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Creating alternative therapeutic spaces in psychiatry: a tribute to Loren R. Mosher

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ABSTRACT

Background: For much of the 20th century, psychosocial approaches to psychosis were rejected by conventional psychiatry. However, Loren R. Mosher, an American psychiatrist, drawing on the ideas of R. D. Laing and the tenets of interpersonal phenomenology, set up the Soteria project in California, and in so doing made his mark on the psychosocial treatment of psychosis. This essy revisits Mosher's life's work, analysing some of the implications derived from his creation of alternative therapeutic spaces in psychiatry for those stigmatized, medicalized, and objectified within a psychiatric category.

Methods: Using a selection of relevant works from the literature (including many written by Mosher alone or in collaboration with others), this paper is a timely reconsideration of this question, as there is a growing acknowledgment today of the need for alternatives to the current drug-centered approach to the care of people who are going through psychotic episodes.

Results and Discussion: As I will show here, Mosher was a potent precursor of the so-called community-based approach, imbuing his clinical praxis with a strong phenomenological vision of psychosis. He also showed his work to be compatible with robust research, and provided empirical evidence for its efficacy, without rejecting drug prescriptions when necessary.

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Background

Despite the hegemony of biological-organic approaches to mental illness within conventional psychiatry during the 20th century, there were also professionals who strongly advocated for a complete change in how mental patients were treated. Among the many figures who represented sources of inspiration for this transformation were the British psychiatrist Ronald D. Laing (1927–1989) and the American psychiatrist Loren R. Mosher (1933–2004), who are worthy of note for their serious efforts to offer humane and supportive alternatives to inpatient care and the forced medication of people experiencing acute episodes of psychosis.

This paper focuses on Mosher, who ideated an approach that became known as the Soteria treatment model. The name derives from the Greek goddess "Soteria", variously translated as "deliverance" (Mosher et al., 2004), "salvation" and "protection" (Ciompi, 1997; B. Mullan, 1999), and encapsulates Mosher's idea that to save one person is to save the world. The model drew on the ideas of Mosher's Harvard mentor, Elvin V. Semrad (1909–1976), a prominent American psychoanalytic psychiatrist. Most of what we know about Semrad is through his students, like Mosher, who

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acknowledged his indelible influence by identifying his own approach as Semradian. Semrad, in turn, was strongly influenced by Harry S. Sullivan (1892–1949), and in Mosher's eyes was notable for his ability to relate to psychotic persons, which was significant as it predated the predominance of neuroleptic drugs in the treatment of psychosis (Mosher, 1996, p. 2).

Perhaps because of his strong, markedly psychoanalytic, identification with Semrad, Mosher's project has been misjudged by some, such as Davidson et al. (2010, p. 20), who consider that it tended to romanticize psychosis in terms of a spiritual journey of discovery or self-actualization. If Mosher were alive today, I strongly believe he would disagree that psychosis is a spiritual journey of discovery or self-actualization, but rather the greatest catastrophe of subjectivity than can happen to a person. Indeed, Mosher considered the experiential and behavioural attributes of "psychosis" – including irrationality, terror, and mystical experiences – as extremes of basic human experiences (Aderhold, 2009, p. 329). Davidson et al. (2010) also criticize Mosher for denying access to certain interventions, such as medication, even though these might have lessened people's distress, out of a conviction that the distress needed to be "worked through". This statement is imprecise and lacks grounds, since Mosher, like many others, documented the sterility and futility of trying to explain and treat "madness" with the crude concepts and tools of biological psychiatry and offered alternatives (Read et al., 2013, p. 5).

Equally, in considering these accusations against Mosher it is worth noting, in my view, that he did not reject medication *per se*, but only in cases of acute episodes of psychosis. The clearest evidence in favour of this is that Mosher (1996, p. 23) advocated for minimal neuroleptic use – if possible, none for the initial 6 weeks. Mosher thus carried out experimental research with individuals diagnosed with schizophrenia, using control and experimental groups, in an attempt to prove how beneficial treatment without neuroleptics could be under certain conditions. Mosher also argued that there was no sound evidence confirming that schizophrenia was a brain disease, and felt its widespread acceptance was a function of "fashion, politics and money" (Redler, 2004). This latter assertion, as I will show later, is indubitably associated with Mosher's open letter of resignation to the APA at the end of 1998, expressing his weariness with the excess of medication and the financial benefits accruing to the large pharmaceutical companies from prescription drugs. In becoming a critical conscience for psychiatry, Mosher, for me, shared a kindred concern with so-called "antipsychiatrists" such as R. D. Laing, D. Cooper, T. S. Szasz and F. Basaglia (Mosher, 1996, pp. 5–6), psychiatrists who conferred a high value on the psychosocial aspects of mental illness, without ignoring the potentially associated "chemical imbalances". His genuine efforts in this direction are corroborated by his affirmation that Soteria was also an attempt to develop a humane alternative for care in response to the well-developed critiques of psychiatric institutions. He sought to test the validity of these critiques within the special setting of the Soteria project, and was highly critical of a diagnostic system within psychiatry that focused on symptoms without taking note of psychosocial factors. As supportive arguments to his criticism, in his book written collaboratively with Burti, Mosher says:

> (. . .) Psychiatry's current obsession with how many Schneiderian symptoms can dance on the head of a schizophrenic is one that our experience has taught us is mostly antitherapeutic in its induction of a we/them separation. (. . .) The current practice of focusing on symptoms in the individual in order to arrive at a diagnosis is to decontextualize, dehistorify and depower the individual. The person's gestalt is lost. It also results, largely because it takes places in the zoo (office) instead of the jungle (the community), in a thrust toward separating persons from their worlds. This separation, as reinforced by the treatment system, is the source of stigmatization. (Mosher & Burti, 1994, p. 8)

With this in mind, the aim of this paper is to revisit Mosher's work as a psychiatrist. It begins with a biographical sketch, as in my view it is almost impossible to speak of his life's work without considering the man behind the work. This is followed by a detailed examination of his first-hand knowledge of Kingsley Hall, the experimental community created by Laing and his colleagues in the UK. I will then look at the lessons Mosher took from Basaglia and the Italian movement for mental health reform, highlighting the importance of the political context surrounding such initiatives. The following two sections focus on the model conceived by Mosher for treating schizophrenia without

drug therapy, and his letter of resignation from the APA, where he denounces the great economic dependence of psychiatry on pharmaceutical companies and allied consortia. I will then end the paper with some personal conclusions.

Biographical sketch

Loren R. Mosher was born 3 September 1933 in Monterey, California, and died 10 July 2004 in Germany, where he was being treated for liver cancer. He took his first degree at Stanford University and his MD at Harvard Medical School, where he subsequently did his psychiatric training. About those formative years, during his internship, he particularly recalled his daily confrontation with sickness, unkindness, and death, situations over which, he says, he had little influence or control. He therefore sought a means to respond, without embracing the habitual attitude of dehumanizing patients he frequently encountered (Mosher et al., 2004). He was recommended the book *Existence: A new dimension in psychiatry and psychology* (May et al., 1958), and found the existential-phenomenological approach chimed with his own ideas on psychiatric treatment. Armed with these ideas, he arrived for his psychiatric residency at the Massachusetts Mental Health Center, an institution long known as the "Psycho" for its previous name (The Boston Psychopathic Hospital), whose doors were to close forever in 2003. There, he was instructed by Dr. Semrad, mentioned in the opening section of this paper, who immediately banished in him the *doing to* stance of the usual medical therapeutic model and replaced it with a *being with* investigate attitude quite in keeping with Mosher's phenomenological inclination. In addition, Semrad also proscribed intellectualization as a means of dealing with incomprehensible human miseries (Mosher et al., 2004). The residency was followed by research training at the NIMH, after which he spent the years 1966–1967 in the UK. Here Mosher came into contact with Anna Freud (1895–1982) at the Hampstead Clinic, John Bowlby (1907–1990) and members of the Object Relations Analytic Group at the Tavistock Clinic, and Elliot Slater's Psychiatric Genetics Unit at the Maudsley Hospital (Mosher, 1997a, p. 9). Mosher also made contact with the experimental community at Kingsley Hall (1965–1970), run by Laing, with whom he maintained sporadic contact. Writing some 30 years on, Mosher (1997a, p. 12) recalled: *After our intensive London contact of 1966–67, Laing and I met on numerous subsequent occasions in London, Washington and elsewhere. They were unpredictable, occasionally unpleasant, always stimulating. I joined him at several stops on his 1972 post-India visit lecture tour of the US*. In the next section of this paper, I will speak in detail on Mosher's personal and professional relationship with Laing and Kingsley Hall. Back in the US, Mosher became the first director of the Centre for Schizophrenia Studies (1966–80) at the NIMH. He was dismissed from this post in 1980 for his strong stand against the overuse of medication and the NIMH's disregard for drug-free interventions to treat psychological disorders. In similar vein, with the cessation of NIMH funding had ceased, despite careful data collection methods and positive results, the Soteria (1971–1983) and Emanon (1974–1980) projects only remained open for 12 and 6 years respectively (Aderhold, 2009). Regarding the reasons Mosher gave for being forced out of his research position by the NIMH and, by extension, for the closure of both projects, I will offer a detailed account in the section on drug-free treatment of people with schizophrenia. For now, I will say that both projects were federally funded research demonstration projects that he developed between 1968 and 1980, namely, when he was director of the Schizophrenia Branch of the NIMH. Both projects sought as their main objective to investigate the effects of a supportive milieu therapy ("being with and doing with" – Mosher, 1996, p. 24) for individuals diagnosed with "schizophrenia", who were experiencing acute psychotic episodes for the first or second time in their lives. The basic tenet of "being with" consisted of an attentive but non-intrusive, gradual way of getting oneself "into the other person's shoe" so that a *shared meaningfulness* of the subjective aspects of the psychotic experience could be established within a confiding relationship. This required unconditional acceptance of the experience of others as valid and understandable

within the historical context of their life – even when it could not be consensually validated (Mosher & Bola, 2013, p. 365). As a result, in these programmes neuroleptics were either completely avoided or given in low dosages only (Aderhold, 2009, p. 328). Some years after both projects ended, in a lecture at the School of Social Work at the University of Maryland (Baltimore), Mosher (1996, p. 4) recounted how the Soteria project began: "So, in 1971, a 12-year long, interpersonal phenomenologic treatment studied with logical positivist scientific methods called the Soteria project began. Members of the audience with a philosophic bent will note the paradox inherent in the project from the outset" (underlining original). On the defunding of this and its sister project, Emanon, Mosher (1996, p. 17) noted in his characteristic sardonic tone: "Emanon closed in 1980, its research support finished. Soteria closed in 1983 after an 18-month funding hiatus. The project's house staff and research team split up. Conservatism ruled, and invitations became rare. Like many dissident Argentines the Soteria project became one of the 'disappeared' (Mosher, 1996, p. 19). In sum, these two houses closed because the NIMH withdrew research funding and the local public mental health system did not want to support 'experimental' public facilities with so few beds".

In spite of this, Mosher continued to work hard until the end of his life, passing away on 10 July 2004. At the time of his death, aged 70, Mosher was clinical professor of psychiatry at the University of California, San Diego. Among his many academic and professional achievements, he held professorships and headed mental health programmes on the US east and west coasts, and published more than 100 articles and reviews, along with several books. He also ran his own consulting company, Soteria Associates, aimed at providing mental health research and forensic consultation.

Mosher-Laing at the crossroads

As mentioned in the previous section, in 1966–67 Mosher did research training at the Tavistock Clinic, London (Redler, 2004). There he also visited the experimental community at Kingsley Hall, founded by Laing and his colleagues in the Philadelphia Association (PA), which offered an alternative to psychiatric treatment for people in extremes of mental suffering. As Mosher (1997a, p. 8) details, his relationship with Laing covered 25 years. They met in 1964, and those 1964 conversations with Laing, with their shared interest in families, phenomenology and existentialism, and their similar anti-authoritarianism and rejection of psychiatric hospitals, made Mosher decide to spend time with Laing as part of a year's fellowship in London. A significant factor in Mosher's decision, in my view, was the PA's guiding principle of permitting patients to go through the experience of psychosis without unduly pathologizing influences, that is, leaving them to express their emotions freely and not under the lens of whatever preconceived ideas on mental illness. Despite the many commonalities, Aderhold (2009, p. 329) comments that Mosher ultimately felt like an outsider at Kingsley Hall, and the institution seemed rather helpless in confronting the difficulties of its residents. As a result, his experience became a reference point for the subsequent development of the Soteria model in both positive and negative ways. As a positive influence, Mosher (1997a, pp. 11–12) recounts Laing's answer to why there were no rules at Kingsley Hall, that to have a proper social scene you must not introduce the structure from outside, but instead provide the physical structure and let people develop the rules appropriate to their needs. Laing also noted that if rules and policies were not superimposed from without, they would be much easier to change as needs changed. As a negative influence, Mosher speaks of Kingsley Hall's aversion to organized routines regarding the purchase and preparation of the residents' food in the name of "freedom to be oneself", which was, in Mosher's view, a mistake. At Soteria, Mosher says, a week's worth of food money was supplied at a time and staff and clients were expected to buy food regularly and prepare dinners together nightly. More eloquently, Mosher expressed his dissatisfaction during his visits to Kingsley Hall, declaring:

> Following our discussion, we adjourned upstairs for dinner (. . .). Upstairs, I felt for the first time the discomfort that would accompany in some degree all of my many visits to Kingsley Hall. Why? To begin with, I felt a stranger in this group, some of whom had lived together for as long as a year. As time passed, I came to know most of the people fairly well, yet I never relaxed in Kingsley Hall. The major barrier to inclusive relationships, I now believe, was an unspoken community rule against the ordinary social amenities. Introductions, handshaking, and get-acquainted small talk were virtually forbidden. Thus, I always felt like an outsider who had come to dinner in someone´s home where he was uncertain of genuine welcome. (Mosher et al., 2004, p. 294)

A more interesting interpretation of what was underlying Mosher's discomfort, however, in my view, is what I will label "prickly deception". In this respect, Mosher (Mosher et al., 2004, pp. 294–96) alludes to a set of changes that had taken place by the autumn of 1966. The first of these concerned the organization of Kingsley Hall. So, for instance, the meetings changed from problem-solving discussions among experts to a forum where Dr. Laing (now Ronnie) could present his views. No longer were "cases" discussed and advice sought. There was usually no formal agenda; meetings were called because a problem had arisen in the community, or to greet a visiting dignitary. Mosher was also critical of the primary functions of such a setting – allowing individuals sufficient time and space to, in Mosher's words, go on their own trips – to act either as though the surrounding society did not exist or was there only to be attacked. In a sense, Mosher (Mosher et al., 2004, p. 295) recalled, such a stance contradicted a cardinal taboo of Kingsley Hall – the attribution to, or the imposition of, one's views on others. Accordingly, the isolationist, anti-everything-out-there position Mosher perceived at Kingsley Hall, was, for him, unrealistic. In Mosher's view, the world "out there" could kill you, if you were unwilling to deal with it realistically (Mosher et al., 2004, p. 295). In sum, even though Kingsley Hall relied solely on altruism and friendship to generate interpersonal involvement, Mosher thought that the result was that unattractive residents spent large amounts of their time alone on their "trips". For this reason, although this solution could be fraught with its own problems, Mosher believed that a community governed by a number of salaried staff, whose job it was to be non-aggressively involved with spaced-out residents, would achieve better results than leaving the mad to their loneliness and misery.

If these were the feelings of Mosher on Laing and Kingsley Hall, we might also wonder what were those of Laing on Kingsley Hall, and by extension, Mosher and his project of creating Soteria. In this respect, in a memorable evening with the Laings, shortly after the birth on 24 June 1975 of Max (Laing's last child with his second wife, Jutta Werner), besides discussing the wonder of their children's birth and growth, Mosher described the Soteria project to Laing in some detail. Of the conversation Mosher (1997a, p. 12) notes: "Well trained in scientific methods, Laing grasped the importance of this study to his views of madness, seeing it as a contextually demanded attempt to evaluate scientifically his notions both about the possibility of growth from psychosis and about the destructive effects of anti-psychotic drugs. Later he [Laing] visited Soteria House and was always interested in the progress of the experiment". Further, Mosher (1997a, p. 13) affirms that "today, psychiatry, largely disregards what it should have learned from Kingsley Hall and its descendant Soteria. There are, however, some flickers of hope. Still Laing's responsibility for the development of what the NIMH is calling 'crisis residences'– really third generation Kingsley Halls – has never been explicitly acknowledged by mainstream mental health".

Nonetheless, when Laing was asked for his memories of Kingsley Hall in its early years (R. Mullan, 2017, p. 199) he admitted that he had not written about it for a number of reasons. One was that he still had not put it on his to-do list. The other was that, in Laing's view, it could be called a draw, in a way, as far as it went. Thus, the thing was still in progress. In spite of this, when Laing recounted his personal impressions of those years, he dedicated laudatory comments towards his colleague Mosher, saying:

> I think I withdrew into myself more in the late '70s, with a conviction that the side of this that I had seen as a possible example that other people could pick up was actually picked up by John Perry and in the West Coast by Loren Mosher with Soteria House. That was funded some time by the American National Institute of Mental Health, and there was of course Bethesda, and this or that initiative here and there. It wasn't going to break

> through the concrete of the existing state of affairs, especially with the new wave of biological psychiatry and propaganda that these guys were consistently putting out to discredit everything else except that. (R. Mullan, 2017, pp. 196–97)

Likewise, the influence of Laing on Mosher, in both the personal and professional spheres, is recognised by Mosher (1997a) in the commemorative volume edited by B. Mullan to pay homage to the deceased Laing. In this autobiographical text, from his first impressions on arrival in the UK and his time spent in the company of Laing and others, Mosher says in a tone full of emotion:

> The awakening that characterized my London experience was, I believe, a microcosm of Laing's contribution to contemporary culture. In the 1960s, he led a revolt against the hypocrisy and constricted consciousness of the silent generation. He energized, prodded and encouraged open questioning of anything, but especially everything we accepted unquestioningly. He hated ignorance, dishonesty, silliness and self-serving denial. Everything was up for discussion. (Mosher, 1997a, p. 10)

After these thoughts that for me invite reflection, I would like to end this section giving voice to Mosher on the lessons he learnt from Kingsley Hall:

> Kingsley Hall taught me the do's and don'ts of organizing the unique social environments at the heart of the Soteria project. The basic aim was to provide a safe, consistent, quiet, non-intrusive and accepting place that would provide an opportunity for the healing powers of time, open and honest human relationships and self-help to be fully tried without interference from mind-numbing chemicals. (Mosher, 1997a, p. 11)

Also it is worth noting here that the debt to Kingsley Hall is reflected in the change in title of the article Mosher co-authored with Bola, originally published as "Treatment of acute psychosis without neuroleptics: two-year outcomes from the Soteria Project" (Bola & Mosher, 2003), and re-issued as a book chapter two years later as "The Legacy of Kingsley Hall I: Treatment of acute psychosis without neuroleptics: two-year outcomes from the Soteria Project" (Bola & Mosher, 2005). The companion chapter, "The Legacy of Kingsley Hall II: The Soteria-concept. Theoretical bases and practical 13-year-experience with a milieu-therapeutic approach of acute schizophrenia" (Ciompi, 2005) honours the same debt, having originally been published in 1997 as "The Soteria-concept. Theoretical bases and practical 13-year-experience with a milieu-therapeutic approach of acute schizophrenia" (Ciompi, 1997).

Reflections on the Italian mental health reform

As I will expound in this section, Mosher knew of Law 180 (popularly known as "Basaglia's Law"), passed by the Italian Parliament on 13 May 1978 (Scheper-Hughes & Lovell, 1987), two years before Basaglia's death. In a work co-authored with Burti in the 1990s, Mosher eulogized the Law thus:

> What is notable and unique about the Italian psychiatric reform of 1978 is that a whole nation decided to do away with the state hospitals and has ever since demonstrated that it is possible to treat mental patients without resorting to these dinosaurs (Mosher & Burti, 1994, p. 182).

The main architect of this Law, as was widely known, was Franco Basaglia (1924–1980), whose work towards changing how psychiatry was practised Mosher and Burti characterized in this way:

> Basaglia's approach was also clearly sociological in orientation, nonmedical, and to some extent antipsychiatric. However, it differed substantially from English antipsychiatry and the American radical movement in that it was less radical in principle and more pragmatic and action-oriented. Basaglia and associates were especially critical of the American radical movement, whose extreme libertarianism, in their eyes, could actually result in abandoning patients, especially in the case of the nonconsenting ones. (Mosher & Burti, 1994, p. 183)

In fact, Mosher had already published a paper on this topic in the eighties. Its noteworthy title, *Italy's Revolutionary Mental Health Law: An Assessment* (Mosher, 1982), was indicative of the profound interest that the passage of the law had excited in him. In particular, Mosher called attention to several aspects of the law which differed from what usually then prevailed in the United States. In numerical order, these were: 1) Involuntary commitment did not use

dangerousness as a criterion for commitability; 2) Health and social welfare dollars were not distinguished; 3) The law's attention to community-based catchmented services was not unlike the community mental health center (CMHC) legislation in the US, except that the Italian law left greater latitude as to the kinds of services that could be developed. It specifically provided that no more than a maximum of 15 beds in Diagnosis and Treatment units in general hospitals could be established in each prescribed geographical area (*unita sanitaria locale)*, the basic catchment area for all health services, usually containing 100,000 to 120,000 people (Double, 2006). In short, among the inherent benefits of this Law were that it prevented new admissions to existing mental hospitals and decreed a shift of perspective from segregation and control in the asylum to treatment and rehabilitation in society (Balbuena Rivera, 2023).

With Law 180 in its early stages, Mosher undertook a 7-month observational study of its implementation from March to October 1980, culminating in his 1982 article assessing the impact of the law, the main objective of which was to give a considered response to the following questions (Mosher, 1982, p. 199): "How did this radical new law come to be? What were the forces operating to bring about passage of a law that would attempt to convert an early twentieth-century mental health system into a twenty-first-century one in the course of several years? Finally, how is it being implemented and what are the results?" Aware of the inherent difficulty in adequately answering these crucial questions, especially the first two, Mosher points to two factors which paved the way for the implementation of this radical law in Italy. In his opinion, one factor was Italy's system of government, which consisted of a large number of deputies from the Communist party, the Christian Democrats, who had been in power since 1946, and a number of smaller parties which wielded power by acting as "swing" parties in coalition governments. In similar fashion, another critical factor in the development of the new law was the widespread social-reform-oriented foment in Italy from 1968 onwards. In line with this, Mosher (1982, p. 200) recognizes that, even though Basaglia was an extraordinarily gifted clinician as well as an important leader and catalyst, without the Italian political system and the general social context of change, it was much less likely that his efforts would have been successful. Linked to this, as Foot (2014) observes, the law restructured mental health care and called for the closure of all psychiatry hospitals, a hard task, which undoubtedly required a deep change in mentality on the part of the psychiatric establishment as well as society. The clearest sign of the resistance to change was that the definitive closure would take at least 20 years to come into effect. Thus, giving voice to Mosher's ideas (Mosher, 1982, p. 200) again, psychiatry and politics were then inexorably, and *openly*, intertwined in Italy.

Mosher (1982, p. 200) came to the conclusion that Basaglia and his co-workers in Italian asylums had evolved a philosophy which included a set of interrelated beliefs: that psychiatry was politics, that psychiatry provided scientific support of the existing establishment, that scientific neutrality was a myth, and that existing standards of normality and deviance resulted in the oppression of certain groups in society. In response, their approach was thus largely nonmedical and anti-technological. In my view, these affirmations indicate a robust affinity between Basaglia and Mosher, the latter also including among his beliefs an opposition to the strong dependence of psychiatry on pharmaceutical companies.

Mosher (1982, p. 202) was also aware while writing his paper that the law had been in effect for only 2½ years, and each regional government had had to pass implementing legislation along the way, so that in some regions the law did not really come into effect until as late as September 1979. In fact, northern Italy was conforming to the law more rapidly than southern Italy.

In sum, during his 7 months of study in Italy it became clear to Mosher that the law was being phased in at varying speeds around the country. In this respect, he observes that, almost everyone he talked to was at least verbally committed to trying to conform. Even so, the more conservative psychiatrists were not happy with the rate at which hospital beds were being opened, and the more non-traditional psychiatrists were unhappy with the slow rate at which community-based services were being developed. In ending his article, he also noted that there was no wholesale turning out of

patients from the hospital into the community as was so often the case of deinstitutionalization in the United States (Mosher, 1982, p. 203).

Twelve years later, in the book Mosher co-authored with Burti, the two psychiatrists evaluated the effects of Law 180, affirming:

> In contrast to other countries with community psychiatry, where alternative services have simply been added to those already existing, including the mental hospital, Italy has developed a psychiatric system without the mental hospital, knowing that the adding of new services eventually recruits new patients but leaves the mental hospital unaffected. Interestingly enough, the law dictates that the new services are to be staffed with the existing mental health personnel, thus stressing again the principle of reallocating the resources in order to change the system. (Mosher & Burti, 1994, p. 186)

Following these considerations of Basaglia and the Italian mental health reform, it now seems the appropriate time to look at Mosher's approach to community mental health and to gauge the tenor of his ideas on effective community-based treatment which avoided overuse or misuse of a drug-oriented psychiatric praxis.

Drug-free treatment of people with schizophrenia

When in the 1970s Mosher ideated his project to create alternative therapeutic spaces in psychiatry for psychosis, psychosocial approaches to "schizophrenia" had largely been relegated to an adjunctive role by psychopharmacologic interventions (Mosher & Bola, 2013). As an exception to this rule, however, Mosher developed a model based on environmental-psychosocial principles. In this respect, it is important to note, as mentioned above, that Mosher did not reject medication *per se*, but wanted its use limited to only certain cases of acute psychosis. Further, it is worth remembering that Mosher retained a life-long scepticism vis-à-vis models of schizophrenia. At the heart of this distrust towards these models of understanding psychosis was that:

> Most psychiatrists who see schizophrenic patients these days have never encountered any free of neuroleptic drugs. Doctors view schizophrenics as "no-fault victims of brain disease" who need lifelong drug treatment, an approach that some of us view as merely transferring the former state hospital functions of maintenance, custody and social control to the community. (Mosher, 1997a, p. 13)

This biological reductionism in the understanding of schizophrenia also clashed with the Mosher's openly phenomenological view (Aderhold, 2009, p. 329), particularly since use of the term schizophrenia had not diminished the enigma of the phenomena. From this perspective, Mosher saw psychosis as a coping mechanism and a response to years of various events that were subjectively experienced as traumatic and led the person to retreat from reality. In consonance with this conception of psychosis, Mosher was instrumental in developing an innovative, non-drug, non-hospital, home-like, residential treatment facility for newly identified acutely psychotic persons (Redler, 2004). Thus, in his twelve-year study of alternatives to mental hospitalization, Mosher compared residential treatment in the community and minimal use of antipsychotic medication with "usual" hospital treatment for patients with early episode schizophrenia spectrum psychosis (Bola & Mosher, 2003). In doing so, his 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, could produce equivalent or better outcomes in treating newly diagnosed patients with schizophrenia compared with general hospital psychiatric ward treatment with antipsychotic medication (Mosher et al., 1995, p. 158). 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 per cent of the Soteria group had had continuous drug treatment compared with 98 per cent 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 two year follow-up, 42 per cent of Soteria patients had been drug free throughout, compared with 3 per cent of hospital treated patients. In sum, only 19 per cent of Soteria patients had received continuous drug treatment (Bola & Mosher, 2003). In spite of this, as Moncrieff explains, there were other problems. Of these and their implication for future research, she says:

> 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)

Emphasizing the merits more than demerits, the Soteria Project resulted in four major achievements (B. Mullan, 1999), that Mosher (1997b, p. 2) himself listed in these terms: 1. It dehospitalised madness, through taking care of patients/residents in a homelike setting in the community; 2. It demedicalised madness, through its focus on interpersonal help; 3. It deprofessionalised 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 the spring of 1984, a year after the closure of Soteria, the approach was replicated by Luc Ciompi, a former collaborator of Christian Müller (1921–2013) and colleagues, at Berne Psychiatric University Hospital. Bearing this in mind, in June 2023 I arranged a Skype meeting with Dr. Ciompi. He spoke warmly of the friendship that he and Mosher had enjoyed from 1977 until Mosher's death in 2004. In Ciompi's view, Mosher was "a very gentle, friendly, cordial, clever and communicative person", endowed with much humour and creativity, especially in inventing new forms of treatment and institutions for the mentally ill. Ciompi also felt that Mosher had displayed "dogmatic" extremism in his radical rejection of neuroleptics, and his accusations of corruption within the pharmaceutical industry. Mosher had also exercised significant influence on Ciompi by demonstrating with his Soteria San Francisco project that practical alternatives of dealing with acute psychosis were available. Ciompi himself set up a Soteria community in Berne in 1984 (which is still flourishing today). It is this "humanistic" (and phenomenologically influenced) approach that Ciompi felt to be Mosher's legacy for mainstream psychiatry (L. Ciompi, personal communication, 24 June, 2023).

Compared to Soteria California, Soteria-Berne uses more prophylactic medication maintenance during the reintegration phase, or restitution of the fragmented personality in a protected context (the second phase, preceded by the first, "acute crises", and followed by the third "orientation to the outside world"), and a more systematic approach in individual and family treatments (Aderhold, 2009, p. 337). As a result, the Soteria-Berne replication provides support for the idea that a well-organized social environment can significantly reduce the need to rapidly initiate antipsychotic treatment in earliest episodes of acute psychosis, resulting in comparable or better results with an important reduction in medication dependence and side effects (Mosher & Bola, 2013, p. 370). Maybe for this reason, Ciompi prefers low doses to drug-free treatment. So, in recent years, neuroleptics have been given within two or three weeks if symptoms persisted. Further, low dose maintenance neuroleptics are prescribed as a rule to prevent relapse, given that relapse rates were only moderately reduced at Soteria California (first cohort) and not at all in Soteria-Berne. In saying this, it should be noted that, in 1976, when Mosher left his role as principal investigator, Soteria used a quasi-experimental (consecutive admission) design in the first cohort (1971–76; $n = 79$) and an experimental design with random assignment in the second (1976–79; $n = 100$) (Mosher & Bola, 2013). Four years later, in 1983, however, Soteria closed. Mosher (1996, p. 17) claimed in retrospect, that he was forced out of his research position by the NIMH for adhering to the truth. The main reason for this decision was that "Soteria's NIMH funding overseers subjected the project to frequent,

microscopic review, and they did not scruple to meddle with the study's design". Thus, in Mosher's view, "Soteria was never able to obtain the stability of funding (5 years minimum) necessary to collect a modest set of data from a relatively slowly acquired set of research subjects who were to be followed for 2 years. In its 12-year life, the longest grant term awarded was for 3 years" (underlying original).

These difficult conditions, which Mosher labels as Soteria's marginalization, precipitated the following four results: 1. Acute, newly identified psychotics were not offered treatment in a comfortable home-like setting without neuroleptics. There were no such programs, so far as he [Mosher] knew, at that time in the United States; 2. The serious attention Soteria gave to understanding the meaningfulness of acute psychosis had been wasted and almost lost. With rare exceptions this psychologically powerful, often life-long self-defining aspect of human experience – "schizophrenia" – remained understood and misunderstood as a "disease"; 3. Neuroleptic drugs were overprescribed to repress the psychotic experience by those too frightened of it to deal with it directly (Mosher, 1996, p. 20). Persons who may actually have needed antipsychotic drugs temporarily were given them for longer and in higher doses than necessary. Important psychosocial/contextual factors in the precipitation and development of psychosis were avoided or denied. The fact that five percent per year of persons maintained on neuroleptics would develop Tardive Dyskinesia was accorded too little attention (Mosher, 1996, p. 19); and, finally, 4. Relationships and natural support systems – important cornerstones of long-term recovery – were generally viewed as having little relevance to the therapeutic process. Their initiation, development, and maintenance received little attention and thus, withdrawal from real interpersonal involvement with the most disturbed and disturbing persons was encouraged (Mosher, 1996, pp. 19–20). In spite of this, much to Mosher's surprise and those working alongside him, the Soteria environment proved to be as effective as antipsychotics for acute symptom reduction (Mosher & Bola, 2013). Such achievements, however, did not prevent Mosher from making his irrevocable decision at the end of 1998 to no longer form part of the APA. In the next section I will consider his motives for this decision and his reflections on it.

Criticisms of the APA: Mosher's open letter of resignation

Anyone in Mosher's position should have found it difficult to resign from the APA, a professional organization to which he had belonged for 35 years. In explaining his reasons for taking this decisive step, Mosher himself ironically alluded to his sincere conviction of belonging to the American Psychopharmacological Association, instead of the APA, sardonically noting that, luckily, the organization's true identity required no change in the acronym. He strongly felt that psychiatry had been almost completely bought out by the drug companies. In highly critical terms, he also accused the APA of maintaining its status and privileges through its servile behaviour towards the pharmaceutical companies, who, ultimately, paid for its meetings, grand rounds luncheons, trips to luxurious settings and so on. The power of these drug companies, he insisted, also extended to psychiatric training, where the most important part of a resident's curriculum was the art and quasi-science of dealing drugs, i.e. prescription writing (Mosher, 1998). Profoundly disappointed in this way of practicing psychiatry, he recognized that it was not within his capacities to buy into the current biomedical-reductionistic model heralded by the psychiatric leadership as once again marrying practitioners to somatic medicine. So, in his view, psychiatry provided a rationale in the form of neurobiological tunnel vision. This implied, paraphrasing Mosher, a partial understanding of the mentally ill as molecule conglomerates whom psychiatrists had come to define as patients. In working under these premises, psychiatrists kept their distance from patients, while simultaneously promoting the overuse and misuse of toxic chemicals with known and serious long-term effects. Thus, Mosher warns, the sole role of psychiatrists would be as prescription writers, or ciphers in the guise of being "helpers". In opposition to this, Mosher argued for a psychiatric praxis guided by an ethical and professional

responsibility that placed clinical judgement before potential conflicts of interests due to a toxic servitude to drugs companies and propaganda. Boldly, in Mosher's view, such a serious charge implied that psychiatrists carefully consider their role:

> Refusing to take drug company money would be a start. If that proves difficult, you will at least have learned just how dependent your department, journal or professional organization has become. We have to start somewhere to gain back control. (Mosher et al., 2013, p. 134)

In retrospect, all of us today might consider the disadvantages of Mosher's letter of resignation: Might his desire to change the system have been better served by remaining in the "tent" rather than casting himself as a bitter outsider? To this question, I respond with an unhesitating NO. Although presumably condemned to severe ostracism within mainstream psychiatry, Mosher opted for being faithful to himself and coherent with his psychiatric project.

Concluding remarks

In Pies' view, psychiatry as science and practice is slowly moving away from the so-called "biological revolution" of the 1990s to a more balanced and pluralistic model of illness and treatment. In this respect, he correctly observes that George L. Engel's (1913–1999) "biopsychosocial model" (Engel, 1977) has been – and remains – at the core of academic psychiatry, for at least the past 40 years, notwithstanding the market-driven forces that have greatly undermined its application (Pies, 2016, p. 60). Seeing this desolating panorama of the development of psychiatry, I believe that maybe now is the time that both models of understanding the illness, the biomedical model and the biopsychosocial model, come closer and consider uniting forces in a partial confluence of concepts and interests, albeit not without debate and controversy (Ghaemi, 2010). In this respect, I would add here what, in my view, is the subtle difference between both models, the biomedical and the biopsychosocial. So, while the former conceives of and treats mental illness as a purely biomedical condition, the latter, without negating the bodily processes, considers the value of psychic and social factors as facilitating and potentially generating behavioural-cognitive-emotional change. In practical terms, for me, considering three factors (the bio, psycho and social) instead of one (bio), provides a more detailed picture of the human condition. In connection with this controversy, tired of this futile struggle to see which of the two models might consolidate the power of psychiatry, Mosher sadly declared in his letter of resignation to the APA on 4 December 1998 that "no longer do we seek to understand whole persons in their social contexts" (Redler, 2004). In his criticism, Mosher accused psychiatrists of keeping their distance from patients, while promoting the overuse of toxic chemicals with known and serious long-term effects.

Mosher was clearly deeply sceptical of psychiatric practice as endorsed by the APA, which, he argued, reflected and reinforced, in word and deed, our drug-dependent society. In affirming the unlimited power and pressure of the pharmaceutical companies on the prescription of medication for mental illnesses, he became a serious critic of psychiatry. As a result, his work and critique of conventional psychiatric practice earned him little support in his profession, and even less from the pharmaceutical industry. In spite of this, Mosher believed that medicalization is not the only means of reverting and helping mental patients, but that other psychosocial approaches to mental illness should be considered and tried. Bearing this in mind, it seems very appropriate now to consider psychiatry as more than anything a science preoccupied by people and their problems with living, without new advances in biological psychiatry being left out. Neurobiological findings and the psychosocial aspects of mental illness can complement each other, thus giving a more complete picture of what madness is. Recent developments supporting this argument include advances in the neuroscience of the self (Schore, 2010), psychotherapy (Schore, 2010, 2022), attachment, and trauma (Lahousen et al., 2019). Consequently, I am convinced that there is reason to believe that "a third way" – neither purely biological, nor purely psychosocial – may evolve over the next few decades in the treatment of mental illnesses. What will happen remains to be seen in the years ahead.

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