The Soteria Project: Twenty Five Years of Swimming Upriver

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ABSTRACT

The article, starting from the experience of the Soteria Project, describe the psychosocial approach to therapy and rehabilitation of schizophrenic patient in comparison with the pharmacological treatment carried our by using neuroleptic drugs.

INTRODUCTION

Four years after it opened in 1971 the Soteria Project first published outcome data indicating that 1st and 2nd episode persons labeled as having schizophrenia could be successfully treated in a special milieu without the use of the neuroleptic drugs(Mosher et al 1975). In the intervening 25 years the project has continued to publish papers (40 in all) confirming and extending the initial results (see especially Mosher and Menn,1978; Matthews, et al 1979; and Mosher, et al 1995). These findings continue to challenge many firmly held beliefs about how best to intervene with persons labeled as having "schizophrenia". This methodologically rigorous study is providing, once again, an opportunity to question today's neuroleptic dominated treatment with new analyses of two year outcomes, which will be briefly presented here (Bola and Mosher, 1999, 2000). Needless to say this study's results have been not welcomed with open arms in the American mental health community. The study's results challenge the basic tenets of the mental health community with regard to "schizophrenia": the need for hospitalization, the necessity of mental health professionals as the primary caregivers and, most importantly, the universal use of the anti-psychotic drugs.), it is not at all surprising that the study has been treated as if it were never conducted. In fact, the neglect of this study and its findings in the literature and in the treatment of psychotic persons is itself striking. Hence the title: 25 years of swimming upriver against the prevailing biological zeitgeist, into the current of the ways in which dominant paradigms prevent contrary opinions from being heard or given credence (Kuhn, 1970). Because this was the latest (to our knowledge) American study that compared a "pure" psychosocial treatment for schizophrenia with standard neuroleptic treatment and hospitalization, these data are particularly valuable. Except for Ciompi et al.'s (1992) replication of the Soteria experiment in Bern, Switzerland, today's studies of psychosocial treatments for this disorder are almost always conducted with subjects simultaneously receiving "adequate anti-psychotic drug treatment." Although the Soteria Project's methods and findings will be described briefly, the principal focus of this paper is clinical: How can the effectiveness of the unconventional Soteria model of treatment be explained?

THE RESEARCH

A.) Design: The research was a two 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. In addition to having less than 30 days of previous hospitalization, the Soteria study selected 16-30 year old, unmarried subjects met DSM-II criteria for schizophrenia (by three independent raters) and who were experiencing at least four of the seven Bleulerian symptoms of the disorder (thinking or speech disturbances, catatonic motor behavior, paranoid ideation, hallucinations, delusional thinking other than paranoid, blunted or inappropriate emotion, disturbance of social behavior and interpersonal relations). First and second episode subjects were selected so as to avoid, in so far as possible, the learned patient role. The early onset (16-30) unmarried status criteria were designed to identify a subgroup of persons diagnosed with schizophrenia who were at statistically high risk for long term disability, i.e., candidates for "chronicity." We believed that an experimental treatment should be provided to those individuals most likely to have high service needs over the long term. All the participants were public sector (uninsured and government insured) clients screened in the psychiatric emergency rooms of two suburban San Francisco Bay Area public general hospitals.

B.) Experimental Facilities: The 6 bed original Soteria House opened in 1971. A replication facility opened in1974 in another suburban San Francisco Bay Area City. This was done because clinically it appeared that the Soteria-method worked. Immediate replication addressed the potential criticism that our results were a one-time product of a unique group of charismatic persons and expectation effects. So, there were in fact two geographically separated Soteria-type facilities in California, the second one called "Emanon". Emanon closed in 1980 and Soteria in 1983. C.) Results: (Total sample= 179, Soteria/Emanon treated=82, Hospital treated=97)

1.) Admission characteristics:— Experimental and control subjects were remarkably similar on 10 demographic, 5 psychopathology, 7 prognostic, and 7 psychosocial preadmission (independent) variables. Because of our selection criteria and the suburban location of the intake facilities both Soteria treated and control subjects were young (mean age 21), mostly white (10% minority), relatively well educated (high school graduates) men and women raised in typical lower middle class, blue-collar American suburban families.

2.) Six-week outcome—In terms of psychopathology, subjects in both groups improved significantly and comparably, despite only 24 percent of Soteria subjects having received neuroleptic drugs for two or more weeks during this initial assessment period. All control patients received standard courses of anti-psychotic drug treatment during their entire hospital stayed and were universally discharged on maintenance dosages. More than half stopped the medications over the two-year follow-up period (Mosher & Menn, 1978; Matthews et al., 1979).

3.) Two-Year Outcomes. The relationship between outcome and neuroleptic drug intake was recently analyzed and presented (Bola & Mosher, 1999). Forty-two percent of all Soteria treated subjects received NO neuroleptics during the two-year study period. Three baseline variables predicted membership in this group: acute onset (symptoms evident for less than 6 months), low levels of paranoia and being older. These were predictive despite the homogeneity, and hence little variance, of this specially selected sample. As a group, experimentally treated subjects had significantly better outcomes on a composite outcome scale (+.54 of a standard deviation, p=.024) representing the dimensions of rehospitalization, psychopathology, independent living, social and occupational functioning and on three of eight component measures. When individuals with DSM IV schizophrenia (i.e., those predicted to have poorer outcomes) were analyzed separately, experimental treatment was even more effective (+.97 of a standard deviation on composite outcome, p=.003; Bola & Mosher

2000). These and previous results from the Soteria study continue to challenge conventional wisdom on the benefits of early administration of antipsychotic drugs in treating newly diagnosed psychotic individuals. –

III CLINICAL CONSIDERATIONS

A) Philosophy

The Soteria Project owes much of its clinical methodology to the phenomenological/existential thinkers who provided a breath of fresh air in a psychoanalytic theory dominated field (see Mosher, 1999 for a more extensive summary). During his psychiatric training the first author became interested in the meaningfulness of madness, understanding families and systems and the conduct of research. In addition, he had an unpleasant "total" institutional experience while in psychiatric training (Goffman, 1961) and had to ask, "if places called hospitals are not good for disturbed and disturbing behavior, what kinds of social environments are?" In 1966-67, R.D. Laing (1967) and his colleagues (all influenced by phenomenological and existential thinking) at the Philadelphia Association's Kingsley Hall in London provided the first author with "in vivo" training in the do's and don'ts of the operation of an alternative to psychiatric hospitalization. The deconstruction of madness and the madhouse that took place at Kingsley Hall was fertile ground for the development of ideas about how a community based, supportive, protective, normalizing, relationship-focused environment might facilitate reintegration of psychologically disintegrated persons without artificial institutional disruptions of the process. Sullivan's (1962) interpersonal theory and his specially designed milieu for persons with schizophrenia at Shepard-Pratt Hospital in the 1920's provided the projects other major theoretical underpinning. In part because of the harm done to persons with "schizophrenia" stemming from unproven theories, Soteria adopted atheoretical and interpersonal phenomenological positions. One can argue of course that interpersonal phenomenology IS a theory; it should not be one if practiced properly. Rather, it is an attitude, a stance, a method, an approach to an experiential field containing two or more persons.

The study's anti-neuroleptic drug approach stemmed from the first author's not finding a Lazarus among anti-psychotic drug treated patients. On the contrary, the high rate of failure to respond to these medications and the torment many suffered as a result of drug treatment-especially in the long term- led to a position of minimal use of anti-psychotics during an initial six week trial period.

B) Methods

How was interpersonal phenomenology put into practice in the Soteria Project? To begin with, when dealing with psychotic persons some contextual constraints had to be established: Do no harm; treat everyone, and expect to be treated, with dignity and respect; asylum, quiet, safety, support, protection, containment and food and shelter are guaranteed. And, perhaps most importantly, the atmosphere must be imbued with the notion that recovery from psychosis is to be expected. Within this carefully defined and predictable social environment interpersonal phenomenology can be practiced. The most basic tenet of this practice is "being with" -an attentive but non-intrusive, gradual way of getting oneself "into the other person's shoes" so that a shared meaningfulness of the psychotic experience can be established via a relationship. In contrast with the diagnose and treat approach of the medical model, this approach requires an unconditional acceptance of the experience of others as valid and understandable within the historical context of each person's life -even when it cannot be consensually validated. The Soteria approach also included thoughtful attention to the caregiver's experience of situation. This was a new emphasis on the interpersonal aspects of phenomenology. While it may seem a

departure from the traditions of phenomenology, it brought the method more into step with modern concepts of the requirements of interactive fields without sacrificing the basic open-minded, immediate, accepting, non-judgmental, non-categorizing, "what you see is what you got" core principles. It is in this way that the whole "being"("dasein") in relation to others can be kept in focus. It is unwise to exclude well-known, seemingly universal ingredients in interpersonal fields-i.e., by their very presence and reaction participants' have an effect on the interactions. This application of the Heisenberg Principle to interpersonal fields provides us with additional information while preventing us from being uninvolved observers. Unfortunately it is too often the case that the time and space (a proper context) are not provided for empathic, well-meaning persons to meet- where all persons can feel safe, protected, cared for and accepted for what they are. It is only in this kind of environment that important healing interactions can take place. The conceptual definition and replication of this healing context is as much Soteria's contribution as its application of interpersonal phenomenology within its confines. So, can we live without a medical theory and a treatment manual to direct our therapeutic interventions; and, if so, to what effect? Empirical data presented from the Soteria Project would indicate that, not only can such an approach be carried out, but that it results in more favorable client outcomes than standard drug and hospital treatments.

B) The Working Ingredients

It is always difficult to evaluate and describe why a complex psychosocial setting "works". However, it appears that it was the settings themselves, the characteristics of the milieu, the relationships formed, the personal qualities and attitudes of the staff, and the social processes that went on in the facilities that contributed to the favorable outcomes. Probably the single most important component was the quality of the relationships established between the participants-staff, clients, volunteers, students-anyone that spent a significant amount of time in the facility. In this regard, it is certainly useful to ask "how does one establish a confiding relationship with a disorganized psychotic person?" It is in this arena that the "contextual constraints" or "setting characteristics" mentioned earlier are so important. A quiet, safe, supportive, protective, and predictable social environment is required. This kind of environment can be established in a variety of places: A special small home-like facility that sleeps no more than 10 persons, including staff, the psychotic person's place of residence that includes the involvement of significant others, or almost anywhere in which the context can be established that allows for 1:1 or 2:1 "being with" contact on an on-going basis. Such environments usually cannot be established within psychiatric hospitals or on their grounds because the expectation of "chronicity" for "schizophrenia" is too pervasive. Eventually the dominant biomedical approach will stigmatize the individuals being cared for and undermine relational trust between staff and clients.

Another important characteristic of effective treatment appears to reside in the personality characteristics of staff. The Soteria staff were psychologically strong, independent, mature, warm, and empathic. They shared these traits with the staff of the control facilities. However, Soteria staff was significantly more intuitive, introverted, flexible, and tolerant of altered states of consciousness than the general hospital psychiatric ward staff (Mosher et al., 1973; Hirschfeld et al.,1977). This cluster of cognitive-attitudinal variables appears highly relevant to Soteria's effectiveness. It is safe to say, however, that the staff's ability to relate to the clients and to each other was vital to the program's success. Their interactions are best described in the treatment manual (Mosher et al., 1992; translated into German as "Dabeisein," Mosher et al.,1994). Because staff worked 24 or 48-hour shifts they were afforded the

opportunity to "be with" residents (their term for clients/patients) for longer periods of time than staff of ordinary psychiatric facilities. Thus, they were able to experience, first hand, completely "disordered" cycles. Ordinarily, only family members or significant others have such experiences. Although the official staffing at Soteria was 2 for 6 clients, over time it became clear that the optimal ratio was about 50 percent disorganized and 50 percent more or less sane persons. This 1 to 1 ratio was usually made possible by use of volunteers and clients well into recovery from psychosis who developed close supportive relationships with other residents. In this context it is important to remember that the average length of stay was about 5 months. For the most part, at least partial recovery took about 6 to 8 weeks. Hence, many clients were able to be "caregivers" during the latter part of their stays.

Viewed from an ethnographic/ anthropologic perspective the basic social processes differed greatly between the houses and the control facilities-the general hospital psychiatric wards. Five categories were identified in both experimental settings that set them apart from the hospitals: 1.) Approaches to social control that avoided 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 unknown outsiders into the settings. 4.) Working out social order on an emergent face-to-face basis. 5.) Commitment to a non-medical model that did not require symptom suppression. In contrast, the control wards were characterized as utilizing a "dispatching process" that involved patching, medical screening, piecing together a story, labeling and sorting, and distributing patients to various other facilities and programs (Wilson 1978,1983). With the passage of time it has been possible to try to understand why Soteria "worked" from a variety of overlapping perspectives. Twelve essential characteristics have been defined (Mosher & Burti, 1994):

1. Small and home-like, sleeping no more than 10 persons including staff

2. Two staff on duty, a man and a woman, in 24 to 48 hour shifts

3. Ideologically uncommitted staff and program director(to avoid failures of "fit")

4. Peer/fraternal relationship orientation to mute authority

5. Preservation of personal power and with it, the maintenance of autonomy

6. Open social system to allow easy access, departure and return if needed 7. Everyone shares day to day running of the house to the extent they can 8. Minimal role differentiation to encourage flexibility

9. Minimal hierarchy to allow relatively structureless functioning

10. Integrated into the local community

11. Post-discharge continuity of relationships encouraged

12. No formal in-house "therapy" as traditionally defined

A set of interventions (remember, the word "therapy" was eschewed at Soteria) have also been described:

1. An interpersonal phenomenological stance

2. "Being with" and "doing with" without being intrusive

3. Extensive 1:1 contact as needed

4. Living in a temporary family

5.Yoga, massage, art, music, dance, sports, outings, gardening, shopping, cooking etc.

6. Meetings scheduled to deal with interpersonal problems as they emerged

7. Family mediation provided as needed

It is also likely that Soteria's four explicit rules contributed to its success: 1.No violence to self or others 2. No unknown, unannounced visitors (family and friends had easy access, but as a home its boundaries to outsiders were like those of usual families) 3. No illegal drugs (there was enough community noted deviance at Soteria already) and

4. No sex between staff and clients was allowed. Note, sex between clients and clients or between staff and staff was not forbidden. The project director introduced the first three rules. The fourth was put in

place by staff and clients in a house meeting after the second month of the project's operation.

IV Soteria as an Example of Frank's Non-Specific Factors in Psychocial Treatment

Was Soteria's therapeutic impact based on the five non-specific factors common to successful psychotherapy described by Jerome Frank in 1973? In his massive review of studies of therapy he found that variables ordinarily thought to be predictive of outcome such as therapist experience, duration of treatment, type of problem, patient characteristics, theory of the intervention etc. generally bore no relationship to client outcome. The five he did identify warrant discussion in light of the subject at hand-why did Soteria work? They are: 1. The presence of what is perceived as a healing context. 2. The development of a confiding relationship with a helper. 3. The gradual evolution of a plausible causal explanation for the reason the problem at hand developed. 4. The therapist's personal qualities generate positive expectations. 5. The therapeutic process provides opportunities for success experiences. Certainly the two California facilities came to be seen as healing contexts. Unfortunately we do not know the degree to which they were perceived as more so than the hospitals. A major defect in the Soteria Project was the lack of a measure of client satisfaction. Actually, because of their uniqueness they might well have been seen as healing contexts only after some period of time whereas hospitals are immediately accorded this function by shared cultural definition. Because relationships were so highly valued at Soteria the development of a confiding relationship was very difficult to avoid. In addition, the context was structured in such a way as to remove usual institutional barriers to the growth of such relationships. Finding "meaningfulness" in the psychosis, which is to say a "plausible causal explanation", was also important to recovery. The creation of an atmosphere that included an expectation of recovery from psychosis was the product of both client and staff attitudes. This culture was inevitably carried from generation to generation of clients by the staff. What could be more positive than to expect recovery of persons experiencing the most severe, and putatively least curable, of crises, "schizophrenia?" Modest achievable goals seemed to be set and progress toward them noted positively. In fact, starting with very disorganized persons makes it relatively easy to provide opportunities for success experiences-like bathing after some weeks of not doing so. While I do not believe Frank's formulation can account completely for why Soteria "worked" it does provide a set of generic principles to apply in the implementation and evaluation of therapeutic programs. What is also particularly appealing (to LRM) in Frank's work is its totally atheoretical formulation.

V The Future

Soteria-type facilities can be very useful for the provision of a temporary artificial social network when a natural one is either absent or dysfunctional. However, common sense would tell us that immediate intervention at the crisis site is really preferable, when possible, because it avoids medicalization (i.e., locating "the problem" in one person through the labeling process) of what is really a social system problem. Dedicated facilities cannot, by definition, be where the problem originates. There is no inherent reason why these special contextual conditions of Soteria-type programs cannot be created in a family home, in a non-family residence, or in a network meeting held nearly anywhere. This approach has been systematically applied by Alanen et al. (1994) and has spread throughout much of Scandinavia with rather remarkable positive results. It appears that there is now a team of swimmers. Humanistic treatment of disturbed and disturbing persons may still become a reality.

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