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The Soteria project recounted by Mosher and its clinical resonances today

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Abstract

Background: The American psychiatrist Loren R. Mosher has passed to posterity as an eager proponent of a psychosocial approach to psychosis. The best example of this is the Soteria project that he founded in San Jose, California, in the 1970s. The contribution of Alma Zito Menn, ACSW, also merits attention as project director of Soteria and for her links to the Mental Research Institute, Palo Alto. She was later replaced as program director by Voyce Hendrix, LCSW, when she turned to other preoccupations linked to the grant continuation of Soteria. Equally, the nonprofessional staff of the facility should receive appreciation.

Aim/objective: Bearing this in mind, the main aim of this paper is to reflect upon the Soteria project, giving voice to Mosher himself, while simultaneously connecting his ideas with other empirical works that have been published on this topic in recent decades.

Methods: Using a selection from the extant literature assessing the implementation and outcomes of adapting Soteria-elements to different settings, I present here provisional results obtained from current research. First, I expound what Mosher hoped to achieve in creating Soteria and why it worked. In this respect, I go beyond what is commonly reported in scholarly works, where the Soteria project is considered without paying too great attention to its main architect, as if the project could be separated from the man who created it.

Results and conclusions: As I have corroborated here, there is today growing and promising scientific evidence validating the principles of the Soteria project. Undoubtedly, this would not have been possible without the pioneering work of Mosher, who, imbued with the tenets of interpersonal phenomenology, shook the psychiatric establishment, leading others to follow the path that he had begun.

Keywords

Ciompi, Mosher, healing context, medication, psychosis, Soteria project

Introduction

Twenty-years ago, psychiatrist Loren R. Mosher (1933–2004), a serious advocate of psychosocial approaches to psychosis, died. His many years of hard work devoted to *being with* instead of *doing to*[1] (Hendrix, 2012) individuals diagnosed with psychosis did not fall into oblivion, however, even though his vocal criticisms of mainstream psychiatry meant he was often ignored[2] (Lehmann, 2010). The clearest evidence of this renewed interest in his work are the papers published in recent decades on different aspects of his main life's work, the Soteria project.[3] In this regard, it is also important to say that the same year he passed away, saw the publication of his book, co-written with two other authors, *Soteria. Through madness to deliverance* (Mosher et al., 2004). In my view, with this final contribution to psychiatric literature, he offered us his last gift.

Some psychiatrists might today regard Mosher's lifework as a failed attempt to transform the landscape of psychiatry, referring to it exclusively in ridiculous and pejorative terms as a historical, testimonial, almost marginal, experiment in psychiatry.[4] However, given that we still have many unanswered questions about the functioning of the brain and the causes of altered states of mind, particularly with respect to psychosis, the most prudent approach is to await more evidence that accounts for the complex mind-brain interrelations. In this respect, the only statement that we make is that the drugs reduce the psychotic symptoms, but at the cost of also provoking a set of adverse effects as a result of medication. These effects include terrifying, incontrollable neck and face muscle spasms (dystonia); involuntary finger movements (tremor)

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and facial and other muscular stiffness like that found in Parkinson's disease; motor restlessness syndrome (akathisia) and immobility (akinesia). There is also evidence that persons treated continuously with these drugs develop uncontrollable twitching of the tongue, facial, and neck muscles (tardive dyskinesia – late occurring abnormal muscle movements; Breggin & Cohen, 2000).

Under these premises, guided by an attitude of deep modesty, in the preface of this collective work, the volume's authors (Mosher et al., 2004, p. xviii) say that this social experiment in psychiatry, sustained by tenets of interpersonal phenomenology, may be helpful to those who wish to learn from Soteria or imitate it.[5] In affirming this, the authors are aware of individual successes and failures. Thus, they draw upon the community's memory to convey a sense of what happened in a special place and to describe some of the approaches used to deal with the kinds of problems encountered there.[6,7] In this respect, in the pursuit of minimizing potentially undesirable behavior in the internal functioning of this unlocked facility, the Soteria staff attempted to find a way to impose order without establishing a rigid structure. Thus, even though early in its history the Soteria community embraced three rules – no violence, no uninvited guests, and no illegal drugs, namely, the universal explicit indefinite rules – the staff defined only two rules, the clear violation of which could lead to discharge for any member of the community. The first of these was the prohibition of illegal drugs, which coincided with administrative strictures; the second forbade sex between staff and residents (Mosher et al., 2004, p. 227). This latter was taken seriously as necessary to allow both groups to achieve maximum interpersonal closeness without inappropriate intimacy. If any of these rules was broken, a group discussion would invariably follow. Possible disciplinary measures included the expulsion of the offender, though neither Hendrix[8] nor Mosher could remember this possibility ever being exercised (Mosher et al., 2004, p. 228). Additionally, after the Soteria program had been running for 3 years, the community members also decided to adopt a third universal rule in response to the need for more control over some potentially violent residents. This call for a formal mandate went beyond the rule adopted against threats of violence and assaults when Soteria opened. Mosher explained the reasons that led to this important decision, in the following text:

> *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 to 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 a violent act against him, most of the others saw it as preventive measure* (Mosher et al., 2004, p. 228).

Extending my analysis of the system of rules operating at Soteria, I will focus on those rules of limited duration (explicit definitive rules). If I do this it is because such rules usually had greater impact on the program than the universal explicit indefinite rules mentioned above. In this sense, violation of fixed rules could lead to penalties ranging from reprimand to discharge. In similar vein, failure to participate in housework or gardening could provoke a warning; malicious lying could lead to expulsion. The reasons for acting in that way, are explained in these terms:

> *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 to provide tolerable limits within which the residents could choose their own directions towards therapeutic ends* (Mosher et al., 2004, p. 229).

The important lesson to be learnt from this, in my view, is that staff at Soteria behaved towards patients within a therapeutic milieu characterized by a deep respect for their freedom and capacity for making their own decisions, and not using coercive measures, but instead allowing people the opportunity to change in a safe, supportive environment. As a result, the rules were successful in direct proportion to the degree that they allowed freedom of interaction. In this respect, *unnecessary rules could have been detrimental and are usually unenforceable in any case* (Mosher et al., 2004, p. 229). A possible way of making a mental picture of how everything that happened at Soteria, in my view, is giving voice Mosher himself, who affirmed:

> *Soteria's environment adapted itself flexibly and spontaneously to the expressed needs of its inhabitants. There was no procedure manual. When contingencies occurred, the community coped. Activities often took unpredictable turns* (Mosher et al., 2004, p. 235).

From a different perspective, it is also important to note that, although the Soteria project was a community-based, experimental residential treatment facility, it stood out from other community-based mental health residential facilities in several ways. The strong reasons that account for this assertion were:

> *Although it was not a hospital and its program was not run by doctors (or nurses for delegation), it admitted only clients who would have otherwise been hospitalized. Neuroleptic drugs, the standard treatment for "schizophrenia," were used as infrequently as possible and preferably not at all. The nonprofessional staff had primary treatment responsibility, power, and authority. Most importantly, unlike the thousands of group homes established nationwide since the mid-1970s to serve as post-hospitalization halfway houses for previously institutionalized patients, Soteria (. . .) offered an alternative to hospitalization rather than a follow-up to it* (Mosher et al., 2004, p. 2).

As a corollary, it can be inferred that the project's purpose was stimulated by the idea of finding out whether Soteria's approach and milieu were as effective in promoting recovery from madness as that provided in a nearby general hospital's psychiatric ward, where the preferred treatment was antipsychotic drugs (Mosher et al., 2004, p. 4). This, in my view, involved a shift in the conception of the psychotic experience, usually viewed as irrational and mystifying, to one which, if treated in an open, non-judgemental way, could be valid and comprehensible. Thus, more than enumerating the symptoms of psychosis and prescribing drugs, Soteria attempted to make sense of the psychotic experience according to the principles of interpersonal phenomenology, and so help the psychotic sufferer to alleviate his or her anxiety and reconnect with other human beings. Bearing this in mind, the challenge ahead was enormous, and the self-imposed onus on Mosher and co-workers to remedy their patients' situation was difficult to implement, since their precepts went contrary, then as now, to mainstream psychiatry. Logically, I refer here to the very extended and accepted idea for many that psychosis is exclusively a brain disorder and the only effective treatment is through medication.

After setting out these ideas, the main objective of my paper is to give voice to Mosher, taking his collaborative volume published in 2004 as the pivotal axis of my paper. In doing this, I will present the content of his last book, published in the year of his death, as a form of establishing a *dialogue in absentia* with Mosher. Through this sort of imaginary conversation with him, I will first reflect on his ideas and work in creating and developing the Soteria project, beginning by asking the questions that Mosher hoped to be able to respond to with the Soteria project. In the following sections, I will analyze the clinical implications of his project in the literature today, paying meticulous attention to those works that analyze the pro and cons of the work carried out by Mosher and his collaborators decades back. I will end my paper by sharing with the readers my own reflections on Mosher's work in benefit of those who were misunderstood, marginalized, medicalized and frequently ignored by many in society.

What Mosher hoped to respond

When Mosher ideated his project of creating a community-based, experimental residential treatment facility – the Soteria project – in the early 1970s, he deeply interrogated conventional treatment in the pursuit of answers to the following questions: 'Could persons newly labeled "schizophrenic" and deemed so dysfunctional as to require hospitalization be successfully treated in a small, home-like, nonhospital setting without antipsychotic drugs? How would their clinical outcomes compare at 6 weeks, 6 months, and 1 and 2 years, to those of a group of similarly selected and studied persons who received the usual inpatient and outpatient follow-up care?' Using a quasi-experimental research design, Mosher evidenced that both questions would be answered in the affirmative.

Before continuing our discussion, it should be noted that the outcomes in the second question referred to whether factors such as hospitalization, medication, and psychotic symptoms continued and whether levels of psychosocial functioning improved or deteriorated (Mosher et al., 2004, p. 5). With these factors in mind, Mosher, as the project's designer and chief theoretician, based the Soteria treatment model for early psychosis on a psychosocial approach.[9,10] He thus planned that staff would learn to view the 'schizophrenic' reaction as someone's altered state of consciousness in response to a crisis (Mosher et al., 2004, p. 11). So, in his 12-year study (1971–1983) working collaboratively with others in envisioning alternatives to mental hospitalization, Mosher compared residential treatment in the community and minimal use of drugs with 'usual' hospital treatment for patients with early episode schizophrenia spectrum psychosis (Bola & Mosher, 2003). In doing so, his main purpose was to assess whether a specially designed intensive psychosocial treatment, a relationship-focused therapeutic milieu incorporating minimal use of antipsychotic medications for 6 weeks, would be able to produce equivalent or better outcomes in treating newly diagnosed individuals with schizophrenia compared with general hospital psychiatric ward treatment with antipsychotic medication. Summarizing the many reasons that led Mosher to look at the 6-week outcome data were the following hypotheses:

> *(. . .) that the experimental subjects, most of whom did not receive neuroleptic drugs between admission and the six-week assessment point, would have higher levels of psychopathology as compared with the hospital and neuroleptic treated control subjects. The six-week comparison provides the opportunity to compare the influence of a purely psychosocial treatment strategy with that of a psychotropic drug oriented short-term hospital based intervention. (. . .) If a psychosocial intervention could be shown to be effective relatively rapidly (6 weeks in this instance) then a case could be made for expanded use of special psychosocially oriented treatment milieus, with minimal or no use of neuroleptics, for at least a subset of persons labelled as having schizophrenia. Provision for a true non-neuroleptic treatment option for acute psychosis would avoid or minimize the problems encountered with the use of psychotropic drugs* (Mosher et al., 1995, p. 158).

In practical terms, this implied that successive potential admissions with early onset schizophrenia were admitted by random allocation either to Soteria or to the local psychiatric hospital (Moncrieff, 2006). Soteria also intended to reduce the proportion of patients maintained on antipsychotic medications (thereby reducing exposure to drug-induced toxicities) and to reduce the rate at which early-episode clients became chronic users of mental

health services. As a result, in an early evaluation of the first 6 weeks of care based on 100 patients, only 12% of the Soteria group had had continuous drug treatment compared with 98% of the controls. Thus, based on these data, and the well-known short- and long-term toxicities of neuroleptic drugs, it was highly recommended that mental health systems include in their array of services a Soteria-type facility for newly diagnosed psychotic patients (Mosher et al., 1995, p. 172). In similar vein, at the 2 year follow up, 42% of Soteria patients had been drug free throughout compared with 3% of hospital-treated patients. In sum, only 19% of Soteria patients had received continuous drug treatment (Bola & Mosher, 2003).

These results, however, as Moncrieff (2006) well observes, did not prevent other problems, alerting us to its clinical implications for future research in these terms:

> *Numerous outcome measures were used and very complex analysis was employed, so it is not easy to make direct comparisons between the groups. Also some reports exclude people who dropped out the Soteria project before 28 days, who would remove some of the people who would be considered to be failures for the Soteria group. However, despite these drawbacks the project suggests that a substantial proportion of patients with early onset schizophrenia can be cared for without the use of antipsychotic drugs and achieve a comparable outcome to those who are prescribed these drugs* (Moncrieff, 2006, p. 130).

In emphasizing the positive aspects of the Soteria Project over the negative, Mosher (1997, p. 2) summarized the achievements of their treatment repertories as follows: 1. It dehospitalized madness, through taking care of patients/residents in a homelike setting in the community; 2. It demedicalized madness, through its focus on interpersonal help; 3. It deprofessionalized madness, because it required of its workers no mental health training or experience; and, finally, 4. It dedrugged madness, by declining to treat most residents with antipsychotic medication. In spite of this, a major defect in the Soteria project, was the lack of a measure of client satisfaction (Mosher et al., 2004, p. 269).

Why Soteria worked

After ending the preceding section with the achievements that resulted from the implementation of Soteria project, it now seems an appropriate time to explain the reasons that led to its success. In this respect, Soteria worked effectively as a result of a combination of factors: the settings' and milieu characteristics, relationships formed, personal qualities and attitudes of the staff, and the social processes that went in the facilities (Mosher & Bola, 2004, p. 12; Mosher et al., 2004, p. 267). Possibly the most important of those components was the exquisite and warm quality of relationships established between participants – staff, clients, volunteers, and students – anyone that spent a significant amount of time in the facility. In that emotional atmosphere, whoever chose to work there, acted under the premise of establishing and maintaining over time a genuine involvement, a bond of significant others, in the sense of *being with* and not *doing to* those diagnosed of schizophrenia. In this sense, it is safe to say, that the staff's ability to relate to the patients and each other was vital to the program's success (Mosher & Bola, 2004, p. 13). It follows that if carefully choosing who should work with patients was an important requisite, it implied that Soteria was also set up in a different way to general psychiatric wards. Among the characteristics setting it apart from hospitals were: 1. the avoidance of codified rules, regulations, and policies; 2. keeping basic administrative time to a minimum to allow a great deal of undifferentiated time; 3. limiting intrusion by outsiders; 4. working out social order on an emergent face-to-face basis; and, finally, 5. following a nonmedical model that did not require symptom suppression.[11] Another key element that ensured Soteria's success was that its staff unconsciously embraced the principles that Jerome D. Frank (1909–2005) found to be essential for positive psychotherapeutic outcomes (Frank, 1961). Inspired by such tenets and their experience at Soteria, Mosher and associates identify the following factors as conducive to therapeutic change (Mosher et al., 2004, p. 269): 1. presence of what is perceived as a *healing context*; 2. development of a confiding relationship with a helper; 3. evolution of a *plausible causal* explanation for the reason the problem at hand developed; 4. generation of positive *expectations* by the therapist's personal qualities; and, lastly, 5. provision of opportunities for success through therapeutic processes. In my view, these ingredients became key elements for pursuing therapeutic change because they helped in creating a communal identification. In this sense, when patients saw themselves as part of the group, of a larger Soteria network, they were motivated to change. The group then became their major source of support, so available social space – physical and spiritual – was critical (Mosher et al., 2004, p. 73). From other perspective, in my view, these factors are connected to Ciompi's ideas on the dynamic effects of emotions in schizophrenia. Ciompi (2015) observes that, according to his analysis and clinical experience, the nature and role of emotions in schizophrenia are multifaceted and partly contradictory. A conceivable explanation of this enigmatic fact may be related to an insufficient consideration for certain key properties of emotions, especially their energizing effects. Thus, Ciompi points to an alternative view based on his concept of affect-logic, a view which favors further evidence-based research and conceptualization. Moreover, it also would open a new understanding of crucial developmental aspects of the psychosis, especially its outbreak in vulnerable persons under the influence of increasing emotional tensions, leading thus to innovative therapeutic strategies which seem quite effective (Ciompi, 2015, p. 320).

In line with these ideas, placing Ciompi's ideas on affect-logic at the centre of therapeutic work alongside the potential of the Soteria approach to adapt and to restore self-disturbances, Nischk and Rusch (2019) suggest that it is precisely this property of the Soteria paradigm in adjusting the self-disturbances and even in offering opportunities for their relief, that induces sustained relaxation in patients. This, according to the researchers, provides empirical support to the central claim of affect-logic that the provision of sustained emotional relaxation by the therapeutic milieu is the central mechanism by which remission of symptoms is achieved (Ciompi, 2015). Emotions thus are seen as a control parameter with the ability to filter and even suddenly switch prevailing patterns of thinking and acting (Nischk & Rusch, 2019). For these reasons, the reduction of affective tension through Soteria is assumed to have an antipsychotic effect similar to that of neuroleptic medication. However, even the massive body of research that illustrates the many ways in which Soteria model may promote a reduction in affective tension, there still remain questions that have not been adequately answered. One such question, for example, is how and why specific elements of the Soteria model reduce affective tension in psychotic individuals. In their defense, Nischk and Rusch (2019) argue that, because affect-logic represents a general theory, with Soteria being just one of its applications, it does not address any properties of the schizophrenia syndrome. More controversial still, these same researchers affirm, is the assumption that the created therapeutic milieu in itself could be seen a sufficient agent for treating acute psychosis. For all that, it could be argued that this array of testable hypotheses still needs more solid theoretical arguments based on serious and robust research. In doing so, I am sure that we will able to provide Soteria with a stronger theoretical and empirical base to promote its further dissemination. In similar vein, it would inspire sensible modifications to conventional treatment settings, and open new territories and opportunities not only for patients and their families, but also for all professionals involved in and committed to the difficult field of psychosis.

Scientific reviews today

As has been seen in the previous section, the Soteria project demonstrated that there were alternative ways of dealing with madness, thus giving scientific credibility to a social experiment that many considered ineffective (and in fact distanced itself from any consistent ideological framework) when compared with conventional, medication-based approaches (Ciompi et al., 1992, 1993; Calton & Spandler, 2009; Lichtenberg, 2017). Recent decades have witnessed a growing interest in investigating the clinical implications of Soteria House. In one such systematic review, a group of four British researchers assessed the efficacy of the Soteria paradigm for the treatment of adults and adolescents diagnosed with first- or second-episode schizophrenia spectrum disorders (Calton et al., 2008). Using a systematic search strategy to identify controlled studies (randomized, pseudorandomized, and nonrandomized) and employing the criteria for schizophrenia spectrum disorders according to ICD-10 and DSM-IV-TR, the authors identified three controlled trials involving a total of 223 participants diagnosed with first- or second episode schizophrenia spectrum disorders. The studies reviewed suggested that the Soteria paradigm yielded equal and in certain specific areas of functional recovery (e.g. independent living and occupational functioning) clearly better results in the treatment of people diagnosed with first- or second-episode schizophrenia spectrum disorders when compared to controls treated with conventional, mainly medication-based approaches, although the lack of both quantity and quality of the evidence base makes further research necessary. In this respect, the authors suggest employing rigorous trial methodologies, in-depth qualitative research utilizing user-centered outcomes, and long-term follow-up to evaluate the paradigm's longitudinal effects. In similar vein, it would also be interesting to give due consideration to appropriate subgroups analyses in order to attempt and identify those people (e.g. those diagnosed with true schizophreniform disorder), who might garner particular benefit from the paradigm (Calton et al., 2008).

In contrast with this, given Soteria's focus on the individual's subjective experience of psychosis, the patient perspective has been also considered in terms of whether and how Soteria contributes to a more subjective form of recovery. Examination of what facilitates or hinders the patient's process of PR (personal recovery) could provide insight into potential active ingredients for PR-oriented interventions. Guided by this idea, Leendertse et al. (2023) used a qualitative method, consisting of semi-structured in-depth interviews with people who had been admitted to the only operating Soteria house in the Netherlands (Soteria NL). Their inductive approach enabled them to explore how participants conceptualize their experiences and the role of Soteria in PR in their own words, which forms an addition to the findings of the more deductive research performed thus far (Leendertse et al., 2023). Notably, after interviewing 10 respondents, and corroborating that the coding process indicated that assessing more data did not yield any substantial new insights, they identified togetherness (in contact with staff, and with peers), feeling at home and being active as facilitating factors. Furthermore, these three facilitating factors have in common that they defy (self-) stigma, which is known to inhibit PR in young (hospitalized) people with psychosis (Leendertse et al., 2023). By contrast, the main hindering factors were perceived lack of spirituality and medication. The fact that spirituality might be conceptualized

differently among patients and professionals makes the collaborative exploration of meaning or spiritual dimensions necessary in (early episode) psychosis. Analogously, medication was described by the majority of respondents as 'prominently present in treatment' might have had to do with the fact that Soteria NL was organized within a mental healthcare institute. Finally, since PR is – in part – distinct from symptomatic recovery in some ways, the interplay between affect, PR, and symptomatic remission from psychosis within the context of Soteria is an interesting subject for future research. In this respect, ongoing research is looking into the longitudinal effects of Soteria on PR compared to care as usual (Leendertse et al., 2023).

Another aspect which has been examined is the influence of the implementation of Soteria elements on coercive measures in an acute psychiatric ward after reconstruction in 2017, thereby comparing the year 2016 (before the reconstruction) to the year 2019 (after the reconstruction), in the Hennigsdorf Hospital, a facility which is part of the Oberhavel Hospitals in Germany (Wolf et al., 2021). The data collected from all legally accommodated patients (and thus more severely affected patients) in the 4-year interval of time were statistically analyzed in a pre-post mirror quasi-experimental design. The results clearly indicated that the establishment of Soteria elements compared to traditional treatment led to a less violent environment of care for acutely ill patients, and debriefing of coercive measures such as mechanical restrains or compulsory medication (Wolf et al., 2021). In spite of these positive results, because the vast majority of all patients diagnosed with schizophrenia were treated in the Hennigsdorf Hospital in 2016 and 2019 on a voluntary basis, Fabel et al. (2023) decided to evaluate the implementation of Soteria-elements in the hospital's only acute ward as well as assess the efficiency of the treatment with Soteria-elements of patients suffering from schizophrenia. In this respect, results suggested that inpatient treatment with Soteria-elements was not only feasible but also beneficial in terms of a less restricted and harmful treatment experience in an acute psychiatric ward, facilitating shorter treatment duration in a locked ward and lower medication dosage (Fabel et al., 2023).

Outside Europe, the establishment, implementation and sustained functioning of Soteria homes has been also investigated in Israel (Friedlander et al., 2022), where Soteria homes have been operating since 2016. The study involved 486 residents staying in one of three Soteria homes during the implementation period (September 2016 to the end of 2020): a men's home in Jerusalem operating since September 2016, a women's home in Jerusalem established in October 2017, and a mixed-gender home north of Tel Aviv, 'Soteria Sharon', set up in September 2019. Among the challenges faced in the course of implementing the model, the authors first note the management of acute psychiatric states involving violent behaviors and suicidality, observing that one resident committed suicide during the implementation period. Likewise, the most challenging events predominantly happened in patients undergoing a severe manic episode, either with or without psychotic features. As a result of these undesirable circumstances, in the most extreme situations, the resident had to be transferred to an inpatient ward in a psychiatric hospital, sometimes involuntarily.

In order to pre-empt and improve the management of acute states and thus create a better ethos of care the facility introduced preventive measures which included closer supervision of suicidal residents as well as adjustment of the entrance criteria to Soteria. Other internal changes made in the organization of this setting were associated with medication. So, whereas during the first year of implementation the Soteria home allowed residents to choose whether to take medications, policy was modified and patients exhibiting violent tendencies towards themselves or others could be required a medication regimen during their stay. Moreover, those residents who were coping with psychosis with violence, could choose, following an open discussion, whether to take medication or not, as in the original Soteria (Friedlander et al., 2022).

In sum, the implementation of the Soteria model, as has been briefly shown here in the literature examined, can be seen as a viable alternative to institutionalization. It is also true that to corroborate this assertion further it is necessary to characterize more precisely the people who can be spared institutional care and remain in a Soteria or Soteria-type facilities in the community. Likewise, further research and critical assessment are needed to add to the growing body of evidence. Then, maybe, those skeptical psychiatric professionals of might begin to question seriously the principles and premises on which their clinical practice rests, without rejecting drug therapy, but only accompanying this with a complementary vision of human nature based on an empathic, humane and interpersonal relationship with those afflicted by psychosis.

In disseminating and gradually establishing a broader perspective on mental illness, and in particular the treatment of psychosis offered by the Soteria model, it would be opportune, in my view, to begin with medical students and junior doctors. This is because their medical training is based on the idea that all illness, physical, and mental, has a bodily cause. In this model, mental illness is largely determined by genetic predisposition and chemical imbalances, that is, somatic malfunctioning. Without rejecting the underlying bodily processes implicit in all illnesses, I believe it would be beneficial for medical students and junior doctors to be instructed also in psychosocial approaches to psychosis, starting with the pioneering work of Mosher, and thereafter more recent publications. Their awareness of the range of interventions available to current psychiatry would be enriched beyond brain research and the prescription of drugs as the only two viable alternatives.

Having suggested ideas which I hope invite serious reflection among the medical community and especially

those intending to practice psychiatry, I will end my paper with my own reflections on Mosher's work and his legacy for future generations.

Concluding remarks

Looking back, now 53 years after the idea for Soteria began to take shape, we can recognize that its fundamental nature was its demedicalization of madness. To this effect, Mosher planned a way of deconstructing madness, namely alleviating and reversing through treatment the torment many suffered, especially in the long term. Accordingly, the Soteria project was conceived as a residential alternative to conventional psychiatric hospitalization. Nevertheless, as is well known, the original Soteria House closed in 1983, when its federal grants ended and no local support could be found. With regret from the forced closure, Mosher and Bola (2004, p. 15) confessed that:

> *Despite numerous publications, 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. In fact, it called nearly every one of biopsychiatry's tenets into question: it demedicalized, dehospitalized, deproffesionalized, and deneurolepticized "schizophrenia", and produced better client outcomes! As far as mainstream American psychiatry is concerned, it is, to this day, an experiment as if never conducted, or at a minimum, the object of studied neglect.*

With this in mind, an important consequence of seeing psychotic sufferers (another way to call clients/patients diagnosed with psychosis) and their treatment from this perspective was that of disavowing explicitly that 'schizophrenia' was a medical disease. Contrary to this, Soteria and all who lived in this facility, worked collaboratively guided by a patient-centered philosophy that relied upon the idea that, if a 'psychosis' developed, it evolved in and affected the psychosocial matrix of the entire family or other intimate group forming the disturbed person's ecology. This implied that all those people working at Soteria acted within an interpersonal phenomenological approach to 'schizophrenia', according to which they enthusiastically attempted to understand and share the psychotic person's experience – without judging, labeling, derogating, or invalidating – as well as their own reactions to it (Mosher et al., 2004, p. 18). In similar fashion, the role of the staff, therefore, is to train rather than to do therapy, to cure (Mosher et al., 2004, p. 32). Put another way, the nature of Soteria involvement was to interact with patients in as normal ways as possible given the difficult conditions. As a result, change in community-based models comes from teaching. In other words, the staff instruct the patients in life skills. Under these important premises, at Soteria Mosher et al. (2004) developed a psychosocial approach to psychosis, postulating that if this social experiment proved to be effective it could dehospitalize (or deinstitutionalize) the treatment of schizophrenia, resulting in a shift away from the use of hospitals to the use of alternative methods of residential care. Such a change would constitute a serious crisis for the mental hospital industry (Mosher et al., 2004, p. 276). Thus, as Ciompi (2017, p. 13) well notes, and I fully concur with him, the Soteria approach is much more than just a marginal psychiatric curiosity or a nostalgic relic of the last century.[12,13] It is thus today more than ever before in the present history of psychiatry an approach with considerable therapeutic and theoretical potential. In this respect, Soteria worked with the controversial idea that there were no preconceived notions about the causes of madness separating what individual members of the community saw as 'what is' from what program defined as 'what is'. In sum, everyone was entitled to his or her view of 'reality' (Mosher et al., 2004, p. 25). Finally, if the ideas espoused here have some resonance in the minds and hearts of the mental health professionals who read this paper and feel deeply unsatisfied, I would suggest that they revisit Mosher, who always seemed to be deeply pondering how to create and establish more complementary and symmetrical relationships with those who were marginalized, dehumanized, isolated and considered as alien to the rest of society. Thus, although the original Soteria original project ended, its data and its humane way of understanding the psychotic condition, like its message, will always survive, and will be a source of inspiration to those permanently seeking to help others in serious need.

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Notes

1. The basic tenet of *being with* consists of an attentive but non-intrusive, gradual way of getting oneself 'into the other person's shoes' so that a *shared meaningfulness* of the subjective aspects of the psychotic experience can be established within a confiding relationship. As Mosher and Bola (2013, p. 365) explain, this requires unconditional acceptance of the experience of others as valid and understandable within the historical context of their life – even when it cannot be consensually validated.
2. As Friedlander et al. (2022, p. 100) attest, the strongest evidence that the original Soteria project and Mosher's work are still very present today lies in the spread of the Soteria model around the world, with various Soteria homes established, albeit not always persevered, in the US, Switzerland, the Netherlands, Sweden, Germany, Japan (Ciompi, 2017), the UK, France (Turnpenny et al., 2018), and Hungary (Weber & Bugarszki, 2007).
3. Technically, it was labeled Project 37, its grant name. The task of naming the project proved particularly difficult, the first option 'Together house' lasting just 3 weeks. Mosher suggested that naming be postponed until someone came up with a name with larger connotations. Eventually, Alma Zito Menn, the project administrator, discovered *Soteria* in a dictionary of proper names (Mosher et al., 2004, pp. 107–108).
4. All those psychiatrists who concur with this statement should remind themselves of the changing psychiatric context in which the original Soteria project was conceived. As Hendrix (2012, p. 78) notes, Soteria existed at a time when the USA was transitioning from the large state hospital system to what would be known as a 'system of care' model. The *Mental Health Systems Act* was passed by the federal government and would be structured to provide care in the local communities. In this respect, California had just begun closing state hospitals and transferring the responsibility for the care of the mentally ill to the counties.
5. This would explain, in my opinion, the inherent Soteria philosophy according to which 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 thus mostly the result of the staff's inability, because of fear, 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. In addition, staff and residents normalized the experience of psychosis by avoiding jargon when discussing it: clients were *freaked out* rather than psychotic, *bummed out* rather than depressed, *spacey* rather than autistic (Mosher et al., 2004, p. 201).
6. In my view, it is very interesting in relation to this to note the level of subtle detail in which the typical days at Soteria are recounted and recreated (Mosher et al., 2004). If I say this it is because I have not found in the literature consulted any work that retrospectively analyses the emotional atmosphere created in those days and its clinical implications. And in my opinion, this omission is important because the social network and norms of functioning between staff and residents that was implemented at Soteria served to facilitate and promote change in the behavior and emotional bonds of all who lived there and worked jointly towards alleviating the mental condition of psychotic sufferers.
7. In this respect, in contrast to Laing's Kingsley Hall, that was formally rule-free, the Soteria community agreed to certain rules considered necessary. They were either *explicitly* set by the community, the staff members, or the administration, or *implicitly* transmitted through nonverbal behavior, which everyone understood despite the absence of formal agreements. Among the explicit rules, Soteria enforced two kinds, those enforced at all times – *universal* – and those affecting specific individuals at particular times – *limited*. The former lasted *indefinitely*; the latter for a specified (or *definitive*) period of time. As example of universal rule was the use of illegal drugs (itself a felony). Obviously, it was also expected that members of Soteria community refrain from other acts forbidden by civil authorities such as murder, rape, robbery, etc. (Mosher et al., 2004, p. 227).
8. From Voyce Hendrix, LCSW, who became program director at Soteria in the summer of 1974, whom I have already referenced in the first lines of this introductory section (Hendrix, 2012), I will speak about him again in more detail in footnote no. 10 of my paper.
9. The Soteria staff played a key role in carrying out this difficult enterprise, and the enthusiastic support from various administrators was determinant. Notable among these was Alma Zito Menn (originally as project director, then as principal investigator), whom I have already mentioned in footnote no. 3. Alma had previously worked as a social worker and therapist on the Rappaport-Silverman ward at Agnes State Hospital. This large hospital was located near San Jose, in Santa Clara County, California (Mosher et al., 2004, p. 105). In my view, she could be described as the *alma mater* of Soteria, in the literal sense of the phrase ('generous mother'). She originally acted as a liaison between the house and its program and the community at large, thus freeing staff members to devote all their energy to working within the house. In similar vein, Alma also served as a confidant and advisor to staff and residents, not as a timekeeper or disciplinarian. Accordingly, people at house were able to talk out their frustrations, uncertainties, and fears with Alma, someone who knew the situation intimately yet was able to provide a different perspective on it (Mosher et al., 2004, p. 58).
10. In this context, another key figure at Soteria was Voyce Hendrix (see footnote no. 8), who replaced Alma as program director in the summer of 1974 when she turned to other preoccupations (Mosher et al., 2004, p. 114). The vacuum created by Alma's departure came about when she began to spend most of her time at the Mental Health Institute, rewriting the grant continuation. Alma's reallocation of time became necessary because the grant had to be renewed if Soteria was to continue to operate (Mosher et al., 2004, p. 109). Thus, when Alma left a void, the person designated to fill the position was Voyce Hendrix. This latter thus became a major source of administrative continuity and strength. There when the project opened, there when it closed, Voyce was both staff and liaison, colleague and leader. His charismatic and attractive personality was reflected when staff and residents alike turned to him for comfort and help in good times and bad (Mosher et al., 2004, p. 59).
11. Another relevant differential ingredient that distinguished the Soteria network from most other treatment settings, especially from many current community-based programs, was Soteria's maintenance of connection with its former

members. 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 on the part of both staff and residents, as well as the long hours and the blurred roles, led to feelings almost like those among family members (Mosher et al., 2004, p. 199).

12. Specifically, Luc Ciompi and I discussed this important question and others associated with Mosher and the Soteria project in a fruitful meeting via Skype in June 2023 that lasted nearly 2 hours. He commented on the importance and relevance of scientifically validating the Soteria approach through means like the Soteria Fidelity Scale (L. Ciompi, personal communication, June 24, 2023). We both fully agreed that the Soteria approach should rank alongside other methods that likewise investigate the therapeutic ingredients for improving the quality of life of persons with psychosis.
13. Among the dimensions evaluated in the Soteria Fidelity Scale are 'spatial setting', 'care team', 'treatment setting', and 'Soteria everyday life' (Fabel et al., 2023). The beneficial effects of wards with Soteria-elements for persons with psychosis is starting to generate growing research that only in the coming decades will be evaluated through of longitudinal studies and meta-analysis.

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