

## **The Soteria Project: A forerunner of “a third way” in psychiatry?**

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### **Summary**

The article presents a somehow forgotten, yet largely controversial, experiment and therapeutic phenomenon known as Soteria Research Project. History, circumstances and main methodological assumptions of the experiment are briefly presented. Theoretical inspirations behind therapeutic model of Soteria are discussed and analyzed, and the results of the experiment are shortly described. The Soteria Research Project is placed in historical and contemporary context and compared to other theoretical propositions and practical solutions. A summary of critical arguments against Soteria is presented. Results of the Soteria Research Project suggest that therapeutic methods employed there were at least as effective as hospital treatment as usual, despite a radical reduction in, or even a complete lack of, pharmacotherapy. These results are still very important in the context of the debate concerning effective and ethical treatment of psychiatric disorders. It is claimed that Soteria was an attempt of restoring the importance of subjective experiences and subjectivity of a psychiatric patient in organized mental health care and a forerunner of contemporary postpsychiatric approaches, which postulate larger autonomy of patients, criticize sole reliance on pharmacotherapy and contemporary diagnostic systems, and underline the importance of psychotherapeutic interventions.

**Key words:** Soteria, schizophrenia, psychotherapy of psychotic disorders

### **Introduction**

In his article published as an introduction to a discussion on psychotherapy in the *Diametros* journal, Jerzy W. Aleksandrowicz made an argument that therapy “breaches the patient’s autonomy in the most personal areas. Acting for the patient’s good – the main principle of deontology – allows for such an intervention [...] but it is the psychotherapist who decides about the nature of this good” [1]. It seems that this statement could be extended onto other elements of psychiatric procedure, in which not only the scale of patient’s autonomy, but also the importance of considering his beliefs and subjective experiences in the diagnosis and in estimating the goal and course of the

treatment, seem to be left in a much larger extent to the decision of the doctor than in other branches of medicine. The main reason of such state of affairs is not only reduced subjectivity of the patient and weakening of his or her cognitive abilities, in particular critical thinking, characteristic of a many mental disorders, but also specific cultural and historical context which has been accompanying the phenomenon of mental illness for centuries. It influences the social perception of the patient as well as his or her professional diagnosis, treatment and methods of care.

The latter issue seems to be especially sensitive, because its resolution depends not only on current medical doctrine or customs of nursing care, but also on fundamental beliefs about the nature, genesis and location of mental illness, as well as on the answer to the question about the patient's possible contribution to his own suffering. The resolutions in these questions decided about the choice of therapeutic strategies, but they also resulted in shaping views on mentally ill people, who began to be considered not only as a medical problem, but also a moral one.

It appears that since the symbolic beginning of psychiatry as a separate science – the liberation of mentally ill patients from chains by Pinel in late 18<sup>th</sup> century [2] – the discussion about the nature of mental illness, its treatment and the scale of patient's autonomy had oscillated between two extremes, now described as naturalist and constructivist approach. The conflict between them is based mainly on the question whether “the notion of an illness can be defined in normatively neutral scientific terms (as proposed by naturalists), or are socially-ingrained normative notions necessary to apply (as claimed by constructivists)” [3, p. 96]. The former option, as it seems, is best represented in contemporary biomedical approach, embodied by pharmacology, directive therapeutic treatment and isolation of patients most affected by illness; the latter is embodied by antipsychiatry, according to which diagnosis of a mental illness does not include only medical factors, but also social, ethical and political ones, and according to which – as said by Thomas Szasz – a mental illness is “a metaphor which we have come to mistake for a fact” [4]. If we wanted to synthetically summarize the difference between these approaches from a perspective relevant to this article, we could argue (backed up by historical facts), that while the biomedical model imposed an “excess” of medical care, antipsychiatry's “cardinal sin” was mainly leaving patients to their own devices, without care [5].

In this article, we would like to present a lesser-known, historical solution – a “third way”, which involves both elements of mainstream medicine and alternative, constructive influences. It will be a reconstruction, analysis and discussion of Soteria, a therapeutic phenomenon, the value of which stems mainly from a successful combination of these seemingly incompatible perspectives into a coherent and, as proven in analyses, effective form of mental health care. First, we will present a historical outline of this phenomenon.

### Soteria Research Project

The *Soteria Research Project* (in Greek: “σωτηρια” – ‘salvation’, ‘rescue’) lasted from 1971 to 1983. Its founder and director was Loren Mosher, promoted in 1968 to the position of the head of the schizophrenia research centre at the National Institute of Mental Health. The principle of this quasi-experiment was to compare (using various scales referring to social functioning, psychopathology and criteria such as the number of subsequent hospitalizations and their duration) the results of treatment two years after admission into a “traditional” hospital, with the results of treatment in a specially established experimental center [6]. Initially, there was only one house called Soteria, located in San Jose, California; in 1974, another one followed, located near San Francisco and called Emanon (“No name” spelled backwards) – as an additional “experimental group”. The point was to recreate, possibly faithfully, the conditions and basic rules applied in the first house in order to find out whether results achieved in Soteria are not only owed to situational factors and relations between them (people, *genius loci*, other unpredicted variables), which could question the assumptions of the method and dismiss the potential therapeutic success as a coincidence, thus cancelling the results of the entire project [7].

Initially, it was planned to accept into Soteria only patients who met the criteria of schizophrenia according to DSM-II (confirmed by three independent psychiatrists), who would display at least 4 out of 7 criteria of schizophrenia according to Bleuler’s classification (confirmed by two psychiatrists), who were hospitalized earlier not more than once or no longer than 30 days, aged 18–30 and unmarried [8]. In the final statistical analyses, the age is described as 15–32 [10]. Initially accepted criteria were aimed at excluding from the experiment those people who could “internalize the patient’s role” – in the perspective of the founders of the center, that would mean an overly dependent approach and a lacking initiative. On the other hand, according to the then-contemporary knowledge, single people of young age had the worst long-term prognosis – if psychosocial approach could help them, it would provide an additional proof for the effectiveness of the model applied in Soteria [11].

At the center, there were no more than 10 people present at once, including personnel consisting of two employees (male and female) working in 24 and 48-hour shifts. Daily duties at the house were divided between all participants, while minimum hierarchy and role division were supposed to help to maintain the patients’ autonomy [11]. Mosher preferred to use the term “client” (associated with humanist currents in psychotherapy), or even a more informal term like “tenants”, and “graduates” in relation to people who completed their therapy at Soteria.

During initial six months of stay at the center, neuroleptics were allowed only if it was assumed that medication could help overcome aggressive or suicidal behaviors which could not have been prevented otherwise, or if the patient suffered so much that sole presence of others and “interpersonal means” did not bring relief, or if the tenant asked for the medication themselves [7].

### **“Being with”**

One of the key elements of the therapeutic process in Soteria was so-called being with. “Being with” had evolved from an idea to “keep vigil” with the client during an acute phase of psychosis in a special room. The room did not contain any hard pieces of furniture aside from a stereo set, it was lined with rugs and pillows, there were also a few small lamps allowing to regulate the amount of light according to the patient’s needs. The room was located in the central part of the house, as it was assumed that “something which is hidden may appear scarier”, it was also aimed at encouraging the tenants to cooperate. Above all, the room was supposed to be safe and provide minimal stimulation.

It turned out soon that such a special room does not fulfill its role and contradicts the structure-free nature of Soteria, so it was formally used only twice. In practice, it was discovered that the role intended for the separate room can as well be applied to the entire house and that any quite room suffices, as long as the person in crisis is accompanied by someone trusted. Such sessions could last for several hours, or even two subsequent days. Shorter sessions took place for example two times a day, while in between patients could function more or less normally.

An important factor which could have influenced positive results of treatment in Soteria was also the support network which had emerged naturally between tenants, personnel and “graduates”. Strong personal engagement in the lives of people admitted into Soteria, softening the roles and encouraging friendly relationships led to an authentic bond, which continued also after clients left the center [7].

### **Basic principles**

For Mosher [10], after visiting Kingsley Hall, opened in London by Ronald D. Laing, it became clear that certain “contextual limitations” should be applied at the house: do not hurt anybody, treat everybody with dignity and respect and expect the same from others, guarantee silence, support, protection and “interpersonal validation”, provide food and shelter, but above all, the atmosphere should be full of hope that recovering from psychosis is possible without antipsychotic medication.

Three directly expressed principles, with which Soteria began its activity, were: banning violence, entry forbidden for strangers without agreement from tenants, and a ban on illegal drugs. During the house’s functioning, under the influence of events at the centre, a fourth rule was introduced, forbidding sexual contact between personnel and patients. The principle was a result of one of the patients’ provocative behavior towards the members of the staff. Additionally, other temporary rules were introduced in response to events at the house, with an agreement and usually at the community’s initiative, for example, regarding the use of sharp tools [7].

## Results

The most complete analysis of all the data collected throughout the duration of the experiment was published only in 2003 [6]. In the analysis, eight measures were used: repeated admission into psychiatric care (yes or no), number of days spent in 24-hour care during subsequent admissions, result on the general psychopathology scale (1 to 7), result on the general improvement scale (coded from 1 to 7, 1 = significant improvement, 4 = no change, 7 = significant worsening), living on one's own or with people of similar age (yes or no), employment (no employment, part-time or full-time employment), and a subscale of social functioning from Brief Follow-up Rating. The data was collected by a group of independent researchers, the level of judges congruence was maintained on the Kappa > 0.80 level. The estimations were made after admission, after 72 hours (which was supposed to exclude drug-induced psychoses), after six weeks and two years.

Unfortunately, there is not enough space here to describe and analyze the data in detail. In general, the results on most scales were comparable for the groups treated at a hospital and in Soteria as soon as after six weeks from the start of the treatment, despite avoiding neuroleptics in the experimental group. People undergoing treatment in Soteria, regarding the last measure which was made, achieved on the collective scale – which was an adequate transformation of eight previous measures, so it could be considered in terms of standard deviation – minimally (statistically insignificantly) better results in comparison to the hospital patients ( $N = 160$ ,  $+0.17 SD$ ), while their chance of living on their own or with people of the same age was higher by 18% ( $p = 0.05$ ). The results of 129 patients which could have been accessed after two years from admission to the hospital or to Soteria, were insignificantly better by one-third of the standard deviation ( $N = 129$ ,  $+0.35 SD$ ;  $p = 0.09$ ) for experimentally treated patients. They also had a statistically significantly higher chance (by 21%) for avoiding psychopathological symptoms or for a low result on this scale ( $p = 0.01$ ). After applying Heckman procedure, which allows for correcting results which could have been skewed due to a different number of people in the experimental and control groups from whom data was not collected after two years, patients treated in Soteria achieved results statistically significantly better by nearly half of the standard deviation ( $+0.47 SD$ ;  $p = 0.03$ ), 20% higher probability of achieving one of two lowest results on the psychopathology scale ( $p = 0.03$ ) and by nearly one standard deviation fewer chance of admission to 24-hour psychiatric care ( $-0.98$ ;  $p = 0.02$ ). Results regarding other scales and indexes were very similar between the experimental and the control group.

While in Soteria, 24% of patients took neuroleptic drugs at least once, and 16% used them for more than a week [9]. 43% people from the experimental group did not take any antipsychotic medication during the whole two-year research and follow-up period and this group achieved the best results on the general scale ( $+0.82 SD$ ). 94% of patients treated at the hospital were medicated [10]. Presented data allow us to conclude

that the therapeutic model at Soteria was, despite using smaller doses of medication or not using any, at least as effective as traditional hospital treatment.

### **Soteria in historical and contemporary context**

Soteria, even in the context of fairly varied therapeutic offer of its era, stood out from other social and community-based solutions aimed at helping people in crisis. It appears that its unique status was a result of a few qualities:

- even though the project was not a hospital and was not directly managed by doctors, only people who qualified for hospitalization were admitted;
- use of neuroleptics, common in other institutions, was limited with an ideal goal of not using them at all;
- the responsibility for treatment and management was in the hands of unqualified personnel (without psychological or psychiatric education).

Still, the quality which stood out the most was the fact that Soteria was not a post-hospitalization care center. It did not serve as an extension of hospital therapy, but as an alternative to it [7]. The Soteria Research Project put into question not only a medical model of madness, the necessity of treatment of patients with schizophrenia in hospitals, the effectiveness of neuroleptics in treatment and prevention of alarming behaviors, but it also questioned the necessity of employing qualified staff in the therapeutic process. Perhaps this is the reason why in Mosher's work it is so difficult to find explicitly expressed, complex and complete vision of schizophrenia and of therapy which he wanted to put into practice in Soteria. This lack correlates in general with his idea of theory-free approach to patients. He mentions a number of certain inspirations, but does not elaborate on them. In many places, he appears to be self-contradicting. In fact, a coherent vision may have been non-existent at all – Mosher made many conclusions about events at Soteria once the project was finished. Yet still, inspirations mentioned by him and a number of other features allow for distinguishing key theoretical, practical and worldview-related aspects and implications of his vision.

Soteria referred to an idealistically perceived era of “moral healing”, a sort of perspective Michel Foucault [12] would not agree with, as Foucault saw there rigor and ruling by fear. His objections seem justified when we consider one of the sources of moral therapy – Romantic psychiatry, which in contrary to somatic psychiatry (which sought physical etiology of mental ailments), pointed at psyche-related sources of madness – incorrect behaviors or passions. It became a starting point for considering the psychiatric patient's guilt for their own state. One of the pioneers of such approach, Johann Christian August Heinroth, claimed that despite mental illness is a result of morality-based disorders of the soul, it is the ill person who carries the responsibility for its presence – in short, the patient is guilty of their own illness. As a remedy, “moral therapy” was used – a persuasion technique which was supposed to affect the patient's

conscience and consciousness directly and help them return to “the right course”, which they have consciously – which should be emphasized once again – left [13]. At the same time, stressing the importance of “being with” and applying a home-like attitude to a therapeutic unit can bring to mind ideas of certain 19<sup>th</sup> century psychiatrists, such as George Man Burrows and William Charles Ellis.

Burrows propagated using the name “psychiatric unit”, which at the time carried less negative association than commonly used term “madhouse”. It can be seen as an attempt to remove stigma from madness. Burrows stressed the importance of a mild approach to patients and considering their complaints, expressed during an acute phase of illness, seriously. Ellis believed that the most important component of moral therapy is constant, persistent and mindful kindness, which was supposed to bring results even with people whose “sanity remained very scarce” [2, p. 56].

Soteria locates itself in the trend of objection against institutional psychiatry. Mosher, similarly to Thomas S. Szasz, appears to treat the notion of schizophrenia as an artificial concept which refers mainly to values, not to an actual disease process. However, contrary to the author of *Myth of mental illness*, the founder of Soteria did not question the pathological nature of the state which diagnosed people are in. Clearly expressed statements like “they denied their illness” or “the staff assumed they may be concealing many symptoms” indicate that one cannot qualify Mosher as an antipsychiatrist who would propagate an entirely subjective approach to the nature of one’s own state – even though in other places we can find statements that Soteria “refuses the metaphor of a mental illness”.

Even though Mosher does not clearly explain what he understands under the terms “support system” or “interpersonal network”, which he often uses – the model of Soteria matches, to an extent, the approach of systemic or family therapy [14]. Certainly, Mosher – like Laing – was influenced by the double bind theory, put forward by Bateson in the 1950s and locating the roots of schizophrenia in problems with communication in the family, various contradicting messages and demands expressed on verbal and non-verbal level. Remaining under the influence of mixed messages was supposed to develop in child a perception of reality as something unclear and full of contradictions, which would result in an inability to react adequately and develop symptoms typical for schizophrenia. Laing seemed to pay more attention to internal contradictions stemming from unclearly defined roles played by various members of the family [15]. In Soteria, a person in crisis was intended to – while spending time without their family – develop their own methods of dealing with problems and train interpersonal communication with personnel and other patients. Eventually, the family was supposed to become a part of the support network, with an end goal of a degree of self-sufficiency and independence, both from the family and from the Soteria community.

It needs to be stressed again that it is difficult to think of Mosher as a founder of a concrete and precisely described therapeutic model. Perhaps the lack of such a model had a therapeutic effect. What happened in Soteria and in Emanon had mainly a situational character and was mostly dependent on people present at the centers at

a given time. When the personnel consisted of people who were familiar with Jung's works, his ideas sneaked into the relationships between tenants; when the staff was fascinated with Eastern philosophy, the entire house became more oriental [7]. Lack of an overwhelming number of regulations, the dynamics of relationships in an accepting, understanding group and relations which emerged thanks to these qualities seem to be the most important – yet we cannot exclude that the environment simply allowed certain patients to safely last through the “natural course of psychosis”.

The emphasis which Mosher put on relations resembles Jerome Frank's conclusions and opinions. Frank believed that the therapist's theoretical background practically does not matter, as long as explanations provided by a particular theory are accepted by the patient. He perceived psychotherapy as a process in which patients, initially deprived of hope, gain it back – more due to the relationship than technical procedure of therapy. His conclusions are generally confirmed by empirical research, and often the relationship between the therapist and the client is perceived as key feature [16]. It can be said that in the case of Soteria, ordinary people took on the roles of therapists, and therapeutic relationships could have emerged naturally.

### **Criticism of Soteria**

The most extensive critique (containing also majority of the arguments against Soteria raised elsewhere) was announced by Carpenter and Buchanan [17]. They claim that schizophrenia is an illness which should be perceived and researched in a clinical context in the biopsychosocial model, which allows for the best integration of approaches stemming from various theories and traditions and referring to various areas of human activity. They claim that Soteria was based on an “antimedical” and “anti-disease” model. At the same time, they agree that pharmacology is often put to the foreground, and practicing psychiatrists lack knowledge about alternative methods of intervention – even those whose efficiency was proven. Thus, they admit that integration of various approaches within the biopsychosocial model and their balance is an illusion, maintained since the 1970s. Read, Mosher and Bentall [18] point out that the key element of the biopsychosocial model is the concept of “vulnerability-stress”, in which – despite life circumstances being taken into consideration – the role of stressful events is reduced to a “spark”, which would “ignite” a genetic susceptibility (against the basic assumptions of this concept, in which “vulnerability” would have an acquired, psychological nature). In their opinion, it proves the “colonization” of social approach by the biological one rather than balance and integration of models.

Carpenter and Buchanan [17] raise the accusation of anti-medical nature of Soteria and ask if applying the Soteria model would be possible without such a defying character. Since mid-1980s, there has been a “Soteria Berne” center functioning in Switzerland, based on principles similar to the ones propagated by Mosher, but lacking the anti-medical or anti-pharmacological approach. In this center, results similar to hospital ones are achieved using much smaller doses of medication than in traditional



hospitals. The results appear to be even more positive in terms of subjective-emotional, family and social level of functioning [19]. It is difficult to disagree with another accusation listed by Carpenter and Buchanan [17], according to which persons with first diagnosed episode of schizophrenia have usually better prognoses and long-term results of treatment than people who had a larger number of episodes; but in this particular case, this argument does not seem to apply – in Mosher’s experiment, both compared groups (hospital and Soteria-treated) included people with a new diagnosis.

Even though Carpenter and Buchanan [17] admit that careful application of neuroleptics or withdrawing them in general could have contributed to the successful result of treatment in Soteria, they seem to omit the fact that usually the answer to the question, whether neuroleptics should be applied in the first psychotic episode, is positive (APA, 1997). Nowadays, it is even claimed that intervention should be performed possibly quickly, especially in research on the Duration of Untreated Psychosis – even though the research is burdened with a number of methodological issues, and received results, even in the case of psychoses untreated for over 6 months, are contradicting, often on the border of statistical and clinical significance [20]. The results achieved in the Soteria Research Project appear to contradict common practice and indicate a necessity to take a closer look at the issue.

Mosher did not refuse pharmacological treatment entirely:

*Today, my position is that, since no real alternatives to antipsychotic drugs are currently available, to be totally against them is untenable. Thus, for seriously disturbed people, I occasionally recommend them – as part of collaborative planning with my client – but in the lowest dosage and for the shortest length of time possible. Instead of antipsychotics, however, I prefer to calm acute psychosis and restore sleep/woke cycles with an initial course of minor tranquilizers accompanied by in-home crisis intervention [7, p. 303].*

A similar model of care seems to be currently in use – with very good results – in the Open Dialogue approach [21, 22].

### **Soteria as an attempt to restore the subjectivity of a psychiatric patient**

Biological approaches to psychiatric illnesses can be seen as perspectives depriving patients of agency, subjectivity and responsibility. Victor Frankl had already pointed out deformations in the image of a human being, which stem from assigning him to only one selected dimension and from becoming stuck in “isms” (psychologism, sociologism) [23]. Individual narratives and more psychologically oriented concepts emphasize personal meaning, sense and roots of psychotic experiences. What can be a source of hope for someone – the fact that science, medicine, pharmacy can harness madness – for others can become a source of trauma, an experience of dehumanization and depriving of identity, which becomes limited to a level of neurotransmitters,

abnormal brain structures and law of physics. An additional trauma is provided by specialists, who provide an authoritarian assessment of one's identity as diseased, abnormal, incorrect. The following bitter record given by a person diagnosed with schizophrenia provides an apt illustration:

*I have spent years of my life existing as a footnote, a case note, a clinical note, clinging to the understanding that I was a defective biological unit. Somehow time, matter and the joke of genes and enzymes had exiled me to the sidelines of being. This may truly be a valuable perspective for those who observe mental illness, but for me, as subject, this tree bore only dry and tasteless fruit.*

*I have a chemical imbalance; it wasn't really me that did those things.*

*I have a chemical imbalance; I really didn't feel those things.*

*I have a chemical imbalance; I didn't really experience those things.*

*I have a chemical imbalance; I didn't really think those things.*

*I am chemical and I don't really think.*

*Here is an insight! The entire human drama of love, suffering, ecstasy, and joy, just chemistry [24, p. 317].*

Estroff [24] points out that there are many accounts expressing disappointment, pain, anger, experiencing obliviousness from the personnel; their common denominator seems to be that patients do not feel treated as a subject, but an object in the system of medical care. Former patients often share a feeling that coercion associated with hospitalization and questioning experiences from the psychosis period by doctors may cause a sensation of despair, failure and shame, often more difficult to deal with than the primal symptoms of their illness. Obviously, such narratives are hard to include in a discourse focused on evidence-based medicine, but their marginalization does not contribute to the understanding of schizophrenia – and as such, it does not expand our knowledge about practical help for people with such diagnosis. Soteria, with its individual, existential, maybe even personalist approach seemed to respond better to these needs.

Adoption of value-based medicine postulates, which stresses the importance of including, besides scientific data, also the value given to certain interventions by patients themselves, could partly resolve this conflict [25]. Qualitative research suggests that many patients indicate a need to be heard, understood, a need to “be with” [26]. Perhaps an attempt to apply individual meaning to intense psychotic experiences, as well as “normalizing” messages and expectations from the personnel (which was a part of Soteria's treatment process), may paradoxically become more helpful than unambiguous classification of such experiences as an illness.

Opoczyńska [27] also seems to notice that patients often try to apply meaning to the experience of schizophrenia, that it seems to be treated by themselves as a kind of a development process. For many of them, helping others becomes later a basic value in life, which corresponds with Soteria's model of “support networks”, in which former tenants, remaining in close relationships, can provide help to each other and respond in

daily life and in crisis. It also seems important that idiographically (not nomothetically), looking at life stories of schizophrenic patients, one can notice emotional, family, systemic, environmental, social or simply intrapsychic factors. Such an approach has been applied by John Modrow [28] (in a partly autobiographical book), or by university psychologists Arnhild Lauveng [29] and Eleanor Longden [30], who were diagnosed with schizophrenia at a young age. Daniel Fisher, a schizophrenia-diagnosed, practicing psychiatrist writes: “If you and the people around you believe that your mind will be defective and sick for the rest of your life, you are left without hope of ever having the agency to build a life. This dire prediction can become a self-fulfilling prophecy” [31].

### Concluding remarks

Of course, a wide and completely faithful to the original application of the Soteria treatment model would have been very difficult today, if only because of formal and legal aspects associated with the participation of unqualified staff or prolonged “vigils”. The Soteria Project has nevertheless asked questions about the nature of schizophrenia and its adequate treatment which resonates very well with contemporary debate, and the answers that it strived to provide were very similar to some of today’s propositions.

One of the issues raised was the status of the schizophrenia diagnosis. Bentall [32] points out that a wide array of behaviors which the schizophrenia diagnostic criteria consists of may cause a situation in which two people, behaving entirely differently, and whose symptoms virtually do not match at all, may receive an identical diagnosis. Hence, Bentall postulates abandoning the category in clinical and research practice. Sir Murray [33] (who received a knighthood for his services to medicine), reflecting in *Schizophrenia Bulletin* on 40 years of his psychiatric clinical and research career, expects that the concept of schizophrenia should soon be abandoned. Wojciszke [34, p. 5], a rather empirically-oriented social psychologist, writes about love that its scientific analyses resemble “drawing conclusions about the nature of a hurricane on the basis of its part which a hard-working researcher managed to catch into a jar”. These words seem to match the condition of psychology and psychiatry in general, they also describe well the scientific attempts to understand schizophrenia, which appears to be a phenomenon as multi-aspected, ephemeral, hard to define, but also strongly rooted and co-created by culture, as love. Following Wojciszke’s analogy, it may be correct to state that in the case of schizophrenia, a critical analysis of the history and scientific studies on the concept may lead to the conclusion that as researchers aiming at objectivity and certainty, we cannot be sure what we caught in our jars, or even if our jar – the set of methods we create and use – is of any use at all.

Perhaps this can be related to an impression sometimes articulated by patients: that their experience cannot be entirely described, that psychiatrists do not understand it, perhaps even do not want to and maybe they will never be able to, but on the other hand – psychiatrists often believe that patients with a schizophrenic diagnosis, due

to lack of insight, cognitive issues and other factors, do not want to and are unable to understand the psychiatric perspective [see 24]. This dilemma, probably impossible to solve, relates to the possibility of getting to know oneself and another person in general, still, it seems that Soteria tried to tone down the conflict between visions of the nature of madness, perspective of the experiencing and the judging party – by placing an accent on mutual experiencing, abandoning therapeutic distance and engaging into “being with”, which could lead to subjective reduction of a sensation of misunderstanding and alienation. In turn, it could have facilitated establishing a therapeutic relationship in which the patient is a subject, not an object. It also seems that in order to better help people with schizophrenia diagnosis, also in scientific work, it is worth to pay attention to their own accounts and to analyze their own opinions about themselves and their treatment. In such perspective, the Soteria Research Project could be situated in the contemporary movement of postpsychiatry, or critical psychiatry, which accentuates, e.g., a fuller participation of the patient in selecting the proper therapy. In postpsychiatry, patients are even taking the role of experts. Their perspective is considered as justified account from a complex human being. The “service users” are given larger autonomy, while models of treatment focused solely on pharmacotherapy and contemporary diagnostic systems are criticized, instead more attention is given to other types of intervention [35, 36].

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