and the trickery involved in "finding things out."

4. *Labeling and sorting.* Once there is sufficient data to justify some decisions, patients are stamped with a psychiatric label. For the most part, patients in the study setting fell into the following diagnostic categories: schizophrenic, manic-depressive, alcohol or drug abuse, or violent character disorder of some type. *Labeling* acts as a key in deciding which medications to order and which aftercare placements to begin exploring. It also provides staff with an additional source of control in their dealings with patients, for with diagnoses comes an increased sense of being able to predict patient behavior and the ability to deal with patient communications and behaviors as typifications--"That's her hysterical personality coming out; those are just delusions, etc."

5. *Distributing.* The official goal of Community Mental Health legislation in California also includes a goal of moving mentally ill persons back into "the community" as rapidly as possible. Yet, psychiatric professionals in the study setting are constantly balancing this mandate against their perceived mandate to act as protectors of society and their patients. Consequently, staff act as fate-makers by distributing their "charges" to one of a variety of placement options for follow-up and aftercare. A property of the distributing stage of dispatching is its revolving door nature. Many of the setting's patients are "old familiars," who periodically rotate through the study setting and back out again. A number of patients are *tracked* by community liaison workers which contributes additional data taken into account when distributing decisions are made. Reports include that one aftercare facility or another "won't take her back again," so the options become limited by virtue of exhausting some of them over time.

The above conceptualization of "usual psychiatric care" in the study setting conveys, I hope, the complex nature of the psychiatric decision making and deposition process that goes on. Consequences of these operations include (a) A very hectic and busy pace of work for staff while the hours "drift by" for patients. (b) A low accessibility of staff for patients--sitting and talking with patients has very low priority in view of all the tasks that must be accomplished. (c) A substitution of technology for potential face-to-face contacts (e.g., there's a mechanical cigarette lighter on the wall to discourage patients from bothering busy staff for lights; medications are announced over a loud speaker instead of passed out by a nurse who seeks out patients around the ward, etc). (d) Staff spend the majority of their time in interaction with other staff--in report, team meetings, intake interviews, and other meetings. (This observation differed on the two wards with more staff/patient contact on Ward I, in ritualized formats such as "anger group," "feelings group," etc., but these contacts were low on spontaneity, low on openness, and high on superficiality and control.) (e) Staff are the constants on the units with patients only passing through, thus a lot of energy is devoted to intrastaff conflict, problems, and the distribution of labor. (f) Most staff have a lot of integrity about their work--their value systems are relatively congruent with conventional psychiatric and medical model explanations of madness. (pp. 156-158).

How Patients Change--Social Rehabilitation Models

Social rehabilitation facilities mainly serve individuals *after* they been treated in hospitals. The social rehabilitation movement won greater acceptance in the 1980s, after hospitals had emptied large numbers of their disabled clients into communities that lacked facilities to care for them. A high percentage of these refugees had never learned, or had lost through disuse in the institutions, the basic social and instrumental skills needed to survive in the community. In the social rehabilitation model, the disabled change when they are taught basic living skills that enable reentry into the

mainstream of society. The implication is that the recovering person at one point, in the past, was "habilitated" and needs only to learn or to regain those skills to return successfully to the community. Hence, residential social rehabilitation settings provided some responses to the widespread criticism of the process of deinstitutionalization.

In this system, staff and patients have some potential for normal relationships. Social rehabilitation models, reflecting psychosocial paradigms, are less medically oriented than hospital ones. These community-based settings employing paraprofessional staff members operate with the expectation that learning basic living skills can assist the client's integration into the community. The role of the staff, therefore, is to train rather than to do therapy, to cure. Change in community-based models comes from teaching--the staff instructs the patients in life skills. Whether they actually do more than provide decent supervised housing remains an empirical question.

How Residents Change--Soteria Model

The Soteria model incorporates aspects of both the hospital model and the social rehabilitation model, but it differs from both in that the primary cause of change is based neither on therapeutic intervention nor in learning basic living skills. Change occurs through normal interactive processes, when the system's members interact. As a result, issues surrounding the nature of relationships between and among staff and residents become central to change Soteria style.

The relationship between therapist and client is by definition one of inequality. To elaborate: The implication is that the therapist, by virtue of his/her role, rules. When the patient becomes capable of exerting acceptable self-control, s/he will likely be discharged, terminating his/her active participation in the therapeutic network.

In contrast, many of Soteria's graduates kept in close touch with the community. Continuing involvement is important because of the level of the personal commitment among the Soteria community members. The relationships were *personal* and, therefore, had implications beyond separation, for the clients as well as for the staff and volunteers. At Soteria, therapeutic involvement went beyond the boundary of the official relationships framed by admission and discharge.

Why? Because relationships were critical: If they didn't happen at Soteria, neither did change. It was nearly impossible not to develop *some* kind of relationship in the Soteria process. The issue became a question of *what* kind should be encouraged. In hospital or rehabilitation settings, relationships between staff and clients often developed around the degree of a patient's dependency upon a particular staff member. Such a relationship was usually abruptly terminated upon discharge.

Size also plays a major role in how relationships form in institutional and noninstitutional settings. (See *Structure,* page 64 for elaboration.) It also dictates some aspects of structure: Large groups of people require more elaborate sets of controls to maintain a functional system than do small groups. If the desire is to develop the capacity to follow orders, as in the military, then a large institutional process would be appropriate. If the intention is to develop the capability to maintain a productive existence in the broader community, it would be unnecessary--or even harmful--to instill that degree of conformity.

The nature of the Soteria involvement was not to "do therapy" on the client but to interact with him or her in as normal a way as possible given the conditions. Put another way, Soteria believed in "being with" instead of "doing to."

Space for Interpersonal Networks

Soteria made sure that its philosophical belief in the paramount importance of relationships was matched by a physical and psychological setting wherein they could develop. Interpersonal networks take time, energy (physical and mental), and *space*. This space differs from that available for *involvement*--the kind that occurs between people having only limited or one-time contacts, such as those between clerks and customers or among people sharing a common space, such as neighbors. It also differs from *intrapersonal* involvement, the time spent alone.

Areas of personal contact are of limited availability but play a major role in one's interaction with his/her environment. Because interpersonal relationships among community members were key factors at Soteria, the house strove to establish a milieu conducive to such lasting interactions. This concept deviates significantly from traditional modes of treatment and calls for several operational factors:

- a willingness on the part of the staff to view a client as a potential peer
- a process that allows and/or encourages both clients and staff the opportunity to establish and maintain a shared, equal relationship
- available network space

The last point is of critical importance.

Interactions are more affected by network availability than most people think. Staff working in hospitals are discouraged from personal interactions with patients through overt rules, through implicit programmatic procedures, and through covert training techniques. Hospital staff are typically instructed not to touch clients any more than necessary, for example, and to keep relationships with patients on a professional level. Staff at most hospitals have a well-established network system that includes other staff members and excludes patients. As a result, staff has little room for interpersonal involvement with patients. These patients, isolated from their normal networks by the trauma of being hospitalized, have an enormous need to fill the void. No wonder hospital staffs do not want to open up potentially endless floods of involvement, especially given the large number of patients who generally fill psychiatric wards.

Other typical hospital procedures distinguish sharply between the duties of the staff and the patients; Soteria's did not. Most hospital workers *do to* patients rather than *be with* them, an active-passive set of roles that helps to reinforce their differences.

Medications

Soteria's policy toward drugs as an instrument of psychological healing or maintenance was also experimental. While medication was in some extreme instances offered to residents as an option, it was never administered against their wills.

In 1979, Alma and Loren explained Soteria's approach in *New Directions for Mental Health Services*. Supporting their position with numerous references, they wrote, in part*

> We live in an over-medicated, too frequently drug-dependent culture despite ambivalence which is resolved by creating two categories of drugs: Good ones like alcohol and bad ones like LSD. Psychiatry's attitude is no different from that of the wider social context: We are all still looking for the magical answer from a pill. The antipsychotic drugs have provided psychiatrists with real substance for their magical-cure fantasy applied to schizophrenia. But, as is the case with most such exaggerated expectations, the fantasy is better than the reality. After two decades, it is now clear that the antipsychotic drugs do not cure schizophrenia. It is also clear that they have serious, sometimes irreversible, toxicities,...that recovery may be impaired by them in at least some schizophrenics,...and that they have little effect on long-term psychosocial adjustment... These criticisms do not deny their extraordinary helpfulness in reducing and controlling symptoms, shortening hospital stays, and revitalizing interest in schizophrenia. One aim of the Soteria project is to seek a viable informed alternative to the overuse of these drugs and excessive reliance on them, often to the exclusion of psychosocial measures. We use drugs infrequently and, when prescribed, they are primarily under the individual resident's (patient's) control. That is, s/he is asked to monitor his/her responses to the drug very carefully to give us feedback, so we can adjust dosage, and, after a trial period of two weeks, s/he is given a major role in determining whether or not s/he will continue to use drugs. (p. 73).

In Sum

The differences between the hospital and the Soteria model are clear. Not so clear is how Soteria differs from the social rehabilitation model. The potential for a process like Soteria's to occur in a social rehabilitation facility is high. Such institutions are usually staffed by less medically-oriented people than psych wards; they are usually located in minimally institutional settings like houses; and they are usually small. It is the inherent difference in the concept of change that points out a basic dissimilarity.

If the predominance of the healer's work is finished when the client has learned his/her basic living skills, then it becomes unimportant to continue to interact interpersonally with the client. For Soteria, however, the interaction was the work.The potential for ongoing relationships, therefore, existed as a natural part of the process without the expectation that they would end after discharge.

In fact, the Soteria program existed mainly to bring people together to establish ongoing relationships. A secondary reason was protection. Like social rehabilitation programs, Soteria temporarily protected the disabled by making available food, shelter, and other essentials at a time when individuals could not provide for themselves. So social rehabilitation programs might, like Soteria, protect and establish relationships. Because of their other mission, however, they would not be able to do what Soteria believed critical--establish and encourage appropriate long-term relationships. The rehabilitation policies of discharging clients to other programs--independent living centers, halfway houses, day-care centers, and other after-care programs--affirms their expectation that the healed would move on without the support formerly necessary.

In short: The relationship of patient to hospital is unequal and temporary; that of client to rehabilitation center, tutorial and transitional; that of resident to Soteria, equitable and--potentially--permanent.

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*See "Soteria: An alternative to hospitalization for schizophrenia," *New Directions for Mental Health Services, 1*, 73-83, for a full explanation.

SOME PROBLEMS AND SOME SOLUTIONS

Physical violence is of enormous concern in a residential psychiatric setting, a concern of both the program as well as the community in which it exists. Unfortunately, the violent patient has received a great deal of attention through books, TV, and other media. Although violent acts are frequently portrayed, understanding for the motivation behind them is rare, except, occasionally, with respect to suicide. For some, the psychotic personality is synonymous with violence. Although violent criminal acts are not more common among psychotics than in the general population, there is good clinical evidence that for many of them dealing with anger and aggression is particularly troublesome.

Aggression

In many cases at Soteria, it was helpful for residents to locate the objects of their anger, to learn why that anger exists, and to find safe outlets for releasing the hostility generated. Soteria staff, therefore, allowed individuals in their altered states of consciousness as much expression of anger as possible. Staff tolerated substantial property damage--property is expendable and its protection, secondary. Staff members tried to tune into people's feelings of aggression rather than encouraging repression. Staff also discussed techniques for dealing with their own fears of violence, acknowledged individual differences in ability to tolerate it, and identified those best able to deal with it. Staffer Della described her belief that understanding was the best way to handle fears about violence:

> I guess one of the things that would screw up your being able to handle really aggressive behavior is if you were to show to the person who is really angry and violent that you're terrified of what physically might happen to you. Being aware of the person's space, what's going on inside, helps me. It makes me feel more competent to deal with it because I figure, "I'm not like that right now. I'm together enough so that I'm not in a rage, so I can be of some help." It's kind of hard to explain. If I met somebody just off the street, and they came up and just started being violent, I'm sure I would react very differently. Maybe I would show my fear; maybe I'd run like hell; probably I would scream, but that doesn't happen here. Part of it is because you know the people. It's not like strangers' violence or rage that you don't understand. I think it's the not *understanding* that scares you.

The early days at Soteria saw many discussions of violence, which, it became apparent, takes various forms as well as has different impacts. Several of the staff members, for example, believed that a certain level of aggressiveness was desirable because it gave them material for therapeutic encounters. Others disagreed, finding all forms of violence unacceptable. Many hours of discussion produced no answer; however, for a number of years, uncontrollable violence presented no major problems because of the adequate support always available--at various times, staff and volunteers lived in the house, and both paid and unpaid helpers were willing to come to the house at a moment's notice. This was a positive aspect of the project's counterculture notoriety. In addition, and probably more significantly, staff were actively and continuously involved with clients on a one-to-one or a two-to-one basis for the duration of any difficulty, and in Soteria's 12 years, violent residents caused fewer than 10 injuries, almost all minor.

Still, Soteria recognized an obligation to provide a safe environment for everyone at the house and therefore developed some general precautions. The staff also tried to curb aggression when they thought it might become dangerous. Staff learned to pick up clues from residents in a destructive mood, and, by anticipating violence, sometimes prevented its occurrence. For example, Geoff noted,

> Naomi played the Rolling Stones when she was angry. When they came on, you knew that Naomi was going to come out and stomp around and maybe try to break a window or something. The Stones were a signal. Now she'll go back to her room and put on that goddamned "Squeaky Fingers" or whatever the name of it is. She turns it up full blast, and everyone will know that Naomi's angry. Then somebody will go back and be with her. That's all she plays right now. That's the message: "Goddamn it, you've got to pay attention to me because I'm pissed off, and I'm going to break walls, etc...." And you go back and that's exactly the mood she's in.

Said Susannah, one of Soteria's original staff members,

> When Tracy was angry she started talking about burning. She'd say she wanted to burn the house down or wanted to see flames or talk about the flames of hell or whatever. Flames, fire, burning would come into conversation. It might be an hour or two beforehand. She'd let you know, generally.

Another check on violence was Soteria's high tolerance of deviant behavior. Staff actively intervened to control only when clients were dangerous to themselves or others. When aggression reached a point that it threatened the initiator, staff, other residents, or the program, it was halted. In one such situation, staffer Kay explained the limitations on violence to a resident and then helped her deal with those limits.

> After she had broken one of the big windows, Kelly was just sitting on the floor in the living room, fairly frightened. I sat next to her on the floor and said, "You know, if you keep on breaking the windows, which could hurt you or cut others, you won't be able to stay here. Also, we can't have the house destroyed." She said "OK, I'll leave." I said, "That's not what I'm saying. I don't want you to leave. I want you to stay. I want you to be able to stay, but to stay is not to break windows." At the same time I said, "You're free to leave. It's your choice. I'm not going to keep you here if you want to go." Kelly seemed relieved that she didn't need to leave but said, "But I need to break windows."
>
> I said, "When you're going to break a window, or when you're going to start a fire or anything like that, just tell me you're going to do it, and I'll take the responsibility from then on in." I said, "Will you do that? Will you tell me?" She answered that she would. So we just talked. About an hour later, she'd gone upstairs and then came back down and walked casually by--very fast--and said, "I feel like breaking a window."
>
> So I got up and went with her right away. She went into her room, into the bathroom--I guess to break a window--and I just held her there, and she turned around smiling and said, "Well you told me to tell you, and I told you." I said, "Well that's all right; now I've got the responsibility for you, and you didn't break it. It's OK."
>
> And that worked out. After that, she was much more explicit and told me ahead of time. Not way ahead of time: She wouldn't come up and say, "Hey, I want to break a window. Stop me." She'd make you pick up on it. She'd throw it out in the middle of a conversation or, off-handedly as she walked by: "I feel like breaking a window. I feel like lighting a fire."
>
> Even that didn't work forever, however. It worked for a while though.

No one was forced to take medication. In fact, during residents' first six weeks at Soteria, the research design forbade drug therapy, except under highly unusual circumstances. If an emergency situation seemed to require medication, staff or the attending psychiatrist *persuaded* the resident to take it. Soteria had no syringes or needles with which to forcibly administer drugs. Voyce, who had worked with violent patients and trained staff at the local state hospital wrote, retrospectively, that

> as a member of the admissions team, I was available at all times for backup anywhere in the hospital. As a consequence, I became one of the staff who trained new employees to deal with hostile patients. What I found most unusual at Soteria (as compared to the situation in the hospital) was the residents' infrequent aggressive behavior.
>
> Not for a year did I understand some of the reasons for the difference between the hospitals' psychiatric patients and Soteria's residents. First, at Soteria clients were not forced to do what they didn't want to do or what they didn't believe was in their best interest. They didn't *have* to take medication or be secluded, for instance. Nor were they prevented from flight--Soteria's doors were not locked.
>
> The third difference was more subtle. I felt as if I never *really* knew any patient at the hospital; the reverse was true at Soteria where it was difficult *not* to know people who stayed for more than two or three weeks because of the way you interacted with them. Put another way, there were no interpersonal consequences when I dealt with patients at the hospital. On the contrary, I suspect that the residents at Soteria--depending on the degree of time spent in the house--found it difficult to breach the barrier between verbal and physical violence. The personal consequences could have been too great.

But, although violence at Soteria--to others, to self, and to property--was unusual, it did occur and had to be dealt with.

Violence Towards Others--The Reasons

Violence, especially that directed at others, is a major source of anxiety for the staff in most treatment settings that help acutely psychologically distressed individuals. Physical aggression exhibited at Soteria was a result of anger, panic, loss, and/or frustration, which often stemmed, paradoxically, from a desire to save others.

FRUSTRATION

While violence usually took the form of verbal aggression--that is, threats--there were occasions when it went beyond the verbal to the physical. When this happened, it usually turned inward. When violence erupted against others, it often did so because someone was prevented from taking a desired action. For instance, one new resident, Alfred, became so obsessed with his need to leave Soteria in order to board a spaceship to prevent its landing, dangerously, in Rio de Janeiro, that it took six members of the community--staff, residents, and volunteers--to hold him down. Eventually, he accepted a bag of popcorn in place of his journey and calmed down. Whether Alfred's expression of violence came because the community was in his way or because it wouldn't help him get to his destination was never clear.

PANIC

Panic could also trigger violence toward others. The most unpredictable and the least understood form of physical violence, panic was usually directed against the person closest to the sufferer. After suddenly hitting a friend, a resident commented, "I don't know what came over me. My voices told me she was going to kill me." Even such "explanations" as this are rare, however, and usually unrelated to the events that led to the violent act.

The most common episodes of panic violence occurred when clients were either entering or emerging from regressive states. Male clients not infrequently struck at women staff in such panics. For instance,

> Kevin, a resident who had just been readmitted to Soteria because he felt that he was "going crazy again," was sitting in his room when a female staff member to whom he had been close came in to say hello. Kevin suddenly became verbally threatening and then chased her into the kitchen where other members of the community were eating breakfast. The group subdued him. Several minutes of talk between Kevin and his would-be victim--with others present--defused the tension.

This was atypical behavior for Kevin, who had no history of violence before or after this incident. Although he never said why he suddenly attacked someone to whom he normally felt close, he reestablished and maintained a close relationship with her after the incident.

ANGER

More than three fourths of the violent episodes at Soteria stemmed from anger--usually consequent to rejection by someone close. It also resulted from intrusions into someone's "space"--real or imagined. Finally, a resident's feeling deprived at something or of someone sometimes produced a violent outburst. Voyce's memories of the frequently violent results of compelling patients in the hospital rather than persuading them encouraged Soteria staff to use force as infrequently as possible. Sometimes, however, residents had to be made to stop actions that could hurt themselves or others or do serious damage to property. For instance, wrote Hal, a 21-year-old resident named Tom

> had decided to go over to the our favorite restaurant, the Harvest Inn, to get a milk shake. He became confused and began shouting. At that point, a waitress called Soteria and asked for assistance, so she wouldn't have to call the police. Two members of the staff and a resident who were close to Tom drove over and tried to talk him into coming home.
>
> We had made an agreement with Tom that, on the one hand, we would do whatever we could to get him back to Soteria and avoid situations that might get him hospitalized. On the other hand, we promised that he only had to say "Stop," and we would let him go, unless there were danger of injury to him or someone else.
>
> When we arrived, Tom refused to leave and became upset with the manager, who was asking him to leave. When it became clear that Tom's behavior was going to warrant a call to the police, we said we were going to take him back home, and, if he wanted us not to, he would have to say, "Stop." One staff member took him by the hand and led him out the door. As soon as the door closed, Tom decided that he was going to run back in and do *something*--what wasn't clear to us--but something we felt would make the situation worse. The three of us grabbed him and put him in the car--with Tom attempting to hit and otherwise trying to escape--but he never said, "Stop."
>
> When we returned to Soteria, Tom became remorseful and apologetic. Within two hours

he went over to a fast food restaurant and ordered a milk shake without any problem. The difference this time--a former resident went along.

Examining this episode makes it evident how difficult it is to determine who is the aggressor and who is the respondent. We assumed Tom was going back into the restaurant to *misbehave*. But he *may* have wanted to go in to apologize to the manager.

The question here: Did Tom throw the first blow, or did the three members of the community who restrained him? This issue is important (see box). Residents justifying their violent behavior raise just such questions even though, unlike certain other treatment facilities, Soteria staff made every effort to preserve freedom. Voyce remembers a similar struggle, but with different results, at a state facility where he had worked earlier.

The Use of Force

Voyce Remembers

The last incident with which I was involved at the job I had prior to Soteria involved a young man admitted to the hospital sometime before the day shift arrived on the ward. During the change of shift, I first noticed him sitting in a corner of the ward, making gestures with his hand in front of his face, smiling, and talking to himself continuously.

The ward was over-full, and the night shift had had a difficult time. Several new patients had come on the ward, and several "incidents" had occurred during the night. In addition, we were understaffed by two, which made it even more a of problem trying to deal with over 40 potentially violent or unknown (recently admitted) patients. At that time, the maximum security patients and the new ones were on the same ward.

During the change of shifts, I noticed that the head nurse was looking upset about the smiling patient's behavior. She asked the night charge psychiatric technician if the patient had taken any medication. "No," said the technician, "he just arrived on the ward." We stopped the meeting to confirm that medications had been ordered. A nurse was told to give the new patient his medications.

As the nurse approached, the patient stopped smiling and gesturing and began to act "weird." Before the nurse said anything, he warned, "I'm allergic to that stuff." She checked his chart for an allergy to Thorazine™ (the most common tranquilizer at the time). Because there was none mentioned, she obtained an order for an injection. The patient refused to submit, suggesting that she give the shot to the head nurse instead.

She returned with five of the staff, including me, to make sure he cooperated.

When he saw us coming, he began to run. We were, of course, able to subdue him--he was restrained in a locked room--but he resisted violently.

As a result, he was secluded, and his chart annotated his hostility and aggression toward the staff. While he was in the seclusion room, he bit off a chunk of his arm.

Later, it was discovered that he *was* allergic to the medication.

As a member of the treatment team, I felt we had followed the right processes. Not until months later, when I was working at Soteria, did I realize that the incident would not have occurred there. In this case, the patient was defending himself against what he rightly identified as a violent act. The staff was wrong to give him medication to which he was allergic. But further, I wondered, was it actually necessary to medicate the patient? If so, need it have been done so disruptively?

My perspective, from the staff's point of view, before starting to work at Soteria, suggested affirmative answers to both questions:

o Upsetting the ward, especially given its overpopulation and staff shortage, was to be avoided.

o The patient was behaving psychotically, which called for "treatment," and medication is treatment.

But when I came to bring my Soteria experience to bear, I came to some different conclusions. *Someone* was upset, and the nurse thought that someone was the *patient*. But, on closer observation, someone else was upset as well--*the head nurse*. *Her* solution was to cure the patient's upset with medication (which seemed counterproductive because he became even more upset). *His* solution--to give *her* medication instead--might have worked *if*, as they both believed, medication had the power to calm people. In addition, his solution would have allowed the patient to continue enjoying himself, to keep smiling, thus avoiding a crisis for the patient and the rest of the ward.

The patient's solution, though probably flawed by the limitations of the medication, certainly was better than the nurse's.

Due to Soteria's philosophy, violent episodes resulting from the staff's compelling client behaviors were comparatively uncommon and usually mild.

Violence spawned by feelings of rejection was more common, happening occasionally when residents felt they were not receiving appropriate attention. Rarely did clients hit or become violent with the person by whom they felt rejected. Their ire usually fell upon a rival for his/her attention. Although caused by rejection, such violence took the form, thus, of anger. A

resident, Toni, followed this pattern. Wrote a staff member,

> Toni had been out shopping and returned to find that the staff member she called "Mother" had gone to a film with a male resident she disliked. When the two returned, Toni was eating dinner in the kitchen. When "Mother" and her companion walked into the kitchen, Toni accused--"Mother, I thought you couldn't leave the house today because there wasn't enough help?"--and poured hot coffee on the other resident.

In this case, although the moviegoer had not provoked Toni directly, he was the victim of her misplaced anger.

An even more common form of such unprovoked violence occurred as a result of something that happened before clients came to Soteria. Thus residents sometimes struck out at staff members who reminded them of their parents. Other forms of free-floating anger that sometimes led to violence at Soteria occurred when clients aggressively protected what they called their "space" against intruders. Residents hit, kicked, or bit, because they felt cheated, defrauded, robbed, or otherwise treated unfairly.

Such perceptions could, of course, elicit aggressive responses in normal people. Residents at Soteria responded to situations that would anger many people, but often in more dramatic ways. The difference in degree was a function of the residents' level of crisis, which was often exaggerated by the fact that they had been taken out of their normal environments--most often against their will--and housed with a group of people whom they saw as alien. Soteria's residents' violent acts were similar to those of the general public but exaggerated.

Actual violent behavior at Soteria was rare. For some staff members, it even played a useful role with regard to their interaction with specific clients, and for such staff its absence actually posed something of a problem.

Violence Towards Self

Staff members found it more painful to deal with self-destructive impulses than with aggression directed toward other people or property. Self-abuse in its broadest sense is a more common form of violence than violence towards others. Aggression in this area culminates in suicide, true, and other obvious forms of self-destructiveness. But there are more insidious self-destructive behaviors--for example, that of the person who smokes unceasingly from the time of rising in the morning until retiring at night; that of the person who stays awake for three days; that of the person who eats nonstop or not at all. Self-directed traumas like these can be more detrimental in the long run than a single, failed suicidal gesture.

Violence towards self at Soteria fell into four categories: the common *insidious* traumas, the rare *elicited* and *acute* traumas, and the suicide attempts. The motivating factors behind self-directed violence were unresolved anger and the need to attract attention and/or reduce anxiety. Anger and anxiety were the major reasons at Soteria for self injury, anger being the predominant force behind acute and elicited traumas; anxiety reduction, behind insidious trauma.

Staff felt an awesome (sometimes unwarranted) responsibility for residents threatening to hurt themselves. The following dialogue between Alma, Soteria's social worker/administrator, and Tara O'Neill, one of the house's

original staff members, demonstrates the impact of work with acutely suicidal residents.

ALMA. Did you ever find yourself catching someone's fear?
TARA. I did once. It was with Iris, and I really picked up on her fear. Iris, you know, is never really physically violent, but one night she was very angry about something that was going on downstairs, so we two had gone upstairs together. I had a sense that I didn't want to leave her alone. I went into her room, and she started throwing things, picking things up, and throwing them at the window. The more frustrated she became, the more impotent she felt, the more enraged she became, flinging stuff, yelling, and swearing. She was talking about how she wanted to kill herself and wished she were dead. I really picked up on her fear because she was much more angry than she was scared. I was scared to leave her: I was scared to take my eyes off her. I don't think I dealt with her as well as I could have, or had before, when I hadn't been that emotionally involved with her, feeling so much what she was feeling.
ALMA. How long did this go on?
TARA. The throwing things and the swearing combined lasted an hour, maybe a little bit longer, and then I took her for a ride. Getting away from the house calmed her down somewhat. She was still very angry and seemed very withdrawn. At one point during the drive, she talked again about killing herself, about different ways she could do so. I started to get scared again and felt the responsibility, thinking maybe it was a really dumb thing to take her out for a ride. So I turned the car around and came back; however, that made her even madder. She wanted to drive around forever. I told her why I had stopped driving--because I was scared that she would try to jump out of the car. So then she just went upstairs. I went up too and stayed with her all night. She hardly slept at all.
ALMA. You didn't sleep either?
TARA. Not that night. Usually when staying up with somebody who needs me--somebody who is too scared, too angry, too violent, or needs watching, or whatever--I'd fall asleep for a little bit from sheer exhaustion. That night my fear kept me awake. That's the only incident that I can recall that I was so touched by what was happening with a person that I caught the fear or the anger or whatever. I really, really felt it, and that scared me.
ALMA. You weren't really afraid she would do something to *you?*
TARA. I was afraid she would kill *herself.* I was really convinced she was going to kill herself, if I took my eyes off her and didn't watch her every second. I had a feeling she was scared enough, angry enough, even strong enough to do it. So I wasn't about to let her out of my sight.

VIOLENCE INWARD---->LOSING:
EVAN
It is sometimes hard to see suicide purely as self abuse, because--"successful" or not--it is also abusive to others. The suicide of Evan, a former resident who killed himself at Soteria while enrolled as a resident in another psychiatric program, exemplifies this double thrust, while that of Tammy seemed more purely self-focused. Tammy committed suicide several months after she had left Soteria in a city some 300 miles away. While Evan's act was the result of a complex and unclear series of events and emotions, Tammy's was

precipitated by her discovery of her former lover in bed with another woman.

Voyce summarized Evan's background:

> Evan's difficulty apparently began when he lived in Idaho. There, he said, he began experiencing difficulty after a "bad LSD trip." One staff member said that Evan told her that "I was at the end of a cycle of good times and was about to begin a period of bad times." Between the LSD trip and Soteria, Evan had made numerous suicide attempts and had been hospitalized on several occasions, primarily because of them.
>
> He showed a few other overt signs of psychosis. For example, one staff member reported that "Evan also complained of hearing voices (female) that instructed him in various ways." Evan was otherwise fairly reasonably behaved, however, expressing his depression only through his suicidal gestures. "His character can best be described as an intensely mellow," observed one former resident.
>
> After several pseudo-suicide attempts, Evan was admitted to the local county crisis unit, with the recommendation that he be kept in a secure place. Soteria staff feared that if left alone, Evan would succeed in his quest to commit suicide. After a week, Evan was admitted to a local community psychiatric hospital where he obtained day passes for short periods of time.
>
> He began coming to Soteria, asking to be readmitted, but because there was no apparent change in his attitude toward self-abuse, he was refused. The house had dealt unsuccessfully with Evan's suicidal behavior, which did not abate, for several months. The Soteria community reached consensus that its best efforts had made no headway with Evan and that, therefore, unless he could offer some assurance that he would not kill himself, readmission to Soteria would be pointless and useless. Such decisions were not made lightly or frequently, and suicidal tendencies were never, in themselves, a reason to refuse anyone a place at the house.
>
> Several days later, Evan was out on a day pass from the long-term "locked" (*L*) facility where he was a resident. Believing him to be ready for discharge as soon as a place in the community opened up, *L* facility staff issued Evan passes on request. This time, however, Evan went to a local gas station and bought a can of gas. Without anyone noticing, he slipped into Soteria's back yard, laid several books and different types of fruit on a blanket, sat down on it himself, pored the gas over everything, and lit it.
>
> A few minutes later, one of the residents discovered the pyre and shouted for help. As the rest of the community came out to put out the fire, the fire department and ambulances arrived. In the middle, Evan, fatally burned, protested, on the one hand, "I did it because of you," and pleaded, on the other, "Please don't hate me for this."
>
> Evan presented himself as concerned with the state of the world; however, he believed that *he* was the cause of the world's conflicts and, as such, had to do something to alleviate them. His method of suicide also probably had international motivation: The Soteria community hypothesized that Evan chose self-immolation because of a recent widely publicized suicide by burning taking place in India.
>
> A year before coming to Soteria, Evan seemed fundamentally sane. An above-average student, he had attended a local university and had a successful work history. His family apparently provided a good social environment. Then something went terribly wrong, something that led to hospitalization, to residence at Soteria, to institutionalization at two other facilities, and finally to death by fire.
>
> What happened?

Evan's case presented many difficulties both for members of the Soteria community and for his parents. First, how could someone who less than a year earlier seemed to be living the American dream have committed suicide? Second, why did he use Soteria as the stage for his statement? Third, why did the

community feel at once angry at Evan and hurt and sad? One fundamental problem shared by Soteria and Evan's parents, who participated in the community meetings after his suicide, was that they were almost as victimized by his act as he.

A few thought that Evan committed suicide not because he believed that life wasn't worth living but because he wanted to make a statement. They remembered comments such as "If only people could understand what I'm trying to say." Or his apology to Voyce, who finally managed to extinguish the fire: "I did it for you."

The implication here was that his apparently successful earlier life experiences were not inconsistent with the final act, but a precondition that gave more impetus to his "statement." This view was most strongly held by a former resident, who saw Evan not as "psychotic" but as someone willing to pursue an idea to its conclusion at any cost. This attempt to find something positive in Evan's suicide was unusual, however; most took a different view.

The most negative view of Evan's act was that of the staff member closest to him. She thought Evan's act was directed at Soteria in general and her in particular, because he was refused readmittance without assurance that he would stop his self-destructive behavior, and she had been most adamantly opposed to his return.

Evan's parents took opposite positions in this painful debate. His father, like the former resident, saw Evan's act as a positive statement. His mother saw it as supremely negative, a blow to all who cared for him. While the community's discussions served, eventually, to alleviate somewhat the pain, grief, and anger Evan's suicide left in its wake, the sense of loss persisted among the members of Soteria who were there during Evan's short and dramatic stay.

VIOLENCE INWARD——>LOSING

TAMMY

Twenty-three-year-old Tammy was admitted to Soteria two days after Thanksgiving. She had attempted suicide by ingesting paint thinner, following an argument with her uncle at Thanksgiving dinner.

On admission, she had severe blocking, showed thought disorder, was mostly without affect, and exhibited catatonic motor behavior. She was convinced that she was the devil incarnate. Auditory hallucinations told her of her "badness."

The preceding May, she had returned home following an auto accident in the metropolitan area to which she recently moved. Although she had not been badly injured, escaping only by a lucky chance, she felt she "ought to have been killed" and decided to change her life style to "find Jesus." She moved in with the Catholic aunt and uncle who had raised her and worked as a full time volunteer in a fundamentalist religious mission.

Nonetheless, in the two or three months prior to admission, she began to believe she was "Lucifer" and was responsible for evil. She thought that by killing herself she would "rid the world of evil."

History

Tammy, the youngest in the family, lived in the East with her mother, father, sister, and brother until she was five years old. At that time her father died of a heart attack and a maternal uncle committed suicide. One year later, her mother was hospitalized in a state institution because of "her inability to

cope with the death of her husband and the raising of three small children on her own." Diagnosed as schizophrenic, Tammy's mother was never discharged.

At that point, Tammy and her older sister and brother were sent to live on a farm with an aunt, an uncle, and their nine children. All were raised in a strict Catholic environment and attended parochial schools. In 1967, the entire family moved to California, when her uncle took a job with an electronics firm.

In high school Tammy was a good student, well behaved, and her uncle's favorite. But shortly after Tammy left for college, her older sister died of asthma soon after admission to a state hospital for "extremely withdrawn behavior." Tammy did not know her sister very well because "she was very quiet and hid in corners a lot."

Tammy stayed in college for three quarters, did poorly, and dropped out without finishing her first year. After that, she lived communally in a variety of hippie environments, became sexually involved with many men, and at one point lived alone in a tent for several months. Because she did not conceal her promiscuous behavior from her aunt and uncle, Tammy was unwelcome in their home. During this period, she became pregnant and went to New York for an abortion. She returned and adjusted, marginally, to her life style until the auto accident.

At Soteria

At first, Tammy remained quiet, withdrawn, without affect, and preoccupied with her role as the devil. About a month after admission, she attempted suicide with rat poison because she felt responsible for an outburst of violence by another client. She improved gradually over the next several months but remained impassive and preoccupied with the devil. She had great difficulty sleeping when it was dark and occasionally took neuroleptics to help.

In April, some six months later, three days of intensive staff work occurred that seemed to be pivotal for her recovery. Loren and Katy summarized the process.

> Everyone was drinking wine until 3:00 or 4:00 AM, Tammy remaining impassive.
>
> Finally her facade broke down, and she began to express crazy sentiments, again believing she was the devil and should die. She sobbed and sobbed--angry, upset, and nervous.
>
> Katy and I held her for a long time, saying little except to comfort her and support her. Later Tammy went to bed, Katy with her. I joined them, sat by the bed and held her hand.
>
> She continued to talk about being the devil. She wanted to die: "I should be killed because I am so bad." I asked her who in her life was the devil, and she responded immediately, "My uncle." "He raised people in a warped way," she continued, "treating them like flowers and bushes. He said that they should grow straight as he wanted them to."
>
> She went on to say how her behavior for the past several years had been her way of showing him that she didn't like his ways, but that then she felt bad and that she should die. I pointed out that she was wanting to kill her uncle in her. She picked that up and began to focus on how angry she was with him for what he'd done to her.
>
> She also said he had caused her sister's death from asthma because he had made it so that her sister no longer cared to live. At that point Tammy began to wheeze, which she continued to do as we talked about her sister--how she'd liked her but hadn't really known her. Tammy felt bad that she'd been stoned when she found out about her sister's death. She had gone to the funeral but hadn't been to the grave since.

She then focused her anger at her uncle in a very real way. She ought to tell him she wanted little to do with him, she said, and with this connection of her negative feelings to him, her mood lightened, she was much less depressed, and she could even laugh. By sunup she was very much together: She was relaxed and her asthma had gone.

She went to sleep peacefully.

The next day, Loren found Tammy sitting quietly and asked how she was. She talked about being angry at everything and everyone but explained how difficult it was for her to be angry. At that point she went into her devil trip and said she wanted to get $89 and go to Hawaii. Loren pointed out that, since the devil was part of her, he'd make it to Hawaii also.

Suddenly, she became sad and was about to cry but wouldn't really let herself. Loren indicated that being sad was "OK" and offered to *be with* her. Tammy decided against a possibly intense experience because she said she was "numb," she "felt nothing," which Loren said might be easier than being sad. She heartily agreed.

Then, Katy, Tammy, and Loren shared some of their early life experiences. Tammy and Loren had both been raised Catholics and had both left the church, stands that were, unfortunately, accompanied by considerable guilt.

Without much further brooding, Tammy then talked for about an hour, almost non-stop, about her losses: Father, mother, sister, cousin--in that order. When talking about her sister's death, Tammy slipped back into her conviction that she was the devil and again asserted that she needed to die. Loren gently redirected her to her sister's death and she continued to unburden herself.

Sadly, poignantly, she talked about her mother. She'd resented her sister telling Tammy *she'd* be her mother, when Tammy felt no one other than her mother could fulfill that role. Tammy's feelings about and recollections of her mother are all positive. For example, "she made me feel safe and good when I went to bed." She was similarly warm about her father.

And her brother, she said, was "always there when I needed him." During this monologue her affect was always appropriate: Sad about her losses, angry and somewhat sympathetic about her uncle, who has alienated the children he hoped would take care of him late in life.

Loren and Katy's major efforts were to take her back to the stimulus which spun her off into madness. They also acknowledged the incredible number of losses she'd suffered, pointed out that putting them into perspective did not necessarily mean blaming anyone but did help sort them out.

There was an immense sadness in her that made Loren sad himself. He acknowledged and supported her efforts to keep in touch with her feelings and pointed out again and again that it was avoiding them that had led her to feel like the devil with all his "badness."

Finally, Katy and Loren and Tammy spoke about her fear of losing people, a fear that prevented her from letting people get close. Katy said it was hard for Tammy to acknowledge closeness to her: "I will go off duty in two days," Katy warned, "but I'll be back and I'll miss you."

Tammy was quite calm and at peace and went to sleep readily.

Katy and Loren were the staff combination one more night during Tammy's stay. As Tammy and others were sitting round the table, Katy noticed that Tammy was behaving differently than previously: She was acting silly rather

than either being down or feeling good. Loren conjectured that this mood was related to the staff change coming the next morning, and Tammy agreed readily.

Over the next several hours we discussed this issue, including relating it to her many other losses. Occasionally she slipped away from the pain and acted silly--but in the context of the relationship with Katy and Loren seemed able to return to it, tolerate it, and come to terms with it.

Again, a natural resolution of her pain allowed her to go comfortably to sleep. In the course of the discussion, Loren, Katy, and Tammy acknowledged their regard for each other, a regard Tammy noted that she didn't hold for many people.

Following this evening, Tammy improved dramatically and began to make plans for herself. For the next two months, there were few signs of continuing psychosis. The weaving she had begun in a desultory way she now pursued with great care and attention.

First Leavetaking

Tammy arranged to live with a staff couple in a nearby city and left Soteria, after a stay of nearly eight months. For the next two years Tammy remained well, living communally with the staff couple for nearly a year and then moving to her own apartment. She worked full time as a waitress and continued weaving.

A year after discharge, she met a man she liked very much and, two months later, moved with him to a farm in a nearby state. But after nine months, the relationship broke up, and Tammy began to go downhill.

Having received no formal treatment or medication during her two years in the community, Tammy was readmitted to Soteria in a state very similar to her original. She was suicidal and preoccupied with her "badness."

But this time she stayed at Soteria only six weeks. She chose to take neuroleptics for a month of this stay but discontinued them two weeks before leaving. She reorganized rapidly and arranged a job and living situation for herself in the same area of the nearby state from whence she'd just come. As before, at discharge she was in no way psychotic.

Last Leavetaking

"Everyone was pleased," remembered Katy, "that Tammy had gotten better so much more rapidly this time. We thought her quick recovery portended well for the long term."

Five days after resettling near the farm, however, Tammy made an unannounced visit to her friend. She found him in bed with a woman, took his gun off the wall, stepped outside, and shot herself through the head. She died instantly.

VIOLENCE INWARD——>WINNING

KELLY

Responsibility for dealing with dangerous, self-destructive behavior could continue even when the staff member was off duty and away from the house. Loren recalled one such intervention from Susannah:

> I found Hal with Kelly sitting beside the front room heater. She had blindfolded herself and then poked holes in her right wrist, lacerating it superficially. She was clutching pieces of broken glass in her left hand. I told her that I wouldn't let her hurt herself and that I

wanted her to give them to me--she grasped them tighter. Hal made the same request with the same effect.

Luckily Susannah (who was not working) called back to see if she was needed. Hal and I tried to persuade Kelly to talk to Susannah. She said yes by allowing us to lead her (still blindfolded) to the phone, but she said nothing. Susannah spoke to her, and in a couple of minutes she gave Hal the large pieces of water glass. Her hand was *uncut*.

Susannah had told Kelly that she loved her and accepted her but didn't want her to hurt herself anymore--Kelly hurt enough inside without having to hurt her wrists.

Without ever saying a word on the telephone, Kelly followed Susannah's request and handed Hal the shards.

Why did Kelly resist help from men, wondered Loren. She needed and wanted women's acceptance, something she never had from her mother, who had consistently rejected her. The question is, he continued, why does Kelly think only women can tolerate and accept her "badness"? When she felt a woman (i.e., Susannah) could, Kelly reverted to an infantile, within-the-womb state of blindness (even to a blindfold), silence, and need to be cared for. Her experience with her mother led Kelly to predict rejection by females, especially if she were to do something "bad." Not finding this to be the case, Kelly was able to stop mutilating herself.

Interpersonally Problematic Responses

Soteria residents expressed themselves in a number of ways that some would consider bizarre. Staff members learned to respect these statements where appropriate, to alter them where useful, and--on occasion--to halt them altogether. Three particular responses came up and had to be handled frequently--residents exhibiting withdrawn, infantile, and sexual behaviors. Staff dealt with each situation uniquely; however, certain community members had better tolerance for certain behaviors than others. Sometimes, it was possible to "specialize" and assign particular individuals to deal with the behaviors with which they felt most comfortable.

Withdrawn Behavior

Staff members dealt with withdrawn persons idiosyncratically; however, a number of kinds of approaches seemed often to work. For example, Tara's and Ed's responses were restrained. Tara explained,

I left Tamara pretty much to herself when she was in that withdrawn stage. I wouldn't try to force her. I remember the first time I met her. She was lying on the couch, and I went up, leaned over the couch, and said, "Welcome, my name is Tara."

She barely looked at me and said "Hi" in a very quiet voice, not responding at all otherwise. I don't remember how long she was like that. I would sit with her. I would tell her that it was time for dinner and sometimes bring her food to her, but usually she ate with everybody else. I'd keep an eye on her, but I never pressed her, like "Let's get to know each other." I just didn't think that kind of pressure was indicated or right.

Ed related to a withdrawn resident named Leo similarly.

For the first couple of weeks, Leo must have spent close to 20 hours a day in his room. He'd come down for lunch, dinner, and a cup of coffee late at night. I would go up and talk to him in his room and ask him if he really wanted to stay there when he was welcome anywhere in the

house. I reassured him, however, that this was his room, and if he didn't want me or anybody else in there in there, "Just say so, and I'll leave." But I'd invite him to come down for a cup of coffee and stuff like that. He'd just kind of work into it.

Another staff member, Susannah, found nonverbal means to forge a relationship with Leo, who was still withdrawn.

For some reason, it was very difficult for Leo to use words to communicate. So, when you sat down and tried to have a conversation with him, you were unwittingly threatening him, putting him on the defensive, rather than building your relationship.

So I guessed we should think about activities in which we might engage Leo where he wouldn't be obliged to talk. One night I remember, he wanted a beer, so I took him to a liquor store to get one. I didn't know the way, so he was giving me signals with his hands--which way to turn and so forth. When we got there, Leo didn't have money or identification, so I paid for the beer, and then we came home. There was no conversation either way.

After we walked in, I was really tired, so I lay down on the living room sofa to rest for a minute. I suddenly became aware that it was very cold in the room. Then I looked up and Leo was standing there, putting his jacket over my shoulders to keep me warm. And then he just walked away. I guess you could interpret that in a lot of ways, but to me it seemed he was telling me "thank you" for the beer by returning a favor.

But it was a mind-blowing experience, because it was all nonverbal. And doubly mind-blowing because I think we all saw Leo as absorbed in his own fantasy world, as comparatively unaware of other people's needs. And yet that night he knew what I wanted--a coat--without my even saying so.

Still another staff member, Geoff, expressed to Alma his serious doubts about whether such gradual methods of building a relationship were valid:

GEOFF. My first reaction to that really heavy withdrawal is to give Leo a kick in the ass. At first, I thought of almost forcing myself into that space. Forcing myself into it with him; or forcing him to come out to me--one of the two. The other one would be just to stay with him for 3 weeks for 24 hours a day, for as long as it took, but I don't think I've got the energy to do that.

Sometimes I have the fantasy of going in and dropping a bomb--a really very aggressive kind of "Goddamn it, relate to me!" That's what we did in the psychodrama groups with which I worked before, and usually it worked. You dropped the bomb and then went around and picked up the pieces and put them back together and held the person. And, there's a really heavy aversion, which at times really upsets me, against that approach around this house. It's almost like saying, "That's the space he's in, and don't do anything with it."

ALMA. But sometimes I think there is also the part, that you are OK, no matter what you do. And I really think the only thing that will make you understand is to, some day, watch them wake up from that withdrawal and tell you what's been going on. And then you will be less likely to want to intrude.

GEOFF. Yeah.

ALMA. There can be a great deal of work going on.

GEOFF. The thing that worries me--my main worry--is that it doesn't put any faith in Leo. Because what if he stays there? What if everybody gets used to that, and says OK, that's where Leo's at. We'll let him stay there. And, three years later, he still hasn't come out. You know, how do you then do something about it? By then, the pattern is established. What can you do then besides just putting him on a ward somewhere, because somebody didn't do something at the right time, or the environment wasn't right, and the person just didn't come back...

Infantile Behavior

With severely regressed residents, Soteria staff found the simple reassurance imparted by physical contact to be particularly important. (Although traditional modes of therapy caution against touching a schizophrenic person, staff found that physical contact was a significant means of expressing warmth and concern.) Touching was thus an important form of communication at Soteria, and staff member Ed found it natural to hold and rock Kris, a young man regressing to infancy:

> I think I'd been here a week. I put Kris in my lap, and he accepted the gesture completely, lying there for about an hour and a half. Then, I stayed with him all night. He'd get a little sick once in a while and spit into a pan that we had there. I'd be washing his face off with a wet cloth; then, he finally sat up, and I just gave him a back rub. I stayed with him the rest of the night. When someone's regressed down, and you're nursing him, there are no sexual feelings. You have the feeling that the person is two years old, no matter how big they are. With both Kris and Chuck--I didn't see Kris as 20 or Chuck as 18. I felt as if I were holding two-year-old boys in my hands, in my arms.
>
> With Kris, it was the first time I'd done it, and I was sort of watching myself doing it and saying, "My god, he's two years old; that's all he is." I was like a father and a mother together. You're not aloof from the experience thinking, "Now this person s regressing, and I have to hold him." You're just doing it instinctively.

Sometimes a regression to infancy includes a desire to nurse. Staff member Kay described such an event when she was tending to Tamara:

> I had had three hours of sleep, and even that had been broken sleep. Sleeping with and guarding Tamara is not especially conducive to good resting. I was sleeping on the floor by the door, so I would wake up, if she tried to leave. She awakened at 6 o'clock demanding food. I got up and started to fix her breakfast. She was sitting at the table, waiting most impatiently and then urinating on the bench. I took her to the bathroom and changed her pants; then, we went back to the kitchen. I fed her at the table. She finished and sat quietly for about two minutes. Then she looked at me with a fearful expression on her face and asked me what day it was.
>
> I told her it was Sunday.
>
> "No, I mean what day is it *really*? You know what I mean!"
>
> "Sunday, September 5th."
>
> I knew that this was Tamara's birthday, but I just didn't want to deal with it then. I was tired. I was sad. Here it was, Tamara's 16th Birthday--"Sweet 16"--her special day to celebrate, and there she sat in Soteria, soiling herself, terrified of dying, of being alone, of being with people, of spiders, of noises, of being loved, of being unloved.
>
> "Happy Birthday, Tamara"--it was so goddamned sad.
>
> When I told her the date, she was stunned. She sat completely still and stared at me. Then came the change--fear, anxiety, joy, little-girl pleasure, sorrow, and pain all flashed over her face. Then she started to cry, a slow, sad, and painful cry. And then she said, "It's my birthday. Say 'Happy Birthday' to me." And I did. Then she got up and came over to me and sat down. She took my hand in both of hers and said, "Hold me!" I held her, while she cried for a few minutes.
>
> Then she sat up and said, "Give me a present. Give me something. Give me anything. Give me something you don't want anymore. Give me something you hate. Just give me anything of yours, and I'll love it forever." I told her that she would be getting birthday presents later in the day--that we hadn't forgotten her.

I was wearing a T-shirt that morning, one that Tamara liked. She asked me then if I would wear her shirt and could she wear mine, just for her birthday. No one else in the house was awake--it was early, and it was Tamara's birthday--so we exchanged shirts.

When I took my shirt off, Tamara stared at my breasts and seemed to freeze for a few seconds. I can't describe even to myself the expression that was on her face, so I won't try here. She collapsed into my chest with her eyes closed, completely limp. I almost fell under her weight. Her face was toward my chest, and she moved it a little and started sucking my breast. For a very brief moment I panicked, afraid of being bitten and wanting to pull away. But that feeling passed quickly, and I didn't withdraw.

Maybe it was instinctive. It just all felt so *right* to me then. Without thinking of appropriate therapeutic moves or words, I held her, cuddled her, nursed her, cooed to her--all very freely and naturally--and it ended.

Suddenly, Tamara moved away from me and said, "I'm not your baby: You're mine." She then ignored the episode and went on to deal with the rest of the day. She seemed much more in touch with her environment for the next 24 hours, and the staff guessed that this episode may have been in part responsible. As usual, however, there was not *one* answer, one cure. Such temporary periods of recovery were characteristic of residents emerging from deep regressions.

Regression, while never induced at Soteria, was allowed when it happened naturally. It often seemed to be an important step toward reintegration. Soteria staff dealt not infrequently with incontinence and permitted messing about with food and/or paint. When staff member, Keith, realized how helpful smearing was to Tracy in expressing her emotions, he thus encouraged her:

Tracy had been working for weeks, six to ten hours a day, on a big oil painting "by numbers" to give to her mother. When her mother finally told Tracy that she could not come home for Easter, Tracy was really angry. She took the paints and started with the brush to make wider sweeps, finally using her hand, mixing all the paints together and smearing them on the painting until the original design was practically obliterated. But she was smearing with style.

She was creating another kind of painting. At one point, she stopped and looked at it and said, "What do you think?" I said, "It's the best painting you've ever done." I really liked it. There was anger in it the way she was using the colors. This one had meaning, whereas the painting by numbers didn't have much. She kept on working and finished it up. At the same time, she was getting back at her mother.

When she finally finished the picture, she started painting on the wall, drawing figures, writing the names of people in her family... She looked around to see if it was all right, and I thought, well, she had half the wall already done--she might as well keep going on this section.

Finishing that wall, she left the art room and was starting to splotch paint around the house.

"Let's stick to paper," I suggested. "I don't know if that stuff will come off or not. I think it will, but I'm not sure." There was paper on the walls for painting and I said, "Use the paper." She did. But when she was done, she dumped the whole pan on the living room carpeting as a finishing touch.

She was writing members of her family's names over pictures of things like cats and dogs biting, mixing people in the house with her biological family. The result was really good, both as smearing and as a real expression of herself, something she hadn't been able to do for a long time.

During the painting, I talked to her about what I saw in it and what she saw in it. I sometimes asked her, "Who's this? Who's that?" She'd say, "That's the girlfriend I had in high

school. That's my younger sister. That's my mother. That's my uncle..." She was writing 'cat' and 'dog' and 'witch' and stuff like that. We just talked about what they were. One of the reasons why it was effective was that it wasn't done as therapy, as me helping *her* see what she was creating.

I was curious as to who they were. *I* didn't know.

Keith's spontaneous interaction with Tracy, combining his genuine interest in her with a responsible attitude toward the house as a whole, was typical of Soteria's approach at its most successful.

Sexual Behavior

Original fears that staff and residents might engage sexually--despite the extant incest taboo--proved exaggerated, and staff members quickly learned to deal with sexual expressions with relative ease. Susannah explained,

> Ike was, I guess, seemingly much more together than most of the other residents we've had, and Ike got a crush on everybody as far as I can remember. He'd want to go for walks with you and put his arms around you, and, you know, act the way a little 16-year-old would act with his girlfriend. You had to let him know that, although you weren't his girlfriend and weren't going to become his girlfriend, this didn't mean that you didn't like him and didn't care about him--he was manly, exciting, and so on and so forth. But he's the only one that I've ever had to deal with on that kind of level, because most of the others were too spaced out to ever do much with their crush.

Staff members usually found it easy to distract acutely disturbed persons acting sexually, simply by paying attention and calmly discouraging overtures. Keith remembered,

> Tamara would come up--This was the time she was running around naked, and she would come up and jump at you and wrap her legs around your hips, and she would start jumping up and down and say, "Let's fuck." I didn't feel at all threatened. It was always hard to keep myself from laughing. Maybe that's some kind of a nervous reaction. I would just always unwrap her arms from around my neck and try to get her legs off and sit her down, and I would stay with her.

Staff members recognized that sometimes sexual expressions actually expressed anger or worked out conflicts. Ed saw Iris' performance, framed into a "safe" game, as more a result of anger than lust:

> Iris would play at being the sexy southern belle, and she was really good at it. One night she put on a big, round, broad-rimmed hat, tied her blouse up, and was swinging her hips all over the place seductively. "Hi, boys, how ya doing," she drawled. That it was a game made it safe, allowed her feelings to come out. Sometimes she'd get into a kind of sly viciousness. One night, for instance, she was playing a heavy come-on. But when we responded, she'd cut off fast. She'd call you in and then slap your face and then start again.
>
> At one point, she offered--seductively--to make me some coffee. So I said, "Sure, go ahead." It was in the game. She went and got the coffee and filled it full of hot sauce. Returning, with a changed expression, she very sweetly gave me the coffee.
>
> The first drink burned the shit out of my mouth. She made this into a game too: "You burned yourself, boy? Gettin' hot now, boy?" It was all in play, so it was all right, safe.
>
> There was anger in there too, though. My burned mouth testified that she had been able to express it.

Many times, because residents were afraid of their sexuality, they were scrupulously careful not to engage in sexual expression. Others tried to defuse their fears with lascivious talk. Wrote Tara,

> I know that right now Naomi is very uncomfortable about the homosexual thing and gets paranoid about the whole question of massage. I try to be really careful with her, not careful because I'm afraid that she's going to try to make love to me or whatever, but careful because she's so scared: She's thinking, "If you give me a little back rub, does that mean you're hot for my body?" I know that she's thinking that, so I'm very careful. Naomi's also going through a stage where she's thinking about sex all the time. She talks to me about her sexual fears. She also likes to talk to Susannah about them, and she talks about how all she thinks about is sex, orgasm, and fucking--and not just with men but with women and dogs and clothes and walls and everything. It's a real scary preoccupation with her now.

Susannah recognized and helped defuse lesbian fears in another resident, Tracy:

> That one weekend when I was watching Tracy very closely, I'd been with her during the day, and if she'd want to take a nap or something, I'd sit on the floor. At night, when she wanted to go to sleep, she didn't want me to be in there. I still wanted to watch her closely, but she was getting really up tight and couldn't sleep--she was staying awake, watching me.
>
> So I finally said, "I'm going to sit on the floor outside your door. I'm going to sleep here tonight, so if you need anything just let me know." She said, "OK. Thanks."
>
> This promise let her know that she was both private and safe.

Fighting Fighting--Soteria Style

Sometimes an effective technique was to fight violence with violence. When a resident, terrified by his/her aggressive impulses, was afraid that others could not stop him/her from destroying people or property, sometimes a staff member returned the aggression to show control, to demonstrate competence in dealing with others' aggression.

Kris' Case

For example, at one point Kris, a resident, began to go on a rampage, breaking things and verbally assaulting others. At this point, a staff member, Daniel, followed Kris into the living room and physically subdued him. As they wrestled, Daniel in control, this dialogue occurred:

KRIS. Let me go. *(Almost crying.)* You are humiliating me.
DANIEL. So what. You humiliated me. You've been humiliating me all night, doing all that stuff.
KRIS. I know it.
DANIEL. That's right, you know it, so don't bullshit me.
KRIS. Fuck you, queer.
DANIEL. I'm not going to let you fuck me.

Daniel allowed the struggle to become more even and then took solid control again, repeating the process several times. When neither was winning, Daniel called Kris the same names Kris called Daniel, giving some credence or

validation to Kris' phase of fear and anger. The situations of equality-in-struggle and Kris-under-control balanced; Daniel and Kris thus stayed in touch emotionally and verbally.

At this point, the two remained at almost equal position in struggle; Daniel having gained a slight advantage. Encouraged and expecting momentarily to have Kris under control, Daniel explained, "When you get outa hand, I just have to show ya." When Daniel took control, the weight of responsibility lifted off Kris, but the struggle acknowledged and validated that Kris was a young man testing his strength.

Shortly, Daniel released Kris, who sat in the living room for a few moments and then went into the kitchen where, mad at the world in general, he threw a cup on the floor. His rage built, seeming to focus on *everyone* in the house (instead of just the girls as it had earlier). When Kris noisily continued breaking things, Daniel again confronted Kris with the ready-to-fight affect in physical carriage, tone of voice, and expression.

DANIEL *(about a foot and a half away)*. Well, what are you doing?
KRIS *(straightforwardly, not angry, not afraid)*. Well, you sure are angry.
DANIEL. Well, so are you, so what!
KRIS. Well, so what!
DANIEL. Yeah, so what.

The tone of their dialogue modulated between anger and rough play. The mood of the two admitted the emotion and tried to figure it out a little--but more simply experienced it. Kris' fear of Daniel, so evident earlier, disappeared; at times, they seemed like two angry comrades stomping around and trying to figure out what to do next. Eventually, Daniel succeeded not only in subduing Kris' aggression but also showing that it is okay to be angry, that anger is safe when it can be controlled and subdued by others.

Another staff member, Kay, used a diversionary technique with Kris. She reported,

> On one of those afternoons, Voyce had taken somebody out for a ride, and I was the only staff person in the house--this was rare. We were all in the living room. All of a sudden, doors started slamming upstairs, and Kris was carrying on and going into his usual "fucking slut" routine. He came downstairs and opened up the door of the room and just slammed it as hard as he could and stomped out, kicking, yelling, and demanding, "Where's the food? Where's the goddamned lunch?"
>
> I thought that he was really starting to get into one of his rages, and I had a moment of panic and I thought, "Oh damn it, I can't handle Kris when he starts to get physical." Then I just got pissed off, because I felt he was taking advantage of there being nobody in the house but four women. So I went into the kitchen.
>
> Kris was standing there glaring at me. He called me a slut or something, so I started banging cupboard doors and going on about how there was never anything to eat in the house.
>
> "I'm so sick of this mess! Nobody ever cleans up the kitchen!" I continued, going into a phony rage about the mess.
>
> I slammed the back door and went out into the back yard.
>
> With a smile, Kris looked at me in a surprised way and went upstairs to his room. He didn't make any more noise. I felt proud of myself, but I didn't know what else to do. I knew I couldn't handle him if he got into a rage.

Tracy's Case

Finally, staff sometimes used acts of aggression as therapeutic tools. By staying with residents in crisis states as long as necessary, staff members sometimes were able to uncover troubling things still fresh in mind. (See further *Treatment Techniques: Being With,* pages 41-60.) In this case, a resident named Tracy had early one morning set her bed on fire, hoping to cremate herself. At about 6:00 AM, after the fire was extinguished, she and Loren began to talk. He recalled,

> I asked her what was happening with her; she sat quietly and without any show of emotion told me she was the devil and that the radio and TV had been giving her messages to "burn, baby burn," to feel the fire of hell. She said subsequently that later she'd gone to a Puritan‡ gas station. Her logic: The Puritans burned witches, and she was a witch; therefore, because Halloween was coming, she would burn.
>
> I told Tracy that it seemed to me she was saying she was bad in some sense, that she'd done something wrong, and her way of handling these very painful feelings was to see herself as the devil. I then inquired about recent life events that might have resulted in her feeling a "bad person."
>
> She related, at first in a very disorganized way, something about having had a fight with her sister in L.A. I asked again about recent events of note; she gave me, in a much more organized way and with some real sadness, the story of how she'd not gone to her maternal grandfather's funeral last May, although her sister had called and asked her to. She said she'd not gone because she was afraid of funerals, she didn't want to see her grandmother hurt and crying, and she was afraid to try to deal with her mother and sister.
>
> Both descriptions were punctuated by occasional silly giggles, questions as to whether *I* thought she was the devil, and assertions that she, in fact, was. I said it seemed to me she talked about being the devil whenever she began to experience the pain of her sadness and badness. In time we agreed that her irrational, but firmly held, beliefs (delusions) and her notions that many events going on around her were intended to have special meaning for her (ideas of reference) came to the forefront when she was confronting the pain of her life. Later, we agreed that her belief that she was the devil might be her way of avoiding that pain.
>
> I went into some detail with her about her relationship with her grandfather and how she'd lived with her grandparents when things were bad for her at home. We also talked about the funeral she hadn't attended; she knew her grandfather had wanted to be cremated and wondered what in fact had happened to him.
>
> She said then that morning's fire was no accident. Intending to cremate herself, she had placed a lit cigarette in the mattress, watched it catch fire, and allowed it to burn her hair before deciding that burning the place up would be unfair to *everyone* else there, so she went to get Hal.
>
> Our chat then returned to her sister. The story unfolded--complete with photos and a heart rending letter about her sister's complete hysterectomy. The sister's letter described how empty, depressed, unfeminine, and hopeless she'd felt. Several remarks Tracy made about her sister made me think that theirs was a self-destructive, competitive sexual relationship in which Tracy was always the "bad one," the "irresponsible one," the loser in the eyes of her mother and sister. I thought that Tracy's burning herself might also be an attempt to destroy her femininity. At this point, she unravelled a tale of nearly life-long sexual promiscuity. Since her sister's surgery, however, she had for the first time gotten into a variety of homosexual relations and into kinky heterosexual ones.

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‡There actually was a company with this name.

Around 9:00 AM, we switched to the living room couch, and, as we focused on these events, she began to cry quietly. When I got inattentive or sleepy, she would bring up the radio and TV messages "addressed to me." (They told her how bad she was.) I suggested that maybe they were Tracy talking to Tracy and brought up some of the situations we'd discussed about which she felt so guilty. She really delighted in those notions and brought them up many times over the next several days.

During our time together, I often told her I thought she was really all right but recognized how bad a person she felt she was. When she asked me what was good about her, I told her I thought she was bright, competent, and pretty--each of which she was. I held her hand, stroked her burnt hair, and made small talk. Often I found myself reaching out to her, because she was so sad, and I wanted to comfort her and let her know that I could stand to share it with her.

When I tired, Voyce moved quite comfortably in to be with her. Earlier Tara had taken care of brushing out Tracy's hair and tying it back so it didn't look bad. Everyone involved performed a role--changing places as necessary over the six-hour span. I was not "the designated therapist," with others subservient. Several of us shared this *being with:* Immediately after the fire I was primary, but later Tara, Voyce, and Daniel were very much involved with Tracy.

By noon, Loren concluded Tracy's outcome was positive. She was in touch with her feelings, both pleasant and not. Her face was now mobile and appropriately expressive. Her psychotic disorganization, delusions, and ideas of reference had receded almost completely. While Tracy could by no means be called happy, she was responsive, having lost the deadened, zombie-like appearance that characterized her between 6:00 and 9:00 that morning.

Softening the Blow

Violence of any sort affected all of Soteria, and the staff learned to be particularly conscious of the fears violent actions frequently generated. Often cooperative action resolved the situation--while some staff members provided support and control for a resident in acute crisis, others dealt with the remaining residents' fears regarding the crisis. For example, Tara recounted the effect of Kris' violence on another resident, Katherine. The team approach was vital:

Kris would usually flare up and then it would be all right for a day, maybe. He'd go to bed. He'd control himself. (He couldn't do "it" that night, he'd explain.)

But one night, he was throwing things and talking about wanting to get knives. He picked up an ashtray and threw it at Katherine. Kris was just all over the place, rolling on the floor, bumping into things.

I'm quite sure that if Daniel hadn't been there to handle him, Kris would have come even more unstrung. I, myself, was scared, but Katherine was flipping out. Her eyes were rolling around in her head, and she was just holding on to me and not wanting to move. I was trying to get her up to my room, because at that time my room was the only one that had a lock on it. I finally got her back to the bedroom and she was really scared. She was trembling and started to cry, though she tried not to. Part of her was concerned for Kris, wondering "why is he like this?" But *his* violence also brought out all *her* fears.

To help calm her and because she was hungry--during these days she was always hungry, so I made a little tea party. I got crackers and cheese and tea, and we just locked ourselves in the room for quite a long time.

Susannah recalled another of Soteria's peacemaking ventures. A fire of uncertain origin had just flared upstairs. She remembered,

> Once we got the fire out, Naomi, Chuck, and Leo were all still here. Both Naomi and Leo got really frightened by it. At one point, Naomi darted out of the house and ran down the street and around the corner. I went off looking for her, but she came back on her own. Shortly after that, Katy spent a lot of time with her.
>
> Then Leo was going to leave. Evidently he had walked out on the porch and asked Katy where to rent a room. So I went out and talked to him. I asked him if he wanted to move out, and he made no response. He said he had his check and wanted to cash it. On Sunday night there was no place he could, so I offered to lock it up in the box upstairs. He was talking about how he needed a gun to protect himself and his check.
>
> We just talked about how he could leave if he wanted to leave but how also he could stay and still be protected if he were feeling that he couldn't hold on any longer. He could stay here and let go, and there would be people here to protect him at all times. The gun wouldn't be necessary. We talked like this for pretty close to 45 minutes, after which he turned around, came back in the house, gave me the check, and told me to lock it check up. There was no more talk of a gun. He had been scared, and the gun symbolized the protection that Soteria wasn't giving--at that point. Once the house protected again, the gun wasn't necessary. Nor was he leaving. He felt safe again.

TREATMENT TECHNIQUES

More than anything else, they [schizophrenics] are simply human.

--Harry Stack Sullivan

Some of members of Soteria's founding group had worked on a somewhat similar project, the study by Julian Silverman and Maurice Rappaport based at Agnews State Hospital (San Jose) in the late 1960s and early 1970s. There, unmedicated schizophrenics had been treated in a hospital setting. This experience helped staff predict and deal with certain problems arising as Soteria was established. Many of the attitudes and techniques employed at Agnews, however, were dissonant to Soteria's theoretical orientation; thus, the only major technique incorporated into Soteria was the *vigil*.

The vigil was both a treatment and a training tool. For treatment, it was seen as a way to intercede in the psychotic process and have an impact on its course. As training, it gave staff members experience in being with someone in psychosis both as observers and as participants, a concept Sullivan pioneered.

Because of the variety of demands and the large number of disturbed people on the small psychiatric ward at Agnews State Hospital, administrators for this special ward had defined and allotted extra staff to deal with severely disturbed persons in order to avoid medicating them. Paired male and female staff and volunteers stayed with the person in crisis in consecutive shifts of from four to eight hours in a medium-sized, comfortable room designated as the "vigil room." In this way, attendants were able to provide continuous individual help for four or five days at a time. During the vigils, the staff members involved had no duties and were expected only to *be with* the person in crisis in any way that seemed to make sense. Other personnel provided necessary life-sustaining functions such as meals. While the acutely ill person was encouraged to remain in the room, the staff did not prevent exits and could, if indicated, use all of the hospital grounds as an arena for *being with*.

To train staff for the Agnews vigils, a mock vigil took place without a person in crisis. Assigned pairs simply remained in a room with nothing to do for extended periods of time. During group meetings held after each vigil--real or feigned--all staff and volunteers discussed their experiences in detail.

The vigils were successful. One patient, who fought six times and broke four windows on the ward the day preceding his vigil, was not violent either during his vigil (four-and-a-half days and nights) or--towards people--after it. He went through an acute schizophrenic crisis to full reintegration in three months. Not only did all patients given vigils improve, but also there was much lighter property damage, less emergency medication, no injuries, and fewer transfers to the maximum security ward.

Soteria Staff on Agnews' Vigils

Soteria theoreticians originally thought vigil-like experiences would be the most efficient way of helping staff learn to relate to a person in crisis. Some found this kind of preparation useful. Said Daniel,

I think the most time I spent was 12 hours. I think that if you'd done 24 with one person, you could build a kind of comfortable feeling. I learned about my patients‡ and about my own talents. I learned that I have a lot and can take a lot. It was a really good place to learn how to let be, that I didn't need to interfere. I like the vigils. I can really stay on an unthinking level in them. It's a comfort to just be there, and I think it's comfortable for the patient‡ with me to just be there like that.

Others had less meaningful experiences. Tara wrote, for example,

The vigil went on...for a hunk of time, and then you'd come back. I didn't spend a whole lot of time at Agnews, maybe a couple of weeks. The vigil wasn't that exciting or interesting. We would sit in the hospital's vigil room. The patient was able to do whatever he wanted--like he talked. I had it all built up in my mind that the vigil was going to be a really mind-blowing experience, and it wasn't. My idea of what a vigil *should be* was to give somebody who was in really heavy space a good time to zero in and get some good stuff done with them. Well, my patient wasn't like that.

He wasn't really needing a vigil.

The original preconceptions of Soteria's staff called for providing a vigil similar to that at Agnews for every new resident shortly after his/her arrival. They therefore designated and equipped a "vigil room." The first residents taught staff, however, that newcomers usually do not wish to leave the central part of the house. Further, in Soteria's open framework, it was unnecessary to set up a formal structure to allow a few staff to devote full attention to a person in crisis for prolonged periods. As one staff member put it: "The whole house is one constant vigil."

From The Vigil to *Being With*

Prior to the arrival of the first resident at Soteria House, staff participated in a series of vigils at the hospital. The hospital-type vigil, however, proved unnecessary at Soteria and was used with but two clients, the first two, who spent short periods of time in the house's designated vigil room (see box). One of them, Bonnie, resident at Soteria for only a week, had returned from running away the day before.

Wrote staff member Katy,

We felt that a good way to get to know her better would be to spend intense time with her. Bonnie was exhibiting very regressed behavior, spending a great deal of time curled up in the fetal position. She had chosen not to speak and communicated only occasionally by gesturing. We described to her what we wanted to do, and she gave her consent by nodding her head affirmatively. The room was set up to start the vigil.

At this time the staff was not yet working on assigned schedules; thus, members of the group who were closest to Bonnie covered her vigil, which could have lasted for up to two weeks if necessary.

What we discovered was that, unlike the vigil at the hospital, we could get the same effect almost anywhere in the house. All it took was a quiet room with the door shut and one or more persons she felt close to. We also found that the vigil didn't have to be continuous. It could last for three hours in the morning and six hours at night or go on without stopping

‡The word *patient* was shortly thereafter expunged from Soteria's vocabulary in favor of *client* and/or *resident*, which connoted more equal, less passive relationships to the community. See the introduction for further explanation.

for as long as forty-eight hours.

Bonnie's vigil went off and on for three-to-six hour sessions, two or three times a day, for a week and a half. During this time, she changed dramatically from a mute, regressed infant to a person who appeared nearly normal: She talked in a rational way and participated in the activities at the house.

During this process, Bonnie took no medication.

The Vigil Room

Approximately 12 by 15 feet, the vigil room off the kitchen contained no hard furniture except for a stereo set. The carpeted floor was covered with an old, well-preserved Persian rug. Scattered around the floor were several large and small pillows. A set of lights with multicolored bulbs could be moved around to give various effects.

The central location was deliberate to avoid relegating those in acute crisis to a position out of the mainstream and to encourage the rest of the community to be part of the process: (Something potentially frightening can become even more so when hidden.)

At the same time, the vigil room had to be a quiet and comfortable place where people could regress without a lot of intrusion. This goal required everyone's cooperation because not only the kitchen, but also the living room and the art room were nearby.

Staff members and a resident used the "vigil room" formally only once more, because the process didn't seem to demand the well-defined space that it did in the hospital ward. In fact, the prescribed vigil seemed too confining and structured a process for Soteria: In the summer, for example, the process worked better in the backyard. The room became only one of many possible refuges. In retrospect, what evolved was in keeping with an interpersonal phenomenological perspective; community members met residents wherever necessary without regard to preconceived notions of what individuals' processes would be.

Commented Loren: The differences in the "vigils" at the hospital and Soteria offer good examples of the importance of context to what actually happens--despite the same label.

The Soteria Process--Early Stages of *Being With*

Out of the concept of the vigil grew *being with*, the basic mode of the Soteria process. What started as a specific technique eventually developed into a much broader concept.

It was not uncommon for an individual staff member to spend entire shifts for weeks on end with one resident, often even sleeping in the same room. Tara recalled,

For a long time, Monday through Wednesday was my shift, and I'd spend the whole time with Iris when she wasn't asleep. She went through a long period where she just didn't sleep at all at night, like, you know, we'd watch the sun come up every morning talking. Iris was an all-nighter, all right, one of Soteria's most famous all-nighters.

Iris was "consumed by the devil" in the beginning, but she wouldn't t talk about this as much after a while because she knew that people would try to talk her out of it. Then, she really started to believe that there was something inside her beside the devil, and the closer she would come to figuring out things for herself, the more she would talk back to you, really getting a lot of garbage out. She needed a sounding board.

She'd suddenly become more and more rational. She would talk about how she really knew she wasn't the devil, yet inside, she felt so awful. Sometimes I argued with her about it. She would talk about how she was the devil; then, together, we would find coincidences that could prove that *anybody* was the devil or that she wasn't the devil. After a while, when she really became aware that nobody in the house believed that she was the devil, she was sort of pissed off and would, again, try hard to prove she was.

Sometimes I'd get angry at her if she was really carrying on trying to prove she was the devil. I'd tell her about the parts of her that weren't the devil.

While Tara's extended contact with Iris was regarded as a typical daily occurrence in the house, on certain occasions residents were isolated and the prolonged and intense involvement they underwent was close to the hospital's vigil. (See below, "Soteria's *Being With* Chuck: His Vigil"). As the staff gained experience in understanding the needs of people in crisis, their comfort levels increased, and their reactions became more spontaneous.

Soteria's *Being With* Chuck: His Vigil

The following section documents one resident's first week at Soteria and offers a brief follow-up. Neither this interchange--mostly originally from taped discussions by staff members--nor the situation was particularly unusual. Administrators quoted include Research Director Loren; House Director Voyce, Project Director Alma, and consulting House Psychiatrist Stan; Soteria staff Ed and Susannah provided notes and oral recollections. Present at the first vigil, but not contributing directly to the record below were the following volunteers and staff members: Della, Hal, Geoff, Nelly, Katy, and Bart.

Following Soteria procedures Voyce, who picked up Chuck Starr from the emergency service, stayed with the new member he had retrieved. (Whenever possible the original staff contact stayed with a new resident eight hours at the minimum, in conjunction with another member of the community, who was then in a position to relieve the first. This familiar presence had a calming effect on new people and, short though it was, the contact was critical.)

Background

Chuck's father took his son, 16, to the hospital after finding him lying, dazed and confused, at 6:00 AM in an apple orchard. Over the previous week, Chuck had stopped sleeping and going to school and was generally behaving inappropriately. Over the preceding month, he had broken up with a girlfriend, had several dissociative episodes, and believed he could control everything and foretell the future. Before that, however, he had been his father's favorite--a good son, a good student, a good athlete--and had friends.

The child of divorced parents, both of whom had been psychiatrically hospitalized as schizophrenics, Chuck had lived with his father and three

younger siblings (the older children lived with their mother, who had remarried, in the Midwest). About a year before Chuck came to Soteria, Chuck's father had also remarried. Chuck was torn by loyalty to his siblings and his mother; he was a responsible member of his father's family, however, working part time and helping with child care.

He was diagnosed upon admission as "confused, over-talkative, severely thought-disordered, with grandiose and controlling delusions, auditory hallucinations, and exhibiting bizarre behavior--schizophrenia."

First Encounter

VOYCE. I went to pick up Chuck in the early afternoon. I was surprised at how he looked--a blue-eyed, blond young man with a short haircut who looked very straight. The other thing I noticed about him, however, was the fact that he never stopped talking. The first thing he asked was whether I could be his "voice." I agreed, "Sure," but at that point he certainly didn't need another.

So Chuck and I got in my car and drove over to Soteria. All the way back, it was pretty much him talking, talking about his world. (We would later discover that Chuck would alternate periods of talking with ones of total silence.) I stayed with him--as was usual--continually for the first eight hours. (The duration depends, of course, on how the person adapts to the house. Sometimes I stayed with the person much longer.) I showed Chuck around the house and introduced him to the people there. He seemed to settle in quite easily, so after eight hours, I planned to trade off with Ed. But before I did so, Chuck and I went together through a crawling episode that briefly showed his other side, providing a mini-version of what would eventually prove to be a critical experience for him.

We sat in the living room for a few hours. Then Chuck said he was tired and wanted to go to his room. As he was going up the stairs, he went limp, and I had to carry him. When we got to his room he lay on his bed and appeared to sleep, but I got the feeling that actually he really wasn't asleep.

He stayed that way for half an hour or so, then he began to make motions like curling up, rolling over, lifting a leg up. I sat beside him on the couch to keep him from falling on the floor. His body actions became so violent that I actually helped him down on the floor where he wouldn't fall. This went on for approximately 20 minutes.

A couple of times I asked him questions to get him to communicate but received no verbal response, although he seemed aware that I was talking to him. After that, he began to make movements, crawling or scooting on his stomach around the room. No direction to it at all. Then the motion became a more definite circular crawl. While he was crawling around me, I was standing with one arm or hand on him. He started getting up on his knees, each time it was a little higher. He reached out, and I held on to his hand. When he stood up, he continued going around with his head usually back, hanging back, all the time his eyes were closed, never opening his eyes. I continued to hold his hand, and he continued to go around me, head twitching, arms swinging back and forth in sort of a slow motion.

My impression was that he was going through some kind of birth ritual. I didn't become aware of it as such, however, until he started crawling around. (Afterwards, we talked together about being "born again." Sometimes, he seemed to mean this figuratively--his family were fundamentalist Christians. Other times, he meant that he literally wanted to emerge from the womb as a baby. And sometimes, he seemed to mean both religiously and physiologically.)

The whole episode upstairs gave me the feeling that he wanted me to take care of him, that he was reassured that I was there with him. Whenever something happened to make me take my hand off him, he did something to make me touch him.

He seemed so into his world that he was not really clear about things going on around him, but afterwards, he said he was not only aware but felt that he was controlling everything around him. That was one way for him to make his surroundings familiar--to control them himself. After circling about an hour, he suddenly stopped and opened his eyes, apparently back in the state before we'd come to his room some two hours earlier. He indicated he wanted to go back downstairs and meet some more people. We went downstairs, and he started talking to one of the residents in the kitchen.

With hindsight, I realize that this episode was a prelude to the critical week-long interaction--"rebirth"--occurring about six weeks later. Between these two episodes, his behavior was fairly uneventful.

STAN. Voyce, you were Chuck's first contact when he came to the house and spent several hours with him. When he started walking around with his eyes closed, you were with him, following him around. He then started to talk in a steady stream, fragmented, bouncing from one subject to another, but buried in some of the content was his view of you as his mother.

VOYCE. Well, he talked about me "being his voice," my speaking for him, his talking through me. And, as I said, I got the feeling that he wanted me to take care of him, to hold his hand. A couple of times I actually physically held him. For the first few hours, he seemed to be getting acquainted with me--going upstairs, for example, he gave himself over to me to be put to bed. At first, it felt as if Chuck were just talking--if nobody were there, it wouldn't have made any difference. Later, he was looking for somebody to grab onto.

STAN. One kind of psychosis occurs with the fragmenting, the breaking down of the bridge between the subjective inner world and the objective outer world. Chuck was trying to attach that bridge to some objective outer world formed from his own inner experiences. He referred to you as parts of people, as parts of people's functions, as a brother, as a mother.

VOYCE. You're right; he was saying that he and I were brothers, and he did say that I was his mother. He went through some thought that he was actually black like me.

STAN. In your role, Voyce, you made very few comments. You were present--a real, close presence--and you maintained steady contact to help him from feeling angry and unsafe.

VOYCE. Yes, I got the feeling that he wanted to be close all the time. He talked a lot.

STAN. Apart from the content of what was said, if he had made a comment like, "You're my voice," you didn't contradict him, making comments like "No, that's not true, I'm not your voice." You'd agree with him.

VOYCE. Yeah.

Being With Continues

ALMA. Ed, you were on duty six weeks later when Chuck again attempted a birth passage, and you stayed with him exclusively?

ED. Yes.

ALMA. Do you remember why you did this?

ED. Because Chuck was in no state to be alone. Most of what went on took place after people had gone to bed. All that night he referred to me as "dad" or "father." When we were up in the room, he talked about Howard Hughes, the Lear jet, "Harley Bird,"* Steve McQueen, Raquel Welch--the whole bit. One time he said Steve McQueen was his backbone.
VOYCE. And Harley Bird would become Steve McQueen, and then Chuck would become Steve McQueen.
ED. They would be separate, and then they'd be the same again, yeah. He kept talking about how his father was Howard Hughes. At this point he was lying on the bed, and I think I was sitting on the floor next to him. And he was saying he had to find out where his Lear jet was parked. I asked him why he wanted it, and he said he had to get back to Nevada to see his mother. He was complaining that his back was very sore, so I gave him a back massage. He talked more about his mother. He wanted to see his mother and bring her back here. He'd start crying a little bit. This went on for pretty close to a hour. Afterwards he said his back felt better.

He said he could wait to go see his mother, but he still wanted to find his Lear jet. He thought it was parked on the driveway. We went out to the driveway, but it wasn't there. He said it must be at the airport. We came back in the house and went to his room again. He was talking about things that happened in the war between him and Harley Bird.

I wanted some coffee, so we went over to Spivey's [a nearby restaurant], and I bought him a hamburger. He told me all about when he was a kid--about his childhood and his paper routes and his school. Every two or three minutes he'd stop and laugh, "Well, this is silly for me to tell you; you're my father; you already know all this." As we were coming back, he stopped and said "That was really nice. I knew you were going to take me out to dinner some night, Dad. And now we've done it."

When we got back to the house, he told me the Venusians were going to come down and visit him that night. So we went out on the back porch where he could stare at Venus. "I can see them coming down now," he observed. "They are going to be waiting for us." Next, we went across the street under the stoplights, because he had to see the sun, which was just coming up over the side of the house, at the same time he saw Venus. (He had to be between Venus and the Sun for the Venusians to be able to find him.) We waited there for maybe a half hour or 45 minutes. Then, because it was getting light and Venus was disappearing from the sky, he figured, "Well, they aren't going to come today, after all."

We came back to his room around 5:30 or 6 in the morning. He was talking about a belt given him by Harley Bird that allowed him to go through space and time (it was also a seat belt for the Lear jet).

Somewhere thereabouts he fell asleep, and I fell asleep too.
ALMA. Why did you take him outside and to the restaurant?
ED. To the restaurant, because I wanted some coffee--There wasn't any made downstairs, and he was hungry too. And outside because that's what he wanted. He did most of the directing, as to what he wanted to do. I felt comfortable about his actions.

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*Harley Bird was an imaginary person/alter ego Chuck made up. His choice of first name was perhaps influenced by his fascination with Hal's motorcycle, which was a Harley Davidson, but not one of the bigger ones, sometimes nicknamed "hogs." (See below.)

STAN. When he told you you were his father, what did you do?
ED. I didn't say either yes I am, or no I'm not. At that point I was generally just listening. He wasn't asking *whether* I was, he was saying *that* I was.
ALMA. Did you feel uncomfortable with *that?*
ED. No *(changes subject).* He slept until about two the next afternoon--in his assigned room--for the first and last time in a long while. I slept with him.
STAN. About then, Chuck started to repress a lot of the free thought and the reactions to it; he became a little more appropriate, a lot more concrete. Certainly the free flow was shut down, and he ceased some of the kind of events taking place in the preceding 24 hours. As I remember, the repression didn't last, and he went right back into action.
VOYCE. That day we didn't talk too much. He was pretty coherent. We went for a walk, and ate lunch out at Spivey's, and he wanted a newspaper.
SUSANNAH. I remember I was coming up from the basement from doing the laundry, and he was going down the stairs. We bumped into each other and then I got into the process. Chuck was trying to get on Hal's motorcycle. (Now Hal was his brother.)

Because we were worried that Chuck might take off on the motorcycle, we went with him to the back lawn and lay on the grass, keeping him between the three of us. We followed him through a number of different activities--climbing on the motorcycle, coming into the house, walking up and down the stairs, crawling--sometimes backwards--up and down the stairs, being carried up and down the stairs, going out on the back lawn. He'd climb on the motorcycle, and I'd sit behind him.

Then he went to my car parked on the street. I sat behind him in the car, and he climbed in the driver's seat. Ed sat next to him. He wanted to start the car and drive away. I told him to listen, and he'd hear the engine start. He got into that fantasy and decided that he could hear the motor running and feel the car moving. Eventually, we talked him into coming in to get something to drink.

He was wearing the motorcycle helmet and sunglasses all of this time, Though sweating profusely, he didn't want to be without his helmet.
ED. He did go for a ride with Hal on the motorcycle around the block.

First Rebirth--à la Jung

SUSANNAH. Chuck, Hal, Ed and I ended up in the back bedroom. Chuck was talking about wanting to be reborn, because he had been a blue baby and had come out wrong and wanted to be born right.

So we put him between us on the bed and then he would push down from our chests' level, and then he'd turn over and try it again, keeping his eyes closed all of the time. He was up on the big double bed where he could crawl up to the window and look out--like he was coming up for air or coming up for light. He was lying between Ed and me; Hal would be either on top of him or partially across all three of us, almost surrounding *us.* He pushed out from among us a number of times, each time saying, "It's not quite right." We kept telling him what he was doing was OK.

But we had to stop him when, a couple of times, he tried to crawl out the second floor window. We'd let him put his head out the window and look at the moon, the stars. He would leave the window, crawl to us on his back, head first, and then come back up and lie kind of sandwiched between us. He said he needed to be surrounded--I guess in a womb-like situation, in kind of a family

situation. He didn't get into a sexual thing with me but stayed childlike, making us into mother and father figures.

After about five hours, he started out to the lawn, crawling down the steps, sliding, so we tried to carry and support him as much as possible.

ED. Lying between us, he said that he had to be the result of my and Susannah's love. He said that we had to make love and that he between us would be the result.

SUSANNAH. During that time, I was his mother at times; I was Raquel Welch at times; I was Mother Earth at times. I was the opposite of what Gene was at times. I was the result of his love at times, and the three of us were the result of each other. We said very little. He just kept talking, and he didn't ask questions, and we simply affirmed whatever he was saying by occasionally nodding or smiling. Sometimes I'd say, "Yes, I'm your mother," or "Yes, you're being reborn," but mostly he did the talking.

ALMA. And then how did this whole thing end?

ED. It didn't! It went right on through the night!

Labor Continues

VOYCE. Then I came back, and we went through the same things Ed and Susannah described.

SUSANNAH. We eventually ended up in the next room.

ED. He moved with slow, fluid motions.

SUSANNAH. He knew what he was doing and was quick to find out what he needed to do and what he needed from us.

ED. His actions were deliberate, as if part of a dance or a ritual.

SUSANNAH. About 11 or 12 o'clock, Ed was sleeping in the living room and Voyce on the couch in the same room. I was sitting, back against the wall, legs spread, and he was lying between them, against my chest. I held him for a while, that way. Then he wanted to sit back up and have me move into a variety of positions so that he could move back and forth between my legs. At times he'd begin to get sexual: I'd say he wanted to come out again; he wanted to be born again; then, he would revert back into moving in and out between my legs.

Next, he wanted to exchange jeans. I went into the bathroom, took mine off, and put on my spare pair. He put my jeans on and seemed satisfied to be wearing my clothes for a while. That morning he started getting into boy/girl stuff, becoming more sexual--wanting me to be in high school, wanting me to be his girlfriend and talking about other girl friends, wanting to kiss and hold me... Later, he got out of that.

VOYCE. Sometime after I awoke, he started walking around and went downstairs. He was still talking, more like the day before. He talked a lot about Bangladesh.

ED. When I came back, he was between the mattress and the wall. He said he was in outer space. Once in a while we'd go downstairs. He was exploring the house, making sure where everybody was.

Expanding Theater

VOYCE. Later, we went out for a walk and then sat in the back yard. He was going to look at the sun. He "looked" at the sun with his eyes closed for quite a while.

ED. Still later that day, he tried to crawl out a window on the first floor. He had to get out on the ground. He wouldn't go out the door; he had to go out the window.

Hal and I held him there at the window, so he couldn't crawl out, because he wanted to just drop down on his head. I got someone else to hold him, and then I went outside and caught him as he came out.

SUSANNAH. I was up by that time. And I saw Chuck going out the window.

ED. He had such a need to get to the ground. We were on the first floor, and he must have known that it was safer, that he wouldn't hurt himself. But he mentioned later that he felt frightened. That was the first time he felt frightened.

SUSANNAH. He was wearing Hal's motorcycle helmet then too, wasn't he? Yeah. Then, he wanted to get in my car. He crawled into the back seat, then moved up to the driver's seat. We stayed with him in the car for awhile. He was sweating, dripping, shifting the gears, wanting to drive, but I wouldn't give him the keys. He kept repeating "I want the keys; I have to have my keys."

We finally got him out by telling him we would get him something to drink. After he stuck a Kleenex in his mouth and ate it, we persuaded him to return to the house. It took about 20 minutes to get him out of the car. We wanted to get him back into the house.

ED. He and Hal slept outside that night. He *did* sleep that night; he went to bed very early. Eight or nine, before dark. He was up with the sun the next morning. Most of the day on Saturday he spent with Hal, just sitting out there talking with him. He was drinking a lot of milk, but he kept saying that he had to eat mercury. He was eating toothpaste, too.

Saturday night he and Hal were out back.

Connecting or No More Peter Pan

ED. Chuck and Naomi [another resident] had gotten into a quarrel--he was telling her to "think happy thoughts," and she was angrily saying how shitty she felt:

"Who are you to tell me what to think? I'm not thinking 'happy thoughts.' I'm not happy; why should I think happy thoughts?"

"When I have bad thoughts," answered Chuck,"I don't think about them. I think nice happy thoughts. That's why I am wearing these colored glasses--things look pretty when I wear them."

"If I commit suicide," countered Naomi furiously, "will I go to hell?"

"What do you want to commit suicide for?" Chuck questioned.

Naomi gave him these reasons: She was hallucinating; she didn't feel good; she had a stomach ache and a headache. "That's why!"

"Well," said Chuck agreeably, "go ahead and do it. I'll get you a knife and cut your throat."

"Who are you to tell me to commit suicide? Who are you to give me a knife to cut my own throat?" she shouted, throwing a glass, really hard, against the wall. Chuck was lying on the couch; she was sitting in the rocking chair; she threw it on the wall between them, really smashed it, and got up and walked into her room.

That scared the shit out of Chuck, who went outside and wouldn't come back in. Hal went with him and comforted him as he cried. He came back in temporarily, but wouldn't take off the glasses or the helmet. Then he and Hal then went out on the back porch for a while. Then I joined them.

Chuck was crying and angry--angry at Nixon at this point, for taking over the world, for lying, for using money. A huge tirade, delivered as he clung to the post on the stairs really hard, screaming anger at Nixon, "the

totality of evil," or something like that. Chuck was really hurting, sobbing with anger.

Tending to Necessities

ALMA. I would like to get a little bit of information back from the people involved as to what their subjective experiences were after so prolonged a period of time spent in very intensive contact. How did you feel during and after?

SUSANNAH. I really got turned on by it; I was really impressed with Chuck's being in touch with what he needed and what he wanted--his deciding and choosing and making the rebirth happen and, if it wasn't right, making it happen again. Insisting on its being right. I was really impressed by that. I didn't get tired as I expected I would. I was with Chuck from dusk of Thursday night until noon on Friday--about 15 hours straight.

Chuck had a good sense of humor and that would come out quite often. It was just a delight, very refreshing. By the time I did finish I was tired, and yet it didn't seem to me to be too long.

ALMA. You weren't bored.

SUSANNAH. Oh, no.

ALMA. What about taking care of yourself? Did you eat and bathe?

SUSANNAH. I don't remember!

ED. Chuck took a shower about midnight. That's when we went down and got some coffee and took a break. While he was in the shower, I went in and talked to him.

VOYCE. Chuck took a shower that morning, too.

ED. That was about his third shower of the day. I remember him as having a fourth one as well.

Meaningful Work

ALMA. Can we hear about how you felt about participating in the whole thing?

VOYCE. I remember the feeling I had when I was going to pick Chuck up. A lot of anxiety--what's it going to be like? When I saw him, though, all of a sudden I was relieved--my mental picture of him was all wrong. I didn't expect Chuck: I expected somebody quite different. He was a pleasant surprise. Talking to him was easy, kind of a relief. Later, during the long hours with him, I would get a lot of real comfortable feelings; I felt really good. I can remember at times that night I was very sleepy but really not wanting to quit.

ALMA. How did you feel when you returned from sleeping? I can fantasize that I might think, "Well, Jesus Christ, it's still going on, not more of that."

VOYCE. No, I didn't feel like that. I remember on the way over here that it was easy to return. I didn't feel put out.

ALMA. Certainly, no one seemed to feel put out by the end.

VOYCE. My impression of the rest of the staff was that there was really a good feeling there, even though everybody was tired. I was surprised that they all kept going.

SUSANNAH. I was tremendously impressed by the whole staff operation. Everybody was taken care of without having to talk about it.

ALMA. Anything more you had to say, Ed, about your subjective reaction to the whole thing? This was a new kind of person coming into the house for you, wasn't it?

ED. I never saw anybody come in this intense.

VOYCE. I remember Susannah was tired, but she was really having good contact.

Everything was working beautifully.
ALMA. It sounds like everything did. The whole thing went on for about a week?
ED. It ended about 7:00 Wednesday, when Chuck did his final birth and "came out right."
ALMA. How did you keep the house running? At that time we had how many other residents here?
SUSANNAH. Four others. But somehow everybody pulled together without talking about it and took care of everybody else. The meals got cooked, and most of the dishes got done.

Naomi was frightened, I remember, when Chuck first came. I spent time with her. Somebody was here to take over when I was not with her. The same happened with Iris and Kelly. There was a continual flow of people to pick up when others would tire.
ALMA. Do you know how that happened?
VOYCE. It wasn't planned...
ED. It had to be done.
ALMA. Susannah, I know that when you're here, you usually take a lot of responsibility for the meals. Did you verbally communicate with anybody to say "Hey"....
SUSANNAH. I didn't...
VOYCE. All I can remember is Chuck.
SUSANNAH. I can remember feeling okay about working with him--I felt very safe. Everything was being taken care of. I didn't worry about everybody else.
ALMA. Who was taking care of the rest of the house during that time?
ED. Nelly was here at that point; Katy was here; Geoff was here; Hal was here; Bart was here. Whoever wasn't with Chuck would be downstairs with someone else. He also wasn't into the thing the whole time that intensely. Friday he went to bed. Saturday he went out in the back yard with Hal and watched the tennis tournament on TV.
ALMA. How was he talking at that time?
ED. Pretty straight, at that point. He just wasn't into any kind of ritualistic talking at that point. He was still talking about Harley Bird off and on and about Howard Hughes. He and Hal had a real thing going. Hal watched the tennis tournament too.
VOYCE. Usually, if Chuck wants to do something, he does it. He initiates things himself.
ALMA. Did he eat Saturday?
ED. Saturday he was eating a lot of salad and a lot of liquids--milk, water, juice, whatever.
SUSANNAH. During his heavy time we gave him milk out of the baby bottle. He would drink it out of the bottle but without the nipple. He would take the top off and just drink it down that way. That was fine. He had two or three bottles like that right in a row.
ALMA. Were you concerned about his not eating?
SUSANNAH. None of us ate. Forgot about food.
ED. Saturday and Sunday, he didn't seem to be that heavy. Seemed like he broke it off for a couple of days.
ALMA. Did you provide close supervision for him during that period?
VOYCE. Somebody was with him all the time. I played frisbee with him for awhile and Geoff did too.
ED. We all played badminton.
ALMA. Did he talk about what had happened to him?

ED. Yeah, off and on he would talk about his rebirth. Very matter-of-factly, just saying that it happened. The feeling was that this was the intermission, that it hadn't been completed yet, that he was just taking a rest.
VOYCE. Sunday he talked a lot about the hospital.

Analyzed Loren later: Chuck's behavior just described offers a particularly good example of the episodic recovery process. He alternated between periods of quiet near sanity and silence and highly energetic times of psychosis.

The Last Push

ED. Sunday night and Monday there was a lot of pathological talk. Mercury, Venus, the moon, the hospital talk, Bangladesh.
VOYCE. The hospital took away his powers.
ED. There was a dynamo somewhere and he could hear it running in the hospital where they were programming him. That's how he explained everything; by saying he was programmed to do all this stuff by a big machine in the hospital.

Right around dinner time Monday he had been lying for a couple of hours on the couch in the living room with a big pillow over his head. Geoff in the rocking chair was next to him. All of a sudden, he crawled off the couch. Geoff called, so I went in. Chuck was crawling toward the door on all fours, flat on his stomach. He was pulling himself and pushing with his legs, and he started crawling up the steps. Geoff got behind him, keeping a hand on his leg. I was in front of him. I would just touch his hand. He didn't want me to pull him; he wanted to do it himself. He was sweating really profusely and really straining.

He crawled all the way up the stairs, turned in the right direction, and crawled all the way back to the back room. His eyes were closed all the time, but he knew exactly where he was going--into the back room and toward the window. He started crawling up the window up to reach out of it. Geoff and I both grabbed him around the waist. He said "I'm not going to jump; I just have to see the sun." We said "OK," and he leaned against the window sill, his eyes still closed. He breathed deeply for maybe five or ten minutes, as we repeated, "There's the heat of the sun; you can feel it on your eyes. You can feel the heat of it on your face."

When he lay back down, we put him in my lap. He lay there for maybe ten minutes. I had to go fix dinner, so I gave him to Geoff. Then Della came upstairs too. Lying in Geoff's lap, he had his arms resting on Della. Then he made motions that he wanted to lie in Della's lap. When I got back, he was in Della's lap. There he stayed for maybe an hour. We brought up his milk in his bottle.

It was pretty hot. He'd use a towel to wipe the sweat off of him, then Della would wipe it off for him, then he would take the towel and do it himself again. They were lay there for close to an hour, Della talking to him softly and breathing very deeply, so he could feel her body breathing.

All of a sudden he got rigid and turned around and doubled up into a ball, a fetus, and crawled out from between her legs and got up on his knees. He opened his eyes with an amazed expression and asked "Where am I?" Della said, "You were just born" and gave him a big hug. And he got just this big smile--a really broad grin on his face and gave her a big hug back. They sat there for a while and talked about it. He was lucid again at that point. He described it as he was in a dark pit and crawling out through this

channel...the canal...up some steps. He said he felt as if he were being reborn at that point and that he came out right. At that point he didn't have any more rebirths.

He became quiet then and was calm for an hour or so, then became overactive. He didn't want any dinner. He was talking fast.

The Journey After Birth

ED. Stan came in at about this point and said, "You're hungry." So Chuck came to the dinner table. He talked about his rebirth, his "mothers," and then again started saying he had to go to Bangladesh. He ate a little and then became really vehement.

He had to go to Bangladesh.

There was just no way out of it.

He had to call the hospital and find out where "they" were hiding his jet.

He had to get to Bangladesh for an eclipse at noon the following day.

Then, he would get his total power.

He couldn't go in a fantasy any more; he had to go physically.

Up to this point we had been encouraging him to go on his journeys in his head. Said Susannah, "You've managed to stay in the house and go to Venus and the moon, and you've been reborn all while being in the house."

"I can't do that any more," he said. "I have to go there physically" and went to get his jacket.

"It's a physical impossibility," I said.

"There's no way to go," Geoff said.

Chuck yelled, really angry, that he couldn't go there in his head. We shouted back that had to stay. At that point he had his jacket on.

ALMA. Did you try to initiate the fantasy?

ED. Yeah, the same way that we had worked the ones about the motorcycle: "Feel yourself moving."

He got really pissed off, saying, "I can't do it that way this time; I have to go there."

He shouted that had to go there to get his total powers, to see the eclipse, to watch the world being totally dark, totally black at Bangladesh at noon on Tuesday. He had to be there for that. The sun, symbolically, had been his father--that his last name was "Starr" may have played into all this somehow. The eclipse of the sun would be his mother. And he had been born.

Actually, he was talking about Venus and the moon and the sun throughout his time at Soteria. When he went into the process after feeling the heat of the sun--when he lay back on Della--the sun was out. An hour later, when he had had his birth, there was a half or quarter moon out, with Venus about four degrees from it: The only two "stars" in the sky were the moon and Venus. The last thing he had seen before birth was the sun at the window; the next time he was at the window, after birth, the moon and Venus were up. It fit psychologically.

He returned to the eclipse. His father was the sun, light. His mother was darkness. The two opposites. He was experiencing this; he wasn't talking about it symbolically.

Different Reactions

ED. Geoff tried to explain the symbolism to Chuck, who got very angry: "I don't want to hear that." Della and Bart were into astrology and were saying

that Venus means one thing, the sun another. Chuck would pick up what he agreed. To what he didn't, he'd say "I'm not talking about that." There was a straight conversation running through all of this.
ALMA. Della and Geoff were a different kind of team?
ED. The birth thing was the same with all of the staff--it had the same kind of intensity. Everyone knew exactly what to do and was sure it was the right thing. Each had the same feeling of total confidence , without doubts. And the *actions* different people tried were a lot the same. Chuck lay in Della's lap in the same way he had in Susannah's.
ALMA. But the *responses* were different?
ED. Yeah. The people working on weekends were into astrology. Also Chuck was conversing by then; he wasn't just laying out what had to be done. He wasn't acting; he wanted to talk.
ALMA. Do you think that had anything to do with the expectations of the people around him?
ED. There weren't many expectations, if any. One was that he would get a good birth. I was really glad to see it; I was awful surprised. Just the one was enough at that time.
ALMA. This was what I wondered. How would you explain the different quality of the interaction?
ED. Just different personalities.
ALMA. Let's get back to the description of what went on. You decided that he couldn't go to Bangladesh. What happened then?
ED. At that point I was physically holding him. So was Geoff. We both pulled him. "No, you can't go."

This was the first time since he had been here that he didn't feel believed; therefore, he couldn't trust us back. The fact that we were going to physically hold him here--he was frightened by that. He was also angered and was laying out some pretty effective guilt trips--"Everything was nice until *you* tried to ruin everything by not letting me go to Bangladesh."
ALMA. And you felt bad.
ED. Yeah, I felt guilty about it. I felt we didn't do it right. We should have let him go out of the house and walked with him at that point...
ALMA. Was there any physical reason why you didn't want to do that?
ED. I was really exhausted. This was Monday; I'd been here since Wednesday. I was really tired.

> *Looking back, Loren noted that the staff's theorizing created a disjunction between them and Chuck. Loren also pointed out that the staff's exhaustion made them try to put limits on Chuck's behavior and the result was that he became afraid, frustrated, and then angry in the space of under an hour. A worn-out staff, Loren explained, is less tolerant than a fresh one.*

Encouraging Fantasy
ED. I was also angry at him for saying that he couldn't go to Bangladesh in a fantasy, when he had done everything else with fantasies, and for setting up a situation where I had no choices.

There was also our fear that he would go out into the street and get hurt.

ALMA. What made you feel differently about taking him out? You'd taken him out before in the middle of the night.
ED. Yeah, he was more lucid at this point. He wasn't spaced out. He was using logical arguments, explaining, for example, "No, I can't do it that way. Before I did things in fantasy, and I know they were in fantasy. This time has to be physical. The other things were all right; they were good; they were necessary; they were in my head. This one I have to do with my body." Those are logical arguments, and he set up an impossible demand on me.
ALMA. How did he plan to get there?
ED. He was going to get money from the people at the hospital. They were going to pay for his trip. He wanted to call them and find out where Harley Bird was. Howard Hughes had his jet waiting for him at the airport. He was going to go to the hospital first, get the money, and then fly to Bangladesh.
ALMA. You were going to drive him to the hospital?
ED. No, that was what I wouldn't do.
ALMA. I mean, if you had been willing...that's what he wanted you to do?
ED. Yeah, if I had been willing, that would have been fine. Otherwise, he'd find some other way to get there. But this time was a physical thing that had to be done in reality.
ALMA. I wonder what would have happened if you had just walked out into the street with him.
ED. That was my qualm. That we would have handled it better if I had just asked, "Where are we going to go?" and stayed with him. This was the first time that I hadn't been with him in an experiential way. And that stopped the trip he was on.
ALMA. That decision might have come from your own exhaustion or something, because you let him climb out the window, let him get in the car, let him take the risks.
ED. They weren't felt risks. This was a *real* felt risk.
ALMA. So what happened then?
ED. One reason I was pissed was because I hadn't been with him all the time. During the birth, it was Geoff and Della. Then he came down for dinner afterwards and was telling me that I had to take him to Bangladesh. And I was kind of mad because I was involved with other people at that point, and my inclination was for him to stay with Geoff and Della.
ALMA. And he didn't stay with Geoff and Della. Why not?
ED. Because they also told him, "No."
ALMA. I see.
ED. He was already angry at them when he came down. And he was angry at Stan, at Dr. Redd.
ALMA. So what happened then?
ED. Then we stayed up the rest of the night. We kept explaining why Chuck couldn't go to Bangladesh physically. Then he just started talking and talking. It had kind of worked out before I left around three that morning--He had realized that he couldn't make it there physically, but he still wanted to go sometime, somehow.

By this time he was having a good conversation with Della and Geoff, talking about the whole thing. They got into an exhausting exchange about what was happening. They all went to sleep about four.

That was the last of Chuck's "trips" for two or three weeks.

Commented Loren: Ed's expression of his annoyance with Chuck was consistent with Soteria's philosophy. Staff members were allowed to say what they felt, even if their positions disagreed with others--what was important was that each communicated openly and clearly.

After the Trips

ALMA. So that was the end of it. The next morning he was up at six--two hours after he went to bed--cleaning the kitchen?
ED. Yeah, he had to justify being here. He was very helpful, trying to get the place in shape, make things a little cleaner. He didn't do much sleeping; he went to bed late and got up early. He also didn't eat much at that point. Then he began being a therapist and solving the problems of the other residents. Being helpful and analyzing...
ALMA. One other question: How did you feel about the ending of the intensive period?
ED. I didn't like the way it ended; I felt bad about it. I don't know how much of that is my own guilt. I feel that I handled it poorly. I wish I had done it differently. There was an alternative, for example, which at that point didn't occur to me, of walking outdoors with him.
ALMA. I would like to think about that. Perhaps the staff was doing too much interpreting?
ED. How so?
ALMA. Were you expecting him to intellectualize too much at that point? Maybe his press to leave had to do with wanting to get away from the situation. It sounds like there was a burst of interpretation in the end.
ED. No, there was almost no conversation then. Nothing was said. Afterwards he explained it all, what was happening. He said he felt that he had been reborn.
VOYCE. I kept feeling that the Bangladesh thing might have been a way of leaving. So might his wanting to go to the hospital. The first day, he seemed sort of uncomfortable at one point, and, by going back to the hospital, he could get sway.
ALMA. The other things he was saying indicated his idea that people were controlling him. By Wednesday he was calling *Soteria* a hospital and in many ways he was trying to control, to undo what had happened. I think it's really worth thinking about. The possibility is that was as far as he wanted to go at that time.

But we want to know if there are any things we could do better.

Loren's analysis: Here, Alma introduced a supervisory view, correctly bringing attention to the staff's need to interpret, in Jungian terms, what Chuck had experienced. By so doing, she brought them back to interpersonal phenomenology, encouraging them to relate to the experience rather than judging or categorizing it.

Journey's End

Chuck's psychic journey ended at this point. Six weeks later, he went through a similar acute phase, which lasted four or five days. At that point, Voyce remembered, Chuck was again crawling around, but this time pointing his finger as if it were a "ray gun" with the power to "zap things out of existence" and making humming sounds. Chuck's regression at this point took place when

Soteria was short-staffed and serving several other residents in crisis; it was therefore less well-equipped to deal with his needs. This second crisis took place over a three-week period and was resolved after a 24-hour stint--fully clothed--in a warm bath. Finally, he got out, shed his wet clothes, put on dry ones, and appeared finished with his second major regression.

At that point he went back to functioning very well, even doing some work for Stan. Since then, he moved gradually toward complete reintegration. Four and a half months after admission, he was a remarkably mature and self-confident young man who lived at Soteria as a volunteer, went to school, and worked at a part-time job.

Later, he moved out to live with his brother, keeping in close touch with Voyce through tennis, visits, and (see below) by accompanying Voyce's family on a vacation. Finally, he moved to his mother's in the Midwest where an older brother's wedding made him the focus of his mother's wrath and led to his rehospitalization. A year and a half after first graduating from Soteria, Chuck was readmitted.

> *Loren summarized: This admission lasted six months with a similar content to the psychosis and similar behavior in the house (i.e., alternate periods of talkativeness and quiet). Staff were not able to contain his destructiveness (he broke several windows and threatened several staff and clients), and he required drug treatment for 10 days. This time his period of manifest psychosis was shorter, less intensive, and the degree of regression less.*

Chuck moved out after six months to live with another former Soteria client, then with a relative, and was not readmitted for almost three years. Over that period, he maintained contact with Voyce. Then, wrote Voyce,

> Chuck was threatening to sue people again, which is an indication that he's beginning to get into his power and control space again. This time when he came to Soteria, he never really got into his verbal or his quiet space in the same way. There was sort of a combination of somewhere in between both of those spaces, but it lasted only for two or three weeks at the most, at which point he came out of it and moved back home with his brother again, after staying only two months.
>
> I haven't been able to locate him since then, but he is probably doing what he normally does--getting a job and making himself busy.
>
> Sometimes I feel as if we have almost a father-son relationship, but in other ways it is more like a peer relationship. It depends on where Chuck is with it. When he is spaced out, he's quite a heavy person to be around, but when he's out of it and together, he is pleasant and enjoyable.
>
> I see Chuck as going through some type of growth process. He seems to be developing and changing with each experience of psychosis. I feel that at some point he will be able to avoid these episodes completely.

Loren concluded: Chuck's journey is an example of "growth from psychosis," a notion to which a number of writers such as Karl A. Menninger, John Perry, and Laing have referred. Chuck's progress, Loren believes, could not have occurred without the Soteria milieu; instead, "Chuck would probably have remained in hospitals, his growth processes interrupted by neuroleptic drugs."

Being With Matures

The core concept of the Soteria model gradually shifted from the formal vigil motif into the broader concept of *being with,* which offered more potential for interaction in a variety of social contexts. In the vigil room, both noninvolvement and self-absorption were possible, limited by the confines of the room itself. Only a few activities or stimuli could exist therein.

Staff discovered the *concept* of an enclosed space around an individual worked better at Soteria than *actual confinement* in a specific place. Meaningful interactions among people can have the effect of closing off surrounding distractions, even in a crowd. Staff member Nelly describes such a situation:

> Toni was a former Soteria resident who had been hospitalized at the local in-patient ward of a private hospital. She had been isolated as too psychotic to spend time with other patients because of concern that her "crazy" behavior would upset them. When we found out about her situation, we arranged to have her released into our custody. We had decided to go to the beach that morning, however, and it would be difficult to spare a staff member to stay home with Toni, so the trip was canceled.
>
> When the staff member returned with Toni, she was upset because she had been told that the community was going to the beach, and she insisted that she be allowed to go also. After a long group discussion, we decided that we would try to find a quiet beach and make several staff members and residents to whom Toni felt close responsible for *being with* her.
>
> When we arrived at the beach, Toni and four members of the group went down to the water's edge. It was a hot day, and the usually quiet beach was quite crowded. Toni was behaving abnormally: She was making strange, gesturing motions that, on occasion, fit in with others' dancing and, on occasion, did not. She was also talking to herself, as if she were hearing voices, and making disconnected statements and observations. But she appeared to be having fun, and her attention was so caught up with her companions and her inner processes that she didn't seem to be aware of the crowd (nor they of her).

The effect sought from the vigil is the fusing of awareness among individuals by excluding excess stimuli. This process need not take place in confinement but for it to occur without physical confinement requires significantly more attention to minimize outside intrusions. So more people at the beach had to engage Toni than would been needed to achieve the same interaction in a quiet room.

Being With in Three Stages

The three stages of *being with,* as the process occurred with most Soteria residents, were

- the major crisis, when the client most needed basic care
- the reconstitution, when the client re-established his/her personality in relation to the new surroundings
- the extension, when the client began to expand boundaries of relationships

These stages weren't completely separate; they overlapped, did not always occur, and were manifest in different sequences.

Stage One

Stage one began when a staff member picked up the client at the screening center. The person who made the first contact initiated through *being with* the

Soteria process of interpersonal bonding. While relationships generally develop over a long period of time, some basic ties take less than an hour to develop when the environment is new and the faces, unfamiliar. A friendship an hour old can seem firm and important, especially if it rescues the sufferer from a frightening place.

Stage one took advantage of this condition: Thus, the person who brought the new client home made the introductions to the group and stayed with him or her continuously until s/he connected sufficiently to someone else. Once such a connection had been established, the vigil can continue to establish the interpersonal connections that have to develop before meaningful change can occur. The primary care giver during stage one, therefore, must be the person(s) who are most able to interact comfortably with the new resident.

Stage one was the "tight" vigil, as differentiated from the "loose" vigil of stage two. In most cases, the tight vigil took place in one room--usually the client's--but on many occasions it happened in other places in the house or the yard--as in Chuck's case (above).

During stage one, staff tried to make and maintain contact with the person having difficulty interacting. The tight vigil also initiated a basic support network. This kind of involvement became the bonding material for long-term personal relationships. Through common experience, two individuals can quickly create a closeness similar to that among family members. These relationships are the building blocks of change at Soteria. And material generated in the tight vigil led to the second stage of *being with*.

> *Loren's comment: Soteria's provision of a low-stimulation, consistent, quiet milieu, which offered interpersonal support, acceptance, and predictability, was especially important to a successful journey through stage one.*

Stage Two

If the first stage of *being with* was bonding, the second stage was development. During this part of the process, a variety of relationships began to form, relationships that became the core of change Soteria-style. Without basic interpersonal relationships to establish supportive networks, clients were unable to support identities separate from their families of origin. This failure guaranteed the eventual return of the crisis in these young, recently psychotic individuals, usually coming to Soteria fresh from their childhood homes.

The content of *being with* in this process was creating normative interactions. The degree to which the members of Soteria could achieve such relationships was the degree to which positive change was possible. During the second stage, the content of activities encouraged symmetrical relationships,* and residents were allowed a myriad of choices as to how they would spend their time. Staff avoided scheduling too many organized functions for clients in stage two, encouraging such residents to take the initiative in organizing their own time in relation to the community's activities.

In this stage, validation of their experiences in the context of a safe, protected environment away from the site where the trouble had its roots began

*See *Change Soteria Style*, pages 7-14, for a discussion of complementary and symmetrical relationships.

to effect change. This was, in turn, reflected in increased socialization and involvement in the Soteria community.

Stage Three

The complaint that "I'm bored, and there's nothing to do" often meant that stage two was moving toward stage three. Such a complaint is usually a sign that the client is interested in doing *something*--but something that s/he finds interesting rather than distasteful. Dishwashing, no, for example; a walk or a drive, yes. Having to come up with an alternative rather than simply complaining offers an opportunity for developing internal motivation.

At this point, *all* community members--including but not exclusively the staff--tried especially to reserve time to devote to the client entering stage three. In fact, an important part of this last stage was the breaking of boundaries among groups in community activities and the expanding of relationships within and without the house. In the third stage of *being with*, people at Soteria related to each other as individuals, not as staff, residents, volunteers, and so forth. For example, a former resident remembered a time when she wanted to go skiing and hadn't quite known how to organize the activity. She turned to another resident for help, and he was able to meet her needs:

> You remember that week when we went skiing at Dodge Ridge? I really appreciated Henry [another resident] for going through all that trouble getting everybody to come to the meeting that day. I think that if he didn't help me I would never gotten the group to go by myself.

On a similar note, Voyce recalled that after Chuck (see above) had entered stage three, his relationships with members of the Soteria community changed dramatically. Rather than having his crisis occupy the house as it did during his first week, he helped the house psychiatrist tend to other residents. His relationship with Voyce changed as well:

> Chuck and I would go play tennis a lot and do things together on a daily basis. In fact, I went to Disneyland that summer with my kids, and Chuck went along with us and had a good time. It was a lot of fun for all of us.

Of this friendship, Loren wrote,

> Chuck's very real, down-to-earth relationship with Voyce after his stay at the house is unusual for traditional psychiatric treatment (but not for Soteria). While not defined as psychotherapy, it was clearly therapeutic. Voyce provided Chuck with a model of efficacy and competence (especially self-control) to emulate, and their shared life experiences and positive emotional ties seem to have been critical in Chuck's change over time.

Continued Loren: Stage three within the milieu involved extensive collaboration, planning, and negotiation in the context of involvement in a--by then--familiar, trusted, and tightly knit social group whose members played a variety of roles with differing statuses. State three was much more complicated than the first stage.

The Soteria Network

Soteria's maintenance of connection with its former members distinguished it from most other treatment settings, especially from current community-based programs. The decision to keep in touch with departing staff and clients evolved in response to the feelings aroused in the community when people left--the intensity of involvement by both staff and residents as well as the long hours and the blurred roles led almost to feelings almost like those among family members. "It was like losing a sibling or a roommate when someone moved out," explained one resident.

Early on, Soteria built rituals around leave takings. There were parties--at Soteria or at the graduate's new home. When clients left, the community (including former residents) helped them to find a place to stay, to deal with landlords, to pack up, and, finally, to go. Often residents moved in with other Soteria graduates. Sometimes a newly discharged resident needed a familiar face around to help in the transition. If this were the case, a member of the community stayed with the new graduate temporarily. When staff moved out, either to become day workers or to take another job, the process was formalized to minimize the pain of separation. Sufficient notice was a requirement.

Once no longer in residence, however, both former staff and clients maintained contact with Soteria. Some graduates were frequent visitors at the house, receiving needed support and comfort from familiar friends. Others built networks of Soteria graduates outside the house, keeping in touch by telephone and letter as well as face-to-face. In both cases, the continuing nature of the Soteria experience offered help to fragile people who often still needed help maintaining ongoing relationships.

Later research data affirmed, Loren noted, that it was this peer-based, easily accessible, tolerant, and affirming social network that accounted for the differences in long-term (two-year) outcomes found among the 1971-1976 cohort of patients treated at Soteria.

Therapy Soteria Style

In retrospect, wrote Loren, seven therapeutic qualities appeared to be essential within the Soteria environment. Interestingly, but not surprisingly, given the community's disinterest in formal procedures of any sort, the seven were never explicitly articulated during the life of the project. These qualities, however, were basic to the ambiance that made Soteria a powerful therapeutic milieu.

1. There was a shared view that psychosis could be a positive learning experience.
2. The presence of multiple, shifting, and often ill-defined roles and relationships created an environment that could respond rapidly and flexibly to changing demands.
3. Clients spent sufficient time at Soteria to imitate and identify with staff members, volunteers, and other residents in ways that allowed mastery of new strategies for coping. Clients had the opportunity to observe, internalize, and practice such skills with the help of people they esteemed.
4. The psychotic experience was accepted for what it was--an unusual state of being that could be understood and have shared meaning when sufficient information became available. Its incomprehensibility was mostly the result of the staff's inability, because of fright, disinterest, fatigue, or other failings, to put themselves into the shoes of the "psychotic" person,

to understand him/her and find meaning, and hence validation, in his/her experience.

5. Staff saw as their primary responsibility to *be with* disorganized residents, having been specifically charged not to *do* anything except prevent harm.

6. Unusual ("crazy") behavior was accepted and acceptable. Controlling such behavior was specifically forbidden unless a situation became dangerous. Staff were instructed to leave events stimulating personal anxiety alone or, if necessary, seek others' help in dealing with them.

7. Staff and residents normalized the experience of psychosis by avoiding jargon when discussing it: Clients are *freaked out* rather than psychotic, *bummed out* rather than depressed, *spacey* rather than hallucinating. When appropriate, staff shared similar qualities, framed in understandable and positive terminology.

STRUCTURE

Neither Too Big Nor Too Small

Soteria's small size was critical. Ideally, two full-time staff with some part-time and volunteer support worked with six residents. Greater or smaller populations were often therapeutically ineffective--Only a limited number of people could interact without creating difficulty for the community.

If too many people were involved, the group no longer survived as a whole but split into several parts. Such a breakdown fostered group interactions but discouraged interpersonal ones. During periods when too many people lived at Soteria, the program experienced its greatest difficulties, difficulties affecting the community as a whole but the staff in particular. Bigness seemed to exacerbate conflicts among staff members. In contrast, established residents in the crowded house seemed able to participate in disputes with little difficulty, making alliances with apparent ease, as their symptoms became less the focus of the group and their support became helpful. For residents in crisis, however, problems resulting when too many were in the community fed their confusion.

Too few people presented a different dilemma for Soteria, fostering isolation. Interpersonal relations, instead of giving way to interactions among groups, were replaced by *intra*personal ones that presented problems for everyone. The resident experiencing psychological distress felt even more out of control. The recovering resident complained of not enough support--or too much. Residents on their way to self-sufficiency, not surprisingly, were not seriously affected.

For the staff, however, a shortage of clients was almost always a problem. If only a few clients, spending most of their time at the house, were in residence, and a couple of them experienced crises, the staff had a very difficult time. When the shortage involved only fairly stable residents, the condition could, briefly, be pleasant. But if it lasted too long, the staff had time to look intensely at *their* own relationships. Ironically, this examination often led to major conflicts, even when Soteria housed fairly calm groups.

What constituted *large* or *small* varied considerably, depending on the demographics and the climactics of Soteria at any given time. If most members of the community were experiencing difficulties, *large* was smaller than when most residents were fairly stable. And in the summer, the environment widened as people spent less time in the house. Private space expanded in the warm months.

Generally, if 12 to 15 people spent more than four or more hours a day at Soteria, conflicts associated with too many people began to arise. On the other hand, if fewer than six people spent under four hours a day at Soteria, flawed interpersonal processes tended to result. So, for Soteria, the numbers were essential. Its experience is consistent with that in other communal situations such as those happening in extended families, communes, Tavistock groups, group therapy, and psychology's experimental task groups. Eight to twelve people are the most who can function effectively without breaking up into subgroups.

Soteria Days*

On a typical day at Soteria in the mid-1970s, two staff members (one male and one female) and one volunteer work the shift that begins at noon and lasts through the night. They are responsible for six residents. In addition, the house director, Voyce, stops by daily, as does the house psychiatrist, Ken, but only once a week. Also spending part of the day at Soteria are several former residents, a friend, and a volunteer named Ned.

On the day in question, one of the six residents, Nicholas, is still having some acute psychotic symptoms but is able to stay alone most of the day with only periodic staff contact. Two residents, nearing their discharge dates, are dealing with separation issues. One of them, Kate, has a job; the other, Tom, is looking for an apartment. After six years of private treatment, a fourth, Ethan, has been referred to Soteria. Along with the other two residents, Nora and Len, Ethan is deeply involved in the program.

The staff members on duty, both of whom began as volunteers, have been working harmoniously together for six months. Adam, who has worked at Soteria for two years, sees himself as an artist and a writer. Francie, a five-year veteran of Soteria, has recently finished her baccalaureate in English at a small college in the New England area. She had very little work experience before coming to Soteria.

Business as Usual

7:00 AM

Kate, the resident who is about to leave Soteria, gets up and goes to work. Since she gets a ride with a volunteer who works near her place of employment, she must leave at 8:30. After she eats cereal for breakfast, she showers downstairs, because one of the residents complains that the shower wakes him up.

Before Kate leaves, she goes upstairs to wake Francie as requested. Francie is already up talking to Ethan, who is unhappy about being waked by Francie's showering next to his room.

FRANCIE. You never complained before.
ETHAN. I told Kate.
FRANCIE. If you'd come to the house meetings, you could let everybody know that the shower wakes you up in the morning.
ETHAN. They seem so boring. All you guys ever talk about is the house not being clean and who's mad at who today.
FRANCIE. Well, I suggest you either come to the meeting tomorrow or don't complain when the next person who uses the shower wakes you up. Why don't you ask Kate to change rooms with you since she gets up earlier?
ETHAN. That's a good idea. She said she wished she had my room anyway, because she could grow her plants in it.

8:00 AM

Bob, a volunteer, arrives to pick up Kate. Francie fixes breakfast for herself and Nora. While Francie is making breakfast, Bob, Nora, and Kate sit around the table and talk about going to see a movie at a local theater.

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*Roles frequently shifted at Soteria, as people originally admitted as residents "graduated" and then frequently returned as volunteers, as friends, sometimes as staff. For a list of residents and staff, see page 5.

At 8:30, Kate and Bob leave for work while Francie and Nora eat breakfast. Before they finish, another resident comes in and eats some of the bacon and eggs Francie cooked. Nora finishes her breakfast and goes upstairs to get ready for her appointment at the Supplementary Security Income Office. Francie warns her of Ethan's complaint about the shower next to his room. Nora responds: "He should be up anyway. He sleeps too much."

9:00 AM-11:00 AM

Just before Francie and Nora leave, Adam gets up and wakes Len. Both Adam and Len had decided to go running this morning. Francie suggests that they wait until she returns, because Nicholas, who is still experiencing an acute crisis, might get up while they are out running. Francie will be back in about 20 minutes, since she just plans to drop Nora off. Nora will return by bus.

Before Francie returns, Nicholas and Tom have gotten up, and Adam helps Nicholas cook a cheese omelette. As Francie arrives, Adam and Len are on their way out the door. Nicholas asks if he can join them on their run. Asked if he'd run before, Nicholas replies, "Only a little." The three jog around the block twice to check Nicholas' stamina and continue their run with him.

As Adam and Len are leaving with Nicholas, Voyce arrives and talks with Francie and Tom about the day's events. Voyce is going a meeting of the California Association of Social Rehabilitation Agencies that will take him away from Soteria from noon until 4:00 PM, but he will then stay until 6:00.

After Nicholas, Adam, and Len return from running, they join the kitchen cabinet. Nicholas had more stamina than either Adam or Len and complains because they don't want to run any further. Francie and Tom believe that running "isn't always good for you," while Len and Nicholas claim that it "extends your life and makes you look healthier."

The discussion meanders until Francie's discomfort about the runners' odor leads her to recommend showers for all three. When Tom balks at her suggestion that he do the breakfast dishes, Francie agrees to help him.

11:00 AM-2:00 PM

Ethan gets up again and comes downstairs, still complaining about having his sleep interrupted by people taking showers. He asks Francie to make breakfast for him, a request she refuses because she has to go shopping for dinner. Next, Ethan travels upstairs to ask Adam to make breakfast, but Adam also tells Ethan to make his own. Angrily, Ethan comes back to the kitchen and begins cooking some eggs, complaining to Voyce: "What are you paying staff for anyway?"

When Ethan's eggs are about half cooked, Ned (a volunteer) arrives. Ethan immediately asks *him* to finish breakfast, claiming that "I don't know how to fix eggs." Ned helps.

When Francie returns from shopping, she takes Tom to see an apartment that he found in the want ads, while Adam spends some time with Ethan who has been having trouble with side effects of medications. Since the house psychiatrist is coming at 2:00 PM, Adam suggests that Ethan ask Ken for some medical help in getting rid of the side effects.

Nora returns, upset at her unsuccessful time at the federal assistance office. She had to wait two hours before seeing anyone, and then she couldn't complete the process because she didn't have her birth certificate along. She will have to go back the following week.

2:00 PM-4:00 PM

When Ken arrives, Adam, Ned, Nicholas, and Ethan are at the kitchen table, drinking the lemonade Nicholas made. Ned plans to get Ethan and Nicholas to help him work in the garden. Ken joins the group for a glass of lemonade, reintroducing himself to Nicholas because he is unsure if Nicholas, who had been very disorganized when originally interviewed, will remember him from the week before. After thinking a minute, Nicholas recalls Ken's face but not his name.

Following Adam's suggestion, Ethan brings up his medications and asks if they can be reduced. Ken reminds Ethan that it was *he* who wanted the extra medication, that Ken had originally recommended less. The three go upstairs to talk about Ethan's medication problem. Before they go, Ken reminds Nicholas that they will need to talk to further to complete the chart.

4:00 PM-8:00 PM

Ethan and Nicholas being unavailable, Ned goes upstairs and gets Nora to help him work in the garden. Ken leaves at 4:00--about 10 minutes before Voyce returns from his meeting. By then, most of the residents are again in the kitchen with Adam. Francie and Ned are discussing the evening meal in the living room. Ned, responsive to Nora's wish to get out of the house because of the hot weather, wants to take the group to Alum Rock Park to have a barbecue but is careful talk the idea over with a staff member before suggesting it to the rest of the house.

Francie OK's the idea and invites him to ask other people in the house if they want to go. Everyone (including Kate whom Ned calls at work) is interested except Ethan; however, he gives in to group pressure and finally agrees to go.

The first groups leave in Ned's and in Voyce's cars; the second contingent will take Francie's car when Kate gets home. But when Bob and Kate arrive at Soteria, Ethan presents a problem by deciding that he really doesn't want to go. Finally, Francie decides to stay at home with Ethan, who seems troubled. Bob takes Kate over to the park and will bring back a load later.

By the time Bob and Kate arrive at the park, the first group almost has dinner ready. Nora prepares the meal, while Adam leads an expedition along the trails. Voyce remains, in spite of his plan to leave at 6:00. After eating and playing some volleyball, the picnickers return to Soteria. There, a note from Francie explains that she and Ethan had gone for a walk to the local park and to dinner at one of the area's pizza houses. The group discovers Spence, an ex-resident, waiting in the living room watching television.

8:00 PM-11:00 PM

Nora remembers plans for going to the movies with Bob, who says, however, that he is too tired and needs to go home. Nora asks Ned if he will take her and Kate. Although Ned reluctantly agrees, Kate decides that she's too tired, but Ethan announces that he wants to go. Unfortunately, he doesn't have any money. Ned agrees to lend it to Ethan if Ethan pays him back the following week.

Spence begins to play the piano and sing; Francie and Kate join in. Adam and Nicholas go upstairs to talk about Nicholas' concern that Nora hates him because she looks at him in a strange way. Adam suggests that Nicholas should talk to Nora about this feeling when she gets home from the movies, an idea that makes him uncomfortable. Adam refuses Nicholas' request to have the

conversation for him but agrees to be there when Nicholas talks to Nora.

After about 45 minutes, the two join the sing-along. At 10:30, Kate announces that she is going to go upstairs to read and get ready for bed. Francie suggests that they stop playing the piano in deference to the neighbors' complaints about loud music at night.

Spence tells Tom there will be a vacancy in his rooming house by that weekend. Spence has asked the manager not to rent it until he had a chance to talk to Tom and promises to call the manager on Tom's behalf in the morning. In clinical terms, an extended peer social network is functioning nicely in this interaction.

11:00 PM-3:00 AM

Someone turns on the television to watch the news, and most of the people in the house start to watch too. Francie and Nicholas are in the kitchen talking about his problem with Nora. Kate has fallen asleep while reading on the bed in the upstairs common room.

When Ethan, Nora, and Ned return from the movies, Nicholas asks Nora if he can talk to her in the kitchen. He has decided to face her alone. In conversation, they realize that they went to the same high school and have had several friends in common.

Nicholas' fear that Nora doesn't like him is never discussed in the two hours that they talk.

At 1:00 AM, Spence goes home; Tom goes to bed; and Kate wakes up and goes to bed. After an hour's talk with Adam, Nicholas goes to bed. But Ethan and Nora again argue, first about the shower, then over other conflicts. Periodically, Adam and Francie must mediate until, after an hour of quarreling, the combatants go to their rooms for the night, leaving Len and Ned watching a late movie.

Francie and Adam go upstairs to talk about the day and to exchange back rubs.

A few minutes later, Ned falls asleep on the couch.

Len snaps the television off and goes to bed.

After making sure that Nicholas is asleep, at 3:00 AM, Francie and Adam go to sleep.

Soteria in Crises

During the stress engendered by psychological crises, members of the house try to continue their interactions and to maintain some kind of structure under chaotic circumstances.

6:00 AM-7:00 AM

At 6:00 AM, four of the five clients in residence are asleep--only Charlotte, a long-term resident planning to leave in two weeks, is up. She cooks breakfast for herself and the two full-time staff members on duty--Ophelia, a California School of Professional Psychology graduate and former volunteer, and Keith, a veteran staffer, working on his dissertation.

Ida, who has been awake for 24 hours, is in her second day at Soteria and is still in serious distress. She has just drifted off to sleep on the living room couch. Keith gets up after sleeping four hours in order to relieve Ophelia, who has been with Ida since 2:00 AM. Keith will be off duty in four hours, but Ophelia has another full day ahead.

As Ophelia, Charlotte, and Keith have breakfast, they talk about calling Voyce to set up a vigil for Ida. Ophelia worries that it will be difficult for

her to maintain the level of intensity for the remainder of her shift. Charlotte suggests waiting until Ida wakes up to see "what space she's in," and Keith offers to stay until noon when one of the volunteers is set to arrive. This way, Ophelia can sleep longer while he and Stuart--another veteran staffer who was formerly a psychologist's assistant--take care of the house. Charlotte offers to organize dinner and go shopping if someone drives her to the store.

7:00 AM-10:30 AM

Ophelia goes upstairs to sleep. Fifteen minutes later, Michael, who has been readmitted to Soteria because of a crisis provoked when his woman friend moved out, goes out the front door, whose squeaking hinges alert everyone in the kitchen of his exit. Keith catches up with Michael first and asks where he is going. "Home." Keith reminds him that, because Michael and his father quarrel, his parents told him that he couldn't couldn't come home. Keith tells Charlotte, who is standing on the front porch, to wake up Ophelia if Ida gets up because he must be with Michael.

Keith and Michael walk toward downtown, talking, among other things, about how scary it is to be away from home. After nearly an hour, the two have walked a circle and are now back in front of the house. Keith asks Michael if he would like some breakfast. Michael says yes, suggesting that Keith cook pancakes. Keith agrees.

When Keith and Michael enter the kitchen, they find Ida, eating eggs and drinking orange juice, sitting at the table with Charlotte. Charlotte is describing how she felt when she first came to Soteria. That Charlotte used to think that Stuart was the devil and could read her mind now seems cause for laughter.

Michael asks Ida if he can have the rest of the eggs still in the frying pan, and Keith suggests that Michael cook bacon to go with the eggs.

At this point, Voyce walks in the door, and Keith invites him to breakfast. Sitting down at the table, Voyce tells Keith that Ophelia called about Ida and Michael. If both these residents stay up all night, Voyce points out, it will be hard for Ophelia and Keith to make it through the next night without help. Voyce says he's "on call," if things become too difficult.

Keith goes up to wake Conrad, another resident, in time to make his 10:30 AM dental appointment. He meets Conrad emerging from the shower, ready to get dressed for his appointment. Elmer, a volunteer who has spent the night, has gotten up and is getting ready to go with Conrad to his appointment (which is just across the street).

When Keith comes back downstairs, Voyce suggests that they try to work out some plan for the day: There may be difficulties if both Michael and Ida start to experience crises. Neither has had much sleep in the last three days, a factor that could exacerbate problems. Keith suggests waiting for Stuart to arrive to participate in the discussion. Voyce also reminds Keith that Ida is scheduled for some psychological testing at 1:00 PM, and that Michael needs to be at the Supplementary Security Income Office at 2:00.

Elmer and Conrad leave for the dentist at 10:15, and Stuart arrives at 10:30, late as usual. Five minutes later, Saul arrives and immediately starts to wash dishes (a chore he likes). He claims that it "makes me feel like a part of this place." (Until a month ago, Saul was a Soteria resident. He is now a volunteer.) Saul's shifting roles in the Soteria community are the norm rather than the exception.

10:30 AM-2:00 PM

Ida starts to cry, and Charlotte puts her arm around her and asks, "What's wrong?" Ida doesn't know. She seems to be talking to someone but is not speaking loud enough to be understood. Because Ida seems most comfortable with females, she and Charlotte go into the backyard to talk.

Suddenly, everyone realizes that Michael is not there. Leaving Stuart in the house, Voyce and Keith go looking for Michael, who has managed to get to a local restaurant, where he is arguing loudly with one of the waitresses. He is talking to himself and making other patrons nervous.

Because Michael usually responds to Voyce better than to Keith, Voyce talks to Michael while Keith reassures the waitress. Finally, Voyce and Michael begin to walk back to Soteria. Voyce explains the difficulty that this kind of behavior poses and says Michael should tell the community when he wants to go out "so that we can talk about it."

"Why should I have to tell you that I'm going somewhere?" Michael replies. "You're not my father." Voyce explains that Michael doesn't *have to* say where he's going but that Voyce would *like* to know.

As Voyce and Michael walk home, Voyce invites Michael to come along to buy glass to replace a window broken the previous day. Michael accepts. They alert Stuart that they are going and set off.

Ida and Charlotte are still out in the backyard talking. Elmer and Conrad return and join them. Ophelia gets up and, with Stuart and Keith, discusses the change of shifts. Ten minutes later, a former resident named Howard arrives and asks Keith to play basketball. Keith agrees if Howard finds out who else wants to play with them. Elmer, Conrad, Stuart, Charlotte, and Ida are all interested. Ophelia is taking a shower, so the game proceeds with uneven teams.

Voyce and Michael return. By now, Charlotte and Ida are ready for a break from the game, so Voyce and Michael take their places. By the time Ethan gets angry at Howard for accusing him of fouling, everyone is tired and ready to quit.

2:00 PM-4:00 PM

Saul goes over to San Jose State to get an application.

Keith goes home.

Howard asks Stuart for a ride home.

Howard and Stuart leave.

The rest of the group sits down to eat the sandwiches that Ophelia and Ida made. At 2:00 while the group is eating, Len arrives. His background is like Ophelia's: He is a graduate student at the California School of Professional Psychology volunteering at Soteria. He greets everyone and hugs Charlotte, Ophelia, and Stuart before sitting down at the table. Charlotte immediately asks him if he will take her shopping for dinner.

"Yes," he promises, but first he wants to learn what has happened since last week. He introduces himself to Ida and explains what he does at Soteria.

Voyce wants to put the window in, so he goes to his van and gets the glass and putty. Michael helps Voyce, Michael quietly talking to himself as he works. Voyce asks if Michael is hearing voices. Michael replies: "Yes, the V-O-Y-C-E type." They both laugh at the joke, and Michael explains that his voices bother him sometimes: "They tell me to do things I know I shouldn't do." After they install the window, the two go back downstairs.

As they enter the living room, Voyce notices Ida asleep on the couch and

asks if she should be awakened now so that she will be able to sleep better tonight. Ophelia points out that Ida needs to sleep, because she has had so little since she arrived at Soteria.

As Ophelia speaks, the research assistant walks in, ready to test Ida. He asks where his subject is. Ophelia gently puts her hand on Ida's shoulder. When Ida awakens, Ophelia asks her to help with some necessary paperwork and introduces her to the researcher. She leads Ida and the researcher upstairs to the common room at the end of the hall, informing them that she will be downstairs, and closing the door behind her.

As Ophelia enters the kitchen, the phone rings. On the other end is Howard, upset about his roommate Brett, whom he had met at Soteria when both were residents there. Howard found Brett sitting in the middle of the floor of their living room, surrounded by strewn clothes and furniture. Howard tried to find out what happened but couldn't get Brett to say anything coherent or do anything but stare blankly at the walls as if he were looking at something outside. Suddenly, before Howard knew what was happening, Brett bolted out the door and down the street. Howard ran after him for a short distance. When he realized that he couldn't keep up, Howard called Soteria.

Because Brett and Howard live only five blocks away, Stuart, Elmer, and Voyce get into the van and to try to find Brett. As they turn the first corner, Elmer spots Brett standing in a vacant lot, staring up at the sky, and talking to himself. From two blocks away, they can see Howard running toward them.

Stuart and Elmer go over to talk to Brett, while Voyce tries to get more background information about Brett from Howard. Pedestrians and drivers stop and try to figure out what is going on, when Brett starts to shout that Howard is trying to kill him. While Stuart and Elmer try to explain to Brett that this is not so, Voyce and Howard stay some distance from Brett. After about ten minutes, a police car arrives, and Voyce tells the officers what is going on. They ask if they can help. Voyce suggests that, because Brett appeared to become excited when they arrived, it might be a good idea if they stay out of sight but nearby. They agree to drive down the street, turn the corner, and wait to see what happens.

A few minutes after the officers leave, Brett begins to calm down. Stuart and Elmer start walking Brett to Soteria. Voyce and Howard go over to the officers to thank them and to give them details about Brett and about Soteria's purpose.

On the way back to the house, Voyce and Howard decide that Howard should try to talk to Brett about his delusion about Howard's murderous intentions, but Voyce suggests waiting to see "where Brett is" when they return to Soteria.

Arriving, they find Ophelia and Stuart with Brett in one of the quietest rooms in the house. It was recently vacated by the last resident who left Soteria, and Ophelia had slept in it that morning. Ophelia is sitting on the bed with Brett holding his hand; Stuart sits on the floor by the bed resting his head on Brett's knees. Elmer, who has known Brett from previous work at Soteria, remains outside the door until he leaves with Voyce to go into the common room to explain what has been happening.

Brett seems no longer to think that *Howard* was trying to kill him; however, Elmer is afraid that Brett still believes that *someone* is trying to kill him. Elmer says that Brett hasn't been eating for a long time and that he

has been afraid to leave his and Howard's apartment for a week but that Charlotte is making food for him now.

4:00 PM-6:00 PM

While Charlotte is getting Brett something to eat, Len is making out a shopping list, and Conrad and Ida are suggesting what Charlotte might cook for dinner.

Michael is in the living room, looking depressed. Howard sits down beside Michael and starts talking to him. "I'm nervous," Howard says, "and need to go for a walk." He asks Michael if he would like to come along. Howard tells Len and Charlotte that he and Michael are going to Kim's market around the corner to get a soda. Len reminds them that dinner will be ready sometime between 6:00 and 7:00.

When she comes downstairs from feeding Brett, Charlotte goes shopping for dinner with Len and Ida. In the meantime, Ophelia and Stuart think they would like some back-up help tonight. During the last two nights, Michael and Ida had difficult times.

Voyce calls Natalie, a 40-year-old volunteer who lives near Soteria. She offers to arrive at the house around 7:00 PM. If there is an emergency, however, she says that she can get there earlier and can stay until 8:00 AM the next morning, if she leaves from Soteria for a 9:00 appointment.

As Voyce hangs up, Ophelia is waiting to discuss the possibility of readmitting Brett to Soteria. She explains: "Brett is really out of it. He can't keep a thought going for more than one sentence. He also seems afraid of something but can't or won't say what." Voyce asks Ophelia if she thinks the house could handle another resident at this time. She says it would "not be a problem," if he and Natalie were available when needed. Voyce assures her that both of them would be there all night if necessary.

Voyce calls the house psychiatrist to let him know what's going on and tells Ophelia to have Brett sign an admission form. Voyce also suggests a community discussion at dinner to see if anyone has a problem with Brett's coming back to Soteria. He reassures Ophelia that she need not to worry about dinner or cleaning up--the group will take care of both.

6:00 PM-7:00 PM

Michael and Howard come back from their walk, and Charlotte, Len, and Ida return from shopping. Charlotte rounds up everybody (except Brett, Ophelia, and Stuart) to help with dinner. Len has already started to make the spaghetti sauce; Michael is cleaning off the table; Ida and Howard are washing lunch and snack dishes; Conrad and Ethan are putting together a salad.

Voyce, who hates to cook, promises to wash the dishes after dinner.

While all this is going on, Natalie walks in through the living room, which wallows in a three-day mess of overflowing ashtrays and other debris, her night bag in one hand and a pillow case full of dirty laundry in the other. She says, "Voyce, you sounded so desperate on the phone that I sent my friend home and brought my laundry with me. I'll go down and put it in the washing machine now, and then I'll clean the mess in the living room." Saul walks in the door, and Natalie instantly asks him to help her clean the living room. She suggests that he start by folding the blankets on the couch where someone had slept the night before.

7:00 PM-9:00 PM

Charlotte and Ida set the table, while Natalie and Ethan put out the food. Len asks Conrad to go upstairs to see if Stuart, Ophelia, and Michael want to eat, and, if so, where, but the crash of breaking glass interrupts mealtime progress. Len, Voyce, Ethan, and Howard run upstairs to see what is going on. When they arrive, they find Ophelia and Stuart holding Brett down on the bed to keep him away from the window, one pane of which lies in shards on the floor. Brett's right hand appears to be bleeding seriously.

After Voyce looks at the hand more closely, he suggests that someone take Brett to the emergency room. By this time, Brett has calmed down and is sitting on the bed holding his injured hand. After Len and Ethan clean up the glass on the floor, Voyce asks Len to get a work glove out of the van so he can remove the remaining glass from the window frame without cutting himself.

Brett wants to see if he needs stitches in his hand, so Stuart and Len take him to the emergency room at San Jose Hospital. Ophelia stays and tells Voyce what happened:

> We had been sitting with Brett for an hour, talking about letting him come back to Soteria for a while. For the last ten minutes of our conversation, however, he seemed to be asleep. Stuart and I were talking about working out some kind of sleeping pattern for the night when Brett suddenly jumped off the bed and started to run. He tripped and fell against the window. We weren't sure what was going on with him, so we automatically grabbed him. I don't think he was trying to hurt himself; he just sort of freaked out and accidentally fell into the glass. I think it scared him when he tripped, and we jumped on him. I know it did me.

Voyce and Ophelia go down to the kitchen and join the group eating dinner. Ophelia again explains what just happened upstairs, and a lot of discussion about what to do when Brett gets back from the emergency room follows. Conrad talks about how he felt when he panicked one day and tried to jump out of a moving car. His story precipitates a long discussion about schizophrenia that goes on through 8:30 when Voyce begins, as promised, to wash the dinner dishes. Charlotte starts to help, but Voyce tells her, "You've done enough today."

Howard asks Ophelia for a back rub. She says she will give him one if he will reciprocate. Charlotte and Ethan and Ida and Conrad strike the same bargain, so the living room becomes a massage parlor. Everybody participates, except Voyce who is still washing dishes.

9:00 PM-1:00 AM

Stuart and Len come back with Brett, laughing about the emergency room nurse who thought that Brett had tried to cut his wrist and missed, even though Stuart assured her that wasn't the case. As soon as they enter the massage parlor, Len offers to give Brett a back massage.

Stuart tells Voyce that he is going upstairs to take a nap while things are quiet. Voyce suggests that both he and Ophelia get some sleep. While they sleep upstairs, and Brett dozes on the living room couch, the door bell rings. Suddenly Charlotte remembers that her mother is going to pick her up to spend the night with the family. After introducing everyone to her mother, she goes upstairs, collects some necessities, and leaves.

The rest of the group wanders into the kitchen to watch Voyce finish the dishes and listen to him reminisce about "the good old days" at Soteria, when the community used to stay up three and four days when necessary to get

somebody through a "crazy place." He remembers a resident who liked to get him to take a group up to Mount Hamilton to look at the city lights at 2:00 in the morning. Ida says that looking at the city lights sounds fun and wants Voyce to take them up there.

Len and Natalie offer to watch Brett in case he wakes up, and Voyce agrees to take the group to Mount Hamilton. He suggests that they get something to drink on the trip. Conrad suggests beer, but Voyce doesn't want them have anything stronger than "coke"--*Coca-Cola*, that is.

As they get into the van, Michael and Conrad argue about who is going to sit in the front seat. When Conrad wins, Michael decides not to go. Len and Natalie feel comfortable with Michael staying behind, knowing Ophelia and Stuart are upstairs if they need them.

Drinks purchased, Voyce starts driving the group to Lick Observatory at the top of Mount Hamilton. On the way, they stop at a mountain creek and dance to the music coming from the van radio. They spend an hour in the parking lot of the Observatory, looking at the city lights and talking.

1:00 AM-3:00 AM

The van pulls in to Soteria. Ida sleeps in Howard's lap. Conrad snores in the front seat, his head leaning against the window. Ethan and Saul are talking about going over to Santa Cruz in the morning to look at girls on the beach.

The house seems to begin to shut down. As people get out of the van, Len and Brett sit on the front porch talking. Ida and Conrad say good night; Howard and Saul leave for home; Ethan goes into the kitchen to make himself a sandwich and then goes to bed.

Michael, who was asleep on one of the couches, wakes eager to continue the argument over the front seat. He has talked to Len about his concerns while the group was gone, and Len has suggested that he try to work out the issue with Conrad when he got back. What began as an argument turns into a discussion; then, Michael and Conrad sit down to a game of chess.

The voices bring Ophelia and Stuart sleepily downstairs. Len tells Ophelia and Stuart that he and Brett, who is getting nervous, are going to go for a walk. He wants somebody to come with them in case he needs help. Ophelia feels like walking and joins them. Stuart goes into the kitchen to get something to eat.

Voyce announces that he is going home. He will be back in the morning with paychecks.

Fifteen minutes after Voyce leaves, Ida comes down to the kitchen to tell Stuart about her bad dream. As Conrad and Michael play chess, they listen. When Ida finishes, Stuart begins to interpret. Conrad disagrees with Stuart's interpretation. Then, Michael comes up with *his* interpretation. Ida dislikes it and tells him to go back to chess. The conversation shifts into a general discussion about dreams.

At 2:30 AM, Len, Ophelia, and Brett return. Len has some classes tomorrow morning and needs to get some sleep, but Ophelia and Brett continue the discussion in the living room that they began during their walk.

3:00 AM-5:00 AM

Conrad and Michael decide to go to bed while Ida and Stuart continue to talk. Around 3:30, Ophelia and Brett join Stuart and Ida in the kitchen, and the four of them talk there for a half hour before going into the living room.

There, Stuart lies on the couch, Ophelia and Ida sit on the floor next to him, and Brett gathers up pillows and lays them across the room. The only lights on in the house are in the kitchen, and in five minutes, Brett is asleep.

After a few minutes, Ida appears so also. Stuart and Ophelia hope both stay that way so *they* can get some sleep before tomorrow but notice that Ida is crying softly. When Ophelia asks her what's wrong, Ida doesn't answer and goes back to sleep.

Stuart moves Ida to the couch where he was lying and covers her. Ophelia covers Brett. Stuart plans to sleep on the other couch in the living room. He sends Ophelia upstairs to go to sleep. He will call her if he needs to.

At 5:00 AM, Brett wakes and asks Stuart to tell him in which room to sleep.

"You can sleep in the room where you broke the window or stay here," Stuart says.

"Where are you going to sleep?"

"On the couch where I am."

Brett, who wants to stay with Stuart, turns over and goes back to sleep. Stuart's unpremeditated response is flexible, spontaneous, involved, protective, and of genuine help to Brett. Yet an outsider might be hard put to distinguish staff and volunteers from residents, never, of course, a problem in a psychiatric hospital. A day like the one that has just passed at Soteria would never transpire in a medical setting.

> *Loren points out: In Soteria's environment, it is truly difficult to tell the players without a program (although there's a* list *on page 5). Reciprocal support is the order of the day, with those in special need getting more help at this point than they were able to give.*

A Quiet Sunday

Quiet days occurred when fairly stable residents were becoming independent of Soteria's services. Dramatic but largely nontraumatic shifts in activity often took place when several residents left in a short space of time. Since the replacement process could be slow, quiet periods usually lasted a number of days.

Residents' leave takings remind the others of their own eventual fate. Those staying on tend to become less dependent on the program and focus more on the time they too will step into the wider community. The difficulty of separation leads to some withdrawal on both the part of the residents and the staff. This withdrawal, which accentuates the quiet, is strongest when the absent resident was active--positively or negatively--in the program.

On this Sunday, no crises erupt, and operations proceed uneventfully. Most of the residents involve themselves in "reentry" activities such as going to school, going to work, and seeing friends from outside the community. Three residents remain in the program, and three others have recently moved into the surrounding community. One of the remaining residents is Chip, who has lived at Soteria for two months and is taking a class at the local state college. Christine is the most recently admitted person, and only she still shows signs of having serious difficulties. Orville, the third resident, came to Soteria as a private referral and been in residence for six months.

Also at Soteria is Hildegaard,* a psychologist from Germany, toward the end of her two-week stay. She hopes to set up a program like Soteria's in Germany. Whether she was successful or not remains unknown.

Tabitha and Lewis are the two staff members on duty. Tabitha, a former secretary, now also plays in a local band. Lewis, 35, has recently returned from 10 years' residence in Europe.

Two former residents and a volunteer also make contact with the house during this day. One of the former is Henry, who hasn't been to Soteria in a year. Luke, the volunteer, is a student at the University of California at Santa Cruz.

Loren notes: The community offers an excellent example of an informally organized open social system.

10:00 AM-12 M

Tabitha is the first person awake. She takes a shower and goes downstairs to read the Sunday morning paper. As she is reading, Hildegaard and Christine come downstairs. Hildegaard is willing to cook some breakfast if anyone wants some. Tabitha replies affirmatively, but Christine decides that she just wants cold cereal.

Christine gets a bowl of cereal, sits beside Tabitha, and starts to read the comics. While she reads, Chip and Lewis come downstairs and turn the TV on to a football game. Christine complains that that makes it hard for her to read, so Lewis unplugs the TV and takes it into the music room next to the kitchen.

When Hildegaard finishes making breakfast, she joins Chip and Lewis in the music room. Orville is up but is still sitting in his room writing a letter to his sister in Los Angeles. The front door opens, and Henry walks in and asks Tabitha if she knows where the TV is (it's not where it was when he was a resident). Tabitha points to the music room, and Henry hurries through the kitchen to see the game.

While Henry and Chip argue over who is going to win, Hildegaard and Lewis talk about Soteria. Hildegaard asks about incidents that have happened while she has been at Soteria, and Lewis tries to explain why they were handled as they were. Hildegaard also tries to find out about the day's plans.

Hungry, Lewis asks Hildegaard to come in the kitchen, so he can cook breakfast while they talk. Lewis and Hildegaard move into the kitchen, and when Henry decides that he wants to go to Kim's market, Hildegaard suggests that he bring back some orange juice.

Tabitha reminds Christine that her parents are going to pick her up at 11:00 to take her to San Francisco, and Christine goes upstairs to get ready.

After he finishes eating, Lewis returns to the football game, asking Chip for the score and a summary of what he's missed. A big touchdown by the Rams, Chip says facetiously (Lewis is a Forty-Niners' fan). There actually hasn't been any scoring, so far.

Just before Christine's parents arrive, Hildegaard tells Tabitha that she is going to visit a friend in Berkeley and not to save dinner for her. Christine offers Hildegaard a ride to San Francisco, but Hildegaard says she needs to spend some time alone, so she thanks Christine but prefers the bus.

*Her name has been changed.

A few minutes later, Christine's parents arrive, and she leaves. Hildegaard follows shortly afterwards.

Half-time.

The Rams are leading the Forty-Niners 14 to nothing, and Henry, now uninterested in the game, heads back to his apartment, while Chip leaves for the library at San Jose State to study. Lewis turns off the TV and goes into the living room to read the paper, but, instead, begins to talk with Tabitha about how quiet the house is. Tabitha goes up to see if Orville wants something to eat. She finds him asleep.

12:00 M-9:00 PM

Tabitha and Lewis clean the house for about two hours. When Tabitha hears someone taking a shower upstairs, she goes up to check on Orville and finds him, naked and embarrassed, in the hall. After he pulls on some pants, he opens the door and responds with enthusiasm to her invitation to go to a movie with her and Lewis later in the afternoon. He immediately puts in a request to see a popular science fiction film. Not overjoyed, Tabitha suggests that the three negotiate.

In the end, they agree to Orville's choice.

After the movie and dinner at the Spaghetti Factory, they pick up Chip at the library and go by a bar where a former resident is playing in a band. Without thinking about it, the group is networking--casually and vitally.

9:00 PM-1:00 AM

Back at Soteria, they find Luke, a volunteer whom they had forgotten was coming, in the living room with Todd, a former resident who hadn't been back to Soteria in a long time. The two of them had had several hours to become acquainted.

Tabitha gives Todd a big hug of welcome, but she is the only person who knows him from his days at Soteria. The group goes into the kitchen, sits at the kitchen table, and listen to Todd's stories about Soteria "before their times."

Loren's comment: Note here the transgenerational transmission of a unique culture.

Orville and Lewis start to play poker, using popcorn as money. After their first game, everybody else joins in. "Soteria Rules" prevail--it is OK to steal popcorn from the inattentive, but it is also fair to slap the thief's hand if caught in the act.

The game falls apart when people begin to spend more time trying to steal popcorn than playing poker. A war with popcorn and pillows as weapons is followed by a half hour's clean-up time. Todd is on his way--he has to go to work tomorrow; Chip goes to bed because of his class in the morning; and Luke leaves for the night.

At about 11:30, Orville brings the TV back into the living room and turns on the late movie channel. Tabitha and Lewis join him. Christine calls to say that she is going to stay overnight with her parents.

The movie ends.

Everyone goes to sleep.

Soteria's Sunday could have happened in a college dormitory or a group house--the line between the normal and the abnormal is blurred.

Rules in an Open System

Laing's Kingsley Hall was formally rule free. In contrast, Soteria's community agreed to certain fundamental controls. Soteria's boundaries--various rules considered necessary--were either *explicitly* set by the community, the staff members, or the administration or *implicitly* transmitted through nonverbal or unwritten behavior. Everyone understood the implicit rules in spite of the absence of formal agreements.

Soteria enforced two kinds of explicit rules, those affecting everyone at all times--*(universal)*--and those affecting specific individuals at particular times--*(limited)*. The former lasted *indefinitely;* the latter for a specified (or *definite)* period of time.

The rule against using illegal drugs--itself a felony--was a universal rule. Obviously, members of the Soteria community were also expected to refrain from acts forbidden by civil authorities--murder, rape, robbery, etc. The rule requiring that the knife box be locked for a set period after a new resident arrived was a limited one.

*Explicit Indefinite Rules**

Early in Soteria's history, the staff tried to figure out how to impose controls without establishing a rigid structure. Although the *administration* had originally embraced three rules--against violence, uninvited guests, and illegal drugs, the *staff* defined only two rules whose violation could lead to discharge for any member of the community. Their first, prohibiting illegal drugs coincided with administration strictures; their second, forbid sex between staff and residents.

Staff paid lip service to the administration's regulations about violence and strangers while embracing the shared stricture against illegal drugs. The rule against sex between staff and clients, an incest taboo, was taken seriously. This rule was necessary to allow both groups to achieve maximum interpersonal closeness without inappropriate intimacy. Clear boundaries were useful for the staff and clients alike. Were either of the *community's* rules broken, a group discussion invariably followed. One possible action was expulsion of the offender, though neither Voyce nor Loren can remember that this option was ever exercised.

Seconding the administration's prohibition, the community also eventually decided to adopt a its own third universal rule against violence--threats or assaults--when the program was three years old. The need for more control over some potentially violent residents called for a formal mandate beyond the rule adopted when Soteria opened. It was clear that a rule against dangerous residents wouldn't in itself have a major effect on diminishing violence, but its formulation gave the group something on which focus as it came to grips with the underlying anxieties that violence produced. An unexpected result of formally prohibiting violence was that some residents began to discuss issues that for others in the group didn't seem to concern violence. For example, while one new resident saw the locked knife box as violent against him, most of the others saw it as a preventive measure. Oddly, the rule against illegal drugs was the most difficult to enforce. Because of the screening process, Soteria rarely housed clients with serious substance abuse problems, but, on occasion, clients would bring street drugs--rarely

*See *Introduction*, page 3.

anything other than marijuana--onto the premises. On the unusual occasions the community suspected or discovered such drugs, they became key issues at the next house meeting. "Using" residents justified their behavior as follows: The practice

- helped assert independence from the group
- was a self-medicating process that covered up the voices
- gave pleasure

No matter what the reason, use of illegal drugs was grounds for expulsion. When California decriminalized possession of marijuana, its use became less a focus of attention; at no time, however, was its use permitted in Soteria's public areas.

Explicit Definite Rules

Rules of limited duration, fixed around specific issues or people because of particular problems, usually had greater impact on the program than the universal indefinite ones. Violation of fixed rules could lead to penalties ranging from reprimand to discharge. Failure to participate in housework or gardening could provoke a warning; malicious lying could lead to expulsion.

Limited rules were one of many ways to encourage change in clients at Soteria. Clearly defined boundaries set the structure that guided many members of the community through important changes when a predetermined end had been established. But the rules usually served not to dictate the change to come but provide tolerable limits within which the residents could choose their own directions toward therapeutic ends.

The rules were successful in direct proportion to the degree that they allowed freedom of interaction. *Unnecessary rules could have been detrimental and are usually unenforceable in any case.*

One effective and necessary rule established around an issue helped Hugh, a Soteria client, control the problem he developed with alcohol. (Prior to the episode of psychological distress that sent him to Soteria, he had not exhibited alcoholic tendencies.) After he was admitted, however, every day about 5:00 PM, he would drink excessively and come home acting in a bizarre way that disrupted normal activities. This pattern went on for two weeks while members of the Soteria community tried by various means to change it. Nothing worked.

Instead of giving Hugh an ultimatum to either desist or leave, the community took a different approach. At a house meeting it was decided to remove the focus from Hugh because, as he put it, "It's not my problem. I'm having fun." No one could reasonably be upset with him, he said, because he "just got a little drunk every now and then." The community disagreed. Hugh's drinking problem had become the house's, and its members and staff decided not to drink for two weeks to break the troublesome pattern.

Everyone agreed to this policy, but many doubted its efficacy. To Soteria's amazement, Hugh stopped drinking, and so did everyone else. After the two weeks were up, the house went back to its normal policy of allowing consumption of alcoholic beverages. At first, Hugh was no less bizarre without alcohol than with it, but gradually his strange behavior ceased.

Soteria faced several issues with its two weeks of abstinence. It acknowledged there was a problem and admitted the failure of solving it by making it Hugh's alone. Because Hugh didn't think he had a problem, this approach gave him no reason to stop drinking. It was the *group* that had a

problem with Hugh's drinking, and the solution had somehow, therefore, to include to group in the process.

Soteria's solution to Hugh's drinking stayed true to its commitment to create as open a system as possible to allow people the opportunity to change in a safe supportive environment. When rules had to be made, they needed to exist for specific reasons; when the reasons went, so did the rules. Soteria's approach was basic and flexible: It promulgated only useful, enforceable restrictions, which were revoked when no longer necessary.

The Sources of Authority

Soteria maintained a structure with some basic ground rules, defined primarily by the present occupants. Another form of boundaries, however, were traditions, which played a major role in the Soteria process. When former residents returned to Soteria, their memories and progress allowed the program to develop a rich history that influenced its current course.

There was actually considerable structure at Soteria at any given time. Its source, however, rested not administrative policies and procedures as in the case of hospitals, but in the community as a whole.

Healthy structures, such as those guiding Soteria, are dynamic forces ever changing to fit what is currently happening. Still, certain aspects of Soteria had to fit into larger systems--for example, the mental health community, the public sector, the neighborhood, among others--so it also had to define itself in these contexts.

If Soteria's tradition conflicted with that of the broader society, Soteria's ability to effect change could have been compromised. Soteria, defined as a element of the broader social structure, had to decide to what degree to conform. Soteria, isolated from the broader society, could fail in its mission to promote behavior that would assure survival in that world. Such a state would threaten Soteria's existence.

For Soteria's process to function as intended, most of its attention had to be directed internally. In concrete terms, the immediate members of the Soteria community--staff, residents, volunteers, and friends--had to be able to interact a great deal and respond to internal pressures with appropriate changes. Attention to this mission, however, could make it difficult to monitor the relationship to the broader community. To avoid potential conflicts, the administrative staff had to represent Soteria to the outside community, attend to forces that impinged on the program from outside, and report its findings to clinical groups. This boundary function was essential to the community's survival.

Maintaining Soteria

> In the real world, there's a bunch of people at this house. You know, we all have to eat and keep it clean and stuff like that. I think we always get in touch with the necessities of running a house when we have to--when you run out of peanut butter and jelly, you kind of drop the therapeutic trip, or whatever else is going on and say, "OK, somebody's got to get it together enough to take the money out, get in a car, go to the grocery store, and buy peanut butter and jelly." There's always somebody together enough to have the energy to go and do that.
>
> *--Geoff, Soteria staff*

Soteria was a home with all of its basic needs and tasks. Staff and residents did maintenance tasks spontaneously, and the quality of the cleaning and cooking at any particular time reflected the interests and needs of the group present. Sometimes individuals had different opinions as to whom should be completing necessary work and how it should be done. Explained Tara,

> I refuse to cook all the nights I'm here. It's a male-female problem with some of the staff members. Often I'll make the male staff member cook one night, and I'll cook another night. I'll say, "You pick your night, and I'll take the other night," and he usually can do that, or else we don't eat.

In addition to the cooking, staff and residents maintained the lawn, did the laundry, decorated the house, purchased necessary clothes, sewed and mended, and fixed the plumbing (when possible).

> *Loren's note: Basic maintenance is vital to every household that contains individuals with an interest in the welfare of each other. So it was at Soteria.*

Recreation Soteria Style

Recreational activities were also usually fundamentally unplanned. Staff member Katy described some of the house activities:

> We've had birthday parties for everybody who's been here. Kelly and Iris would bake on their own. There's been some candle making. We got into tie-dyeing. Kris really got caught up in that. The garden, that's been a really good thing for Chuck.
>
> We've played tennis, and we've gone to the park. We go to the beach. I've taken Kelly and Kris ice skating, and Chuck goes roller skating once in a while. We go to movies. We've gone to the Japanese gardens. We've gone to the parks up in San Francisco on the weekends.
>
> We've done some redecorating in the rooms sometimes. Some of the girls have been into sewing. The girls have made some leather things at times. Naomi's talking about making jewelry now. We've done some work with clay. The girls have made mobiles. Kris did a lot of art work. Chuck's done a lot of writing, and so have Naomi, Kelly, and Katherine. There's quite a bit of activity actually. The fellows go and play baseball now, and basketball. We do a lot of walking or sliding, like we rode up to the snow and had snow- ball fights. We've gone to Mt. Hamilton to see the sun rise when nobody's feeling sleepy. Stuff like that.

Often recreational activities facilitated interaction among house members. Katy continued,

> For a while there, we were playing a lot of Casino and cribbage and stuff like that. Especially with Iris, chess gave us a safe structure in which to interact. It became a regular habit every night; we'd play at least one game of chess. It wasn't really important who won, and a lot would happen during that time--you know, you might end up not making a move for twenty minutes, just talking.
>
> Iris would ask if I wanted to play chess, and we would start talking, and she would lay out where she was at on a lot of stuff. (I enjoy playing chess to begin with.) Once we started doing it, we both recognized what it was and said what it was. I'd wait for her to ask me--when she wanted to.

Recreational activities were also helpful at times to release the tension that sometimes built up in the house. Hal recalled several trips that seemed to

serve that purpose:

> On that night everyone was really depressed, up tight, so we all kind of agreed to get the hell out of there for a while. We went up on the mountainside. About half-way up, we just sat there and screamed at the top of our lungs--the four of us sitting on the mountainside just holding arm and arm, just screaming. And every once in a while, our screams would all get at the same pitch and just reverberate through our skulls. Kelly would scream out what she was really angry about and call every name. Iris would get into it. Naomi was kind of hesitant, but then so would she, and then so would I. We just sat there and screamed for an hour--really let it out.
>
> And then, we came back down and went over to Spivey's for some coffee. After we had the coffee, I bought them ice cream--banana splits and stuff like that. Everybody was stealing everybody else's stuff--you know, you take a bit of yours and reach over real fast and take somebody else's. When we were done with that, Kelly said she wanted to be alone for a while, and so she walked back. Iris, Naomi, and I rode back afterwards.
>
> Other trips are also really nice. One night we were up all night with Chuck and Iris; no one could sleep. About five in the morning, they asked me if they could go for a ride. So, we went for a ride up to Hamilton again. This was just as the sun was starting to come up, and we stopped five or six places along the way and picked some flowers and watched the deer. And we got to the top just after the sun had risen and sat on the cliff there and watched the whole Bay area. That was really pretty. We were all in good space even before we went up. Iris got up there in the countryside, and she chased the deer through the woods and picked different kinds of flowers and stuff.
>
> Other times I've taken Naomi up when she was really angry, really upset and nervous. Halfway up the mountainside, she has the radio blaring hard rock. As we drive up, she turns it further down and further down and finally off. And, she doesn't turn it back on until we hit Alum Rock, coming back down again.

Loren's comment: Soteria's environment adapted itself flexibly and spontaneously to the expressed needs of its inhabitants. No procedure manual covered contingencies, and activities often took unpredictable turns.

For example, reported staff member Della,

> Kris, Katherine, Kelly, and I were making cupcakes and I was mixing up some of the frosting, real gummy stuff. I started to put it on the cupcakes, and they grabbed them as soon as I did it. Then Kelly picked up one and just kind of looked at it and looked at me and grinned and went splat right in my face with it.
>
> I stood there for a minute. I could just feel this immediate tension with Katherine, who had her eyes big. Kris was just standing there. I laughed. I grabbed Kelly by the neck and scooped up some icing and rubbed it in her face. Then all of us got into it and messed around with the icing for a while. I guess we did it for about five minutes or so.

One of the most popular activities in the house was massage. Both staff and residents found that massages relaxed tension and helped them get acquainted with their bodies. For residents less able spontaneously to touch and be touched, massage provided a safe structure in which physical contact could occur. Susannah described how massage fostered communication between her and one very withdrawn resident.

That day we were having a real massage workshop. There were about 15 of us sitting around the living room, and we began the workshop by giving each other hand massages. My partner was Leo, and I was very unsure as to how he would react to my suddenly taking and manipulating his hands. So I began very gently, putting some lotion on his hands and then spreading it around with very light strokes.

His fingers were just phenomenal ...incredible tension and rigidity in them. I tried to bend them, ever so slightly, and they fought me like tigers. They were like ten steel cylinders sticking up in the air. His hands were nearly as bad. The knuckles, bones, and veins just stood out on the surface from tension. There was no flexibility anywhere in his hands. They could have been the hands of an automaton. Touching Leo's hands drew me into what was happening inside of him, and I felt my own body go tense and rigid. For an instant, I wanted to burst into tears...just to let all that tension go, in me and in him.

I looked at him and saw an incredible struggle going on. His face was twisted, grimacing, contorted...fighting God only knows who or what. I would have to be very gentle, or he would go back inside himself completely.

I began trying to relax just one finger at a time. Stroke it, hold it...At length, it did relax, a fraction of an inch, then stiffened back up again immediately. The other fingers followed suit. (God, his hands are as cold as ice!) And his face softened, just a little bit.

This went on for maybe five minutes. I was feeling very much in contact with Leo...His hands spoke eloquently of things he is not yet ready to tell us in words. And I was making my hands very soft, gentle, attentive, to tell him it's OK to let go, to relax not to be tense, to tell him I cared for him. And at length those fingers softened a little, his eyes opened, and he smiled a little.

I moved my hands so that his hands could cup around mine and explore them, if he wished. But he was not ready for that yet. We smiled, and I kept on holding his hands. A voice broke in from the outside world... The workshop leader was telling us to separate hands. I let go of Leo.

He sat for a moment, then started looking at his own hands as if he'd never seen them before. He stroked one hand, then the other, just as I touched them... grinning all the time. I grinned back. I get this message (but in smiles, not words) "Hey! These are my hands! They have feeling in them!"

The massage lady told each pair to talk among themselves about the experience they've just had. A lot of chatter all around us, but Leo and I just sat and grinned at each other. Our communication has been without words. We've said it all without them.

Loren points out this highly perceptive level of empathy.

From time to time, either because of extreme disturbances in the house or to avoid having staff remain beyond their normal shifts, residents were invited to visit with staff at home. Susannah, who had three different residents come home with her, described some of the positive and negative aspects of such visits:

I'm aware that they're there. It isn't that comfortable. I have a feeling of being available to them. One part of me is alert all the time. But it's good for me to take them home. It's good for my kids, because then they see what I'm doing, and it's not so separate from them.

It was very good for Tracy and Iris. I don't know how good it was for Kelly. My kids dividing my attention are hard for her to take.

Susannah's experiments were not routine. They required excellent judgment, trust, common sense, and serious attention to possible impacts on disturbed

clients. Because of their attention to context and thrust toward normalization, however, "home visits" were never seriously challenged as a legitimate part of life at Soteria.

Community Relations

Staff members had anticipated that, since Soteria was to be an unlocked facility directly in the community, they would be dealing with difficult situations involving the larger environment. Such situations arose involving neighbors, a nearby nursing home, shops, medical facilities, and the police.

Such incidents, however, were relatively infrequent; furthermore, they were merely embarrassing rather than dangerous to those involved. In most cases, staff dealt with such situations with a minimum of turmoil. Tara remembered one such time:

> Alma and Tracy and I took Kelly to get her birthday present, and Tracy couldn't keep up or didn't want to and was wandering around. So I stayed with Tracy. She went into "Eastridge Imports." There was a card rack of romantic cards with big faces. She set up one of the cards as a kind of altar and knelt down and started saying the rosary in front of it.
>
> There weren't a lot of people in the store, but the lady at the desk was watching. I started to feel uncomfortable, and I didn't know what to do. Finally, I just told Tracy, "Come on, let's go." She was in sort of an ecstacy and wasn't paying any attention to me. She had her face up and her eyes closed, and she was praying. Every once in a while she'd look up at this picture of a woman. For her, it could have been the Virgin Mary or whatever.
>
> Tracy was praying and looking very holy. I figured I should buy the cards, so I paid for a couple. The lady kept looking up, but she didn't say anything, and I didn't say anything. I just went over to Tracy. Tracy started to fall into the card rack, knocking it over. With one arm I was trying to grab Tracy, so she would fall against me, and, with the other, I tried to straighten the card rack, which was very flimsy.
>
> By then, Tracy was crying. I got her up and latched on to her and dragged her out. We went through that a couple more times, just stopping, praying, kneeling down... I just stayed with her. People were staring, but nobody was coming close enough to laugh at her or say anything. (Of course, she wasn't really disturbing anybody. She wasn't into any kind of destruction. She was just praying.) I stayed with her until we found Alma again.
>
> That was hours later, and I was beginning to get very nervous.

At another time, when Tara saw the possibility that a similar excursion could result in real danger both to the residents and to other shoppers, she took firm control of the situation to avert trouble before it began:

> There was the time that I took Tracy and Naomi both. At that time, Tracy was no longer into her sweet, prayerful stage. She was into breaking things, burning things, and being very mischievous. Naomi at that time was following the leader. Tracy would break a window; Naomi would break a window. Plus, Naomi was very scared of Tracy.
>
> So, I had Chuck come with me--to keep an eye on Naomi. We got into the shopping center, and Tracy started saying, "All these windows," with a nasty look on her face. Then, Naomi started laughing, "Yeh, that would be fun. Let's break some windows."
>
> I started getting scared. And I thought, "Crap!" I didn't know what I would do if anybody started breaking windows at Eastridge, the biggest shopping center in the world and brand new! Finally, I got pissed off and said, "If either of you break a window, I'm going to beat your butts, and we're leaving here right now!"

That shut them up for long enough to get back to the car. I drove back *home* where everybody could handle them.

Loren comments: Tara's remarkable clinical evaluation and response are possible because of her extensive knowledge of the residents involved.

Alma recalled that one of the most serious disturbances in the community involved a severely regressed 16-year-old named Tamara. For about three weeks, Soteria provided two staff members for her at all times. But

one afternoon, when left alone for a minute, Tamara climbed out a window and was discovered about 10 minutes later riding, naked, down the street on a bicycle.

During that 10 minutes, Tamara had run to the neighbor's house, and, finding the door unlocked, entered, picked up the brand new color TV from the table and placed it gently on the floor, knocked down three vases of plastic flowers, entered the children's room, played with their toys, disrobed, placed her clothes in the washer and pedalled off on the bike she found in the garage.

The neighbor and her children returned home at the end of this caper. "Who's been playing in my house?" she exclaimed, both furious and frightened. She called the police, her husband, and her parents. For about half an hour she refused to speak with anyone from the house. When we spoke about one hour later, she was convinced that our house was ruining the neighborhood and the moral life of her daughters. She told me that Tamara should be locked up forever in the state hospital.

She kept asking me over and over again, "Doesn't she have a mother?" By the time the police arrived, however, the lady was considerably calmer. She seemed especially relieved to learn that Soteria housed emotionally disturbed young people--not drug abusers as she had thought--and with my sincere apologies and reassurance from the police that we were indeed a legitimate facility, she did not press charges against Tamara.

In retrospect, Tamara's adventure may seem humorous, but at the time it was Soteria's most difficult encounter with the community. The worried mother and her young daughters lived next door to Soteria. The patient explanations Voyce and other staff members provided helped her to find *meaning* in this unusual event rather than merely danger.

Loren finds this interaction to be "interpersonal negotiation at its finest. Real people," he comments, "are talking to real people about real events."

Introducing New Members

Staff and clients were recruited differently at Soteria than at other mental health facilities. Soteria tried to bring into its company people who not only would involve themselves in official roles in the program, but who also were comfortable being interpersonally enmeshed in the system beyond the period of critical need. Although residents could not be selected on the basis of extended involvement, most learned from staff members fairly quickly what was expected. New staff had to be compatible with the personalities of established members of the Soteria community. But not until Soteria was two years old did a clear policy begin to emerge on the process of introducing new members into the Soteria community.

The approach that turned out to make the most sense for Soteria's needs was the audition model, some variation of which was used with all persons entering Soteria--residents, staff, volunteers, and administrators. The key ingredient in this process called for newcomers to spend a given amount of time with present members of the Soteria community to allow input from both members and would-be initiates into the acceptance process. This time also gave the potential entrant a chance to see if the Soteria program were what s/he expected.

Although the house *had* to admit all residents identified and sent by the Medical Research Institute team, Soteria staff instituted a modified audition process for everyone. This procedure reflected the community's perceived need for *everyone* to go through some type of "try out." The process was another way of muting inequalities within the community--thus making role definitions more fluid than in other settings.

So while residents were admitted as required, staff openly discussed with their new clients the two-week courtship period promulgated to fulfill many needs. One such need was the frequent original desire of new residents to leave. During the limited courtship period, reluctant residents often agreed to stay until the community could reach mutual judgment that they were ready for discharge. Although residents did occasionally leave after two weeks, most eventually returned if they were still dysfunctional enough to need residential care.

The Process for Hiring Staff

The first attempt to use Soteria's audition model to hire staff did not work because of a split opinion within the established group over which of two applicants to hire. The solution to this problem was to modify the consensus process by giving one person the authority to make a final decision. This process still allowed the group input without the same potential for divisiveness. The modified audition took place in a series of six steps.

Hiring

Potential staff was

1. identified
2. screened and scheduled
3. given person-to-person contact with community members
4. evaluated by all affected
5. discussed by all affected
6. hired or not

Volunteers applied to the program already familiar with the community, and Soteria recognized donated time as a sign of commitment; therefore, volunteer applicants had an original advantage over totally unknown ones. Volunteers played a variety of roles at Soteria, in which they were expected to be competent. But not all volunteers were good role models, so volunteering by no means guaranteed future employment. If a volunteer appeared able to function as staff and had been involved long enough to be known by all the members of the Soteria community, only the fifth and sixth steps were necessary. If not, the process would start at the third and fourth steps of the audition process.

If, however, there were no volunteers who wanted or who could succeed in a staff position, the community went through the hiring process in its entirety.

STEP ONE

Everyone in the broader Soteria community would be asked to refer interested applicants to the person designated to screen and schedule. Using word-of mouth rather than want ads had a number of advantages. It usually produced known applicants who understood the kind of commitment needed to work at Soteria. It also seemed to limit the pool of applicants to a reasonable size.

But word-of-mouth had its disadvantages as well. It tended to produce a homogeneous group while an important quality of Soteria staff was its diversity. It included men and women of various ages, cultures, nationalities, lifestyles, and educational levels. Word-of-mouth recruiting also failed to guarantee compliance with equal opportunity responsibilities.

STEP TWO

Once the applicants called, the screening and scheduling process began. The first appointment weeded out obviously inappropriate candidates and helped applicants get a clearer understanding of the Soteria program.

STEPS THREE AND FOUR

Once screening was complete, the remaining applicants were given appointments to talk to *all* Soteria members, in groups if possible or individually if necessary.

Steps three and four both stressed the importance of contact between applicants and members of the Soteria community. They differed, however, in that one focused on individual interactions and the other on group processes. Step three required a significant period of time to make an adequate judgment; step four insured enough input to enrich the next step.

STEP FIVE

The fifth step was a house meeting specifically aimed at gathering input from as many as possible. While Soteria meetings were not mandatory, the importance of bringing a new member into the group led to well-attended sessions.

Through trial and error, this sequence evolved: At the first meeting, held without the applicants present, community members discussed each individual applicant separately at any reasonable length. The final decision, however, was the program director's rather than the result of consensus. Previous attempts to be democratic had led to discord.

STEP SIX

In the end, the final authority went to the program director for a number of reasons: He was intimately involved with the day-to-day processes; he had the authority--by job description--as well as by the respect and trust of the group; he was the natural person to whom the new staff member would be answerable; and he was willing to face the group's anger if necessary. After the hiring meeting was over, therefore, the program director took the group's information, evaluated it, and the next day informed the Soteria community of his choice. Generally his decision merely made the consensus official.

The Process for Recruiting Other Groups

After being refined by the process of hiring staff, the audition model proved useful in choosing other members of the community.

ACCEPTING RESIDENTS

Once accepted, Soteria's new residents "tried out" for two weeks to allow people in the house the opportunity to make necessary critical assessments. All applicants identified by the Medical Research Institute auditioned, unless for some reason the community immediately thought an individual would get better care elsewhere. This method made the community responsible for persuading the potential resident to want to stay, a task made difficult by the fact that most clients preferred to be at home, which was not usually an option.

The first four steps were skipped over quickly, early in the two-week period. (There was no need to recruit, a job taken care of by the research team). Screening and scheduling were also unnecessary because all new residents were asked to spend the first two weeks primarily at the house to give community members ample time to get to know them. Any *critical* information about matters such as aggressiveness toward self or others was disseminated to the group before the prospective residents arrived. Because psychiatric histories rarely contributed positively to a new resident's reputation, Soteria deliberately withheld information *not* essential to the health of the community or the individuals within it. This policy, critical to the practice of interpersonal phenomenology, allowed new residents to establish relationships not based on his previous history.

After the two-week audition, Soteria followed steps five and six. It gathered for its forum, the regular weekly house meeting, and, in the absence of burning issues, decided to invite the new resident to stay. If a problem arose, it was either discussed to resolution or forwarded to the program director who made the final decision, in consultation with the house psychiatrist if appropriate. But this latter process was rarely necessary--Soteria's auditions usually led to acceptance, with residents who stayed two weeks almost inevitably being invited to remain.

CHECKING VOLUNTEERS

Because of the variety of roles they played at Soteria, volunteers came into the community in many ways. Former residents who became volunteers needed much less investigation than people with no previous knowledge of Soteria. Some helped after no formal introduction as, for example, in the case of ex-residents who hung around the house because of their need to participate in some way.

Others went through a formal process similar to the staff-hiring procedure. People known by the members of the community--ex-residents; friends of Soteria members who had visited frequently; relatives of community members--generally didn't need the first four steps. In most cases, once someone expressed interest in becoming a volunteer, his or her offer would be brought up in a house meeting. This procedure would complete the audition to step five, leaving only step six, the decision.

The decision process for volunteers partook of elements of both the staff and resident processes. At a regular weekly house meeting, appropriate discussion took place. If there were reservations, the process resulting was

like that for controversial new residents. Either the group then decided, or, if, they couldn't agree, the decision, again, was the house director's. Eventually, volunteers were required to offer at least eight hours of service weekly on an as-needed basis. This restriction kept the group to a manageable size, minimized the number of people a resident had to face, and provided Soteria with real, essential help.

> *Loren's comment: So many groups composed of people involved in various and changing relationships led inevitably to blurred roles. Among others, Soteria welcomed former residents, students, friends, family, hangers-on, and so forth.*

BRINGING IN FRIENDS

Friends of the Soteria community were a diverse group, including a French-Canadian psychiatrist who spent a sabbatical year at the house, a European psychologist who visited for two weeks, and the next-door neighbors who interacted for over a decade. Although most of Soteria's friends had a direct personal relationship with one or more members of the Soteria community, in only one case was the staff/client incest taboo broken when the brother of a staff member, who was living at Soteria, had sex with a resident. The incident was discussed in an open house meeting and resolved by conferring volunteer status on the offender, thus bringing him under the prohibitions of the incest taboo. (See *Introduction,* page 4.)

Situations where strangers live together usually necessitate a screening process for new members; however, within such living groups, friends are usually selected much less formally. At Soteria, friends usually visited initially on various errands and then became a part of the group because they and the community found something of mutual benefit or pleasure. For example, the next door neighbor came over every day after work to play basketball, and a resident's sister became a good friend of several community members. Many friends' interaction with residents was indistinguishable from that of volunteers, and, indeed, friends who sought temporary refuge at Soteria were officially designated as volunteers. Most volunteers came consistently, however, and saw themselves as having official roles.

But friends went through none of the steps in the audition. They were simply friends--an informal and invaluable association that extended the house's network.

LOOKING BACK AND AHEAD

This report provides a detailed account of many of the types of interactions that took place at Soteria (and a couple of those at Emanon), yet a critical question remains: What was it specifically about these environments that made them such powerful antipsychotic milieux? What were the necessary characteristics to produce the dramatic reduction of symptoms noted in the research team's evaluation that often took place during a resident's initial six weeks at Soteria? (See progress report in the appendix.)

To answer these questions from a logical positivist perspective, one would have to dissemble the model piece by piece until the parts no longer made up an effective whole. Or, perhaps more logically, one might organize an environment sharing many but not all of the characteristics of Soteria and make a comparison.

As research director of the project and as one of the two primary contributors to this report, I realize that it fails to address a most important question:

What would the six-week outcomes of experimental patients in a Soteria-type of atmosphere been had they been given neuroleptics?

This question is the basis of a badly needed study.

Having raised the central unanswered question, I would like to offer an opinion on the answer, based on the clinical experience gathered over a number of years at the unique settings offered by Soteria and Emanon. Administrators, staff, and residents have experientially found the ingredients they believe essential for a Soteria-like recipe to work. Without those ingredients, we think any attempt at replication would be flawed. We also wish to acknowledge explicitly that separating out the working parts of a special social community is not only virtually technically impossible but also potentially dangerous. On the other hand, such a process could serve to sharpen our thinking.

To begin with, to be a place where normalization occurs, the facility itself must be normal, must be, in this case, a home. Next, the home should not contain more people than would an extended family. Hence, the maximum number sleeping should be no more than 10. (See *Structure*, page 64.)

Next, because the client stays will be time-limited by the transient nature of their residence, the staff will be the major source of cultural transmission. It is therefore important that staff members be nondogmatic, pragmatic, down-to-earth problem solvers, who are oriented to the needs of individual clients in rapid, responsive, flexible manners. Although staff members will frequently find themselves in parental roles, the thrust over time should be for them to evolve into older sibling and/or peer relationships. This, in concert with a minimally hierarchical setting, will mute the natural tendency to disempower residents and make them unnecessarily dependent.

Third, for clients in the throes of acute psychosis, the environment must provide safety, stability, predictability, and respite. It must control stimulation, validate clients' realities, and provide interpersonal experiences of support, acceptance, and tolerance. The staff must, therefore, be willing and enthusiastic about *being with* residents. *Doing to* should be explicitly limited to clients in potentially harmful situations. Staff should be designated as generalists, who can perform whatever functions required by individual clients and their families at almost any point in time, not as

counselors or therapists. Such an undifferentiated role enables staff to serve as models for an array of people, keeps staff grounded, and helps prevent the unhealthy exercise of specialness, charisma, power--by whatever name.

It follows that the facility should be part of an open social system that allows easy and informal access and departure. Former clients from Soteria and Emanon were formidable resources both for psychological change--they, after all, knew the territory best--and concrete help in tasks such as finding employment. Former residents were the major actors in an embracing peer-based social network.

Finally, stable, predictable, supportive, and strong leadership is critical to the maintenance of staff morale in situations, which were often chaotic and psychologically stressful, before--usually--working themselves out.

This document provides data about settings, personnel, and practices that differ dramatically from those found on psychiatric wards. Yet every resident admitted to Soteria (or Emanon) would otherwise have been a patient in a psychiatric hospital. (On this, see Holly Wilson's analysis of the two control wards' social processes [pages 8-9] in contrast to the Soteria approach.) It is remarkable that these two communities, with the techniques described here, dealt as effectively with acute psychotic behavior--mostly without the aid of neuroleptic drugs--as psychiatric hospitals and their medications dealt with patients. For details see the attached final progress report.

At Soteria, people designated as "schizophrenic" were valued, validated, attended, and empowered. They engaged in real relationships with caring individuals in a nonjudgmental, reciprocal, social subsystem under the guidance of an extended, peer-based, natural social network. Such treatment for "schizophrenics"--whatever they are--is almost unheard of today.

This document and the associated research results indict current overmedicalized approaches based on theories of brain disease and dominated by psychopharmacology. There are alternative ways of dealing with madness. The Soteria project has established the scientific credibility of one of them.

Can science overcome power politics? I doubt it. Doctors, hospitals, and pharmaceutical companies are too powerful.

I do, however, respectfully submit Soteria's evidence.

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Research Director
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