

Soteria and Other Alternatives to Acute Psychiatric Hospitalization

A Personal and Professional Review

LOREN R MOSHER, M.D.^{1,2}

ABSTRACT: The author reviews the clinical and special social environmental data from the Soteria Project and its direct successors. Two random assignment studies of the Soteria model and its modification for long-term system clients reveal that roughly 85% to 90% of acute and long-term clients deemed in need of acute hospitalization can be returned to the community without use of conventional hospital treatment. Soteria, designed as a drugfree treatment environment, was as successful as anti-psychotic drug treatment in reducing psychotic symptoms in 6 weeks. In its modified form, in facilities called Crossing Place and McAuliffe House where so-called long-term "frequent flyers" were treated, alternative-treated subjects were found to be as clinically improved as hospital-treated patients, at considerably lower cost. Taken as a body of scientific evidence, it is clear that alternatives to acute psychiatric hospitalization are as, or more, effective than traditional hospital care in short-term reduction of psychopathology and longer- social adjustment. Data from the original drug-free, home-like, nonprofessionally staffed Soteria Project and its Bern, Switzerland, replication indicate that persons without extensive hospitalizations (<30 days) are especially responsive to the positive therapeutic effects of the well-defined, replicable Soteria-type special social environments. Reviews of other studies of diversion of persons deemed in need of hospitalization to "alternative" programs have consistently shown equivalent or better program clinical results, at lower cost, from alternatives. Despite these clinical and cost data, alternatives to psychiatric hospitalization have not been widely implemented, indicative of a remarkable gap between available evidence and clinical practice. J Nerv Ment Dis 187:142-149, 1999

1 Soteria Associates, 2616 Angell Avenue, San Diego, California 92122.
Clinical Professor of Psychiatry, School of Medicine, University of California at San Diego.

2 Soteria House staff, with Mosher L, Menn A, Vallone R, Fort D (1992). Treatment at Soteria House: A manual for the practice of interpersonal phenomenology, Unpublished Monograph Published in German as: *Dabeisein---Das Manual zur Praxis in der Soteria*. Bonn. Psychiatrie Verlag, 1994.

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Introduction

In 1961, while serving as a medical intern, knowing I was soon to embark on a career as a psychiatrist, I suffered what retrospectively could be labeled an existential crisis. For the first time I experienced the responsibility of caring for persons who would soon die-and I was powerless to do anything about it-except to try to understand their experience of it. They frequently expressed how helpless and depersonalized they felt, "I'm just the one with lung cancer" or "Why can't you do something so I can breathe-- drowning" or "All this place has done is to make me into a nobody-you can't do anything for me so you steer clear." For the first time I faced my own mortality and with it the degrading, dehumanizing and helplessness of the process that could accompany it-particularly if I had the misfortune of being in a hospital like the one in which I worked.

Previous intensive psychotherapy as a medical student had obviously not prepared me to face mortality compounded by the degradation ceremonies I presided over within the institution. As a sometime intellectual, I sought help with my conundrum in the library. Rollo May's *Existence* (1958) was the beginning of a quest for an intellectual foundation for the depth of what I was experiencing personally. With the help of May's book and an existential analytic tutor (Dr. Ludwig Lefebre), I studied the writings of a number of the phenomenologic/existential thinkers (e.g., Allers, 1961; Boss, 1963; Hegel, 1967; Husserl, 1967; Sartre, 1956; Tillich, 1952; and others) in greater depth. I concluded that their open minded, noncategorizing, no preconceptions approach was a breath of fresh air in the era of rationalistic theory driven approaches (such as psychoanalysis) to disturbed and disturbing persons.

So, I brought to my psychiatric residency a phenomenology-based "what you see is what you've got" bias to my interactions with patients and a sensitivity to the issues of a degradation and power especially as embodied in conventional institutional practices. The good mentors (e.g., Drs. Elvin Semrad and Norman Paul) in my psychiatric training

taught me how to listen and attempt to find meaning in the distorted communications of my patients and their families (in 1962!) by doing my best to put my feet into their shoes. Harry Stack Sullivan (1962) and the double bind theory (Bateson et al., 1956) provided intellectual support. I also learned how to ask and look for answers to questions of interest from research gods (e.g., Dr. Martin Orne). On the other hand, the institution itself gave me master classes in the art of the "total institution" (Goffman, 1961); authoritarianism, the degradation ceremony, the induction and perpetuation of powerlessness, unnecessary dependency, labeling, and the primacy of institutional needs over those of the persons it was ostensibly there to serve--the patients. These institutional lessons were not part of the training program. In fact, my efforts to be helpful to my patients were interrupted by these institutional needs. When brought up they were denied, rationalized, or simply invalidated, "You're just a resident and aren't yet able to understand why these processes are not as you see them." From a series of such experiences, I began to believe that psychiatric hospitals were not usually very good places in which to be insane.

Although the Thorazine assault troops (Smith, Klein, and French's own terminology for its 1956 charge to the company's detail men--see BradenJohnson [1990]) had already successfully done their job --selling the neuroleptics -- never became a true believer in the "magic bullet" attribution commonly ascribed the neuroleptic drugs. Despite being trained by psychopharmacologic icons (e.g., Dr. Gerald Klerman), I somehow never found a Lazarus among those I treated with the major tranquilizers. Again, my experience led me to question the emerging psychopharmacologic domination of the treatment of very disturbed and disturbing persons. Actually those persons seemed to appreciate my sometimes clumsy attempts to understand them and their lives. Because I hadn't found a large role for drugs in the helping process, I was led to believe more in interpersonal than neuroleptic "cures." I did worry about what went on in the 164 hours a week when my patients were not with me -- was the rest of their world trying to understand and relate meaningfully to them?

So, as a career unfolded, the questioning of conventional wisdom remained part of me, albeit not always acted upon in a way that would bring undue attention and consequent retribution. To interests in the meaningfulness of madness, understanding families, and the conduct of research, I added one from my institutional experience; if places called hospitals were not good for disturbed and disturbing behavior, what kinds of social environments were? In 1966-1967, this interest was nourished by R.D. Laing and his colleagues in the Philadelphia Association's Kingsley Hall in London. The deconstruction of madness and the madhouse that took place there generated ideas about how a community-based, supportive, protective, normalizing environment might facilitate reintegration of psychologically disintegrated persons without artificial institutional disruptions of the process. This, combined with my existential/phenomenologic-psychotherapy and anti-neuroleptic drug biases resulted, in 1969-1971, in the design and implementation of the Soteria Research Project. Soteria is a Greek word meaning salvation or deliverance. In addition to my interests, the project included ideas from the era of "moral treatment" in American psychiatry (Bockhoven, 1963), Sullivan's (1962) interpersonal theory and his specially designed milieu for persons with schizophrenia at

Sheppard and Enoch Pratt Hospital in the 1920s, labeling theory (Scheff, 1966), intensive individual therapy based on Jungian theory (Perry, 1974) and Freudian psychoanalysis (Fromm-Reichman, 1948; Searles, 1965), the notion of growth from psychosis (Laing, 1967; Menninger, 1959), and examples of community-based treatment such as the Fairweather Lodges (Fairweather et al., 1969).

The Soteria Project (1971-1983)

This project's design was a random assignment, 2-year follow-up study comparing the Soteria method of treatment with "usual" general hospital psychiatric ward interventions for persons *newly diagnosed as having schizophrenia* and deemed in need of hospitalization. It has been extensively reported (see especially Mosher et al., 1978, 1995). In addition to less than 30 days previous hospitalization (i.e., "newly diagnosed"), the Soteria study selected 18- to 30- unmarried subjects about whom three independent raters could agree met DSM-11 criteria for schizophrenia and who were experiencing at least four of seven Bleulerian symptoms of the disorder (Table 1). The early onset (18 to 30 years) and marital status criteria were designed to identify a subgroup of persons diagnosed with schizophrenia who were at statistically high risk for long- disability. We believed that an experimental treatment should be provided to those individuals most likely to have high service needs over the long term. All subjects were public sector clients screened at the psychiatric emergency room of a suburban San Francisco Bay Area county hospital.

TABLE 1: The Soteria Project: research admission/selection criteria

1. Diagnosis: DSM II schizophrenia (3 independent clinicians)
2. Deemed in need of hospitalization
3. Four of seven Bleulerian diagnostic symptoms (2 independent clinicians)
4. Not more than one previous hospitalization for 30 d or less
5. Age: 18-30
6. Marital status: single

Basically, the Soteria method can be characterized as the 24 hour a day application of interpersonal phenomenologic interventions by a nonprofessional staff, usually without neuroleptic drug treatment, in the context of a small, homelike, quiet, supportive,

protective, and tolerant social environment. The core practice of interpersonal phenomenology focuses on the development of a nonintrusive, noncontrolling but actively empathetic relationship with the psychotic person without having *to do* anything explicitly therapeutic or controlling. In shorthand, it can be characterized as "being with," "standing by attentively," "trying to put your feet into the other person's shoes," or "being an LSD trip guide" (remember, this was the early 1970s in California). The aim is to develop, over time, a shared experience of the meaningfulness of the client's individual social context-current and historical. Note, there were no therapeutic "sessions" at Soteria. However, a great deal of "therapy" took place there as staff worked gently to build bridges, over time, between individuals' emotionally disorganized states to the life events that seemed to have precipitated their psychological disintegration. The context within the house was one of positive expectations that reorganization and reintegration would occur as a result of these seemingly minimalist interventions.

The original Soteria House opened in 1971. A replication facility ("Emanon") opened in 1974 in another suburban San Francisco Bay Area city. This was done because clinically we soon saw that the Soteria method "worked." Immediate replication would address the potential criticism that our results were a one-time product of a unique group of persons and expectation effects. The project first published systematic 1-year outcome data in 1974 and 1975 (Mosher and Menn, 1974; Mosher et al., 1975). Despite the publication of consistently positive results (Mosher and Menn, 1978; Matthews et al., 1979) for this subgroup of newly diagnosed psychotic persons from the first cohort of subjects (1971-1976), the Soteria Project ended in 1983. Because of administrative problems and lack of funding, data from the 1976-1983 cohort were not analyzed until 1992. Because of our selection criteria and the suburban location of the intake facilities, both Soteria-treated and control subjects were young (age 21), mostly white (10% minority), relatively well educated (high school graduates) men and women raised in typical lower middle class, blue-collar suburban families.

Results

Cohort 1 (1971-1976)

Briefly summarized, the significant results from the initial, Soteria House only, cohort were:

Admission Characteristics. Experimental and control subjects were remarkably similar on 10 demographic, 5 psychopathology, 7 prognostic, and 7 psychosocial preadmission (independent) variables.

Six-Week Outcome. In terms of psychopathology, subjects in both groups improved significantly and comparably, despite Soteria subjects not having received neuroleptic drugs. All control patients received adequate anti-psychotic drug treatment in hospital and were discharged on maintenance dosages. More than half stopped medications over

the 2-year follow-up period. Three percent of Soteria subjects were maintained on neuroleptics.

Milieu Assessment. Because we conceived the Soteria program as a recovery-facilitating social environment, systematic study and comparison with the CMHC were particularly important. We used Moos' Ward Atmosphere Scale (WAS) and COPES scale for this purpose (Moos, 1974, 1975). The differences between the programs were remarkable in their magnitude and stability over 10 years. COPES data from the experimental replication facility, Emanon, was remarkably similar to its older sibling, Soteria House. Thus, we concluded that the Soteria Project and CMHC environments were, in fact, very different and that the Soteria and Emanon milieus conformed closely to our predictions (Wendt et al., 1983).

Community Adjustment. Two psychopathology, three treatment, and seven psychosocial variables were analyzed. At 2 years postadmission, Soteriatreated subjects from the 1971-1976 cohort were working at significantly higher occupational levels, were significantly more often living independently or with peers, and had fewer readmissions; 571/16 had never received a single dose of neuroleptic medication during the entire 2-year study period.

Cost. In the first cohort, despite the large differences in lengths of stay during the initial admissions (about 1 month versus 5 months), the cost of the first 6 months of care for both groups was approximately \$4000. Costs were similar despite 5-month Soteria and 1-month hospital initial lengths of stay because of Soteria's low per them cost and extensive use of day care, group, individual, and medication therapy by the discharged hospital control clients. (Matthews et al., 1979; Mosher et al., 1978).

Cohort II (1976-1982; includes all Emanon-treated subjects)

Admission, 6-week, and milieu assessments replicated almost exactly the findings of the initial cohort. Nearly 25% of experimental clients in this cohort received some neuroleptic drug treatment during their initial 6 weeks of care. Again, all hospital-treated subjects received anti- drugs during their index admission episode. In this cohort, half of the experimental and 70% of control subjects received postdischarge maintenance drug treatment. However, in contrast to Cohort 1, after 2 years, no significant differences existed between the experimental and control groups in symptom levels, treatment received (including medication and rehospitalization), or global good versus poor outcomes. Consistent with the psychosocial outcomes in Cohort I, Cohort II experimental subjects, as compared with control subjects, were more independent in their living arrangements after 2 years.

Interestingly, independent of treatment group, good or poor outcome is predicted by four measures of preadmission psychosocial competence (Mosher et al., 1992): level of education (higher), precipitating events (present), living situation (independent), and

work (successful). Good outcome was narrowly defined as having no more than mild symptoms *and* either living independently or working or going to school at both 1- and 2-year follow-up (Mosher et al., 1995).

The Second Generation

Although closely involved in the California-based Soteria Project throughout the study's life, I lived in Washington, D.C., while working for the NIMH. In 1972, I became psychiatric consultant to Woodley House, a half-way house founded in Washington, D.C., in 1958. In consultation, staff were often distressed when describing house residents who went into crisis, and there was no option but to hospitalize them. Recovery from such institutionalizations they saw as taking nearly 18 months. So, in 1977, a Soteria-like facility (called "Crossing Place") was opened by Woodley House Programs that differed from its conceptual parent in that it:

- 1) admitted any nonmedically ill client deemed in need of psychiatric hospitalization regardless of diagnosis, length of illness, severity of psychopathology, or level of functional impairment;
- 2) was an integral part of the local public community mental health system, which meant that most patients who came to Crossing Place were receiving psychotropic medications; and
- 3) had an informal length of stay restriction of about 30 days to make it economically appealing.

So, beginning in 1977, a modified Soteria method was applied to a much broader patient base, the so-called "seriously and persistently mentally ill". Although a random assignment study of a Crossing Place model has only recently been published (Fenton et al., 1998), it was clear from early on that the Soteria method "worked" with this nonresearchcriteria-derived heterogeneous client group. Because of its location and "open" admissions Crossing Place clients, as compared with Soteria subjects, were older (37), more nonwhite (70%), multiadmission, long-term system users (averaging 14 years) who were raised in poor urban ghetto families. From the outset, Crossing Place was able to return 90% or more of its 2000 plus (by 1997) admissions directly to the community-completely avoiding hospitalization (Kresky-Wolff et al., 1984). In its more than 20 years of operation, there have been no suicides among clients in residence, and no serious staff injuries have occurred. Although the clients were different, as noted above, the two settings (Soteria and Crossing Place) shared staff selection processes (Hirschfeld et al., 1977; Mosher et al., 1973), philosophy, institutional and social structure characteristics, and the culture of positive expectations.

In 1986 the social environments at Soteria and Crossing Place were compared and contrasted as follows:

In their presentations to the world, Crossing Place is conventional and Soteria unconventional. Despite this major difference, the actual in-house interpersonal interactions are similar in their informality, earthiness, honesty, and lack of professional jargon. These similarities arise partially from the fact that neither program ascribes the usual patient role to the clientele. Crossing Place admits "chronic" patients, and its public funding contains broad length-of-stay standards (1 to 2 months). Soteria's research focus views length of stay as a dependent variable, allowing it to vary according to the clinical needs of the newly diagnosed patients. Hence, the initial focus of the Crossing Place staff is: What do the clients need to accomplish relatively quickly so they can resume living in the community?

This empowering focus on the client's responsibility to accomplish a goal(s) is a technique that Woodley House has used successfully for many years. At Soteria, such questions were not ordinarily raised until the acutely psychotic state had subsided-usually 4 to 6 weeks after entry. This span exceeds the average length of stay at Crossing Place. In part, the shorter average length of stay at Crossing Place is made possible by the almost routine use of neuroleptics to control the most flagrant symptoms of its clientele. At Soteria, neuroleptics were almost never used during the first 6 weeks of a patient's stay. Time constraints also dictate that Crossing Place will have a more formalized social structure than Soteria. Each day there is a morning meeting on "what are you doing to fix your life today" and there are also one or two evening community meetings.

The two Crossing Place consulting psychiatrists each spend an hour a week with the staff members reviewing each client's progress, addressing particularly difficult issues, and helping develop a consensus on initial and revised treatment plans. Soteria had a variety of ad-hoc crisis meetings, but only one regularly scheduled house meeting per week. The role of the consulting psychiatrist was more peripheral at Soteria than at Crossing Place: He was not ordinarily involved in treatment planning and no regular treatment mee

In summary, compared to Soteria, Crossing Place is more organized, has a tighter structure, and is more oriented toward practical goals. Expectations of Crossing Place staff members are positive but more limited than those of Soteria staff. At Crossing Place, psychosis is frequently not addressed directly by staff members, while at Soteria the client's experience of acute psychosis is often a central subject of interpersonal communication. At Crossing Place, the use of neuroleptics restricts psychotic episodes. The immediate social problems of Crossing Place clients (secondary to being system "veterans" and also because of having come mostly from urban lower social class minority families) must be addressed quickly: no money, no place to live, no one with whom to talk. Basic survival is often

the issue. Among the new to the system, young, lower class, suburban, mostly white Soteria clients, these problems were present but much less pressing because basic survival was usually not yet an issue.

Crossing Place staff members spend a lot of time keeping other parts of the mental health community involved in the process of addressing client needs. The clients are known to many other players in Lite system. Just contacting everyone with a role in the life of any given client can be an all-day process for a staff member. In contrast, Soteria clients, being new to the system, had no such cadre of involved mental health workers. While in residence, Crossing Place clients continue their involvement with their other programs if clinically possible. At Soteria, only the project director and house director worked with both the house and the community mental health system. At Crossing Place, all staff members negotiate with the system. Because of the shorter lengths of stay, the focus on immediate practical problem solving, and the absence of clients from the house during the daytime, Crossing Place tends to be less consistently intimate in feeling than Soteria. Although individual relationships between staff members and clients can be very intimate at Crossing Place, especially with returning clients ... it is easier to get in and out of Crossing Place without having a significant relationship (Mosher et al., 1986, pp. 262-264).

A Second Generation Sibling

In 1990, McAuliffe House, a Crossing Place replication, was established in Montgomery County, Maryland. This county's southern boundary borders Washington, D.C. Crossing Place helped train its staff; for didactic instruction there were numerous articles describing the philosophy, institutional characteristics, social structure, and staff attitudes of Crossing Place and Soteria and a treatment manual from Soteria. My own continuing influence as philosopher/clinician/godfather/supervisor is certain to have made replicability of these special social environments easier. In Montgomery County, it was possible to implement the first random assignment study of a residential alternative to hospitalization that was focused on the seriously mentally ill "frequent flyers" in a living, breathing, never before researched, "public" system of care. Because of this well funded system's early crisis-intervention focus, it hospitalized only about 10% of its more than 1500 long-term clients each year. Again, because of a well-developed crisis system, less than 10% of hospitalizations were involuntary- our voluntary research sample was representative of even the most difficult multi-problem clients. The study excluded *no one* deemed in need of acute hospitalization except those with complicating medical conditions or who were acutely intoxicated. The subjects were as representative of suburban Montgomery County's public clients as Crossing Place's were of urban Washington, D.C.; mid-thirties, poor, 25% minority, long durations of illness, and multiple previous hospitalizations. However, many of the Montgomery County

nonminority clients came from well-educated affluent families. The results (Fenton et al., 1998) were not surprising. The alternative and acute general hospital psychiatric wards were clinically equal in effectiveness, but the alternative cost about 40% less. For a system, this means a savings of roughly \$19,000 per year for each seriously and persistently mentally ill person who uses acute alternative care exclusively (instead of a hospital). Based on 1993 dollars, total costs for the hospital in this study were about \$500 per day (including ancillary costs) and the alternative about \$150 (including extramural treatment and ancillary costs).

Important Therapeutic Ingredients

Descriptively, the therapeutic ingredients of these residential alternatives, ones that clearly distinguish them from psychiatric hospitals, in the order they are likely to be experienced by a newly admitted client, are:

- 1) The setting is indistinguishable from other residences in the community, and it interacts with its community.
- 2) The facility is small, with space for no more than 10 persons to sleep (6 to 8 clients, 2 staff). It is experienced as home-like. Admission procedures are informal and individualized, based on the client's ability to participate meaningfully.
- 3) A primary task of the staff is to understand the immediate circumstances and relevant background that precipitated the crisis necessitating admission. It is anticipated this will lead to a relationship based on shared knowledge that will, in turn, enable staff to put themselves into the client's shoes. Thus, they will share the client's perception of their social context and what needs to change to enable them to return to it. The relative paucity of paperwork allows time for the interaction necessary to form a relationship.
- 4) Within this relationship the client will find staff carrying out multiple roles: companion, advocate, case worker, and therapist-although no therapeutic sessions are held in the house. Staff have the authority to make, in conjunction with the client, and be responsible for, on-the-spot decisions. Staff are mostly in their mid-20s, college graduates, selected on the basis of their interest in working in this special setting with a clientele in psychotic crisis. Most use the work as a transitional step on their way to advanced mentalhealth-related degrees. They are usually psychologically tough, tolerant, and flexible and come from lower middle class families with a "Problem" member. (Hirschfeld et al., 1977; Mosher et al., 1973, 1992) In contrast to psychiatric ward staff, they are trained and closely supervised in the adoption and validation of the clients' perceptions. Problem solving and supervision focused on relational difficulties (*e.g.*, "transference" and "counter-transference") that they are experiencing is available from fellow staff, onsite program directors, and the consulting psychiatrists (these last two will be less obvious to clients). Note that the M.D.s are not in charge of the program.

5) Staff is trained to prevent unnecessary dependency and, insofar as possible, maintain autonomous decision making on the part of clients. They also encourage clients to stay in contact with their usual treatment and social networks. Clients frequently remark on how different the experience is from that of a hospitalization. This process may result in clients reporting they feel in control and a sense of security. They also experience a continued connectedness to their usual social environments.

6) Access and departure, both initially and subsequently, is made as easy as possible. Short of official readmission, there is an open social system through which clients can continue their connection to the program in nearly any way they choose; phone-in for support, information or advice, drop-in visits (usually at dinner time), or arranged time with someone with whom they had an especially important relationship. All former clients are invited back to an organized activity one evening a week.

Characteristics of Healing Social Environments

Both clinical descriptive and systematic staff and client perception data (from Moos, 1974, 1975) are available to compare and contrast Soteria, Crossing Place, and McAuliffe House with their respective acute general hospital wards and each other (Mosher, 1992; Mosher et al., 1986, 1995; Wendt et al., 1983).

Clinical characteristics of the hospital comparison wards included in the original Soteria study have been previously described (see Wendt et al., 1983) and are applicable to the hospital psychiatric ward studied in the Montgomery County research. The clinical Soteria-Crossing Place description and "Important Therapeutic Ingredients" explicated earlier are applicable across all three alternative settings. The Moos scale data comparing Soteria with Crossing Place and McAuliffe House are consistent between the three settings and different from the findings from the comparison wards in the general hospitals.

The Moos instrument, the Community-Oriented Program Environment Scales (COPES), is a 100-item true/false measure that yields 10 psychometrically distinct variables that can be grouped into three supraordinate categories: relationship/psychotherapy, treatment, and administration. The patterns of similarities and differences between the two types of alternatives (Soteria vs. Crossing Place and McAuliffe House) have remained constant over many testings, as have the hospital differences and similarities to the two kinds of alternatives. The alternative programs share high scores on all three relationship variables (involvement, spontaneity, and support) and two of four treatment variables: personal problem orientation and staff tolerance of anger. Crossing Place and McAuliffe House, however, differ from Soteria in two of three administrative variables: the second generations are perceived as more organized and exerting more staff control (somewhat similar to the hospital scores) than the parent (Soteria). The differences are to be expected, given the differing nature of the clientele and the much shorter average length of stay (<30 days) in the Soteria offspring.

Other Alternatives to Hospitalization

In the 25 plus years since the Soteria Project's successful implementation, a variety of alternatives to psychiatric hospitalization have been developed in the U.S. Their results (including those of the Soteria Project) have been extensively reviewed by Braun et al., 1981; Mesler et al., 1982a, 1982b; Straw, 1982; Stroul, 1987. A subset were described in greater detail by Warner (1995).

Each of these reviews found consistently more positive results from descriptive and research data from a variety of alternative interventions as compared with control groups. Straw, for example, found that in 19 of 20 studies he reviewed, alternative treatments were as, or more, effective than hospital care and on the average 43% less expensive. The Soteria study was noted to be the most rigorous available in describing a comprehensive treatment approach to a subgroup of persons labeled as having schizophrenia. It was also noted that, for the most part, the effects of various models of hospitalization had not been subjected to equally serious scientific scrutiny.

Except in California, where there are a dozen, few "true" residential alternatives to acute hospitalization have been developed. Within the public sector, because of cost concerns, there is now a movement to develop "crisis houses." Their extent or success has not been completely described. However, they are not usually viewed or *used* as alternatives to acute psychiatric hospitalization-although this is subject to local variation. It is surprising that managed care, with its focus on reducing use of expensive hospitalization, has neither developed nor promoted the use of these cost-effective alternatives. It is truly notable that nearly all residential alternatives to acute psychiatric hospitalization are in the public mental health system. Private insurers and HMOs have been extremely reluctant to pay for care in such facilities (see Mosher, 1983).

The Fate of Soteria

As a clinical program Soteria closed in 1983. The replication facility, Emanon, had closed in 1980. Despite many publications (37 in all), without an active treatment facility, Soteria disappeared from the consciousness of American psychiatry. Its message was difficult for the field to acknowledge, assimilate, and use. It did not fit into the emerging scientific, descriptive, biomedical character of American psychiatry, and, in fact, called nearly every one of its tenets into question. In particular, it demedicalized, dehospitalized, deprofessionalized, and deneuroleptized what Szasz (1976) has called "psychiatry's sacred cow"-- As far as mainstream American psychiatry is concerned, it is, to this day, an experiment that appears to be the object of studied neglect. Neither of the two recent "comprehensive" literature reviews and treatment recommendations for schizophrenia references the project (Frances et al., 1996; Lehman and Steinwachs, 1998).

There are no new U.S. Soteria replications. It is possible that, if a replication were proposed as research, it might not receive I.R.B. approval for protection of human subjects as it would involve withholding a known effective treatment (neuroleptics) for a minimum of 2 weeks.

Surprisingly, Soteria has reemerged in Europe. Dr. Luc Ciompi, professor of social psychiatry in Bern, Switzerland, is primarily responsible for its renaissance. Operating since 1984, Soteria Bern has replicated the original Soteria study findings. That is, roughly two-thirds of newly diagnosed persons with schizophrenia recover with little or no drug treatment in 2 to 12 weeks (Ciompi, 1994, 1997a, 1997b; Ciompi et al., 1992). As original Soteria Project papers diffused to Europe and Ciompi began to publish his results, a number of similar projects were developed. At an October 1997 meeting held in Bern, a Soteria Association was formed, headed by Professor Weiland Machleidt of the Hannover University Medical Faculty. Soteria lives, and thrives, admittedly as variations on the original theme, in Europe.

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